PLAN YEAR 2022 - INDIVIDUAL HEALTH PLANS ON NH EXCHANGE MARKETPLACE

Plan ID/ Form Schedue #	75841NH0090005	75841NH0100009	75841NH0090026	75841NH0100026	96751NH0150036	59025NH0370039
Issuer	Ambetter	Ambetter	Ambetter	Ambetter	Anthem	Harvard Pilgrim
Plan Name	Secure Care 5	Secure Care 5 with 1000 Adult Dental	Secure Care 20	Secure Care 20 with 1000 Adult Dental	Pathway X Enhanced HMO 1500 15	ElevateHealth Gold HMO 1500
Metal Level	Gold	Gold	Gold	Gold	Gold	Gold
Plan Documents & Links	Schedule of Benefits Provider Directory Covered Drugs	Schedule of Benefits Provider Directory Covered Drugs	Schedule of Benefits Provider Directory Covered Drugs	Schedule of Benefits Provider Directory Covered Drugs	Schedule of Benefits Provider Directory Covered Drugs	Schedule of Benefits Provider Directory Covered Drugs
Deductible-Individual/Family	$1450 / $2900	$1450 / $2900	$750 / $1500	$750 / $1500	$1500 / $4500	$1500 / $3000
Coinsurance	20%	20%	35%	35%	15%	15%
Max Out of Pocket-Individual/Family	$6300 / $12600	$6300 / $12600	$7500/ $15000	$7500/ $15000	$8700 / $17400	$8700 / $17400
PCP Visits (not wellness)	$15	$15	$35	$35	$25	$25
Specialist Visits	$35	$35	$55	$55	$35	$50
Diagnostic Services (CT, MRI, PET Scans)	20% Coinsurance after deductible	20% Coinsurance after deductible	35% Coinsurance after deductible	35% Coinsurance after deductible	15% Coinsurance after deductible	15% Coinsurance after deductible
Outpatient Facility/Surgical Center	20% Coinsurance after deductible	20% Coinsurance after deductible	35% Coinsurance after deductible	35% Coinsurance after deductible	15% Coinsurance after deductible	15% Coinsurance after deductible
Emergency Room	20% Coinsurance after deductible	20% Coinsurance after deductible	35% Coinsurance after deductible	35% Coinsurance after deductible	$250 Copay and 15% Coinsurance after deductible	$300 Copay after deductible
Inpatient Hospital Services	20% Coinsurance after deductible	20% Coinsurance after deductible	35% Coinsurance after deductible	35% Coinsurance after deductible	$500 Copay per Stay and 15% Coinsurance after deductible	$500 Copay after deductible, then 15% Coinsurance
Generic Drugs	$15 copay	$15 copay	$15 copay	$15 copay	15% Coinsurance after deductible	$5 Copay
Special Plan Notes	30% Coinsurance after deductible for Non-Preferred Brand & Specialty drugs	30% Coinsurance after deductible for Non-Preferred Brand & Specialty drugs	50% Coinsurance after deductible for Non-Preferred Brand & Specialty drugs	50% Coinsurance after deductible for Non-Preferred Brand & Specialty drugs	Plan has Level 1 and Level 2 Network pharmacies. Level 2 has higher copays and coinsurance	Emergency Services that do not meet the definition of Medical Emergency is covered at 50% coinsurance after deductible

The information provided above is summary level. Consumers are urged to consult the plan documents for the full plan details and costs associated with all services.

