2018 Individual Plans

Plan ID / Form Schedue #	59025NH0330024	59025NH0330028	75841NH0090001	75841NH0090002	96751NH0150015	96751NH0150018	96751NH0150020
Insurance Company	Harvard Pilgrim of NE	Harvard Pilgrim of NE	Ambetter (offered by Celtic)	Ambetter (offered by Celtic)	Anthem Health Plans of NH	Anthem Health Plans of NH	Anthem Health Plans of NH
Plan Name	ElevateHealth Gold 1000	ElevateHealth Silver 3500	Ambetter Secure Care 1 (2018) with 3 Free PCP Visits	Ambetter Balanced Care 8 (2018)	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
Metal Level	Gold	Silver	Gold	Silver	Bronze	Bronze	Silver
	Summary of Benefits	Summary of Benefits	Summary of Benefits	Summary of Benefits	Summary of Benefits	Summary of Benefits	Summary of Benefits
Plan Documents & Links	Plan Brochure	<u>Plan Brochure</u>	Plan Brochure	<u>Plan Brochure</u>	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	Cheshire; Coos; Grafton; Hillsborough; Merrimack; Rockingham; Strafford; Sullivan	Cheshire; Coos; Grafton; Hillsborough; Merrimack; Rockingham; Strafford; Sullivan	Statewide	Statewide	Statewide	Statewide	Statewide
Deductible-	\$1,000 per person	\$3,500 per person	\$1,000 per person	\$6,750 per person	\$5,150 per person	\$5,750 per person	\$3,000 per person
Individual/Family	\$2,000 per family	\$7,000 per family	\$2,000 per family	\$13,500 per family	\$10,300 per family	\$11,500 per group	\$6,000 per family
Max Out of Pocket-	\$4,000 per person	\$7,350 per person	\$6,350 per person	\$7,150 per person	\$6,650 per person	\$7,350 per person	\$6,650 per person
Individual/Family	\$8,000 per family	\$14,700 per family	\$12,700 per family	\$14,300 per family	\$13,300 per family	\$14,700 per family	\$13,300 per family
PCP Visits	\$20 copay	\$40 copay	20% coinsurance after deductible	\$30 copay	25% coinsurance after deductible	\$40 copay with deductible; 10% coinsurance after deductible	10% coinsurance after deductible
Specialist Visits	\$40 copay	\$80 copay	20% coinsurance after deductible	\$60 copay	25% coinsurance after deductible	%50 copay after deductible; 10% coinsurance after deductible	10% coinsurance after deductible
Urgent Care	\$40 copay	\$80 copay	20% coinsurance after deductible	30% coinsurance after deductible	\$50 copay after deductible; 25% coinsurance after deductible	%50 copay after deductible; 10% coinsurance after deductible	\$50 copay after deductible
Emergency Room	\$100 copay after deductible	\$300 copay after deductible	\$250 copay after deductible	\$150 copay after deductible	\$500 copay after deductible; 25% coinsurance after deductible	\$500 copay after deductible; 10% coinsurance after deductible	\$500 copay after deductible; 10% coinsurance after deductible
Generic Drug	\$20 copay	\$30 copay	\$10 copay	\$25 copay	Tier 1: 25% coinsurance after deductible; Tier 2: 35% coinsurance after deductible	10% coinsurance after deductible	10% coinsurance after deductible
Preferred Brand Drug	\$50 copay	\$50 copay	\$25 copay after deductible	\$50 copay	Tier 1: 25% coinsurance after deductible; Tier 2: 35% coinsurance after deductible	10% coinsurance after deductible	10% coinsurance after deductible

*Ambetter has indicated that the final list of covered drugs will be able via this link no later than November 1, 2017

Plan details are contained in the plan documents linked on this plan compare, please consult these for full benefit explanations and limitations

