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Health Plan Benefits & Qualifications (HPBQ) Advisory Committee

October 25, 2017

Today's Agenda

A. Call to Order and Introductions
B. Public Comment
C. Vote: September 20, 2017 Meeting Minutes
D. Certification Requirements
    - Committee Goals
    - AHCT Vision, Mission, Strategic Goals
    - Follow-Ups from Previous Meetings
    - Certification Discussion Topics, continued
G. Next Steps
H. Adjournment

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Public Comment

(2 Minutes per Commenter)

➢ Vote

- September 20, 2017 Meeting Minutes

- **Certification Requirements**

HPBQ Advisory Committee Goals

- AHCT policy titled: 'Establishing Requirements For Certification, Recertification And Decertification Of Qualified Health Plans'
  - Approved November 29, 2012
  - Policy states as follows: 'Members of the Exchange staff (the "Staff"), in consultation with the Exchange's Health Plan Benefits and Qualifications Advisory Committee (the "Committee"), are charged with evaluating options and making recommendations to the Board of the Exchange regarding requirements for the certification, recertification and decertification of QHPs.'
    - Certification requirements include those outlined by Affordable Care Act (ACA) as well as those established by AHCT, such as:
      - At least one Gold and one Silver plan, with associated Cost Sharing Reduction (CSR) plans, must be offered by an issuer via the Exchange
      - Submit the prescribed standardized plans approved by the AHCT Board of Directors (BOD)
      - Meet the Essential Community Provider (ECP) standard of contracting with at least 50% of the Federally Qualified Health Centers (FQHCs) in Connecticut, as well as 50% of the non-FQHC providers contained on the AHCT ECP list

AHCT Vision/Mission/Goals

Vision

- The CT Health Exchange supports health reform efforts at the state and national level that provide CT residents with better health, and an enhanced and more coordinated health care experience at a reasonable, predictable cost.

Mission

- To increase the number of insured residents, improve health care quality, lower costs and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and provider that give them the best value.

Strategic Goals

- Focus on providing access to quality insurance choices for individuals and small businesses, delivering a positive customer experience, improving quality, cost transparency and reducing disparities in health care; which will result in healthier people, healthier communities and a healthier Connecticut.

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Follow-Ups From Previous Meetings

- HPBQ Advisory Committee (HPBQ AC) Meetings Scheduled:
  - November 29, 2017
  - December 13, 2017
  - January 10, 2018
  - February 7, 2018
- URL to 2018 AHCT Standardized Plans
  - http://agency.accesshealthct.com/healthplaninformation#one
- Standardized Plans: Requirement in Other States
- Consumer Feedback on Plan Designs
- Value-Based Insurance Design

Standardized Plans – State Requirements for 2017

Standardized Plan Requirements	FFM	SPM	SBM-FP	SBM	Grand Total
No guidance located - assume not requiring			1	3	4
Not requiring standard plans				1	1
Not requiring standard plans for 2018 - nothing definitive found for 2017				1	1
Optional for carriers			1		1
Optional - no standard plans filed	12	3			15
Optional - some standard plans submitted in 2017	16	3	1		20
Standard plans only (non-standard plans not permitted)				1	1
Standard plans not required for 2017-2018, but expect to implement for 2019				1	1
Standard plans required (vary by plan)			2	5	7
Grand Total	28	6	5	12	51

SBMs:

- ***5 states do not require or do not appear to require standardized plans***
- ***1 state is developing standardized plans for 2019***
- ***1 state requires only limited standardized plans***
- ***5 states require standardized plans***

Standardized plans were first available in FFMs/SPMs for 2017, but were optional for carriers

FFM: Federally-facilitated marketplace
SPM: State partnership marketplace
SBM-FP: State-based marketplace using the federal platform
SBM: State-based marketplace

Refer to Appendix for information on each state

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AHCT "Leaver" Study: November 2016

FACTORS IMPORTANT IN PLAN SELECTION

Keeping monthly premiums low is the most important factor for customers when selecting a plan. Out of pocket costs are also an important factor for many.

