



Access Health Connecticut

Health Plan Benefits & Qualifications Advisory Committee (HPBQ AC) Meeting
January 28, 2021

Agenda

- Call to Order and Introductions
- Public Comment
- Vote: Meeting Minutes (March 18, 2020)
- AHCT Vision, Mission and Values
- Plan Management Certification Life Cycle
- 2021 Individual Market Landscape
- Certification Requirements
- 2022 Individual Market Standard Plan Designs
- 2022 Plan Year (PY) Timeline: Certification Requirements
- HPBQ AC Meeting Schedule
- Next Steps

Public Comment

Vote:

**Review and Approval of Minutes:
March 18, 2020 HPBQ AC Special Meeting**

AHCT Vision and Mission

AHCT 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.

AHCT Mission

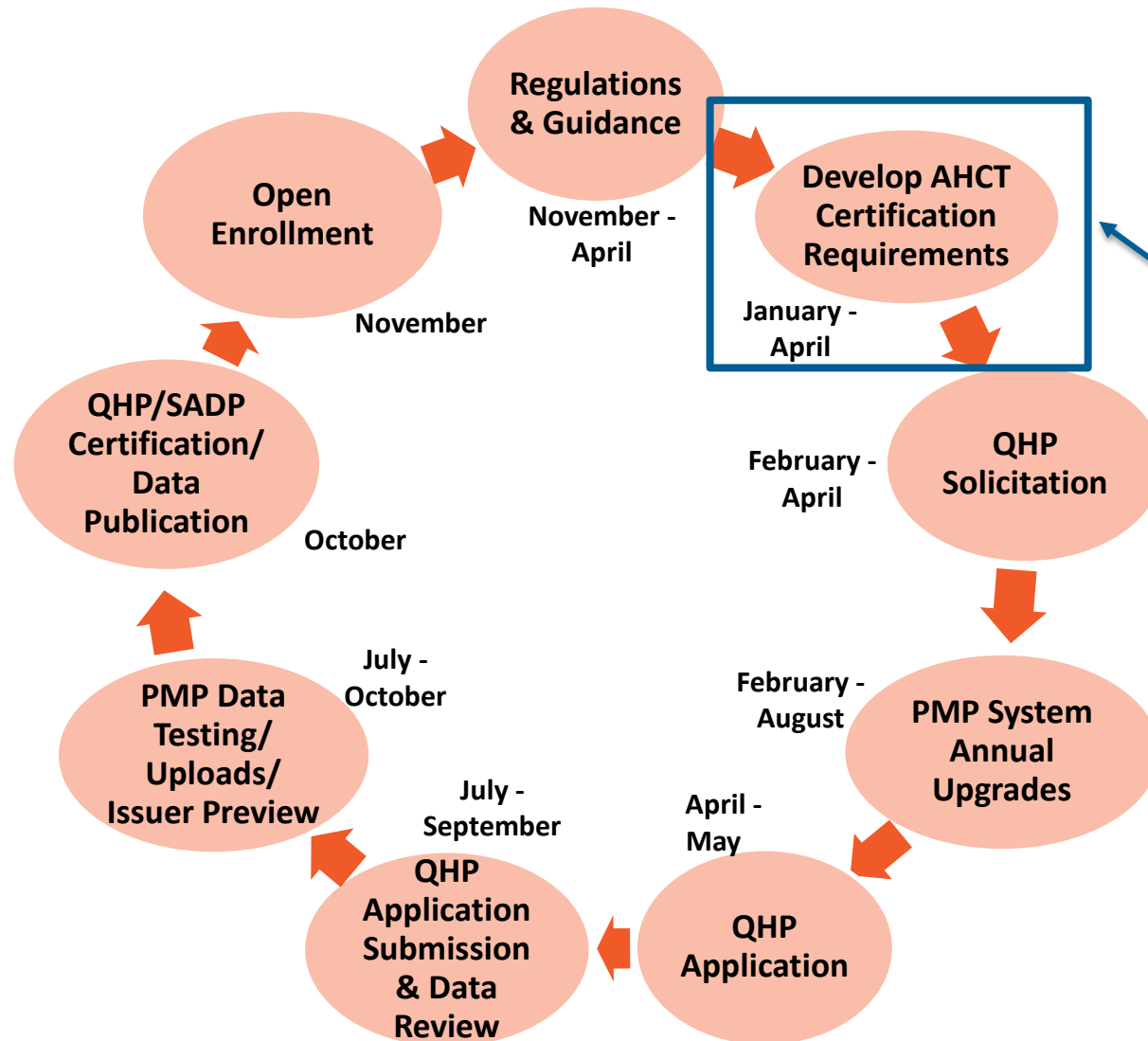
- To increase the number of insured residents, improve health care quality, lower costs and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and provider that give them the best value.

AHCT Values in Action

At Access Health CT, it is with our customers and our employees in mind that we seek to promote these collective values and to live by these behaviors. Our culture of acceptance welcomes and values everyone. We challenge the status quo to find new ways to grow and improve our community, our company and ourselves. Our people take pride in the service we provide, and in the spirit of the common good that we share.

| Authenticity | Integrity | Excellence | Ownership | One Team | Passion |
|---|---|--|-------------------------------------|-------------------------|---|
| Act with sincerity, credibility and self-awareness. | Commit to doing the right thing with genuine intention. | Aim high and challenge the status quo. | Take responsibility and initiative. | Collaborate to succeed. | Dedication to creating opportunities for greater health and well-being. |

Plan Management Certification Life Cycle



Each plan year, the cycle begins with the release of regulations and guidance, including the Actuarial Value Calculator (AVC) tool used to develop standardized plans, and ends once Open Enrollment commences

The Health Plan Benefits and Qualifications Advisory Committee (HPBQ AC) assesses the need for certification requirement changes each year

Note: timeframes subject to change

2021 Individual Market Landscape

Plan Filing Summary

| Carrier | Exchange Status | HMO | POS | PPO | Total |
|---------------|-----------------|----------|-----------|----------|-----------|
| Anthem | Off | 9 | | | 9 |
| Anthem | On | 5 | | 4 | 9 |
| CBI | On | | 11 | | 11 |
| CCI | Off | 4 | 2 | | 6 |
| CICI | Off | | 5 | | 5 |
| Grand Total | | 18 | 18 | 4 | 40 |

50% of plans filed in the Individual Market offered through AHCT

| Carrier | Exchange Status | Gold | Silver | Bronze | Catastrophic | Total |
|---------------|-----------------|----------|----------|----------|--------------|-----------|
| Anthem | Off | 2 | 3 | 3 | 1 | 9 |
| Anthem | On | 3 | 1 | 4 | 1 | 9 |
| CBI | On | 4 | 1 | 5 | 1 | 11 |
| CCI | Off | 1 | 2 | 3 | | 6 |
| CICI | Off | 1 | 4 | | | 5 |
| Grand Total | | 11 | 11 | 15 | 3 | 40 |

Majority of plans filed in the Individual Market are at the Bronze metal level

2021 Individual Market Landscape

Comparison: 'On' & 'Off-Exchange' Plans

Individual Market Plans Filed for 2021 as of CID rate filing approval on September 11, 2020

Bronze

- In every county, 4 Bronze plans offered via AHCT are lower in premium than any of the other 11 Bronze plans filed in the Individual 'On/Off Exchange' Market for Plan year 2021

Silver

- In 4 counties, 2 Silver 'Off-Exchange' plans are lower in premium than either of the Silver plans available in the Individual 'On-Exchange' Market for Plan Year 2021
- In 4 counties, 5 Silver 'Off-Exchange' plans are lower in premium than either of the Silver plans available in the Individual 'On-Exchange' Market for Plan Year 2021

Gold

- In 4 counties, 4 Gold 'On-Exchange' plans are lower in premium than any of the other 7 Gold plans filed in the Individual 'On/Off Exchange' Market for Plan Year 2021
- In 4 counties, 2 Gold 'On-Exchange' plans are lower in premium than any of the other 9 Gold plans filed in the Individual 'On/Off Exchange' Market for Plan Year 2021

Certification Requirements

| Certification Requirements | Modified for 2021 | 2022 Suggested Topics |
|---|-------------------|---|
| Essential Health Benefits (EHB) Benchmark Plan | ✗ | CMS EHB benchmark plan selection submission deadline: 5/8/20 for 2022 (State of CT) |
| Prescription Drug Formulary Review Responsibility | ✗ | ✗ |
| Tobacco Use Premium Surcharge in the Individual Market | ✗ | ✗ |
| Broker Compensation | ✗ | ✗ |
| Network Adequacy Standards | ✗ | ✗ |
| Essential Community Provider (ECP) Contracting Standards | ✗ | ✗ |
| Pediatric Dental Coverage in Medical Plans | ✗ | ✗ |
| Lowest Cost Silver Plan in the Individual Market | ✗ | ✗ |
| “Plan Mix”: Individual Market Medical | ✗ | ✗ |
| “Plan Mix”: Individual Market Stand-Alone Dental Plans (SADP) | ✗ | ✗ |
| “Plan Mix”: SHOP Medical | ✗ | ✗ |
| “Plan Mix”: SHOP Stand-Alone Dental Plans (SADP) | ✗ | ✗ |
| Standardized Plan Development – Individual Market Medical | ✓ | ✓ |
| Standardized Plan Development – SADP | ✗ | ✗ |
| OTHER: <ul style="list-style-type: none"> Topics impacted by new federal / state regulations and guidance [e.g., impact to changes in funding for CSR plans, reinsurance, etc.] Items suggested by AHCT Board of Directors, HPBQ AC or other constituents including customer preferences/input | ✗ | ✓ (plan designs to incorporate State legislation regarding diabetes coverage) |

Access Health CT

2022 Individual Market Standard Plan Designs

January 28, 2021

PRESENTED BY

Julie Andrews, FSA, MAAA – Sr. Consulting Actuary

Brad Heywood, ASA, MAAA – Associate Actuary

Agenda

2022 Plan Design Review

- Proposed Regulatory Changes
 - Proposed Federal Actuarial Value Calculator (AVC) Changes
 - Statutory Changes
 - Preliminary 2022 Calculator Results
-
- Appendix: Notes and Caveats

2022 Plan Design Review

Regulation Changes for 2022

- Proposed annual limitation on cost sharing was increased to \$9,100 (from \$8,550 in 2021)
 - Note: This limit does not apply to HSA (Health Savings Account) qualified High Deductible Health Plans (HDHPs). That limit is released by the IRS in the spring.
 - CSR (Cost Sharing Reduction) Variations proposed annual limitation on cost sharing. The 2022 and 2021 limits are:
 - 100-150% **FPL: \$3,000/\$6,000 (single/family)
 - 2021 - \$2,850/\$5,700 (single/family)
 - 150%-200% **FPL: \$3,000/\$6,000 (single/family)
 - 2021 - \$2,850/\$5,700 (single/family)
 - 200%-250% **FPL: \$7,250/\$14,500 (single/family)
 - 2021 - \$6,800/\$13,600 (single/family)
 - We anticipate the above limits will be increased upon the release of the Final 2022 Notice of Benefit and Payment Parameters (NBPP)
 - Federal HDHP minimum deductible and Maximum Out of Pocket (MOOP) limits are not yet released for 2022.
 - For 2021 the single deductible is set at a minimum of \$1,400 and the MOOP maximum limit is \$7,000.

Regulation Changes for 2022

- The 2021 Appropriations And COVID-19 Stimulus Package
 - No Surprises Act: comprehensive new protections against surprise medical bills.
 - Transparency For Consumers:
 - January 1, 2022, Insurers will have to offer a price comparison tool (online and by phone) so enrollees can compare cost-sharing amounts for a certain item or service by any provider.
 - Separately, consumers will be entitled to receive an “advanced” explanation of benefits (EOB).
- Other: Hospital Transparency Bill
 - effective January 1, 2021
 - requirement that most hospitals to post charge information on shoppable services publicly at a payer-specific level.

Proposed Changes to the Federal AVC for 2022

- The Federal AVC has not yet been finalized, changes to the final model may impact results
- No underlying changes were made to the draft 2022 Federal AVC calculator
 - 0% Trend was applied for 2021-2022
- Changes made to the final 2021 calculator were as follows:
 - Data underlying the calculator was updated from prior year
 - Now based on 2017 individual and small group data trended to 2021
 - Medical Trend: 3.25% (2017-2018) and 5.4% Annually (2018-2021)
 - Pharmacy Trend: 9.0% (2017-2018) and 8.7% Annually (2018-2021)

Statutory Changes for 2022 Plans

Connecticut Public Act 20-4

Diabetic Drugs And Emergency Insulin

- Under the act, covered individuals generally do not pay more out-of-pocket than:
 - \$25 for each 30-day supply of a covered, prescribed, medically necessary insulin or non-insulin glucagon drug, and
 - \$100 for each 30-day supply of a covered, medically necessary diabetes device or diabetic ketoacidosis device.
- These out-of-pocket limits only apply to HDHPs to the extent that is permitted by federal law and they do not disqualify insureds with these plans from certain federal tax benefits.

Statutory Changes for 2022 Plans

Connecticut Public Act 20-4

Diabetic Drugs And Emergency Insulin Estimate of Cost-sharing impact

- Data source: Wakely ACA Database ("WACA"): Wakely's ACA Database, named "WACA" contains detailed claims, eligibility and premium data from Edge Servers for almost 7 million individual and small group market lives in 2017. Data was limited to the Northeast Region for this analysis.
- Diabetics identified using Hierarchical condition category (HCC) coding from Federal risk-adjustment model

| Metal Level | Prevalence | Estimated Cost-Sharing Increase | Estimated Premium Impact for Standard Plans |
|-------------|------------|---------------------------------|---|
| *Bronze | 2.3% | 0.2% | 0.1% |
| Gold | 6.2% | 0.1% | 0.1% |
| Silver | 5.8% | 0.2% | 0.2% |
| Silver 73% | 7.3% | 0.2% | NA |
| Silver 87% | 7.8% | 0.0% | NA |
| Silver 94% | 8.1% | 0.0% | NA |

* Bronze plan seen above reflects Non-HSA Bronze Standardized plan

Statutory Maximum Copays

Existing Copay Maximums Remain Unchanged

- Sec. 38a-511a limits physical therapy copays to \$30 for individual policies. See Sec. 38a-550a for similar provisions for group policies.
- Sec. 38a-550(a) limits advance imaging cost-sharing to \$75 copay, \$375 maximum annually for group plans. See Sec. 38a-511 for similar provisions for individual policies.

**Note: Maximum copays provided reflect Federal AV Calculator Inputs*

Summary of 2021 AV Changes

| Individual Market | Gold | Silver | Bronze | Bronze HSA |
|--|------------------------------|-----------------|-----------------|-------------|
| Permissible AV Range | 76.0%-82.0% | 66.0%-72.0% | 56.0%-65.0% | 56.0%-65.0% |
| 2021 AV (Final) ¹ | 81.60% - 82.87% ³ | 70.69% - 71.83% | 64.26% - 64.90% | 64.98% |
| 2022 AV (Prelim. Before Diabetic Drug Adj.) | 81.60% - 82.87% ³ | 70.69% - 71.83% | 64.26% - 64.90% | 64.98% |

¹ Wakely AV Calculation

| Individual Market - CSR Plan Variations: Silver | 73% AV CSR | 87% AV CSR | 94% AV CSR |
|--|-----------------|------------------------------|-----------------|
| Permissible AV Range | 72.0%-74.0% | 86.0%-88.0% | 93.0%-95.0% |
| 2021 AV (Final) ¹ | 72.83% - 73.85% | 87.41% - 88.42% ³ | 94.71% - 94.96% |
| 2022 AV (Prelim. Before Diabetic Drug Adj.) | 72.83% - 73.85% | 87.41% - 88.42% ³ | 94.71% - 94.96% |

¹ Wakely AV Calculation

² 73.0% CSR Silver must have a differential of 2.0%+ with Standard Silver

³ The Gold and Silver 87% CSR plans passed by all issuers, but not Wakely.

**Note: Given that there was no change from 2021 – 2022 calculator, results shown do not include the Diabetics Bill*

Benefit Changes for 2022 Plans

Diabetic Drug Utilization

- Analysis of Impact is issuer specific
 - dependent upon their own utilization and diabetic drug tiering
 - Dependent upon their own definition of “diabetes device or diabetic ketoacidosis device”

Other Reason for Changes to Plan Design

- Offset premium rate increases

2022 Plan Design Overview

The plans have been reviewed for AVC with additional Diabetics Bill. Mental Health Parity compliance has been reviewed by Carriers

Notes and Caveats

- Other services not included in the AVC, but will be specified cost sharing for each standardized plan

| In-Network Services |
|--|
| Other Services |
| Mammography Ultrasound |
| Chiropractic Services (up to 20 visits per calendar year) |
| Diabetic Supplies & Equipment |
| Durable Medical Equipment |
| Home Health Care Services (up to 100 visits per calendar year) |
| Ambulance Services |
| Urgent Care Center or Facility |
| Pediatric Dental Care (for children under age 19) |
| Diagnostic & Preventive |
| Basic Services |
| Major Services |
| Orthodontia Services (medically necessary) |
| Pediatric Vision Care (for children under age 19) |
| Out-of-Network Services |
| All services, deductible and maximum out-of-pocket |

Notes and Caveats

- The cost sharing shown on the following slides represents costs for in-network services only.
- The deductible and MOOP limits shown are for individuals. The family limits are 2x the individual limit for all plans except where noted.
- Preventive care is covered at no cost to the member for all plans.
- Mental Health cost sharing is the same as Primary Care for all plans.
- Silver loading for defunded cost-sharing reduction plans will persist in 2021.
- All plans include 'embedded' deductible approach (not aggregate)

Summary of 2022 Gold Plan AV

| Benefit Category | 2020/2021 Individual Market Gold Plan |
|---|--|
| Medical Deductible | \$1,300 (INN)/\$3,000 (OON) |
| Rx Deductible | \$50 (INN)/\$350 (OON) |
| Coinsurance | 30% |
| Out-of-pocket Maximum | \$5,250 (INN)/\$10,500 (OON) |
| Primary Care | \$20 |
| Specialist Care | \$40 |
| Urgent Care | \$50 |
| Emergency Room | \$400 |
| Inpatient Hospital | \$500 per day (after ded., \$1,000 max. per admission) |
| Outpatient Hospital | \$300@ASC/\$500 otherwise (after ded.) |
| Advanced Radiology (CT/PET Scan, MRI) | \$65 |
| Non-Advanced Radiology (X-ray, Diagnostic) | \$40 (after ded.) |
| Laboratory Services | \$10 (after ded.) |
| Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type | \$20 |
| Chiropractic Care 20 visit calendar maximum | \$40 |
| All Other Medical | 30% |
| Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx | \$5 / \$35 / \$60 / 20% (spec. after ded., \$100 max per spec. script) |
| 2021 AVC Results | 81.60% - 82.87% |
| 2022 AVC Results | NA |

2022 Benefit changes:

- \$25 for each 30-day supply of a covered, prescribed, medically necessary insulin or non-insulin glucagon drug, and
- \$100 for each 30-day supply of a covered, medically necessary diabetes device or diabetic ketoacidosis device.

Summary of 2022 Silver Plan AV

| Benefit Category | 2020/2021 Individual Market Silver Plan | 2020/2021 Individual Market Silver Plan (73%) | 2020/2021 Individual Market Silver Plan (87%) | 2020/2021 Individual Market Silver Plan (94%) |
|---|---|---|---|--|
| Medical Deductible | \$4,300 (INN)/ \$8,600 (OON) | \$3,950 | \$650 | \$0 |
| Rx Deductible | \$250 (INN)/ \$500 (OON) | \$250 | \$50 | \$0 |
| Coinsurance | 40% | 40% | 40% | 40% |
| Out-of-pocket Maximum | \$8,150 (INN)/ \$16,300 (OON) | \$6,500 | \$2,500 | \$900 |
| Primary Care | \$40 | \$40 | \$20 | \$10 |
| Specialist Care | \$60 | \$60 | \$45 | \$30 |
| Urgent Care | \$75 | \$75 | \$35 | \$25 |
| Emergency Room | \$450 (after ded.) | \$450 (after ded.) | \$150 (after ded.) | \$50 |
| Inpatient Hospital | \$500 per day (after ded., \$2,000 max. per admission) | \$500 per day (after ded., \$2,000 max. per admission) | \$100 per day (after ded., \$400 max. per admission) | \$75 (\$300 max. per admission) |
| Outpatient Hospital | \$300@ASC/\$500 otherwise (after ded.) | \$300@ASC/\$500 otherwise (after ded.) | \$60@ASC/\$100 otherwise (after ded.) | \$45@ASC/\$75 otherwise |
| Advanced Radiology (CT/PET Scan, MRI) | \$75 | \$75 | \$60 | \$50 |
| Non-Advanced Radiology (X-ray, Diagnostic) | \$40 (after ded.) | \$40 (after ded.) | \$30 (after ded.) | \$25 |
| Laboratory Services | \$10 (after ded.) | \$10 (after ded.) | \$10 (after ded.) | \$10 |
| Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type | \$30 | \$30 | \$20 | \$20 |
| Chiropractic Care (20 visit calendar maximum) | \$50 | \$50 | \$35 | \$30 |
| All Other Medical | 40% | 40% | 40% | 40% |
| Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx | \$10 / \$45 / \$70 / 20% (all but generic after ded., \$200 max per spec. script) | \$10 / \$45 / \$70 / 20% (all but generic after ded., \$100 max per spec. script) | \$10 / \$25 / \$40 / 20% (non-preferred brand and spec. after ded., \$60 max per spec. script) | \$5 / \$10 / \$30 / 20% (\$60 max per spec. script) |
| 2021 AVC Results | 70.69% - 71.83% | 72.83% - 73.85% | 87.41% - 88.42% | 94.71% - 94.96% |
| 2022 AVC Results | NA | NA | NA | NA |

Summary of 2022 Bronze Non-HSA Plan AV

| Benefit Category | 2021 Bronze Non-HSA Plan |
|--|---|
| Combined Medical & Rx Deductible | \$6,550 (INN)/\$13,100 (OON) |
| Coinsurance | 40% |
| Out-of-pocket Maximum | \$8,550 (INN)/\$17,100 (OON) |
| Primary Care | \$50 |
| Specialist Care | \$70 (after ded.) |
| Urgent Care | \$75 |
| Emergency Room | \$450 (after ded.) |
| Inpatient Hospital | \$500 per day (after ded., \$1,000 max. per admission) |
| Outpatient Hospital | \$300@ASC/\$500 otherwise (after ded.) |
| Advanced Radiology (CT/PET Scan, MRI) | \$75 (after ded.) |
| Non-Advanced Radiology (X-ray, Diagnostic) | \$40 (after ded.) |
| Laboratory Services | \$10 (after ded.) |
| Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type | \$30 (after ded.) |
| Chiropractic Care (20 visit calendar maximum) | \$50 (after ded.) |
| All Other Medical | 40% (after ded.) |
| Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx | \$20 / 50% / 50% / 50% (all but generic after ded., \$500 max per spec. script) |
| 2021 AVC Results | 64.26% - 64.90% |
| 2022 AVC Results | NA |

Summary of 2022 Bronze HSA Plan AV

| Benefit Category | 2021 Bronze HSA Plan |
|--|--|
| Combined Medical & Rx Deductible | \$6,350 (INN)/\$12,700 (OON) |
| Coinsurance | 20% |
| Out-of-pocket Maximum | \$6,900 (INN)/\$13,800 (OON) |
| Primary Care | 20% (after ded.) |
| Specialist Care | 20% (after ded.) |
| Urgent Care | 20% (after ded.) |
| Emergency Room | 20% (after ded.) |
| Inpatient Hospital | 20% (after ded.) |
| Outpatient Hospital | 20% (after ded.) |
| Advanced Radiology (CT/PET Scan, MRI) | 20% (after ded.) |
| Non-Advanced Radiology (X-ray, Diagnostic) | 20% (after ded.) |
| Laboratory Services | 20% (after ded.) |
| Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type | 20% (after ded.) |
| Chiropractic Care (20 visit calendar maximum) | 20% (after ded.) |
| All Other Medical | 20% (after ded.) |
| Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx | 20% / 25% / 30% / 30% (all after ded., \$500 max per spec. script) |
| 2021 AVC Results | 64.98% |
| 2022 AVC Results | NA |

Appendix

Statutory Changes for 2022 Plans

HDHP: IRS Notice N-19-45.

- Notice defining the expanded allowable preventive services for HSA plans. The notice clarifies that these services may be considered as preventive for ACA-compliant plans, but these plans are not required to do so

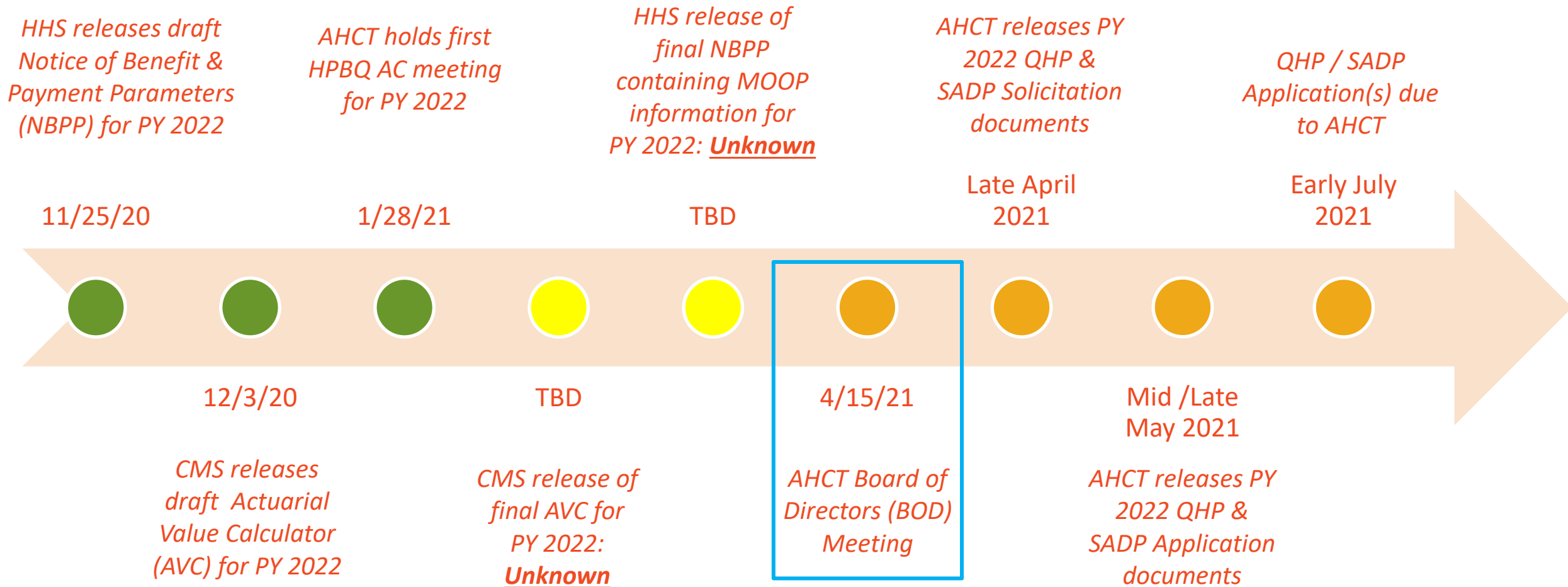
| Preventive Care for Specified Conditions | For Individuals Diagnosed with |
|---|--|
| Angiotensin Converting Enzyme (ACE) inhibitors | Congestive heart failure, diabetes, and/or coronary artery disease |
| Anti-resorptive therapy | Osteoporosis and/or osteopenia |
| Beta-blockers | Congestive heart failure and/or coronary artery disease |
| Blood pressure monitor | Hypertension |
| Inhaled corticosteroids | Asthma |
| Insulin and other glucose lowering agents | Diabetes |
| Retinopathy screening | Diabetes |
| Peak flow meter | Asthma |
| Glucometer | Diabetes |
| Hemoglobin A1c testing | Diabetes |
| International Normalized Ratio (INR) testing | Liver disease and/or bleeding disorders |
| Low-density Lipoprotein (LDL) testing | Heart disease |
| Selective Serotonin Reuptake Inhibitors (SSRIs) | Depression |
| Statins | Heart disease and/or diabetes |

Notes: Benefit Cost-Sharing

- Clarification of treatment of mental health intensive outpatient program and partial hospitalization (MH IOP/PHP)

| Outpatient Facility | Outpatient Facility MH (IOP/PHP) | Outpatient Physician MH (IOP/PHP) |
|-----------------------|----------------------------------|---|
| Deductible then Copay | Deductible then Copay | Match Primary Care Physician (not subject to the deductible). |

2022 Plan Year (PY) Timeline: Development of Certification Requirements



HPBQ AC Meeting Schedule

| Proposed Meeting Agendas | Target Dates |
|---|--------------------------------------|
| Kick-off Meeting: <ul style="list-style-type: none"> Plan Management Certification Life Cycle 2021 Individual Market Landscape Certification Requirements 2022 Individual Market Standard Plan Designs / Review of Draft Actuarial Value Calculator Results Potential Meeting Schedule for 2022 Plan Year Certification Review | January 28, 2021 |
| <ul style="list-style-type: none"> 2021 Enrollment Overview Certification requirements: proposed changes for 2022 AVC Results: impacts of draft 2022 tool on recommended changes for standardized plans (Wakely & carriers) | February 2021 |
| <ul style="list-style-type: none"> Certification requirements: proposed changes AVC Results: impacts of draft/final 2022 tool on recommended changes for standardized plans (Wakely & carriers) | March 2021 (1st week) |
| <ul style="list-style-type: none"> Certification requirements: proposed changes AVC Results: impacts of draft/final 2022 tool on recommended changes for standardized plans (Wakely & carriers) | March 2021 (3 rd week) |
| <ul style="list-style-type: none"> Certification requirements: recommendations for AHCT Board of Directors, including modifications to standardized plans for 2021 | April 2021 No later than 4/8/21 |

