2016 SHOP Medical Platinum and Gold Plans

Plan ID/ Form Schedue #	19304NH0100010		96751NH0160011	96751NH0160005	19304NH0100008		19304NH0100009		59025NH0320004	59025NH0300008	61163NH0360001
Issuer	Community Health Options		Anthem Blue Cross and Blue Shield of New Hampshire	Anthem Blue Cross and Blue Shield of New Hampshire	Community Health Options		Community Health Options		Harvard Pilgrim Health Care of New England	Harvard Pilgrim Health Care of New England	Minuteman Health
Plan Name	Community Premier		Anthem Gold Pathway X HMO 1500 10 3000 w HSA	Anthem Gold Pathway X HMO 1500 20 3000	Community Advantage		Community Prime		ElevateHealth HMO 2000	Best Buy Tiered Copayment HMO LP 2000	MyDoc HMO Gold Basic 1000
Metal Level	Platinum		Gold	Gold	Gold		Gold		Gold	Gold	Gold
Product Type	PPO		HMO	HMO	PPO		PPO		HMO	HMO	HMO
Network Coverage	New Hampshire Statewide Network		Pathway X	Pathway X	New Hampshire Statewide Network		New Hampshire Statewide Network		ElevateHealth	Full HMO	HMO
	In-Network	Out-of-Network	In-Network	In-Network	In-Network	Out-of-Netowrk	In-Network	Out-of-Netowrk	In-Network	In-Network	In-Network
Deductible-Individual/Family	$500 per person | $1000 per group	$2000 per person | $4000 per group	$1500 Individual $3000 per person | $3000 per group	$1500 per person | $3000 per group	$750 per person | $1500 per group	$2500 per person | $5000 per group	$1500 per person | $3000 per group	$3000 per person | $6000 per group	$2000 per person | $4000 per group	$2000 per person | $4000 per group	$1000 per person | $2000 per group
Coinsurance	10%	30%	10%	20%	20%	40%	30%	40%	10%	10%	0%
Max Out of Pocket-Individual/Family	$1250 per person | $2500 per group	$2500 per person | $5000 per group	$3000 Individual $6000 per person | $6000 per group	$3000 per person | $6000 per group	$4250 per person | $8500 per group	$8250 per person | $16500 per group	$3700 per person | $7400 per group	$7500 per person | $15000 per group	$3500 per person | $7000 per group	$3500 per person | $7000 per group	$3500 per person | $7000 per group
Preventive Care	No Charge	100% Coinsurance after deductible	No Charge	No Charge	No Charge	100% Coinsurance after deductible	No Charge	100% Coinsurance after deductible	No Charge	No Charge	No Charge
PCP Visits (not wellness)	$20	100% Coinsurance after deductible	10% Coinsurance after deductible	$20 Copay for first three visits Thereafter 20% Coinsurance after deductible	$25	100% Coinsurance after deductible	$20	100% Coinsurance after deductible	$20	$20	$30
Specialist Visits	$50	30% Coinsurance after deductible	10% Coinsurance after deductible	$20 Copay for first three visits Thereafter 20% Coinsurance after deductible	$75	40% Coinsurance after deductible	$75	40% Coinsurance after deductible	$40	$40	20% Coinsurance after deductible
Urgent Care	$50	30% Coinsurance after deductible	10% Coinsurance after deductible	20% Coinsurance after deductible	$75	40% Coinsurance after deductible	$75	40% Coinsurance after deductible	$40	$40	20% Coinsurance after deductible
Outpatient Facility/Surgical Center	10% Coinsurance after deductible	30% Coinsurance after deductible	10% Coinsurance after deductible	20% Coinsurance after deductible	20% Coinsurance after deductible	40% Coinsurance after deductible	30% Coinsurance after deductible	40% Coinsurance after deductible	$150	$150	20% Coinsurance after deductible
Outpatient Physician' Surgical Center	10% Coinsurance after deductible	30% Coinsurance after deductible	10% Coinsurance after deductible	20% Coinsurance after deductible	20% Coinsurance after deductible	40% Coinsurance after deductible	30% Coinsurance after deductible	40% Coinsurance after deductible	No Charge	No Charge	20% Coinsurance after deductible
Emergency Room	$250	$250	10% Coinsurance after deductible	20% Coinsurance after deductible	$500	$500	$500	$500	$250 Copay after deductible	$250 Copay after deductible	20% Coinsurance after deductible
Inpatient Hospital Services	10% Coinsurance after deductible	30% Coinsurance after deductible	10% Coinsurance after deductible	20% Coinsurance after deductible	20% Coinsurance after deductible	40% Coinsurance after deductible	30% Coinsurance after deductible	40% Coinsurance after deductible	10% Coinsurance after deductible	10% Coinsurance after deductible	20% Coinsurance after deductible
Generic Drug	$5	30% Coinsurance after deductible	10% Coinsurance after deductible	$15	$10	40% Coinsurance after deductible	$10	40% Coinsurance after deductible	$5	$5	$10
Preferred Brand Drug	$15	30% Coinsurance after deductible	10% Coinsurance after deductible	$40	$30	40% Coinsurance after deductible	$30	40% Coinsurance after deductible	30%	30%	30%
Durable Medical Equipment	10% Coinsurance after deductible	30% Coinsurance after deductible	10% Coinsurance after deductible	20% Coinsurance after deductible	20% Coinsurance after deductible	40% Coinsurance after deductible	30% Coinsurance after deductible	40% Coinsurance after deductible	20% Coinsurance after deductible	20% Coinsurance after deductible	20% Coinsurance after deductible
Chiropractic Care	10% Coinsurance after deductible	30% Coinsurance after deductible	10% Coinsurance after deductible	$20 Copay for first three visits Thereafter 20% Coinsurance after deductible	20% Coinsurance after deductible	40% Coinsurance after deductible	30% Coinsurance after deductible	40% Coinsurance after deductible	$20	$20	$30
Adult Dental	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Dental	50% Coinsurance after deductible	50% Coinsurance after deductible	Not Covered	Not Covered	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	Not Covered	Not Covered	Not Covered

Updated 10-27-2015