2020 Individual Plans

Plan ID / Form Schedule #	96751NH0150024	59025NH0370019	75841NH0090009	96751NH0150018	96751NH0150026	59025NH0370017	59025NH0370018
Insurance Company	Matthew Thornton Health Plan	Harvard Pilgrim Health Care of New England	Ambetter (offered by Celtic Insurance Company)	Matthew Thornton Health Plan	Matthew Thornton Health Plan	Harvard Pilgrim Health Care of New England	Harvard Pilgrim Health Care of New England
Plan Name	Anthem Catastrophic Pathway X Enhanced HMO 8150 0	ElevateHealth HMO Catastrophic	Ambetter Essential Care 1 (2020)	Anthem Bronze Pathway X Enhanced HMO 5750 10	Anthem Bronze Pathway X Enhanced HMO 6500 40	ElevateHealth HMO Bronze 6000	ElevateHealth HMO Bronze 6500
Metal Level	Catastrophic	Catastrophic	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
Network Coverage	All Counties	Excludes Carroll County	All Counties	All Counties	All Counties	Excludes Carroll County	Excludes Carroll County
Individual Deductible	$8,150	$8,150	$8,150	$5,750	$6,500	$6,000	$6,500
Family Deductible	$16,300	$16,300	$16,300	$11,500	$13,000	$12,000	$13,000
Individual Maximum Out of Pocket	$8,150	$8,150	$8,150	$8,150	$8,150	$7,900	$7,900
Family Maximum Out of Pocket	$16,300	$16,300	$16,300	$16,300	$16,300	$15,800	$15,800
PCP Visits	$40 Copay	$40 Copay for first 3 Visits, No Charge After Deductible for All Remaining	No charge after deductible	$40 Copay, 10% Coinsurance After Deductible	40% Coinsurance After Deductible	$40 Copay for first 3 visits, 20% Coinsurance after deductible for Remaining Visits	40% Coinsurance after deductible
Specialist Visits	No charge after deductible	No charge after deductible	No charge after deductible	Tier 1: $50 Copay, 10% Coinsurance After Deductible	Tier 1: 40% Coinsurance After Deductible	$80 Copay for first 3 visits, 20% Coinsurance after deductible for remaining visits	40% Coinsurance after deductible
Urgent Care	No charge after deductible	No charge after deductible	No charge after deductible	Tier 1: $50 Copay, 10% Coinsurance After Deductible	Tier 1: 40% Coinsurance After Deductible	$50 Copay for the first 4 visits, 20% Coinsurance after deductible for remaining visits	40% Coinsurance after deductible
Emergency Room	No charge after deductible	No charge after deductible	No charge after deductible	$500 Copay, 10% Coinsurance After Deductible	40% Coinsurance After Deductible	$500 Copay after deductible	40% Coinsurance after deductible
Generic Drug	No charge after deductible	No charge after deductible	No charge after deductible	Tier 1: 10% Coinsurance After Deductible	Tier 1: 25% Coinsurance After Deductible	$10 Copay	$10 Copay
Preferred Brand Drug	No charge after deductible	No charge after deductible	No charge after deductible	Tier 1: 10% Coinsurance After Deductible	Tier 1: 20% Coinsurance After Deductible	30% Coinsurance after deductible	35% Coinsurance after deductible

