# 2010 Health Plan Comparison Chart

| Benefits | BlueCross BlueShield Plan<br>1-877-691-5856<br>www.carefirst.com | EHP Classic<br>1-800-261-2393 • www.ehp.org | | Kaiser Permanente<br>(HMO)<br>1-800-777-7902<br>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<br>$750 per family | None | $250 per person<br>$750 per family | None |
| Annual out-of-pocket maximum | $1,500 per person<br>$4,500 per family | $1,500 per person<br>$4,500 per family | $3,000 per person<br>$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<br>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<br>Well baby: 100% covered (through age 17) | Routine annual adult physical and OB/GYN exam: 100% covered<br>Well baby: 100% covered (through age 17) | Routine annual adult physical and OB/GYN exam: 70% covered (no deductible)<br>Well baby: 70% covered (no deductible) through age 17 | 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;<br>100% covered after deductible, if JHU network provider | 80% covered | 70% covered after deductible | $10 copay per visit<br>$20 specialist copay per visit |
| Physician services (medical and surgical) | 80% covered after deductible;<br>100% covered after deductible, if JHU network provider | 80% covered | 70% covered after deductible | Inpatient 100% covered;<br>outpatient $10 copay<br>$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 deductible and $250 hospital copay | 80% covered after $250 hospital copay | 70% covered after deductible and $250 hospital copay | 100% covered after $250 hospital copay |
| Emergency care (sudden and serious and accidental injury) | Facility: $75 copay (waived if admitted)<br>Physician: 80% covered after deductible | Facility: $75 copay (waived if admitted)<br>Physician: 80% covered | Facility: $75 copay (waived if admitted)<br>Physician: 70% covered after deductible | $75 copay per hospital visit (waived if admitted) |
| Outpatient surgery | Facility: 100% covered<br>Physician: 80% covered after deductible | Facility: 100% covered<br>Physician: 80% covered | Facility: 70% covered after deductible<br>Physician: 70% covered after deductible | $10 copay per visit<br>$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.

# 2010 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 after deductible and $250 hospital copay | 80% covered after $250 hospital copay | 70% covered after deductible and $250 hospital copay | 100% covered after $250 hospital copay; partial hospitalization at $20 per visit |
| Mental and nervous (outpatient) | 80% covered after deductible | 80% covered | 70% covered after deductible | $20 per individual visit; $10 per group visit |
| Alcohol and drug addiction (inpatient) | 80% covered after deductible and $250 hospital copay | 80% covered after $250 hospital copay | 70% of allowable charges covered after deductible and $250 hospital copay | 100% covered after $250 hospital copay; partial hospitalization at $20 per visit |
| Alcohol and drug addiction (outpatient) | 80% covered after deductible | 80% covered | 70% of allowable charges covered after deductible | $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 | 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 | 100% covered per visit;<br>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 |
| 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% 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<br>$20 Formulary brand<br>$35 Non-formulary brand | $10 Generic<br>$20 Formulary brand<br>$35 Non-formulary brand | | *Retail (up to 60-day supply)*<br>*Kaiser pharmacy/Community pharmacy*<br>$10/$20 Generic<br>$20/$40 Formulary brand<br>$35/$55 Non-formulary brand |
| Mail order | Up to a 90-day supply for maintenance drugs:<br>$20 Generic<br>$40 Formulary brand<br>$70 Non-formulary brand | Up to a 90-day supply for maintenance drugs:<br>$20 Generic<br>$40 Formulary brand<br>$70 Non-formulary brand | | Maintenance drug program (up to a 90-day supply for one copay) available |

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