Access Health Connecticut

Health Plan Benefits & Qualifications Advisory Committee (HPBQ AC) Meeting

February 1, 2023

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Agenda

- Call to Order
- Public Comment
- Vote: Meeting Minutes (January 10, 2023)
- Follow-ups from January 10, 2023 Meeting
- Results of Testing for Proposed Plan Changes - QHP
- SADP Standard Plan Design & Potential Vote
- 2024 Plan Year Timeline
- HPBQ AC Meeting Schedule
- Next Steps

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Public Comment

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Vote

Review and Approval of Minutes: January 10, 2023 HPBQ AC

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AHCT Mission and Vision

AHCT Mission

To decrease the number of uninsured residents, improve the quality of healthcare, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health coverage that gives them the best values.

AHCT Vision

Provide Connecticut residents with access to the most equitable, simple and affordable health insurance products to foster healthier communities.

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Our Values in Action

Authenticity

Act with sincerity, credibility, & self-awareness

- Be genuine and kind, empathetic and ethical
- Engage in constructive and actionable dialogue
- Contribute to creating a positive, fun, and friendly environment
- Be yourself; balance work, family, community, and self

Integrity

Commit to doing the right thing with genuine intention

- Create an environment of open and honest communication
- Act in the best interest of employees and customers
- Deliver on commitments

Excellence

Aim high & challenge the status quo

- Create opportunities to learn and grow
- Be knowledgeable and well informed
- Be innovative and resourceful
- Be open to new ideas; seek new perspectives
- Transform mistakes into learning experiences
- Exceed expectations

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Ownership

Take responsibility & initiative

- Embrace your superpower to create unique solutions
- Seek out knowledge and develop skills
- Be accountable for behaviors and actions
- Focus until you finish

One Team

Collaborate to succeed

- Trust each other
- Respect and listen to others
- Foster team spirit
- Celebrate success and each other

Passion

Dedication to creating opportunities for greater health & well-being

- Commit to benefiting the lives of others
- Embrace challenges to overcome obstacles
- Demonstrate loyalty to our mission and vision

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Follow-ups
January 10, 2023 Meeting

- Value Based Insurance Designs
- Utilization Data for Preventive Services

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Value Based Insurance Design (VBID)

Data previously provided during 02/21/2019 HPBQ AC Meeting

- **National workgroup developed VBID approach for Individual Exchange business**
  - Representation included: CMS, the Massachusetts Health Connector and Covered California, clinicians and the University of Michigan's Center for Value-Based Insurance Design
  - Workgroup identified high and low value services, and reviewed multiple disease states to determine areas of focus
- **Consultant developed VBID standards**
  - Report released June 2019 – link provided in appendix

Value Based Insurance Design (VBID)

2023 UPDATE

- Massachusetts Connector
  - Reduced cost sharing for:
    - Medication-Assisted Treatment (MAT)
    - Insulin Products
    - PCP sick visits & OP Mental Health visits
    - Common prescription drugs for diabetes (non-insulin), coronary artery disease, hypertension, and asthma

- Covered California
  - Focus on first dollar coverage and having benefits accessible pre-deductible
  - Has not implemented VBID in standard plans

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2024 Individual Market Standard Plan Designs

February 1, 2023

PRESENTED BY

Julie Andrews, FSA, MAAA – Sr. Consulting Actuary

Brad Heywood, ASA, MAAA – Consulting Actuary

Agenda

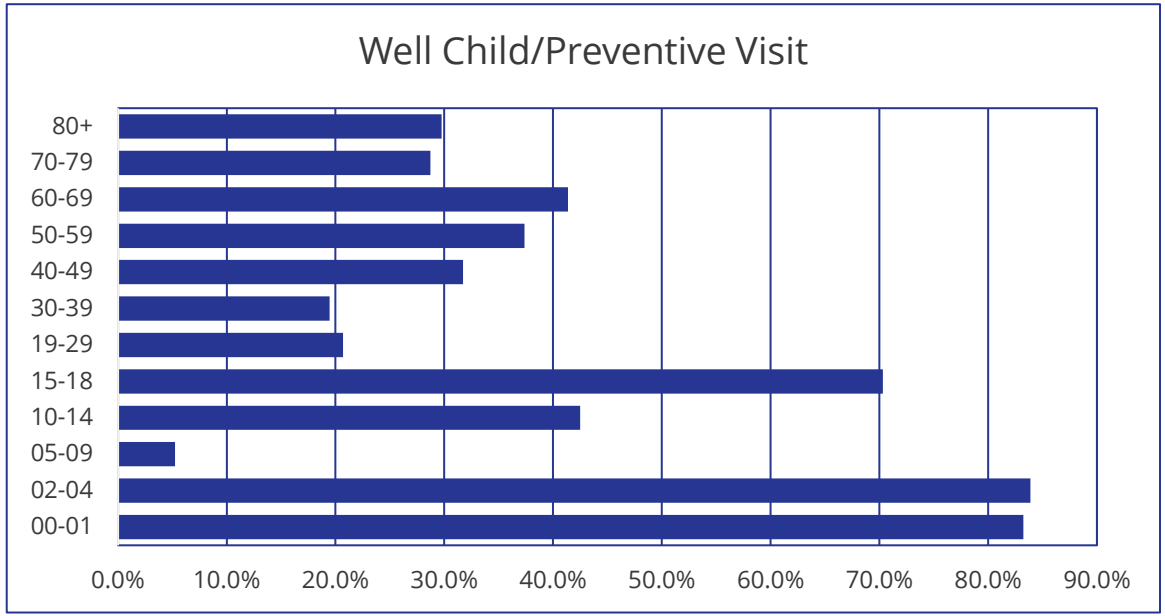
2024 Plan Design Review

- Preventive Data Samples
- Proposed Regulatory Changes
- Proposed Federal Actuarial Value Calculator (AVC) Changes
- Preliminary 2024 Calculator Results

Preventive Service Utilization

Preventive Service Utilization: Exams

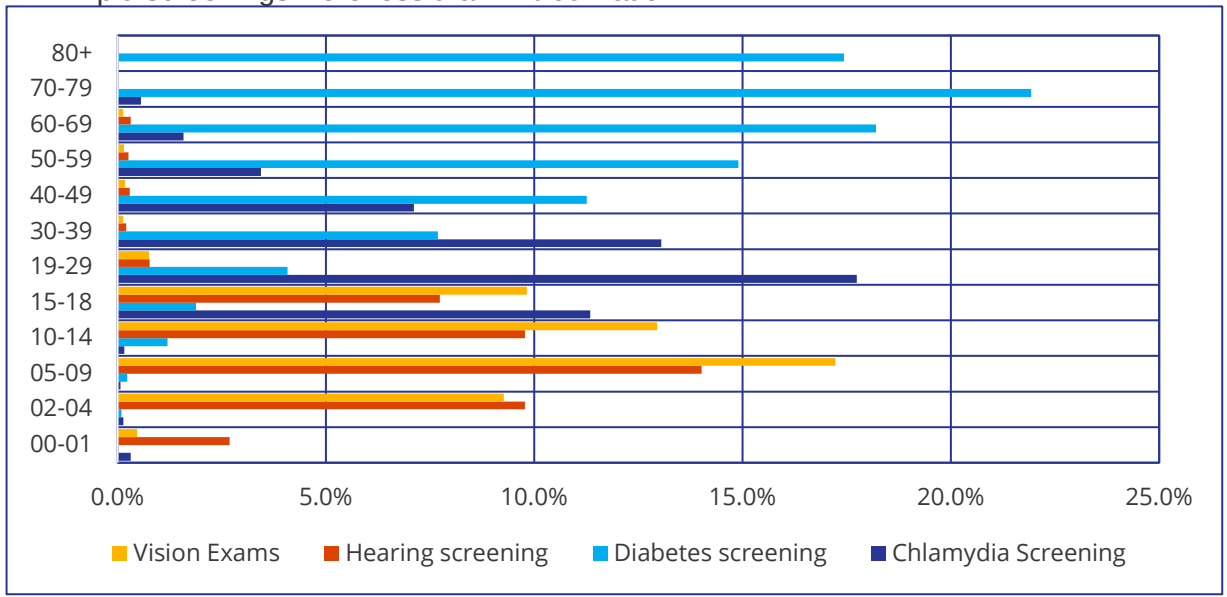
- Wakely's proprietary database* was used to evaluate the percentage of enrolled lives with 12 months of exposure utilizing preventive services by age grouping
- Note: Utilization limited to no-cost preventive services, some age groups sought multiple visits during the year



* *Data Source:* Wakely ACA Database ("WACA") contains detailed claims, eligibility and premium data from 2019 Edge Servers from participating issuers in the Northeast Region in Individual plans.

