J-1 SCHOLAR 2026 MEDICAL & PRESCRIPTION DRUG PLANS AT-A-GLANCE

	POINT OF SERVICE		PERSONAL CHOICE PPO - BASIC		PERSONAL CHOICE PPO - HIGH	
BENEFIT DESCRIPTION	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
IS A REFERRAL NEEDED TO SEE A SPECIALIST?	Yes		No		No	
EMPLOYER HEALTH SAVINGS ACCOUNT CONTRIBUTION	No		No		No	
INTERNATIONAL TRAVEL	BCBS Global Core Included. For more information on the services covered internationally, please call the service center at 1-800-810-2583		BCBS Global Core Included. For more information on the services covered internationally, please call the service center at 1-800-810-2583		BCBS Global Core Included. For more information on the services covered internationally, please call the service center at 1-800-810-2583	
DEDUCTIBLE (INDIVIDUAL/FAMILY)	$200 / $400	$600 / $1,200	$300 / $600	$1,000 / $2,000	None	$500 / $1,000
OUT-OF-POCKET MAXIMUM (INDIVIDUAL/FAMILY)	$3,000 / $6,000	$6,000 / $12,000	$2,000 / $4,000	$3,000 / $6,000	$2,000 / $4,000	$3,000 / $6,000
PREVENTIVE CARE SERVICES	No Charge	Plan pays 70%	No Charge	Plan pays 70%	No Charge	Plan pays 80%
PRIMARY CARE PHYSICIAN (PCP)	$20 copay	Plan pays 70%*	$20 copay	Plan pays 70%*	$15 copay	Plan pays 80%*
TELADOC**	No Charge	N/A	No Charge	N/A	No Charge	N/A
SPECIALIST OFFICE VISIT	$40 copay	Plan pays 70%*	$30 copay	Plan pays 70%*	$25 copay	Plan pays 80%*
OUTPATIENT SERVICES (SURGERY)	$50 copay	Plan pays 70%*	Plan pays 90%*	Plan pays 70%*	No Charge	Plan pays 80%*
INPATIENT SERVICES	$100/day copay; max of 5 copays/admission	Plan pays 70%*	Plan pays 90%*	Plan pays 70%*	No Charge	Plan pays 80%*
DIAGNOSTIC LABORATORY	$20 copay	Plan pays 70%*	No Charge	Plan pays 70%*	No Charge	Plan pays 80%*
DIAGNOSTIC X-RAY	$20 copay	Plan pays 70%*	Plan pays 90%*	Plan pays 70%*	No Charge	Plan pays 80%*
IMAGING (MRI, CT-SCAN)	$80 copay	Plan pays 70%*	Plan pays 90%*	Plan pays 70%*	No Charge	Plan pays 80%*
EMERGENCY ROOM	$250 copay	Covered at in-network level	$250 copay	Covered at in-network level	$250 copay	Covered at in-network level
URGENT CARE CENTER	$50 copay	Plan pays 70%*	$50 copay	Plan pays 70%*	$50 copay	Plan pays 80%*
OUTPATIENT SERVICES FOR MENTAL HEALTH/BEHAVIORAL/SUBSTANCE ABUSE	$20 copay	Plan pays 70%*	Plan pays 90%*	Plan pays 70%*	No Charge	Plan pays 80%*
PRESCRIPTION DRUG BENEFITS						
RETAIL PHARMACY (UP TO A 30-DAY SUPPLY)	Generic: $15 copay Preferred Brand: $35 copay Non-Preferred Brand: $55 copay Specialty: $75 copay	Plan pays 30%	Generic: $15 copay Preferred Brand: $35 copay Non-Preferred Brand: $55 copay Specialty: $75 copay	Plan pays 30%	Generic: $15 copay Preferred Brand: $35 copay Non-Preferred Brand: $55 copay Specialty: $75 copay	Plan pays 30%
MAIL ORDER (UP TO A 90-DAY SUPPLY)	Generic: $30 copay Preferred Brand: $70 copay Non-Preferred Brand: $110 copay Specialty; N/A	Not available	Generic: $30 copay Preferred Brand: $70 copay Non-Preferred Brand: $110 copay Specialty: N/A	Not available	Generic: $30 copay Preferred Brand: $70 copay Non-Preferred Brand: $110 copay Specialty: N/A	Not available

* The plan year deductible must be satisfied before the plan will pay for services.
** Includes Teledermatology and Telebehavioral health