Access Health Connecticut

Health Plan Benefits & Qualifications Advisory Committee (HPBQ AC) Meeting
May 14, 2021

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Agenda

- Call to Order and Introductions
- Public Comment
- Vote: Meeting Minutes (March 25, 2021)
- Status of 2022 Standardized Plans
- 2022 Individual Market Standard Plan Designs
  - Possible Votes
- Next Steps

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Public Comment

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Vote:

Review and Approval of Minutes:
March 25, 2021 HPBQ AC Special Meeting

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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.

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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.

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Status of 2022 Standardized Plans

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2022 Plan Design Development

- Previous meetings included discussion of plan design modifications related to:
  - Deductible for laboratory services
  - State legislation on diabetes effective January 2022
    - Connecticut Insurance Department guidance

AHCT Standardized Plans in Individual Market: Summary of Previously Recommended Changes for Plan Year 2022

Metal Level	State Legislation: In-network Cost Sharing Maximums for Diabetes Treatment	In-Network Laboratory Services Not Subject to Plan Deductible
Gold	• $25 for each thirty-day supply of a medically necessary covered insulin drug • $25 for each thirty-day supply of a medically necessary covered non-insulin drug • $100 for a thirty-day supply of all medically necessary covered diabetes devices and diabetic ketoacidosis devices that are included in an insured's diabetes treatment plan	Not Incorporated (Unable to comply with AV and/or MHP requirements)
Silver (70%)		$10 after deductible → $20 copay Individual MOOP: $8150 → $8600
Silver 73% CSR		$10 after deductible → $20 copay Individual MOOP: $6500 → $6800
Silver 87% CSR		$10 after deductible → $10 copay Individual MOOP: $2500 → $2725
Silver 94% CSR		Plan already includes copay ($10) for laboratory services not subject to deductible
Bronze (non-HSA)		$10 after deductible → $20 copay Individual MOOP: $8550 → $8800
Bronze HSA-compatible	Maximums outlined above apply once the in-network plan deductible is met; Individual MOOP: $6900 → $7000	Not Incorporated (Would not meet IRS requirements for HDHP)

AV = Actuarial Value / MHP = Mental Health Parity / MOOP = Maximum Out-of-Pocket / CSR = Cost Sharing Reduction
HSA = Health Savings Account / HDHP = High Deductible Health Plan

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2022 Individual Market Standard Plan Designs

May 14, 2021

PRESENTED BY

Julie Andrews, FSA, MAAA – Sr. Consulting Actuary

Brad Heywood, ASA, MAAA – Associate Actuary

Regulation Changes for 2022

- The annual limitation on cost sharing was increased to **$8,700** (from $8,550 in 2021)
  - Note: This limit does not apply to HSA (Health Savings Account) qualified High Deductible Health Plans (HDHPs).
  - CSR (Cost Sharing Reduction) Variations annual limitation on cost sharing. The 2022 and 2021 limits are:
    - 100-150% **FPL: **$2,900/$5,800** (single/family)
      - 2021 - $2,850/$5,700 (single/family)
    - 150%-200% **FPL: **$2,900/$5,800** (single/family)
      - 2021 - $2,850/$5,700 (single/family)
    - 200%-250% **FPL: **$6,950/$13,900** (single/family)
      - 2021 - $6,800/$13,600 (single/family)
- Federal HDHP minimum deductible and Maximum Out of Pocket (MOOP) limits have been released by the IRS for 2022.
  - Single deductible is set at a minimum of $1,400 (same as 2021)
  - MOOP maximum limit increased from $7,000 to $7,050.

Final Changes to the Federal AVC for 2022

- The Federal AVC has been finalized
- No underlying changes were made to the 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 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*

Statutory Changes for 2022 Plans

Connecticut Public Act 20-4

An Act Concerning Diabetes and High Deductible Health Plans

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 a 30-day supply of all covered, medically necessary Diabetic device or diabetic ketoacidosis device.
  - Connecticut Insurance Department issued guidance in Bulletin HC-129*: $100 cap is to be applied as a thirty-day supply cumulative cap for all such devices

- 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.

*https://portal.ct.gov/-/media/CID/1_Bulletins/Bulletin-HC-129.pdf

Summary of 2022 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)	81.60% - 81.76%	70.69% - 71.83%	64.26% - 64.90%	64.98%
2022 AV - Preliminary	81.60% - 81.76%	70.69% - 70.81%	64.33% - 64.47%	64.98%

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)	72.83% - 73.85%	87.41% - 87.97%	94.71% - 94.96%
2022 AV- Preliminary	72.83% - 72.92%	87.37% - 87.97%	94.39% - 94.71%

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

2022 Plan Design Change Overview

Changes from April 15th Board Meeting

The plans **have been** reviewed for AV with the State Diabetes Bill.
Mental Health Parity compliance **has been** reviewed by all Carriers

2022 Plan Designs Overview

The plans **have been** reviewed for AV with the State Diabetes Bill. Mental Health Parity compliance **has been** reviewed by all Carriers

Benefit 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

Benefit 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 outpatient visit cost sharing is the same as Primary Care visit for all plans.
- Silver loading for defunded cost-sharing reduction plans will persist in 2022.
- All plans include ‘embedded’ deductible approach (not aggregate)

Summary of 2022 Bronze Non-HSA Plan AV

Benefit Category	2021 Ind. Standard Bronze Non-HSA Plan	2022 Ind. Standard Bronze Non-HSA Plan (Alt 2)
Combined Medical & Rx Deductible	$6,550 (INN)/$13,100 (OON)	$6,550 (INN)/$13,100 (OON)
Coinsurance	40%	40%
Out-of-pocket Maximum	$8,550 (INN)/$17,100 (OON)	**$8,800 (INN)/$17,600 (OON)
Primary Care	$50	$50
Specialist Care	$70 (after ded.)	$70 (after ded.)
Urgent Care	$75	$75
Emergency Room	$450 (after ded.)	$450 (after ded.)
Inpatient Hospital	$500 per day (after ded., $1,000 max. per admission)	$500 per day (after ded., $1,000 max. per admission)
Outpatient Hospital	$300@ASC/$500 otherwise (after ded.)	$300@ASC/$500 otherwise (after ded.)
Advanced Radiology (CT/PET Scan, MRI)	$75 (after ded.)	$75 (after ded.)
Non-Advanced Radiology (X-ray, Diagnostic)	$40 (after ded.)	$40 (after ded.)
Laboratory Services	$10 (after ded.)	**$20**
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	$30 (after ded.)	$30 (after ded.)
Chiropractic Care 20 visit calendar maximum	$50 (after ded.)	$50 (after ded.)
All Other Medical	40% (after ded.)	40% (after ded.)
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	$20 / 50% / 50% / 40% (all but generic after ded., $500 max per spec. script)	$20 / 50% / 50% / 40% (all but generic after ded., $500 max per spec. script)
2022 AVC Results	***64.33% - 64.47%**	***64.38% - 64.47%**

Previously Approved Plan Design:
MOOP Exceeds final regulatory limit of $8700

2022 Benefit changes:

- $25 for each 30-day supply of a covered, prescribed, medically necessary insulin or non-insulin drug, and
- $100 for a 30-day supply of all covered, medically necessary Diabetic devices or diabetic ketoacidosis devices.

New Options: 2022 Bronze Non-HSA Plan AV

Benefit Category	2021 Ind. Standard Bronze Non-HSA Plan	2022 Ind. Standard Bronze Non-HSA Plan (Alt 3)	2022 Ind. Standard Bronze Non-HSA Plan (Alt 4)
Combined Medical & Rx Deductible	$6,550 (INN)/$13,100 (OON)	$6,550 (INN)/$13,100 (OON)	**$6,650 (INN)/$13,300 (OON)**
Coinsurance	40%	40%	40%
Out-of-pocket Maximum	$8,550 (INN)/$17,100 (OON)	**$8,700 (INN)/$17,400 (OON)	**$8,700 (INN)/$17,400 (OON)
Primary Care	$50	$50	$50
Specialist Care	$70 (after ded.)	$70 (after ded.)	$70 (after ded.)
Urgent Care	$75	$75	$75
Emergency Room	$450 (after ded.)	$450 (after ded.)	$450 (after ded.)
Inpatient Hospital	$500 per day (after ded., $1,000 max. per admission)	$500 per day (after ded., $1,000 max. per admission)	$500 per day (after ded., $1,000 max. per admission)
Outpatient Hospital	$300@ASC/$500 otherwise (after ded.)	$300@ASC/$500 otherwise (after ded.)	$300@ASC/$500 otherwise (after ded.)
Advanced Radiology (CT/PET Scan, MRI)	$75 (after ded.)	$75 (after ded.)	$75 (after ded.)
Non-Advanced Radiology (X-ray, Diagnostic)	$40 (after ded.)	$40 (after ded.)	$40 (after ded.)
Laboratory Services	$10 (after ded.)	**$20**	**$20**
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	$30 (after ded.)	$30 (after ded.)	$30 (after ded.)
Chiropractic Care 20 visit calendar maximum	$50 (after ded.)	$50 (after ded.)	$50 (after ded.)
All Other Medical	40% (after ded.)	40% (after ded.)	40% (after ded.)
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	$20 / 50% / 50% / 40% (all but generic after ded., $500 max per spec. script)	$20 / 50% / 50% / 40% (all but generic after ded., $500 max per spec. script)	$20 / 50% / 50% / 40% (all but generic after ded., $500 max per spec. script)
2022 AVC Results	***64.33% - 64.47%**	***64.52% - 64.70%**	***64.47% - 64.65%**

2022 Benefit changes:

- $25 for each 30-day supply of a covered, prescribed, medically necessary insulin or non-insulin drug, and
- $100 for a 30-day supply of all covered, medically necessary Diabetic devices or diabetic ketoacidosis devices.

Vote

Summary of 2022 Bronze HSA Plan AV

Previously Approved Plan Design:

Benefit Category	2021 Bronze HSA Plan	2022 Bronze HSA Plan
Combined Medical & Rx Deductible	$6,350 (INN)/$12,700 (OON)	$6,350 (INN)/$12,700 (OON)
Coinsurance	20%	20%
Out-of-pocket Maximum	$6,900 (INN)/$13,800 (OON)	**$7,000 (INN)/$14,000 (OON)**
Primary Care, Specialist Care, Urgent Care, Emergency Room, Inpatient Hospital, Outpatient Hospital, Advanced Radiology (CT/PET Scan, MRI), Non-Advanced Radiology (X-ray, Diagnostic), Laboratory Services, Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational), Chiropractic Care	20% (after ded.)	20% (after ded.)
Diabetic Supplies	20% (after ded.)	**20% (after ded.)
All Other Medical	20% (after ded.)	20% (after ded.)
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	20% / 25% / 30% / 30% (all after ded., $500 max per spec. script)	*20% / 25% / 30% / 30% (all after ded., $500 max per spec. script)
2022 AVC Results	**64.98%**	**64.98%**

**$25 maximum for each thirty-day supply of a medically necessary covered insulin drug; $25 maximum for each 30-day supply of a medically necessary covered non-insulin drug.*
***20% coinsurance after in-network deductible is met to a $100 maximum per month for all covered medically necessary equipment and supplies.*
Maximums apply after in-network deductible is met.

