

Medical PPO Plan Schedule of Benefits (Effective 01/01/2023)

Johns Hopkins Hospital/Johns Hopkins Health System Corporation



Medical Deductibles

	EHP Preferred Network Provider	EHP Network Provider	Out of Network Provider
Calendar Year Deductible			
Individual	\$150 (under \$50K) / \$200 (\$50K to \$119,999K) / \$300 (\$120K and over)	\$150 (under \$50K) / \$200 (\$50K to \$119,999K) / \$300 (\$120K and over)	\$750
Family	\$300 (under \$50K) / \$400 (\$50K to \$119,999K) / \$600 (\$120K and over)	\$300 (under \$50K) / \$400 (\$50K to \$119,999K) / \$600 (\$120K and over)	\$1500
Co-Insurance Out of Pocket			
Individual	\$1500 (under \$50K) / \$2000 (\$50K to \$119,999K) / \$3000 (\$120K and over)	\$1500 (under \$50K) / \$2000 (\$50K to \$119,999K) / \$3000 (\$120K and over)	\$3500
Family	\$3000 (under \$50K) / \$4000 (\$50K to \$119,999K) / \$6000 (\$120K and over)	\$3000 (under \$50K) / \$4000 (\$50K to \$119,999K) / \$6000 (\$120K and over)	\$7000
Lifetime Maximum			
Individual	Unlimited	Unlimited	Unlimited
Family	Unlimited	Unlimited	Unlimited

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September 28, 2022

Group Number

E00090, E00091, E00092, E00093, E00190, E00192, E00194, E00198

Plan Codes

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Medical Services and Supplies

	EHP Preferred Network Provider	EHP Network Provider	Out of Network Provider
Acupuncture			
Medically necessary services for anesthesia, pain control, and therapeutic purposes	90%, deductible applies (20 visit annual maximum for all networks combined)	80%, deductible applies (20 visit annual maximum for all networks combined)	70% of allowed benefit; deductible applies (20 visit annual maximum for all networks combined)
Allergy Tests & Procedures			
Allergy tests	90%, deductible applies	80%, deductible applies	70% of allowed benefit; deductible applies
Desensitization materials and serum	90%, deductible applies	80%, deductible applies	70% of allowed benefit; deductible applies
Ambulance Transportation			
Medically necessary ground transport	100%, deductible applies	100%, deductible applies	100% of allowed benefit; deductible applies
Medically necessary air transport	100%, deductible applies	100%, deductible applies	100% of allowed benefit; deductible applies
Biofeedback			
Biofeedback	90%, deductible applies (pre-authorization required)	80%, deductible applies (pre-authorization required)	70% of allowed benefit; deductible applies (pre-authorization required)
Chemo & Radiation Therapy			
Physician visit	90%, deductible applies	80%, deductible applies	70% of allowed benefit; deductible applies
Materials and treatment	90%, deductible applies	80%, deductible applies	70% of allowed benefit; deductible applies
Chiropractic Care			
Chiropractor restricted to initial exam, x-rays, and spinal manipulations	90%, deductible applies (20 visit annual maximum for all networks combined)	80%, deductible applies (20 visit annual maximum for all networks combined)	70% of allowed benefit; deductible applies (20 visit annual maximum for all networks combined)
Chiropractor with PT privileges (physical therapy services)	Refer to Therapy Section	Refer to Therapy Section	Refer to Therapy Section
Diabetes Prevention Program			
Program	100% of allowed amount; deductible waived	100% of allowed amount; deductible waived	70% of allowed benefit; deductible applies
Dialysis			
Medically necessary services	90% at Fresenius/Davita Dialysis Centers; deductible applies	80%, deductible applies	70% of allowed benefit; deductible applies
Durable Medical Equipment			
Breast pumps (standard) and related supplies	100% for Johns Hopkins Home Care Group/Pharmaquip; deductible waived	100%, deductible waived	70% of allowed benefit; deductible applies
Contraceptive devices	100%, deductible waived	100%, deductible waived	70% of allowed benefit; deductible applies
Custom DME, including custom wheelchairs	90%, deductible applies (pre-authorization required)	90%, deductible applies (pre-authorization required)	70% of allowed benefit; deductible applies (pre-authorization required)

