

2016 Individual Medical Platinum and Gold Plans

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|--|---------------------------------------|--|---|---|--|--|--|--------------------------------------|
| Plan ID/ Form Schedue # | 61163NH0010001 | 75841NH0090001 | 96751NH0150023 | 96751NH0330006 | 59025NH0330002 | 59025NH0330004 | 59025NH0340004 | 61163NH0030001 |
| Issuer | Minuteman Health | Ambetter from NH Healthy Families, offered by Celtic Insurance | 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 |
| Plan Name | MyDoc HMO Platinum | Ambetter Secure Care 1 (2016) with 3 Free PCP Visits | Anthem Gold Pathway X Enhanced HMO 1000 10 | Anthem Blue Cross and Blue Shield Gold DirectAccess, a Multi-State Plan | ElevateHealth Gold HMO | Harvard Pilgrim ElevateHealth Gold HSA HMO | Harvard Pilgrim New Hampshire Network HMO Gold | MyDoc HMO Gold Basic 1000 |
| Metal Level | Platinum | Gold | Gold | Gold | Gold | Gold | Gold | Gold |
| Product Type | HMO | EPO | HMO | HMO | HMO | HMO | HMO | HMO |
| Network Coverage | HMO | Granite State Health Plan | Pathway X Enhanced | Pathway X Enhanced | ElevateHealth | ElevateHealth | New Hampshire Network | HMO |
| | In-Network | In-Network | In-Network | In-Network | In-Network | In-Network | In-Network | In-Network |
| Deductible-Individual/Family | \$0 per person \$0 per group | \$1000 per person \$2000 per group | \$1000 per person \$2000 per group | \$1000 per person \$2000 per group | \$1250 per person \$2500 per group | \$1500 per person \$3000 per group | \$1000 per person \$2000 per group | \$1000 per person \$2000 per group |
| Coinsurance | 0% | 20% | 10% | 10% | 0% | 10% | 10% | 0% |
| Max Out of Pocket-Individual/Family | \$5000 per person \$10000 per group | \$6350 per person \$12700 per group | \$4050 per person \$8100 per group | \$4050 per person \$8100 per group | \$4750 per person \$9500 per group | \$3500 per person \$7000 per group | \$6850 per person \$13700 per group | \$3500 per person \$7000 per group |
| Preventive Care | No Charge | No Charge | No Charge | No Charge | No Charge | No Charge | No Charge | No Charge |
| PCP Visits (not wellness) | \$20 | 20% Coinsurance after deductible | \$30 | \$30 | \$20 | 10% Coinsurance after deductible | \$20 | \$30 |
| Specialist Visits | \$35 | 20% Coinsurance after deductible | 10% Coinsurance after deductible | 10% Coinsurance after deductible | \$60 | 10% Coinsurance after deductible | \$60 | 20% Coinsurance after deductible |
| Urgent Care | \$20 | 20% Coinsurance after deductible | \$50 Copay and 10% Coinsurance after deductible | \$50 Copay and 10% Coinsurance after deductible | \$60 | 10% Coinsurance after deductible | \$60 | 20% Coinsurance after deductible |
| Outpatient Facility/Surgical Center | 10% | 20% Coinsurance after deductible | 10% Coinsurance after deductible | 10% Coinsurance after deductible | No Charge after deductible | 10% Coinsurance after deductible | 10% Coinsurance after deductible | 20% Coinsurance after deductible |
| Outpatient Physician' Surgical Center | 10% | 20% Coinsurance after deductible | 10% Coinsurance after deductible | 10% Coinsurance after deductible | No Charge after deductible | 10% Coinsurance after deductible | 10% Coinsurance after deductible | 20% Coinsurance after deductible |
| Emergency Room | 10% | \$250 Copay after deductible | \$200 Copay and 10% Coinsurance after deductible | \$200 Copay and 10% Coinsurance after deductible | \$200 Copay after deductible | \$200 Copay after deductible | \$200 Copay after deductible | 20% Coinsurance after deductible |
| Inpatient Hospital Services | 10% | 20% Coinsurance after deductible | \$500 Copay per Stay before deductible and 10% Coinsurance after deductible | \$500 Copay per Stay before deductible and 10% Coinsurance after deductible | No Charge after deductible | 10% Coinsurance after deductible | 10% Coinsurance after deductible | 20% Coinsurance after deductible |
| Generic Drug | \$15 | \$10 | \$15 | \$15 | \$15 | \$15 Copay after deductible | \$15 | \$10 |
| Preferred Brand Drug | \$30 | \$25 Copay after deductible | \$40 | \$40 | \$50 | \$40 Copay after deductible | \$45 | 30% |
| Durable Medical Equipment | 20% | 20% Coinsurance after deductible | 10% Coinsurance after deductible | 10% Coinsurance after deductible | No Charge after deductible | 10% Coinsurance after deductible | 10% Coinsurance after deductible | 20% Coinsurance after deductible |
| Chiropractic Care | \$20 | 20% Coinsurance after deductible | \$30 | \$30 | \$20 | 10% Coinsurance after deductible | \$20 | \$30 |
| Adult Dental | Not Covered | Not Covered | Not Covered | Not Covered | Not Covered | Not Covered | Not Covered | Not Covered |
| Pediatric Dental | Not Covered | Not Covered | Not Covered | 40% Coinsurance after deductible | Not Covered | Not Covered | Not Covered | Not Covered |