Keeping monthly premiums low is the main concern of customers, regardless of demographics or plan characteristics

Important Factors in Selecting Health Plan (unaided)

	Current Enrollees	Disenrollees
Keeping the monthly premiums low	62%	55%
Having a low deductible	28%	23%
Keeping co-pays low	23%	23%
Having a plan that provides good health benefits	20%	20%
Having a plan that includes your doctor or health center in the network	18%	12%
Having a wide range of benefits	13%	12%
Having a plan with a wide range of doctors or hospitals	11%	7%
Having a plan that covers my prescription drug(s)	6%	10%
Having a benefit that you need	6%	5%
Other	7%	8%

Percentage providing unaided response to question

Importance of Factors in Selecting Health Plan (aided)

	Enrollees		Disenrollees	
	Subsidized	Non-subsidized	Subsidized	Non-subsidized
The monthly cost of your premium.	**85%**	**77%**	**85%**	**81%**
Your out-of-pocket costs such as plan deductible, copayments, coinsurance.	**76%**	**65%**	**74%**	**62%**
Whether or not your doctors are in the plan.	**67%**	**61%**	**63%**	**57%**

Percentage indicating factor was very or somewhat important when selecting a health plan

Percentage indicating factor was very or somewhat important when selecting a health plan

Customers focus on premiums, but have less of an understanding of how other out-of-pocket costs may impact their overall health care spending.

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Value-Based Insurance Design (VBID)

- VBID Approach
  - Intended to improve health care quality and reduce costs, often through:
    - Incentives for consumers to obtain appropriate medical services that yield positive health outcomes and can prevent more costly health care problems in the future, such as preventive care, wellness screenings, maintenance medications
    - Reducing out-of-pocket costs for 'high clinical value' services
    - Discouraging utilization of services that may not be necessary
  - May focus on specific chronic conditions that can result in high claims when patients are non-compliant with medications or do not obtain regular care to manage the disease
  - Must comply with non-discrimination and mental health parity requirements
  - Implementation in group plans can be effective when employers are able to provide incentives such as increased contribution towards cost of health insurance when employee participates in biometric health assessment

Certification Requirements

Topics Reviewed by Board of Directors

Topic	Discussion Date
Broker Compensation	2017
Certification Requirements (Policy, Requirements & Procedures: Cert/Recert/Decert)	2012
Essential Community Provider (ECP) Contracting Standards	2012, 2013, 2017
Essential Health Benefits (EHB) Benchmark Plan	2012, 2015
*Lowest Cost Silver Plan in the Individual Market**	2013
Network Adequacy Standards	2014, 2017
*Pediatric Dental Coverage in Medical Plans**	2014
*Plan Mix (Standard/Non-Standard Plan Offerings)**	2012, 2013, 2014, 2015
Plan Mix – Stand-Alone Dental Plans (SADPs)	2014
Prescription Drug Formulary Standards	2014, 2017
*Standardized Plan Design**	2013, 2014, 2015, 2016, 2017
Tobacco Surcharge	2017

**Current discussion topics*

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Discussion Points

- Should AHCT remove the requirement for carriers to submit standardized plans in the Individual Market?
- Should AHCT continue to permit carriers to submit non-standard plans in the Individual Market?
- Should AHCT continue to prescribe the maximum number of plans that carriers can offer via the Exchange?
- How should AHCT structure requirements for number of plans that can be submitted ("Plan Mix")?
- Should AHCT eliminate the requirement that the lowest cost Silver plan in the Individual Market be the AHCT standardized plan?

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Should AHCT remove the requirement for carriers to submit standardized plans in the Individual Market?

Reasons to Retain Standardized Plans	Reasons to Eliminate Standardized Plans
• Ensures desired products, cost sharing (e.g., lower upfront cost-sharing for some services, maximum copay for high cost prescription drug tiers), benefit features (e.g., embedded pediatric dental) and network structure (e.g., includes out-of-network coverage) are available to consumers • Promotes transparency, ease, and simplicity for comparison shopping as plans offered by multiple issuers can be differentiated through premium, network, formulary and 'other' features (e.g., adult vision, mail order drug, etc.) • Assures that AHCT can deliver upon its Vision of providing residents with "…health care experience at a reasonable, predictable cost" • Provides AHCT with advance information about plan features that may result in the need for system enhancements • High risk probability of market disruption, member confusion and reduction in auto-renewal efforts if standard plans are removed • Could result in fewer plan choices offered per carrier	• Issuers have expertise in plan design development, incorporating changing market patterns quickly • Requiring standardized plans could impact an issuer's decision to participate 'On-Exchange' • When developing standardized 'patient-centered' designs, higher premium rates due to 'richer' benefits can result • Challenges exist in ensuring that carriers can meet all filing requirements (e.g., Mental Health Parity) for standardized plans

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➢ Summary

Should AHCT continue to permit carriers to submit non-standard plans in the Individual Market?

