2019 Individual Plans

	59025NH0370001	59025NH0370002	59025NH0370007	59025NH0370010	75841NH0090001	75841NH0090002	75841NH0090011
Insurance Company	Harvard Pilgrim of NE	Harvard Pilgrim of NE	Harvard Pilgrim of NE	Harvard Pilgrim of NE	Ambetter (offered by Celtic)	Ambetter (offered by Celtic)	Ambetter (offered by Celtic)
Plan Name	ElevateHealth HMO Silver 3500	ElevateHealth HMO Gold 1500	ElevateHealth HMO Silver 5000	ElevateHealth HMO Catastrophic	Ambetter Secure Care 1 (2019) with 3 Free PCP Visits	Ambetter Balanced Care 8 (2019)	Ambetter Balanced Care 11 (2019)
Metal Level	Silver	Gold	Silver	Catastrophic	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	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs
Network Coverage	Excludes Carroll County	Excludes Carroll County	Excludes Carroll County	Excludes Carroll County	Statewide	Statewide	Statewide
Deductible-Individual/Family	$3,500 per person $7,000 per family	$1,500 per person $3,000 per family	$5,000 per person $10,000 per family	$7,900 per person $15,800 per family	$1,000 per person $2,000 per family	$7,650 per person $15,300 per family	$6,000 per person $12,000 per family
Max Out of Pocket-Individual/Family	$7,900 per person $15,800 per family	$7,900 per person $15,800 per family	$7,900 per person $15,800 per family	$7,900 per person $15,800 per family	$6,350 per person $12,700 per family	$7,900 per person $15,800 per family	$7,900 per person $15,800 per family
PCP Visits	$40 copay	$25 copay	$40 copay	$40 copay*	20% coinsurance after deductible*	$30 copay after deductible	$30 copay after deductible
Specialist Visits	Tier 1: $40 copay*	Tier 1: $25 copay*	$80 copay	No charge after deductible	20% coinsurance after deductible	$60 copay after deductible	$60 copay after deductible
Urgent Care	Tier 1: $40 copay*	Tier 1: $25 copay*	$50 copay with deductible	No charge after deductible	20% coinsurance after deductible	30% coinsurance after deductible	$100 copay after deductible
Emergency Room	$500 copay*	$300 copay*	$500 copay	No charge after deductible	$250 copay after deductible	$150 copay after deductible	40% coinsurance after deductible
Generic Drug	$10 copay	$5 copay	$10 copay with deductible	No charge after deductible	$10 copay after deductible	$25 copay after deductible	$20 copay after deductible
Preferred Brand Drug	$65 copay with deductible	$50 copay	$65 copay with deductible	No charge after deductible	$25 copay after deductible	$50 copay after deductible	$50 copay after deductible
Plan Notes	*Specialist: Tier 2: $80 copay Urgent Care: Tier 2: $50, Tier 3: $250 For ER visits, some services are subject to 50% coinsurance. Please reference the Schedule of Benefits for full cost sharing details.	*Specialist: Tier 2: $50 copay; Urgent Care: Tier 2: $35 copay, Tier 3: $150; For ER visits, some services are subject to 50% coinsurance. Please reference the Schedule of Benefits for full cost sharing details.		*PCP: First 3 visits subject to copay. Summary of Benefits and Plan Brochures will be updated prior to open enrollment along with other Plan Year 2019 information.	*PCP: First 3 visits are not subject to cost sharing.		