2018 Individual Plans

Plan ID / Form Schedue #	96751NH0150022	96751NH0150024	96751NH0150025	96751NH0150026	96751NH0150027	96751NH0150030	96751NH0150033
Insurance Company	Anthem Health Plans of NH	Anthem Health Plans of NH	Anthem Health Plans of NH	Anthem Health Plans of NH	Anthem Health Plans of NH	Anthem Health Plans of NH	Anthem Health Plans of NH
Plan Name	Anthem Silver Pathway X Enhanced HMO 3800 0	Anthem Catastrophic Pathway X Enhanced HMO 7350 0	Anthem Silver Pathway X Enhanced HMO 3500 0			Anthem Silver Pathway X Enhanced HMO 2500 30	
Metal Level	Silver	Catastrophic	Silver	Bronze	Silver	Silver	Silver
	Summary of Benefits	Summary of Benefits	Summary of Benefits	Summary of Benefits	Summary of Benefits	Summary of Benefits	Summary of Benefits
Dian Daamaanta 8 Linka	Plan Brochure	Plan Brochure	Plan Brochure	Plan Brochure	Plan Brochure	Plan Brochure	Plan Brochure
Plan Documents & Links	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	Statewide	Statewide	Statewide	Statewide	Statewide	Statewide	Statewide
Deductible-	\$3,800 per person	\$7,350 per person	\$3,500 per person	\$6,350 per person	\$5,300 per person	\$2,500 per person	\$6,300 per person
Individual/Family	\$7,600 per family	\$14,700 per family	\$7,000 per family	\$12,700 per family	\$10,600 per family	\$5,000 per family	\$12,600 per family
Max Out of Pocket-	\$5,800 per person	\$7,350 per person	\$7,350 per person	\$7,350 per person	\$6,750 per person	\$7,350 per person	\$7,350 per person
Individual/Family	\$11,600 per family	\$14,700 per family	\$14,700 per family	\$14,700 per family	\$13,500 per family	\$14,700 per family	\$14,700 per family
PCP Visits	\$40 copay with deductible	\$40 copay with deductible	\$40 copay	40% coinsurance after deductible	\$35 copay	\$35 copay with deductible; 30% coinsurance after deductible	\$40 copay
Specialist Visits	\$60 copay after deductible	No charge after deductible	\$50 copay after deductible	40% coinsurance after deductible	25% coinsurance after deductible	\$50 copay after deductible; 30% coinsurance after deductible	30% coinsurance after deductible
Urgent Care	\$50 copay after deductible	No charge after deductible	\$50 copay after deductible	40% coinsurance after deductible	\$50 copay after deductible	\$50 copay after deductible; 30% coinsurance after deductible	\$50 copay after deductible
Emergency Room	\$500 copay after deductible	No charge after deductible	\$750 copay after deductible	40% coinsurance after deductible	25% coinsurance after deductible	\$500 copay after deductible; 30% coinsurance after deductible	30% coinsurance after deductible
Generic Drug	Tier 1: \$20 copay; Tier 2: \$30 copay	0% coinsurance after deductible	Tier 1: \$15 copay; Tier 2: \$25 copay	Tier 1: 25% coinsurance after deductible; Tier 2: 35% coinsurance after deductible	Tier 1: \$10 copay; Tier 2: \$20 copay	Tier 1: \$10 copay; Tier 2: \$20 copay	Tier 1: \$15 copay; Tier 2: \$25 copay
Preferred Brand Drug	Tier 1: \$45 copay; Tier 2: \$55 copay	0% coinsurance after deductible	Tier 1: \$100 copay; Tier 2: \$110 copay	Tier 1: 35% coinsurance after deductible; Tier 2: 45% coinsurance after deductible	Tier 1: \$40 copay; Tier 2: \$50 copay	Tier 1: \$30 copay; Tier 2: \$40 copay	Tier 1: \$45 copay; Tier 2: \$55 copay