New Options: 2022 Bronze HSA Plan AV

- Not subject to deductible: 4 of the 6 items permitted per IRS Notice 2019-45 for individuals diagnosed with diabetes listed below (subject to plan coinsurance)
  - Insulin and other glucose lowering agents*
  - Glucometer*
  - Hemoglobin A1c testing
  - Retinopathy screening

  *State legislation maximum cost sharing applies ($25 for each 30-day supply of a medically necessary covered insulin drug; $25 for each 30-day supply of a medically necessary covered noninsulin drug; $100 for a 30-day supply of all medically necessary covered diabetes devices and diabetic ketoacidosis devices)
- After deductible: maximums noted above to apply per state legislation on diabetes for any applicable service required by legislation but not included in IRS guidance noted above, such as blood glucose test strip, continuous glucometer, lancet, lancing device or insulin syringe

HSA Bronze Plan Revision	Deductible	MOOP
Current	$6,350 (Current) / $12,700 OON	$6,900 / $13,800 OON
New Option 1	$6,350 (Current) / $12,700 OON	$7,000 / $14,000 OON
New Option 2	$6,500 / $13,000 OON	$7,000 / $14,000 OON
New Option 3	$6,700 / $13,400 OON	$7,000 / $14,000 OON

New Options: 2022 Bronze HSA Plan AV

Benefit Category	2021 Bronze HSA Plan	2022 Bronze HSA Plan Option 1	2022 Bronze HSA Plan Option 2	2022 Bronze HSA Plan Option 3
Combined Medical & Rx Deductible	$6,350 (INN) /$12,700 (OON)	$6,350 (INN)/ $12,700 (OON)	$6,500 (INN)/ $13,000 (OON)	$6,700 (INN)/ $13,400 (OON)
Coinsurance	20%	20%	20%	20%
Out-of-pocket Maximum	$6,900 (INN) /$13,800 (OON)	**$7,000 (INN) /$14,000 (OON)**	**$7,000 (INN) /$14,000 (OON)**	**$7,000 (INN) /$14,000 (OON)**
Primary Care, Specialist Care, Urgent Care, Emergency Room, Inpatient Hospital, Outpatient Hospital, Advanced Radiology (CT/PET Scan, MRI), Non-Advanced Radiology (X-ray, Diagnostic), Laboratory Services, Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational), Chiropractic Care	20% (after ded.)	20% (after ded.)	20% (after ded.)	20% (after ded.)
Diabetic Supplies	20% (after ded.)	**20% (after ded.)	**20% (after ded.)	**20% (after ded.)
All Other Medical	20% (after ded.)	20% (after ded.)	20% (after ded.)	20% (after ded.)
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	20% / 25% / 30% / 30% (all after ded., $500 max per spec. script)	*20% / 25% / 30% / 30% (all after ded., $500 max per spec. script)	*20% / 25% / 30% / 30% (all after ded., $500 max per spec. script)	*20% / 25% / 30% / 30% (all after ded., $500 max per spec. script)
2022 AVC Results	**64.98%**			

- Not subject to deductible: 4 of the 6 items permitted per IRS Notice 2019-45 for individuals diagnosed with diabetes listed below (subject to plan coinsurance)
  - Insulin and other glucose lowering agents*
  - Glucometer*
  - Hemoglobin A1c testing
  - Retinopathy screening

  *State legislation maximum cost sharing applies ($25 for each 30-day supply of a medically necessary covered insulin drug; $25 for each 30-day supply of a medically necessary covered noninsulin drug; $100 for a 30-day supply of all medically necessary covered diabetes devices and diabetic ketoacidosis devices)
- After deductible: maximums noted above to apply per state legislation on diabetes for any applicable service required by legislation but not included in IRS guidance noted above, such as blood glucose test strip, continuous glucometer, lancet, lancing device or insulin syringe

Vote

Next Steps

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Appendix

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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

Red italic font signifies field included in Actuarial Value Calculator

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

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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

Red italic font signifies field included in Actuarial Value Calculator

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); $300 copayment after INET plan deductible (Ambulatory Surgery Center)	50% coinsurance per visit after OON 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 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

Red italic font signifies field included in Actuarial Value Calculator

Yellow shading represents change from 2020 Plan Year	2021 Standard Bronze HSA	
Plan Overview	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Deductible: Individual (medical & Rx)	$6,350	$12,700
Deductible: Family (medical & Rx)	$12,700	$25,400
Out-of-Pocket Maximum: Individual	$6,900	$13,800
Out-of-Pocket Maximum: Family	$13,800	$27,600
Provider Office Visits		
Preventive Visit (Adult/Child)	$0	50% coinsurance
Provider Office Visits (Primary Care, Mental & Behavioral Health, Substance Abuse)	20% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON deductible
Specialist Office Visits	20% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON deductible
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	20% coinsurance per service after INET plan deductible is met	50% coinsurance per service after OON deductible
Laboratory Services	20% coinsurance per service after INET plan deductible is met	50% coinsurance per service after OON deductible
Non-Advanced Radiology (X-ray, Diagnostic)	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)		
Tier 1	20% coinsurance per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Tier 2	25% coinsurance per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Tier 3	30% coinsurance per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Tier 4	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		
Speech Therapy (40 visits per calendar year limit combined for PT/ST/OT)	20% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Physical and Occupational Therapy (40 visits per calendar year limit combined for PT/ST/OT)	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
Outpatient Services (in a hospital or ambulatory facility)	20% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
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)	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
Emergency Room	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

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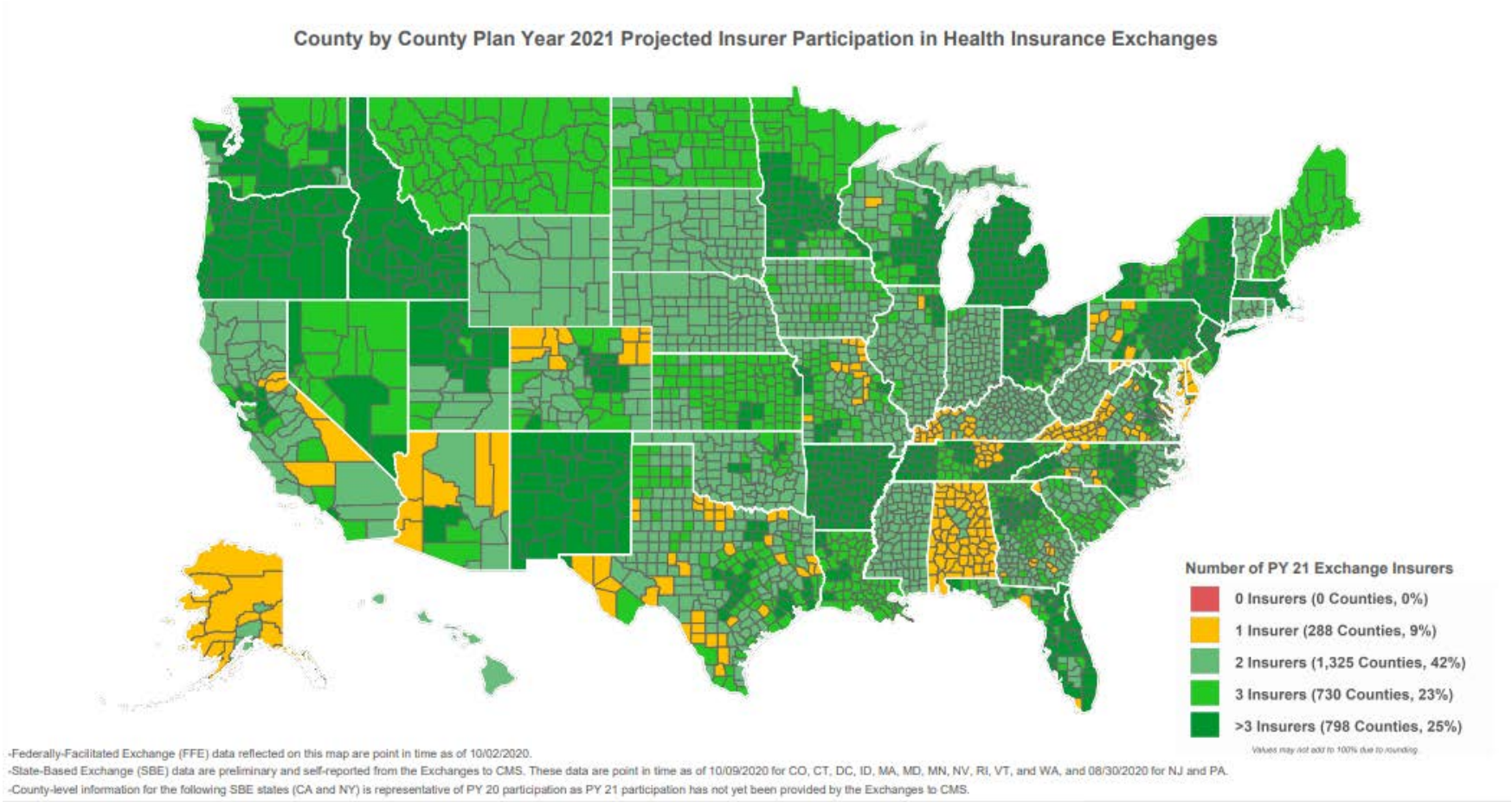
County by County Plan Year 2021 Insurer Participation in Health Insurance Exchanges