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2019 Individual Plans

	96751NH0150015	96751NH0150018	96751NH0150020	96751NH0150022	96751NH0150024	96751NH0150025
Insurance Company	Matthew Thorton Health Plan	Matthew Thorton Health Plan	Matthew Thorton Health Plan	Matthew Thorton Health Plan	Matthew Thorton Health Plan	Matthew Thorton Health Plan
Plan Name	Anthem Bronze Pathway X Enhanced HMO 25 for HSA	Anthem Bronze Pathway X Enhanced HMO 5750 10	Anthem Silver Pathway X Enhanced HMO 10 for HSA	Anthem Silver Pathway X Enhanced HMO 3800 0	Anthem Catastrophic Pathway X Enhanced HMO 7900 0	Anthem Silver Pathway X Enhanced HMO 3500 0
Metal Level	Bronze	Bronze	Silver	Silver	Catastrophic	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
Network Coverage	Statewide	Statewide	Statewide	Statewide	Statewide	Statewide
Deductible-Individual/Family	$5,150 per person $10,300 per family	$5,750 per person $11,500 per family	$3,000 per person $6,000 per family	$3,800 per person $7,600 per family	$7,900 per person $15,800 per family	$3,500 per person $7,000 per family
Max Out of Pocket-Individual/Family	$6,700 per person $13,400 per family	$7,900 per person $15,800 per family	$6,700 per person $13,400 per family	$5,800 per person $11,600 per family	$7,900 per person $15,800 per family	$7,900 per person $15,800 per family
PCP Visits	25% coinsurance after deductible	$40 copay with deductible; 10% coinsurance after deductible	10% coinsurance after deductible	$40 copay with deductible; 10% coinsurance after deductible	$40 copay with deductible; 10% coinsurance after deductible	$40 copay
Specialist Visits	25% coinsurance after deductible	$50 copay with deductible; 10% coinsurance after deductible	10% coinsurance after deductible	$60 copay	No charge after deductible	$50 copay with deductible*
Urgent Care	$50 copay after deductible; 25% coinsurance after deductible	$50 copay ; 10% coinsurance	$50 copay after deductible; 10% coinsurance after deductible	$50 copay after deductible	No charge after deductible	$50 copay*
Emergency Room	$500 copay after deductible; 25% coinsurance after deductible	$500 copay ; 10% coinsurance	$500 copay after deductible; 10% coinsurance after deductible	$500 copay after deductible	No charge after deductible	$750 copay*
Generic Drug	Tier 1: 25% coinsurance after deductible; Tier 2: 35% coinsurance after deductible	Tier 1: 10% coinsurance; Tier 2: 20% coinsurance	Tier 1: 10% coinsurance after deductible; Tier 2: 20% coinsurance after deductible	Tier 1: $20 copay ; Tier 2: $30 copay	No charge after deductible	Tier 1: $15 copay with deductible; Tier 2: $25 copay with deductible
Preferred Brand Drug	Tier 1: 25% coinsurance after deductible; Tier 2: 35% coinsurance after deductible	Tier 1: 10% coinsurance; Tier 2: 20% coinsurance	Tier 1: 10% coinsurance after deductible; Tier 2: 20% coinsurance after deductible	Tier 1: $45 copay ; Tier 2: $55 copay	No charge after deductible	Tier 1: $100 copay with deductible; Tier 2: $110 copay with deductible
Plan Notes						*Specialist, Urgent Care, and ER visits: Copay applies until the deductible is met.