Reasons to Continue Permitting Non-Standard Plans	Reasons to Eliminate Option to Submit Non-Standard Plans
• If non-standard plans are not also available, could result in fewer innovative plan design offerings through the exchange • Provides consumers with additional plan choices • May result in increased competition • High risk probability of market disruption, member confusion and reduction in auto-renewal efforts if standard plans are removed • Catastrophic plans are 'non-standard' and bring a valued plan option to the young, invincible population	• Could reduce administrative and operational costs for both AHCT and carriers • May result in improved understanding of plan benefits (i.e., health literacy) with focus on fewer plans

➢ Summary

Should AHCT continue to prescribe the max number of plans that carriers can offer on the Exchange?

Reasons to Continue…	Reasons to Eliminate…
• Ensures that an excessive amount of plan choices will not be available, which could be burdensome for consumers in plan selection • Allows for a broad array of plan options and metal tiers to accommodate consumers with varying income levels and health needs across the spectrum • Allows AHCT to plan for system capacity and operational support	• Carriers have not historically submitted the maximum number of non-standard plans per metal tier, so there may be limited risk of 'too many' plans being available

Plan Mix - Medical

Current Guidelines: Number of Plans Permitted per Issuer				
	Individual Market		Small Group Market*	
	Standardized	Non-Standard	Standardized	Non-Standard
Platinum	1 (Optional)	2	0	4 (Optional)
Gold	1	3	0	Min 1 – Max 6
Silver	1	3	0	Min 2 – Max 6
Bronze	2	3	0	Min 2 – Max 4
Catastrophic	N/A	1	N/A	N/A
TOTAL	4 Required / 1 Optional	12 Optional	0 Required	5 Required / 15 Optional
Maximum	17		20	

2018 Submitted Plans

20 in Individual market (two issuers):

- **8 standardized plans (no Platinum)**
- **Non-standard plans: 1 Gold, 5 Silver, 4 Bronze and 2 Catastrophic**

14 in Small Group market (two issuers):

- **Non-standard plans:**
- **1 Platinum, 3 Gold, 5 Silver, 5 Bronze**

*Effective for the 2018 plan year, AHCT removed the requirement for Issuers to submit standardized plans for SHOP;
The minimum count of plans are required to include out-of-network coverage and include pediatric dental EHBs

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➢ Summary

How should AHCT structure requirements for number of plans that can be submitted ("Plan Mix")?

Individual Market - Considerations	Small Group Market - Considerations
• Platinum: Consider eliminating inclusion of a standardized Platinum plan, but permitting 'non-standard' Platinum plan options • Gold: Consider reducing the number of non-standard plans that can be submitted, as only 5 Gold plans are available market-wide • Silver: Consider eliminating the option for non-standard plans at the Silver metal level • Bronze: Consider no modification to current approach • Catastrophic: Consider no modification to current approach	• Consider no modification to current approach, implemented for 2018 plan year

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➢ Summary

Should AHCT eliminate the requirement that the lowest cost Silver plan in the Individual Market be the AHCT standardized plan?

Reasons to Continue…	Reasons to Eliminate…
• Results in 'affordability' as defined by ACA of the AHCT standardized Silver plan • Could result in the calculation of PTCs based on non-standard Silver plans that are less costly due to features such as: different product type, narrow network composition, streamlined formulary, most services subject to annual plan deductible, HSA-compatible plans, exclusion of pediatric dental coverage (if an ACA compliant stand-alone dental plan is available) • Could result in lower out-of-pocket plan costs for consumers • Could result in significant movement from current plan selection to an alternative plan at renewal for many enrollees in an attempt to minimize premium impact, as the amount of premium tax credit (PTC) might be based on a lower cost plan	• May result in overall reduction in premium for Silver plans as a result of increased competition

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➢ Summary

➢ Next Steps

Looking Ahead: Future Agenda Items

Certification Review Topics	2017/2018 Discussion Date	Board Review
Standardized Plan Design Decision	September & October	November, 2017
Plan Mix (Standard/Non-Standard Plan Offerings)	September & October	November, 2017
Pediatric Dental Coverage in Medical Plans	September & October	November, 2017
Lowest Cost Silver Plan in the Individual Market	September & October	November, 2017
Essential Health Benefits (EHB) Benchmark Plan	November	January, 2018
Network Adequacy Standards	November	January, 2018
Essential Community Provider (ECP) Contracting Standards	November	January, 2018
Prescription Drug Formulary Standards	November	January, 2018
Tobacco Surcharge	December	January, 2018
Broker Compensation	December	January, 2018
Certification Requirements (Policy, Requirements & Procedures)	December – January	January, 2018
Standardized Plan Development - Medical	*December – February*	*February, 2018*
Plan Mix – Stand-Alone Dental Plans (SADPs)	January - February	February,2018
Standardized Plan Development – SADP	January - February	February,2018