EXHIBIT 2.0



Released by CMS 10/19/20

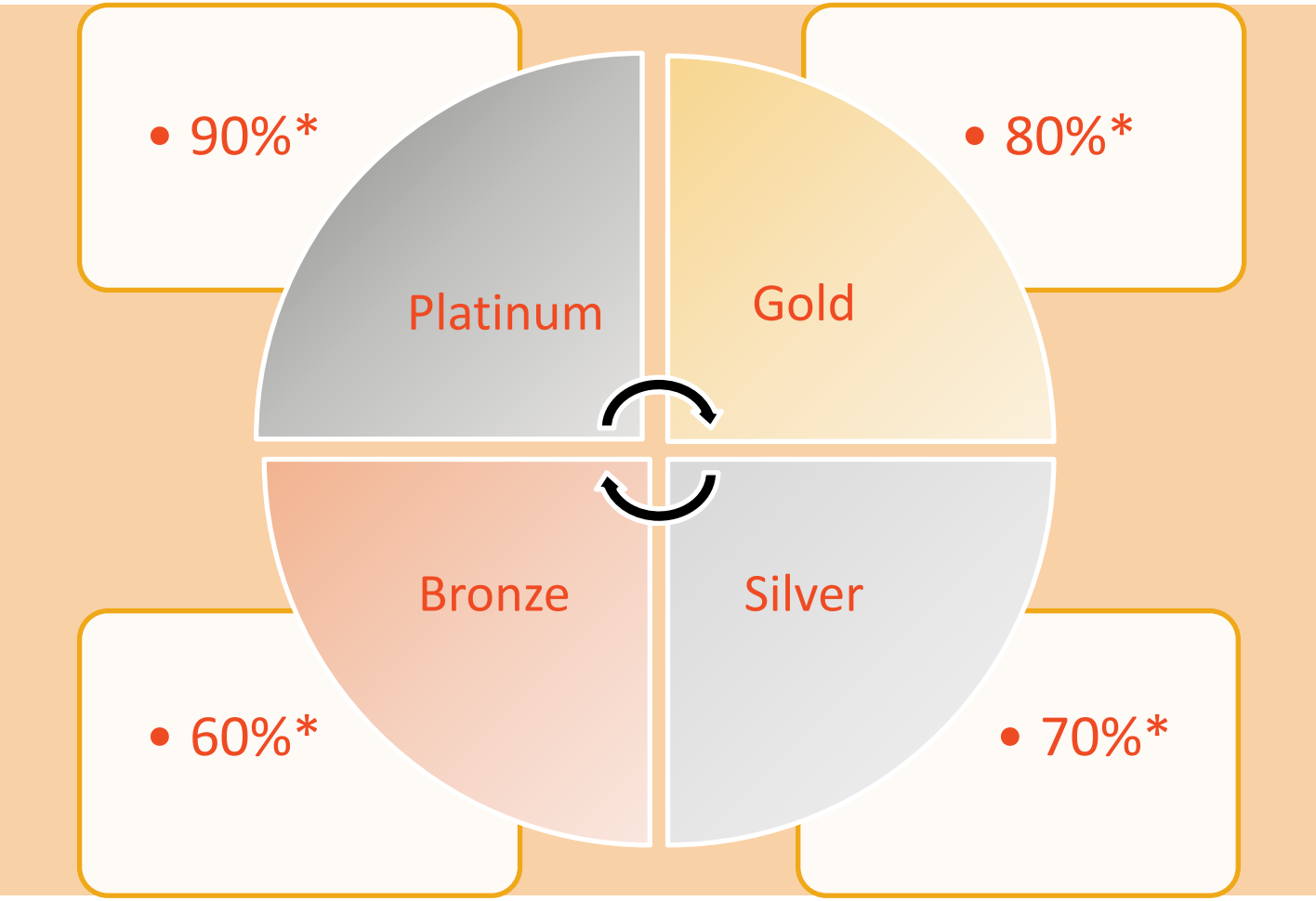
Available at:
https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/10-16-2020-County-Coverage-Map.pdf

access health CT

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%*

AV represents percentage of total <u>average</u> costs for covered in-network EHB covered by a health plan

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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

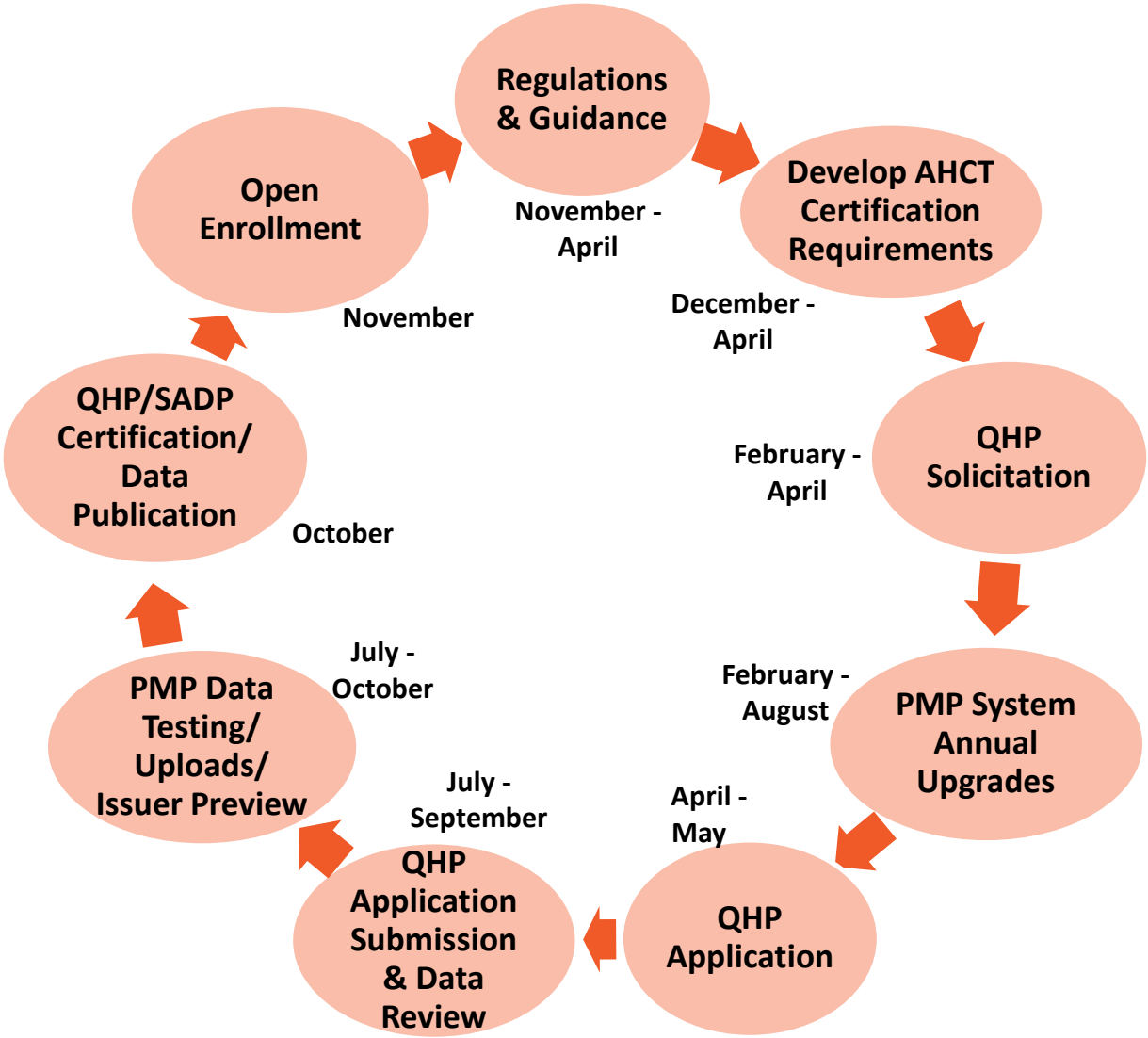
Prescription Drug Benefits Subject to Deductible (Yes or No) Subject to Coinsurance (Yes or No) Coinsurance (Insurer's Cost Share) or Copay Values (Member Cost Share)
Generics
Preferred Brand Drugs
Non-Preferred Brand Drugs
Specialty Drugs (i.e. high-cost)

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

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

EXHIBIT 6.0

AHCT	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

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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

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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

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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
        - 38a-492d(b) & 38a-518d(b) identify "Noninsulin drug" as a drug, including, but not limited to, a glucagon drug, glucose tablet or glucose gel, that does not contain insulin and is approved by FDA to treat diabetes
        - Section 2 outlines that Section 20-616 of the general statute is updated to include the following: (1) "Diabetes device" means a device, including, but not limited to, a blood glucose test strip, glucometer, continuous glucometer, lancet, lancing device or insulin syringe, that is (A) a legend device or nonlegend device, and (B) used to cure, diagnose, mitigate, prevent or treat diabetes or low blood sugar;
    - 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

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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). While the notice clarifies that certain medical services and items for individuals diagnosed with specified chronic conditions are preventive care for purposes of section 223(c)(2)(C), the services and items are not treated as preventive care required to be provided without cost sharing for purposes of section 2713 of the PHS Act. Therefore, the notice does not affect the definition of preventive care provided in § 54.9815-2713.*

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IRS Notice 2019-45: Additional Preventive Care Benefits Permitted to be Provided by a High Deductible Health Plan Under §223

EXHIBIT 8.1

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

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

EXHIBIT 9.0

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%
Gold	CBI	Compass Gold Alternative POS	N/A	New	On	76.16%	76.20%

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

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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

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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

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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

Anthem: Anthem Health Plans, Inc. / CBI: ConnectiCare Benefits, Inc. / CCI: ConnectiCare, Inc. / CICI: ConnectiCare Insurance Company, Inc.

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

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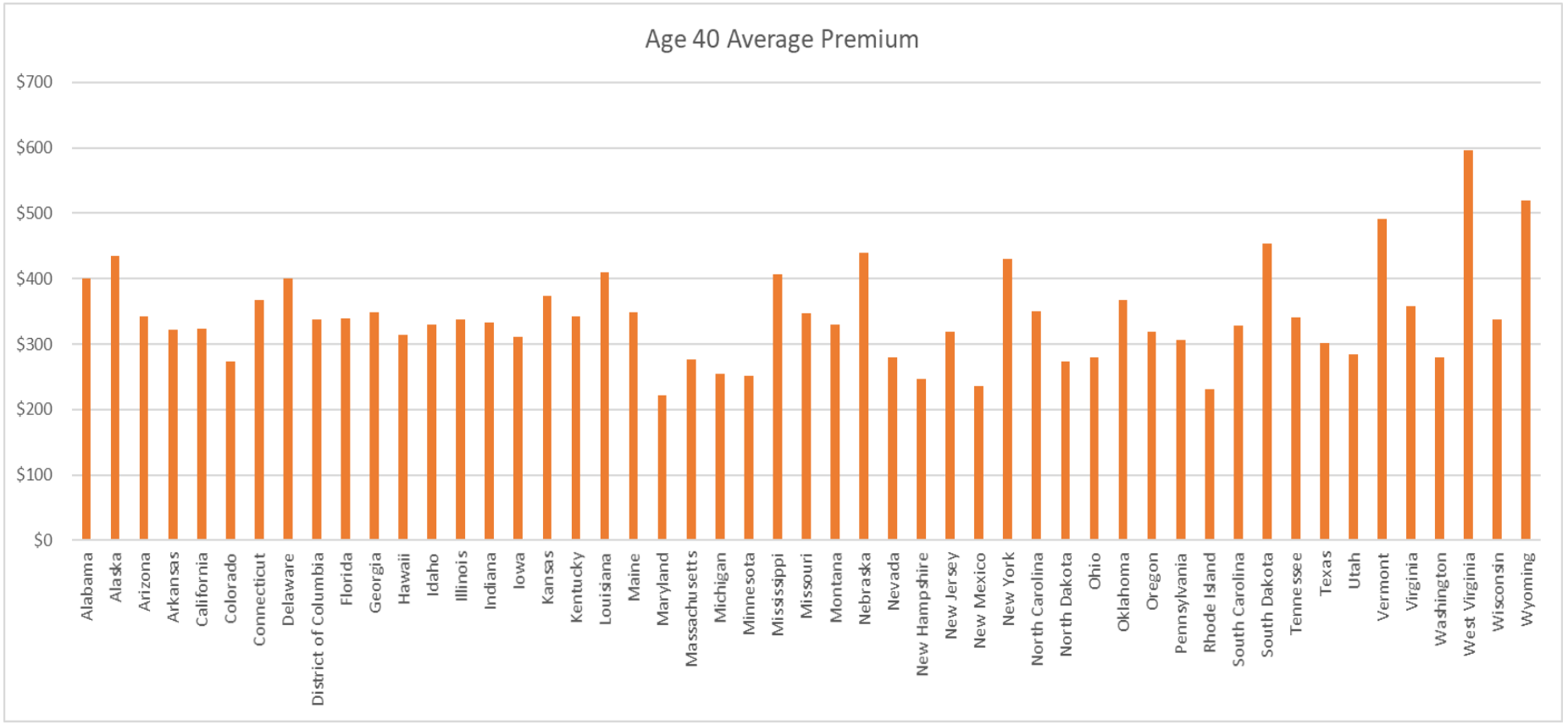
Anthem: Anthem Health Plans, Inc. / CBI: ConnectiCare Benefits, Inc. / CCI: ConnectiCare, Inc. / CICI: ConnectiCare Insurance Company, Inc.

