

2016 Individual Medical Bronze and Catastrophic Plans

Plan ID/ Form Schedue #	96751NH0150015	96751NH0150016	96751NH0150017	96751NH0150018	59025NH0330012	59025NH0330010	59025NH0340006	61163NH0330001	61163NH0350001	61163NH0250001	61163NH0310001	96751NH0150024	61163NH0370001
Issuer	Anthem Blue Cross and Blue Shield of New Hampshire	Anthem Blue Cross and Blue Shield of New Hampshire	Anthem Blue Cross and Blue Shield of New Hampshire	Anthem Blue Cross and Blue Shield of New Hampshire	Harvard Pilgrim Health Care of New England	Harvard Pilgrim Health Care of New England	Harvard Pilgrim Health Care of New England	Minuteman Health	Minuteman Health	Minuteman Health	Minuteman Health	Anthem Blue Cross and Blue Shield of New Hampshire	Minuteman Health
Plan Name	Anthem Bronze Pathway X Enhanced HMO 25 for HSA	Anthem Bronze Pathway X Enhanced HMO 0 for HSA	Anthem Bronze Pathway X Enhanced HMO 5400 20	Anthem Bronze Pathway X Enhanced HMO 5750 10	ElevateHealth Bronze HMO	Harvard Pilgrim ElevateHealth Bronze HSA HMO	New Hampshire Network Bronze HSA HMO	MyDoc HMO Bronze HSA 5800	MyDoc HMO Bronze 6300	MyDoc HMO Bronze Value 3750	MyDoc HMO Bronze Basic 4500	Anthem Catastrophic Pathway X Enhanced HMO 6850 0	MyDoc HMO Simple Care
Metal Level	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Catastrophic	Catastrophic
Product Type	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
Network Coverage	Pathway X Enhanced	Pathway X Enhanced	Pathway X Enhanced	Pathway X Enhanced	ElevateHealth	ElevateHealth	New Hampshire Network	HMO	HMO	HMO	HMO	Pathway X Enhanced	HMO
	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network
Deductible-Individual/Family	\$4500 per person \$9000 per group	\$5700 per person \$11400 per group	\$5400 per person \$10800 per group	\$5750 per person \$11500 per group	\$6600 per person \$13200 per group	\$6300 per person \$12600 per group	\$4500 per person \$9000 per group	\$5800 Individual \$6000 per person \$11600 per group	\$6300 per person \$12600 per group	\$3750 per person \$7500 per group	\$4500 per person \$9000 per group	\$6850 per person \$13700 per group	\$6850 per person \$13700 per group
Coinsurance	25%	0%	20%	10%	50%	0%	30%	20%	0%	0%	30%	0%	0%
Max Out of Pocket-Individual/Family	\$6550 per person \$13100 per group	\$6550 per person \$13100 per group	\$6850 per person \$13700 per group	\$6850 per person \$13700 per group	\$6850 per person \$13700 per group	\$6450 per person \$12900 per group	\$6450 per person \$12900 per group	\$6550 Individual \$6850 per person \$13100 per group	\$6850 per person \$13700 per group	\$6850 per person \$13700 per group	\$6850 per person \$13700 per group	\$6850 per person \$13700 per group	\$6850 per person \$13700 per group
Preventive Care	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
PCP Visits (not wellness)	25% Coinsurance after deductible	No Charge after deductible	\$35 Copay for first two visits thereafter 20% Coinsurance after deductible	\$40 Copay for first two visits thereafter 10% Coinsurance after deductible	\$30 Copay after deductible	No Charge after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	No Charge after deductible	\$30 Copay after deductible	\$50 Copay after deductible	\$40 Copay for first three vists Thereafter No Charge after deductible	\$35 Copay for first three visits Thereafter No Charge after deductible
Specialist Visits	25% Coinsurance after deductible	No Charge after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	\$90 Copay after deductible	No Charge after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	No Charge after deductible	\$50 Copay after deductible	30% Coinsurance after deductible	No Charge after deductible	No Charge after deductible
Urgent Care	\$50 Copay and 25% Coinsurance after deductible	\$50 Copay before deductible	\$50 Copay and 20% Coinsurance after deductible	\$50 Copay and 10% Coinsurance after deductible	\$90 Copay after deductible	No Charge after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	No Charge after deductible	\$30 Copay after deductible	\$50 Copay after deductible	No Charge after deductible	No Charge after deductible
Outpatient Facility/Surgical Center	25% Coinsurance after deductible	No Charge after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	50% Coinsurance after deductible	No Charge after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	No Charge after deductible	\$750 Copay after deductible	30% Coinsurance after deductible	No Charge after deductible	No Charge after deductible
Outpatient Physician' Surgical Center	25% Coinsurance after deductible	No Charge after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	50% Coinsurance after deductible	No Charge after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	No Charge after deductible	No Charge after deductible	30% Coinsurance after deductible	No Charge after deductible	No Charge after deductible
Emergency Room	\$500 Copay and 25% Coinsurance after deductible	\$500 Copay after deductible	\$500 Copay and 20% Coinsurance after deductible	\$200 Copd 10% Coinsurance ay after deductible	\$300 Copay after deductible	No Charge after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	No Charge after deductible	\$750 Copay after deductible	\$200 Copay and 30% Coinsurance after deductible	No Charge after deductible	No Charge after deductible
Inpatient Hospital Services	25% Coinsurance after deductible	\$500 Copay per Stay after deductible	\$500 Copay and 20% Coinsurance per Stay after deductible	\$500 Copay and 10% Coinsurance per Stay after deductible	50% Coinsurance after deductible	No Charge after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	No Charge after deductible	\$1000 Copay per Stay after deductible	30% Coinsurance after deductible	No Charge after deductible	No Charge after deductible
Generic Drug	25% Coinsurance after deductible	No Charge after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	\$15	25% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	\$30 Copay after deductible	\$30	\$30	No Charge after deductible	No Charge after deductible
Preferred Brand Drug	25% Coinsurance after deductible	No Charge after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	\$60	25% Coinsurance after deductible	30% Coinsurance after deductible	30% Coinsurance after deductible	\$60 Copay after deductible	\$60 Copay after deductible	\$60 Copay after deductible	No Charge after deductible	No Charge after deductible
Durable Medical Equipment	25% Coinsurance after deductible	No Charge after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	50% Coinsurance after deductible	No Charge after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	20% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	No Charge after deductible	No Charge after deductible
Chiropractic Care	25% Coinsurance after deductible	No Charge after deductible	\$35 Copay for first two visits thereafter 20% Coinsurance after deductible	\$35 Copay for first two visits thereafter 10% Coinsurance after deductible	\$30 Copay after deductible	No Charge after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	No Charge after deductible	\$30 Copay after deductible	\$50 Copay after deductible	No Charge after deductible	No Charge after deductible
Adult Dental	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Dental	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered