

2015 Individual Medical Silver Plans (p. 1 of 2)

Plan ID/ Form Schedule #	96751NH0150020	96751NH0150022	96751NH0330005	59025NH0290006	59025NH0260005	59025NH0270003	59025NH0270002	19304NH0140001		19304NH0130001		19304NH0040001	
Issuer	Anthem	Anthem	Anthem	Harvard Pilgrim	Harvard Pilgrim	Harvard Pilgrim	Harvard Pilgrim	Maine CHO		Maine CHO		Maine CHO	
Plan Name	Anthem Silver Pathway X Enhanced HMO 10 for HSA	Anthem Silver Pathway X Enhanced HMO 3250	Anthem Blue Cross and Blue Shield Silver DirectAccess, a Multi-State Plan	Harvard Pilgrim ElevateHealth Silver HSA HMO	Harvard Pilgrim ElevateHealth Silver HMO	Harvard Pilgrim NH Network Silver HMO Premium	Harvard Pilgrim NH Network Silver HMO Preferred	Community Value		Community Value Plus		Community Choice	
Metal Level	Silver	Silver	Silver	Silver	Silver	Silver	Silver	Silver		Silver		Silver	
Product Type	HMO	HMO	HMO	HMO	HMO	HMO	HMO	PPO		PPO		PPO	
Network Coverage	NHN002	NHN002	NHN201	NHN002	NHN002	NHN003	NHN003	NHN001		NHN001		NHN001	
								In-Network	Out-Of-Network	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Deductible-Individual/Family	\$2500 / \$5000	\$3250 / \$6500	\$1500 / \$3000	\$2500 / \$5000	\$4000 / \$8000	\$2000 / \$4000	\$3000 / \$6000	\$2350 / \$4700	\$5000 / \$10000	\$2350 / \$4700	\$5000 / \$10000	\$2000 / \$4000	\$5000 / \$10000
Coinsurance	10%	0%	30%	15%	20%	30%	30%	50%	50%	50%	50%	30%	50%
Max Out of Pocket-Individual/Family	\$4000 / \$8000	\$5000 / \$10000	\$6000 / \$12000	\$4000 / \$8000	\$6000 / \$12000	\$6000 / \$12000	\$6000 / \$12000	\$6600 / \$13200	\$10000 / \$20000	\$6600 / \$13200	\$10000 / \$20000	\$6600 / \$13200	\$10000 / \$20000
Preventive Care	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	Not Covered	No Charge	Not Covered	No Charge	Not Covered
PCP Visits (not wellness)	10% Coinsurance after deductible	\$40 for first 3 visits, thereafter subject to deductible	\$35 for first 2 visits, thereafter 30% Coinsurance after deductible	15% Coinsurance after deductible	\$ 30	\$ 30	\$ 30	\$ 20	Not Covered	\$ 20	Not Covered	\$ 30	Not Covered
Specialist Visits	10% Coinsurance after deductible	No Coinsurance after deductible	30% Coinsurance after deductible	15% Coinsurance after deductible	\$ 90	\$ 90	\$ 90	\$ 50	50% Coinsurance after deductible	\$ 50	50% Coinsurance after deductible	\$ 80	50% Coinsurance after deductible
Urgent Care	\$50 Copay and 10% Coinsurance after deductible	\$50 Copay after deductible	\$50 Copay and 30% Coinsurance after deductible	\$125 Copay after deductible	\$ 125	\$ 125	\$ 125	\$ 50	50% Coinsurance after deductible	\$ 50	50% Coinsurance after deductible	\$ 80	50% Coinsurance after deductible
Outpatient Facility/Surgical Center	10% Coinsurance after deductible	No Coinsurance after deductible	30% Coinsurance after deductible	15% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible
Emergency Room	\$200 Copay and 10% Coinsurance after deductible	\$200 Copay after deductible	\$200 Copay and 30% Coinsurance after deductible	\$300 Copay after deductible	\$300 Copay after deductible	\$300 Copay after deductible	\$300 Copay after deductible	\$ 500	\$ 500	\$ 500	\$ 500	\$ 500	\$ 500
Inpatient Hospital Services	10% Coinsurance after deductible	\$500 Copay per Stay after deductible	\$500 Copay per Stay, 30% Coinsurance after deductible	15% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible
Generic Drugs	10% Coinsurance after deductible	\$ 15	\$ 15	\$15 Copay after deductible	\$ 15	\$ 15	\$ 15	\$ 15	50% Coinsurance after deductible	\$ 15	50% Coinsurance after deductible	\$ 15	50% Coinsurance after deductible
Preferred Brand Drugs	10% Coinsurance after deductible	\$ 40	\$ 40	\$50 copay after deductible	\$ 50	\$ 50	\$ 50	30% Coinsurance after deductible	50% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible
Durable Medical Equipment	10% Coinsurance after deductible	No Coinsurance after deductible	30% Coinsurance after deductible	15% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible
Chiropractic Care	10% Coinsurance after deductible	No Coinsurance after deductible	30% Coinsurance after deductible	15% Coinsurance after deductible	\$ 30	\$ 30	\$ 30	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	30% Coinsurance after deductible	50% 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	Yes	Yes	No	No
Dental Check-Up for Children	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	No Charge	No Charge	Not Covered	Not Covered