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2020 Individual Plans

Plan ID / Form Schedule #	75841NH0090010	75841NH0090004	96751NH0150015	96751NH0150037	59025NH0370021	75841NH0090011	75841NH0090014
Insurance Company	Ambetter (offered by Celtic Insurance Company)	Ambetter (offered by Celtic Insurance Company)	Matthew Thornton Health Plan	Matthew Thornton Health Plan	Harvard Pilgrim Health Care of New England	Ambetter (offered by Celtic Insurance Company)	Ambetter (offered by Celtic Insurance Company)
Plan Name	Ambetter Essential Care 10 (2020)	Ambetter Essential Care 4 HSA (2020)	Anthem Bronze Pathway X Enhanced HMO 25 for HSA	Anthem Bronze Pathway X Enhanced HMO 4000 10	ElevateHealth HMO HSA Bronze 5000	Ambetter Balanced Care 11 (2020)	Ambetter Balanced Care 14 (2020)
Metal Level	Expanded Bronze	Expanded Bronze	Expanded Bronze	Expanded Bronze	Expanded Bronze	Silver	Silver
Plan Documents & Links	Summary of Benefits*	Summary of Benefits*	Summary of Benefits*	Summary of Benefits*	Summary of Benefits*	Summary of Benefits*	Summary of Benefits*
	Plan Brochure*	Plan Brochure*	Plan Brochure*	Plan Brochure*	Plan Brochure*	Plan Brochure*	Plan Brochure*
	Provider Directory	Provider Directory	Provider Directory	Provider Directory	Provider Directory	Provider Directory	Provider Directory
	List of Covered Drugs	List of Covered Drugs	List of Covered Drugs	List of Covered Drugs	List of Covered Drugs	List of Covered Drugs	List of Covered Drugs
Network Coverage	All Counties	All Counties	All Counties	All Counties	Excludes Carroll County	All Counties	All Counties
Individual Deductible	$7,200	$5,400	$5,150	$4,000	$5,000	$6,000	$0
Family Deductible	$14,400	$10,800	$10,300	$8,000	$10,000	$12,000	$0
Individual Maximum Out of Pocket	$8,150	$6,750	$6,850	$8,150	$6,750	$8,100	$8,150
Family Maximum Out of Pocket	$16,300	$13,500	$13,700	$16,300	$13,500	$16,200	$16,300
PCP Visits	50% Coinsurance	30% Coinsurance After Deductible	25% Coinsurance After Deductible	$20 Copay, 10% Coinsurance After Deductible	20% Coinsurance after deductible	$30 Copay	$45 Copay
Specialist Visits	50% Coinsurance After Deductible	30% Coinsurance After Deductible	Tier 1: 25% Coinsurance After Deductible	Tier 1: $40 Copay, 10% Coinsurance After Deductible	20% Coinsurance after deductible	$60 Copay	$95 Copay
Urgent Care	$60 Copay	30% Coinsurance After Deductible	Tier 1: $50 Copay, 25% Coinsurance After Deductible	Tier 1: $50 Copay, 10% Coinsurance After Deductible	20% Coinsurance after deductible	$60 Copay	$60 Copay
Emergency Room	50% Coinsurance After Deductible	30% Coinsurance After Deductible	$500 Copay, 25% Coinsurance After Deductible	$500 Copay, 10% Coinsurance After Deductible	20% Coinsurance after deductible	40% Coinsurance After Deductible	50% Coinsurance
Generic Drug	$20 Copay	30% Coinsurance After Deductible	Tier 1: 25% Coinsurance After Deductible	Tier 1: 25% Coinsurance After Deductible	20% Coinsurance after deductible	$20 Copay	$35 Copay
Preferred Brand Drug	50% Coinsurance After Deductible	30% Coinsurance After Deductible	Tier 1: 20% Coinsurance After Deductible	Tier 1: 25% Coinsurance After Deductible	20% Coinsurance after deductible	$50 Copay	50% Coinsurance