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

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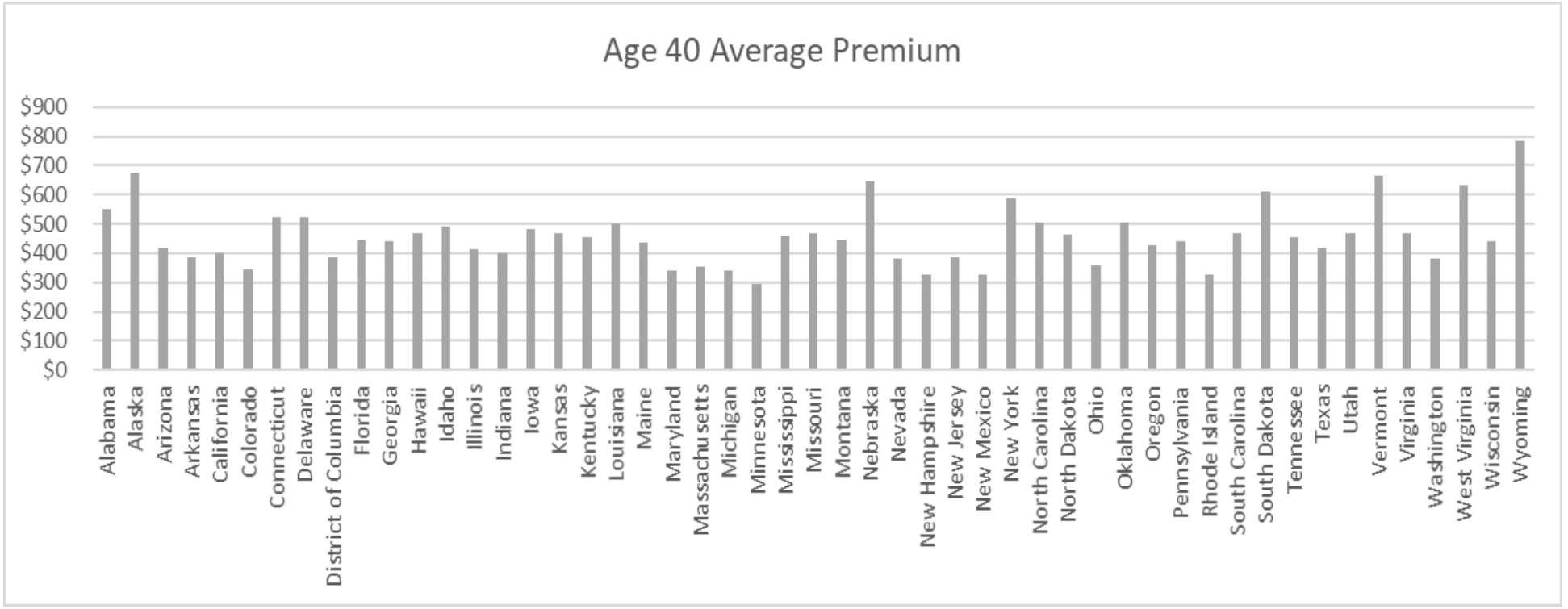
Average Marketplace Premiums by Metal Tier, 2021*

EXHIBIT 12.1

Average Lowest Cost Silver Plan



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

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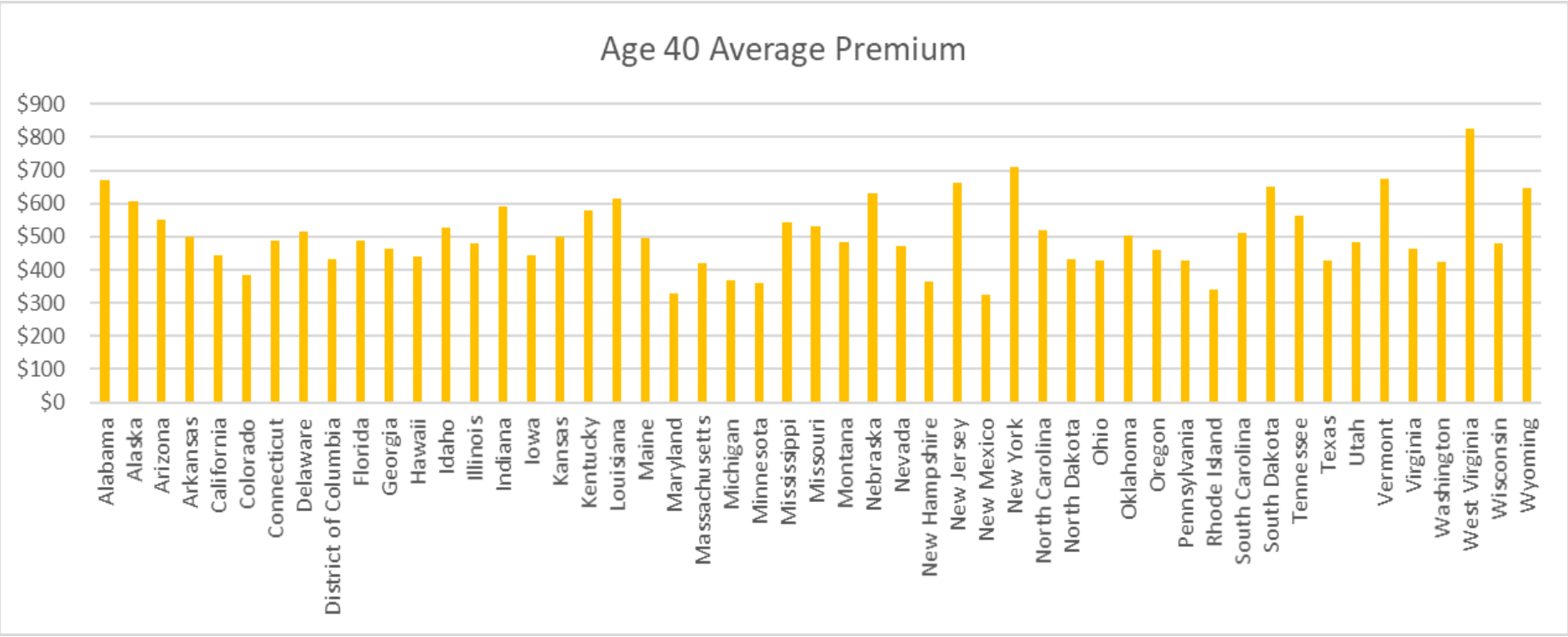
Average Marketplace Premiums by Metal Tier, 2021*

EXHIBIT 12.2

Average Lowest Cost Gold Plan



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

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2021 AHCT Plan Enrollment: Standardized / Non-Standard QHPs

EXHIBIT 13.0

Metal Level	Total	Percent
Catastrophic	2,005	1.91%
Bronze	45,732	43.58%
Silver	49,097	46.78%
Gold	8,112	7.73%
TOTAL	104,946	100.00%

Metal Level	Standardized Plans	Non-Standard Plans	Total	Percent in Std Plans by Metal Level
Catastrophic	N/A	2,005	2,005	0.00%
Bronze*	31,124	14,608	45,732	68.06%
Silver	49,097	0	49,097	100.00%
Gold	4,144	3,968	8,112	51.08%
TOTAL	84,365	20,581	104,946	80.39%

Compared to Plan Year 2020:

- No significant change in percentage of enrollees in Silver plans (46.78% vs 46.27%)
- Percentage of enrollees in standard Gold vs non-standard Gold has declined (51.08% from 60.58%)
- Percentage of enrollees in standard Bronze plans vs non-standard Bronze have declined (68.06% from 76.5%)
- Percentage of enrollees in all standard plans vs non-standard has declined (80.39% from 85.07%)

*Bronze Plans	Standardized Plans	Non-Standard Plans	Total	Percent in Standardized Plans
Non-HSA Bronze	19,699	14,608	34,307	57.42%
HSA Compatible	11,425	0	11,425	100.00%
TOTAL	31,124	14,608	45,732	68.06%

Data for Individual AHCT plans as of end of open enrollment for 2021 plan year

2020 AHCT Plan Enrollment: Standardized / Non-Standard QHPs

EXHIBIT 13.1

Metal Level	Total	Percent
Catastrophic	1,839	1.71%
Bronze	49,326	45.74%
Silver	49,889	46.27%
Gold	6,779	6.29%
TOTAL	107,833	100.00%

Metal Level	Standardized Plans	Non-Standard Plans	Total	Percent in Std Plans by Metal Level
Catastrophic	N/A	1,839	1,839	0.00%
Bronze*	37,733	11,593	49,326	76.50%
Silver	49,889	0	49,889	100.00%
Gold	4,107	2,672	6,779	60.58%
TOTAL	91,729	16,104	107,833	85.07%

*Bronze Plans	Standardized Plans	Non-Standard Plans	Total	Percent in Standardized Plans
Non-HSA Bronze	24,798	11,593	36,391	68.14%
HSA Compatible	12,935	0	12,935	100.00%
TOTAL	37,733	11,593	49,326	76.50%