**May need to meet more frequently than once per month to review all of these topics*

Plan Design Development:
Benefit Cost Sharing Categories

Actuarial Value Calculator (AVC) Inputs
Integrated Medical and Drug Deductible? (Yes or No)
Apply Inpatient Copay per Day? (Yes or No)
Apply Skilled Nursing Facility Copay per Day? (Yes or No)
Use Separate OOP Maximum for Medical and Drug Spending? (Yes or No)
Deductible ($) for Medical, Drug or Combined
Coinsurance (%, Insurer's Cost Share)
Maximum Out-of-Pocket (MOOP)
MOOP if Separate ($)

Medical Benefits: Subject to Deductible (Yes or No) Subject to Coinsurance (Yes or No) Coinsurance (Insurer's Cost Share) or Copay Values (Member Cost Share)
Emergency Room Services
All Inpatient Hospital Services (inc. MHSU)
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)
Specialist Visit
Mental/Behavioral Health and Substance Use Disorder Outpatient Services
Imaging (CT/PET Scans, MRIs)
Speech Therapy
Occupational and Physical Therapy
Preventive Care/Screening/Immunization
Laboratory Outpatient and Professional Services
X-rays and Diagnostic Imaging
Skilled Nursing Facility
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)
Outpatient Surgery Physician/Surgical Services

Prescription Drug Benefits Subject to Deductible (Yes or No) Subject to Coinsurance (Yes or No) Coinsurance (Insurer's Cost Share) or Copay Values (Member Cost Share)
Generics
Preferred Brand Drugs
Non-Preferred Brand Drugs
Specialty Drugs (i.e. high-cost)

Options for Additional Benefit Design Limits:
Set a Maximum on Specialty Rx Coinsurance Payments? (Yes or No) If yes, value:
Set a Maximum Number of Days for Charging an IP Copay? (Yes or No) If yes, value from 1-10:
Begin Primary Care Cost-Sharing After a Set Number of Visits? (Yes or No) If yes, value from 1-10:
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? (Yes or No) If yes, value from 1-10:

Other Elements for Consideration Not Included in AVC
Out-of-Network Deductible and Cost Sharing
Chiropractic Services
Diabetic Equipment and Supplies
Durable Medical Equipment
Home Health Care
Mammography Ultrasound
Urgent Care
Pediatric Services, including vision (exam & hardware) and dental

