Medical Plan Comparison

The chart below compares some coverage details in the medical plan options. For full coverage details, view the Summary Plan Description (SPD) for each plan at myBenefitsJHHS.com.

	Johns Hopkins EPO Plan		Johns Hopkins PPO Plan				Johns Hopkins DPC Plan				Kaiser HMO (Suburban Only)	
	In-network	**Out-of-network**	**In-network**			**Out-of-network**	**In-network**			**Out-of-network**	**In-network**	**Out-of-network**
Annual Deductible[1]	$500 per person $1,000 per family	Not covered	Determined by salary tier <$50K $150 per person $300 per family	$50K–$120K $200 per person $400 per family	>$120K $300 per person $600 per family	$750 per person $1,500 per family	Determined by salary tier <$50K $150 per person $300 per family	$50K–$120K $200 per person $400 per family	>$120K $300 per person $600 per family	$750 per person $1,500 per family	$0	Not covered
Annual Out-of-Pocket Maximum	$3,000 per person $6,000 per family	Not covered	Determined by salary tier <$50K $1,500 per person $3,000 per family	$50K–$120K $2,000 per person $4,000 per family	>$120K $3,000 per person $6,000 per family	$3,500 per person $7,000 per family	Determined by salary tier <$50K $1,500 per person $3,000 per family	$50K–$120K $2,000 per person $4,000 per family	>$120K $3,000 per person $6,000 per family	$3,500 per person $7,000 per family	$1,300 per person $2,600 per family	Not covered
Coinsurance[1] Applies after deductible	Preferred[2]: You pay 10% Cigna: You pay 20%	Not covered	Preferred[2]: You pay 10% Cigna: You pay 20%			You pay 30%	Preferred[2]: You pay 10% Cigna: You pay 20%			You pay 30%	None	Not covered
Primary Care Office Visit[1]	$20 copay	Not covered	$10 copay			You pay 30%	$0 copay for age 18+ with DPC provider $10 copay for non-DPC provider			You pay 30%	$15 copay	Not covered
Emergency Room	$250 copay[3]	Not covered	$250 copay[3]				$250 copay[3]				$100 copay	
Urgent Care	$40 copay	Not covered	$25 copay			You pay 30%	$25 copay			You pay 30%	$25 copay	Not covered

1. *The deductible, coinsurance and copay does not apply to All Children's Hospital physicians, providers or partner facilities for dependent children (excluding the emergency room). You'll pay nothing out of pocket.*
2. *Preferred physicians and providers are those in the Employer Health Programs (EHP) Preferred Provider Network. Visit* ehp.org/find-a-provider *and select* ***Search the EHP Network*** *to find preferred providers.*
3. *For select services such as hospitalization, coverage begins once you have met the deductible for the plan year.*

Prescription Drug

Prescription drug coverage is included with your medical plan. The costs in the chart below apply after the deductible, unless noted otherwise.

	Johns Hopkins EPO Plan		Johns Hopkins PPO Plan		Johns Hopkins DPC Plan		Kaiser HMO (Suburban Only)	
	30-day supply	**90-day supply**	**30-day supply**	**90-day supply**	**30-day supply**	**90-day supply**	**30-day supply**	**90-day supply**
Generic	$10 copay	$30 copay	$10 copay	Retail: $30 copay Mail order: $20 copay	$10 copay	Retail: $30 copay Mail order: $20 copay	$10 copay	$20 copay
Preferred	You pay 25%; min $40, max $60	You pay 25%; min $120, max $180	$40 copay	Retail: $120 copay Mail order: $80 copay	$40 copay	Retail: $120 copay Mail order: $80 copay	$30 copay	$60 copay
Brand[4] & Non-Preferred	You pay 50%; min $65, max $105	You pay 50%; min $195, max $315	$65 copay	Retail: $195 copay Mail order: $130 copay	$65 copay	Retail: $195 copay Mail order: $130 copay	$50 copay	$100 copay
Specialty	You pay 30%, or $0 if enrolled in PrudentRx	Not covered	You pay 30%, or $0 if enrolled in PrudentRx	Not covered	You pay 30%, or $0 if enrolled in PrudentRx	Not covered	Applicable copay for generic, preferred, brand & non-preferred	

4. *If you choose a brand name drug when there's a generic alternative, you'll also pay the cost difference between the two.*