

2009 Health Plan Comparison Chart

Benefits	BlueCross BlueShield Plan 1-877-691-5856 www.carefirst.com	EHP Classic 1-800-261-2393 • www.ehp.org		BlueChoice (HMO) 1-877-691-5856 www.carefirst.com	Kaiser Permanente (HMO) 1-800-777-7902 www.kaiserpermanente.org
		Option 1 (In-Network)	Option 2 (Out-of-Network)		
Annual deductible (does not apply to out-of-pocket maximum)	\$250 per person \$750 per family	None	\$250 per person \$750 per family	None	
Annual out-of-pocket maximum	\$1,500 per person \$4,500 per family	\$1,500 per person \$4,500 per family	\$3,000 per person \$9,000 per family	None	
Annual maximum benefit	None	Options 1 & 2 combined \$5,000,000 per calendar year	Options 1 & 2 combined \$5,000,000 per calendar year	None	
Dependent eligibility	Legally married spouse or same-sex domestic partner (if qualified for coverage under Johns Hopkins University Same-sex Domestic Partnership Benefits Policy) may be covered Unmarried dependent child(ren) may be covered up until their 25th birthday; coverage may continue for unmarried dependent child(ren) up to any age if they cannot support themselves because of a mental or physical disability that occurred before they reached the age limit when coverage would normally end				
Preventive Care					
Preventive care including physical exams and well baby	Routine annual adult physical and OB/GYN exam: 100% covered Well baby: 100% covered (through age 17)	Routine annual adult physical and OB/GYN exam: 100% covered Well baby: 100% covered (through age 17)	Routine annual adult physical and OB/GYN exam: 70% covered, after deductible Well baby: 70% covered (no deductible) (through age 17)	\$10 copay per visit	100% covered
Immunizations (adult) and mammograms	100% covered	100% covered	70% covered, after deductible	100% covered	
Physician Services					
Physician services (office visit)	80% covered, after deductible; 100% covered after deductible, if JHU network provider	80% covered	70% covered, after deductible	\$10 copay per visit \$20 specialist copay per visit	
Physician services (medical and surgical)	80% covered, after deductible; 100% covered after deductible, if JHU network provider	80% covered	70% covered, after deductible	Inpatient 100% covered; outpatient \$10 copay \$20 specialist copay	
Hospital Services					
Hospital copay per inpatient admission (not subject to deductible)	\$250 per inpatient admission	\$250 per inpatient admission	\$250 per inpatient admission	\$250 per inpatient admission	
Hospital service benefits (inpatient)	80% covered after \$250 hospital copay	80% covered, after \$250 hospital copay	70% covered, after \$250 hospital copay and deductible	100% covered after \$250 hospital copay	
Emergency care (sudden and serious and accidental injury)	Facility: \$75 copay (waived if admitted) Physician: 80% covered, after deductible	Facility: \$75 copay (waived if admitted) Physician: 80% covered	Facility: \$75 copay (waived if admitted) Physician: 70% covered, after deductible	\$75 copay per hospital visit (waived if admitted)	
Outpatient surgery	Facility: 100% covered Physician: 80% covered, after deductible	Facility: 100% covered Physician: 80% covered	Facility: 70% covered, after deductible Physician: 70% covered, after deductible	\$10 copay per visit \$20 specialist copay per visit	

This matrix summarizes the features of the medical benefits offered under the various plans. If there are any discrepancies between the content of this matrix and the Plan document, the document will govern.