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Custom-molded orthotics	90%, deductible applies (pre-authorization required)	80%, deductible applies (pre-authorization required)	70% of allowed benefit; deductible applies (pre-authorization required)
Insulin pumps, Continuous Glucose Monitor and related supplies	90%, deductible applies	90%, deductible applies	70% of allowed benefit; deductible applies
Hearing aids	90%, deductible applies (Covered only for dependent children under age 26; up to \$1,400 per aid; pre-authorization required; replacement aids once every 36 months all networks combined)	90%, deductible applies (Covered only for dependent children under age 26; up to \$1,400 per aid; pre-authorization required; replacement aids once every 36 months all networks combined)	70% of allowed benefit; deductible applies (Covered only for dependent children under age 26; up to \$1,400 per aid; pre-authorization required; replacement aids once every 36 months all networks combined)
Non-custom medical equipment and supplies	90% for Johns Hopkins Home Care Group/Pharmaquip, deductible applies	80%, deductible applies	70% of allowed benefit; deductible applies
Prosthetic devices	90%, deductible applies (pre-authorization required)	90%, deductible applies (pre-authorization required)	70% of allowed benefit; deductible applies (pre-authorization required)
Blood Pressure Cuff	90%, deductible waived	80%, deductible waived	70% of allowed benefit, deductible applies
Emergency Services			
Emergency care (facility fees)	\$250 co-pay, then 100%, deductible applies (if admitted, ER co-pay waived); see Inpatient Facility Care for coverage	\$250 co-pay, then 100%, deductible applies (if admitted, ER co-pay waived); see Inpatient Facility Care for coverage	\$250 co-pay, then 100% of allowed benefit; in-network deductible applies (if admitted, ER co-pay waived); see Inpatient Facility Care for coverage
Emergency care (professional fees)	100%, deductible applies	100%, deductible applies	100% of allowed benefit; in-network deductible applies
Home Health Services			
Medically necessary services	90%, deductible applies (40 visit annual maximum for all networks combined; pre-authorization required)	90%, deductible applies (40 visit annual maximum for all networks combined; pre-authorization required)	70% of allowed benefit; deductible applies (40 visit annual maximum for all networks combined; pre-authorization required)
Home infusion therapy	90% for services through Johns Hopkins Home Care Group, deductible applies (pre-authorization required)	80%, deductible applies (pre-authorization required)	70% of allowed benefit; deductible applies (pre-authorization required)
Hospice Care			
Inpatient and home hospice	100%, deductible applies (pre-authorization required)	100%, deductible applies (pre-authorization required)	70% of allowed benefit; deductible applies (pre-authorization required)
Hospital Care			
Inpatient care including newborn nursery care; NICU (facility fees)	\$150 co-pay per admission, then 90%, deductible applies (semi-private, unless private room is medically necessary; pre-authorization required)	\$150 co-pay per admission, then 80%, deductible applies (semi-private, unless private room is medically necessary; pre-authorization required)	\$500 co-pay per admission, then 70% of allowed benefit; deductible applies (semi-private, unless private room is medically necessary; pre-authorization required)
Inpatient care (professional fees)	90%, deductible applies	80%, deductible applies	70% of allowed benefit; deductible applies