May need to consider varying cost sharing by place of service

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- **Adjournment**

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➢ Appendix

Standardized Plan Requirements by State - 2017

State Name	Exchange Type: 2017	Exchange Platform	Standardized Plan Information - 2017 Plan Year
Alabama	FFM	HC.gov	Optional - no standard plans filed
Alaska	FFM	HC.gov	Optional - no standard plans filed
Arizona	FFM	HC.gov	Optional - no standard plans filed
Arkansas*	SBM-FP	HC.gov	Standard plan requirements outlined for 94% Silver CSR only
California	SBM	State	Standard plans only (non-standard plans not permitted)
Colorado	SBM	State	Not requiring standard plans
Connecticut	SBM	State	Standard plans required for Individual Market as of 2018
Delaware	SPM	HC.gov	Optional - no standard plans filed
District Of Columb	SBM	State	Standard plans required
Florida	FFM	HC.gov	Optional - some standard plans submitted in 2017
Georgia	FFM	HC.gov	Optional - some standard plans submitted in 2017
Hawaii	FFM	HC.gov	Optional - some standard plans submitted in 2017
Idaho	SBM	State	No guidance located - assume not requiring
Illinois	SPM	HC.gov	Optional - some standard plans submitted in 2017
Indiana	FFM	HC.gov	Optional - some standard plans submitted in 2017
Iowa	SPM	HC.gov	Optional - no standard plans filed
Kansas	FFM	HC.gov	Optional - some standard plans submitted in 2017
Kentucky*	SBM-FP	HC.gov	Optional - some standard plans submitted in 2017
Louisiana	FFM	HC.gov	Optional - no standard plans filed
Maine	FFM	HC.gov	Optional - no standard plans filed
Maryland	SBM	State	Standard plans not required for 2017-2018, but expect to implement for 2019
Massachusetts	SBM	State	Standard plans required
Michigan	SPM	HC.gov	Optional - some standard plans submitted in 2017
Minnesota	SBM	State	Not requiring standard plans for 2018 - nothing definitive found for 2017
Mississippi	FFM	HC.gov	Optional - some standard plans submitted in 2017
Missouri	FFM	HC.gov	Optional - some standard plans submitted in 2017
Montana	FFM	HC.gov	Optional - no standard plans filed
Nebraska	FFM	HC.gov	Optional - no standard plans filed
Nevada*	SBM-FP	HC.gov	Optional
New Hampshire	SPM	HC.gov	Optional - no standard plans filed
New Jersey	FFM	HC.gov	Optional - no standard plans filed
New Mexico*	SBM-FP	HC.gov	No guidance located - assume not requiring
New York	SBM	State	Standard plans required
North Carolina	FFM	HC.gov	Optional - some standard plans submitted in 2017
North Dakota	FFM	HC.gov	Optional - no standard plans filed
Ohio	FFM	HC.gov	Optional - some standard plans submitted in 2017
Oklahoma	FFM	HC.gov	Optional - no standard plans filed
Oregon*	SBM-FP	HC.gov	Silver (standard & CSRs) and Gold standard plans required
Pennsylvania	FFM	HC.gov	Optional - some standard plans submitted in 2017
Rhode Island	SBM	State	Assume no standard plans, as plans differ per brochure available
South Carolina	FFM	HC.gov	Optional - no standard plans filed
South Dakota	FFM	HC.gov	Optional - some standard plans submitted in 2017
Tennessee	FFM	HC.gov	Optional - some standard plans submitted in 2017
Texas	FFM	HC.gov	Optional - some standard plans submitted in 2017
Utah	FFM	HC.gov	Optional - some standard plans submitted in 2017
Vermont	SBM	State	Standard plans required for Platinum, Gold, Silver (&CSRs), Bronze
Virginia	FFM	HC.gov	Optional - some standard plans submitted in 2017
Washington	SBM	State	Not outlined in the 'Guidance For Participation In The Washington Health Benefit Exchange'
West Virginia	SPM	HC.gov	Optional - some standard plans submitted in 2017
Wisconsin	FFM	HC.gov	Optional - some standard plans submitted in 2017
Wyoming	FFM	HC.gov	Optional - no standard plans filed

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Individual Market Plan Offerings- 2018

PRODUCTS	Off-Exchange ONLY			On-Exchange*			
Company	HMO	POS	EPO	HMO	POS	PPO	TOTAL
Anthem	7		2	7		5	21
CBI					8		8
CCI	2						2
CICI		7					7
Grand Total	9	7	2	7	8	5	38

Metal Level	Catastrophic	Bronze	Silver	Gold	Total
CBI 'On Exchange'	1	3	3	1	8
CICI / CCI 'Off only'	0	3	5	1	9
Total CTC	*1*	*6*	*8*	*2*	*17*
Anthem 'On Exchange'	1	5	4	2	12
Anthem 'Off only'	1	3	4	1	9
Total Anthem	*2*	*8*	*8*	*3*	*21*
COMBINED TOTAL	*3*	*14*	*16*	*5*	*38*
NET CHANGE FROM 2017	*0*	*+3*	*0*	*-4*	*-1*

Abbreviations:
"CTC": ConnectiCare;
"CBI": ConnectiCare Benefits, Inc.;
"CICI": ConnectiCare Insurance Company, Inc.;
"CCI": ConnectiCare Inc.;
"Anthem": Anthem Health Plans, Inc.

Minimal change in net number of plans filed vs 2017

Movement towards more plans at lower Actuarial Value (AV) (i.e., "Metal") levels

Information obtained through review of Connecticut Insurance Department (CID) Health Insurance Rate & Form Filings:
http://www.catalog.state.ct.us/cid/portalApps/RateFilingDefault.aspx
https://filingaccess.serff.com/sfa/home/CT

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2017 AHCT Plan Enrollment: Standardized/Non-Standard QHPs

Enrollment data of Individual AHCT plans as of 9/28/2017

Metal Level	Enrollment	Percent
Catastrophic	1,550	1.61%
Bronze	24,735	25.76%
Silver	60,414	62.93%
Gold	9,310	9.70%
TOTAL	96,009	100.00%