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Plan ID/ Form Schedue #	19304NH0080001		19304NH0090001		61163NH0150001	61163NH0130001	42260NH0110002		42260NH0110004	
Issuer	Maine CHO		Maine CHO		Minuteman Health	Minuteman Health	Time (Assurant)		Time (Assurant)	
Plan Name	Community Preferred		Community Preferred Plus		MyDoc HMO Silver HSA 3000	MyDoc HMO Silver Basic 2000	Assurant Health Silver Plan 001		Assurant Health Silver Plan 002	
Metal Level	Silver		Silver		Silver	Silver	Silver		Silver	
Product Type	PPO		PPO		HMO	HMO	PPO		PPO	
Network Coverage	NHN001		NHN001		NHN001	NHN001	NHN001		NHN001	
	In-Network	Out-Of-Network	In-Network	Out-Of-Network			In-Network	Out-Of-Network	In-Network	Out-Of-Network
Deductible-Individual/Family	\$2300 / \$4600	\$5000 / \$10000	\$2300 / \$4600	\$5000 / \$10000	\$3000 / \$6000	\$2000 / \$4000	\$3500 / \$7000	\$10500 / \$21000	\$2000 / \$4000	6000 / 12000
Coinsurance	30%	50%	30%	50%	10%	30%	0%	0%	50%	70%
Max Out of Pocket-Individual/Family	\$5500 / \$11000	\$10000 / \$20000	\$5500 / \$11000	\$10000 / \$20000	\$4750 / \$9500	\$6000 / \$12000	\$3500 / \$7000	\$10500 / \$21000	\$6350 / \$12700	\$19050 / \$38100
Preventive Care	No Charge	Not Covered	No Charge	Not Covered	No Charge	No Charge	No Charge	No Coinsurance after deductible	No Charge	70% Coinsurance after deductible
PCP Visits (not wellness)	\$ 20	Not Covered	\$ 20	50% Coinsurance after deductible	10% Coinsurance after deductible	\$30 Copay for first 3 visits, then \$30 after deductible	No Coinsurance after deductible	No Coinsurance after deductible	\$ 30	70% Coinsurance after deductible
Specialist Visits	\$ 75	50% Coinsurance after deductible	\$ 75	50% Coinsurance after deductible	10% Coinsurance after deductible	30% Coinsurance after deductible	No Coinsurance after deductible	No Coinsurance after deductible	\$ 30	70% Coinsurance after deductible
Urgent Care	\$ 75	50% Coinsurance after deductible	\$ 75	50% Coinsurance after deductible	10% Coinsurance after deductible	30% Coinsurance after deductible	No Coinsurance after deductible	No Coinsurance after deductible	50% Coinsurance after deductible	70% Coinsurance after deductible
Outpatient Facility/Surgical Center	30% Coinsurance after deductible	50% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible	10% Coinsurance after deductible	30% Coinsurance after deductible	No Coinsurance after deductible	No Coinsurance after deductible	50% Coinsurance after deductible	70% Coinsurance after deductible
Emergency Room	\$ 500	\$ 500	\$ 500	\$ 500	10% Coinsurance after deductible	30% Coinsurance after deductible	\$100 Copay before deductible	\$100 Copay before deductible	\$100 Copay before deductible, and 50% Coinsurance after deductible	\$100 Copay before deductible, and 50% Coinsurance after deductible
Inpatient Hospital Services	30% Coinsurance after deductible	50% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible	10% Coinsurance after deductible	30% Coinsurance after deductible	No Coinsurance after deductible	No Coinsurance after deductible	50% Coinsurance after deductible	70% Coinsurance after deductible
Generic Drugs	\$ 10	50% Coinsurance after deductible	\$ 10	50% Coinsurance after deductible	No Coinsurance after deductible	\$ 20	No Coinsurance after deductible	No Coinsurance after deductible	\$ 15	\$ 15
Preferred Brand Drugs	\$ 40	50% Coinsurance after deductible	\$ 40	50% Coinsurance after deductible	No Coinsurance after deductible	30%	No Coinsurance after deductible	No Coinsurance after deductible	\$ 35	\$ 35
Durable Medical Equipment	30% Coinsurance after deductible	50% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	No Coinsurance after deductible	No Coinsurance after deductible	50% Coinsurance after deductible	70% Coinsurance after deductible
Chiropractic Care	30% Coinsurance after deductible	50% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible	10% Coinsurance after deductible	\$30 Copay after deductible	No Coinsurance after deductible	No Coinsurance after deductible	50% Coinsurance after deductible	70% Coinsurance after deductible
Adult Dental Embedded?	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
Pediatric Dental Embedded?	No	No	Yes	Yes	No	No	Yes	Yes	Yes	Yes
Dental Check-Up for Children	Not Covered	Not Covered	No Charge	No Charge	Not Covered	Not Covered	No Charge	No Charge	No Charge	No Charge