Appendix

Reference Materials - Table of Contents

| HPBQ AC Meeting Date | Exhibit Title | Exhibit Number | Page |
|----------------------|--|----------------|------|
| 1/28/2021 | AHCT 2021 Standardized Plan – Gold | 1.0 | 38 |
| 1/28/2021 | AHCT 2021 Standardized Plan – Silver 70% AV | 1.1 | 39 |
| 1/28/2021 | AHCT 2021 Standardized Plan – Silver 73% AV | 1.2 | 40 |
| 1/28/2021 | AHCT 2021 Standardized Plan – Silver 87% AV | 1.3 | 41 |
| 1/28/2021 | AHCT 2021 Standardized Plan – Silver 94% AV | 1.4 | 42 |
| 1/28/2021 | AHCT 2021 Standardized Plan – Bronze | 1.5 | 43 |
| 1/28/2021 | AHCT 2021 Standardized Plan – Bronze HSA-Compatible | 1.6 | 44 |
| 1/28/2021 | Issuer Participation - 2021 | 2.0 | 45 |
| 1/28/2021 | Affordable Care Act - Health Plan Types | 3.0 | 46 |
| 1/28/2021 | Plan Design Development: AVC Benefit Cost Sharing Categories | 4.0 | 47 |
| 1/28/2021 | Plan Management Certification Life Cycle | 5.0 | 48 |
| 1/28/2021 | 2021 Plan Mix: Number of Plans Required / Permitted per Issuer | 6.0 | 49 |
| 1/28/2021 | Copay Maximums – State Regulation: Imaging Services | 7.0 | 50 |
| 1/28/2021 | Copay Maximums – State Regulation: Physical Therapy & Occupational Therapy Services | 7.1 | 51 |
| 1/28/2021 | Copay Maximums – State Regulation: Medication and Supplies for Treatment of Diabetes | 7.2 | 52 |
| 1/28/2021 | Deductible and Coinsurance Maximums – Home Health Care Services | 7.3 | 53 |
| 1/28/2021 | United States Code (USC) – Title 26 Internal Revenue Code: Health Savings Accounts | 8.0 | 54 |

Reference Materials - Table of Contents

| HPBQ AC Meeting Date | Exhibit Title | Exhibit Number | Page |
|----------------------|--|----------------|------|
| 1/28/2021 | 2021 Plan Actuarial Value: CT Individual Market (On-Exchange) | 9.0 | 55 |
| 1/28/2021 | 2021 Plan Actuarial Value: CT Individual Market (Off-Exchange) | 9.1 | 56 |
| 1/28/2021 | Connecticut Counties by Population | 10.0 | 57 |
| 1/28/2021 | Individual Market: Age 21 Rates Approved by CID for 2021 Plan Year (Part 1 of 2) | 11.0 | 58 |
| 1/28/2021 | Individual Market: Age 21 Rates Approved by CID for 2021 Plan Year (Part 2 of 2) | 11.0 | 59 |
| 1/28/2021 | Average Marketplace Premiums by Metal Tier, 2021: Lowest Premium Bronze | 12.0 | 60 |
| 1/28/2021 | Average Marketplace Premiums by Metal Tier, 2021: Lowest Premium Silver | 12.1 | 61 |
| 1/28/2021 | Average Marketplace Premiums by Metal Tier, 2021: Lowest Premium Gold | 12.2 | 62 |
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| Yellow shading represents change from 2020 Plan Year | | 2021 Standard Gold | |
|--|--|--|---|
| Plan Overview | | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
| Deductible: Individual (medical) | | \$1,300 | \$3,000 |
| Deductible: Family (medical) | | \$2,600 | \$6,000 |
| Deductible: Individual (prescription) | | \$50 | \$350 |
| Deductible: Family (prescription) | | \$100 | \$700 |
| Out-of-Pocket Maximum: Individual | | \$5,250 | \$10,500 |
| Out-of-Pocket Maximum: Family | | \$10,500 | \$21,000 |
| Provider Office Visits | | | |
| Preventive Visit (Adult/Child) | | \$0 | 30% coinsurance |
| Provider Office Visits (Primary Care, Mental & Behavioral Health, Substance Abuse) | | \$20 copayment per visit | 30% coinsurance per visit after OON medical deductible |
| Specialist Office Visits | | \$40 copayment per visit | 30% coinsurance per visit after OON medical deductible |
| Outpatient Diagnostic Services | | | |
| Advanced Radiology (CT/PET Scan, MRI) | | \$65 copayment per service up to a combined annual maximum of \$375 for MRI and CAT scans; \$400 for PET scans | 30% coinsurance per service after OON medical deductible |
| Laboratory Services | | \$10 copayment per service after INET medical deductible | 30% coinsurance per service after OON medical deductible |
| Non-Advanced Radiology (X-ray, Diagnostic) | | \$40 copayment per service after INET medical deductible | 30% coinsurance per service after OON medical deductible |
| Mammography Ultrasound | | \$20 copayment per service | 30% coinsurance per service after OON medical deductible |
| Prescription Drugs - Retail Pharmacy (up to 30 day supply per prescription) | | | |
| Tier 1 | | \$5 copayment per prescription | 30% coinsurance per prescription after OON prescription drug deductible |
| Tier 2 | | \$35 copayment per prescription | 30% coinsurance per prescription after OON prescription drug deductible |
| Tier 3 | | \$60 copayment per prescription | 30% coinsurance per prescription after OON prescription drug deductible |
| Tier 4 | | 20% coinsurance up to a maximum of \$100 per prescription after INET prescription drug deductible | 30% coinsurance per prescription after OON prescription drug deductible |
| Outpatient Rehabilitative and Habilitative Services | | | |
| Speech Therapy (40 visits per calendar year limit combined for PT/ST/OT) | | \$20 copayment per visit | 30% coinsurance per visit after OON medical deductible |
| Physical and Occupational Therapy (40 visits per calendar year limit combined for PT/ST/OT) | | \$20 copayment per visit | 30% coinsurance per visit after OON medical deductible |
| Other Services | | | |
| Chiropractic Services (up to 20 visits per calendar year) | | \$40 copayment per visit | 30% coinsurance per visit after OON medical deductible |
| Diabetic Supplies & Equipment | | 30% coinsurance per equipment/supply | 30% coinsurance per equipment / supply after OON medical deductible |
| Durable Medical Equipment | | 30% coinsurance per equipment/supply | 30% coinsurance per equipment / supply after OON medical deductible |
| Home Health Care Services (up to 100 visits per calendar year) | | \$0 copay | 25% coinsurance per visit after separate \$50 deductible |
| Outpatient Services (in a hospital or ambulatory facility) | | \$500 copayment after INET plan deductible (Outpatient Hospital Facility); \$300 copayment after INET plan deductible (Ambulatory Surgery Center) | 30% coinsurance per visit after OON medical deductible |
| Hospital Services | | | |
| Inpatient Hospital Services (including MH, SA, maternity, hospice and skilled nursing facility*) *(skilled nursing facility stay is limited to 90 days per calendar year) | | \$500 copayment per day to a maximum of \$1,000 per admission after INET plan deductible | 30% coinsurance per admission after OON medical deductible |
| Emergency and Urgent Care | | | |
| Ambulance Services | | \$0 copay | \$0 copay |
| Emergency Room | | \$400 copayment per visit | \$400 copayment per visit |
| Urgent Care Center or Facility | | \$50 copayment per visit | 30% coinsurance per visit after OON medical deductible |
| Pediatric Dental Care (for children under age 19) | | | |
| Diagnostic & Preventive | | \$0 copay | 50% coinsurance per visit after OON medical deductible |
| Basic Services | | 20% coinsurance per visit | 50% coinsurance per visit after OON medical deductible |
| Major Services | | 40% coinsurance per visit | 50% coinsurance per visit after OON medical deductible |
| Orthodontia Services (medically necessary only) | | 50% coinsurance per visit | 50% coinsurance per visit after OON medical deductible |
| Pediatric Vision Care (for children under age 19) | | | |
| Prescription Eye Glasses (one pair of frames & lenses per calendar year) | | \$0 copay for Lenses; \$0 copay for Collection frame; Substantially equal credit for non-collection frame selection | Not Covered |
| Routine Eye Exam by Specialist (one exam per calendar year) | | \$40 copayment per visit | 30% coinsurance per visit after OON medical deductible |

| Yellow shading represents change from 2020 Plan Year | | 2021 Standard Silver - 70% AV | |
|--|--|--|---|
| Plan Overview | | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
| Deductible: Individual (medical) | | \$4,300 | \$8,600 |
| Deductible: Family (medical) | | \$8,600 | \$17,200 |
| Deductible: Individual (prescription) | | \$250 | \$500 |
| Deductible: Family (prescription) | | \$500 | \$1,000 |
| Out-of-Pocket Maximum: Individual | | \$8,150 | \$16,300 |
| Out-of-Pocket Maximum: Family | | \$16,300 | \$32,600 |
| Provider Office Visits | | | |
| Preventive Visit (Adult/Child) | | \$0 | 40% coinsurance |
| Provider Office Visits (Primary Care, Mental & Behavioral Health, Substance Abuse) | | \$40 copayment per visit | 40% coinsurance per visit after OON medical deductible |
| Specialist Office Visits | | \$60 copayment per visit | 40% coinsurance per visit after OON medical deductible |
| Outpatient Diagnostic Services | | | |
| Advanced Radiology (CT/PET Scan, MRI) | | \$75 copayment per service up to a combined annual maximum of \$375 for MRI and CAT scans; \$400 for PET scans | 40% coinsurance per service after OON medical deductible |
| Laboratory Services | | \$10 copayment per service after INET deductible | 40% coinsurance per service after OON medical deductible |
| Non-Advanced Radiology (X-ray, Diagnostic) | | \$40 copayment per service after INET deductible | 40% coinsurance per service after OON medical deductible |
| Mammography Ultrasound | | \$20 copayment per service | 40% coinsurance per service after OON medical deductible |
| Prescription Drugs - Retail Pharmacy (up to 30 day supply per prescription) | | | |
| Tier 1 | | \$10 copayment per prescription | 40% coinsurance per prescription after OON prescription drug deductible |
| Tier 2 | | \$45 copayment per prescription after INET prescription drug deductible | 40% coinsurance per prescription after OON prescription drug deductible |
| Tier 3 | | \$70 copayment per prescription after INET prescription drug deductible | 40% coinsurance per prescription after OON prescription drug deductible |
| Tier 4 | | 20% coinsurance up to a maximum of \$200 per prescription after INET prescription drug deductible | 40% coinsurance per prescription after OON prescription drug deductible |
| Outpatient Rehabilitative and Habilitative Services | | | |
| Speech Therapy (40 visits per calendar year limit combined for PT/ST/OT) | | \$30 copayment per visit | 40% coinsurance per visit after OON medical deductible |
| Physical and Occupational Therapy (40 visits per calendar year limit combined for PT/ST/OT) | | \$30 copayment per visit | 40% coinsurance per visit after OON medical deductible |
| Other Services | | | |
| Chiropractic Services (up to 20 visits per calendar year) | | \$50 copayment per visit | 40% coinsurance per visit after OON medical deductible |
| Diabetic Supplies & Equipment | | 40% coinsurance per equipment / supply | 40% coinsurance per equipment / supply after OON medical deductible |
| Durable Medical Equipment | | 40% coinsurance per equipment / supply | 40% coinsurance per equipment / supply after OON medical deductible |
| Home Health Care Services (up to 100 visits per calendar year) | | \$0 copay | 25% coinsurance per visit after separate \$50 deductible |
| Outpatient Services (in a hospital or ambulatory facility) | | \$500 copayment after INET plan deductible (Outpatient Hospital Facility); \$300 copayment after INET plan deductible (Ambulatory Surgery Center) | 40% coinsurance per visit after OON medical deductible |
| Hospital Services | | | |
| Inpatient Hospital Services (including MH, SA, maternity, hospice and skilled nursing facility*) *(skilled nursing facility stay is limited to 90 days per calendar year) | | \$500 copayment per day to a maximum of \$2,000 per admission after INET plan deductible | 40% coinsurance per admission after OON medical deductible |
| Emergency and Urgent Care | | | |
| Ambulance Services | | \$0 copay | \$0 copay |
| Emergency Room | | \$450 copayment per visit after INET medical deductible | \$450 copayment per visit after INET medical deductible |
| Urgent Care Center or Facility | | \$75 copayment per visit | 40% coinsurance per visit after OON medical deductible |
| Pediatric Dental Care (for children under age 19) | | | |
| Diagnostic & Preventive | | \$0 copay | 50% coinsurance per visit after OON medical deductible |
| Basic Services | | 40% coinsurance per visit | 50% coinsurance per visit after OON medical deductible |
| Major Services | | 50% coinsurance per visit | 50% coinsurance per visit after OON medical deductible |
| Orthodontia Services (medically necessary only) | | 50% coinsurance per visit | 50% coinsurance per visit after OON medical deductible |
| Pediatric Vision Care (for children under age 19) | | | |
| Prescription Eye Glasses (one pair of frames & lenses per calendar year) | | \$0 copay for Lenses; \$0 copay for Collection frame; Substantially equal credit for non-collection frame selection | Not Covered |
| Routine Eye Exam by Specialist (one exam per calendar year) | | \$60 copayment per visit | 40% coinsurance per visit after OON medical deductible |