Metal Level	Standardized Plans	Non-Standard Plans	Total	Percent in Standardized Plans
Catastrophic	0	1,550	1,550	0.00%
Bronze*	21,958	2,777	24,735	88.77%
Silver	51,339	9,075	60,414	84.98%
Gold	7,278	2,032	9,310	78.17%
TOTAL	80,575	15,434	96,009	83.92%

*Bronze Plans	Standardized Plans	Non-Standard Plans	Total	Percent in Standardized Plans
Non-HSA Bronze	7,783	803	8,586	90.65%
HSA Compatible	14,175	1,974	16,149	87.78%
Total	21,958	2,777	24,735	88.77%

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Individual Market "Silver" Plan Information - 2018

Company	Plan Name/Product	General Plan Info
CICI	Choice SOLO POS Copay/Coins. $4,500 ded.	Benefits not subject to $4500 plan deductible include: PCP, Specialist, Preferred Generic and Preferred Brand Drugs (5-tier Rx plan); No charge for PCP visits when obtaining services from specific provider; 20% coinsurance applies for a number of services
CICI	Choice SOLO POS Coins. $2,500 ded.	Benefits not subject to $2500 plan deductible include: PCP, Preferred Generic and Preferred Brand Drugs (5-tier Rx plan); 50% coinsurance applies for a number of services
CICI	Choice SOLO POS Copay/Coins. $5,000 ded.	Benefits not subject to $5000 plan deductible include: PCP, Specialist, Lab, X-Ray, Preferred Generic and Preferred Brand Drugs (5-tier Rx plan); 20% coinsurance applies for a number of services
Anthem	Anthem Silver HMO BlueCare 5800/11600/35%	Benefits not subject to $5800 plan deductible include: PCP, T1 RX, T2 Rx; 35% coinsurance applies for a number of services
CICI	Choice SOLO POS HSA Coins. $3,000 ded.	HSA compatible plan
CBI	Choice Silver Standard POS	AHCT Standard Plan
CBI	Passage Silver Alternative PCP POS	Benefits not subject to $4000 plan deductible include: PCP, Specialist, T1 Rx and T2 Rx; Passage plans require selection of an in-network PCP and referral to see a specialist
CBI	Choice Silver Alternative POS	Benefits not subject to $1750 plan deductible include: PCP, Specialist, T1 RX; No charge for PCP visits when obtaining services from specific provider; 50% coinsurance applies for a number of services

Blue font represents plans offered 'Off-Exchange' only

Black font represents plans available through AHCT

Plans displayed in ascending order by premium rate for Fairfield County (page 1 of 2)

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Individual Market "Silver" Plan Information - 2018

Company	Plan Name/Product	General Plan Info
Anthem	Anthem Silver HMO BlueCare Tiered 4350/6350/0%/20%	Benefits not subject to $4350 "Value Tier" or "$6350 "Participating Tier" plan deductibles include: PCP, Specialist, T1 RX, T2 Rx;
Anthem	Anthem Silver HMO BlueCare 3500/7000/10% for HSA	HSA compatible plan
CICI	Choice SOLO Tiered	Benefits not subject to $3500 Tier 1 plan deductible include: PCP, Specialist, Preferred Generic and Preferred Brand Drugs (5-tier Rx plan); Tier 2 plan deductible does not apply to Preferred Generic & Preferred Brand drugs; 10% coinsurance applies for a number of services when obtained from a Tier 1 provider; 40% coinsurance applies for a number of services when obtained from a Tier 2 provider
Anthem	Silver PPO Standard Pathway X	AHCT Standard Plan
Anthem	Silver Core PPO Pathway X	Benefits not subject to $5300 plan deductible include: PCP, T1 RX, T2 Rx; 25% coinsurance applies for a number of services
Anthem	Silver High Deductible HMO Pathway X Enhanced	Benefits not subject to $6150 plan deductible include: PCP, T1 RX, T2 Rx; 25% coinsurance applies for a number of services
Anthem	Silver Low Deductible HMO Pathway X Enhanced	Benefits not subject to $3950 plan deductible include: T1 RX, T2 Rx; Deductible waived for first 3 PCP visits; 20% coinsurance applies for a number of services
Anthem	Anthem Silver EPO Century Preferred 2800/8400/20%	Benefits not subject to $2800 plan deductible include: PCP, T1 RX, T2 Rx; 20% coinsurance applies for a number of services

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Black font represents plans available through AHCT

Plans displayed in ascending order by premium rate for Fairfield County (page 2 of 2)

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