

2026 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		
Annual Deductible ¹	In-network	Out-of-network	In-network		Out-of-network
	\$500 per person \$1,000 per family	Not covered	Determined by salary tier		\$1,000 per person \$2,000 per family
			<\$50K \$150 per person \$300 per family	\$50K–\$120K \$300 per person \$600 per family	>\$120K \$400 per person \$800 per family
Annual Out-of-Pocket Maximum	\$3,000 per person \$6,000 per family	Not covered	Determined by salary tier		\$4,000 per person \$8,000 per family
			<\$50K \$1,500 per person \$3,000 per family	\$50K–\$120K \$2,500 per person \$5,000 per family	>\$120K \$3,500 per person \$7,000 per family
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%
Primary Care Office Visit ¹	\$20 copay	Not covered	\$10 copay		You pay 30%
Emergency Room	\$250 copay ³	Not covered	\$250 copay ³		
Urgent Care	\$40 copay	Not covered	\$25 copay		You pay 30%

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](#) 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	
Generic	30-day supply	90-day supply	30-day supply	90-day supply
	\$10 copay	\$30 copay	\$10 copay	Retail: \$30 copay Mail order: \$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
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
Specialty	You pay 30%, or \$0 if enrolled in PrudentRx	Not covered	You pay 30%, or \$0 if enrolled in PrudentRx	Not covered

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