Preventive Service Utilization: Screenings

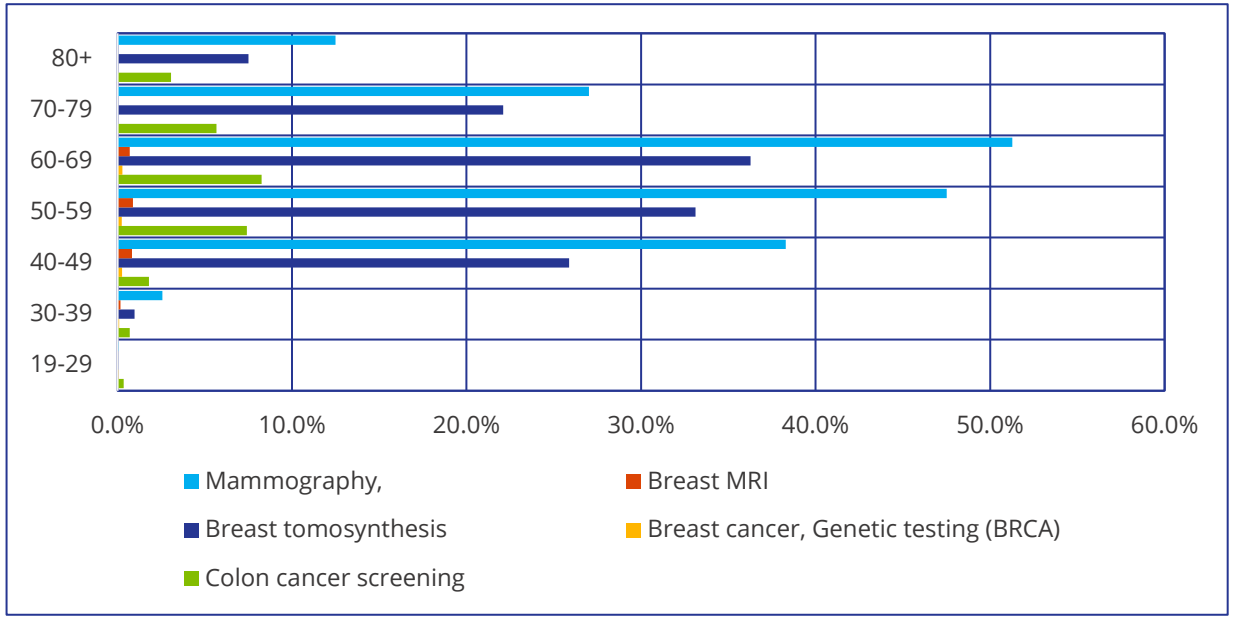
- Wakely's proprietary database* was used to evaluate the percentage of enrolled lives with 12 months of exposure utilizing preventive services by age grouping
- Note: Utilization limited to no-cost preventive services, some age groups sought multiple visits during the year
- Lipid screenings were less than 2% utilization



* *Data Source:* Wakely ACA Database ("WACA") contains detailed claims, eligibility and premium data from 2019 Edge Servers from participating issuers in the Northeast Region in Individual plans.

Preventive Service Utilization: Cancer Screenings

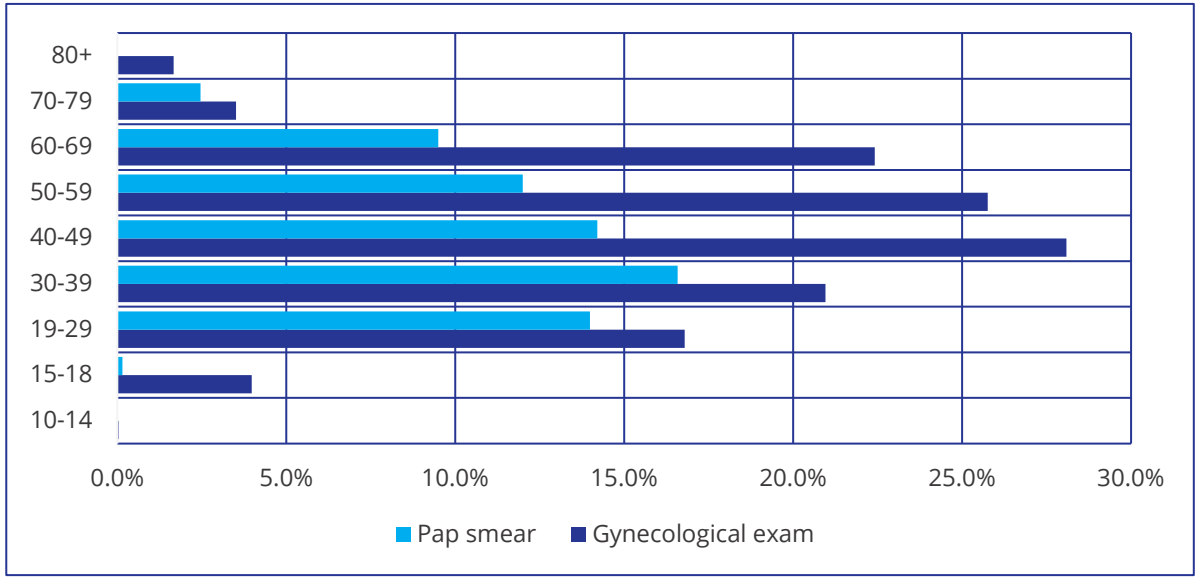
- Wakely's proprietary database* was used to evaluate the percentage of enrolled lives with 12 months of exposure utilizing preventive services by age grouping. All but Colon cancer screenings are limited to Female reported enrollees only.
- Note: Utilization limited to no-cost preventive services, some age groups sought multiple visits during the year



** Data Source:* Wakely ACA Database ("WACA") contains detailed claims, eligibility and premium data from 2019 Edge Servers from participating issuers in the Northeast Region in Individual plans.

Preventive Service Utilization: Exam and Cancer Screening

- Wakely's proprietary database* was used to evaluate the percentage of enrolled lives with 12 months of exposure for Female reported enrollees only utilizing preventive services by age grouping
- Note: Utilization limited to no-cost preventive services, some age groups sought multiple visits during the year



* *Data Source:* Wakely ACA Database ("WACA") contains detailed claims, eligibility and premium data from 2019 Edge Servers from participating issuers in the Northeast Region in Individual plans.

2024 Plan Design Overview

Necessary Regulatory and Issuer Elements for 2024 Analysis

Final Documentation

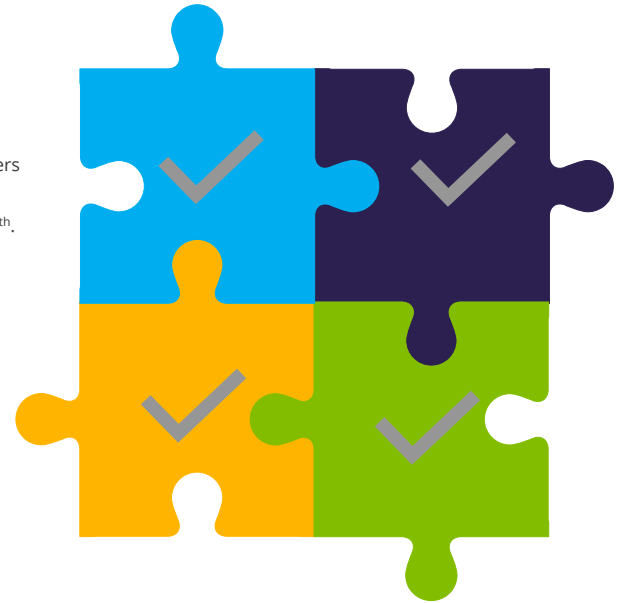
Proposed Documentation

NBPP

- Notice of Benefit and Payment Parameters
- Draft released December 15, 2022
- Public Comment Period ends January 30th.