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Skilled nursing/rehabilitation facility	90%, deductible applies (120 day annual maximum all networks combined for medically necessary services; pre-authorization required)	First 30 days annually covered at 90%, remaining days at 80%, deductible applies (120 day annual maximum all networks combined for medically necessary services; pre-authorization required)	70% of allowed benefit; deductible applies (120 day annual maximum all networks combined for medically necessary services; pre-authorization required)
Short-term acute rehabilitation	90%, deductible applies (120 day annual maximum all networks combined for medically necessary services; pre-authorization required)	First 30 days annually covered at 90%, remaining days at 80%, deductible applies (120 day annual maximum all networks combined for medically necessary services; pre-authorization required)	70% of allowed benefit; deductible applies (120 day annual maximum all networks combined for medically necessary services; pre-authorization required)
Observation care (facility fees)	\$250 co-pay, then 100%, deductible applies (if admitted, ER co-pay waived); see Inpatient Facility Care for coverage	\$250 co-pay, then 100%, deductible applies (if admitted, observation co-pay waived; see Inpatient Facility Care for coverage)	\$250 co-pay, then 100% of allowed benefit; deductible applies (if admitted, observation co-pay waived; see Inpatient Facility Care for coverage)
Observation care (professional fees)	100%, deductible applies	100%, deductible applies	100% of allowed benefit; deductible applies
Outpatient surgery & ambulatory surgical center (facility fees)	90%, deductible applies (includes freestanding surgical centers)	80%, deductible applies (includes freestanding surgical centers)	70% of allowed benefit; deductible applies
Outpatient surgery & ambulatory surgical center (professional fees)	90%, deductible applies	80%, deductible applies	70% of allowed benefit; deductible applies
Hyperbaric Oxygen Therapy			
Medically necessary services	90%, deductible applies (pre-authorization required)	80%, deductible applies (pre-authorization required)	70% of allowed benefit; deductible applies (pre-authorization required)
Immunizations			
Preventive immunizations for communicable diseases	100%, deductible waived	100%, deductible waived	70% of allowed benefit; deductible applies
Travel immunizations	100%, deductible waived	100%, deductible waived	70% of allowed benefit; deductible applies
Infusion Therapy			
Home infusion therapy	90% for services through Johns Hopkins Home Care Group, deductible applies (pre-authorization required)	80%, deductible applies (pre-authorization required)	70% of allowed benefit; deductible applies (pre-authorization required)
Outpatient infusion therapy	90%, deductible applies	80%, deductible applies	70% of allowed benefit; deductible applies
Injections			
Injections	90%, deductible applies	80%, deductible applies	70% of allowed benefit; deductible applies
Materials and serum	90%, deductible applies	80%, deductible applies	70% of allowed benefit; deductible applies

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Laboratory			
Laboratory tests including pathology	90%, deductible applies	80%, deductible applies	70% of allowed benefit; deductible applies
Mental Health & Substance Use Disorder Services			
Outpatient mental health care (facility fees)	\$10 co-pay, then 100%, deductible waived	\$10 co-pay, then 100%, deductible waived	70% of allowed benefit; deductible applies
Outpatient mental health care (professional fees)	\$10 co-pay, then 100%, deductible waived	\$10 co-pay, then 100%, deductible waived	70% of allowed benefit; deductible applies
Inpatient mental health care (facility fees)	\$150 co-pay per admission, then 90%, deductible applies (pre-authorization required)	\$150 co-pay per admission, then 80%, deductible applies (pre-authorization required)	\$500 co-pay per admission, then 70% of allowed benefit; deductible applies (pre-authorization required)
Inpatient mental health care (professional fees)	90%, deductible applies	80%, deductible applies	70% of allowed benefit; deductible applies
Outpatient substance use disorder care (facility fees)	\$10 co-pay, then 100%, deductible waived	\$10 co-pay, then 100%, deductible waived	70% of allowed benefit; deductible applies
Outpatient substance use disorder care (professional fees)	\$10 co-pay, then 100%, deductible waived	\$10 co-pay, then 100%, deductible waived	70% of allowed benefit; deductible applies
Inpatient substance use disorder care (facility fees)	\$150 co-pay per admission, then 90%, deductible applies (pre-authorization required)	\$150 co-pay per admission, then 80%, deductible applies (pre-authorization required)	\$500 co-pay per admission, then 70% of allowed benefit; deductible applies (pre-authorization required)
Inpatient substance use disorder care (professional fees)	90%, deductible applies	80%, deductible applies	70% of allowed benefit; deductible applies
Intensive outpatient program	\$10 co-pay per day, then 100%, deductible waived	\$10 co-pay per day, then 100%, deductible waived	70% of allowed benefit; deductible applies
Partial hospital facility services	\$10 co-pay per day, then 100%, deductible waived	\$10 co-pay per day, then 100%, deductible waived	70% of allowed benefit; deductible applies
Medication management	\$10 co-pay, then 100%, deductible waived	\$10 co-pay, then 100%, deductible waived	70% of allowed benefit; deductible applies
Mental health testing and procedures	\$10 co-pay, then 100%, deductible waived	\$10 co-pay, then 100%, deductible waived	70% of allowed benefit; deductible applies
Methadone Treatment			
Medically necessary outpatient care	\$10 co-pay, then 100%, deductible waived	\$10 co-pay, then 100%, deductible waived	70% of allowed benefit; deductible applies
Nutritional Counseling			
Medically necessary services	90%, deductible applies (limited to 6 visits per plan year for all networks combined)	80%, deductible applies (limited to 6 visits per plan year for all networks combined)	70% of allowed benefit; deductible applies (limited to 6 visits per plan year for all networks combined)
Office Visits for Treatment of Illness or Injury			
Primary care office visit only (Adult)	Designated PCP: \$10 co-pay; then 100%, deductible waived; Non-Designated Medical PCP: \$20 co-pay; then 100%, deductible waived	Designated Medical PCP: \$10 co-pay; then 100%, deductible waived; Non-Designated Medical PCP: \$20 co-pay; then 100%, deductible waived	70% of allowed benefit; deductible applies