January 28, 2022

PLAN YEAR 2022- INDIVIDUAL HEALTH PLANS ON NH EXCHANGE MARKETPLACE

Plan ID/ Form Schedue #	75841NH0090018	7581NH0100008	75841NH0090012	75841NH0100022	75841NH0090011	75841NH0100011	75841NH0090025	75841NH0100025
Issuer	Ambetter	Ambetter	Ambetter	Ambetter	Ambetter	Ambetter	Ambetter	Ambetter
Plan Name	Balanced Care 28	Balanced Care 28 with 1000 Adult Dental	Balanced Care 12	Balanced Care 12 with 1000 Adult Dental	Balanced Care 11	Balanced Care 11 with 1000 Adult Dental	Balanced Care 32	Balanced Care 32 with 1000 Adult Dental
Metal Level	Silver	Silver	Silver	Silver	Silver	Silver	Silver	Silver
Plan Documents & Links	Schedule of Benefits Provider Directory Covered Drugs	Schedule of Benefits Provider Directory Covered Drugs	Schedule of Benefits Provider Directory Covered Drugs	Schedule of Benefits Provider Directory Covered Drugs	Schedule of Benefits Provider Directory Covered Drugs	Schedule of Benefits Provider Directory Covered Drugs	Schedule of Benefits Provider Directory Covered Drugs	Schedule of Benefits Provider Directory Covered Drugs
Deductible-Individual/Family	$0 / $0	$0 / $0	$6500 / $13000	$6500 / $13000	$6000 / $12000	$6000 / $12000	$8100 / $16200	$8100 / $16200
Coinsurance	50%	50%	40%	40%	40%	40%	50%	50%
Max Out of Pocket-Individual/Family	$8200 / $16400	$8200 / $16400	$8400 / $16800	$8400 / $16800	$8500 / $17000	$8500 / $17000	$8700 / $17400	$8700 / $17400
PCP Visits (not wellness)	$50	$50	$35	$35	$30	$30	$45	$45
Specialist Visits	$90	$90	$70	$70	$60	$60	$100	$100
Diagnostic Services (CT, MRI, PET Scans)	No charge after 50% Coinsurance	No charge after 50% Coinsurance	40% Coinsurance after deductible	40% Coinsurance after deductible	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible
Outpatient Facility/Surgical Center	No charge after 50% Coinsurance	No charge after 50% Coinsurance	40% Coinsurance after deductible	40% Coinsurance after deductible	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible
Emergency Room	No charge after 50% Coinsurance	No charge after 50% Coinsurance	40% Coinsurance after deductible	40% Coinsurance after deductible	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible
Inpatient Hospital Services	No charge after 50% Coinsurance	No charge after 50% Coinsurance	40% Coinsurance after deductible	40% Coinsurance after deductible	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible
Generic Drugs	$30	$30	$25	$25	$20	$20	$25	$25
Special Plan Notes	50% Coinsurance after 1500 Ind / 3000 Family Rx ded for All Brand & Specialty drugs	50% Coinsurance after 1500 Ind / 3000 Family Rx ded for All Brand & Specialty drugs	50% Coinsurance after deductible for Non-Preferred Brand & Specialty drugs	50% Coinsurance after deductible for Non-Preferred Brand & Specialty drugs	50% Coinsurance after deductible for Non-Preferred Brand & Specialty drugs	50% Coinsurance after deductible for Non-Preferred Brand & Specialty drugs	50% Coinsurance after deductible for Non-Preferred Brand & Specialty drugs	50% Coinsurance after deductible for Non-Preferred Brand & Specialty drugs

The information provided above is summary level. Consumers are urged to consult the policy plan documents for the full plan details and costs associated with all services.