| Yellow shading represents change from 2020 Plan Year | | 2021 Standard Silver 73% | |
|--|--|-------------------------------|---|
| Plan Overview | | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
| Deductible: Individual (medical) | | \$3,950 | \$8,600 |
| Deductible: Family (medical) | | \$7,900 | \$17,200 |
| Deductible: Individual (prescription) | | \$250 | \$500 |
| Deductible: Family (prescription) | | \$500 | \$1,000 |
| Out-of-Pocket Maximum: Individual | | \$6,500 | \$16,300 |
| Out-of-Pocket Maximum: Family | | \$13,000 | \$32,600 |
| Provider Office Visits | | | |
| Preventive Visit (Adult/Child) | | \$0 | 40% coinsurance |
| Provider Office Visits (Primary Care, Mental & Behavioral Health, Substance Abuse) | | \$40 copayment per visit | 40% coinsurance per visit after OON medical deductible |
| Specialist Office Visits | | \$60 copayment per visit | 40% coinsurance per visit after OON medical deductible |
| Outpatient Diagnostic Services | | | |
| Advanced Radiology (CT/PET Scan, MRI) | \$75 copayment per service up to a combined annual maximum of \$375 for MRI and CAT scans; \$400 for PET scans | | 40% coinsurance per service after OON medical deductible |
| Laboratory Services | \$10 copayment per service after INET deductible | | 40% coinsurance per service after OON medical deductible |
| Non-Advanced Radiology (X-ray, Diagnostic) | \$40 copayment per service after INET deductible | | 40% coinsurance per service after OON medical deductible |
| Mammography Ultrasound | \$20 copayment per service | | 40% coinsurance per service after OON medical deductible |
| Prescription Drugs - Retail Pharmacy (up to 30 day supply per prescription) | | | |
| Tier 1 | \$10 copayment per prescription | | 40% coinsurance per prescription after OON prescription drug deductible |
| Tier 2 | \$45 copayment per prescription after INET prescription drug deductible | | 40% coinsurance per prescription after OON prescription drug deductible |
| Tier 3 | \$70 copayment per prescription after INET prescription drug deductible | | 40% coinsurance per prescription after OON prescription drug deductible |
| Tier 4 | 20% coinsurance up to a maximum of \$100 per prescription after INET prescription drug deductible | | 40% coinsurance per prescription after OON prescription drug deductible |
| Outpatient Rehabilitative and Habilitative Services | | | |
| Speech Therapy (40 visits per calendar year limit combined for PT/ST/OT) | \$30 copayment per visit | | 40% coinsurance per visit after OON medical deductible |
| Physical and Occupational Therapy (40 visits per calendar year limit combined for PT/ST/OT) | \$30 copayment per visit | | 40% coinsurance per visit after OON medical deductible |
| Other Services | | | |
| Chiropractic Services (up to 20 visits per calendar year) | \$50 copayment per visit | | 40% coinsurance per visit after OON medical deductible |
| Diabetic Supplies & Equipment | 40% coinsurance per equipment / supply | | 40% coinsurance per equipment / supply after OON medical deductible |
| Durable Medical Equipment | 40% coinsurance per equipment / supply | | 40% coinsurance per equipment / supply after OON medical deductible |
| Home Health Care Services (up to 100 visits per calendar year) | \$0 copay | | 25% coinsurance per visit after separate \$50 deductible |
| Outpatient Services (in a hospital or ambulatory facility) | \$500 copayment after INET plan deductible (Outpatient Hospital Facility); \$300 copayment after INET plan deductible (Ambulatory Surgery Center) | | 40% coinsurance per visit after OON medical deductible |
| Hospital Services | | | |
| Inpatient Hospital Services (including MH, SA, maternity, hospice and skilled nursing facility*) *(skilled nursing facility stay is limited to 90 days per calendar year) | \$500 copayment per day to a maximum of \$2,000 per admission after INET plan deductible | | 40% coinsurance per admission after OON medical deductible |
| Emergency and Urgent Care | | | |
| Ambulance Services | \$0 copay | | \$0 copay |
| Emergency Room | \$450 copayment per visit after INET medical deductible | | \$450 copayment per visit after INET medical deductible |
| Urgent Care Center or Facility | \$75 copayment per visit | | 40% coinsurance per visit after OON medical deductible |
| Pediatric Dental Care (for children under age 19) | | | |
| Diagnostic & Preventive | \$0 copay | | 50% coinsurance per visit after OON medical deductible |
| Basic Services | 40% coinsurance per visit | | 50% coinsurance per visit after OON medical deductible |
| Major Services | 50% coinsurance per visit | | 50% coinsurance per visit after OON medical deductible |
| Orthodontia Services (medically necessary only) | 50% coinsurance per visit | | 50% coinsurance per visit after OON medical deductible |
| Pediatric Vision Care (for children under age 19) | | | |
| Prescription Eye Glasses (one pair of frames & lenses per calendar year) | \$0 copay for Lenses; \$0 copay for Collection frame; Substantially equal credit for non-collection frame selection | | Not Covered |
| Routine Eye Exam by Specialist (one exam per calendar year) | \$60 copayment per visit | | 40% coinsurance per visit after OON medical deductible |

| Yellow shading represents change from 2020 Plan Year | | 2021 Standard Silver 87% | |
|--|--|---|---|
| Plan Overview | | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
| Deductible: Individual (medical) | | \$650 | \$8,600 |
| Deductible: Family (medical) | | \$1,300 | \$17,200 |
| Deductible: Individual (prescription) | | \$50 | \$500 |
| Deductible: Family (prescription) | | \$100 | \$1,000 |
| Out-of-Pocket Maximum: Individual | | \$2,500 | \$16,300 |
| Out-of-Pocket Maximum: Family | | \$5,000 | \$32,600 |
| Provider Office Visits | | | |
| Preventive Visit (Adult/Child) | | \$0 | 40% coinsurance |
| Provider Office Visits (Primary Care, Mental & Behavioral Health, Substance Abuse) | | \$20 copayment per visit | 40% coinsurance per visit after OON medical deductible |
| Specialist Office Visits | | \$45 copayment per visit | 40% coinsurance per visit after OON medical deductible |
| Outpatient Diagnostic Services | | | |
| Advanced Radiology (CT/PET Scan, MRI) | | \$60 copayment per service up to a combined annual maximum of \$360 for MRI and CAT scans; \$400 for PET scans | 40% coinsurance per service after OON medical deductible |
| Laboratory Services | | \$10 copayment per service after INET deductible | 40% coinsurance per service after OON medical deductible |
| Non-Advanced Radiology (X-ray, Diagnostic) | | \$30 copayment per service after INET deductible | 40% coinsurance per service after OON medical deductible |
| Mammography Ultrasound | | \$20 copayment per service | 40% coinsurance per service after OON medical deductible |
| Prescription Drugs - Retail Pharmacy (up to 30 day supply per prescription) | | | |
| Tier 1 | | \$10 copayment per prescription | 40% coinsurance per prescription after OON prescription drug deductible |
| Tier 2 | | \$25 copayment per prescription | 40% coinsurance per prescription after OON prescription drug deductible |
| Tier 3 | | \$40 copayment per prescription after INET prescription drug deductible | 40% coinsurance per prescription after OON prescription drug deductible |
| Tier 4 | | 20% coinsurance up to a maximum of \$60 per prescription after INET prescription drug deductible | 40% coinsurance per prescription after OON prescription drug deductible |
| Outpatient Rehabilitative and Habilitative Services | | | |
| Speech Therapy (40 visits per calendar year limit combined for PT/ST/OT) | | \$20 copayment per visit | 40% coinsurance per visit after OON medical deductible |
| Physical and Occupational Therapy (40 visits per calendar year limit combined for PT/ST/OT) | | \$20 copayment per visit | 40% coinsurance per visit after OON medical deductible |
| Other Services | | | |
| Chiropractic Services (up to 20 visits per calendar year) | | \$35 copayment per visit | 40% coinsurance per visit after OON medical deductible |
| Diabetic Supplies & Equipment | | 40% coinsurance per equipment / supply | 40% coinsurance per equipment / supply after OON medical deductible |
| Durable Medical Equipment | | 40% coinsurance per equipment / supply | 40% coinsurance per equipment / supply after OON medical deductible |
| Home Health Care Services (up to 100 visits per calendar year) | | \$0 copay | 25% coinsurance per visit after separate \$50 deductible |
| Outpatient Services (in a hospital or ambulatory facility) | | \$100 copayment after INET plan deductible (Outpatient Hospital Facility); \$60 copayment after INET plan deductible (Ambulatory Surgery Center) | 40% coinsurance per visit after OON medical deductible |
| Hospital Services | | | |
| Inpatient Hospital Services (including MH, SA, maternity, hospice and skilled nursing facility*) *(skilled nursing facility stay is limited to 90 days per calendar year) | | \$100 copayment per day to a maximum of \$400 per admission after INET plan deductible | 40% coinsurance per admission after OON medical deductible |
| Emergency and Urgent Care | | | |
| Ambulance Services | | \$0 copay | \$0 copay |
| Emergency Room | | \$150 copayment per visit after INET medical deductible | \$150 copayment per visit after INET medical deductible |
| Urgent Care Center or Facility | | \$35 copayment per visit | 40% coinsurance per visit after OON medical deductible |
| Pediatric Dental Care (for children under age 19) | | | |
| Diagnostic & Preventive | | \$0 copay | 50% coinsurance per visit after OON medical deductible |
| Basic Services | | 40% coinsurance per visit | 50% coinsurance per visit after OON medical deductible |
| Major Services | | 50% coinsurance per visit | 50% coinsurance per visit after OON medical deductible |
| Orthodontia Services (medically necessary only) | | 50% coinsurance per visit | 50% coinsurance per visit after OON medical deductible |
| Pediatric Vision Care (for children under age 19) | | | |
| Prescription Eye Glasses (one pair of frames & lenses per calendar year) | | \$0 copay for Lenses; \$0 copay for Collection frame; Substantially equal credit for non-collection frame selection | Not Covered |
| Routine Eye Exam by Specialist (one exam per calendar year) | | \$45 copayment per visit | 40% coinsurance per visit after OON medical deductible |

| Yellow shading represents change from 2020 Plan Year | | 2021 Standard Silver 94% | |
|--|--|---|---|
| Plan Overview | | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
| Deductible: Individual (medical) | | \$0 | \$8,600 |
| Deductible: Family (medical) | | \$0 | \$17,200 |
| Deductible: Individual (prescription) | | \$0 | \$500 |
| Deductible: Family (prescription) | | \$0 | \$1,000 |
| Out-of-Pocket Maximum: Individual | | \$900 | \$16,300 |
| Out-of-Pocket Maximum: Family | | \$1,800 | \$32,600 |
| Provider Office Visits | | | |
| Preventive Visit (Adult/Child) | | \$0 | 40% coinsurance |
| Provider Office Visits (Primary Care, Mental & Behavioral Health, Substance Abuse) | | \$10 copayment per visit | 40% coinsurance per visit after OON medical deductible |
| Specialist Office Visits | | \$30 copayment per visit | 40% coinsurance per visit after OON medical deductible |
| Outpatient Diagnostic Services | | | |
| Advanced Radiology (CT/PET Scan, MRI) | | \$50 copayment per service up to a combined annual maximum of \$350 for MRI and CAT scans; \$400 for PET scans | 40% coinsurance per service after OON medical deductible |
| Laboratory Services | | \$10 copayment per service | 40% coinsurance per service after OON medical deductible |
| Non-Advanced Radiology (X-ray, Diagnostic) | | \$25 copayment per service | 40% coinsurance per service after OON medical deductible |
| Mammography Ultrasound | | \$20 copayment per service | 40% coinsurance per service after OON medical deductible |
| Prescription Drugs - Retail Pharmacy (up to 30 day supply per prescription) | | | |
| Tier 1 | | \$5 copayment per prescription | 40% coinsurance per prescription after OON prescription drug deductible |
| Tier 2 | | \$10 copayment per prescription | 40% coinsurance per prescription after OON prescription drug deductible |
| Tier 3 | | \$30 copayment per prescription | 40% coinsurance per prescription after OON prescription drug deductible |
| Tier 4 | | 20% coinsurance up to a maximum of \$60 per prescription | 40% coinsurance per prescription after OON prescription drug deductible |
| Outpatient Rehabilitative and Habilitative Services | | | |
| Speech Therapy (40 visits per calendar year limit combined for PT/ST/OT) | | \$20 copayment per visit | 40% coinsurance per visit after OON medical deductible |
| Physical and Occupational Therapy (40 visits per calendar year limit combined for PT/ST/OT) | | \$20 copayment per visit | 40% coinsurance per visit after OON medical deductible |
| Other Services | | | |
| Chiropractic Services (up to 20 visits per calendar year) | | \$30 copayment per visit | 40% coinsurance per visit after OON medical deductible |
| Diabetic Supplies & Equipment | | 40% coinsurance per equipment / supply | 40% coinsurance per equipment / supply after OON medical deductible |
| Durable Medical Equipment | | 40% coinsurance per equipment / supply | 40% coinsurance per equipment / supply after OON medical deductible |
| Home Health Care Services (up to 100 visits per calendar year) | | \$0 copay | 25% coinsurance per visit after separate \$50 deductible |
| Outpatient Services (in a hospital or ambulatory facility) | | \$75 copayment (Outpatient Hospital Facility); \$45 copayment (Ambulatory Surgery Center) | 40% coinsurance per visit after OON medical deductible |
| Hospital Services | | | |
| Inpatient Hospital Services (including MH, SA, maternity, hospice and skilled nursing facility*) *(skilled nursing facility stay is limited to 90 days per calendar year) | | \$75 copayment per day to a maximum of \$300 per admission | 40% coinsurance per admission after OON medical deductible |
| Emergency and Urgent Care | | | |
| Ambulance Services | | \$0 copay | \$0 copay |
| Emergency Room | | \$50 copayment per visit | \$50 copayment per visit |
| Urgent Care Center or Facility | | \$25 copayment per visit | 40% coinsurance per visit after OON medical deductible |
| Pediatric Dental Care (for children under age 19) | | | |
| Diagnostic & Preventive | | \$0 copay | 50% coinsurance per visit after OON medical deductible |
| Basic Services | | 40% coinsurance per visit | 50% coinsurance per visit after OON medical deductible |
| Major Services | | 50% coinsurance per visit | 50% coinsurance per visit after OON medical deductible |
| Orthodontia Services (medically necessary only) | | 50% coinsurance per visit | 50% coinsurance per visit after OON medical deductible |
| Pediatric Vision Care (for children under age 19) | | | |
| Prescription Eye Glasses (one pair of frames & lenses per calendar year) | | \$0 copay for Lenses; \$0 copay for Collection frame; Substantially equal credit for non-collection frame selection | Not Covered |
| Routine Eye Exam by Specialist (one exam per calendar year) | | \$30 copayment per visit | 40% coinsurance per visit after OON medical deductible |