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2019 Individual Plans

	96751NH0150026	96751NH0150033	96751NH0150036	96751NH0150037
Insurance Company	Matthew Thorton Health Plan	Matthew Thorton Health Plan	Matthew Thorton Health Plan	Matthew Thorton Health Plan
Plan Name	Anthem Bronze Pathway X Enhanced HMO 6500 40	Anthem Silver Pathway X Enhanced HMO 6300 30	Anthem Gold Pathway X Enhanced HMO 1500 15	Anthem Bronze Pathway X Enhanced HMO 3750 10
Metal Level	Bronze	Silver	Gold	Bronze
Plan Documents & Links**	Summary of Benefits	Summary of Benefits	Summary of Benefits	Summary of Benefits
	Plan Brochure	Plan Brochure	Plan Brochure	Plan Brochure
	Provider Directory	Provider Directory	Provider Directory	Provider Directory
	List of Covered Drugs	List of Covered Drugs	List of Covered Drugs	List of Covered Drugs
Network Coverage	Statewide	Statewide	Statewide	Statewide
Deductible- Individual/Family	$6,500 per person $13,000 per family	$6,300 per person $12,600 per family	$1,500 per person $4,500 per family	$3,750 per person $7,500 per family
Max Out of Pocket- Individual/Family	$7,900 per person $15,800 per family	$7,900 per person $15,800 per family	$7,900 per person $15,800 per family	$7,900 per person $15,800 per family
PCP Visits	40% coinsurance after deductible	$40 copay	$25 copay	$20 copay with deductible; 10% coinsurance after deductible
Specialist Visits	40% coinsurance after deductible	30% coinsurance after deductible	15% coinsurance after deductible	$40 copay with deductible; 10% coinsurance after deductible
Urgent Care	40% coinsurance after deductible	$50 copay with deductible*	$50 copay with deductible; 15% coinsurance after deductible	$50 copay with deductible; 10% coinsurance after deductible
Emergency Room	40% coinsurance after deductible	30% coinsurance after deductible	$250 copay with deductible; 15% coinsurance after deductible	$500 copay with deductible; 10% coinsurance after deductible
Generic Drug	Tier 1: 25% coinsurance after deductible; Tier 2: 35% coinsurance after deductible	Tier 1: $15 copay ; Tier 2: $25 copay	Tier 1: 15% coinsurance after deductible; Tier 2: 25% coinsurance after deductible	Tier 1: 25% coinsurance after deductible; Tier 2: 35% coinsurance after deductible
Preferred Brand Drug	Tier 1: 35% coinsurance after deductible; Tier 2: 45% coinsurance after deductible	Tier 1: $45 copay ; Tier 2: $55 copay	Tier 1: 15% coinsurance after deductible; Tier 2: 25% coinsurance after deductible	Tier 1: 25% coinsurance after deductible; Tier 2: 35% coinsurance after deductible
Plan Notes		*Urgent Care visits: Copay applies until the deductible is met.		

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2019 SHOP Plans

Plan ID / Form Schedue #	96751NH0160015	96751NH0160016	96751NH0160017	96751NH0160018	96751NH0160019
Insurance Company	Matthew Thorton Health Plan	Matthew Thorton Health Plan	Matthew Thorton Health Plan	Matthew Thorton Health Plan	Matthew Thorton Health Plan
Plan Name	Anthem Gold Pathway X HMO 1000 10 4000	Anthem Gold Pathway X HMO 2000 10 4000	Anthem Silver Pathway X HMO 3000 20 7350	Anthem Silver Pathway X HMO 5000 0 7500	Anthem Silver Pathway X HMO 4000 0 6650 w HSA
Metal Level	Gold	Gold	Silver	Silver	Silver
Plan Documents & Links**	Summary of Benefits Provider Directory List of Covered Drugs	Summary of Benefits Provider Directory List of Covered Drugs	Summary of Benefits Provider Directory List of Covered Drugs	Summary of Benefits Provider Directory List of Covered Drugs	Summary of Benefits Provider Directory List of Covered Drugs
Network Coverage	Statewide	Statewide	Statewide	Statewide	Statewide
Deductible- Individual/Family	$1,000 per person $3,000 per family	$2,000 per person $4,000 per family	$3,000 per person $6,000 per family	$5,000 per person $10,000 per family	$4,000 per person $8,000 per family
Max Out of Pocket- Individual/Family	$4,000 per person $8,000 per family	$4,000 per person $8,000 per family	$7,350 per person $14,700 per family	$7,500 per person $15,000 per family	$6,650 per person $13,300 per family
PCP Visits	$25 copay	$25 copay	$40 copay	$40 copay	0% coinsurance after deductible
Specialist Visits	$50 copay	$50 copay	$80 copay	$80 copay	0% coinsurance after deductible
Urgent Care	$100 copay	$100 copay	$100 copay	$100 copay	0% coinsurance after deductible
Emergency Room	$300 copay	$300 copay	$300 copay	$300 copay	0% coinsurance after deductible
Generic Drug	$25 copay	$25 copay	$25 copay	$25 copay	20% coinsurance after deductible
Preferred Brand Drug	$50 copay or 30% coinsurance after deductible, whichever is greater up to $300	$50 copay or 30% coinsurance after deductible, whichever is greater up to $300	$50 copay or 30% coinsurance after deductible, whichever is greater up to $300	$50 copay or 30% coinsurance after deductible, whichever is greater up to $300	20% coinsurance after deductible

