

Disclaimer: Before enrolling, confirm that your doctor accepts the plan. Select "Check If Your Doctor Is In-Network" in the menu at left, or call your doctor's office to verify participation with the plan.

Plan quality ratings and enrollee survey results are calculated by the federal government, using data provided by health plans. The ratings are displayed for health plans for the current plan year.

- This screen shows the estimated maximum monthly premium cost your household would pay for each of the health plans listed below. These premium costs assume that all of the people in your household who are eligible for a Qualified Health Plan (QHP) enroll in a QHP. Monthly premiums are determined by the number of household members enrolled in the QHP each month. Therefore, your monthly premium may change if certain household members begin or end their coverage. You should report any changes to Maryland Health Connection.
- Once you have selected a QHP, you will be contacted by your health insurance carrier with additional information about your health insurance coverage, including how to pay your monthly premium bill. Payments should be made directly to the insurance company. Please note that your coverage is effective as long as you pay your monthly premium and you continue to qualify for the Qualified health plan. Your QHP must be renewed on an annual basis.
- The maximum amount of the tax credit you may apply towards the QHP premium depends on the monthly premium of the selected QHP. The tax credit amount you selected to apply towards the QHP premium will not exceed the monthly premium. Any tax credit amount that is not applied towards your QHP premium will be applied to your income tax return when you file your federal tax return.

	<b>BluePreferred PPO HSA Bronze \$6,550</b>	<b>BluePreferred PPO HSA Silver \$2,000</b>	<b>HealthyBlue PPO Gold \$1,000</b>
<b>Plan Overview</b>			
Estimated Monthly Premium	<b>\$876.70</b> Price after estimated \$0.00 tax credit.	<b>\$1032.99</b> Price after estimated tax credit.	<b>\$1236.08</b> Price after estimated tax credit.
Health Care Provider	<a href="#">Search Providers</a>	<a href="#">Search Providers</a>	<a href="#">Search Providers</a>
Plan Type	PPO	PPO	PPO
Plan Level	Bronze	Silver	Gold
Quality Rating			
Clinical Quality & Management			
Enrollee Experience			
Plan Efficiency Affordability & Management			
HSA Qualified	Yes	Yes	No

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<b>Cost Sharing Overview : Member Pays</b>			
Deductible	<u>Individual</u> In-Network: \$6550  <u>Family</u> In-Network: \$13100	<u>Individual</u> In-Network: \$2000  <u>Family</u> In-Network: \$4000	<u>Individual</u> In-Network: \$1000  <u>Family</u> In-Network: \$2000
Prescription Drug Deductible	<u>Individual</u> In-Network: Included in deductible Out-of-Network: Included in deductible  <u>Family</u> In-Network: Included in deductible.. Out-of-Network: Included in deductible.	<u>Individual</u> In-Network: Included in deductible Out-of-Network: Included in deductible  <u>Family</u> In-Network: Included in deductible. Out-of-Network: Included in deductible.	<u>Individual</u> In-Network: \$150 Out-of-Network:  <u>Family</u> In-Network: \$150 Per Person Out-of-Network:
Out-Of-Pocket Maximum	<u>Individual</u> In-Network: \$13100 Out-of-Network: \$13100  <u>Family</u> In-Network: \$26200 Out-of-Network: \$52400	<u>Individual</u> In-Network: \$6550 Out-of-Network: \$4000  <u>Family</u> In-Network: \$13100 Out-of-Network: \$26200	<u>Individual</u> In-Network: \$4500 Out-of-Network: \$2000  <u>Family</u> In-Network: \$9000 Out-of-Network: \$18000
Prescription Drug Out-Of-Pocket Maximum	<u>Individual</u> In-Network: Included in Out of Pocket Maximum Out-of-Network: Included in Out of Pocket Maximum  <u>Family</u> In-Network: Included in Out of Pocket Maximum. Out-of-Network: Included in Out of Pocket Maximum.	<u>Individual</u> In-Network: Included in Out of Pocket Maximum Out-of-Network: Included in Out of Pocket Maximum  <u>Family</u> In-Network: Included in Out of Pocket Maximum. Out-of-Network: Included in Out of Pocket Maximum.	<u>Individual</u> In-Network: Included in Out of Pocket Maximum Out-of-Network: Included in Out of Pocket Maximum  <u>Family</u> In-Network: Included in Out of Pocket Maximum. Out-of-Network: Included in Out of Pocket Maximum.
Primary Care Physician Copay	In-Network: No Charge after deductible  Out-of-Network: No Charge after deductible	In-Network: \$30 Copay after deductible  Out-of-Network: \$60 Copay after deductible	In-Network: No Charge  Out-of-Network: \$50 Copay after deductible
Specialist Copay	In-Network: No Charge after deductible  Out-of-Network: No Charge after deductible	In-Network: \$40 Copay after deductible  Out-of-Network: \$60 Copay after deductible	In-Network: \$30.00 Copay  Out-of-Network: \$50 Copay after deductible