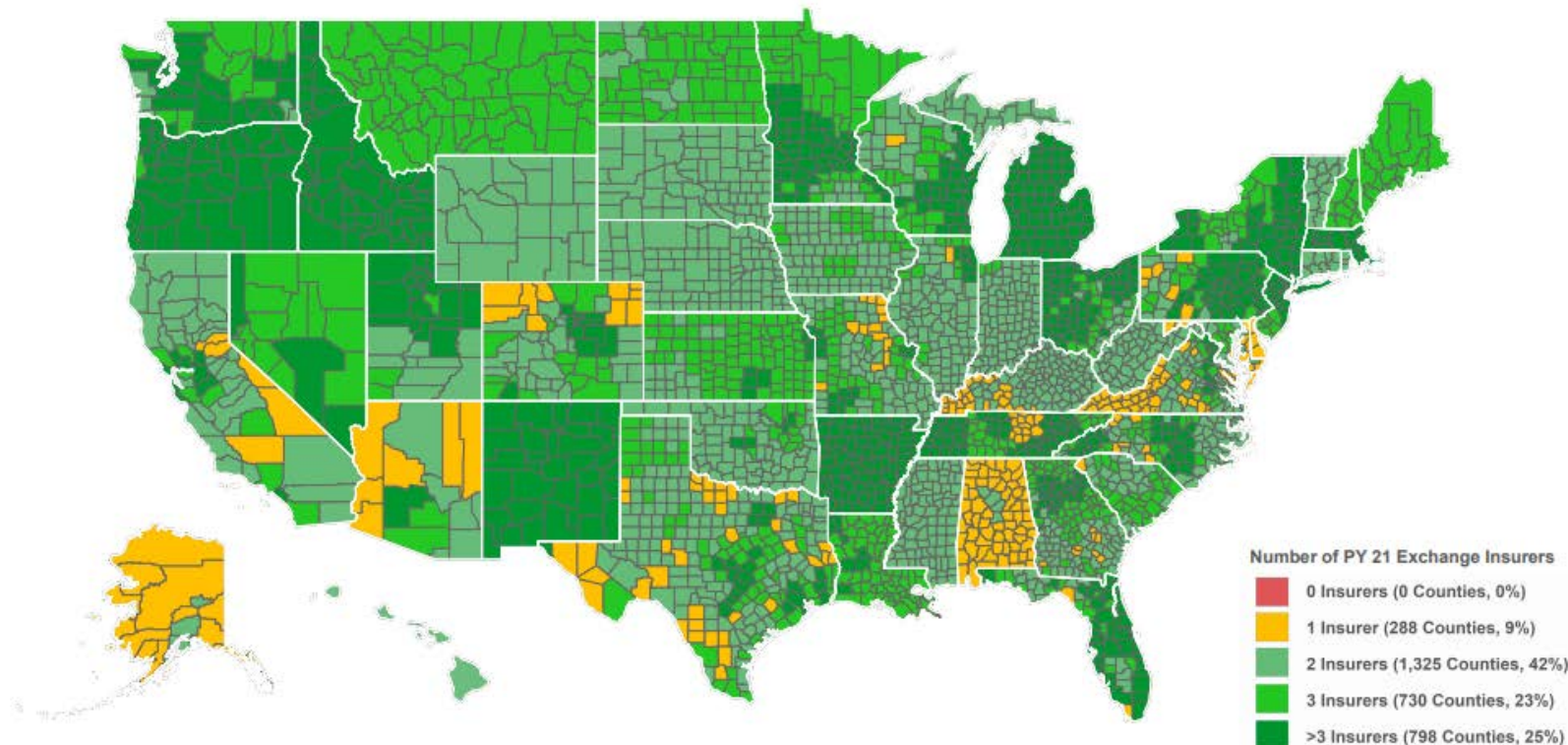
| Yellow shading represents change from 2020 Plan Year | 2021 Standard Bronze (Non-HSA) | |
|--|---|---|
| Plan Overview | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
| Deductible: Individual (medical & Rx) | \$6,550 | \$13,100 |
| Deductible: Family (medical & Rx) | \$13,100 | \$26,200 |
| Out-of-Pocket Maximum: Individual | \$8,550 | \$17,100 |
| Out-of-Pocket Maximum: Family | \$17,100 | \$34,200 |
| Provider Office Visits | | |
| Preventive Visit (Adult/Child) | \$0 | 50% coinsurance |
| Provider Office Visits (Primary Care, Mental & Behavioral Health, Substance Abuse) | \$50 copayment per visit | 50% coinsurance per visit after OON deductible |
| Specialist Office Visits | \$70 copayment per visit after INET deductible | 50% coinsurance per visit after OON deductible |
| Outpatient Diagnostic Services | | |
| Advanced Radiology (CT/PET Scan, MRI) | \$75 copay per service after INET deductible up to a combined annual maximum of \$375 for MRI and CT scans; \$400 for PET scans | 50% coinsurance per service after OON deductible |
| Laboratory Services | \$10 copayment per service after INET deductible | 50% coinsurance per service after OON deductible |
| Non-Advanced Radiology (X-ray, Diagnostic) | \$40 copayment per service after INET deductible | 50% coinsurance per service after OON deductible |
| Mammography Ultrasound | \$20 copayment per service after INET deductible | 50% coinsurance per service after OON deductible |
| Prescription Drugs - Retail Pharmacy (up to 30 day supply per prescription) | | |
| Tier 1 | \$20 copayment per prescription | 50% coinsurance per prescription after OON deductible |
| Tier 2 | 50% coinsurance per prescription after INET deductible | 50% coinsurance per prescription after OON deductible |
| Tier 3 | 50% coinsurance per prescription after INET deductible | 50% coinsurance per prescription after OON deductible |
| Tier 4 | 50% coinsurance up to a maximum of \$500 per prescription after INET deductible | 50% coinsurance per prescription after OON deductible |
| Outpatient Rehabilitative and Habilitative Services | | |
| Speech Therapy (40 visits per calendar year limit combined for PT/ST/OT) | \$30 copayment per visit after INET deductible | 50% coinsurance per visit after OON deductible |
| Physical and Occupational Therapy (40 visits per calendar year limit combined for PT/ST/OT) | \$30 copayment per visit after INET deductible | 50% coinsurance per visit after OON deductible |
| Other Services | | |
| Chiropractic Services (up to 20 visits per calendar year) | \$50 copayment per visit after INET deductible | 50% coinsurance per visit after OON deductible |
| Diabetic Supplies & Equipment | 40% coinsurance per equipment/supply after INET deductible | 50% coinsurance per equipment / supply after OON deductible |
| Durable Medical Equipment | 40% coinsurance per equipment/supply after INET deductible | 50% coinsurance per equipment / supply after OON deductible |
| Home Health Care Services (up to 100 visits per calendar year) | 25% coinsurance per visit after separate \$50 deductible | 25% coinsurance per visit after separate \$50 deductible |
| Outpatient Services (in a hospital or ambulatory facility) | \$500 copayment after INET plan deductible (Outpatient Hospital Facility); | 50% coinsurance per visit after OON deductible |
| | \$300 copayment after INET plan deductible (Ambulatory Surgery Center) | |
| Hospital Services | | |
| Inpatient Hospital Services (including MH, SA, maternity, hospice and skilled nursing facility*) *(skilled nursing facility stay is limited to 90 days per calendar year) | \$500 copayment per day to a maximum of \$1,000 per admission after INET deductible | 50% coinsurance per admission after OON deductible |
| Emergency and Urgent Care | | |
| Ambulance Services | \$0 copay after INET deductible | \$0 copay after INET deductible |
| Emergency Room | \$450 copayment per visit after INET deductible | \$450 copayment per visit after INET deductible |
| Urgent Care Center or Facility | \$75 copayment per visit | 50% coinsurance per visit after OON deductible |
| Pediatric Dental Care (for children under age 19) | | |
| Diagnostic & Preventive | \$0 copay | 50% coinsurance per visit after OON deductible |
| Basic Services | 45% coinsurance per visit after INET deductible | 50% coinsurance per visit after OON deductible |
| Major Services | 50% coinsurance per visit after INET deductible | 50% coinsurance per visit after OON deductible |
| Orthodontia Services (medically necessary only) | 50% coinsurance per visit after INET deductible | 50% coinsurance per visit after OON deductible |
| Pediatric Vision Care (for children under age 19) | | |
| Prescription Eye Glasses (one pair of frames & lenses per calendar year) | \$0 copay for Lenses; \$0 copay for Collection frame; Substantially equal credit for non-collection frame selection | Not Covered |
| Routine Eye Exam by Specialist (one exam per calendar year) | \$70 copayment per visit after INET deductible | 50% coinsurance per visit after OON deductible |

| 2021 Standard Bronze HSA | | |
|--|---|---|
| Plan Overview | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
| <i>Deductible: Individual (medical & Rx)</i> | \$6,350 | \$12,700 |
| Deductible: Family (medical & Rx) | \$12,700 | \$25,400 |
| <i>Out-of-Pocket Maximum: Individual</i> | \$6,900 | \$13,800 |
| Out-of-Pocket Maximum: Family | \$13,800 | \$27,600 |
| Provider Office Visits | | |
| <i>Preventive Visit (Adult/Child)</i> | \$0 | 50% coinsurance |
| <i>Provider Office Visits (Primary Care, Mental & Behavioral Health, Substance Abuse)</i> | 20% coinsurance per visit after INET plan deductible is met | 50% coinsurance per visit after OON deductible |
| <i>Specialist Office Visits</i> | 20% coinsurance per visit after INET plan deductible is met | 50% coinsurance per visit after OON deductible |
| Outpatient Diagnostic Services | | |
| <i>Advanced Radiology (CT/PET Scan, MRI)</i> | 20% coinsurance per service after INET plan deductible is met | 50% coinsurance per service after OON deductible |
| <i>Laboratory Services</i> | 20% coinsurance per service after INET plan deductible is met | 50% coinsurance per service after OON deductible |
| <i>Non-Advanced Radiology (X-ray, Diagnostic)</i> | 20% coinsurance per service after INET plan deductible is met | 50% coinsurance per service after OON deductible |
| Mammography Ultrasound | 20% coinsurance per service after INET plan deductible is met | 50% coinsurance per service after OON deductible |
| Prescription Drugs - Retail Pharmacy (up to 30 day supply per prescription) | | |
| <i>Tier 1</i> | 20% coinsurance per prescription after INET plan deductible is met | 50% coinsurance per prescription after OON plan deductible is met |
| <i>Tier 2</i> | 25% coinsurance per prescription after INET plan deductible is met | 50% coinsurance per prescription after OON plan deductible is met |
| <i>Tier 3</i> | 30% coinsurance per prescription after INET plan deductible is met | 50% coinsurance per prescription after OON plan deductible is met |
| <i>Tier 4</i> | 30% coinsurance up to a maximum of \$500 per prescription after INET plan deductible is met | 50% coinsurance per prescription after OON plan deductible is met |
| Outpatient Rehabilitative and Habilitative Services | | |
| <i>Speech Therapy (40 visits per calendar year limit combined for PT/ST/OT)</i> | 20% coinsurance per visit after INET plan deductible is met | 50% coinsurance per visit after OON plan deductible is met |
| <i>Physical and Occupational Therapy (40 visits per calendar year limit combined for PT/ST/OT)</i> | 20% coinsurance per visit after INET plan deductible is met | 50% coinsurance per visit after OON plan deductible is met |
| Other Services | | |
| Chiropractic Services (up to 20 visits per calendar year) | 20% coinsurance per visit after INET plan deductible is met | 50% coinsurance per visit after OON plan deductible is met |
| Diabetic Supplies & Equipment | 20% coinsurance per equipment/supply after INET plan deductible is met | 50% coinsurance per equipment/supply after OON plan deductible is met |
| Durable Medical Equipment | 20% coinsurance per equipment/supply after INET plan deductible is met | 50% coinsurance per equipment/supply after OON plan deductible is met |
| Home Health Care Services (up to 100 visits per calendar year) | 20% coinsurance per visit after INET plan deductible is met | 25% coinsurance per visit after OON plan deductible is met |
| <i>Outpatient Services (in a hospital or ambulatory facility)</i> | 20% coinsurance per visit after INET plan deductible is met | 50% coinsurance per visit after OON plan deductible is met |
| Hospital Services | | |
| <i>Inpatient Hospital Services (including MH, SA, maternity, hospice and skilled nursing facility*) *(skilled nursing facility stay is limited to 90 days per calendar year)</i> | 20% coinsurance per admission after INET plan deductible is met | 50% coinsurance per admission after OON plan deductible is met |
| Emergency and Urgent Care | | |
| Ambulance Services | 20% coinsurance per service after INET plan deductible is met | 20% coinsurance per service after INET plan deductible is met |
| <i>Emergency Room</i> | 20% coinsurance per service after INET plan deductible is met | 20% coinsurance per service after INET plan deductible is met |
| Urgent Care Center or Facility | 20% coinsurance per service after INET plan deductible is met | 50% coinsurance per visit after OON plan deductible is met |
| Pediatric Dental Care (for children under age 19) | | |
| Diagnostic & Preventive | \$0 copay | 50% coinsurance per visit after OON plan deductible is met |
| Basic Services | 40% coinsurance per visit after INET plan deductible is met | 50% coinsurance per visit after OON plan deductible is met |
| Major Services | 50% coinsurance per visit after INET plan deductible is met | 50% coinsurance per visit after OON plan deductible is met |
| Orthodontia Services (medically necessary only) | 50% coinsurance per visit after INET plan deductible is met | 50% coinsurance per visit after OON plan deductible is met |
| Pediatric Vision Care (for children under age 19) | | |
| Prescription Eye Glasses (one pair of frames & lenses per calendar year) | Lenses: \$0 copayment after INET plan deductible is met; Collection frame: \$0 copayment after INET plan deductible is met; Non-collection frame: members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer. | Not Covered |
| Routine Eye Exam by Specialist (one exam per calendar year) | 20% coinsurance per visit after INET plan deductible is met | 50% coinsurance per visit after OON plan deductible is met |

County by County Plan Year 2021 Insurer Participation in Health Insurance Exchanges

EXHIBIT 2.0

County by County Plan Year 2021 Projected Insurer Participation in Health Insurance Exchanges



-Federally-Facilitated Exchange (FFE) data reflected on this map are point in time as of 10/02/2020.
-State-Based Exchange (SBE) data are preliminary and self-reported from the Exchanges to CMS. These data are point in time as of 10/09/2020 for CO, CT, DC, ID, MA, MD, MN, NV, RI, VT, and WA, and 08/30/2020 for NJ and PA.
-County-level information for the following SBE states (CA and NY) is representative of PY 20 participation as PY 21 participation has not yet been provided by the Exchanges to CMS.

Released by CMS 10/19/20

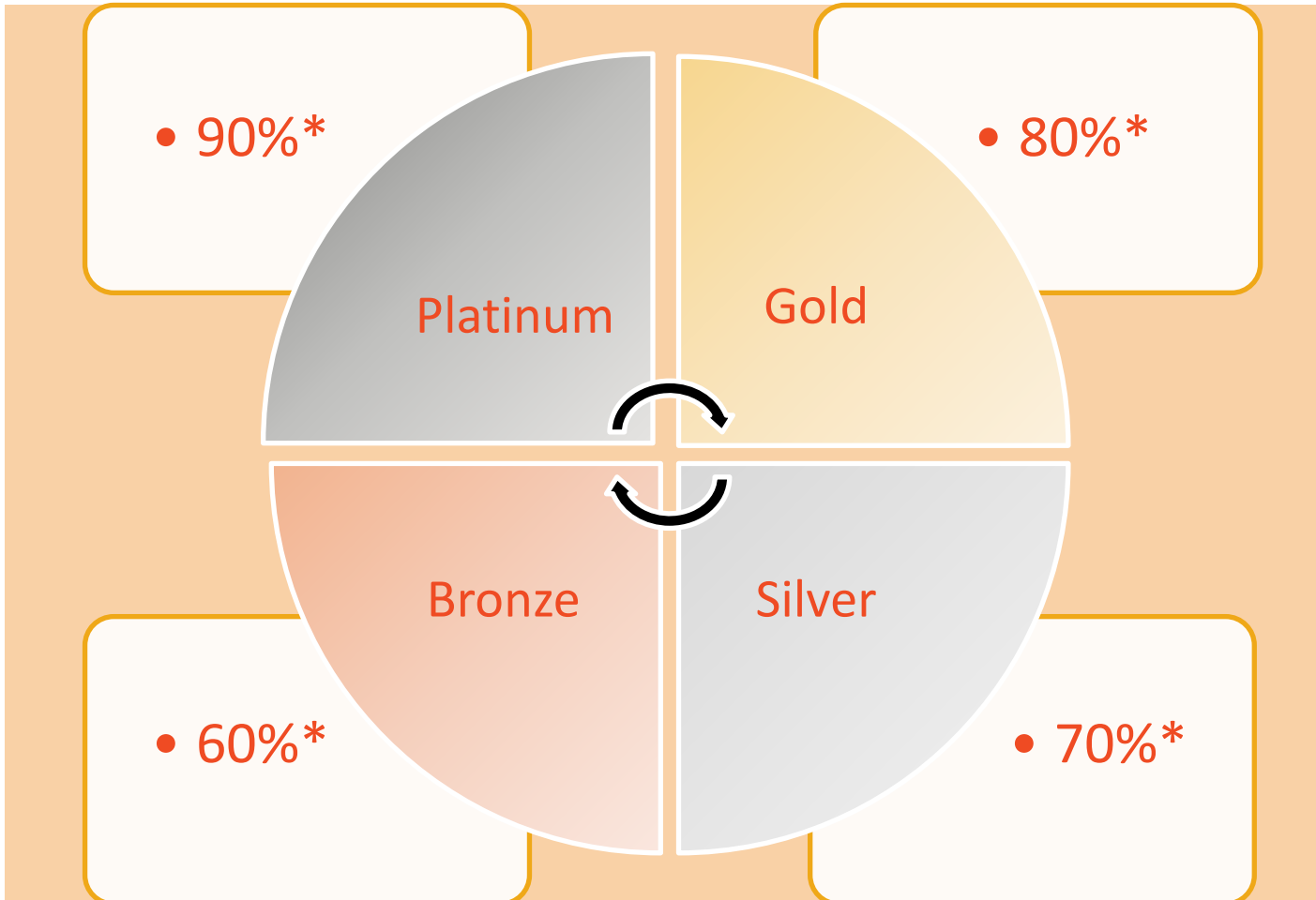
Available at:

