

Maryland Health Insurance Medically Underwritten Product Comparison Chart Provided by TheInsuranceNet.com

Medically Underwritten	BlueChoice HMO Maryland	BlueChoice HMO District of Columbia	Personal Comp	BluePreferred Maryland		BluePreferred District of Columbia		BluePreferred Virginia	
				In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Product Description			Member Copay	Member Copay	Member Copay	Member Copay	Member Copay	Member Copay	Member Copay
Preventive Care									
Annual checkups/physicals (routine preventive care)	Copay	Copay	\$10	\$25 (no deductible)	Deductible + coinsurance	\$25 (no deductible)	Deductible + coinsurance	\$25 (no deductible)	Deductible + coinsurance
Physician's office visits (sick visits)	Copay	Copay	Deductible + coinsurance	\$25 (no deductible)	Deductible + coinsurance	\$25 (no deductible)	Deductible + coinsurance	\$25 (no deductible)	Deductible + coinsurance
Mammograms/ Pap Tests/ PSA's	Paid in full	Paid in full	\$10 (annual after age 40)	Paid in full	Paid in full (up to PA)*	Paid in full (no PSA covg)	Paid in full (up to PA)*	Paid in full	Paid in full (up to PA)*
Well-baby & child care 0-18	Copay	Copay	\$10	\$25 (no deductible)	Coinsurance	Paid in full	Paid in full (up to PA)*	Paid in full	Paid in full (up to PA)*
Family planning	Copay	Copay	Deductible + coinsurance						
In vitro fertilization	50% of Plan Allowance up to \$100,000 maximum	Not Covered	Deductible + coinsurance up to \$100,000 maximum	Deductible + coinsurance/covd with materniy rider	Deductible + coinsurance/covd with materniy rider	Not covered	Not covered	Not covered	Not covered
Artificial insemination	50% of Plan Allowance up to \$100,000 maximum	Not Covered	Deductible + coinsurance up to \$100,000 maximum	Deductible + coinsurance/covd with materniy rider	Deductible + coinsurance/covd with materniy rider	Not covered	Not covered	Not covered	Not covered
Health Education Svcs	Diabeties only-100%	Diabetics only-100%	Value-added svc	Diabetics only-\$25 no deductible	Diabetics only-deductibe + coinsurance	Diabetics only-\$25 no deductible	Diabetics only-deductibe + coinsurance	Diabetics only-\$25 no deductible	Diabetics only-deductibe + coinsurance
Allergy testing	Copay	Copay	Deductible + coinsurance	Deductible + Coinsurance	Deductible + Coinsurance	Deductible + Coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance
Allergy treatment	Copay	Copay	Deductible + coinsurance	\$5 (no deductible)	Deductible + coinsurance	\$5 (no deductible)	Deductible + coinsurance	\$5 (no deductible)	Deductible + coinsurance
Eye exam & hearing screenings Routine up to age 18	Copay	Copay	Covered when billed inclusive with well child visit	Covered when billed inclusive with well child visit	Covered when billed inclusive with well child visit	Covered when billed inclusive with well child visit	Covered when billed inclusive with well child visit	Covered when billed inclusive with well child visit	Covered when billed inclusive with well child visit
Gynecological Exam	Copay	Copay	\$10	\$25 (no deductible)	Deductible + coinsurance	\$25 (no deductible)	Deductible + coinsurance	\$25 (no deductible)	Deductible + Coinsurance
Second Surgical opinion	Copay	Copay	Paid in full	\$25 (no deductible)	Deductible + Coinsurance	\$25 (no deductible)	Deductible + Coinsurance	\$25 (no deductible)	Deductible + Coinsurance
Maternity									
Prenatal & postnatal care	Copay	Covered by endorsement only	Deductible + coinsurance	Covered by endorsement only	Covered by endorsement only	Covered by endorsement only-up to benefit max	Covered by endorsement only-up to benefit max	Covered by endorsement only	Covered by endorsement only
Hospital/facility	Copay	Covered by endorsement only	Deductible + coinsurance	Deductible + Coinsurance	Deductible + Coinsurance	Covered by endorsement only-up to benefit max	Covered by endorsement only-up to benefit max	Covered by endorsement only	Covered by endorsement only
Physician services	Paid in full	Covered by endorsement only	Deductible + coinsurance	Covered by endorsement only	Covered by endorsement only	Covered by endorsement only-up to benefit max	Covered by endorsement only-up to benefit max	Covered by endorsement only	Covered by endorsement only
Nursery care of newborn	Paid in full	Covered by endorsement only	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Covered by endorsement only-up to benefit max	Covered by endorsement only-up to benefit max	Covered by endorsement only	Covered by endorsement only