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2020 Individual Plans

Plan ID / Form Schedule #	75841NH0090003	96751NH0150020	96751NH0150025	96751NH0150022	96751NH0150033	59025NH0370020	59025NH0370013
Insurance Company	Ambetter (offered by Celtic Insurance Company)	Matthew Thornton Health Plan	Matthew Thornton Health Plan	Matthew Thornton Health Plan	Matthew Thornton Health Plan	Harvard Pilgrim Health Care of New England	Harvard Pilgrim Health Care of New England
Plan Name	Ambetter Balanced Care 3 (2020)	Anthem Silver Pathway X Enhanced HMO 10 for HSA	Anthem Silver Pathway X Enhanced HMO 3500 0	Anthem Silver Pathway X Enhanced HMO 4000 0	Anthem Silver Pathway X Enhanced HMO 6300 30	ElevateHealth HMO HSA Silver 3750	ElevateHealth HMO Silver 3500
Metal Level	Silver	Silver	Silver	Silver	Silver	Silver	Silver
Plan Documents & Links	Summary of Benefits*	Summary of Benefits*	Summary of Benefits*	Summary of Benefits*	Summary of Benefits*	Summary of Benefits*	Summary of Benefits*
	Plan Brochure *	Plan Brochure*	Plan Brochure*	Plan Brochure*	Plan Brochure*	Plan Brochure*	Plan Brochure*
	Provider Directory	Provider Directory	Provider Directory	Provider Directory	Provider Directory	Provider Directory	Provider Directory
	List of Covered Drugs	List of Covered Drugs	List of Covered Drugs	List of Covered Drugs	List of Covered Drugs	List of Covered Drugs	List of Covered Drugs
Network Coverage	All Counties	All Counties	All Counties	All Counties	All Counties	Excludes Carroll County	Excludes Carroll County
Individual Deductible	$3,350	$3,000	$3,500	$4,000	$6,300	$3,750	$3,500
Family Deductible	$6,700	$6,000	$7,000	$8,000	$12,600	$7,500	$7,000
Individual Maximum Out of Pocket	$7,450	$6,850	$8,150	$8,150	$8,150	$6,750	$7,900
Family Maximum Out of Pocket	$14,900	$13,700	$16,300	$16,300	$16,300	$13,500	$15,800
PCP Visits	$30 Copay	10% Coinsurance After Deductible	$40 Copay	$40 Copay	$40 Copay	20% Coinsurance after deductible	$40 Copay
Specialist Visits	$60 Copay	Tier 1: 10% Coinsurance After Deductible	Tier 1: $50 Copay	Tier 1: $60 Copay	Tier 1: 30% Coinsurance After Deductible	20% Coinsurance after deductible	$80 Copay
Urgent Care	$60 Copay	Tier 1: $50 Copay, 10% Coinsurance After Deductible	Tier 1: $50 Copay	Tier 1: $50 Copay	Tier 1: $50 Copay	20% Coinsurance after deductible	$50 Copay
Emergency Room	$600 Copay with Deductible	$500 Copay, 10% Coinsurance After Deductible	$750 Copay	$500 Copay	30% Coinsurance After Deductible	20% Coinsurance after deductible	$500 Copay after deductible
Generic Drug	$25 Copay	Tier 1: 10% Coinsurance After Deductible	Tier 1: $15 Copay	Tier 1: $20 Copay	Tier 1: $15 Copay	20% Coinsurance after deductible	$10 Copay
Preferred Brand Drug	$50 Copay	Tier 1: 10% Coinsurance After Deductible	Tier1: $100 Copay	Tier 1: $45 Copay	Tier 1: $45 Copay	20% Coinsurance after deductible	$65 Copay

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2020 Individual Plans

Plan ID / Form Schedule #	59025NH0370014	59025NH0370016	75841NH0090005	96751NH0150036	59025NH0370011
Insurance Company	Harvard Pilgrim Health Care of New England	Harvard Pilgrim Health Care of New England	Ambetter (offered by Celtic Insurance Company)	Matthew Thornton Health Plan	Harvard Pilgrim Health Care of New England
Plan Name	ElevateHealth HMO Silver 3750	ElevateHealth HMO Silver 5000	Ambetter Secure Care 5 (2020)	Anthem Gold Pathway X Enhanced HMO 1500 15	ElevateHealth HMO Gold 1500
Metal Level	Silver	Silver	Gold	Gold	Gold
Plan Documents & Links	Summary of Benefits*	Summary of Benefits*	Summary of Benefits*	Summary of Benefits*	Summary of Benefits*
	Plan Brochure*	Plan Brochure*	Plan Brochure*	Plan Brochure*	Plan Brochure*
	Provider Directory	Provider Directory	Provider Directory	Provider Directory	Provider Directory
	List of Covered Drugs	List of Covered Drugs	List of Covered Drugs	List of Covered Drugs	List of Covered Drugs
Network Coverage	Excludes Carroll County	Excludes Carroll County	All Counties	All Counties	Excludes Carroll County
Individual Deductible	$3,750	$5,000	$1,250	$1,500	$1,500
Family Deductible	$7,500	$10,000	$2,500	$4,500	$3,000
Individual Maximum Out of Pocket	$7,900	$7,900	$5,900	$8,150	$6,500
Family Maximum Out of Pocket	$15,800	$15,800	$11,800	$16,300	$13,000
PCP Visits	$40 Copay	$40 Copay	$15 Copay	$25 Copay	$25 Copay
Specialist Visits	$80 Copay after deductible	$80 Copay	$35 Copay	Tier 1: 15% Coinsurance After Deductible	$50 Copay
Urgent Care	$50 Copay	$50 Copay	$35 Copay	Tier 1: $50 Copay, 15% Coinsurance After Deductible	$35 Copay
Emergency Room	$500 Copay after deductible	$500 Copay after deductible	20% Coinsurance After Deductible	$250 Copay, 15% Coinsurance After Deductible	$300 Copay after deductible
Generic Drug	$10 Copay	$10 Copay	$15 Copay	Tier 1: 15% Coinsurance	$5 Copay
Preferred Brand Drug	$65 Copay	$65 Copay	$30 Copay	No Charge After Deductible	$50 Copay

