2017 Individual Plans

Plan ID / Form Schedule #	61163NH0010001	61163NH0390001	75841NH0090001	96751NH0150023	59025NH0330016	59025NH0340008	61163NH0030001	75841NH0090002
Insurance Company	Minuteman Health	Minuteman Health	Ambetter (offered by Celtic)	Anthem Health Plans of NH	Harvard Pilgrim of NE	Harvard Pilgrim of NE	Minuteman Health	Ambetter (offered by Celtic)
Plan Name	MyDoc HMO Platinum	MyDoc HMO Platinum Extra Value	Ambetter Secure Care 1 (2017) with 3 Free PCP Visits	Anthem Gold Pathway X Enhanced HMO 1000 10	ElevateHealth Gold HSA 1500	New Hampshire Network Gold 1000	MyDoc HMO Gold Basic 1000	Ambetter Balanced Care 8 (2017)
Metal Level	Platinum	Platinum	Gold	Gold	Gold	Gold	Gold	Silver
Plan Documents & Links	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs
Deductible-Individual/Family	$0 per person; $0 per family	$0 per person; $0 per family	$1000 per person; $2000 per family	$1000 per person; $3000 per family	$1500 per person; $3000 per family*	$1000 per person; $2000 per family	$1000 per person; $2000 per family	$3500 per person; $7000 per family
Max Out of Pocket-Individual/Family	$5000 per person; $10000 per family	$6000 per person; $12000 per family	$6350 per person; $12700 per family	$5000 per person; $10000 per family	$3500 per person; $7000 per family	$6850 per person; $13700 per family	$3500 per person; $7000 per family	$6500 per person; $13000 per family
PCP Visits	$20	$5	20% Coinsurance after deductible	$30	10% Coinsurance after deductible	$20	$30	$30
Specialist Visits	$35	$15	20% Coinsurance after deductible	10% Coinsurance after deductible	10% Coinsurance after deductible	$60	$45 Copay after deductible	$60
Urgent Care	$20	$5	20% Coinsurance after deductible	$50 Copay after deductible; 10% Coinsurance after deductible	10% Coinsurance after deductible	$60	$30	30% Coinsurance after deductible
Emergency Room	10%	$250	$250 Copay after deductible	$200 Copay after deductible; 10% Coinsurance after deductible	$200 Copay after deductible	$200 Copay after deductible	20% Coinsurance after deductible	$150 Copay after deductible
Generic Drug	$15	$5	$10	$15	$15 Copay after deductible	$15	$10	$25
Preferred Brand Drug	$30	$25	$25 Copay after deductible	$40	$40 Copay after deductible	$45	30%	$50

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***family deductible is aggregated, meaning an indvidual has to meet the family deductible instead of the per person deductible**

2017 Individual Plans

Plan ID / Form Schedule #	96751NH0150020	96751NH0150027	96751NH0150022	96751NH0150025	59025NH0330014	59025NH0330020	59025NH0340010	61163NH0290001
Insurance Company	Anthem Health Plans of NH	Anthem Health Plans of NH	Anthem Health Plans of NH	Anthem Health Plans of NH	Harvard Pilgrim of NE	Harvard Pilgrim of NE	Harvard Pilgrim of NE	Minuteman Health
Plan Name	Anthem Silver Pathway X Enhanced HMO 10 for HSA	Anthem Silver Pathway X Enhanced HMO 5300 25	Anthem Silver Pathway X Enhanced HMO 4000 0	Anthem Silver Pathway X Enhanced HMO 4200 0	ElevateHealth Silver 3500	ElevateHealth Silver HSA 3000	New Hampshire Network Silver 2500	MyDoc HMO Silver Care
Metal Level	Silver	Silver	Silver	Silver	Silver	Silver	Silver	Silver
Plan Documents & Links	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs
Deductible-Individual/Family	$3000 per person; $6000 per family	$5300 per person; $10600 per family	$4000 per person; $8000 per family	$4200 per person; $8400 per family	$3500 per person; $7000 per family	$3000 per person; $6000 per family	$2500 per person; $5000 per family	$3000 per person; $6000 per family
Max Out of Pocket-Individual/Family	$6550 per person; $13100 per family	$6750 per person; $13500 per family	$5700 per person; $11400 per family	$5900 per person; $11800 per family	$6850 per person; $13700 per family	$5000 per person; $10000 per family	$6850 per person; $13700 per family	$4750 per person; $9500 per family
PCP Visits	10% Coinsurance after deductible	$35	$40 Copay before deductible; No Charge after deductible	$40	$25	15% Coinsurance after deductible	$30	10% Coinsurance after deductible
Specialist Visits	10% Coinsurance after deductible	25% Coinsurance after deductible	No Charge after deductible	$40 Copay after deductible	$75	15% Coinsurance after deductible	$90	10% Coinsurance after deductible
Urgent Care	$50 Copay after deductible; 10% Coinsurance after deductible	$50 Copay after deductible	$50 Copay after deductible	$50 Copay after deductible	$75	15% Coinsurance after deductible	$90	10% Coinsurance after deductible
Emergency Room	$200 Copay after deductible; 10% Coinsurance after deductible	25% Coinsurance after deductible	$500 Copay after deductible	$500 Copay after deductible	$300 Copay after deductible	$300 Copay after deductible	$300 Copay after deductible	10% Coinsurance after deductible
Generic Drug	10% Coinsurance after deductible	$10	$20	$15	$20	$15 Copay after deductible	$20	No Charge after deductible
Preferred Brand Drug	10% Coinsurance after deductible	$40	$50	$50	$50	$50 Copay after deductible	$50	No Charge after deductible