<https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/10-16-2020-County-Coverage-Map.pdf>

Affordable Care Act - Health Plan Types

EXHIBIT 3.0

Metal Levels: Actuarial Value & Average Overall Cost of Providing Essential Health Benefits (EHBs)



**CMS regulations allow for a 'de minimis' range for the Actuarial Value (AV) calculation for each metal level, and for Silver Cost Sharing Reduction plans*

Per regulations effective for the 2018 Plan Year, 'de minimis' AV ranges are as follows:

- *Platinum: 86% - 92%*
- *Gold: 76% - 82%*
- *Silver: 66% - 72%***
- *Bronze: 56% - 62% (AV range permitted for 'Expanded Bronze' plans is up to 65%; plan must include at least 1 major service not subject to deductible or is a High Deductible Health Plan)*

***Silver Cost Sharing Reduction (CSR) Plans:*

- *73% CSR: 72% - 74%, but must be at least 2 points greater than 'standard' Silver plan*
- *87% CSR: 86% - 88%*
- *94% CSR: 93% - 95%*

Plan Design Development: AVC Benefit Cost Sharing Categories

EXHIBIT 4.0

| 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 |

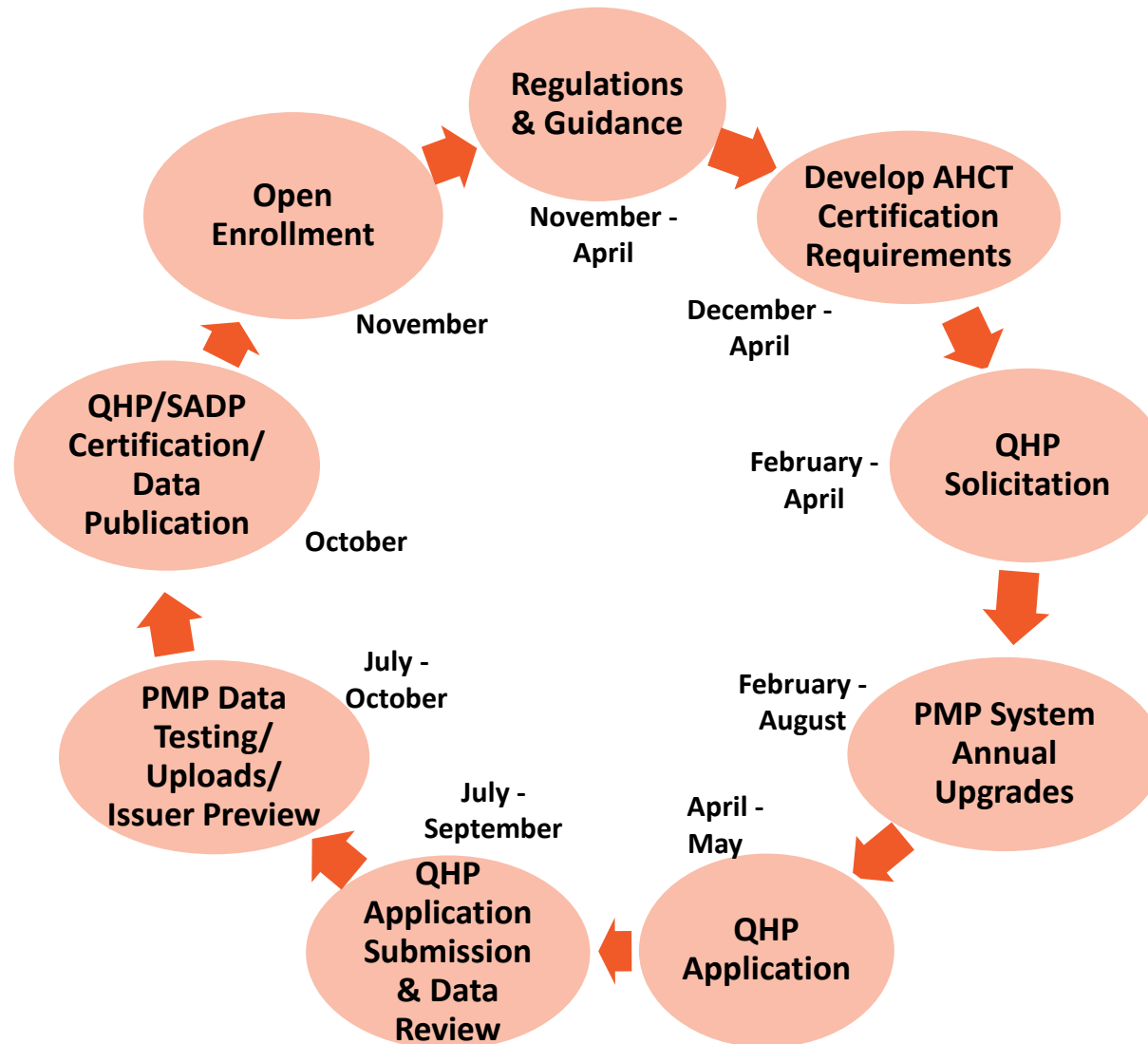
| Prescription Drug Benefits Subject to Deductible (Yes or No) Subject to Coinsurance (Yes or No) Coinsurance (Insurer's Cost Share) or Copay Values (Member Cost Share) |
|---|
| Generics |
| Preferred Brand Drugs |
| Non-Preferred Brand Drugs |
| Specialty Drugs (i.e. high-cost) |

| 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 as a Separate Field 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 |

Plan Management Certification Life Cycle

EXHIBIT 5.0



Each plan year, the cycle begins with the release of regulations and guidance, including the Actuarial Value Calculator (AVC) tool used to develop standardized plans, and ends once Open Enrollment commences

Note: timeframes subject to change

2021 Plan Mix: Number of Plans Required / Permitted per Issuer

EXHIBIT 6.0

| | INDIVIDUAL MARKET | | SHOP |
|--------------|--------------------|--------------------|--------------------------|
| Metal Level | Standardized Plans | Non-Standard Plans | Total |
| Platinum | N/A | 2 | 4 (Optional) |
| Gold | 1 | 3 | Min 1 – Max 6 |
| Silver | 1 | 0 | Min 2 – Max 6 |
| Bronze | 2 | 3 | Min 2 – Max 4 |
| Catastrophic | N/A | 1 | N/A |
| TOTAL | 4 Required | 9 Optional | 5 Required / 15 Optional |
| Maximum | 13 | | 20 |

Copay Maximums – State Regulation

EXHIBIT 7.0

- Copayments for in-network imaging services
 - Connecticut General Statute (CGS)
 - 38a-511 (individual health insurance policy)
 - 38a-550 (group health insurance policy)
 - No health insurer, health care center, hospital service corporation, medical service corporation or fraternal benefit society that provides coverage under a health insurance policy or contract for *magnetic resonance imaging or computed axial tomography* may:
 - require total copayments in excess of three hundred seventy-five dollars for all such in-network imaging services combined annually, or
 - require a copayment in excess of seventy-five dollars for each in-network magnetic resonance imaging or computed axial tomography, provided the physician ordering the radiological services and the physician rendering such services are not the same person or are not participating in the same group practice.
 - No health insurer, health care center, hospital service corporation, medical service corporation or fraternal benefit society that provides coverage under a health insurance policy or contract for *positron emission tomography* may:
 - require total copayments in excess of four hundred dollars for all such in-network imaging services combined annually, or
 - require a copayment in excess of one hundred dollars for each in-network positron emission tomography, provided the physician ordering the radiological service and the physician rendering such service are not the same person or are not participating in the same group practice.
 - Does not apply to a high deductible plan specified in section 38a-493

Copay Maximums – State Regulation

EXHIBIT 7.1

- Copayments for in-network physical therapy and in-network occupational therapy services
 - Connecticut General Statute (CGS)
 - 38a-511a (individual health insurance policy)
 - 38a-550a (group health insurance policy)
 - Applies to policies providing coverage for basic hospital expense coverage, basic medical-surgical expense coverage, major medical expense coverage, hospital or medical service plan contract and hospital and medical coverage provided to subscribers of a health care center
 - Copayments may not be imposed that exceed a maximum of thirty dollars per visit for in-network (1) physical therapy services rendered by a physical therapist licensed under section 20-73, or (2) occupational therapy services rendered by an occupational therapist licensed under section 20-74b or 20-74c

Cost Sharing Maximums – State Regulation

EXHIBIT 7.2

- State of Connecticut Public Act No. 20-4: An Act Concerning Diabetes and High Deductible Health Plans (July 2020 Special Session - House Bill No. 6003)
- Affects Connecticut General Statute (CGS) 38a-492d (individual health insurance policy) and 38a-518d (group health insurance policy) Mandatory coverage for diabetes testing and treatment.
- Effective January 1, 2022
 - Coverage is required for the treatment of all types of diabetes, including laboratory and diagnostic testing and screening, insulin drugs, non insulin drugs, diabetes devices (including diabetic ketoacidosis devices) in accordance with the insured's diabetes treatment plan,
 - Enrollee coinsurance, copayments, deductibles and other out-of-pocket expenses may not exceed:
 - Twenty-five dollars for each thirty-day supply of a medically necessary covered insulin drug
 - Twenty-five dollars for each thirty-day supply of a medically necessary covered non insulin drug
 - One hundred dollars for a thirty-day supply of all medically necessary covered diabetes devices and diabetic ketoacidosis devices for such insured that are in accordance with such insured's diabetes treatment plan
 - These provisions apply to a high deductible health plan to the maximum extent permitted by federal law

Deductible and Coinsurance Maximums – Home Health Care Services

EXHIBIT 7.3

- Mandatory coverage for home health care
 - Connecticut General Statute (CGS)
 - Sec. 38a-493 (individual health insurance policy)
 - Sec. 38a-520 (group health insurance policy)
 - Applies to policies providing coverage for basic hospital expense coverage, basic medical-surgical expense coverage, major medical expense coverage, accident only coverage, limited benefit health coverage, hospital or medical service plan contract and hospital and medical coverage provided to subscribers of a health care center
 - Home health care benefits may be subject to an annual deductible of not more than fifty dollars for each person covered under a policy and may be subject to a coinsurance provision that provides for coverage of not less than seventy-five per cent of the reasonable charges for such services.
 - Specified high deductible plans are not subject to the deductible limits outlined above

United States Code (USC) – Title 26

Internal Revenue Code

EXHIBIT 8.0

- 26 USC §223(c)(2): Health savings accounts
 - Definition: High deductible health plan
 - Has an annual deductible not less than \$1,400 for self-only/\$2,800 for family coverage for calendar year 2021*
 - The sum of the annual deductible and the other annual out-of-pocket expenses required to be paid under the plan (other than for premiums) for covered benefits does not exceed \$7,000 for self-only/\$14,000 for family coverage for calendar year 2021*
 - Shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for preventive care**
 - For plan years beginning on or before December 31, 2021, shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for telehealth and other remote care services.

**Deductible and out-of-pocket limits evaluated by IRS each year – refer to IRS Revenue Procedure 2020-32 for calendar year 2021; Coverage outside of plan network is not taken into account*

***IRS Notice 2019-45 (“Additional Preventive Care Benefits Permitted to be Provided by a High Deductible Health Plan Under § 223”) expanded list of preventive care benefits that could be provided by a HDHP without a deductible, or with a deductible below the applicable minimum deductible (self-only or family).*

2021 Plan Actuarial Value: CT Individual Market (On-Exchange)

EXHIBIT 9.0

2021 On-Exchange Plans:
Information obtained from
Connecticut Insurance
Department (CID) Rate Filings

Abbreviations:
Anth: Anthem Blue Cross and Blue Shield
CBI: ConnectiCare Benefits, Inc.
CSR: Cost Sharing Reduction
AV: Actuarial Value
URRT: Unified Rate Review Template

| Metal Level | Carrier Short Name | Plan Name | CSR Variant Level | Renewal Status | Exchange Status | AV per Screenshot | AV per URRT |
|--------------|--------------------|---|-------------------|----------------|-----------------|-------------------|-------------|
| Catastrophic | Anth | Catastrophic HMO Pathway Enhanced | N/A | Renewing | On | 63.02% | 63.00% |
| Catastrophic | CBI | Choice Catastrophic POS with Dental | N/A | Renewing | On | 63.37% | 63.40% |
| Bronze | Anth | Bronze HMO Pathway Enhanced Tiered | N/A | Renewing | On | 64.78% | 64.80% |
| Bronze | Anth | Bronze HMO BlueCare Prime | N/A | New | On | 64.97% | 65.00% |
| Bronze | Anth | Bronze PPO Standard Pathway | N/A | Renewing | On | 64.33% | 64.30% |
| Bronze | Anth | Bronze PPO Standard Pathway for HSA | N/A | Renewing | On | 64.98% | 65.00% |
| Bronze | CBI | Choice Bronze Standard POS | N/A | Renewing | On | 64.34% | 64.30% |
| Bronze | CBI | Choice Bronze Standard POS HSA | N/A | Renewing | On | 64.98% | 65.00% |
| Bronze | CBI | Choice Bronze Alternative POS with Dental | N/A | Renewing | On | 64.65% | 64.70% |
| Bronze | CBI | Passage Bronze Alternative PCP POS | N/A | Renewing | On | 64.46% | 64.50% |
| Bronze | CBI | Bronze Virtual Alternative POS | N/A | New | On | 65.00% | 65.00% |
| Silver | Anth | Silver PPO Standard Pathway | N/A | Renewing | On | 70.69% | 70.70% |
| Silver | Anth | Silver PPO Standard Pathway | 73% CSR | Renewing | On | 72.83% | N/A |
| Silver | Anth | Silver PPO Standard Pathway | 87% CSR | Renewing | On | 87.97% | N/A |
| Silver | Anth | Silver PPO Standard Pathway | 94% CSR | Renewing | On | 94.71% | N/A |
| Silver | CBI | Choice Silver Standard POS | N/A | Renewing | On | 70.76% | 70.80% |
| Silver | CBI | Choice Silver Standard POS | 73% CSR | Renewing | On | 72.88% | N/A |
| Silver | CBI | Choice Silver Standard POS | 87% CSR | Renewing | On | 86.08% | N/A |
| Silver | CBI | Choice Silver Standard POS | 94% CSR | Renewing | On | 94.21% | N/A |
| Gold | Anth | Gold HMO Pathway Enhanced Tiered | N/A | Renewing | On | 78.07% | 78.00% |
| Gold | Anth | Gold HMO BlueCare Prime | N/A | New | On | 76.61% | 76.60% |
| Gold | Anth | Gold PPO Standard Pathway | N/A | Renewing | On | 81.60% | 81.60% |
| Gold | CBI | Choice Gold Standard POS | N/A | Renewing | On | 81.74% | 81.70% |
| Gold | CBI | Choice Gold Alternative POS with Dental | N/A | Renewing | On | 79.49% | 79.50% |
| Gold | CBI | Gold Virtual Alternative POS | N/A | New | On | 76.02% | 76.00% |
| 55Gold | CBI | Compass Gold Alternative POS | N/A | New | On | 76.16% | 76.20% |