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2019 SHOP Plans

Plan ID / Form Schedue #	96751NH0160020
Insurance Company	Matthew Thorton Health Plan
Plan Name	Anthem Bronze Pathway X HMO 4000 25 6650 w HSA
Metal Level	Expanded Bronze
Plan Documents & Links**	Summary of Benefits Provider Directory List of Covered Drugs
Network Coverage	Statewide
Deductible- Individual/Family	$4,000 per person $8,000 per family
Max Out of Pocket- Individual/Family	$6,650 per person $13,300 per family
PCP Visits	25% coinsurance after deductible
Specialist Visits	25% coinsurance after deductible
Urgent Care	25% coinsurance after deductible
Emergency Room	25% coinsurance after deductible
Generic Drug	25% coinsurance after deductible
Preferred Brand Drug	25% coinsurance after deductible

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2019 SHOP Plans

Plan ID / Form Schedue #	96751NH0160008	96751NH0160010	96751NH0160011	96751NH0160012	96751NH0160013
Insurance Company	Matthew Thorton Health Plan	Matthew Thorton Health Plan	Matthew Thorton Health Plan	Matthew Thorton Health Plan	Matthew Thorton Health Plan
Plan Name	Anthem Bronze Pathway X HMO 6550 0 6550 w HSA	Anthem Silver Pathway X HMO 3000 0 6650 w HSA	Anthem Gold Pathway X HMO 2000 10 3950 w HSA	Anthem Bronze Pathway X HMO 5000 30 6650 w HSA	Anthem Silver Pathway X HMO 4000 10 7500
Metal Level	Bronze	Silver	Gold	Expanded Bronze	Silver
Plan Documents & Links**	Summary of Benefits Provider Directory List of Covered Drugs	Summary of Benefits Provider Directory List of Covered Drugs	Summary of Benefits Provider Directory List of Covered Drugs	Summary of Benefits Provider Directory List of Covered Drugs	Summary of Benefits Provider Directory List of Covered Drugs
Network Coverage	Statewide	Statewide	Statewide	Statewide	Statewide
Deductible- Individual/Family	$6,650 per person $13,300 per family	$3,000 per person $6,000 per family	$2,000 per person $4,000 per family	$5,000 per person $10,000 per family	$4,000 per person $8,000 per family
Max Out of Pocket- Individual/Family	$6,650 per person $13,300 per family	$6,650 per person $13,300 per family	$3,950 per person $7,900 per family	$6,650 per person $13,300 per family	$7,500 per person $15,000 per family
PCP Visits	0% coinsurance after deductible	10% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	$40 copay
Specialist Visits	0% coinsurance after deductible	10% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	$80 copay
Urgent Care	0% coinsurance after deductible	10% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	$100 copay
Emergency Room	0% coinsurance after deductible	10% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	$300 copay after deductible
Generic Drug	0% coinsurance after deductible	20% coinsurance after deductible	10% coinsurance after deductible	Tier 1: 30% coinsurance after deductible	$25 copay
Preferred Brand Drug	0% coinsurance after deductible	20% coinsurance after deductible	10% coinsurance after deductible	Tier 1: 30% coinsurance after deductible	$50 copay or 30% coinsurance after deductible, whichever is greater up to $300

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2019 SHOP Plans

Plan ID / Form Schedue #	96751NH0160014	96751NH0160015
Insurance Company	Matthew Thorton Health Plan	Matthew Thorton Health Plan
Plan Name	Anthem Platinum Pathway X HMO 20 10 4500	Anthem Gold Pathway X HMO 1000 10 4000
Metal Level	Platinum	Gold
Plan Documents & Links**	Summary of Benefits Provider Directory List of Covered Drugs	Summary of Benefits Provider Directory List of Covered Drugs
Network Coverage	Statewide	Statewide
Deductible- Individual/Family	$0 per person $0 per family	$1,000 per person $3,000 per family
Max Out of Pocket- Individual/Family	$4,500 per person $9,000 per family	$4,000 per person $8,000 per family
PCP Visits	$20 copay	$25 copay
Specialist Visits	$40 copay	$50 copay
Urgent Care	10% coinsurance	$100 copay
Emergency Room	$250 copay with deductible ; 10% coinsurance after copay	$300 copay
Generic Drug	$25 copay	$25 copay
Preferred Brand Drug	$50 copay or 30% coinsurance after deductible, whichever is greater up to $300	$50 copay or 30% coinsurance after deductible, whichever is greater up to $300

