

2015 Individual Medical Bronze and Catastrophic Plans (p. 1 of 2)

Plan ID/ Form Schedue #	96751NH0150015	96751NH0150016	96751NH0150017	96751NH0150018	59025NH0280001	59025NH0260003	19304NH0020001		19304NH0030001		19304NH0050001		61163NH0330001
Issuer	Anthem	Anthem	Anthem	Anthem	Harvard Pilgrim	Harvard Pilgrim	Maine CHO		Maine CHO		Maine CHO		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 4400 20	Anthem Bronze Pathway X Enhanced HMO 5750 10	Harvard Pilgrim NH Network Bronze HSA HMO	Harvard Pilgrim ElevateHealth Bronze HMO	Community Option HSA		Community Option		Community Option Plus		MyDoc HMO Bronze HSA 5800
Metal Level	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze		Bronze		Bronze		Bronze
Product Type	HMO	HMO	HMO	HMO	HMO	HMO	PPO		PPO		PPO		HMO
Network Coverage	NHN002	NHN002	NHN002	NHN002	NHN003	NHN002	NHN001		NHN001		NHN001		NHN001
							In-Network	Out-Of-Network	In-Network	Out-Of-Network	In-Network	Out-Of-Network	
Deductible-Individual/Family	\$3600 / \$7200	\$5500 / \$11000	\$4400 / \$8800	\$5750 / \$11500	\$4000 / \$8000	\$6000 / \$12000	\$5000 / \$10000	\$7500 / \$15000	\$5000 / \$10000	\$7500 / \$15000	\$5000 / \$10000	\$7500 / \$15000	\$5800 / \$11600
Coinsurance	25%	0%	20%	10%	25%	20%	50%	60%	50%	60%	50%	60%	10%
Max Out of Pocket-Individual/Family	\$6450 / \$12900	\$6450 / \$12900	\$6600 / \$13200	\$6600 / \$13200	\$6450 / \$12900	\$6500 / \$13000	\$6450 / \$12900	\$12500 / \$25000	\$6600 / \$13200	\$12500 / \$25000	\$6600 / \$13200	\$12500 / \$25000	\$6450 / \$12900
Preventive Care	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	Not Covered	No Charge	Not Covered	No Charge	Not Covered	No Charge
PCP Visits (not wellness)	25% Coinsurance after deductible	No Coinsurance after deductible	\$35 for first 2 visits, thereafter 20% Coinsurance after deductible	\$40 for first 2 visits, thereafter 10% Coinsurance after deductible	25% Coinsurance after deductible	\$40	10% Coinsurance after deductible	Not Covered	\$45	Not Covered	\$45	Not Covered	10% Coinsurance after deductible
Specialist Visits	25% Coinsurance after deductible	No Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	25% Coinsurance after deductible	\$100	50% Coinsurance after deductible	60% Coinsurance after deductible	50% Coinsurance after deductible	60% Coinsurance after deductible	50% Coinsurance after deductible	60% Coinsurance after deductible	10% Coinsurance after deductible
Urgent Care	\$50 Copay and 25% Coinsurance after deductible	\$50 Copay after deductible	\$50 Copay and 20% Coinsurance after deductible	\$50 Copay and 10% Coinsurance after deductible	\$125 Copay after deductible	\$125	50% Coinsurance after deductible	60% Coinsurance after deductible	\$140	60% Coinsurance after deductible	\$140	60% Coinsurance after deductible	10% Coinsurance after deductible
Outpatient Facility/Surgical Center	25% Coinsurance after deductible	No Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	25% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible	60% Coinsurance after deductible	50% Coinsurance after deductible	60% Coinsurance after deductible	50% Coinsurance after deductible	60% Coinsurance after deductible	10% Coinsurance after deductible
Emergency Room	\$200 Copay and 25% Coinsurance after deductible	\$200 Copay after deductible	\$200 Copay and 20% Coinsurance after deductible	\$200 Copay and 10% Coinsurance after deductible	25% Coinsurance after deductible	\$300 Copay after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	\$825	\$825	\$825	\$825	10% Coinsurance after deductible
Inpatient Hospital Services	\$500 Copay per Stay, and 25% Coinsurance after deductible	\$500 Copay per Stay after deductible	\$500 Copay per Stay, and 20% Coinsurance after deductible	\$500 Copay per Stay, and 10% Coinsurance after deductible	25% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible	60% Coinsurance after deductible	50% Coinsurance after deductible	60% Coinsurance after deductible	50% Coinsurance after deductible	60% Coinsurance after deductible	10% Coinsurance after deductible