2018 Individual Plans

Plan ID /		
Form Schedue #	96751NH0150036	
Insurance Company	Anthem Health Plans of NH	
Plan Name	Anthem Gold Pathway X Enhanced HMO 1500 10	
Metal Level	Gold	
Plan Documents & Links	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs	
Network Coverage	Statewide	
Deductible-	\$1,500 per person	
Individual/Family	\$4,500 per family	
Max Out of Pocket-	\$7,350 per person	
Individual/Family	\$14,700 per family	
PCP Visits	\$30 copay	
Specialist Visits	10% coinsurance after deductible	
Urgent Care	\$50 copay after deductible; 10% coinsurance after deductible	
Emergency Room	\$200 copay after deductible; 10% coinsurance after deductible	
Generic Drug	Tier 1: 10% coinsurance after deductible; Tier 2: 20% coinsurance after deductible	
Preferred Brand Drug	Tier 1: 10% coinsurance after deductible; Tier 2: 20% coinsurance after deductible	

2018 SHOP Plans

Plan ID / Form Schedue #	96751NH0160005	96751NH0160006	96751NH0160008	96751NH0160010	96751NH0160011
Insurance Company	Anthem Health Plans of NH	Anthem Health Plans of NH	Anthem Health Plans of NH	Anthem Health Plans of NH	Anthem Health Plans of NH
Plan Name	Anthem Gold Pathway X HMO 1500 20 3000	Anthem Silver Pathway X HMO 3500 10 6000	Anthem Bronze Pathway X HMO 6550 0 6550 w HSA	Anthem Silver Pathway X HMO 3000 0 6550 w HSA	Anthem Gold Pathway X HMO 1750 10 3500 w HSA
Metal Level	Gold	Silver	Bronze	Silver	Gold
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	\$1,500 per person \$3,000 per family	\$3,500 per person \$7,000 per family	\$6,550 per person \$13,100 per family	\$3,000 per person \$6,000 per family	\$3,500 per person \$3,500 per family
Max Out of Pocket-	\$3,000 per person	\$6,000 per person	\$6,550 per person	\$6,550 per person	\$7,000 per person
Individual/Family	\$6,000 per family	\$12,000 per person	\$13,100 per family	\$13,100 per family	\$7,000 per family
PCP Visits	\$20 copay with deductible; 20% coinsurance after deductible	\$35 copay with deductible; 10% coinsurance after deductible	0% coinsurance after deductible	0% coinsurance after deductible	10% coinsurance after deductible
Specialist Visits	\$20 copay with deductible; 20% coinsurance after deductible	\$35 copay with deductible; 10% coinsurance after deductible	0% coinsurance after deductible	0% coinsurance after deductible	10% coinsurance after deductible
Urgent Care	20% coinsurance after deductible	10% coinsurance after deductible	0% coinsurance after deductible	0% coinsurance after deductible	10% coinsurance after deductible
Emergency Room	\$300 copay after deductible	\$300 copay after deductible	0% coinsurance after deductible	0% coinsurance after deductible	10% coinsurance after deductible
Generic Drug	\$25 copay	\$25 copay	0% coinsurance after deductible	20% coinsurance after deductible	10% coinsurance after deductible
Preferred Brand Drug	\$50 copay; 30% coinsurance	\$50 copay; 30% coinsurance	0% coinsurance after deductible	20% coinsurance after deductible	10% coinsurance after deductible

2018 SHOP Plans

Plan ID / Form Schedue #	96751NH0160012		
Insurance Company	Anthem Health Plans of NH		
Plan Name	Anthem Bronze Pathway X HMO 5250 30 6550 w HSA		
Metal Level	Bronze		
Plan Documents & Links	Summary of Benefits Provider Directory List of Covered Drugs		
Network Coverage	Statewide		
Deductible- Individual/Family	\$5,250 per person \$10,500 per family		
Max Out of Pocket-	\$6,550 per person		
Individual/Family	\$13,100 per family		
PCP Visits	30% coinsurance after deductible		
Specialist Visits	30% coinsurance after deductible		
Urgent Care	30% coinsurance after deductible		
Emergency Room	30% coinsurance after deductible		
Generic Drug	30% coinsurance after deductible		
Preferred Brand Drug	30% coinsurance after deductible		