2021 Plan Actuarial Value: CT Individual Market (Off-Exchange)

EXHIBIT 9.1

| Metal Level | Carrier Short Name | Plan Name | CSR Variant Level | Renewal Status | Exchange Status | AV per Screenshot | AV per URRT |
|--------------|--------------------|---|-------------------|----------------|-----------------|-------------------|-------------|
| Catastrophic | Anth | Anthem HMO Catastrophic Pathway Enhanced 8550/0% | N/A | Renewing | Off only | 63.02% | 63.00% |
| Bronze | Anth | Anthem Bronze HMO Pathway Enhanced 6200/12400/40% for HSA | N/A | Renewing | Off only | 64.75% | 64.80% |
| Bronze | Anth | Anthem Bronze HMO BlueCare Prime 8500/50% | N/A | Renewing | Off only | 64.89% | 64.90% |
| Bronze | Anth | Anthem Bronze HMO Pathway Enhanced Tiered 6100/7100/0%/50% | N/A | Renewing | Off only | 64.76% | 64.80% |
| Bronze | CCI | Passage SOLO HMO Copay/Coins. \$7000 ded. | N/A | Renewing | Off only | 64.54% | 64.50% |
| Bronze | CCI | Choice SOLO HMO HSA \$6,500 ded. | N/A | Renewing | Off only | 64.90% | 64.90% |
| Bronze | CCI | Choice SOLO POS HSA Coins. \$6,500 ded. | N/A | New | Off only | 64.72% | 64.70% |
| Silver | Anth | Anthem Silver HMO BlueCare Prime 5100/30% | N/A | Renewing | Off only | 67.49% | 67.50% |
| Silver | Anth | Anthem Silver HMO Pathway Enhanced Tiered 2600/6500/10%/40% | N/A | Renewing | Off only | 71.95% | 71.90% |
| Silver | Anth | Anthem Silver HMO Pathway Enhanced Tiered 2800/3800/10%/40% for HSA | N/A | Renewing | Off only | 70.26% | 70.30% |
| Silver | CICI | Choice SOLO POS Copay/Coins. \$4,500 30% ded. | N/A | Renewing | Off only | 68.53% | 68.50% |
| Silver | CICI | Choice SOLO POS Coins. \$3,250 ded. | N/A | Renewing | Off only | 68.85% | 68.90% |
| Silver | CICI | Choice SOLO POS HSA Coins. \$3,500 ded. | N/A | Renewing | Off only | 67.69% | 67.70% |
| Silver | CICI | Choice SOLO POS Copay/Coins. \$5,500 ded. | N/A | Renewing | Off only | 70.03% | 70.00% |
| Silver | CCI | Choice SOLO POS Copay/Coins. \$4,500 40% ded. | N/A | Renewing | Off only | 67.66% | 67.70% |
| Silver | CCI | SOLO Virtual HMO Copay/Coins. \$7,500 ded. | N/A | New | Off only | 68.94% | 68.90% |
| Gold | Anth | Anthem Gold HMO Pathway Enhanced Tiered 2000/3000/10%/30% | N/A | Renewing | Off only | 78.63% | 78.60% |
| Gold | Anth | Anthem Gold HMO BlueCare Prime 2500/20% | N/A | New | Off only | 76.41% | 76.50% |
| Gold | CICI | Passage SOLO POS Copay/Coins. \$2,200 ded. | N/A | Renewing | Off only | 76.93% | 76.90% |
| Gold | CCI | SOLO Virtual HMO Copay/Coins. \$2,000 ded. | N/A | New | Off only | 80.76% | 80.80% |

2021 Off-Exchange Plans:
Information obtained from
Connecticut Insurance
Department (CID) Rate Filings

Abbreviations:

Anth: Anthem Blue Cross and Blue Shield

CCI: ConnectiCare Inc.

CICI: ConnectiCare Insurance Company, Inc.

CSR: Cost Sharing Reduction

AV: Actuarial Value

URRT: Unified Rate Review Template

Connecticut Counties by Population*

EXHIBIT 10.0

Annual Estimates of the Resident Population for Counties: April 1, 2010 to July 1, 2019

| Geography | April 1, 2010 | | Population Estimate (as of July 1) | | | | | | | | | |
|-------------------|------------------|------------------|------------------------------------|------------------|------------------|------------------|------------------|------------------|------------------|------------------|------------------|------------------|
| | Census | Estimates Base | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
| Fairfield County | 916,829 | 916,904 | 919,355 | 928,000 | 935,099 | 939,924 | 944,196 | 944,943 | 944,347 | 943,038 | 943,971 | 943,332 |
| Hartford County | 894,014 | 894,052 | 895,236 | 896,864 | 897,706 | 897,678 | 897,407 | 896,290 | 894,141 | 893,076 | 892,580 | 891,720 |
| Litchfield County | 189,927 | 189,880 | 189,763 | 188,972 | 187,570 | 186,836 | 185,343 | 184,122 | 182,793 | 181,667 | 181,095 | 180,333 |
| Middlesex County | 165,676 | 165,672 | 165,616 | 166,174 | 165,634 | 165,329 | 164,786 | 163,724 | 163,292 | 162,942 | 162,870 | 162,436 |
| New Haven County | 862,477 | 862,442 | 863,357 | 863,871 | 864,566 | 862,820 | 862,885 | 860,186 | 857,901 | 857,748 | 856,971 | 854,757 |
| New London County | 274,055 | 274,070 | 274,004 | 273,037 | 274,091 | 272,976 | 271,462 | 269,636 | 268,403 | 267,419 | 266,285 | 265,206 |
| Tolland County | 152,691 | 152,747 | 153,239 | 153,050 | 151,967 | 151,778 | 151,693 | 151,734 | 151,162 | 151,009 | 150,689 | 150,721 |
| Windham County | 118,428 | 118,380 | 118,544 | 118,315 | 117,914 | 117,500 | 116,752 | 116,487 | 116,102 | 116,398 | 117,059 | 116,782 |
| | | | | | | | | | | | | |
| CT Total | 3,574,097 | 3,574,147 | 3,579,114 | 3,588,283 | 3,594,547 | 3,594,841 | 3,594,524 | 3,587,122 | 3,578,141 | 3,573,297 | 3,571,520 | 3,565,287 |

*Source: U.S. Census Bureau County Population Totals: 2010-2019 available at:
<https://www.census.gov/data/datasets/time-series/demo/popest/2010s-counties-total.html>

Individual Market: Age 21 Rates Approved by CID for 2021 Plan Year (Part 1 of 2)

EXHIBIT 11.0

| | | Fairfield County | | Hartford County | | Litchfield County | | Middlesex County | | New Haven County | | New London Cty | | Tolland County | | Windham County | |
|---------------|--|------------------|-----------|-----------------|-----------|-------------------|-----------|------------------|-----------|------------------|-----------|----------------|-----------|----------------|-----------|----------------|-----------|
| Carrier | Plan Name | Age 21 Rate | Rank | Age 21 Rate | Rank | Age 21 Rate | Rank | Age 21 Rate | Rank | Age 21 Rate | Rank | Age 21 Rate | Rank | Age 21 Rate | Rank | Age 21 Rate | Rank |
| CBI | Choice Catastrophic POS with Dental | 188.96 | 1 | 161.46 | 1 | 174.58 | 1 | 174.45 | 1 | 174.45 | 1 | 174.58 | 1 | 174.58 | 1 | 174.58 | 1 |
| Anthem | Catastrophic HMO Pathway Enhanced | 233.2 | 2 | 199.58 | 2 | 195.38 | 2 | 214.29 | 2 | 214.29 | 2 | 195.38 | 2 | 195.38 | 2 | 195.38 | 2 |
| Anthem | Anthem HMO Catastrophic Pathway Enhanced 8550/0% | 233.2 | 2 | 199.58 | 2 | 195.38 | 2 | 214.29 | 2 | 214.29 | 2 | 195.38 | 2 | 195.38 | 2 | 195.38 | 2 |
| CBI | Passage Bronze Alternative PCP POS | 308.49 | 4 | 263.59 | 4 | 285.01 | 4 | 284.82 | 4 | 284.82 | 4 | 285.01 | 4 | 285.01 | 4 | 285.01 | 4 |
| CBI | Bronze Virtual Alternative POS | 321.68 | 5 | 274.86 | 5 | 297.2 | 6 | 296.99 | 5 | 296.99 | 5 | 297.2 | 6 | 297.2 | 6 | 297.2 | 6 |
| CBI | Choice Bronze Standard POS | 345.64 | 6 | 295.33 | 6 | 319.34 | 10 | 319.11 | 6 | 319.11 | 6 | 319.34 | 10 | 319.34 | 10 | 319.34 | 10 |
| CBI | Choice Bronze Standard POS HSA | 345.96 | 7 | 295.6 | 7 | 319.63 | 11 | 319.4 | 7 | 319.4 | 7 | 319.63 | 11 | 319.63 | 11 | 319.63 | 11 |
| Anthem | Bronze HMO BlueCare Prime | 351.19 | 8 | 300.57 | 8 | 294.24 | 5 | 322.71 | 8 | 322.71 | 8 | 294.24 | 5 | 294.24 | 5 | 294.24 | 5 |
| CBI | Choice Bronze Alternative POS with Dental | 356.88 | 9 | 304.93 | 9 | 329.71 | 12 | 329.49 | 9 | 329.49 | 9 | 329.71 | 12 | 329.71 | 12 | 329.71 | 12 |
| CCI | Passage SOLO HMO Copay/Coins. \$7000 ded. | 367.56 | 10 | 312.64 | 10 | 311.35 | 8 | 342.62 | 11 | 342.62 | 11 | 313.64 | 8 | 313.64 | 8 | 313.64 | 8 |
| Anthem | Bronze HMO Pathway Enhanced Tiered | 369.93 | 11 | 316.61 | 11 | 309.94 | 7 | 339.94 | 10 | 339.94 | 10 | 309.94 | 7 | 309.94 | 7 | 309.94 | 7 |
| Anthem | Anthem Bronze HMO BlueCare Prime 8500/50% | 376.21 | 12 | 321.98 | 12 | 315.2 | 9 | 345.71 | 12 | 345.71 | 12 | 315.2 | 9 | 315.2 | 9 | 315.2 | 9 |
| Anthem | Anthem Bronze HMO Pathway Enhanced 6200/12400/40% for HSA | 396.68 | 13 | 339.5 | 13 | 332.35 | 13 | 364.52 | 13 | 364.52 | 13 | 332.35 | 13 | 332.35 | 13 | 332.35 | 13 |
| Anthem | Anthem Bronze HMO Pathway Enhanced Tiered 6100/7100/0%/50% | 397.65 | 14 | 340.33 | 14 | 333.17 | 14 | 365.41 | 14 | 365.41 | 14 | 333.17 | 14 | 333.17 | 14 | 333.17 | 14 |
| CCI | Choice SOLO POS HSA Coins. \$6,500 ded. | 409.74 | 15 | 348.52 | 15 | 347.08 | 16 | 381.94 | 16 | 381.94 | 16 | 349.63 | 16 | 349.63 | 16 | 349.63 | 16 |
| CCI | SOLO Virtual HMO Copay/Coins. \$7,500 ded. | 409.92 | 16 | 348.67 | 16 | 347.24 | 17 | 382.11 | 17 | 382.11 | 17 | 349.79 | 17 | 349.79 | 17 | 349.79 | 17 |
| CCI | Choice SOLO HMO HSA \$6,500 ded. | 410.51 | 17 | 349.17 | 17 | 347.74 | 18 | 382.66 | 18 | 382.66 | 18 | 350.29 | 19 | 350.29 | 19 | 350.29 | 19 |
| Anthem | Bronze PPO Standard Pathway for HSA | 412.46 | 18 | 353.01 | 18 | 345.57 | 15 | 379.02 | 15 | 379.02 | 15 | 345.57 | 15 | 345.57 | 15 | 345.57 | 15 |
| Anthem | Gold HMO BlueCare Prime | 417.99 | 19 | 357.74 | 19 | 350.2 | 19 | 384.1 | 19 | 384.1 | 19 | 350.2 | 18 | 350.2 | 18 | 350.2 | 18 |
| CCI | Choice SOLO POS Copay/Coins. \$4,500 40% ded. | 429.4 | 20 | 365.24 | 20 | 363.73 | 21 | 400.27 | 21 | 400.27 | 21 | 366.41 | 21 | 366.41 | 21 | 366.41 | 21 |

| |
|--------------|
| Catastrophic |
| Bronze |
| Silver |
| Gold |

BOLD FONT:
"On-Exchange"
Plan

*Exhibit
sorted in
rank order
by Fairfield
County rates*



Individual Market: Age 21 Rates Approved by CID for 2021 Plan Year (Part 2 of 2)