*PA- Plan Allowance

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Product Description			Member Copay	Member Copay	Member Copay	Member Copay	Member Copay	Member Copay	Member Copay
Inpatient Hospital Services									
Hospital (except maternity)	Copay	Copay	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance
Physicians Services	Paid in full	Paid in full	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance
Ancillary Services	Paid in full	Paid in full	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance
Rehabilitation Services	Paid in full	Paid in full	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance
Surgery	Paid in full	Paid in full	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance
Outpatient Medical & Surgical									
Diagnostic Lab Tests	Copay	Copay	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance
X-rays	Paid in full	Paid in full	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance
Therapeutic Radiology	Copay	Copay	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance
Chemotherapy	Copay	Copay	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance
Outpatient Rehabilitation	Copay	Copay	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance
Outpatient Surgery	Copay	Copay	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance
Outpatient Medical Physician Services	Copay	Copay	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance
Emergency Services									
Ambulance	Paid in full	Paid in full	Deductible + coinsurance	Deductible + coinsurance	Exempt provider*	Deductible + coinsurance	Exempt provider*	Deductible + coinsurance	Exempt provider*
Physicians Office	Copay	Copay	100% of first \$300 for deductibles \$1500 or less (no deductible applies)	\$25(no deductible)	Bona fide emergency processes in-network	\$25(no deductible)	Bona fide emergency processes in-network	\$25(no deductible)	Bona fide emergency processes in-network
Urgent Care facility	Copay	Copay	100% of first \$300 for deductibles \$1500 or less (no deductible applies)	\$25 (no deductible)	Bona fide emergency processes in-network	\$25 (no deductible)	Bona fide emergency processes in-network	\$25 (no deductible)	Bonafide emergency processes in-network
Emergency Room	\$50 (waived if admitted)	\$50 (waived if admitted)	100% of first \$300 for deductibles \$1500 or less (no deductible applies)	\$50 copay, deductible and coinsurance (copay waived if admitted)	Bona fide emergency processes in-network	\$50 copay, deductible and coinsurance (copay waived if admitted)	Bona fide emergency processes in-network	\$50 copay, deductible and coinsurance (copay waived if admitted)	Bonafide emergency processes in-network

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Product Description			Member Copay	Member Copay	Member Copay	Member Copay	Member Copay	Member Copay	Member Copay
Prescription Drugs									
	\$150, \$100 or \$50 Deductible; \$10 Generic, \$25 Formulary Brand, \$40 Brand copay Policy maximum \$500 low option \$1000 for medium or high option	\$150, \$100 or \$50 Deductible; \$10 Generic, \$25 Formulary Brand, \$40 Brand copay Policy maximum \$500 low option \$1000 for medium or high option	Deductible + coinsurance (\$500 maximum)	\$100 deductible, \$10 generic/\$25 Pref/\$45 non-Pref copayment \$1500 annual max	\$100 deductible, \$10 generic/\$25 Pref/\$45 non-Pref copayment \$1500 annual max	\$100 deductible, \$10 generic/\$25 Pref/\$45 non-Pref copayment \$1500 annual max	\$100 deductible, \$10 generic/\$25 Pref/\$45 non-Pref copayment \$1500 annual max	\$100 deductible, \$10 generic/\$25 Pref/\$45 non-Pref copayment \$1500 annual max	\$100 deductible, \$10 generic/\$25 Pref/\$45 non-Pref copayment \$1500 annual max
Dental									
	Available for additional \$	Available for additional \$	Available for additional \$	Not available	Not available	Not available	Not available	Not available	Not available
Durable Medical Equipment									
	50% of Plan's Allowance	50% of Plan's Allowance	Deductible + coinsurance up to	Deductible + coinsurance	Exempt Provider*	Deductible + coinsurance	Exempt Provider*	Deductible + coinsurance	Exempt Provider*
Mental Health									
Outpatient therapy	20% for visits 1-5; 35% for visits 6-30; 50% for visits 31 and above	25% for visits 1-40; 40% for visits 41 and above	Deductible + coinsurance visits 1-5; 35% visits 6-30; 50% visits 31 and above	Deductible plus percent coinsurance for schedule of visits	Deductible plus percent coinsurance for schedule of visits	Deductible + 25% visits 1-40; 40% visits 41+. Payments do not count towards policy out-of-pocket max	Deductible + 25% visits 1-40; 40% visits 41+. Payments do not count towards policy out-of-pocket max	Deductible + coinsurance for visits 1-5; 50% for visits 6-20. Payments do not count towards policy out-of-pocket max	Deductible + coinsurance for visits 1-5; 50% for visits 6-20. Payments do not count towards policy out-of-pocket max
Inpatient Care	Copay	Copay	365 days/yr; Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance. 45 day limit	Deductible + coinsurance. 45 day limit	Deductible + coinsurance. 25 day limit for under age 19; 20 day limit for 19 +	Deductible + coinsurance. 25 day limit for under age 19; 20 day limit for 19 +
Partial Hospitalization	Copay	Copay	60 days/yr deductible + coinsurance	\$25 (no deductible)	Deductible plus percentage; changes based on plan chosen	Deductible + coinsurance	Deductible + coinsurance	Deductible + coinsurance. 15 day limit	Deductible + coinsurance. 15 day limit