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2017 Individual Plans

Plan ID / Form Schedule #	61163NH0270001	61163NH0450001	96751NH0150015	96751NH0150016	96751NH0150026	96751NH0150017	96751NH0150018	59025NH0330018
Insurance Company	Minuteman Health	Minuteman Health	Anthem Health Plans of NH	Anthem Health Plans of NH	Anthem Health Plans of NH	Anthem Health Plans of NH	Anthem Health Plans of NH	Harvard Pilgrim of NE
Plan Name	MyDoc HMO Silver Basic	MyDoc HMO Silver Assistance A	Anthem Bronze Pathway X Enhanced HMO 25 for HSA	Anthem Bronze Pathway X Enhanced HMO 0 for HSA	Anthem Bronze Pathway X Enhanced HMO 6350 40	Anthem Bronze Pathway X Enhanced HMO 5400 30	Anthem Bronze Pathway X Enhanced HMO 5750 10	ElevateHealth Bronze 5750
Metal Level	Silver	Silver	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze
Plan Documents & Links	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs
Deductible-Individual/Family	$2000 per person; $4000 per family	$3500 per person; $7000 per family	$5150 per person; $10300 per family	$6050 per person; $12100 per family	$6350 per person; $12700 per family	$5400 per person; $10800 per family	$5750 per person; $11500 per family	$5750 per person; $11500 per family
Max Out of Pocket-Individual/Family	$6000 per person; $12000 per family	$6850 per person; $13700 per family	$6550 per person; $13100 per family	$6550 per person; $13100 per family	$7150 per person; $14300 per family	$7150 per person; $14300 per family	$7150 per person; $14300 per family	$7000 per person; $14000 per family
PCP Visits	$30 Copay after deductible	$20	25% Coinsurance after deductible	$30 Copay after deductible	40% Coinsurance after deductible	$35 Copay before deductible; 30% Coinsurance after deductible	$40 Copay before deductible; 10% Coinsurance after deductible	$40
Specialist Visits	$50 Copay after deductible	$40	25% Coinsurance after deductible	$40 Copay after deductible	40% Coinsurance after deductible	30% Coinsurance after deductible	10% Coinsurance after deductible	$100
Urgent Care	$30 Copay after deductible	$20 Copay after deductible	$50 Copay after deductible; 25% Coinsurance after deductible	$50 Copay after deductible	40% Coinsurance after deductible	$50 Copay after deductible; 30% Coinsurance after deductible	$50 Copay after deductible; 10% Coinsurance after deductible	$100
Emergency Room	30% Coinsurance after deductible	$250 Copay after deductible	$500 Copay after deductible; 25% Coinsurance after deductible	$500 Copay after deductible	40% Coinsurance after deductible	$500 Copay after deductible; 30% Coinsurance after deductible	$200 Copay after deductible; 10% Coinsurance after deductible	$300 Copay after deductible
Generic Drug	$20	$30	25% Coinsurance after deductible	No Charge after deductible	25% Coinsurance after deductible	30% Coinsurance after deductible	10% Coinsurance after deductible	$20
Preferred Brand Drug	30%	$60	25% Coinsurance after deductible	No Charge after deductible	35% Coinsurance after deductible	30% Coinsurance after deductible	10% Coinsurance after deductible	20% Coinsurance after deductible

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2017 Individual Plans

Plan ID / Form Schedue #	59025NH0330022	59025NH0340012	61163NH0470001	61163NH0350001	61163NH0250001	61163NH0310001	96751NH0150024	61163NH0370001
Insurance Company	Harvard Pilgrim of NE	Harvard Pilgrim of NE	Minuteman Health	Minuteman Health	Minuteman Health	Minuteman Health	Anthem Health Plans of NH	Minuteman Health
Plan Name	ElevateHealth Bronze HSA 6300	New Hampshire Network Bronze HSA 5100	MyDoc HMO Bronze HSA 5800	MyDoc HMO Bronze 6300	MyDoc HMO Bronze Value	MyDoc HMO Bronze Basic 4500	Anthem Catastrophic Pathway X Enhanced HMO 7150 0	MyDoc HMO Simple Care
Metal Level	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Catastrophic	Catastrophic
Plan Documents & Links	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs
Deductible-Individual/Family	$6300 per person; $12600 per family	$5100 per person; $10100 per family	$5800 per person; $11600 per family	$6300 per person; $12600 per family	$4750 per person; $9500 per family	$4500 per person; $9000 per family	$7150 per person; $14300 per family	$7150 per person; $14300 per family
Max Out of Pocket-Individual/Family	$6450 per person; $12900 per family	$6550 per person; $13100 per family	$6550 per person; $13100 per family	$6850 per person; $13700 per family	$7150 per person; $14300 per family	$7150 per person; $14300 per family	$7150 per person; $14300 per family	$7150 per person; $14300 per family
PCP Visits	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 before deductible; No Charge after deductible	$35 Copay before deductible
Specialist Visits	No Charge after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	No Charge after deductible	$50 Copay after deductible	$80 Copay after deductible	No Charge after deductible	No Charge after deductible
Urgent Care	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
Emergency Room	No Charge after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	No Charge after deductible	$750 Copay after deductible	$200 Copay, 30% Coinsurance after deductible	No Charge after deductible	No Charge after deductible
Generic Drug	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	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

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