Federal AVC

- Actuarial Value Calculator (AVC)
- CMS provided tool measuring benefit cost-sharing for allocation of metal tier or cost-sharing reduction plan variation
- Finalization timing unknown



IRS HSA Rules

- Rule released in Spring
- Defines minimum deductible and maximum out of pocket cost-sharing allowances
- Use prior year limits as proposed

Issuer Analysis of AVC and MHP

- Plan analysis of their own actuarial value using the draft Federal calculator with their modifications.
- Plan analysis of passage of Mental Health Parity (MHP) Rules

Regulation Changes for 2024

- Proposed annual limitation on cost sharing (maximum out of pocket) was increased to $9,450 (from $9,100 in 2023)
  - Note: This limit does not apply to HSA (Health Savings Account) qualified High Deductible Health Plans (HDHPs). That limit is released by the IRS in the spring.
  - CSR (Cost Sharing Reduction) Variations proposed annual limitation on cost sharing. The 2023 and proposed 2024 limits are:
    - 100-150% **FPL: $3,150/$6,300 (single/family)
      - 2023 - $3,000/$6,000 (single/family)
    - 150%-200% **FPL: $3,150/$6,300 (single/family)
      - 2023 - $3,000/$6,000 (single/family)
    - 200%-250% **FPL: $7,550/$15,100 (single/family)
      - 2023 - $7,250/$14,500 (single/family)
- Federal HDHP minimum deductible and Maximum Out of Pocket (MOOP) limits are not yet released for 2024.
  - For 2023 the single deductible is set at a minimum of $1,500 and the MOOP maximum limit is $7,500.

**Federal Poverty Level

Proposed Changes to the Federal AVC for 2024

- The Federal AVC has not yet been finalized, changes to the final model may impact results.
- Proposed changes to the 2024 Draft Calculator are as follows:
  - Data underlying the calculator was not updated. Data based on 2018 individual and small group data trended to 2024
    - Medical Trend: 5.4% Annually (2018-2021), 3.2% (2021-2022), 5.8% (2022-2023) , 5.4% (2023-2024)
    - Pharmacy Trend: 8.7% Annually (2018-2021), 4.55% (2021-2022), 8.7% (2022-2023) , 8.2% (2023-2024)
  - Demographic weights adjusted to reflect 2024 anticipated population
  - New Copay Calculation: Copays will no longer count towards the accumulation of the deductible. They will continue to accrue to the MOOP.
  - Algorithm update to more accurately calculate spending during deductible phase for plans with a separate deductible and combined MOOP.

Summary of 2024 Proposed AV Changes

Individual Market	Gold	Silver	Bronze	Bronze HSA
2024 Proposed AV Ranges	78.0% - 82.0%	70.0%-72.0%	58.0%-65.0%	58.0%-65.0%
2023 AV (Final)	**81.43% - 81.65%**	**71.37% - 71.75%**	**64.57% - 64.79%**	**64.27% - 64.45%**
2024 Draft AV Approx. Chg.	82.56%-83.15%	**71.25%-71.83%**	65.0%-65.41%	65.18%-65.34%

Individual Market - CSR Plan Variations: Silver	73% AV CSR	87% AV CSR	94% AV CSR
2024 Proposed AV Ranges	73.0%-74.0%	87.0%-88.0%	94.0%-95.0%
2023 AV (Final)	**73.62% - 73. 96%**	**87.40%-87.99%**	**94.66% - 94.89%**
2024 Draft AV Approx. Chg.	**73.8%-74.29%**	**86.91%-87.25%**	**94.94%-95.17%**

73.0% CSR Silver must have a differential of 2.0%+ with Standard Silver
Bronze ranges reflect Expanded Bronze allowances.

Plan change variability due to changes in Copay and Deductible Accumulation logic. Impact on final plan Avs will differ where plans adjusted for the original anomalous logic.

2024 Plan Design Overview

The plans **have been** reviewed for Mental Health Parity compliance and **have been** reviewed by Carriers

Summary of 2024 Gold Plan AV Options

Benefit Category	2023 Individual Market Gold Plan	2024 Individual Market Gold Plan Option 1
Medical Deductible	$1,300 (INN)/$3,000 (OON)	$1,300 (INN)/$3,000 (OON)
Rx Deductible	$50 (INN)/$350 (OON)	$50 (INN)/$350 (OON)
Coinsurance	30%	30%
Out-of-pocket Maximum	$6,000 (INN)/$12,000 (OON)	**$7,375 (INN)**/$12,000 (OON)
Primary Care	$20	$20
Specialist Care	$40	$40
Urgent Care	$50	$50
Emergency Room	$400	$400
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)	$65	$65
Non-Advanced Radiology (X-ray, Diagnostic)	$40 (after ded.)	$40 (after ded.)
Laboratory Services	$10 (after ded.)	$10 (after ded.)
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	$20	$20
Chiropractic Care 20 visit calendar maximum	$40	$40
All Other Medical	30%	30%
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	$5 / $35 / $60 / 20% (spec. after ded., $100 max per spec. script)	$5 / $35 / $60 / 20% (spec. after ded., $100 max per spec. script)
2023 AVC Results	**81.43% - 81.65%**	
2024 Draft AVC Approximate Change	82.56%-83.15%	**81.83%-81.98%**

Summary of 2023 Silver Plan AV

Benefit Category	2023 Individual Market Silver Plan	2023 Individual Market Silver Plan (73%)	2023 Individual Market Silver Plan (87%)	2023 Individual Market Silver Plan (94%)
Medical Deductible	$5,000 (INN)/ $10,000 (OON)	$4,750	$675	$0
Rx Deductible	$250 (INN)/ $500 (OON)	$250	$50	$0
Coinsurance	40%	40%	40%	40%
Out-of-pocket Maximum	$9,100 (INN)/ $18,200 (OON)	$7,250	$3,000	$950
Primary Care	$40	$40	$20	$10
Specialist Care	$60	$60	$45	$30
Urgent Care	$75	$75	$35	$25
Emergency Room	$450 (after ded.)	$450 (after ded.)	$150 (after ded.)	$50
Inpatient Hospital	$500 per day (after ded., $2,000 max. per admission)	$500 per day (after ded., $2,000 max. per admission)	$100 per day (after ded., $400 max. per admission)	$75 ($300 max. per admission)
Outpatient Hospital	$300@ASC/$500 otherwise (after ded.)	$300@ASC/$500 otherwise (after ded.)	$60@ASC/$100 otherwise (after ded.)	$45@ASC/$75 otherwise
Advanced Radiology (CT/PET Scan, MRI)	$75	$75	$60	$50
Non-Advanced Radiology (X-ray, Diagnostic)	$40 (after ded.)	$40 (after ded.)	$30 (after ded.)	$25
Laboratory Services	$20	$20	$10	$10
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	$30	$30	$20	$20
Chiropractic Care (20 visit calendar maximum)	$50	$50	$35	$30
All Other Medical	40%	40%	40%	40%
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	$10 / $45 / $70 / 20% (all but generic after ded., $200 max per spec. script)	$10 / $45 / $70 / 20% (all but generic after ded., $100 max per spec. script)	$10 / $25 / $40 / 20% (non-preferred brand and spec. after ded., $60 max per spec. script)	$5 / $10 / $30 / 20% ($60 max per spec. script)
2023 AVC Results	**71.37%-71.75%**	**73.62%-73.96%**	**87.40% - 87.99%**	**94.66% - 94.89%**
2024 Draft AVC Approximate Change	**71.25%-71.83%**	**73.8%-74.29%**	**86.91%-87.25%**	**94.94%-95.17%**