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<b>Coverage Examples</b>			
Simple Fracture			
Having A Baby	\$5280	\$2998	\$1480
Managing Type 2 Diabetes	\$5210	\$1350	\$1070
<b>Physician Services : Member Pays</b>			
Preventive Care/ Screening/ Immunization	In-Network: No Charge  Out-of-Network: No Charge after deductible	In-Network: No Charge  Out-of-Network: No Charge after deductible	In-Network: No Charge  Out-of-Network: No Charge after deductible
Primary Care Visit to Treat an Injury or Illness	In-Network: No Charge after deductible  Out-of-Network: No Charge after deductible	In-Network: \$30 Copay after deductible  Out-of-Network: \$60 Copay after deductible	In-Network: No Charge  Out-of-Network: \$50 Copay after deductible
Specialist Visit	In-Network: No Charge after deductible  Out-of-Network: No Charge after deductible	In-Network: \$40 Copay after deductible  Out-of-Network: \$60 Copay after deductible	In-Network: \$30.00 Copay  Out-of-Network: \$50 Copay after deductible
Prenatal and Postnatal Care	In-Network: No Charge  Out-of-Network: No Charge after deductible	In-Network: No Charge  Out-of-Network: \$60 Copay after deductible	In-Network: No Charge  Out-of-Network: \$50 Copay after deductible
<b>Prescription Drugs - 1 Month Supply from a Participating Retail Pharmacy: Member Pays</b>			
Prescription Drugs	<p><u>Preferred Generic</u> In-Network: No Charge after deductible Out-of-Network: No Charge after deductible Limit:</p> <p><u>Preferred Brand</u> In-Network: No Charge after deductible Out-of-Network: No Charge after deductible Limit:</p> <p><u>Non-Preferred Brand</u> In-Network: No Charge after deductible Out-of-Network: No Charge after deductible Limit:</p>	<p><u>Preferred Generic</u> In-Network: \$10 Copay after deductible Out-of-Network: \$10 Copay after deductible Limit:</p> <p><u>Preferred Brand</u> In-Network: \$50 Copay after deductible Out-of-Network: \$50 Copay after deductible Limit:</p> <p><u>Non-Preferred Brand</u> In-Network: \$70 Copay after deductible Out-of-Network: \$70 Copay after deductible Limit:</p>	<p><u>Preferred Generic</u> In-Network: No Charge Out-of-Network: No Charge Limit:</p> <p><u>Preferred Brand</u> In-Network: \$50 Copay after deductible Out-of-Network: \$50 Copay after deductible Limit:</p> <p><u>Non-Preferred Brand</u> In-Network: \$70 Copay after deductible Out-of-Network: \$70 Copay after deductible Limit:</p> <p><u>Specialty</u></p>