Data for Individual AHCT plans as of end of open enrollment for 2020 plan year

2021 AHCT Plan Enrollment by County: Standardized / Non-Standard QHPs

EXHIBIT 14.0

	GOLD		SILVER		BRONZE (NOT HSA compatible)		BRONZE (HSA compatible)		CATASTROPHIC	
County	Standard	Non-Std	Standard	Non-Std	Standard	Non-Std	Standard	Non-Std	Non-Std	Total
Fairfield	1,584	1,098	15,885	0	7,628	3,508	3,901	0	555	34,159
Hartford	945	761	11,243	0	3,624	3,869	2,501	0	472	23,415
Litchfield	221	392	2,979	0	1,306	1,181	908	0	115	7,102
Middlesex	259	210	2,257	0	1,075	736	658	0	121	5,316
New Haven	783	813	11,044	0	4,154	2,975	2,134	0	470	22,373
New London	144	356	3,191	0	1,002	1,156	779	0	147	6,775
Tolland	127	187	1,407	0	579	731	331	0	79	3,441
Windham	81	151	1,091	0	331	452	213	0	46	2,365
Total	4,144	3,968	49,097	0	19,699	14,608	11,425	0	2,005	104,946
	8,112		49,097		34,307		11,425		2,005	
					49,134					

Data for Individual AHCT plans as of end of open enrollment for 2021 plan year

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2020 AHCT Plan Enrollment by County: Standardized / Non-Standard QHPs

EXHIBIT 14.1

	GOLD		SILVER		BRONZE (NOT HSA compatible)		BRONZE (HSA compatible)		CATASTROPHIC	
County	Standard	Non-Std	Standard	Non-Std	Standard	Non-Std	Standard	Non-Std	Non-Std	Total
Fairfield	1,513	817	15,468	0	9,618	2,581	4,427	0	542	34,966
Hartford	978	418	11,370	0	4,532	3,514	2,813	0	454	24,079
Litchfield	252	252	3,228	0	1,553	916	1,020	0	121	7,342
Middlesex	249	120	2,261	0	1,342	531	692	0	112	5,307
New Haven	780	521	11,516	0	5,387	2,227	2,498	0	414	23,343
New London	138	280	3,300	0	1,234	854	841	0	112	6,759
Tolland	125	156	1,534	0	727	598	385	0	57	3,582
Windham	72	108	1,212	0	405	372	259	0	27	2,455
Total	4,107	2,672	49,889	0	24,798	11,593	12,935	0	1,839	107,833
	6,779		49,889		36,391		12,935		6,779	
					49,326					

Data for Individual AHCT plans as of end of open enrollment for 2020 plan year

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AHCT Plan Enrollment: Plan Purchasing History

EXHIBIT 15.0

Percent 2019 Gold plan enrollees continuously enrolled in Gold through 2021: 74.4%

2019	2020	2021
Gold: 3,607	2,959	2,682
		194
		83
	404	34
		356
		14
	244	17
		14
		213

Percent 2019 Silver plan enrollees continuously enrolled in Silver through 2021: 87.0%

2019	2020	2021
Silver: 26,132	532	329
		156
		47
	23,694	368
		22,729
		597
	1,906	61
		249
		1,596

Percent 2019 Bronze plan enrollees continuously enrolled in Bronze through 2021: 89.6%

2019	2020	2021
Bronze: 26,815	202	134
		46
		22
	1,104	35
		984
		85
	25,509	308
		1,171
		24,030

Exhibit includes members in Gold, Silver & Bronze metal level plans that have been covered continuously in plans available through AHCT for each of the plan years (2019, 2020 & 2021); Excludes members selecting a Catastrophic plan during any of these years

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2021 AHCT Enrollment by Plan / Subsidy Eligibility*

EXHIBIT 16.0

Carrier	Plan Name	APTC	APTC + CSR	Not Subsidy Eligible	Grand Total
CBI	Choice Catastrophic POS with Dental	222	32	1,541	1,795
Anthem	Catastrophic HMO Pathway Enhanced	12	4	194	210
CBI	Passage Bronze Alternative PCP POS	2,656	1,062	3,567	7,285
CBI	Bronze Virtual Alternative POS**	1,167	257	1,583	3,007
CBI	**Choice Bronze Standard POS**	**6,578**	**3,120**	**7,117**	**16,815**
CBI	**Choice Bronze Standard POS HSA**	**2858**	**731**	**5,913**	**9,502**
Anthem	Bronze HMO BlueCare Prime**	322	103	367	792
CBI	Choice Bronze Alternative POS with Dental	881	686	505	2,072
Anthem	Bronze HMO Pathway Enhanced Tiered	418	295	739	1,452
Anthem	**Bronze PPO Standard Pathway for HSA**	**535**	**239**	**1,149**	**1,923**
Anthem	Gold HMO BlueCare Prime**	739	302	537	1,578
Anthem	**Bronze PPO Standard Pathway**	**926**	**556**	**1,402**	**2,884**
CBI	**Choice Silver Standard POS**	**7,041**	**27,421**	**2,346**	**36,808**
Anthem	Gold HMO Pathway Enhanced Tiered	582	345	516	1,443
CBI	Gold Virtual Alternative POS**	230	98	119	447
CBI	Compass Gold Alternative POS**	97	40	42	179
Anthem	**Silver PPO Standard Pathway**	**2,551**	**7,761**	**1,977**	**12,289**
CBI	Choice Gold Alternative POS with Dental	117	115	89	321
CBI	**Choice Gold Standard POS**	**1,224**	**605**	**1,637**	**3,466**
Anthem	**Gold PPO Standard Pathway**	**102**	**108**	**468**	**678**
	Total	**29,258**	**43,880**	**31,808**	**104,946**
	Percent of Total	**27.88%**	**41.81%**	**30.31%**	

As of end of Open Enrollment for 2021 Plan Year (Individual Market) - AHCT Standardized plan in **bold font*
Plans displayed in ascending order by premium rate (unsubsidized) in Hartford County
Anthem = Anthem Blue Cross Blue Shield; CBI = ConnectiCare Benefits, Inc.
***New plan offered for 2021*

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2020 AHCT Enrollment by Plan / Subsidy Eligibility*

EXHIBIT 16.1

Carrier	Plan Name	APTC	APTC + CSR	Not Subsidy Eligible	Grand Total
CBI	Choice Catastrophic POS with Dental	160	45	1,458	1,663
Anthem	Catastrophic HMO Pathway X Enhanced	11	7	158	176
CBI	Passage Bronze Alternative PCP POS	2,420	1,397	3,850	7,667
CBI	**Choice Bronze Standard POS**	**7,816**	**4,363**	**9,234**	**21,413**
CBI	**Choice Bronze Standard POS HSA**	**2,971**	**1,084**	**6,776**	**10,831**
CBI	Choice Bronze Alternative POS with Dental	668	667	363	1,698
Anthem	Bronze HMO Pathway X Enhanced Tiered	473	420	867	1,760
Anthem	Bronze PPO Pathway X	140	109	219	468
Anthem	**Bronze PPO Standard Pathway X for HSA**	**562**	**331**	**1,211**	**2,104**
Anthem	**Bronze PPO Standard Pathway X**	**1,042**	**791**	**1,552**	**3,385**
Anthem	Gold HMO Pathway X Enhanced Tiered	391	321	394	1,106
CBI	**Choice Silver Standard POS**	**6,891**	**27,939**	**2,185**	**37,015**
Anthem	Gold PPO Pathway X	560	255	604	1,419
Anthem	**Silver PPO Standard Pathway X**	**2,939**	**8,118**	**1,817**	**12,874**
CBI	Choice Gold Alternative POS with Dental	51	46	50	147
CBI	**Choice Gold Standard POS**	**1,038**	**637**	**1,643**	**3,318**
Anthem	**Gold PPO Standard Pathway X**	**134**	**147**	**508**	**789**
	Total	28,267	46,677	32,889	107,833
	Percent of Total	26.21%	43.29%	30.50%	

**As of end of Open Enrollment for 2020 Plan Year (Individual Market)*
*AHCT Standardized plan in **bold font***
Plans displayed in ascending order by premium rate (unsubsidized) in Hartford County
Anthem = Anthem Blue Cross Blue Shield; CBI = ConnectiCare Benefits, Inc.

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AHCT: Individual Market Enrollment by Product

EXHIBIT 17.0

Enrollment as of end of open enrollment period for plan years 2016 - 2021

	2014	2015	2016	2017	2018	2019	2020	2021
HMO	9,493	8,261	6,469	5,949	5,799	3,544	3,042	5,475
POS	23,590	42,492	63,618	76,827	82,766	86,636	83,752	81,697
PPO	27,650	44,689	45,937	28,766	25,569	20,886	21,039	17,774
Total	60,733	95,442	116,024	111,542	114,134	111,066	107,833	104,946

	2014	2015	2016	2017	2018	2019	2020	2021
HMO	15.6%	8.7%	5.6%	5.3%	5.1%	3.2%	2.8%	5.2%
POS	38.8%	44.5%	54.8%	68.9%	72.5%	78.0%	77.7%	77.8%
PPO	45.5%	46.8%	39.6%	25.8%	22.4%	18.8%	19.5%	16.9%
Total	100%	100%	100%	100%	100%	100%	100%	100%

**Percent totals may not sum to 100% due to rounding.*

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AHCT Open Enrollment Summary Reports

EXHIBIT 18.0

- URLs to Annual Open Enrollment Reports
  - Plan Year 2018: https://agency.accesshealthct.com/wp-content/uploads/2018/01/OE-2018-Summary-Report.pdf
  - Plan Year 2019: https://agency.accesshealthct.com/wp-content/uploads/2019/02/OE-2019-Summary-Report.pdf
  - Plan Year 2020: https://agency.accesshealthct.com/wp-content/uploads/2020/02/OE-2020-Summary-Report.pdf
  - Plan Year 2021:https://agency.accesshealthct.com/wp-content/uploads/2021/02/OE-2021-Summary-Report.pdf

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AHCT Consumers & Buying Patterns:
Metal Tier Product Preferences – 8 Year Overview

EXHIBIT 19.0

Annual End of OE Proportion of Enrollment by Metal Tier and Plan Year *

	2014	2015	2016	2017	2018	2019	2020	2021
Catastrophic	2.2%	2.2%	1.8%	1.8%	1.5%	1.7%	1.7%	1.9%
Bronze	16.2%	22.4%	23.3%	25.3%	35.1%	44.2%	45.7%	43.6%
Silver	63.4%	59.5%	61.5%	63.9%	55.6%	48.5%	46.3%	46.8%
Gold	18.1%	15.1%	12.1%	9.1%	7.8%	5.5%	6.3%	7.7%
Platinum	N/A	.9%	1.4%	N/A	N/A	N/A	N/A	N/A

Temporary federal Risk Corridor & Reinsurance programs were effective for plan years 2014-2016

Platinum tier plans offered in on-exchange individual market during 2015 and 2016

"Silver loading" effective as of 2018 Plan Year (OE5) to offset removal of federal funding for CSR plans

AHCT standard Silver plan not required to be lowest premium Silver plan for 2019 Plan Year (OE 6)

AHCT requires 1 Silver plan and does not permit non-standard Silver plans in the on-exchange individual market beginning with the 2020 Plan Year (OE 7)