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Plan ID/ Form Schedue #	75841NH0090006	75841NH0100002	75841NH0090010	75841NH0100003	75841NH0090021	75841NH0100021	75841NH0090020	75841NH0100020	96751NH0150015	96751NH0150037	96751NH0150018	96751NH0150026	96751NH0150205	59025NH0370049	59025NH0370044	59025NH0370045	59025NH0370046
Issuer	Ambetter	Ambetter	Ambetter	Ambetter	Ambetter	Ambetter	Ambetter	Ambetter	Anthem	Anthem	Anthem	Anthem	Anthem	Harvard Pilgrim	Harvard Pilgrim	Harvard Pilgrim	Harvard Pilgrim
Plan Name	Essential Care 2 HSA	Essential Care 2 HSA with 1000 Adult Dental	Essential Care 10	Essential Care 10 with 1000 Adult Dental	Essential Care 0	Essential Care 0 with 1000 Adult Dental	Essential Care 1500	Essential Care 1500 with 1000 Adult Dental	Pathway X Enhanced HMO 35 HSA	Pathway X Enhanced HMO 4500 15	Pathway X Enhanced HMO 6000 20	Pathway X Enhanced HMO 6500 40	Pathway X Enhanced HMO 8700 0	ElevateHealth HMO HSA 7000	ElevateHealth HMO 6500	ElevateHealth HMO 7200	ElevateHealth HMO 8700
Metal Level	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze
Plan Documents & Links	Schedule of Benefits Provider Directory Covered Drugs	Schedule of Benefits Provider Directory Covered Drugs	Schedule of Benefits Provider Directory Covered Drugs	Schedule of Benefits Provider Directory Covered Drugs	Schedule of Benefits Provider Directory Covered Drugs	Schedule of Benefits Provider Directory Covered Drugs	Schedule of Benefits Provider Directory Covered Drugs	Schedule of Benefits Provider Directory Covered Drugs	Schedule of Benefits Provider Directory Covered Drugs	Schedule of Benefits Provider Directory Covered Drugs	Schedule of Benefits Provider Directory Covered Drugs	Schedule of Benefits Provider Directory Covered Drugs	Schedule of Benefits Provider Directory Covered Drugs	Schedule of Benefits Provider Directory Covered Drugs	Schedule of Benefits Provider Directory Covered Drugs	Schedule of Benefits Provider Directory Covered Drugs	Schedule of Benefits Provider Directory Covered Drugs
Deductible-Individual/Family	$6900 / $13800	$6900 / $13800	$7200 / $14400	$7200 / $14400	$0 / $0	$0 / $0	$1500 / $3000	$1500 / $3000	$6000 / $12000	$4500 / $9000	$6000 / $12000	$6500 / $13000	$8700 / $17400	$7000 / $14000	$6500 / $13000	$7200 / $14400	$8700 / $17400
Coinsurance	0%	0%	50%	50%	50%	50%	50%	50%	35%	15%	20%	40%	0%	0%	20%	50%	0%
Max Out of Pocket-Individual/Family	$6900 / $13800	$6900 / $13800	$8400 / $16800	$8400 / $16800	$8700 / $17400	$8700 / $17400	$8700 / $17400	$8700 / $17400	$7000 / $14000	$8700 / $17400	$8700 / $17400	$8700 / $17400	$8700 / $17400	$7000 / $14000 $7000 Embeded Individual OOP Max	$8700 / $17400	$8700 / $17400	$8700 / $17400
PCP Visits (not wellness)	No charge after deductible	No charge after deductible	No charge after 50% Coinsurance	No charge after 50% Coinsurance	$45	$45	$40	$40	35% Coinsurance after deductible	$20 Copay for first 3 visits, thereafter 15% Coinsurance after deductible	$40 Copay for first 3 visits, thereafter 20% Coinsurance after deductible	40% Coinsurance after deductible	No charge after deductible	No charge after deductible	$40 for first 4 visits per member/B per family 20% Coinsurance after deductible for subsegnt visits	$40 for first 4 non-routine visits 50% Coinsurance after deductible for subsegnt visits	No charge for first 2 non-routine visits No charge after deductible for subsegnt visits
Specialist Visits	No charge after deductible	No charge after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	$115	$115	$125	$125	35% Coinsurance after deductible	$50 Copay and 15% Coinsurance after deductible	$50 copay and 20% Coinsurance after deductible	40% Coinsurance after deductible	No charge after deductible	No charge after deductible	$80 for first 4 visits per member/B per family 20% Coinsurance after deductible for subsegnt visits	50% Coinsurance after deductible	No charge after deductible
Diagnostic Services (CT, MRI, PET Scans)	No charge after deductible	No charge after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	No charge after 50% Coinsurance	No charge after 50% Coinsurance	50% Coinsurance after deductible	50% Coinsurance after deductible	35% Coinsurance after deductible	15% Coinsurance after deductible	20% Coinsurance after deductible	40% Coinsurance after deductible	No charge after deductible	No charge after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible	No charge after deductible
Outpatient Facility/Surgical Center	No charge after deductible	No charge after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	No charge after 50% Coinsurance	No charge after 50% Coinsurance	50% Coinsurance after deductible	50% Coinsurance after deductible	35% Coinsurance after deductible	15% Coinsurance after deductible	20% Coinsurance after deductible	40% Coinsurance after deductible	No charge after deductible	No charge after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible	No charge after deductible
Emergency Room	No charge after deductible	No charge after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	$2500 Copay	$2500 Copay	$2500 Copay after deductible	$2500 Copay after deductible	$500 Copay and 35% Coinsurance after deductible	$500 Copay and 15% Coinsurance after deductible	$500 Copay and 20% Coinsurance after deductible	40% Coinsurance after deductible	No charge after deductible	No charge after deductible	$500 Copay after deductible	50% Coinsurance after deductible	No charge after deductible
Inpatient Hospital Services	No charge after deductible	No charge after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	$3000 Copay per Day	$3000 Copay per Day	$3000 Copay per Day after deductible	$3000 Copay per Day after deductible	35% Coinsurance after deductible	$500 Copay per Stay and 15% Coinsurance after deductible	$500 Copay per Stay and 20% Coinsurance after deductible	40% Coinsurance after deductible	No charge after deductible	No charge after deductible	$500 Copay after deductible then 20% Coinsurance	50% Coinsurance after deductible	No charge after deductible
Generic Drugs	No charge after deductible	No charge after deductible	$25	$25	$35	$35	$35	$35	35% Coinsurance after deductible	25% Coinsurance after deductible	20% Coinsurance after deductible	25% Coinsurance after deductible	No charge after deductible	No charge after deductible	$10	$10	No charge after deductible
Special Plan Notes			50% Coinsurance after deductible for All Brand & Specialty drugs	50% Coinsurance after deductible for All Brand & Specialty drugs	$8800 / $7600 Rx drug deductible for Non-Preferred & Specialty drugs	$8800 / $7600 Rx drug deductible for Non-Preferred & Specialty drugs	$8800 / $7600 Rx drug deductible for Non-Preferred & Specialty drugs	$8800 / $7600 Rx drug deductible for Non-Preferred & Specialty drugs	Plan has Level 1 and Level 2 Network pharmacies. Level 2 has higher copays and coinsurance	Plan has Level 1 and Level 2 Network pharmacies. Level 2 has higher copays and coinsurance	Plan has Level 1 and Level 2 Network pharmacies. Level 2 has higher copays and coinsurance	Plan has Level 1 and Level 2 Network pharmacies. Level 2 has higher copays and coinsurance	Plan has Level 1 and Level 2 Network pharmacies. Level 2 has higher copays and coinsurance		Emergency Services that do not meet the definition of Madical Emergency is covered at 50% coinsurance after deductible		