EXHIBIT 11.0

| | | Fairfield County | | Hartford County | | Litchfield County | | Middlesex County | | New Haven County | | New London Cty | | Tolland County | | Windham County | |
|---------|---|------------------|-----------|-----------------|-----------|-------------------|-----------|------------------|-----------|------------------|-----------|----------------|-----------|----------------|-----------|----------------|-----------|
| Carrier | Plan Name | Age 21 Rate | Rank | Age 21 Rate | Rank | Age 21 Rate | Rank | Age 21 Rate | Rank | Age 21 Rate | Rank | Age 21 Rate | Rank | Age 21 Rate | Rank | Age 21 Rate | Rank |
| Anthem | Bronze PPO Standard Pathway | 431.12 | 21 | 368.97 | 21 | 361.21 | 20 | 396.16 | 20 | 396.16 | 20 | 361.21 | 20 | 361.21 | 20 | 361.21 | 20 |
| CBI | Choice Silver Standard POS | 438.66 | 22 | 374.81 | 22 | 405.27 | 26 | 404.99 | 23 | 404.99 | 23 | 405.27 | 26 | 405.27 | 26 | 405.27 | 26 |
| Anthem | Gold HMO Pathway Enhanced Tiered | 439.83 | 23 | 376.43 | 23 | 368.5 | 22 | 404.16 | 22 | 404.16 | 22 | 368.5 | 22 | 368.5 | 22 | 368.5 | 22 |
| Anthem | Anthem Silver HMO BlueCare Prime 5100/30% | 453.62 | 24 | 388.23 | 24 | 380.06 | 23 | 416.84 | 24 | 416.84 | 24 | 380.06 | 23 | 380.06 | 23 | 380.06 | 23 |
| CBI | Gold Virtual Alternative POS | 460.84 | 25 | 393.77 | 25 | 425.77 | 30 | 425.47 | 25 | 425.47 | 25 | 425.77 | 30 | 425.77 | 30 | 425.77 | 30 |
| CBI | Compass Gold Alternative POS | 470.6 | 26 | 402.11 | 26 | 434.78 | 33 | 434.48 | 26 | 434.48 | 26 | 434.78 | 32 | 434.78 | 32 | 434.78 | 32 |
| Anthem | Anthem Silver HMO Pathway Enhanced Tiered 2600/6500/10%/40% | 477.53 | 27 | 408.7 | 27 | 400.1 | 24 | 438.82 | 27 | 438.82 | 27 | 400.1 | 24 | 400.1 | 24 | 400.1 | 24 |
| Anthem | Anthem Silver HMO Pathway Enhanced Tiered 2800/3800/10%/40% for HSA | 478.99 | 28 | 409.95 | 28 | 401.32 | 25 | 440.16 | 28 | 440.16 | 28 | 401.32 | 25 | 401.32 | 25 | 401.32 | 25 |
| Anthem | Silver PPO Standard Pathway | 495.13 | 29 | 423.76 | 30 | 414.84 | 27 | 454.98 | 29 | 454.98 | 29 | 414.84 | 27 | 414.84 | 27 | 414.84 | 27 |
| CICI | Choice SOLO POS Coins. \$3,250 ded. | 496.52 | 30 | 422.33 | 29 | 420.59 | 28 | 462.84 | 30 | 462.84 | 30 | 423.69 | 28 | 423.69 | 28 | 423.69 | 28 |
| CCI | SOLO Virtual HMO Copay/Coins. \$2,000 ded. | 498.74 | 31 | 424.22 | 31 | 422.47 | 29 | 464.9 | 31 | 464.9 | 31 | 425.58 | 29 | 425.58 | 29 | 425.58 | 29 |
| CBI | Choice Gold Alternative POS with Dental | 510.96 | 32 | 436.59 | 33 | 472.07 | 37 | 471.74 | 32 | 471.74 | 32 | 472.07 | 37 | 472.07 | 37 | 472.07 | 37 |
| CICI | Choice SOLO POS Copay/Coins. \$4,500 30% ded. | 511.05 | 33 | 434.69 | 32 | 432.9 | 32 | 476.38 | 34 | 476.38 | 34 | 436.08 | 33 | 436.08 | 33 | 436.08 | 33 |
| Anthem | Anthem Gold HMO BlueCare Prime 2500/20% | 516.35 | 34 | 441.92 | 36 | 432.62 | 31 | 474.48 | 33 | 474.48 | 33 | 432.62 | 31 | 432.62 | 31 | 432.62 | 31 |
| CICI | Choice SOLO POS HSA Coins. \$3,500 ded. | 516.71 | 35 | 439.5 | 34 | 437.69 | 34 | 481.66 | 35 | 481.66 | 35 | 440.91 | 34 | 440.91 | 34 | 440.91 | 34 |
| CICI | Choice SOLO POS Copay/Coins. \$5,500 ded. | 518.87 | 36 | 441.34 | 35 | 439.52 | 35 | 483.67 | 36 | 483.67 | 36 | 442.76 | 35 | 442.76 | 35 | 442.76 | 35 |
| Anthem | Anthem Gold HMO Pathway Enhanced Tiered 2000/3000/10%/30% | 544.86 | 37 | 466.32 | 37 | 456.51 | 36 | 500.69 | 37 | 500.69 | 37 | 456.51 | 36 | 456.51 | 36 | 456.51 | 36 |
| CBI | Choice Gold Standard POS | 553.88 | 38 | 473.26 | 38 | 511.72 | 39 | 511.37 | 38 | 511.37 | 38 | 511.72 | 39 | 511.72 | 39 | 511.72 | 39 |
| CICI | Passage SOLO POS Copay/Coins. \$2,200 ded. | 587.87 | 39 | 500.03 | 39 | 497.98 | 38 | 547.99 | 39 | 547.99 | 39 | 501.64 | 38 | 501.64 | 38 | 501.64 | 38 |
| Anthem | Gold PPO Standard Pathway | 843.44 | 40 | 721.87 | 40 | 706.67 | 40 | 775.06 | 40 | 775.06 | 40 | 706.67 | 40 | 706.67 | 40 | 706.67 | 40 |

| |
|--------------|
| Catastrophic |
| Bronze |
| Silver |
| Gold |

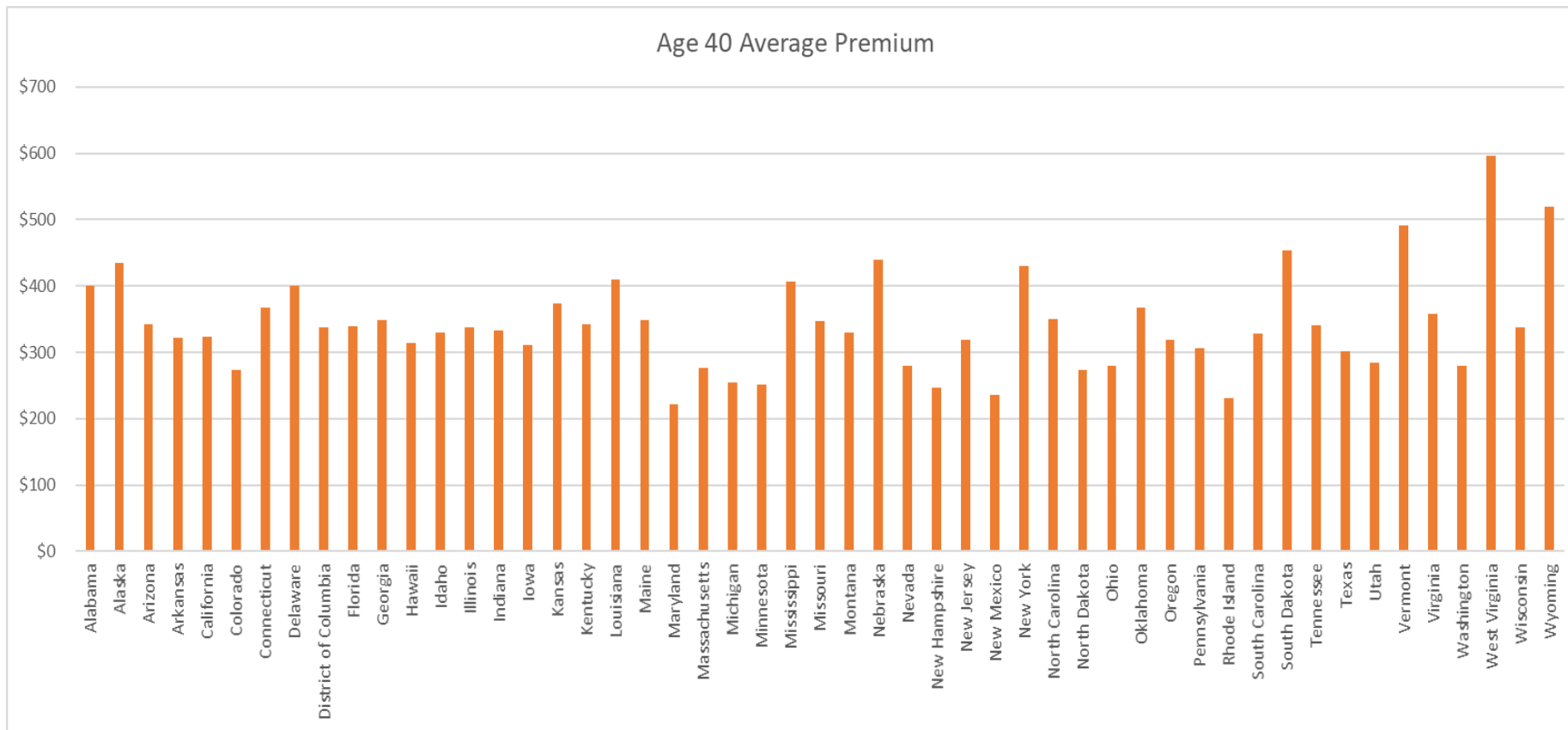
BOLD FONT:
"On-Exchange"
Plan

*Exhibit
sorted in
rank order
by Fairfield
County rates*

Average Marketplace Premiums by Metal Tier, 2021*

EXHIBIT 12.0

Average Lowest Cost Bronze Plan



Maryland: \$222 (lowest)

Connecticut: \$368 (39th)

West Virginia: \$596 (highest)

US: \$328

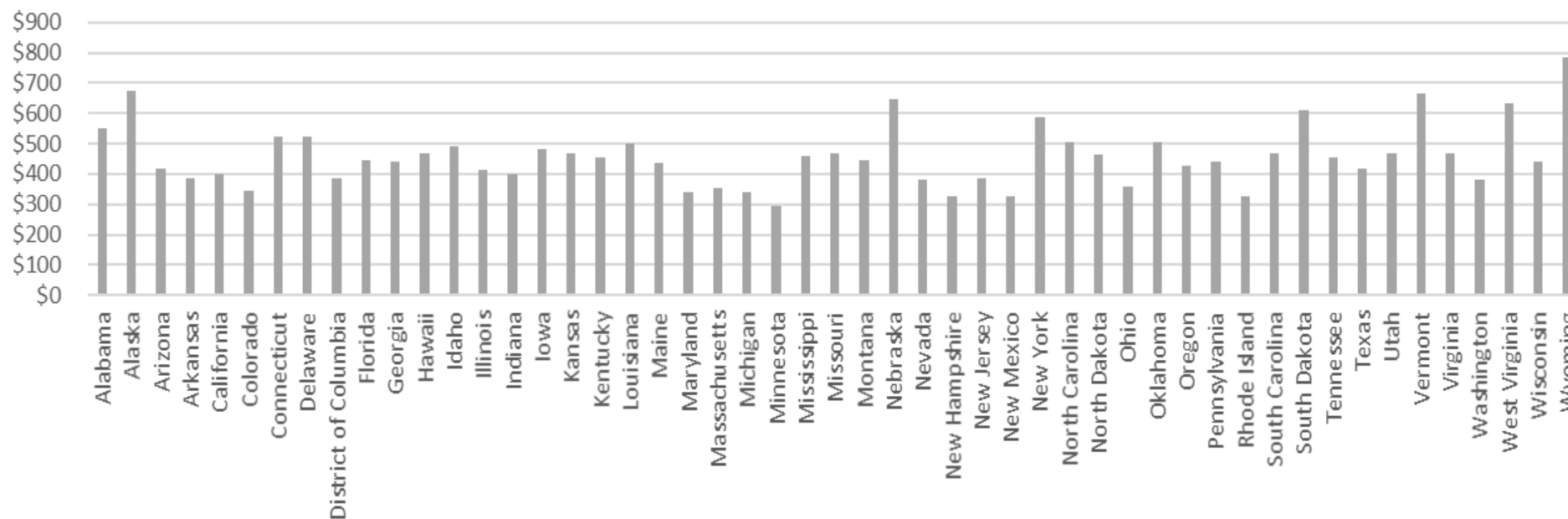
- Individual Market Information obtained from kff.org "State Health Facts": <https://www.kff.org/health-reform/state-indicator/average-marketplace-premiums-by-metal-tier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

Average Marketplace Premiums by Metal Tier, 2021*

EXHIBIT 12.1

Average Lowest Cost Silver Plan

Age 40 Average Premium



Minnesota: \$295 (lowest)

Connecticut: \$523 (43rd)*

Wyoming: \$785 (highest)

US: \$436

***AHCT permits only 1 standardized Silver plan be submitted per carrier*

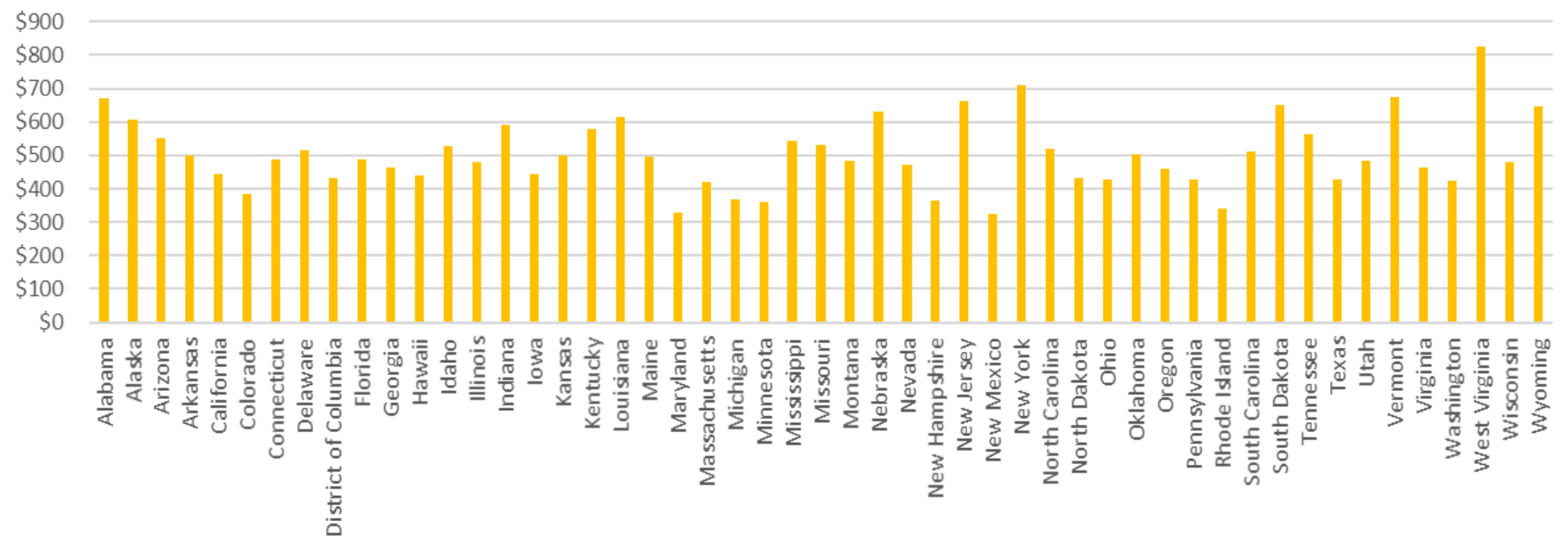
- Individual Market Information obtained from kff.org "State Health Facts": <https://www.kff.org/health-reform/state-indicator/average-marketplace-premiums-by-metal-tier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

Average Marketplace Premiums by Metal Tier, 2021*

EXHIBIT 12.2

Average Lowest Cost Gold Plan

Age 40 Average Premium



New Mexico: \$324 (lowest)

Connecticut: \$489 (26th)

West Virginia: \$825 (highest)

US: \$482

- Individual Market Information obtained from kff.org "State Health Facts": <https://www.kff.org/health-reform/state-indicator/average-marketplace-premiums-by-metal-tier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>