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2020 SHOP Plans

Plan ID / Form Schedule #	96751NH0160012	96751NH0160008	96751NH0160010	96751NH0160028	96751NH0160017
Insurance Company	Matthew Thornton Health Plan	Matthew Thornton Health Plan	Matthew Thornton Health Plan	Matthew Thornton Health Plan	Matthew Thornton Health Plan
Plan Name	Anthem Bronze Pathway X HMO 5000 30 6850 w HSA	Anthem Bronze Pathway X HMO 6850 0 6850 w HSA	Anthem Silver Pathway X HMO 3000 10 6850 w HSA	Anthem Silver Pathway X HMO 3500 10 6850 w HSA	Anthem Silver Pathway X HMO 3500 20 8000
Metal Level	Expanded Bronze	Expanded Bronze	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	All Counties	All Counties	All Counties	All Counties	All Counties
Individual Deductible	$5,000	$6,850	$3,000	$3,500	$3,500
Family Deductible	$10,000	$13,700	$6,000	$7,000	$7,000
Individual Maximum Out of Pocket	$6,850	$6,850	$6,850	$6,850	$8,000
Family Maximum Out of Pocket	$13,700	$13,700	$13,700	$13,700	$16,000
PCP Visits	$40 Copay After Deductible	0% Coinsurance After Deductible	$40 Copay After Deductible	$40 Copay After Deductible	$40 Copay
Specialist Visits	Tier 1: $80 Copay After Deductible	Tier 1: 0% Coinsurance After Deductible	Tier 1: $80 Copay After Deductible	Tier 1: $80 Copay After Deductible	Tier 1: $80 Copay
Urgent Care	Tier 1: $100 Copay After Deductible	Tier 1: 0% Coinsurance After Deductible	Tier 1: $100 Copay After Deductible	Tier 1: $100 Copay After Deductible	Tier 1: $100 Copay
Emergency Room	30% Coinsurance After Deductible	0% Coinsurance After Deductible	10% Coinsurance After Deductible	10% Coinsurance After Deductible	$300 Copay After Deductible
Generic Drug	Tier 1: 30% Coinsurance After Deductible	Tier 1: 0% Coinsurance After Deductible	Tier 1: 20% Coinsurance After Deductible	Tier 1: 20% Coinsurance After Deductible	Tier 1: $25 Copay
Preferred Brand Drug	Tier 1: 30% Coinsurance After Deductible	Tier 1: 0% Coinsurance After Deductible	Tier 1: 20% Coinsurance After Deductible	Tier 1: 20% Coinsurance After Deductible	Tier 1: $50 Copay

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2020 SHOP Plans

Plan ID / Form Schedule #	96751NH0160019	96751NH0160013	96751NH0160018	96751NH0160027	96751NH0160029
Insurance Company	Matthew Thornton Health Plan	Matthew Thornton Health Plan	Matthew Thornton Health Plan	Matthew Thornton Health Plan	Matthew Thornton Health Plan
Plan Name	Anthem Silver Pathway X HMO 4000 10 6850 w HSA	Anthem Silver Pathway X HMO 4000 20 8000	Anthem Silver Pathway X HMO 5000 0 8000	Anthem Silver Pathway X HMO 6000 0 8000	Anthem Silver Pathway X HMO 7500 0 8000
Metal Level	Silver	Silver	Silver	Silver	Silver
Plan Documents & Links	Summary of Benefits*	Summary of Benefits*	Summary of Benefits*	Summary of Benefits*	Summary of Benefits*
	Provider Directory	Provider Directory	Provider Directory	Provider Directory	Provider Directory
	List of Covered Drugs	List of Covered Drugs	List of Covered Drugs	List of Covered Drugs	List of Covered Drugs
Network Coverage	All Counties	All Counties	All Counties	All Counties	All Counties
Individual Deductible	$4,000	$4,000	$5,000	$6,000	$7,500
Family Deductible	$8,000	$8,000	$10,000	$12,000	$15,000
Individual Maximum Out of Pocket	$6,850	$8,000	$8,000	$8,000	$8,000
Family Maximum Out of Pocket	$13,700	$16,000	$16,000	$16,000	$16,000
PCP Visits	$40 Copay After Deductible	$40 Copay	$40 Copay	$40 Copay	$40 Copay
Specialist Visits	Tier 1: $80 Copay After Deductible	Tier 1: $80 Copay	Tier 1: $80 Copay	Tier 1: $80 Copay	Tier 1: $80 Copay
Urgent Care	Tier 1: $100 Copay After Deductible	Tier 1: $100 Copay	Tier 1: $100 Copay	Tier 1: $100 Copay	Tier 1: $100 Copay
Emergency Room	10% Coinsurance After Deductible	$300 Copay After Deductible	$300 Copay After Deductible	$300 Copay After Deductible	$300 Copay After Deductible
Generic Drug	Tier 1: 20% Coinsurance After Deductible	Tier 1: $25 Copay	Tier 1: $25 Copay	Tier 1: $25 Copay	Tier 1: $25 Copay
Preferred Brand Drug	Tier 1: 20% Coinsurance After Deductible	Tier 1: $50 Copay	Tier 1: $50 Copay	Tier 1: $50 Copay	Tier 1: $50 Copay