Summary of 2024 Silver Plan AV Options

Benefit Category	2024 Individual Market Silver Plan	2024 Individual Market Silver Plan (73%) Option 1	2024 Individual Market Silver Plan (87%) Option 1	2024 Individual Market Silver Plan (94%) Option 1
Medical Deductible	$5,000 (INN)/ $10,000 (OON)	$4,750	$675	$0
Rx Deductible	$250 (INN)/ $500 (OON)	$250	$50	$0
Coinsurance	40%	40%	40%	40%
Out-of-pocket Maximum	$9,100 (INN)/ $18,200 (OON)	**$7,475**	**$2,925**	**$1,050**
Primary Care	$40	$40	$20	$10
Specialist Care	$60	$60	$45	$30
Urgent Care	$75	$75	$35	$25
Emergency Room	$450 (after ded.)	$450 (after ded.)	$150 (after ded.)	$50
Inpatient Hospital	$500 per day (after ded., $2,000 max. per admission)	$500 per day (after ded., $2,000 max. per admission)	$100 per day (after ded., $400 max. per admission)	$75 ($300 max. per admission)
Outpatient Hospital	$300@ASC/$500 otherwise (after ded.)	$300@ASC/$500 otherwise (after ded.)	$60@ASC/$100 otherwise (after ded.)	$45@ASC/$75 otherwise
Advanced Radiology (CT/PET Scan, MRI)	$75	$75	$60	$50
Non-Advanced Radiology (X-ray, Diagnostic)	$40 (after ded.)	$40 (after ded.)	$30 (after ded.)	$25
Laboratory Services	$20	$20	$10	$10
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	$30	$30	$20	$20
Chiropractic Care (20 visit calendar maximum)	$50	$50	$35	$30
All Other Medical	40%	40%	40%	40%
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	$10 / $45 / $70 / 20% (all but generic after ded., $200 max per spec. script)	$10 / $45 / $70 / 20% (all but generic after ded., $100 max per spec. script)	$10 / $25 / $40 / 20% (non-preferred brand and spec. after ded., $60 max per spec. script)	$5 / $10 / $30 / 20% ($60 max per spec. script)
2023 AVC Results	**71.37%-71.75%**			
2024 Draft AVC Approximate Change	**71.25%-71.83%**	**73.44%- 73.95%**	**87.03%-87.35%**	**94.81%-94.95%**

Summary of 2024 Bronze Non-HSA Plan AV Options

Benefit Category	2023 Bronze Non-HSA Plan	2024 Bronze Non-HSA Plan Option 1
Combined Medical & Rx Deductible	$6,550 (INN)/$13,100 (OON)	$6,550 (INN)/$13,100 (OON)
Coinsurance	40%	40%
Out-of-pocket Maximum	$8,800 (INN)/$17,600 (OON)	**$9,100 (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	$20	$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% / 50% (all but generic after ded., $500 max per spec. script)	$20 / 50% / 50% / 50% (all but generic after ded., $500 max per spec. script)
2023 AVC Results	**64.57% - 64.79%**	
2024 Draft AVC Approximate Change	65.0%-65.41%	**64.78%-64.97%**

Summary of 2024 Bronze HSA Plan AV Options

Benefit Category	2023 Bronze HSA Plan	2024 Bronze HSA Plan Option 1
Combined Medical & Rx Deductible	$6,500 (INN)/ $13,000 (OON)	$6,500 (INN)/ $13,000 (OON)
Coinsurance	20%	20%
Out-of-pocket Maximum	**$7,000 (INN) /$14,000 (OON)**	**$7,225 (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)
2023 AVC Results	**64.27% - 64.45%**	
2024 Draft AVC Approximate Change	65.18%-65.34%	**64.78%-64.94%**

- 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

CMS Annual Limitation on Cost Sharing

Stand-Alone Dental Plans (SADP)

- For plan year 2024, the SADP annual limitation on cost sharing for one covered child increased to $400 for one covered child and $800 for two or more covered children for in-network coverage
  - This is based on a 15.336 percentage point increase of the CPI for dental services for 2022 of 528.630 over the CPI of 458.330 for dental services for 2016
  - Value would result in an increase of $53.68 if not for the regulation 45 CFR 156.150(d), which requires incremental increases to be rounded down to the next lowest multiple of $25
- For plan year 2023, AHCT maintained the annual limitation on cost sharing at $350/$700.
  - The annual limitation on cost sharing was last modified for plan year 2016

EXHIBIT 2.0

2023 Standardized Plan Design - SADP

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 one child	$350
Two or more children	$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 three years*)	
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*)	
Sealants *	

Plan Overview	In-Network (INET) Member Pays
Basic Services	
Filings	20% after deductible is met
Simple Extractions	
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	
Medically-Necessary Orthodontic Services *	50% after deductible is met
Waiting Periods and Plan Maximums ***(for covered persons not eligible for dependent child benefit)***	
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 member

*For child, stepchild, or other dependent child until end of plan year once dependent turns 26.

AHCT standardized plan designs available at: https://agency.accesshealthct.com/healthplaninformation

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SADP Potential Vote

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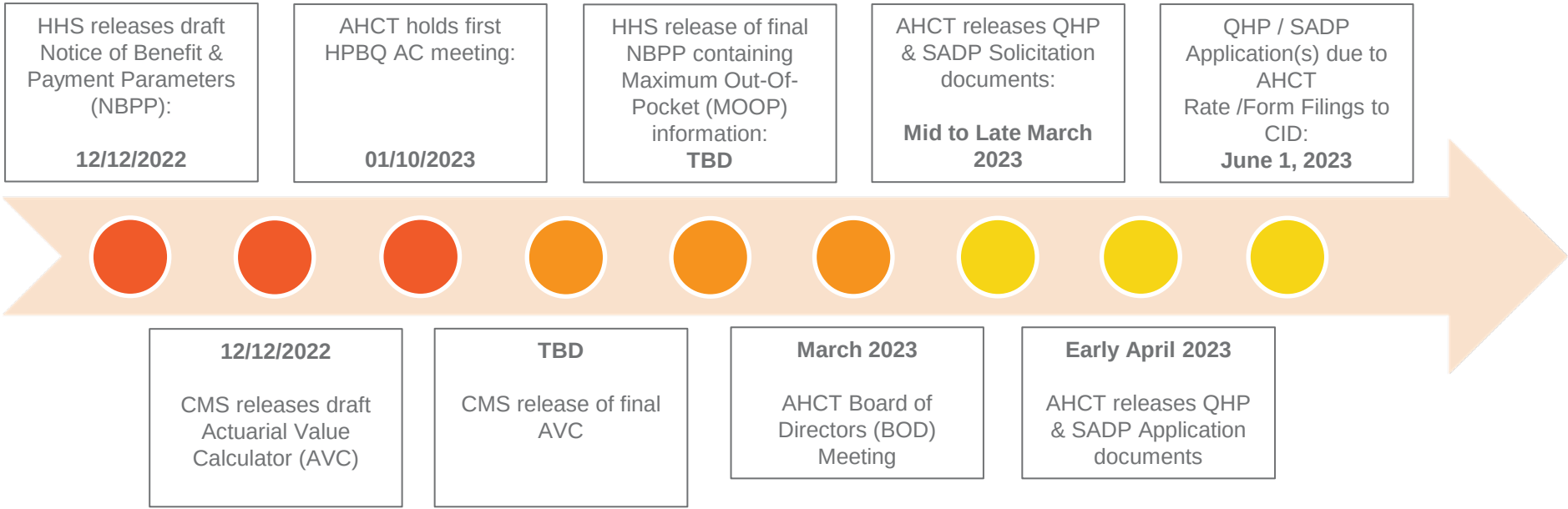
2024 Plan Year Timeline

Development of Certification Requirements



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HPBQ AC Proposed Agendas

- **February 27, 2023 (11:00am – 12:00 EST) – Tentative**
  - 2023 Enrollment Overview
  - Certification requirements: Continued discussions on open topics
  - Draft AVC Results: Continued discussion on impacts to standard plan designs and recommended changes
- **March 13, 2023 (11:00am – 12:00 EST)**
  - Certification requirements: Recommendations for AHCT Board of Directors

Next Steps

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Appendix

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Reference Materials

HPBQ AC Meeting Date	Exhibit Title	Exhibit Number
1/10/2023	AHCT 2023 Standardized Plan – Bronze	1.0
1/10/2023	AHCT 2023 Standardized Plan – Bronze HSA-Compatible	1.1
1/10/2023	AHCT 2023 Standardized Plan – Silver 70% AV	1.2
1/10/2023	AHCT 2023 Standardized Plan – Silver 73% AV	1.3
1/10/2023	AHCT 2023 Standardized Plan – Silver 87% AV	1.4
1/10/2023	AHCT 2023 Standardized Plan – Silver 94% AV	1.5
1/10/2023	AHCT 2023 Standardized Plan – Gold	1.6
1/10/2023	AHCT 2023 SADP Standardized Plan	2.0
1/10/2023	CMS Coverage Map	3.0
1/10/2023	Affordable Care Act – Metal Levels	3.0
1/10/2023	Plan Design Development: AVC Benefit Cost Sharing Categories	4.0
1/10/2023	Plan Design Development: Other Specified Cost Sharing	4.1
1/10/2023	ARPA - Contribution Rates	5.0
1/10/2023	2023 Plan Mix: Number of Plans Required / Permitted per Issuer	6.0
1/10/2023	Copay Maximums – State Regulation: Imaging Services	7.0
1/10/2023	Copay Maximums – State Regulation: Physical Therapy & Occupational Therapy Services	7.1
1/10/2023	Copay Maximums – State Regulation: Medication and Supplies for Treatment of Diabetes	7.2
1/10/2023	Deductible and Coinsurance Maximums – Expanded Coverage for Women's Health	7.3
1/10/2023	Deductible and Coinsurance Maximums – Home Health Care Services	7.4