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2019 Individual SADP Plans

Plan ID / Form Schedue #	57601NH0420003	57601NH0420004	57601NH0420005	87701NH0070001	87701NH0080001	87701NH0090001	87701NH0100001
Insurance Company	Anthem Health Plans of NH	Anthem Health Plans of NH	Anthem Health Plans of NH	Delta Dental	Delta Dental	Delta Dental	Delta Dental
Plan Name	Anthem Dental Family	Anthem Dental Family Enhanced	Anthem Dental Family Value	Delta Dental Family High	Delta Dental Family Low	Delta Dental Pediatric High Plan	Delta Dental Pediatric Low Plan
Metal Level	Low	High	Low	High	Low	High	Low
Plan Documents & Links	Summary of Benefits Provider Directory	Summary of Benefits Provider Directory	Summary of Benefits Provider Directory	Plan Brochure Provider Directory	Plan Brochure Provider Directory	Plan Brochure Provider Directory	Plan Brochure Provider Directory
Network Coverage	Statewide	Statewide	Statewide	Statewide	Statewide	Statewide	Statewide
Deductible-Individual/Family	$50 per person	$25 per child $50 per Adult	$50 per person	$50 per person	$150 per person	$50 per person	$150 per person
Max Out of Pocket-Individual/Family	$350 per person $700 per family	$350 per person $700 per family	$350 per person $700 per family	$350 per person $700 per family	$350 per person $700 per family	$350 per person $700 per family	$350 per person $700 per family
Dental Check-Up for Children	No charge after deductible	No charge after deductible	No charge after deductible	$15 copay	$30 copay	$15 copay	$30 copay
Basic Dental Care - Child	40% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible	$15 copay; 20% coinsurance after deductible	$30 copay; 40% coinsurance after deductible	$15 copay ; 20% coinsurance after deductible	$30 copay; 40% coinsurance after deductible
Orthodontia - Child	50% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance
Major Dental Care - Child	50% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	$15 copay; 50% coinsurance after deductible	$30 copay; 50% coinsurance after deductible	$15 copay ; 50% coinsurance after deductible	$30 copay; 50% coinsurance after deductible
Routine Dental Services - Adult	No charge after deductible	No charge after deductible	No charge after deductible	$15 copay	$30 copay	N/A	N/A
Basic Dental Care - Adult	50% coinsurance after deductible	20% coinsurance after deductible	50% coinsurance after deductible	$15 copay; 20% coinsurance after deductible	$30 copay; 40% coinsurance after deductible	N/A	N/A
Orthodontia - Adult	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	N/A	N/A
Major Dental Care - Adult	70% coinsurance after deductible	50% coinsurance after deductible	70% coinsurance after deductible	$15 copay; 50% coinsurance after deductible	$30 copay; 50% coinsurance after deductible	N/A	N/A

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2019 SHOP SADP Plans

Plan ID / Form Schedue #	57601NH0390003	57601NH0390004
Insurance Company	Anthem Health Plans of NH	Anthem Health Plans of NH
Plan Name	Anthem Dental Family	Anthem Dental Family Enhanced
Metal Level	Low	High
Plan Documents & Links	Summary of Benefits Provider Directory	Summary of Benefits Provider Directory
Network Coverage	Statewide	Statewide
Deductible-Individual/Family	$50 per person	$25 per child $50 per adult
Max Out of Pocket-Individual/Family	$350 per person $700 per family	$350 per person $700 per family
Dental Check-Up for Children	No charge after deductible	No charge after deductible
Basic Dental Care - Child	40% coinsurance after deductible	20% coinsurance after deductible
Orthodontia - Child	50% coinsurance after deductible	50% coinsurance after deductible
Major Dental Care - Child	50% coinsurance after deductible	50% coinsurance after deductible
Routine Dental Services - Adult	No charge after deductible	No charge after deductible
Basic Dental Care - Adult	50% coinsurance after deductible	20% coinsurance after deductible
Orthodontia - Adult	Not Covered	Not Covered
Major Dental Care - Adult	70% coinsurance after deductible	50% coinsurance after deductible

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