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2020 SHOP Plans

Plan ID / Form Schedule #	96751NH0160015	96751NH0160011	96751NH0160016	96751NH0160026	96751NH0160014
Insurance Company	Matthew Thornton Health Plan	Matthew Thornton Health Plan	Matthew Thornton Health Plan	Matthew Thornton Health Plan	Matthew Thornton Health Plan
Plan Name	Anthem Gold Pathway X HMO 1000 10 5000	Anthem Gold Pathway X HMO 2000 10 4075 w HSA	Anthem Gold Pathway X HMO 2000 10 5500	Anthem Gold Pathway X HMO 3000 10 5500	Anthem Platinum Pathway X HMO 20 15 5000
Metal Level	Gold	Gold	Gold	Gold	Platinum
Plan Documents & Links	Summary of Benefits*	Summary of Benefits*	Summary of Benefits*	Summary of Benefits*	Summary of Benefits*
	Provider Directory	Provider Directory	Provider Directory	Provider Directory	Provider Directory
	List of Covered Drugs	List of Covered Drugs	List of Covered Drugs	List of Covered Drugs	List of Covered Drugs
Network Coverage	All Counties	All Counties	All Counties	All Counties	All Counties
Individual Deductible	$1,000	$2,000	$2,000	$3,000	$0
Family Deductible	$3,000	$4,000	$4,000	$6,000	$0
Individual Maximum Out of Pocket	$5,000	$4,075	$5,500	$5,500	$5,000
Family Maximum Out of Pocket	$10,000	$8,150	$11,000	$11,000	$10,000
PCP Visits	$25 Copay	$25 Copay After Deductible	$25 Copay	$25 Copay	$20 Copay
Specialist Visits	Tier 1: $50 Copay	Tier 1: $50 Copay After Deductible	Tier 1: $50 Copay	Tier 1: $50 Copay	Tier 1: $40 Copay
Urgent Care	Tier 1: $100 Copay	Tier 1: $100 Copay After Deductible	Tier 1: $100 Copay	Tier 1: $100 Copay	Tier 1: $100 Copay
Emergency Room	$300 Copay After Deductible	10% Coinsurance After Deductible	$300 Copay After Deductible	$300 Copay After Deductible	$250 Copay
Generic Drug	Tier 1: $25 Copay	Tier 1: 10% Coinsurance After Deductible	Tier 1: $25 Copay	Tier 1: $25 Copay	Tier 1: $25 Copay
Preferred Brand Drug	Tier 1: $50 Copay	Tier 1: 10% Coinsurance After Deductible	Tier 1: $50 Copay	Tier 1: $50 Copay	Tier 1: $50 Copay