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	<u>Specialty</u> In-Network: No Charge after deductible Out-of-Network: 100.00% Coinsurance Limit:	<u>Specialty</u> In-Network: \$150 Copay after deductible Out-of-Network: 100.00% Coinsurance Limit:	In-Network: \$150 Copay after deductible Out-of-Network: 100.00% Coinsurance Limit:
Prescription Drug (Formulary) Search	Search Prescription Drugs	Search Prescription Drugs	Search Prescription Drugs
<b>Urgent and Emergency Care: Member Pays</b>			
Urgent Care Centers or Facilities	In-Network: No Charge after deductible  Out-of-Network: No Charge after deductible	In-Network: \$60 Copay after deductible  Out-of-Network: \$60 Copay after deductible	In-Network: \$50.00 Copay  Out-of-Network: \$50.00 Copay
Emergency Room Services	In-Network: No Charge after deductible  Out-of-Network: No Charge after deductible	In-Network: 30% Coinsurance after deductible  Out-of-Network: 30% Coinsurance after deductible	In-Network: \$300 Copay after deductible  Out-of-Network: \$300 Copay after deductible
Emergency Transportation/ Ambulance	In-Network: No Charge after deductible  Out-of-Network: No Charge after deductible	In-Network: \$40 Copay after deductible  Out-of-Network: \$40 Copay after deductible	In-Network: \$30 Copay after deductible  Out-of-Network: \$30 Copay after deductible
<b>Hospital Services: Member Pays</b>			
Inpatient Hospital Services	In-Network: No Charge after deductible  Out-of-Network: No Charge after deductible	In-Network: 30% Coinsurance after deductible  Out-of-Network: 50% Coinsurance after deductible	In-Network: \$450 Copay per Day after deductible  Out-of-Network: \$550 Copay per Day after deductible
Inpatient Services for Maternity Care	In-Network: No Charge after deductible  Out-of-Network: No Charge after deductible	In-Network: 30% Coinsurance after deductible  Out-of-Network: 50% Coinsurance after deductible	In-Network: \$450.00 Copay after deductible  Out-of-Network: \$550.00 Copay after deductible
Skilled Nursing Facility	In-Network: No Charge after deductible  Out-of-Network: No Charge after deductible	In-Network: 30% Coinsurance after deductible  Out-of-Network: 50% Coinsurance after deductible	In-Network: \$75 Copay per Stay after deductible  Out-of-Network: \$150 Copay per Stay after deductible

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<b>Outpatient Services: Member Pays</b>			
Outpatient Facility	In-Network: No Charge after deductible  Out-of-Network: No Charge after deductible	In-Network: \$300 Copay after deductible  Out-of-Network: \$400 Copay after deductible	In-Network: \$300.00 Copay  Out-of-Network: \$400 Copay after deductible
Home Health Care Services	In-Network: No Charge after deductible  Out-of-Network: No Charge after deductible	In-Network: No Charge after deductible  Out-of-Network: \$60 Copay after deductible	In-Network: No Charge  Out-of-Network: \$50 Copay after deductible
Advanced Imaging	In-Network: No Charge after deductible  Out-of-Network: No Charge after deductible	In-Network: \$250 Copay after deductible  Out-of-Network: \$300 Copay after deductible	In-Network: \$250.00 Copay  Out-of-Network: \$300 Copay after deductible
X-rays and Diagnostic Imaging	In-Network: No Charge after deductible  Out-of-Network: No Charge after deductible	In-Network: \$55 Copay after deductible  Out-of-Network: \$105 Copay after deductible	In-Network: \$55.00 Copay  Out-of-Network: \$115 Copay after deductible
Laboratory Outpatient Services	In-Network: No Charge after deductible  Out-of-Network: No Charge after deductible	In-Network: \$25 Copay after deductible  Out-of-Network: \$75 Copay after deductible	In-Network: \$15.00 Copay  Out-of-Network: \$65 Copay after deductible
<b>Substance Abuse, Mental &amp; Behavioral Health: Member Pays</b>			
Mental & Behavioral Health Inpatient Service	In-Network: No Charge after deductible  Out-of-Network: No Charge after deductible	In-Network: 30% Coinsurance after deductible  Out-of-Network: 50% Coinsurance after deductible	In-Network: \$450 Copay per Day after deductible  Out-of-Network: \$550 Copay per Day after deductible
Mental & Behavioral Health Outpatient Service	In-Network: No Charge after deductible  Out-of-Network: No Charge after deductible	In-Network: \$30 Copay after deductible  Out-of-Network: \$60 Copay after deductible	In-Network: No Charge  Out-of-Network: \$50 Copay after deductible
Substance Use Disorder Inpatient Services	In-Network: No Charge after deductible  Out-of-Network: No Charge after deductible	In-Network: 30% Coinsurance after deductible  Out-of-Network: 50% Coinsurance after deductible	In-Network: \$450 Copay per Day after deductible  Out-of-Network: \$550 Copay per Day after deductible

