Maryland
DEPARTMENT OF BUDGET AND MANAGEMENT

Health Benefits

Together, we are working toward a **healthier community**.

CONTRACTUAL/VARIABLE HOUR EMPLOYEES
Subsidized Rates
Effective 01/01/2027 thru 12/31/2027
Rates for employees who work 30 hours per week or an average of 130 hours per month.

MEDICAL - EMPLOYEE MONTHLY PREMIUM RATES

Plan Name	Employee Only	Employee & Child or Employee & Spouse	Employee & Family
CAREFIRST BLUECROSS BLUESHIELD PPO	$178.54	$321.36	$446.36
UNITED HEALTHCARE PPO	$175.62	$316.14	$439.10
CAREFIRST BLUECROSS BLUESHIELD EPO	$158.88	$333.44	$413.08
UNITED HEALTHCARE EPO	$159.84	$332.42	$396.36
KAISER PERMANENTE EPO	$164.44	$345.12	$427.56

MEDICAL - EMPLOYEE PER PAY PERIOD PREMIUM RATES

Plan Name	Employee Only	Employee & Child or Employee & Spouse	Employee & Family
CAREFIRST BLUECROSS BLUESHIELD PPO	$82.40	$148.32	$206.01
UNITED HEALTHCARE PPO	$81.06	$145.91	$202.66
CAREFIRST BLUECROSS BLUESHIELD EPO	$73.33	$153.90	$190.65
UNITED HEALTHCARE EPO	$73.77	$153.42	$182.94
KAISER PERMANENTE EPO	$75.90	$159.29	$197.34

PRESCRIPTION DRUG - EMPLOYEE MONTHLY PREMIUM RATES

	Employee Only	Employee & Child	Employee & Spouse	Employee & Family
MedImpact	$90.94	$120.86	$150.92	$181.90

PRESCRIPTION DRUG - EMPLOYEE PER PAY PERIOD PREMIUM RATES

	Employee Only	Employee & Child	Employee & Spouse	Employee & Family
MedImpact	$41.97	$55.78	$69.66	$83.95

DENTAL - EMPLOYEE MONTHLY PREMIUM RATES

Plan Name	Employee Only	Employee & Child	Employee & Spouse	Employee & Family
DELTA DENTAL DHMO	$18.24	$36.56	$31.84	$51.32
UNITED CONCORDIA DPPO	$33.06	$63.08	$66.04	$123.68

DENTAL - EMPLOYEE PER PAY PERIOD PREMIUM RATES

Plan Name	Employee Only	Employee & Child	Employee & Spouse	Employee & Family
DELTA DENTAL DHMO	$8.42	$16.87	$14.70	$23.69
UNITED CONCORDIA DPPO	$15.26	$29.11	$30.48	$57.08

ENROLLMENT FORMS CAN BE FOUND ON OUR WEBSITE AT: www.dbm.maryland.gov/benefits

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CONTRACTUAL/VARIABLE HOUR EMPLOYEES
Non-Subsidized Rates
Effective 01/01/2027 thru 12/31/2027
Rates for employees who work under 30 hours per week or less than an average of 130 hours per month.

MEDICAL - EMPLOYEE MONTHLY PREMIUM RATES			
Plan Name	**Employee Only**	**Employee & Child or Employee & Spouse**	**Employee & Family**
CAREFIRST BLUECROSS BLUESHIELD PPO	$714.18	$1,285.46	$1,785.44
UNITED HEALTHCARE PPO	$702.50	$1,264.56	$1,756.38
CAREFIRST BLUECROSS BLUESHIELD EPO	$635.52	$1,333.78	$1,652.36
UNITED HEALTHCARE EPO	$639.38	$1,329.70	$1,585.48
KAISER PERMANENTE EPO	$657.82	$1,380.50	$1,710.26

MEDICAL - EMPLOYEE PER PAY PERIOD PREMIUM RATES			
Plan Name	**Employee Only**	**Employee & Child or Employee & Spouse**	**Employee & Family**
CAREFIRST BLUECROSS BLUESHIELD PPO	$329.62	$593.29	$824.05
UNITED HEALTHCARE PPO	$324.23	$583.64	$810.64
CAREFIRST BLUECROSS BLUESHIELD EPO	$293.32	$615.59	$762.63
UNITED HEALTHCARE EPO	$295.10	$613.71	$731.76
KAISER PERMANENTE EPO	$303.61	$637.15	$789.35

PRESCRIPTION DRUG - EMPLOYEE MONTHLY PREMIUM RATES				
	Employee Only	**Employee & Child**	**Employee & Spouse**	**Employee & Family**
MedImpact	$363.76	$483.44	$603.72	$727.58

PRESCRIPTION DRUG - EMPLOYEE PER PAY PERIOD PREMIUM RATES				
	Employee Only	**Employee & Child**	**Employee & Spouse**	**Employee & Family**
MedImpact	$167.89	$223.13	$278.64	$335.81

DENTAL - EMPLOYEE MONTHLY PREMIUM RATES				
Plan Name	**Employee Only**	**Employee & Child**	**Employee & Spouse**	**Employee & Family**
DELTA DENTAL DHMO	$18.24	$36.56	$31.84	$51.32
UNITED CONCORDIA DPPO	$33.06	$63.08	$66.04	$123.68

DENTAL - EMPLOYEE PER PAY PERIOD PREMIUM RATES				
Plan Name	**Employee Only**	**Employee & Child**	**Employee & Spouse**	**Employee & Family**
DELTA DENTAL DHMO	$8.42	$16.87	$14.70	$23.69
UNITED CONCORDIA DPPO	$15.26	$29.11	$30.48	$57.08

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ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE PREMIUM RATES		
Amount	**Individual Only**	**Family**
$100,000	$1.20	$2.30
$200,000	$2.40	$4.60
$300,000	$3.60	$6.90

TERM LIFE INSURANCE PREMIUM RATES			
Age of Employee/ Retiree	**Employee Retiree Rates (per $1,000)**	**Age of Spouse**	**Spouse Rates (per $1,000)**
Under 30	$0.03	Under 30	$0.09
30 to 34	$0.04	30 to 34	$0.10
35 to 39	$0.05	35 to 39	$0.12
40 to 44	$0.08	40 to 44	$0.18
45 to 49	$0.13	45 to 49	$0.28
50 to 54	$0.20	50 to 54	$0.42
55 to 59	$0.37	55 to 59	$0.65
60 to 64	$0.52	60 to 64	$1.00
65 to 69	$0.77	65 to 69	$1.45
70 to 74	$1.38	70 to 74	$2.28
75 to 79	$2.06	75 to 79	$2.28
80 and older	$2.06	80 and older	$2.28
Dependent Child Coverage is $0.14 per $1,000 per month.			

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