Plan ID/ Form Schedue #	96751NH0150024	59025NH0370047
Issuer	Anthem	Harvard Pilgrim
Plan Name	Pathway X Enhanced HMO 8700 0 Catastrophic	ElevateHealth HMO Catastrophic
Metal Level	Catastrophic	Catastrophic
Plan Documents & Links	Schedule of Benefits Provider Directory Covered Drugs	Schedule of Benefits Provider Directory Covered Drugs
Deductible-Individual/Family	$8700 / $17400	$8700 / $17400
Coinsurance	0%	0%
Max Out of Pocket-Individual/Family	$8700 / $17400	$8700 / $17400
PCP Visits (not wellness)	$40 Copay for first 3 visits; No charge after deductible subsequent visits	$40 Copay for first 3 visits; No charge after deductible for subsequent visits
Specialist Visits	No charge after deductible	No charge after deductible
Diagnostic Services (CT, MRI, PET Scans)	No charge after deductible	No charge after deductible
Outpatient Facility/Surgical Center	No charge after deductible	No charge after deductible
Emergency Room	No charge after deductible	No charge after deductible
Inpatient Hospital Services	No charge after deductible	No charge after deductible
Generic Drugs	No charge after deductible	No charge after deductible
Special Plan Notes	Plan has Level 1 and Level 2 Network pharmacies. You pay higher copays and coinsurance with Level 2 pharmacies	