2018 Individual SADP Plans

Plan ID / Form Schedue #	57601NH0420003	57601NH0420004	57601NH0420005	87701NH0070001	87701NH0080001
Insurance Company	Anthem Health Plans of NH	Anthem Health Plans of NH	Anthem Health Plans of NH	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
Metal Level	Low	High	Low	High	Low
Plan Documents & Links	Summary of Benefits Provider Directory	Summary of Benefits Provider Directory	Summary of Benefits Provider Directory	<u>Plan Brochure</u> <u>Provider Directory</u>	Plan Brochure Provider Directory
Network Coverage	Statewide	Statewide	Statewide	Statewide	Statewide
Deductible- Individual/Family	\$50 per person	\$25 per person	\$50 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			
Dental Check-Up for Children	No charge after deductible	No charge after deductible	No charge after deductible	\$15 copay	\$30 copay
Basic Dental Care - Child	40% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible	\$15 copay after deductible; 20% coinsurance after deductible	\$30 copay after deductible; 40% coinsurance after deductible
Orthodontia - Child	50% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance	50% coinsurance
Major Dental Care - Child	50% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	\$15 copay after deductible; 50% coinsurance after deductible	\$30 copay after deductible; 50% coinsurance after deductible
Routine Dental Services - Adult	No charge after deductible	No charge after deductible	No charge after deductible	\$15 copay	\$30 copay
Basic Dental Care - Adult	50% coinsurance after deductible	20% coinsurance after deductible	50% coinsurance after deductible	\$15 copay after deductible; 20% coinsurance after deductible	\$30 copay after deductible; 40% coinsurance after deductible
Orthodontia - Adult	N/A	N/A	N/A	N/A	N/A
Major Dental Care - Adult	70% coinsurance after deductible	50% coinsurance after deductible	N/A	\$15 copay after deductible; 50% coinsurance after deductible	\$30 copay after deductible; 50% coinsurance after deductible

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2018 Individual SADP Plans

Plan ID / Form Schedue #	87701NH0090001	87701NH0100001	
Insurance Company	Delta Dental	Delta Dental	
Plan Name	Delta Dental Pediatric High Plan	Delta Dental Pediatric Low Plan	
Metal Level	High	Low	
Plan Documents & Links	<u>Plan Brochure</u> <u>Provider Directory</u>	<u>Plan Brochure</u> <u>Provider Directory</u>	
Network Coverage	Statewide	Statewide	
Deductible- Individual/Family	\$50 per person	\$150 per person	
Max Out of Pocket- Individual/Family	\$350 per person \$700 per family	\$350 per person \$700 per family	
Dental Check-Up for Children	\$15 copay	\$30 copay	
Basic Dental Care - Child	\$15 copay after deductible; 20% coinsurance after deductible	\$30 copay after deductible; 40% coinsurance after deductible	
Orthodontia - Child	50% coinsurance	50% coinsurance	
Major Dental Care - Child	\$15 copay after deductible; 50% coinsurance after deductible	\$30 copay after deductible; 50% coinsurance after deductible	
Routine Dental Services - Adult	N/A	N/A	
Basic Dental Care - Adult	N/A	N/A	
Orthodontia - Adult	N/A	N/A	
Major Dental Care - Adult	N/A	N/A	

Plan details are contained in the plan documents linked on this plan compare, please consult these for full benefit explanations and limitations

2018 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	Summary of Benefits	
	Provider Directory	Provider Directory	
Network Coverage	Statewide	Statewide	
Deductible- Individual/Family	\$50 per person	\$25 per person	
Max Out of Pocket-	\$350 per person	\$350 per person	
Individual/Family	\$700 per family	\$700 per family	
Dental Check-Up for	No charge after	No charge after	
Children	deductible	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 -	No charge after	No charge after	
Adult	deductible	deductible	
Basic Dental Care - Adult	50% coinsurance after	20% coinsurance after	
Basic Dental Care - Auurt	deductible	deductible	
Orthodontia - Adult	N/A	N/A	
Major Dental Care - Adult	70% coinsurance after deductible	50% coinsurance after deductible	