2009 Health Plan Comparison Chart (continued)

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		Option 1 (In-Network)	Option 2 (Out-of-Network)		
Mental Health/Substance Abuse					
Mental and nervous (inpatient)	80% covered for 30 days, after deductible; 60% covered for 31 st day and beyond, but not subject to out-of-pocket maximum; \$250 inpatient copay	80% covered for 30 days; 60% covered for 31 st day and beyond but not subject to out-of-pocket maximum; \$250 inpatient copay	70% covered for 30 days after deductible; 50% covered for 31 st day and beyond but not subject to out-of-pocket maximum; \$250 inpatient copay	100% covered; subject to authorization from Magellan; \$250 copay	100% covered; partial hospitalization at \$20 per visit up to 60 days; \$250 copay
Mental and nervous (outpatient)	Visits 1-10 — 80% covered after deductible Visits 11-30 — 65% covered after deductible Visits 31-100 — 50% covered after deductible	Visits 1-10 — 80% covered Visits 11-30 — 65% covered Visits 31-100 — 50% covered (100 visits per calendar year combined Option 1 and Option 2)	50% covered, after deductible (100 visits per calendar year combined Option 1 and Option 2)	Visits 1-5 – 80% of allowable charges Visits 6-30 – 65% of allowable charges Visits 31(+) – 50% of allowable charges	\$20 per individual visit \$10 per group visit
Alcohol and drug addiction (inpatient)	Alcohol: 80% covered after deductible and \$250 copay; additional benefit of \$1,000 paid at 50% Drug Abuse: 80% covered after deductible and \$250 copay <i>See Chapter 3, "Medical Benefits," of the Health and Welfare Handbook for other limitations and maximums</i>	80% covered after \$250 copay <i>See Chapter 3, "Medical Benefits," of the Health and Welfare Handbook for other limitations and maximums</i>	70% of allowable charges covered after deductible and \$250 copay <i>See Chapter 3, "Medical Benefits," of the Health and Welfare Handbook for other limitations and maximums</i>	100% covered; partial hospitalization at \$10 per day for up to 60 days; \$250 inpatient copay	100% covered; partial hospitalization at \$20 per visit for up to 60 days; \$250 inpatient copay
Alcohol and drug addiction (outpatient)	Alcohol: 80% covered up to 30 visits after deductible Drug Abuse: 80% covered after deductible <i>See Chapter 3, "Medical Benefits," of the Health and Welfare Handbook for other limitations and maximums</i>	Must be pre-certified; 80% covered for 30 visits up to \$1,000; 50% covered for 31 st visit and beyond up to an additional \$1,000 <i>See Chapter 3, "Medical Benefits," of the Health and Welfare Handbook for other limitations and maximums</i>	Must be pre-certified; 70% of allowable charges covered for 30 visits after deductible up to \$1,000; 50% of allowable charges covered for 31 st visit and beyond up to additional \$1,000 <i>See Chapter 3, "Medical Benefits," of the Health and Welfare Handbook for other limitations and maximums</i>	Visits 1-5 – 80% of allowable charges Visits 6-30 – 65% of allowable charges Visits 31(+) – 50% of allowable charges (combined with outpatient mental or nervous)	\$20 per individual visit \$10 per group visit
Reproductive Health					
Pre- and post-natal care	80% covered, after deductible; 100% covered after deductible if JHU network provider	80% covered	70% covered, after deductible	\$20 specialist copay (not more than \$200 per pregnancy)	100% covered except \$10 copay to confirm pregnancy; \$20 specialist copay to confirm pregnancy
Family planning & fertility testing	Family planning not covered; fertility testing 80% covered after deductible, subject to review	Must be pre-certified; family planning not covered; fertility testing 80% covered	Must be pre-certified; family planning not covered; fertility testing 70% covered, after deductible	\$10 copay per visit \$20 specialist copay per visit	100% covered per visit; testing covered at 50%
Artificial insemination	An approved plan of treatment is required; benefits are limited to 6 attempts per live birth; 80% covered after deductible	Must be pre-certified; 80% covered, medical criteria must be met, unlimited attempts; \$100,000 lifetime maximum for all infertility treatments combined	Must be pre-certified; 70% of allowable charges covered, after deductible; medical criteria must be met; unlimited attempts; \$100,000 lifetime maximum for all infertility treatments combined	50% of allowable charges	50% of allowable charges
In vitro fertilization	An approved plan of treatment is required; benefits are limited to 3 attempts per live birth; 80% covered after deductible; \$100,000 lifetime maximum	Must be pre-certified for all services; 80% covered, medical criteria must be met; limited to 3 attempts per live birth; \$100,000 lifetime maximum for all infertility treatments combined	Must be pre-certified for all services; 70% of allowable charges covered, after deductible, medical criteria must be met; limited to 3 attempts per live birth; \$100,000 lifetime maximum for all infertility treatments combined	50% of allowable charges; \$100,000 lifetime maximum or 3 attempts per live birth	50% covered up to 3 attempts per live birth; \$100,000 lifetime maximum
Prescription Drugs (Administered by Medco Health Solutions for all plans except for Kaiser Permanente)					
Retail (up to a 30-day supply)	\$10 Generic \$20 Formulary brand \$35 Non-formulary brand	\$10 Generic \$20 Formulary brand \$35 Non-formulary brand		\$10 Generic \$20 Formulary brand \$35 Non-formulary brand	<i>Retail (up to 60-day supply)</i> <i>Kaiser pharmacy/Community pharmacy</i> \$10/\$20 Generic \$20/\$40 Formulary brand \$35/\$55 Non-formulary brand
Mail order	Up to a 90-day supply for maintenance drugs: \$20 Generic \$40 Formulary brand \$70 Non-formulary brand	Up to a 90-day supply for maintenance drugs: \$20 Generic \$40 Formulary brand \$70 Non-formulary brand		Up to a 90-day supply for maintenance drugs: \$20 Generic \$40 Formulary brand \$70 Non-formulary brand	Maintenance drug program (up to a 90-day supply for one copay) available