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Product Description			Member Copay	Member Copay	Member Copay	Member Copay	Member Copay	Member Copay	Member Copay
Alcohol & Substance Abuse									
Outpatient therapy	Combined with Mental Health benefits	Copay	Combined with Mental Health benefits	Combined with Mental Health benefits	Combined with Mental Health benefits	Deductible + coinsurance. Payments do not count towards policy out-of-pocket max. Limit 30 visits	Deductible + coinsurance. Payments do not count towards policy out-of-pocket max. Limit 30 visits	Combined with Mental Health benefits	Combined with Mental Health benefits
Inpatient care	Combined with Mental Health benefits	Copay	Combined with Mental Health benefits	Combined with Mental Health benefits	Combined with Mental Health benefits	Deductible + coinsurance. 30 day limit	Deductible + coinsurance. 30 day limit	Combined with Mental Health benefits	Combined with Mental Health benefits
Partial Hospitalization	Combined with Mental Health benefits	Copay	Combined with Mental Health benefits	Combined with Mental Health benefits	Combined with Mental Health benefits	Deductible + coinsurance	Deductible + coinsurance	Combined with Mental Health benefits	Combined with Mental Health benefits
Skilled Nursing Facility									
Bed/Board & Care	Paid in full; 60 day limit per calendar year	Paid in full; 60 day limit per calendar year	Not covered	Deductible + coinsurance; 60 day limit	Deductible + coinsurance; 60 day limit	Deductible + coinsurance; 60 day limit	Deductible + coinsurance; 60 day limit	Deductible + coinsurance; 60 day limit	Deductible + coinsurance; 60 day limit
Home Health Services									
	Copay	Copay	Deductible + coinsurance; 90 days per year	Deductible + coinsurance; 40-4 hour visit limit	Deductible + coinsurance; 40-4 hour visit limit	Deductible + coinsurance; 90-4 hour visit limit	Deductible + coinsurance; 90-4 hour visit limit	Deductible + coinsurance; 90-4 hour visit limit	Deductible + coinsurance; 90-4 hour visit limit
Hospice Services									
	Paid in full to policy maximum	Paid in full to policy maximum	Deductible + coinsurance - also covers drugs	Deductible + coinsurance; 180 hospice eligibility	Deductible + coinsurance; 180 hospice eligibility	Deductible + coinsurance; 180 hospice eligibility	Deductible + coinsurance; 180 hospice eligibility	Deductible + coinsurance; 180 hospice eligibility	Deductible + coinsurance; 180 hospice eligibility
Accupuncture									
	Not Covered See Carefirst Options	Not Covered See Carefirst Options	Deductible + coinsurance - 50 visits/yr	Not Covered See CareFirst Options	Not Covered See CareFirst Options	Not Covered See CareFirst Options	Not Covered See CareFirst Options	Not Covered See CareFirst Options	Not Covered See CareFirst Options
Chiropractic									
	Not Covered See Carefirst Options	Not Covered See Carefirst Options	Deductible + coinsurance - 50	Deductible + coinsurance	Exempt provider*	Deductible + coinsurance	Exempt provider*	Deductible + coinsurance	Exempt provider*
Waiting Period for Pre-ex									
	None	None	9 months	10 months	10 months	10 months	10 months	10 months	10 months
Policy Maximum									
	Unlimited	Unlimited	\$ 1 million	\$2 million	\$2 million	Unlimited	Unlimited	Unlimited	Unlimited

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