2017 SHOP Plans

Plan ID / Form Schedule #	96751NH0160011	96751NH0160005	59025NH0300058	61163NH0360001	96751NH0160010	96751NH0160006
Insurance Company	Anthem Health Plans of NH	Anthem Health Plans of NH	Harvard Pilgrim of NE	Minuteman Health	Anthem Health Plans of NH	Anthem Health Plans of NH
Plan Name	Anthem Gold Pathway X HMO 1500 10 3000 w HSA	Anthem Gold Pathway X HMO 1500 20 3000	Best Buy Gold HMO LP 2000	MyDoc HMO Gold Basic 1000	Anthem Silver Pathway X HMO 3000 0 6550 w HSA	Anthem Silver Pathway X HMO 3500 10 6000
Metal Level	Gold	Gold	Gold	Gold	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
Deductible- Individual/Family	$1500 per person; $3000 per family*	$1500 per person; $3000 per family	$2000 per person; $4000 per family	$1000 per person; $2000 per family	$3000 per person; $6000 per family	$3500 per person; $7000 per family
Max Out of Pocket- Individual/Family	$3000 per person; $6000 per family*	$3000 per person; $6000 per family	$3500 per person; $7000 per family	$3500 per person; $7000 per family	$6550 per person; $13100 per family	$6000 per person; $12000 per family
PCP Visits	10% Coinsurance after deductible	$20 Copay before deductible; 20% Coinsurance after deductible	$20	$30	No Charge after deductible	$35 Copay before deductible; 10% Coinsurance after deductible
Specialist Visits	10% Coinsurance after deductible	$20 Copay before deductible; 20% Coinsurance after deductible	$40	$45 Copay after deductible	No Charge after deductible	$35 Copay before deductible; 10% Coinsurance after deductible
Urgent Care	10% Coinsurance after deductible	20% Coinsurance after deductible	$40	$30	No Charge after deductible	10% Coinsurance after deductible
Emergency Room	10% Coinsurance after deductible	$300 Copay after deductible	$250 Copay after deductible	20% Coinsurance after deductible	No Charge after deductible	$300 Copay after deductible
Generic Drug	10% Coinsurance after deductible	$25	$5	$10	20% Coinsurance after deductible	$25
Preferred Brand Drug	10% Coinsurance after deductible	$50; 30%	30%	30%	20% Coinsurance after deductible	50; 30%

Plan details are contained in the plan documents linked on this plan compare, please consult these for full benefit explanations and limitations

***family deductible and max out of pocket is aggregated, meaning an indvidual has to meet the family limit instead of the per person limit**

2017 SHOP Plans

Plan ID / Form Schedue #	59025NH0320030	59025NH0320032	59025NH0320036	59025NH0300064	59025NH0300062	59025NH0300070
Insurance Company	Harvard Pilgrim of NE	Harvard Pilgrim of NE	Harvard Pilgrim of NE	Harvard Pilgrim of NE	Harvard Pilgrim of NE	Harvard Pilgrim of NE
Plan Name	ElevateHealth Silver HMO 4000	ElevateHealth Silver HMO 3000 with Rx Deductible	ElevateHealth Silver HSA HMO 3000	Best Buy Silver HMO LP 4000	Best Buy Silver HMO LP 3000 with Rx Deductible	Best Buy Silver HSA HMO 3000
Metal Level	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
Deductible-Individual/Family	$4000 per person; $8000 per family	$3000 per person; $6000 per family	$3000 per person; $6000 per family	$4000 per person; $8000 per family	$3000 per person; $6000 per family	$3000 per person; $6000 per family
Max Out of Pocket-Individual/Family	$6500 per person; $13000 per family	$5500 per person; $11000 per family	$6450 per person; $12900 per family	$6500 per person; $13000 per family	$6000 per person; $12000 per family	$6450 per person; $12900 per family
PCP Visits	$40	$40	No Charge after deductible	$40	$40	No Charge after deductible
Specialist Visits	$80	$80	No Charge after deductible	$80	$80	No Charge after deductible
Urgent Care	$80	$80	No Charge after deductible	$80	$80	No Charge after deductible
Emergency Room	$250 Copay after deductible	$250 Copay after deductible	No Charge after deductible	$250 Copay after deductible	$250 Copay after deductible	No Charge after deductible
Generic Drug	$5	$5 Copay after deductible	20% Coinsurance after deductible	$5	$5 Copay after deductible	20% Coinsurance after deductible
Preferred Brand Drug	30%	30% Coinsurance after deductible	20% Coinsurance after deductible	30%	30% Coinsurance after deductible	20% Coinsurance after deductible

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2017 SHOP Plans

Plan ID / Form Schedue #	61163NH1640001	96751NH0160012	96751NH0160008	59025NH0300072	61163NH1660001
Insurance Company	Minuteman Health	Anthem Health Plans of NH	Anthem Health Plans of NH	Harvard Pilgrim of NE	Minuteman Health
Plan Name	MyDoc HMO Silver HSA 3000	Anthem Bronze Pathway X HMO 5250 30 6550 w HSA	Anthem Bronze Pathway X HMO 6550 0 6550 w HSA	Best Buy Bronze HSA HMO 6250	MyDoc HMO Bronze HSA 6000
Metal Level	Silver	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
Deductible- Individual/Family	$3000 per person; $6000 per family	$5250 per person; $10500 per family	$6550 per person; $13100 per family	$6250 per person; $12500 per family	$6000 per person; $12000 per family
Max Out of Pocket- Individual/Family	$4750 per person; $9500 per family	$6550 per person; $13100 per family	$6550 per person; $13100 per family	$6450 per person; $12900 per family	$6450 per person; $12900 per family
PCP Visits	10% Coinsurance after deductible	30% Coinsurance after deductible	No Charge after deductible	25% Coinsurance after deductible	No Charge after deductible
Specialist Visits	10% Coinsurance after deductible	30% Coinsurance after deductible	No Charge after deductible	25% Coinsurance after deductible	No Charge after deductible
Urgent Care	10% Coinsurance after deductible	30% Coinsurance after deductible	No Charge after deductible	25% Coinsurance after deductible	No Charge after deductible
Emergency Room	10% Coinsurance after deductible	30% Coinsurance after deductible	No Charge after deductible	25% Coinsurance after deductible	No Charge after deductible
Generic Drug	No Charge after deductible	30% Coinsurance after deductible	No Charge after deductible	25% Coinsurance after deductible	No Charge after deductible
Preferred Brand Drug	No Charge after deductible	30% Coinsurance after deductible	No Charge after deductible	25% Coinsurance after deductible	30% Coinsurance after deductible

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