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Reference Materials

HPBQ AC Meeting Date	Exhibit Title	Exhibit Number
1/10/2023	United States Code (USC) – Title 26 Internal Revenue Code: Health Savings Accounts	8.0
1/10/2023	Connecticut Insurance Department (CID) - 2023 Carrier Reported Enrollment	9.0
1/10/2023	2023 Enrollment by Carrier and Plan Name - Includes AV	10.0
1/10/2023	Population Estimates - Connecticut Counties	11.0
1/10/2023	Individual Market: Age 21 Rates Approved by CID for 2023 Plan Year (Part 1 of 2)	12.0
1/10/2023	Individual Market: Age 21 Rates Approved by CID for 2023 Plan Year (Part 2 of 2)	12.1
1/10/2023	Average Marketplace Premiums - Bronze	13.0
1/10/2023	Average Marketplace Premiums - Silver	13.1
1/10/2023	Average Marketplace Premiums - Gold	13.2
1/10/2023	2023 QHP Plan Mix	14.0
1/10/2023	2023 QHP Individual Market Landscape	15.0
1/10/2023	2023 SADP Plan Mix	16.0
2/1/2023	Value Based Insurance Design	17.0

EXHIBIT 1.0

2023 Standardized Plan Design - QHP

2023 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	$8,800	$17,600
Out-of-Pocket Maximum: Family	$17,600	$35,200
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	$20 copayment per service	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

2023 Standard Bronze (Non-HSA)		
Plan Overview	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
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 DME item after INET deductible	50% coinsurance per DME item 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 (covered persons up to age 26)		
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 (covered persons up to age 26)		
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	50% coinsurance per visit after OON deductible
Routine Eye Exam by Specialist (one exam per calendar year)	$70 copayment per visit after INET deductible	50% coinsurance per visit after OON deductible

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EXHIBIT 1.1

2023 Standardized Plan Design - QHP

2023 Standard Bronze HSA		
Plan Overview	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Deductible: Individual (medical & Rx)	$6,500	$13,000
Deductible: Family (medical & Rx)	$13,000	$26,000
Out-of-Pocket Maximum: Individual	$7,000	$14,000
Out-of-Pocket Maximum: Family	$14,000	$28,000
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

2023 Standard Bronze HSA		
Plan Overview	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
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 DME item after INET plan deductible is met	50% coinsurance per DME item 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 (covered persons up to age 26)		
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 (covered persons up to age 26)		
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.	50% coinsurance per visit after OON deductible
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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EXHIBIT 1.2

2023 Standardized Plan Design - QHP

2023 Standard Silver - 70% AV		
Plan Overview	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Deductible: Individual (medical)	$5,000	$10,000
Deductible: Family (medical)	$10,000	$20,000
Deductible: Individual (prescription)	$250	$500
Deductible: Family (prescription)	$500	$1,000
Out-of-Pocket Maximum: Individual	$9,100	$18,200
Out-of-Pocket Maximum: Family	$18,200	$36,400
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	$20 copayment per service	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

2023 Standard Silver - 70% AV		
Plan Overview	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
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 DME item	40% coinsurance per DME item 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 (covered persons up to age 26)		
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 (covered persons up to age 26)		
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	50% coinsurance per visit after OON deductible
Routine Eye Exam by Specialist (one exam per calendar year)	$60 copayment per visit	40% coinsurance per visit after OON medical deductible

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EXHIBIT 1.3

2023 Standardized Plan Design - QHP

2023 Standard Silver - 73% AV		
Plan Overview	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Deductible: Individual (medical)	$4,750	$10,000
Deductible: Family (medical)	$9,500	$20,000
Deductible: Individual (prescription)	$250	$500
Deductible: Family (prescription)	$500	$1,000
Out-of-Pocket Maximum: Individual	$7,250	$18,200
Out-of-Pocket Maximum: Family	$14,500	$36,400
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	$20 copayment per service	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

2023 Standard Silver - 73% AV		
Plan Overview	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
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 DME item	40% coinsurance per DME item 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 (covered persons up to age 26)		
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 (covered persons up to age 26)		
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	50% coinsurance per visit after OON deductible
Routine Eye Exam by Specialist (one exam per calendar year)	$60 copayment per visit	40% coinsurance per visit after OON medical deductible

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EXHIBIT 1.4

2023 Standardized Plan Design - QHP

2023 Standard Silver - 87% AV		
Plan Overview	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Deductible: Individual (medical)	$675	$10,000
Deductible: Family (medical)	$1,350	$20,000
Deductible: Individual (prescription)	$50	$500
Deductible: Family (prescription)	$100	$1,000
Out-of-Pocket Maximum: Individual	$3,000	$18,200
Out-of-Pocket Maximum: Family	$6,000	$36,400
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	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

2023 Standard Silver - 87% AV		
Plan Overview	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
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 DME item	40% coinsurance per DME item 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 (covered persons up to age 26)		
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 (covered persons up to age 26)		
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	50% coinsurance per visit after OON deductible
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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EXHIBIT 1.5

2023 Standardized Plan Design - QHP

2023 Standard Silver - 94% AV		
Plan Overview	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Deductible: Individual (medical)	$0	$10,000
Deductible: Family (medical)	$0	$20,000
Deductible: Individual (prescription)	$0	$500
Deductible: Family (prescription)	$0	$1,000
Out-of-Pocket Maximum: Individual	$950	$18,200
Out-of-Pocket Maximum: Family	$1,900	$36,400
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

2023 Standard Silver - 94% AV		
Plan Overview	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
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 DME item	40% coinsurance per DME item 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 (covered persons up to age 26)		
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 (covered persons up to age 26)		
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	50% coinsurance per visit after OON deductible
Routine Eye Exam by Specialist (one exam per calendar year)	$30 copayment per visit	40% coinsurance per visit after OON medical deductible

Green shading represents change from 2022 Plan Year

Blue italic font signifies field included in Actuarial Value Calculator

AHCT standardized plan designs available at: https://agency.accesshealthct.com/healthplaninformation

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EXHIBIT 1.6

2023 Standardized Plan Design - QHP

2023 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	$6,000	$12,000
Out-of-Pocket Maximum: Family	$12,000	$24,000
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

2023 Standard Gold		
Plan Overview	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
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 DME item	30% coinsurance per DME item 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 (covered persons up to age 26)		
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 (covered persons up to age 26)		
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	50% coinsurance per visit after OON deductible
Routine Eye Exam by Specialist (one exam per calendar year)	$40 copayment per visit	30% coinsurance per visit after OON medical deductible

Green shading represents change from 2022 Plan Year

Blue italic font signifies field included in Actuarial Value Calculator

AHCT standardized plan designs available at: https://agency.accesshealthct.com/healthplaninformation

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EXHIBIT 2.0

2023 Standardized Plan Design - SADP

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 one child	$350
Two or more children	$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 three years*)	
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*)	
Sealants *	

Plan Overview	In-Network (INET) Member Pays
Basic Services	
Filings	20% after deductible is met
Simple Extractions	
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	
Medically-Necessary Orthodontic Services *	50% after deductible is met
Waiting Periods and Plan Maximums ***(for covered persons not eligible for dependent child benefit)***	
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 member

*For child, stepchild, or other dependent child until end of plan year once dependent turns 26.