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2020 Individual SADP Plans

Plan ID / Form Schedule #	57601NH0420003	57601NH0420005	87701N0080001	72953NH0040002	72953NH0060002	87701N0100001	57601NH0420004	87701N0070001	72953NH0040001
Insurance Company	Anthem Health Plans of NH	Anthem Health Plans of NH	Delta Dental Plan of New Hampshire Inc.	Renaissance Life and Health Insurance Company of America	Renaissance Life and Health Insurance Company of America	Delta Dental Plan of New Hampshire Inc.	Anthem Health Plans of NH	Delta Dental Plan of New Hampshire Inc.	Renaissance Life and Health Insurance Company of America
Plan Name	Anthem Dental Family	Anthem Dental Family Value	Delta Dental Family Low	New Hampshire Preferred Plan	New Hampshire Preferred Plan Pediatric Only	Delta Dental Pediatric Low	Anthem Dental Family Enhanced	Delta Dental Family High	New Hampshire Preferred Plus Plan
Metal Level	Low	Low	Low	Low	Low	Low	High	High	High
Plan Documents & Links	Plan Brochure	Plan Brochure	Plan Brochure	Plan Brochure	Plan Brochure	Plan Brochure	Plan Brochure	Plan Brochure	Plan Brochure
	Summary of Benefits	Summary of Benefits	Summary of Benefits	Summary of Benefits	Summary of Benefits	Summary of Benefits	Summary of Benefits	Summary of Benefits	Summary of Benefits
Network Coverage	All Counties	All Counties	All Counties	All Counties	All Counties	All Counties	All Counties	All Counties	All Counties
Deductible-Individual	$50	$50	$150	$50	$50	150	$25	50	$50
Deductible-Family	$0	$0	$0	$150	$150	$0	$0	$0	$150
Max Out of Pocket-Individual	$350	$350	$350	$350	$350	$350	$350	$350	$350
Max Out of Pocket-Family	$700	$700	$700	$700	$700	$700	$700	$700	$700
Dental Check-Up for Children	$0	$0	$30	N/A	N/A	$30 Copay	$0	$15 Copay	N/A
Basic Dental Care - Child	40% Coinsurance	40% Coinsurance	$30 copay , 40% Coinsurance After Deductible	N/A	N/A	$30 Copay, 40% Coinsurance After Deductible	20% Coinsurance	$15 copay, 20% Coinsurance After Deductible	N/A
Orthodontia - Child	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance
Major Dental Care - Child	50% Coinsurance	50% Coinsurance	$30 copay , 50% Coinsurance After Deductible	$0	$0	$30	50% Coinsurance	$15 Copay, 50% Coinsurance After Deductible	$0
Routine Dental Services - Adult	$0	$0	$30	$0	$0	$0	$0	$15	$0
Basic Dental Care - Adult	50% Coinsurance	50% Coinsurance	$30 copay , 20% Coinsurance After Deductible	$0	$0	$0	20% Coinsurance	$15 Copay, 20% Coinsurance After Deductible	$0
Orthodontia - Adult	Not Covered	Not Covered	0%	0%	0%	0%	Not Covered	0%	0%
Major Dental Care - Adult	70% Coinsurance	Not Covered	$30 copay , 50% Coinsurance After Deductible	50% Coinsurance	0%	0%	50% Coinsurance	$15 Copay, 50% Coinsurance After Deductible	50% Coinsurance

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2020 Individual SADP Plans

Plan ID / Form Schedule #	87701N0090001	72953NH0060001
Insurance Company	Delta Dental Plan of New Hampshire Inc.	Renaissance Life and Health Insurance Company of America
Plan Name	Delta Dental Pediatric High	New Hampshire Preferred Plus Plan Pediatric Only
Metal Level	High	High
Plan Documents & Links	Plan Brochure Summary of Benefits	Plan Brochure Summary of Benefits
Network Coverage	All Counties	All Counties
Deductible-Individual	$50	$50
Deductible-Family	$0	$150
Max Out of Pocket-Individual	$350	$350
Max Out of Pocket-Family	$700	$700
Dental Check-Up for Children	$15 Copay	N/A
Basic Dental Care - Child	$15 Copay, 20% Coinsurance After Deductible	N/A
Orthodontia - Child	50% Coinsurance	50% Coinsurance
Major Dental Care - Child	$15 Copay, 50% Coinsurance After Deductible	$0
Routine Dental Services - Adult	$0	$0
Basic Dental Care - Adult	$0	$0
Orthodontia - Adult	0%	0%
Major Dental Care - Adult	0%	0%

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2020 SHOP SADP Plans

Plan ID / Form Schedule #	57601NH0390003	57601NH01420004
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	Plan Brochure	Plan Brochure
	Summary of Benefits	Summary of Benefits
Network Coverage	All Counties	All Counties
Deductible-Individual	$50	$25
Deductible-Family	$0	$0
Max Out of Pocket-Individual	$350	$350
Max Out of Pocket-Family	$700	$700
Dental Check-Up for Children	$0	$0
Basic Dental Care - Child	40% Coinsurance	20% Coinsurance
Orthodontia - Child	50% Coinsurance	50% Coinsurance
Major Dental Care - Child	50% Coinsurance	50% Coinsurance
Routine Dental Services - Adult	0%	0%
Basic Dental Care - Adult	50% Coinsurance	20% Coinsurance
Orthodontia - Adult	N/A	N/A
Major Dental Care - Adult	70% Coinsurance	50% Coinsurance

NOTE: The above serves only as a high level summary, for further details please reference the Plan Brochures and Summary of Benefits PDFs