**Percent totals may not sum to 100% due to rounding.*

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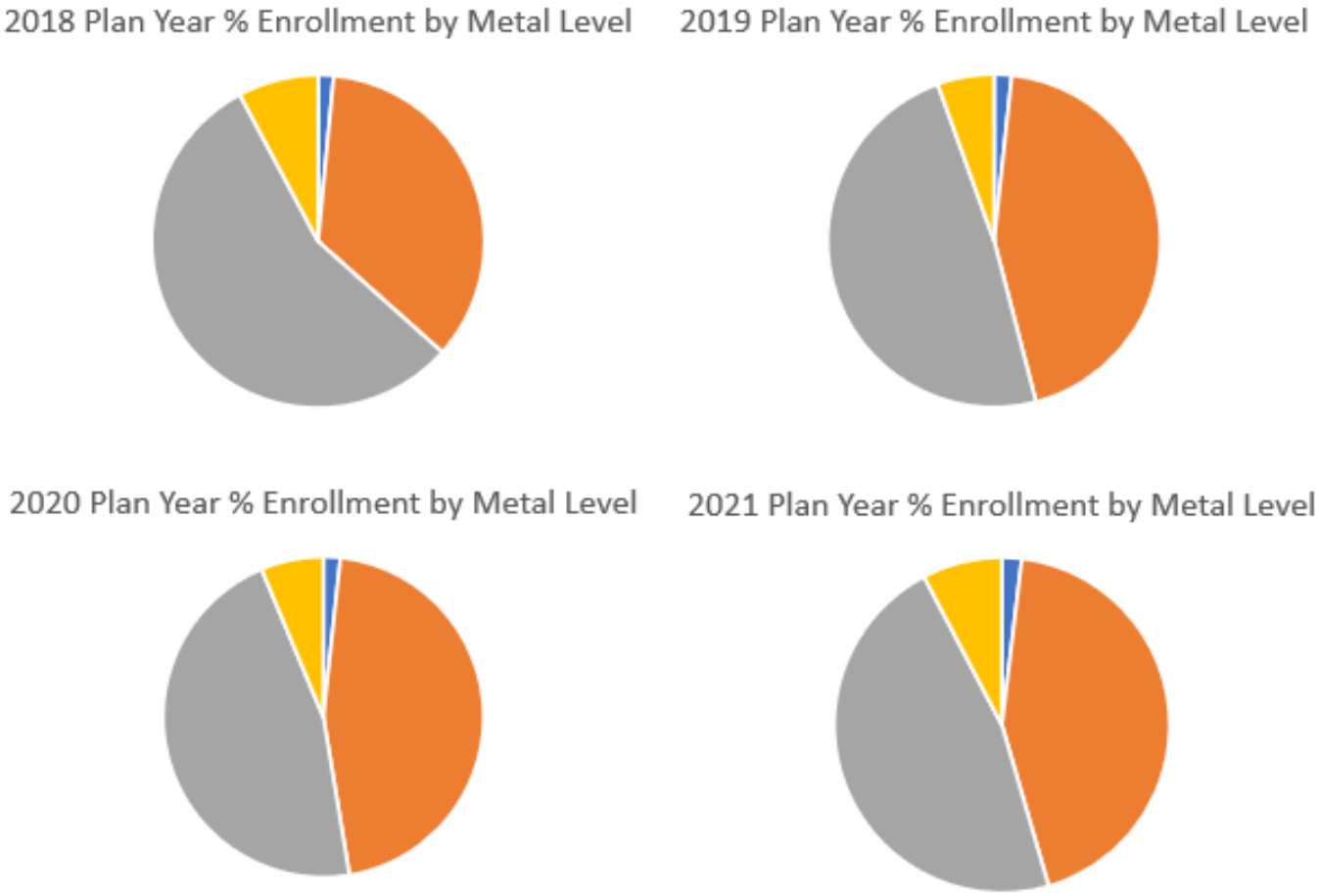
AHCT Plan Enrollment by Metal Level:
Plan Years 2018 through 2021

EXHIBIT 20.0



	Percent Enrollment by Metal Level			
Metal Level	2018	2019	2020	2021
Catastrophic	1.5%	1.7%	1.7%	1.9%
Bronze	35.1%	44.2%	45.7%	43.6%
Silver	55.6%	48.5%	46.3%	46.8%
Gold	7.8%	5.5%	6.3%	7.7%

Data for Individual AHCT plans as of end of open enrollment for plan year

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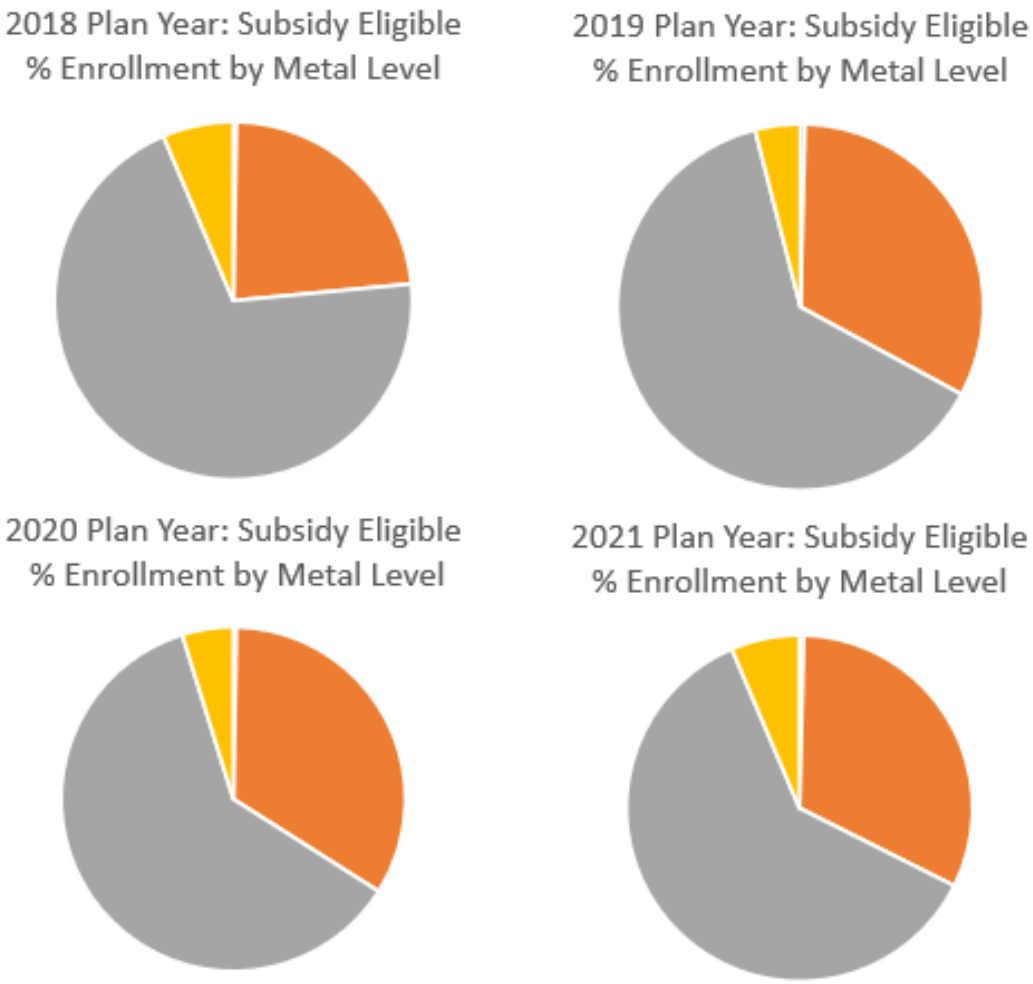
AHCT Plan Enrollment (Subsidy Eligible) by Metal Level: Plan Years 2017 through 2020

EXHIBIT 20.1



	Percent Enrollment by Metal Level			
Metal Level	2018	2019	2020	2021
Catastrophic	0.3%	0.4%	0.3%	0.4%
Bronze	23.2%	32.5%	33.7%	32.0%
Silver	70.1%	63.1%	61.2%	61.2%
Gold	6.4%	4.0%	4.8%	6.4%

Data for Individual AHCT plans as of end of open enrollment for plan year

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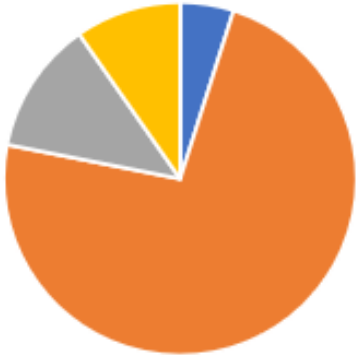
AHCT Plan Enrollment (Not Subsidy Eligible) by Metal Level: Plan Years 2017 through 2020

EXHIBIT 20.2

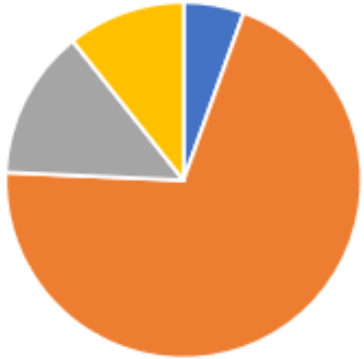
2018 Plan Year: Unsubsidized
% Enrollment by Metal Level

2019 Plan Year: Unsubsidized
% Enrollment by Metal Level

2020 Plan Year: Unsubsidized
% Enrollment by Metal Level



2021 Plan Year: Unsubsidized
% Enrollment by Metal Level



	Percent Enrollment by Metal Level			
Metal Level	2018	2019	2020	2021
Catastrophic	4.8%	5.0%	4.9%	5.5%
Bronze	67.8%	72.7%	73.2%	70.2%
Silver	15.7%	13.0%	12.2%	13.6%
Gold	11.7%	9.2%	9.7%	10.7%

Legend

Catastrophic Bronze Silver Gold

Data for Individual AHCT plans as of end of open enrollment for plan year

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AHCT Consumers & Buying Patterns:

Top 5 most popular plans (Subsidized vs. Non-subsidized)

EXHIBIT 21.0

SUBSIDIZED ENROLLEES							
2018 Top 5 Plans	2018 Enrollment	2019 Top 5 Plans	2019 Enrollment	2020 Top 5 Plans	2020 Enrollment	2021 Top 5 Plans	2021 Enrollment
Choice Silver Standard POS	40,285	Choice Silver Alternative POS	25,685	Choice Silver Standard POS	34,830	Choice Silver Standard POS	34,462
Silver PPO Standard Pathway X	11,268	Choice Bronze Standard POS	11,851	Choice Bronze Standard POS	12,179	Silver PPO Standard Pathway	10,312
Choice Bronze Standard POS HSA	6,782	Choice Silver Standard POS	11,324	Silver PPO Standard Pathway X	11,057	Choice Bronze Standard POS	9,698
Choice Bronze Standard POS	5,172	Silver PPO Standard Pathway X	7,022	Choice Bronze Standard POS HSA	4,055	Passage Bronze Alternative PCP POS	3,718
Choice Gold Standard POS	3,726	Choice Bronze Standard POS HSA	4,978	Passage Bronze Alternative PCP POS	3,817	Choice Bronze Standard POS HSA	3,589