AHCT standardized plan designs available at: https://agency.accesshealthct.com/healthplaninformation

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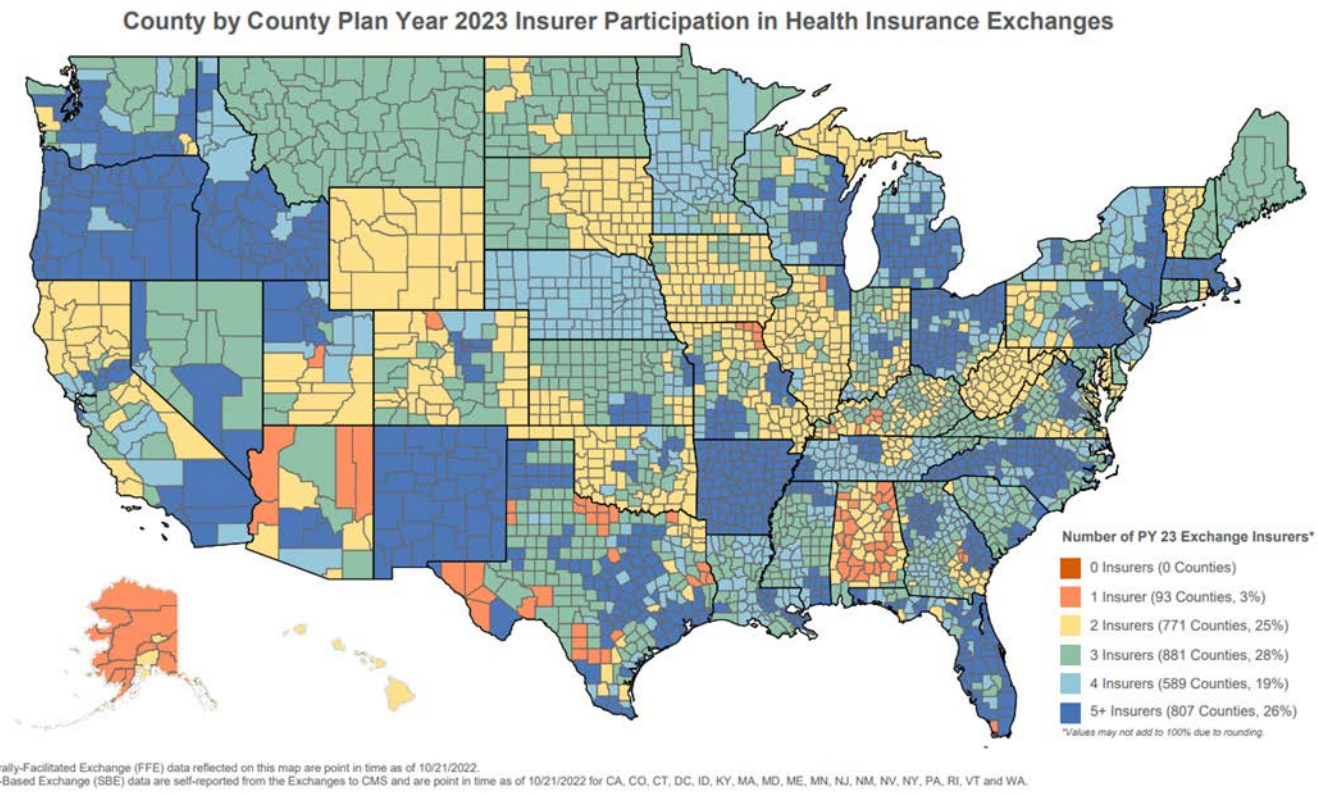
EXHIBIT 3.0

CMS Coverage Map



Released by CMS
10/31/2022

Available at:
https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/health-insurance-exchange-coverage-maps

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EXHIBIT 4.0

Plan Design Development:

AVC Benefit Cost Sharing Categories

User Inputs for Plan Parameters	
Use Integrated Medical and Drug Deductible?	HSA/HRA?
Apply Inpatient Copay per Day?	Tiered Network?
Apply Skilled Nursing Facility Copay per Day?	Deductible ($)
Use Separate MOOP for Medical and Drug Spending?	Coinsurance (%, Insurer's Cost Share)
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	MOOP ($)
Desired Metal Tier	MOOP if Separate ($)

Medical Benefits Subject to Deductible? Subject to Coinsurance? Coinsurance (Insurer's Cost Share) or Copay Values (Member Cost Share)
Emergency Room Services
All Inpatient Hospital Services (inc. MH/SUD)
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 Drugs Benefits Subject to Deductible? Subject to Coinsurance? 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? If yes, enter value.
Set a Maximum Number of Days for Charging an IP Copay? If yes, Enter # Days (1-10)
Begin Primary Care Cost-Sharing After a Set Number of Visits? If yes, Enter # Visits (1-10)
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? If yes, Enter # Copays (1-10)

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EXHIBIT 4.1

Plan Design Development:

Other Specified Cost Sharing

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 Service (up to 100 visits per calendar year)
Ambulance Services
Urgent Care Center or Facility
Pediatric Dental Care (for children under age 26)
Diagnostic & Preventive
Basic Services
Major Services
Orthodontia Services (medically necessary)
Pediatric Vision Care (for children under age 26)
Prescription Eye Glasses
Routine Eye Exam

Out-of-Network Services
Deductible
Maximum Out-of-Pocket (MOOP)
All services

Additional Cost Sharing Notes
Preventive Care is covered at no cost to the member for all plans.
OP Mental Health has same cost sharing as Primary Care for all plans.
All plans include 'embedded' deductibles, not aggregate.

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EXHIBIT 5.0

Pre-ARPA/ ARPA Contribution Rates

Percent of Income Paid for Marketplace Benchmark Silver Premium, by Income		
Income (% of poverty)	**Affordable Care Act** (before legislative change)	**ARPA and IRA (2021-2025)**
Under 100%	Not eligible for subsidies*	Not eligible for subsidies*
100% – 138%	2.07%	0.00%
138% – 150%	3.10% – 4.14%	0.00%
150% – 200%	4.14% – 6.52%	0.0% – 2.0%
200% – 250%	6.52% – 8.33%	2.0% – 4.0%
250% – 300%	8.33% – 9.83%	4.0% – 6.0%
300% – 400%	9.83%	6.0% – 8.5%
Over 400%	Not eligible for subsidies	8.50%
NOTES: *Lawfully present immigrants whose household incomes are below 100% FPL and are not otherwise eligible for Medicaid are eligible for tax subsidies through the Marketplace if they meet all other eligibility requirements.		

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EXHIBIT 6.0

2023 QHP Plan Mix

Plans required/permitted per Issuer by market:

	INDIVIDUAL MARKET		SHOP	
Metal Level	Standardized Plans (Required)	Non-Standard Plans (Optional)	Required*	Optional
Platinum	0	2	0	4
Gold	1	3	1	5
Silver	1	0	2	4
Bronze	2	3	2	2
Catastrophic	0	1	0	0
Total	4	9	5	15
Maximum	13		20	

*While SHOP participants are required to offer specific metal levels, standardized plans are not required.

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EXHIBIT 7.0

Copay Maximums

State Regulation:

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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EXHIBIT 7.1

Copay Maximums

State Regulation:

Copayments for Physical Therapy and Occupational Therapy Services – In-Network -

- **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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EXHIBIT 7.2

Cost Sharing Maximums

State Regulation:

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)

- **Connecticut General Statute (CGS)**
  - 38a-492d (individual health insurance policy)
  - 38a-518d (group health insurance policy)

- **Coverage is required for the treatment of all types of diabetes, including laboratory and diagnostic testing and screening, insulin drugs, non-insulin drugs, diabetes devices (including diabetic ketoacidosis devices) in accordance with the insured's diabetes treatment plan.**
  - Enrollee coinsurance, copayments, deductibles and other out-of-pocket expenses may not exceed:
    - Twenty-five dollars for each thirty-day supply of a medically necessary covered insulin drug
    - Twenty-five dollars for each thirty-day supply of a medically necessary covered non-insulin drug
    - One hundred dollars for a thirty-day supply of all medically necessary covered diabetes devices and diabetic ketoacidosis devices for such insured that are in accordance with such insured's diabetes treatment plan
  - These provisions apply to a high deductible health plan to the maximum extent permitted by federal law
  - Effective January 1, 2022

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EXHIBIT 7.3

Expansion of Coverage

State Regulation:

State of Connecticut Public Act No. 22-90: An act concerning required health insurance coverage for breast and ovarian cancer susceptibility screening

- **Connecticut General Statute (CGS)**
  - 38a-503 (individual health insurance policy)
  - 38a-530 (group health insurance policy)

- **This act expands coverage requirements under certain commercial health insurance policies for specified procedures used to treat or prevent breast or ovarian cancer.**
  - Expands health insurance coverage requirements for breast mammograms, ultrasounds, and magnetic resonance imaging (MRIs).
  - Requires coverage of certain procedures related to breast cancer treatment, including breast biopsies; certain prophylactic mastectomies; and breast reconstruction surgery, subject to certain conditions.
  - Requires coverage for certain (a) genetic testing, including for breast cancer gene one (BRCA1) and breast cancer gene two (BRCA2), under certain circumstances; (b) post-treatment CA-125 monitoring (i.e., a test measuring the amount of the cancer antigen 125 protein); and (c) routine ovarian cancer screenings, including surveillance tests for certain insureds.