Generic Drugs	25% Coinsurance after deductible	No Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	25% Coinsurance after deductible	20%	10% Coinsurance after deductible	30% Coinsurance after deductible	\$30	60% Coinsurance after deductible	\$30	60% Coinsurance after deductible	No Copay after deductible
Preferred Brand Drugs	25% Coinsurance after deductible	No Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	25% Coinsurance after deductible	20%	50% Coinsurance after deductible	60% Coinsurance after deductible	50% Coinsurance after deductible	60% Coinsurance after deductible	50% Coinsurance after deductible	60% Coinsurance after deductible	No Copay after deductible
Durable Medical Equipment	25% Coinsurance after deductible	No Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	25% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible	60% Coinsurance after deductible	50% Coinsurance after deductible	60% Coinsurance after deductible	50% Coinsurance after deductible	60% Coinsurance after deductible	20% Coinsurance after deductible
Chiropractic Care	25% Coinsurance after deductible	No Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	25% Coinsurance after deductible	\$40	50% Coinsurance after deductible	60% Coinsurance after deductible	50% Coinsurance after deductible	60% Coinsurance after deductible	50% Coinsurance after deductible	60% Coinsurance after deductible	10% Coinsurance after deductible
Adult Dental Embedded?	No	No	No	No	No	No	No	No	No	No	No	No	No
Routine Dental Adult	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 Embedded?	No	No	No	No	No	No	No	No	No	No	Yes	Yes	No
Dental Check-Up for Children	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	No Charge	No Charge	Not Covered

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Plan ID/ Form Schedue #	61163NH0350001	61163NH0250001	61163NH0310001	42260NH0110003		42260NH0110001		96751NH0150024	19304NH0010001		61163NH0370001
Issuer	Minuteman Health	Minuteman Health	Minuteman Health	Time (Assurant)		Time (Assurant)		Anthem	Maine CHO		Minuteman Health
Plan Name	MyDoc HMO Bronze HSA 6300	MyDoc HMO Bronze Value 3750	Mydoc HMO Bronze Basic 4500	Assurant Health Bronze Plan 002		Assurant Health Bronze Plan 001		Anthem Catastrophic Pathway X Enhanced HMO 6600 0	Community Safe Harbor		MyDoc HMO Simple Care
Metal Level	Bronze	Bronze	Bronze	Bronze		Bronze		Catastrophic	Catastrophic		Catastrophic
Product Type	HMO	HMO	HMO	PPO		PPO		HMO	PPO		HMO
Network Coverage	NHN001	NHN001	NHN001	NHN001		NHN001		NHN001	NHN001		NHN001
				In-Network	Out-Of-Network	In-Network	Out-Of-Network		In-Network	Out-Of-Network	
Deductible-Individual/Family	\$6300 / \$12600	\$3750 / \$7500	\$4500 / \$9000	\$5000 / \$10000	\$15000 / \$30000	\$6000 / \$12000	\$18000 / \$36000	\$6600 / \$13200	\$6600 / \$13200	\$7500 / \$15000	\$6600 / \$13200
Coinsurance	0%	0%	30%	25%	45%	0%	0%	0%	0%	50%	0%
Max Out of Pocket-Individual/Family	\$6300 / \$12600	\$6600 / \$13200	\$6600 / \$13200	\$6350 / \$12700	\$19050 / \$38100	\$6000 / \$12000	\$18000 / \$36000	\$6600 / \$13200	\$6600 / \$13200	\$19000 / \$38000	\$6600 / \$13200
Preventive Care	No Charge	No Charge	No Charge	No Charge	45% Coinsurance after deductible	No Charge	No Coinsurance after deductible	No Charge	No Charge	Not Covered	No Charge
PCP Visits (not wellness)	No Coinsurance after deductible	\$30 Copay after deductible	\$50 Copay after deductible	\$35 for first 4 visits, thereafter 25% coinsurance after deductible	45% Coinsurance after deductible	No Coinsurance after deductible	No Coinsurance after deductible	\$40 for first 3 visits, thereafter no charge after deductible	No Copay for first three visits, thereafter subject to deductible	Not Covered	\$35 Copay for first 3 visits, then \$35 after deductible
