Compare Health Plans

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.

	BluePreferred PPO HSA Bronze $6,550	**BluePreferred PPO Silver $3,500**	**HealthyBlue PPO Gold $1,000**
Plan Overview			
Estimated Monthly Premium	**$1348.47** Price after estimated $0.00 tax credit.	**$1542.14** Price after estimated tax credit.	**$1709.81** Price after estimated tax credit.
Health Care Provider	Search Providers	Search Providers	Search Providers
Plan Type	PPO	PPO	PPO
Plan Level	Bronze	Silver	Gold
Quality Rating	★★★½	★★★½	★★★½
Clinical Quality & Management	★★★★	★★★★	★★★★
Enrollee Experience	★★★★	★★★★	★★★★
Plan Efficiency Affordability & Management	★★	★★	★★
HSA Qualified	Yes	No	No

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Cost Sharing Overview : Member Pays			
Deductible	Individual In-Network: $6550 Family In-Network: $13100 Per Person	Individual In-Network: $3500 Family In-Network: $7000 Per Person	Individual In-Network: $1000 Family In-Network: $2000 Per Person
Prescription Drug Deductible	Individual In-Network: Included in deductible Out-of-Network: Included in deductible Family In-Network: Included in deductible.. Out-of-Network: Included in deductible.	Individual In-Network: $250 Out-of-Network: Family In-Network: $250 Per Person Out-of-Network:	Individual In-Network: $150 Out-of-Network: Family In-Network: $150 Per Person Out-of-Network:
Out-Of-Pocket Maximum	Individual In-Network: $6550 Out-of-Network: $13100 Family In-Network: $13000 Out-of-Network: $26200	Individual In-Network: $7350 Out-of-Network: $7000 Family In-Network: $14700 Out-of-Network: $29400	Individual In-Network: $6500 Out-of-Network: $2000 Family In-Network: $13000 Out-of-Network: $26000
Prescription Drug Out-Of-Pocket Maximum	Individual In-Network: Included in Out of Pocket Maximum Out-of-Network: Included in Out of Pocket Maximum Family In-Network: Included in Out of Pocket Maximum. Out-of-Network: Included in Out of Pocket Maximum.	Individual In-Network: Included in Out of Pocket Maximum Out-of-Network: Included in Out of Pocket Maximum Family In-Network: Included in Out of Pocket Maximum. Out-of-Network: Included in Out of Pocket Maximum.	Individual In-Network: Included in Out of Pocket Maximum Out-of-Network: Included in Out of Pocket Maximum Family 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: $30.00 Copay 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: $40.00 Copay Out-of-Network: $60 Copay after deductible	In-Network: $30.00 Copay Out-of-Network: $50 Copay after deductible

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Coverage Examples			
Simple Fracture	$1900	$1900	$1280
Having A Baby	$6560	$4630	$2000
Managing Type 2 Diabetes	$6550	$4020	$1873
Physician Services : Member Pays			
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: $30.00 Copay 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: $40.00 Copay 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
Prescription Drugs - 1 Month Supply from a Participating Retail Pharmacy: Member Pays			
Prescription Drugs	<u>Preferred Generic</u> In-Network: No Charge after deductible Out-of-Network: No Charge after deductible Limit: <u>Preferred Brand</u> In-Network: No Charge after deductible Out-of-Network: No Charge after deductible Limit: <u>Non-Preferred Brand</u> In-Network: No Charge after deductible Out-of-Network: No Charge after deductible Limit:	<u>Preferred Generic</u> In-Network: $10.00 Copay Out-of-Network: $10.00 Copay Limit: <u>Preferred Brand</u> In-Network: $50 Copay after deductible Out-of-Network: $50 Copay after deductible Limit: <u>Non-Preferred Brand</u> In-Network: $70 Copay after deductible Out-of-Network: $70 Copay after deductible Limit:	<u>Preferred Generic</u> In-Network: No Charge Out-of-Network: No Charge Limit: <u>Preferred Brand</u> In-Network: $50 Copay after deductible Out-of-Network: $50 Copay after deductible Limit: <u>Non-Preferred Brand</u> In-Network: $70 Copay after deductible Out-of-Network: $70 Copay after deductible Limit: <u>Specialty</u>

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	Specialty In-Network: No Charge after deductible Out-of-Network: 100.00% Coinsurance Limit:	Specialty In-Network: $100 Copay after deductible Out-of-Network: 100.00% Coinsurance Limit:	In-Network: $100 Copay after deductible Out-of-Network: 100.00% Coinsurance Limit:
Prescription Drug (Formulary) Search	Search Prescription Drugs	Search Prescription Drugs	Search Prescription Drugs
Urgent and Emergency Care: Member Pays			
Urgent Care Centers or Facilities	In-Network: No Charge after deductible Out-of-Network: No Charge after deductible	In-Network: $60.00 Copay Out-of-Network: $60.00 Copay	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: $300 Copay after deductible Out-of-Network: $300 Copay 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
Hospital Services: Member Pays			
Inpatient Hospital Services	In-Network: No Charge after deductible Out-of-Network: No Charge after deductible	In-Network: $500 Copay per Day after deductible Out-of-Network: $600 Copay per Day 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: $500 Copay after deductible Out-of-Network: $600 Copay after deductible	In-Network: $450 Copay after deductible Out-of-Network: $550 Copay after deductible
Skilled Nursing Facility	In-Network: No Charge after deductible Out-of-Network: No Charge after deductible	In-Network: $100 Copay per Stay after deductible Out-of-Network: $200 Copay per Stay after deductible	In-Network: $75 Copay per Stay after deductible Out-of-Network: $150 Copay per Stay after deductible

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Outpatient Services: Member Pays			
Outpatient Facility	In-Network: No Charge after deductible Out-of-Network: No Charge after deductible	In-Network: $300.00 Copay 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 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: $250.00 Copay 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: $55.00 Copay Out-of-Network: $105 Copay after deductible	In-Network: $65.00 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: $25.00 Copay Out-of-Network: $75 Copay after deductible	In-Network: $15.00 Copay Out-of-Network: $65 Copay after deductible
Substance Abuse, Mental & Behavioral Health: Member Pays			
Mental & Behavioral Health Inpatient Service	In-Network: No Charge after deductible Out-of-Network: No Charge after deductible	In-Network: $500 Copay per Day after deductible Out-of-Network: $600 Copay per Day 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: $30.00 Copay 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: $500 Copay per Day after deductible Out-of-Network:$600 Copay per Day 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: $30.00 Copay Out-of-Network: $60 Copay after deductible	In-Network: No Charge Out-of-Network: $50 Copay after deductible
Habilitative and Rehabilitative Services: Member Pays			
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: $40.00 Copay 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: $40.00 Copay 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
Pediatric Care: Member Pays			
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
Pediatric Dental Care			
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:
Additional Information			
Plan Costs and Benefits	Plan Costs and Benefits	Plan Costs and Benefits	Plan Costs and Benefits