EXHIBIT 7.4

Deductible & Coinsurance Maximums

State Regulation:

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.**

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EXHIBIT 8.0

United States Code (USC)

Title 26 Internal Revenue Code

26 USC §223(c)(2): Health Savings Accounts (HSA)

- **Definition: High deductible health plan**
  - Has an annual deductible not less than $1,500 for self-only/$3,000 for family coverage for calendar year 2023*
  - 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 $7,500 for self-only/$15,000 for family coverage for calendar year 2023*
  - 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 the IRS* Revenue Procedure 2022-24 *for calendar year 2023; Coverage outside of plan network is not taken into account.* ***Plan year 2024 not available at this time.*

***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).*

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EXHIBIT 9.0

Connecticut Insurance Department (CID)

2023 Carrier Reported Enrollment*

Company	Individual "On-Exchange"	Individual "Off-Exchange"	Individual Sub-Total	Small Group "On-Exchange"	Small Group "Off-Exchange"	Small Group Sub-Total	Total
Anthem Health Plans	22,871	4,827	27,698	617	18,654	19,271	46,969
CTCare Benefits Inc.	75,003		75,003	3,476		3,476	78,479
Aetna Life Insurance Company			0		407	407	407
Cigna Health and Life Insurance Company			0		12,127	12,127	12,127
CTCare Inc.		2,093	2,093		304	304	2,397
CTCare Insurance Co.	6,745	2,037	8,782		16,281	16,281	25,063
Oxford Health Plans (CT), Inc.			0		2,409	2,409	2,409
Oxford Health Insurance, Inc.			0		36,480	36,480	36,480
UnitedHealthcare Insurance Co.			0		1,855	1,855	1,855
Totals from 2023 Rate Filings	**104,619**	**8,957**	**113,576**	**4,093**	**88,517**	**92,610**	**206,186**

Totals from 2022 Rate Filings	**104,542**	**11,260**	**115,802**	**2,477**	**104,181**	**106,658**	**222,460**
Enrollment Change	**0.07%**	**-20.45%**	**-1.92%**	**65.24%**	**-15.04%**	**-13.17%**	**-7.32%**

Information obtained from Unified Rate Review Template (URRT) included in final approved rate filings for 2023.
**Current Enrollment "as of" date varies by carrier.*

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2023 Actuarial Value (AV) by Carrier and Plan

‘On- Exchange’ Only

Carrier	Plan Name	New Plan	AV	Enroll*
CBI	Choice Catastrophic POS with Dental		59.86	
Anth	Catastrophic HMO Pathway Enhanced		61.85	
CBI	Choice Bronze Standard POS HSA		64.29	
Anth	Bronze HMO BlueCare Prime with Added Dental and Vision Benefits		64.33	
CBI	Choice Bronze Alternative POS with Dental		64.27	
CBI	Choice Bronze Standard POS		64.79	
Anth	Bronze HMO Pathway Enhanced Tiered		64.05	
Anth	Bronze PPO Pathway Enhanced Value PCP	X	64.45	
Anth	Bronze PPO Standard Pathway for HSA		64.29	
CICI	FlexPOS Bronze Standard HSA		64.29	
Anth	Bronze PPO Standard Pathway		64.57	
CICI	FlexPOS Bronze Standard		64.79	
CBI	Choice Silver Standard POS		71.75	
CBI	73%		73.83	
CBI	87%		87.34	
CBI	94%		94.66	
Anth	Silver PPO Standard Pathway		71.37	
Anth	73%		73.49	
Anth	87%		87.99	
Anth	94%		94.89	
CICI	FlexPOS Silver Standard		71.75	
CICI	73%		73.83	
CICI	87%		87.34	
CICI	94%		94.66	
Anth	Gold HMO BlueCare Prime with Added Dental and Vision Benefits		78.57	
Anth	Gold HMO Pathway Enhanced Tiered		78.32	
Anth	Gold PPO Pathway with Added Dental and Vision Benefits	X	78.57	
CBI	Choice Gold Standard POS		81.65	
CBI	Choice Gold Alternative POS with Dental		77.87	
CBI	Choice Gold Alternative POS		77.88	
CICI	FlexPOS Gold Standard		81.65	
CICI	Compass EPO Gold Alternative		78.98	
CICI	FlexPOS Platinum Alternative		88.04	

EXHIBIT 10.0

AV data is collected from Connecticut Insurance Department (CID) 2023 Rate Filings (AV Screenshots)

***Enrollment Data will be provided when available in February.**

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EXHIBIT 11.0

Population Estimates

Connecticut Counties*

Annual Estimates of the Resident Population for Counties in Connecticut: April 1, 2010 to July 1, 2021

Geography	4/1/2010										
	Census	Estimates Base	2013	2014	2015	2016	2017	2018	2019	2020	2021
Fairfield County	916,829	916,904	939,924	944,196	944,943	944,347	943,038	943,971	943,332	943,542	959,768
Hartford County	894,014	894,052	897,678	897,407	896,290	894,141	893,076	892,580	891,720	890,395	896,854
Litchfield County	189,927	189,880	186,836	185,343	184,122	182,793	181,667	181,095	180,333	179,937	185,000
Middlesex County	165,676	165,672	165,329	164,786	163,724	163,292	162,942	162,870	162,436	161,950	164,759
New Haven County	862,477	862,442	862,820	862,885	860,186	857,901	857,748	856,971	854,757	852,944	863,700
New London County	274,055	274,070	272,976	271,462	269,636	268,403	267,419	266,285	265,206	265,329	268,805
Tolland County	152,691	152,747	151,778	151,693	151,734	151,162	151,009	150,689	150,721	150,731	150,293
Windham County	118,428	118,380	117,500	116,752	116,487	116,102	116,398	117,059	116,782	116,666	116,418
CT Total	**3,574,097**	**3,574,147**	**3,594,841**	**3,594,524**	**3,587,122**	**3,578,141**	**3,573,297**	**3,571,520**	**3,565,287**	**3,561,494**	**3,605,597**

*Source: U.S. Census Bureau, Population Division:
2010 – 2019 data - https://www.census.gov/data/datasets/time-series/demo/popest/2010s-counties-total.html

2020 data - https://www.census.gov/programs-surveys/popest/technical-documentation/research/evaluation-estimates/2020-evaluation-estimates/2010s-counties-total.html

2021 data - https://www.census.gov/data/datasets/time-series/demo/popest/2020s-counties-total.html

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EXHIBIT 12.0

Individual Market:

Age 21 Rates Approved by CID for 2023 Plan Year (Part 1 of 2)