UNSUBSIDIZED ENROLLEES							
2018 Top 5 Plans	2018 Enrollment	2019 Top 5 Plans	2019 Enrollment	2020 Top 5 Plans	2020 Enrollment	2021 Top 5 Plans	2021 Enrollment
Choice Bronze Standard POS HSA	11,258	Choice Bronze Standard POS HSA	8,314	Choice Bronze Standard POS	9,234	Choice Bronze Standard POS	7,117
Choice Bronze Standard POS	2,839	Choice Bronze Standard POS	7,406	Choice Bronze Standard POS HSA	6,776	Choice Bronze Standard POS HSA	5,913
Bronze PPO Standard Pathway X	2,588	Passage Bronze Alternative PCP POS	2,619	Passage Bronze Alternative PCP POS	3,850	Passage Bronze Alternative PCP POS	3,567
Choice Silver Standard POS	2,521	Bronze PPO Standard Pathway X	2,464	Choice Silver Standard POS	2,185	Choice Silver Standard POS	2,346
Choice Gold Standard POS	2,198	Choice Gold Standard POS	1,981	Silver PPO Standard Pathway X	1,817	Silver PPO Standard Pathway	1,977

Data for Individual AHCT plans as of end of open enrollment for plan year

2018: Subsidized: 83,627 + Unsubsidized: 30,507 = Total: 114,134
2019: Subsidized: 78,654 + Unsubsidized: 32,412 = Total: 111,066
2020: Subsidized: 74,944 + Unsubsidized: 32,889 = Total: 107,833
2021: Subsidized: 73,138 + Unsubsidized: 31,808 = Total: 104,946

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AHCT Consumers & Buying Patterns:

Plan Selection by Enrollees by Subsidy Eligibility Category

EXHIBIT 22.0

Proportion of Enrollment By Plan Metal Level & Year

	2018						2019					
Metal Level	**94% CSR**	**87% CSR**	**73% CSR**	**APTC Only**	**No FA**	**2018 Total**	**94% CSR**	**87% CSR**	**73% CSR**	**APTC Only**	**No FA**	**2019 Total**
Catastrophic	0.1%	0.1%	0.3%	0.7%	4.8%	1.5%	0.1%	0.0%	0.2%	0.8%	5.0%	1.7%
Bronze	3.6%	11.2%	27.1%	39.0%	67.8%	35.1%	4.6%	13.8%	37.4%	55.0%	72.7%	44.2%
Silver	94.6%	86.5%	64.6%	49.6%	15.7%	55.6%	94.4%	84.9%	57.8%	37.3%	13.0%	48.5%
Gold	1.7%	2.1%	8.0%	10.8%	11.7%	7.8%	0.9%	1.3%	4.6%	6.8%	9.2%	5.5%
Grand Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

	2020						2021					
Metal Level	**94% CSR**	**87% CSR**	**73% CSR**	**APTC Only**	**No FA**	**2020 Total**	**94% CSR**	**87% CSR**	**73% CSR**	**APTC Only**	**No FA**	**2021 Total**
Catastrophic	0.0%	0.1%	0.2%	0.6%	4.9%	1.7%	0.1%	0.1%	0.1%	0.8%	5.5%	1.9%
Bronze	4.0%	13.8%	38.4%	56.9%	73.2%	45.7%	3.0%	11.4%	33.3%	55.8%	70.2%	43.6%
Silver	95.0%	84.7%	55.0%	34.8%	12.2%	46.3%	95.8%	86.5%	58.7%	32.8%	13.6%	46.8%
Gold	0.9%	1.4%	6.5%	7.7%	9.7%	6.3%	1.1%	2.1%	7.9%	10.6%	10.7%	7.7%
Grand Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

No FA = No Financial Assistance

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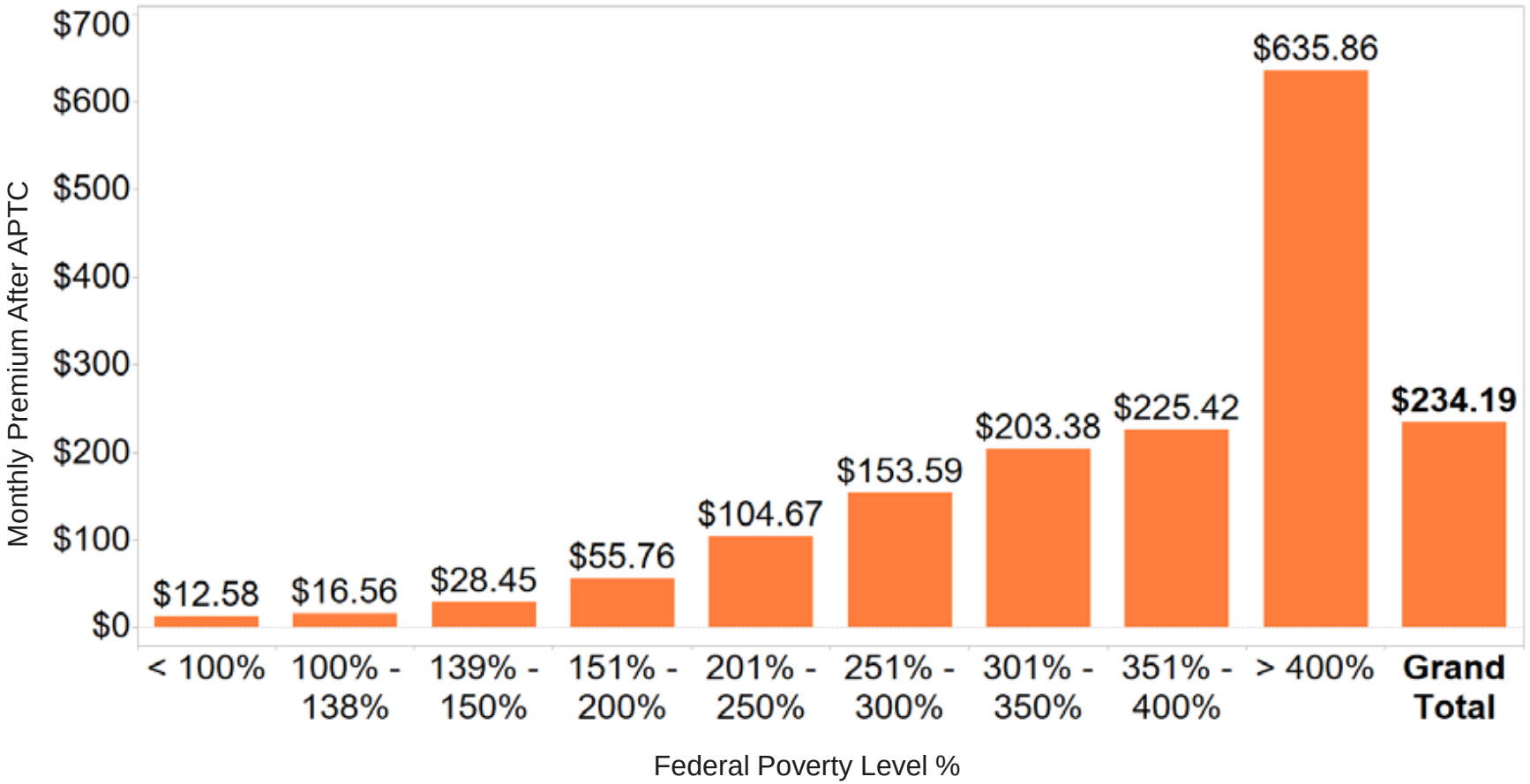
Monthly Plan Premium – FPL Level

EXHIBIT 23.0

Average Monthly Premium After APTC by Household Income (FPL %)*



For customers with income between 151% - 200% FPL (17% of all QHP customers), their average monthly premium after APTC is $55.76.

Households with income above 400% FPL don't qualify for APTC.

**Comparison excludes households with more than 1 enrollee.*

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Monthly Plan Premium – Age Band

EXHIBIT 24.0

Average Monthly Premium After APTC by Age Band and Financial Assistance (F.A.) Level*

For customers between age 55-64 years old (35% of all QHP customers), their average monthly premium after APTC ranges from $54 to $964 depending on level of financial help.

**Comparison excludes households with more than 1 enrollee.*

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Distribution of Enrollee Premium Before Tax Credits

EXHIBIT 25.0

Distribution of Enrollees by Premium Amount Before Tax Credits

Individual Premium Amount Before Tax Credits

	2017	2018	2019	2020	2021
$0	0.2%	0.1%	0.2%	0.1%	0.1%
$0 to $250	12.5%	5.0%	6.0%	5.0%	3.8%
$250 to $500	39.5%	31.3%	36.5%	32.1%	33.1%
$500 to $750	24.5%	26.7%	25.3%	23.9%	22.2%
$750 to $1k	19.4%	17.0%	19.7%	18.9%	20.5%
$1k to $1.25k	3.7%	12.5%	9.3%	13.5%	15.5%
$1.25k to $1.5k	0.3%	6.8%	2.7%	5.8%	4.2%
$1.5k to $1.75k	0.1%	0.3%	0.3%	0.4%	0.3%
$1.75k to $2k		0.1%	0.1%	0.1%	0.1%
$2k to $2.25k		0.0%	0.0%	0.1%	0.1%
$2.25k to $2.5k				0.0%	0.0%
Over $2.5k					0.0%
Average	$537	$682	$625	$684	$692

The average individual enrollee gross premium, before APTC was applied, was $692 in 2021.

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Distribution of Enrollee Deductible

EXHIBIT 26.0

Distribution of Enrollees by Individual Deductible Amount*

Individual Deductible Amount	2017	2018	2019	2020	2021
$0	14.3%	12.2%	4.4%	11.2%	11.4%
$0 to $500	1.8%	0.9%	6.9%		
$500 to $1k	15.8%	15.5%	6.3%	14.8%	14.4%
$1k to $1.5k	4.2%	7.4%	14.2%	3.8%	3.9%
$1.5k to $2k	9.1%	2.4%	0.9%	1.0%	1.4%
$2k to $2.5k	0.4%			1.3%	0.6%
$2.5k to $3k	0.5%	1.2%	0.5%		1.5%
$3k to $3.5k	9.2%	8.4%			
$3.5k to $4k	1.1%	13.9%	8.9%	8.2%	8.2%
$4k to $4.5k	16.3%	0.9%	7.7%	12.3%	13.1%
$4.5k to $5k			4.2%		
$5k to $5.5k	0.2%	0.7%		1.6%	
$5.5k to $6k	15.4%	19.4%	15.1%	13.6%	1.4%
$6k to $6.5k	9.8%	13.5%	22.9%	23.0%	15.7%
$6.5k to $7k		2.1%	6.2%	7.5%	18.7%
$7k to $7.5k	1.8%	1.5%			7.7%
$7.5k to $8k			1.8%		
$8k to $8.5k				1.7%	
$8.5k to $9k					1.9%
Average	$2,941	$3,298	$3,863	$3,956	$4,098

A deductible is what an enrollee pays for covered health care services before their insurance plan starts to pay.