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Primary care office visit (Pediatric: age 19 and under)	Designated Medical PCP: \$10 co-pay; then 100%, deductible waived; Non-Designated Medical PCP: \$20 co-pay, then 100%, deductible waived	Designated Medical PCP: \$10 co-pay; then 100%, deductible waived; Non-Designated Medical PCP: \$20 co-pay, then 100%, deductible waived	70% of allowed benefit; deductible applies
Primary care office visit only (GYN)	GYN PCPs: \$10 co-pay, then 100%, deductible waived	GYN PCPs: \$10 co-pay, then 100%, deductible waived	70% of allowed benefit; deductible applies
Specialty care office visit only (Adult & Pediatric)	90%, deductible applies	80%, deductible applies	70% of allowed benefit; deductible applies
Treatment and diagnostic services in the office	90%, deductible applies	80%, deductible applies	70% of allowed benefit; deductible applies
Preventive Services			
Preventive exam (PCP, GYN and Well Child care)	100%, deductible waived	100%, deductible waived	70% of allowed benefit; deductible applies
Diagnostic services for preventive exam	100%, deductible waived	100%, deductible waived	70% of allowed benefit; deductible applies
Routine preventive screenings: mammogram, colonoscopy, PAP test, etc.	100%, deductible waived	100%, deductible waived	70% of allowed benefit; deductible applies
Routine hearing exams	100%, deductible waived	100%, deductible waived	70% of allowed benefit; deductible applies
Private Duty Nursing			
Private Duty Nursing	Not Covered	Not Covered	Not Covered
Radiology Procedures			
All imaging studies including X-Ray, ultrasound, MRI, CT and PET scans	90%, deductible applies	80%, deductible applies	70% of allowed benefit; deductible applies
Reproductive Health			
Physician office visits (prenatal care only)	Routine prenatal visits covered at 100%; all other pre-natal visits at 90% of allowed amount; deductible applies	Routine prenatal visits covered at 100%; all other pre-natal visits at 80% of allowed amount; deductible applies	70% of allowed benefit; deductible applies
Infertility treatment	Covered at the Johns Hopkins Fertility Center and Shady Grove Fertility Center only: 90%, deductible applies, plus a separate \$1,000 lifetime infertility treatment deductible (pre-authorization required for all services and prescriptions; all criteria must be met; \$30,000 lifetime medical maximum (including lab work and x-rays) and a separate \$30,000 lifetime prescription maximum. In vitro fertilization attempts limited to a maximum of three per lifetime and artificial insemination limited to 6 attempts per live birth within the \$60,000 lifetime medical and prescription maximum.	Covered at the Johns Hopkins Fertility Center and Shady Grove Fertility Center only: 90%, deductible applies, plus a separate \$1,000 lifetime infertility treatment deductible (pre-authorization required for all services and prescriptions; all criteria must be met; \$30,000 lifetime medical maximum (including lab work and x-rays) and a separate \$30,000 lifetime prescription maximum. In vitro fertilization attempts limited to a maximum of three per lifetime and artificial insemination limited to 6 attempts per live birth within the \$60,000 lifetime medical and prescription maximum.	Covered at Johns Hopkins Fertility Center and Shady Grove Fertility Center only
Birth centers (facility fees)	Not available	90%, deductible applies	70% of allowed benefit; deductible applies