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Substance Use Disorder Outpatient Services	In-Network: No Charge after deductible  Out-of-Network: No Charge after deductible	In-Network: \$30 Copay after deductible  Out-of-Network: \$60 Copay after deductible	In-Network: No Charge  Out-of-Network: \$50 Copay after deductible
<b>Habilitative and Rehabilitative Services: Member Pays</b>			
Habilitative Services and Outpatient Rehabilitation Services (Physical Therapy, Occupational Therapy, Speech Therapy)	In-Network: No Charge after deductible  Out-of-Network: No Charge after deductible  Limit: 30 Visit(s) per Benefit Period	In-Network: \$40 Copay after deductible  Out-of-Network: \$60 Copay after deductible  Limit: 30 Visit(s) per Benefit Period	In-Network: \$30.00 Copay  Out-of-Network: \$50 Copay after deductible  Limit: 30 Visit(s) per Benefit Period
Chiropractic Care	In-Network: No Charge after deductible  Out-of-Network: No Charge after deductible  Limit: 20 Visit(s) per Benefit Period	In-Network: \$40 Copay after deductible  Out-of-Network: \$60 Copay after deductible  Limit: 20 Visit(s) per Benefit Period	In-Network: \$30.00 Copay  Out-of-Network: \$50 Copay after deductible  Limit: 20 Visit(s) per Benefit Period
<b>Pediatric Care: Member Pays</b>			
Routine Eye Exam for Children	In-Network: No Charge  Out-of-Network: 100.00% Coinsurance  Limit: 1 Exam(s) per Benefit Period	In-Network: No Charge  Out-of-Network: 100.00% Coinsurance  Limit: 1 Exam(s) per Benefit Period	In-Network: No Charge  Out-of-Network: 100.00% Coinsurance  Limit: 1 Exam(s) per Benefit Period
Eye Glasses for Children	In-Network: No Charge  Out-of-Network: 100.00% Coinsurance  Limit: 1 Item(s) per Benefit Period	In-Network: No Charge  Out-of-Network: 100.00% Coinsurance  Limit: 1 Item(s) per Benefit Period	In-Network: No Charge  Out-of-Network: 100.00% Coinsurance  Limit: 1 Item(s) per Benefit Period
<b>Pediatric Dental Care</b>			
Basic Dental Care	In-Network: 20% Coinsurance after deductible Out-of-Network: 40% Coinsurance after deductible Limit:	In-Network: 20% Coinsurance after deductible Out-of-Network: 40% Coinsurance after deductible Limit:	In-Network: 20% Coinsurance after deductible Out-of-Network: 40% Coinsurance after deductible Limit:

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Major Dental Care	In-Network: 20% Coinsurance after deductible Out-of-Network: 40% Coinsurance after deductible Limit:	In-Network: 20% Coinsurance after deductible Out-of-Network: 40% Coinsurance after deductible Limit:	In-Network: 20% Coinsurance after deductible Out-of-Network: 40% Coinsurance after deductible Limit:
<b>Additional Information</b>			
Plan Costs and Benefits	Plan Costs and Benefits	Plan Costs and Benefits	Plan Costs and Benefits