11% of enrollees enrolled in a plan with $0 deductible because of Cost Sharing Reduction eligibility.

**Deductible amounts reflect in-network value.*

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Distribution of Enrollee Maximum Out-Of-Pocket

EXHIBIT 27.0

Distribution of Enrollees by Individual Out-of-Pocket Amount*

Individual Maximum Out of Pocket Amount	2017	2018	2019	2020	2021
$0	0.1%	0.1%	0.1%	0.1%	0.1%
$500 to $1k	1.3%	12.9%	10.7%	11.1%	11.3%
$1k to $1.5k	14.2%	0.1%	0.6%		
$1.5k to $2k	17.4%	0.6%			
$2k to $2.5k		15.6%	6.0%		
$2.5k to $3k			9.6%	14.8%	14.4%
$3.5k to $4k	7.1%				
$4k to $4.5k		6.7%			
$4.5k to $5k	1.6%				
$5k to $5.5k	0.2%	0.5%	9.1%	3.8%	3.9%
$5.5k to $6k	10.6%	9.3%			
$6k to $6.5k	1.5%	0.0%	4.2%	0.1%	
$6.5k to $7k	16.8%	20.1%	14.3%	20.0%	18.8%
$7k to $7.5k	29.2%	34.2%			
$7.5k to $8k			45.4%		0.3%
$8k to $8.5k				50.0%	15.7%
$8.5k to $9k					35.5%
Average	$4,678	$5,116	$5,717	$6,064	$6,272

Health plans pay for 100% of covered benefits once a maximum out of pocket limit is reached.

36% of enrollees were enrolled in a plan with maximum out of pocket limit over $8,500.

**Maximum out of pocket amounts reflect in-network value*

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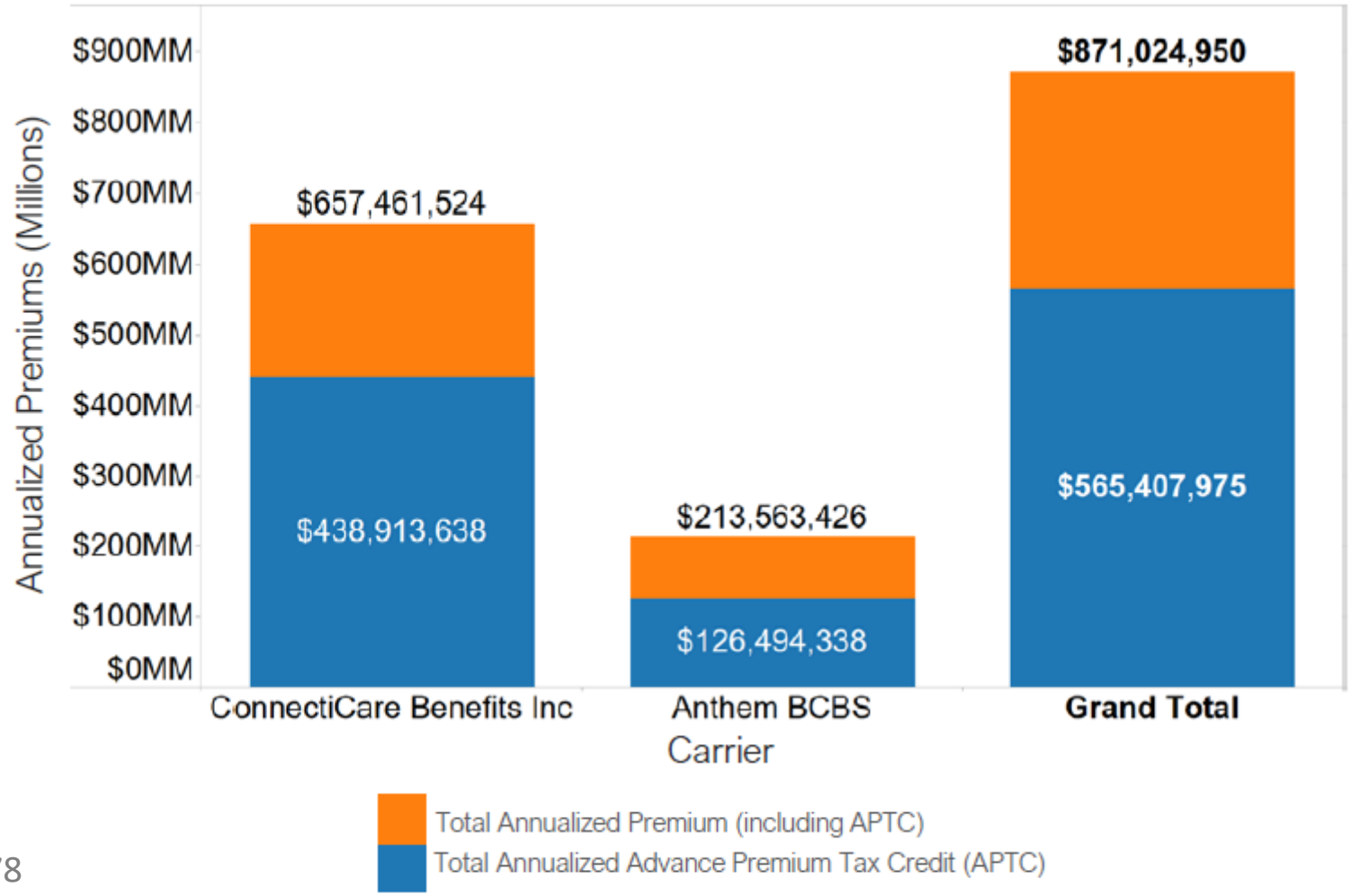
Annual Premium & APTC Projection

EXHIBIT 28.0

Projected Annual Unearned Premium and APTC



Total annualized premiums for the 2021 QHP customer base amounts to $871 million, of which $565.4 million are generated by premium tax credits.

Cost Sharing Reduction (CSR) amounts not included in this projection.

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AHCT Standardized Stand-alone Dental Plan

EXHIBIT 29.0

Plan Overview	In-Network (INET) Member Pays
Deductible *(Does not apply to Preventive & Diagnostic Services)*	$60 per member, up to 3 family members
Out-of-Pocket Maximum (*for children under age 19 only)* For one child Two or more children	$350 $700
Diagnostic Services	
Oral Exams (*twice per year)*	$0
X-Rays: Periapicals (*four per year)* Bitewing Radiographs (*once every year)* Panoramic or Complete Series (*once every 3 yrs)*	
Preventive Services	
Cleanings *(twice per year)*	$0
Periodontal Scaling and Root Planing	
Periodontal Maintenance *once every 3 months following periodontic surgery*	
Fluoride (*twice per year, under age 19)*	
Sealants (*for children under 19)*	
Basic Services	
Filings	20% after deductible is met
Simple Extractions	

Plan Overview	In-Network (INET) Member Pays
Major Services	
Surgical Extractions	40% after deductible is met
Endodontic Therapy (i.e. Root Canal Treatment)	
Periodontal Therapy	
Crowns and Cast Restorations	
Prosthodontics (Complete and Partial Dentures; Fixed Bridgework)	
Other Services *(for children under age 19)*	
Medically-Necessary Orthodontic Services	50% after deductible is met
Waiting Periods and Plan Maximums (*for adults aged 19 and older only)*	
Applicable Waiting Period for Benefit	
Diagnostic and Preventive Services	no waiting period
Basic Services	6 months*
Major Services	12 months*
**Waiver of waiting period available with proof of prior coverage for these services under a dental insurance plan when the termination date was no more than 30 days prior to the effective date of this plan*	
Plan Maximum	$2,000 per adult member age 19 and over

Inclusion of / cost sharing for Out-of-Network is not prescribed by AHCT

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SADPs Available Through AHCT: Plan Features (Part 1 of 2)

EXHIBIT 30.0

Plan Feature	Anthem Family Enhanced	Anthem Family
Market Availability	Individual & SHOP	Individual & SHOP
Deductible	Applies to all but INN Diagnostic & Preventive services; Separate for INN/OON	Applies to all covered services; Combined for INN/OON
Maximum OOP (INN)	$350 (1 child) / $700 (2 or more children)	$350 (1 child) / $700 (2 or more children)
Benefits Offered: Child & Adult	Diagnostic & Preventive; Basic Restorative; Major Services	Diagnostic & Preventive; Basic Restorative; Major Services
Benefits Offered: Child Only	Medically Necessary Orthodontia	Medically Necessary Orthodontia
Annual Plan Maximum (Adults)	$2,000 is most paid by insurance	$1,000 is most paid by insurance
Waiting Period (Adults)	Basic Restorative: 6 months; Major Services: 12 months	Basic Restorative: 6 months; Major Services: 12 months

INN = In-Network; OON = Out-of-Network; OOP = Out-of-Pocket
**No change in rates for second, third or fourth quarters*

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SADPs Available Through AHCT: Plan Features (Part 2 of 2)

EXHIBIT 30.0

Plan Feature	Anthem Family Value	Anthem Dental Family Preventive
Market Availability	Individual	Individual
Deductible	Applies to all covered services; Combined for INN/OON	Applies to all covered services; Combined for INN/OON
Maximum OOP (INN)	$350 (1 child) / $700 (2 or more children)	$350 (1 child) / $700 (2 or more children)
Benefits Offered: Child & Adult	Diagnostic & Preventive; Basic Restorative	Diagnostic & Preventive;
Benefits Offered: Child Only	Major Services; Medically Necessary Orthodontia	Basic Restorative; Major Services Medically Necessary Orthodontia
Annual Plan Maximum (Adults)	$1,000 is most paid by insurance	$1,000 is most paid by insurance
Waiting Period (Adults)	Basic Restorative: 6 months; Major Services: N/A (not covered)	Basic Restorative: N/A (not covered); Major Services: N/A (not covered)

INN = In-Network; OON = Out-of-Network; OOP = Out-of-Pocket

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SADPs Available Through AHCT: Premium Rates

EXHIBIT 31.0

Plan	Market Availability	Monthly Premium (Individual Market)	Monthly Premium (SHOP)*
Anthem Family Enhanced	Individual & SHOP	Children Age 0-18: $32.73 Adults Ages 19+: $71.09	Children Age 0-18: $29.46 Adults Ages 19+: $63.98
Anthem Family	Individual & SHOP	Children Age 0-18: $28.87 Adults Ages 19+: $44.20	Children Age 0-18: $25.98 Adults Ages 19+: $39.78
Anthem Family Value	Individual	Children Age 0-18: $28.87 Adults Ages 19+: $29.59	N/A
Anthem Dental Family Preventive	Individual	Children Age 0-18: $28.87 Adults Ages 19+: $21.70	N/A

**No change in rates submitted in July 2020 filing for second, third or fourth quarters*

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