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Birthing centers (professional fees)	90%, deductible applies	80%, deductible applies	70% of allowed benefit; deductible applies
Inpatient maternity care and delivery; newborn nursery care; NICU (facility fees)	\$150 co-pay per admission, then 90%, deductible applies (pre-authorization required)	\$150 co-pay per admission, then 80%, deductible applies (pre-authorization required)	\$500 co-pay per admission, then 70% of allowed benefit; deductible applies (pre-authorization required)
Inpatient maternity care and delivery; newborn nursery care; NICU (professional fees)	90%, deductible applies	80%, deductible applies	70% of allowed benefit; deductible applies
Interruption of pregnancy	90%, deductible applies	80%, deductible applies	70% of allowed benefit; deductible applies
Female sterilization (professional services for surgery, anesthesia and related pathology)	100%, deductible waived	100%, deductible waived	70% of allowed benefit; deductible applies
Male sterilization (professional services for surgery, anesthesia and related pathology)	100%, deductible waived	100%, deductible waived	70% of allowed benefit; deductible applies
Surgical Procedures			
Surgical treatment for morbid obesity	Covered at Johns Hopkins Bayview Medical Center and Sibley Memorial Hospital only; \$150 facility co-pay, deductible applies; then 90% for professional fees; deductible applies (pre-authorization required)	Covered at Johns Hopkins Bayview Medical Center and Sibley Memorial Hospital only	Covered at Johns Hopkins Bayview Medical Center and Sibley Memorial Hospital only
Primary care office surgical procedures	90%, deductible applies	80%, deductible applies	70% of allowed benefit; deductible applies
Specialist care office surgical procedures	90%, deductible applies	80%, deductible applies	70% of allowed benefit; deductible applies
Outpatient surgery (including freestanding surgical centers) (facility fees)	90%, deductible applies	80%, deductible applies	70% of allowed benefit; deductible applies
Outpatient surgery (including freestanding surgical centers) (professional fees)	90%, deductible applies	80%, deductible applies	70% of allowed benefit; deductible applies
Inpatient surgery (facility fees)	\$150 co-pay per admission, then 90%, deductible applies (pre-authorization required)	\$150 co-pay per admission, then 80%, deductible applies (pre-authorization required)	\$500 co-pay per admission, then 70% of allowed benefit; deductible applies (pre-authorization required)
Inpatient surgery (professional fees)	90%, deductible applies	80%, deductible applies	70% of allowed benefit; deductible applies
Therapy			
Habilitative services for children under the age of 19	90%, deductible applies	80%, deductible applies	70% of allowed benefit; deductible applies (pre-authorization required)
Physical therapy/occupational therapy medically necessary services	90%, deductible applies (60 visit annual maximum for all networks combined; PT/OT pre-authorization required for visits 13-60)	80%, deductible applies (60 visit annual maximum for all networks combined; PT/OT pre-authorization required for visits 13-60)	70% of allowed benefit; deductible applies (60 visit annual maximum for all networks combined; PT/OT pre-authorization required for visits 13-60)

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Speech therapy (non-developmental medically necessary services)	90%, deductible applies (30 visit annual maximum for all networks combined; pre-authorization required)	80%, deductible applies (30 visit annual maximum for all networks combined; pre-authorization required)	70% of allowed benefit; deductible applies (30 visit annual maximum for all networks combined; pre-authorization required)
Pulmonary rehabilitation	90%, deductible applies (pre-authorization required)	80%, deductible applies (pre-authorization required)	70% of allowed benefit; deductible applies (pre-authorization required)
Cardiac rehabilitation	90%, deductible applies (pre-authorization required)	80%, deductible applies (pre-authorization required)	70% of allowed benefit; deductible applies (pre-authorization required)
Vision therapy	Not Covered	Not Covered	Not Covered
Urgent Care Center			
Physician visit	\$25 co-pay; then 100%, deductible waived	\$25 co-pay; then 100%, deductible waived	70% of allowed benefit; deductible applies
Diagnostic services and treatment	100%, deductible waived	100%, deductible waived	70% of allowed benefit; deductible applies

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