Specialist Visits	No Charge after deductible	\$50 Copay after deductible	30% Coinsurance after deductible	\$35 for first 4 visits, thereafter 25% coinsurance after deductible	45% Coinsurance after deductible	No Coinsurance after deductible	No Coinsurance after deductible	No Coinsurance after deductible	No Coinsurance after deductible	50% Coinsurance after deductible	No Coinsurance after deductible
Urgent Care	No Charge after deductible	\$50 Copay after deductible	30% Coinsurance after deductible	25% Coinsurance after deductible	45% Coinsurance after deductible	No Coinsurance after deductible	No Coinsurance after deductible	No Coinsurance after deductible	No Coinsurance after deductible	50% Coinsurance after deductible	No Coinsurance after deductible
Outpatient Facility/Surgical Center	No Coinsurance after deductible	15% Coinsurance after deductible	30% Coinsurance after deductible	25% Coinsurance after deductible	45% Coinsurance after deductible	No Coinsurance after deductible	No Coinsurance after deductible	No Coinsurance after deductible	No Coinsurance after deductible	50% Coinsurance after deductible	No Coinsurance after deductible
Emergency Room	No Charge after deductible	\$750 Copay after deductible	\$200 Copay and 30% Coinsurance after deductible	\$100 Copay before deductible and 25% Coinsurance after deductible	\$100 Copay before deductible and 25% Coinsurance after deductible	\$100 Copay before deductible	\$100 Copay before deductible	No Coinsurance after deductible	No Coinsurance after deductible	No Coinsurance after deductible	No Coinsurance after deductible
Inpatient Hospital Services	No Coinsurance after deductible	\$750 Copay per Stay after deductible	30% Coinsurance after deductible	25% Coinsurance after deductible	45% Coinsurance after deductible	No Coinsurance after deductible	No Coinsurance after deductible	No Coinsurance after deductible	No Coinsurance after deductible	50% Coinsurance after deductible	No Coinsurance after deductible
Generic Drugs	No Copay after deductible	\$ 30	\$ 30	25% Coinsurance after deductible	45% Coinsurance after deductible	No Coinsurance after deductible	No Coinsurance after deductible	No Coinsurance after deductible	No Coinsurance after deductible	50% Coinsurance after deductible	No Coinsurance after deductible
Preferred Brand Drugs	No Copay after deductible	\$60 Copay after deductible	\$60 Copay after deductible	25% Coinsurance after deductible	45% Coinsurance after deductible	No Coinsurance after deductible	No Coinsurance after deductible	No Coinsurance after deductible	No Coinsurance after deductible	50% Coinsurance after deductible	No Coinsurance after deductible
Durable Medical Equipment	No Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	25% Coinsurance after deductible	45% Coinsurance after deductible	No Coinsurance after deductible	No Coinsurance after deductible	No Coinsurance after deductible	No Coinsurance after deductible	50% Coinsurance after deductible	No Coinsurance after deductible
Chiropractic Care	No Coinsurance after deductible	\$30 Copay after deductible	\$50 Copay after deductible	25% Coinsurance after deductible	45% Coinsurance after deductible	No Coinsurance after deductible	No Coinsurance after deductible	No Coinsurance after deductible	No Coinsurance after deductible	50% Coinsurance after deductible	No Coinsurance after deductible
Adult Dental Embedded?	No	No	No	No	No	No	No	No	No	No	No
Routine Dental Adult	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Dental Embedded?	No	No	No	Yes	Yes	Yes	Yes	No	No	No	No
Dental Check-Up for Children	Not Covered	Not Covered	Not Covered	No Charge	No Charge	No Charge	No Charge	Not Covered	Not Covered	Not Covered	Not Covered