			Fairfield County		Hartford County		Litchfield County		Middlesex County		New Haven County		New London County		Tolland County		Windham County	
Carrier	Exchange	Plan Marketing Name	Rating Area 1	Rank	Rating Area 2	Rank	Rating Area 3	Rank	Rating Area 4	Rank	Rating Area 5	Rank	Rating Area 6	Rank	Rating Area 7	Rank	Rating Area 8	Rank
CBI	On	Choice Catastrophic POS with Dental	233.02	1	199.11	1	215.29	1	215.14	1	215.14	1	215.29	3	215.29	3	215.29	3
Anthem	Off	Anthem HMO Catastrophic Pathway Enhanced 9100/0%	260.47	2	218.61	2	218.61	2	237.22	2	237.22	2	209.31	1	209.31	1	209.31	1
Anthem	On	Catastrophic HMO Pathway Enhanced	260.47	2	218.61	2	218.61	2	237.22	2	237.22	2	209.31	1	209.31	1	209.31	1
CBI	On	**Choice Bronze Standard POS HSA**	442.47	4	378.07	5	408.79	11	408.51	5	408.51	5	408.79	14	408.79	14	408.79	14
Anthem	On	Bronze HMO BlueCare Prime with Added Dental and Vision Benefits	444.73	5	373.26	4	373.26	4	405.02	4	405.02	4	357.37	4	357.37	4	357.37	4
CBI	On	Choice Bronze Alternative POS with Dental	448.80	6	383.48	8	414.64	12	414.35	8	414.35	8	414.64	16	414.64	16	414.64	16
Anthem	Off	Anthem Bronze HMO Pathway Enhanced 6200/12400/40% for HSA	451.50	7	378.94	6	378.94	5	411.19	6	411.19	6	362.82	5	362.82	5	362.82	5
Anthem	Off	Anthem Bronze HMO BlueCare Prime 8500/50%	452.86	8	380.08	7	380.08	6	412.42	7	412.42	7	363.90	6	363.90	6	363.90	6
CBI	On	**Choice Bronze Standard POS**	456.93	9	390.42	11	422.15	15	421.86	9	421.86	9	422.15	19	422.15	19	422.15	19
Anthem	On	Bronze HMO Pathway Enhanced Tiered	464.16	10	389.56	9	389.56	7	422.72	10	422.72	10	372.99	7	372.99	7	372.99	7
Anthem	On	Bronze PPO Pathway Enhanced Value PCP	464.63	11	389.96	10	389.96	8	423.15	11	423.15	11	373.36	8	373.36	8	373.36	8
CCI	Off	Passage SOLO HMO Copay/Coins. $7,500 ded	473.58	12	402.82	13	401.16	10	441.45	13	441.45	13	404.11	12	404.11	12	404.11	12
Anthem	On	**Bronze PPO Standard Pathway for HSA**	476.25	13	399.71	12	399.71	9	433.73	12	433.73	12	382.70	9	382.70	9	382.70	9
CICI	On	**FlexPOS Bronze Standard HSA**	481.95	14	419.54	16	461.16	27	474.66	22	444.06	14	443.32	24	466.76	28	447.45	26
Anthem	On	**Bronze PPO Standard Pathway**	496.20	15	416.45	14	416.45	13	451.90	14	451.90	15	398.73	10	398.73	10	398.73	10
CICI	On	**FlexPOS Bronze Standard**	497.71	16	433.25	22	476.24	29	490.18	27	458.57	17	457.81	28	482.01	29	462.08	29
CBI	On	**Choice Silver Standard POS**	497.97	17	425.50	18	460.07	26	459.75	17	459.75	19	460.07	29	460.07	27	460.07	28
Anthem	On	Gold HMO BlueCare Prime with Added Dental and Vision Benefits	498.02	18	417.98	15	417.98	14	453.56	15	453.56	16	400.20	11	400.20	11	400.20	11
CCI	Off	Choice SOLO HMO HSA $6,500 ded.	503.32	19	428.12	19	426.35	17	469.18	19	469.18	21	429.49	21	429.49	21	429.49	21
Anthem	On	Gold HMO Pathway Enhanced Tiered	504.12	20	423.10	17	423.10	16	459.11	16	459.11	18	405.10	13	405.10	13	405.10	13

Catastrophic
Bronze
Silver
Gold
Platinum

BOLD FONT: **"Standard Plans"**

Exhibit sorted in rank order by Fairfield County rates

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EXHIBIT 12.1

Individual Market:

Age 21 Rates Approved by CID for 2023 Plan Year (Part 2 of 2)

			Fairfield County		Hartford County		Litchfield County		Middlesex County		New Haven County		New London County		Tolland County		Windham County	
Carrier	Exchange	Plan Marketing Name	Rating Area 1	Rank	Rating Area 2	Rank	Rating Area 3	Rank	Rating Area 4	Rank	Rating Area 5	Rank	Rating Area 6	Rank	Rating Area 7	Rank	Rating Area 8	Rank
CCI	Off	Choice SOLO POS HSA Coins. $6,000 ded.	505.80	21	430.22	21	428.45	19	471.49	20	471.49	22	431.60	22	431.60	22	431.60	22
Anthem	Off	Anthem Silver HMO Pathway Enhanced Tiered 3000/4000/10%/40% for HSA	510.37	22	428.35	20	428.35	18	464.80	18	464.80	20	410.12	15	410.12	15	410.12	15
Anthem	On	Gold PPO Pathway with Added Dental and Vision Benefits	520.37	23	436.74	23	436.74	20	473.91	21	473.91	23	418.16	17	418.16	17	418.16	17
CCI	Off	Choice SOLO HMO Copay/Coins. $8,000 ded.	520.57	24	442.78	25	440.96	22	485.25	25	485.25	26	444.20	25	444.20	24	444.20	24
Anthem	Off	Anthem Silver HMO BlueCare Prime 5100/30%	524.59	25	440.28	24	440.28	21	477.75	23	477.75	24	421.55	18	421.55	18	421.55	18
CCI	Off	Choice SOLO POS Copay/Coins. $4,750 40% ded	524.71	26	446.31	27	444.47	23	489.11	26	489.11	28	447.74	27	447.74	26	447.74	27
CICI	On	**FlexPOS Silver Standard**	529.48	27	460.91	29	506.64	30	521.47	30	487.85	27	487.03	30	512.78	30	491.57	30
Anthem	Off	Anthem Gold HMO BlueCare Prime 2200/20%	530.06	28	444.87	26	444.87	24	482.74	24	482.74	25	425.94	20	425.94	20	425.94	20
Anthem	Off	Anthem Gold HMO Pathway Enhanced Tiered 2000/3000/10%/30%	547.67	29	459.65	28	459.65	25	498.77	28	498.77	29	440.09	23	440.09	23	440.09	23
CICI	Off	Choice SOLO POS Coins. $4,000 ded	551.57	30	480.14	31	527.78	31	543.23	31	508.21	31	507.36	31	534.18	31	512.09	31
Anthem	On	**Silver PPO Standard Pathway**	556.01	31	466.65	30	466.65	28	506.36	29	506.36	30	446.79	26	446.79	25	446.79	25
CICI	Off	Choice SOLO POS HSA Coins. $3,500 ded	567.80	32	494.27	32	543.31	32	559.21	32	523.16	32	522.29	32	549.90	32	527.15	32
CICI	Off	Choice SOLO POS Copay/Coins. $5,500 30% ded.	568.36	33	494.76	33	543.85	33	559.77	34	523.68	33	522.80	33	550.44	33	527.67	33
CICI	On	Compass EPO Gold Alternative	570.20	34	496.35	34	545.60	34	561.57	35	525.36	34	524.49	34	552.21	34	529.38	34
CICI	Off	Choice SOLO POS Copay/Coins. $6,000 ded	581.71	35	506.37	35	556.61	35	572.91	37	535.97	35	535.08	35	563.36	36	540.06	35
CBI	On	Choice Gold Alternative POS	605.92	36	517.73	36	559.80	37	559.41	33	559.41	36	559.80	36	559.80	35	559.80	36
CBI	On	Choice Gold Alternative POS with Dental	614.87	37	525.38	37	568.08	38	567.68	36	567.68	37	568.08	38	568.08	38	568.08	38
CICI	On	**FlexPOS Gold Standard**	656.23	38	571.25	39	627.93	39	646.31	39	604.63	38	603.63	39	635.54	39	609.25	39
CICI	On	FlexPOS Platinum Alternative	658.36	39	573.10	40	629.96	40	648.40	40	606.59	39	605.58	40	637.60	40	611.23	40
CCI	Off	Choice SOLO HMO Copay/Coins. $2,500 ded	660.74	40	562.01	38	559.70	36	615.91	38	615.91	40	563.82	37	563.82	37	563.82	37
CBI	On	**Choice Gold Standard POS**	679.92	41	580.96	41	628.17	40	627.73	39	627.73	41	628.17	41	628.17	39	628.17	41
Anthem	On	**Gold PPO Standard Pathway**	998.44	42	837.98	42	837.98	42	909.30	42	909.30	42	802.32	42	802.32	42	802.32	42

Catastrophic
Bronze
Silver
Gold
Platinum

BOLD FONT: "Standard Plans"

Exhibit sorted in rank order by Fairfield County rates

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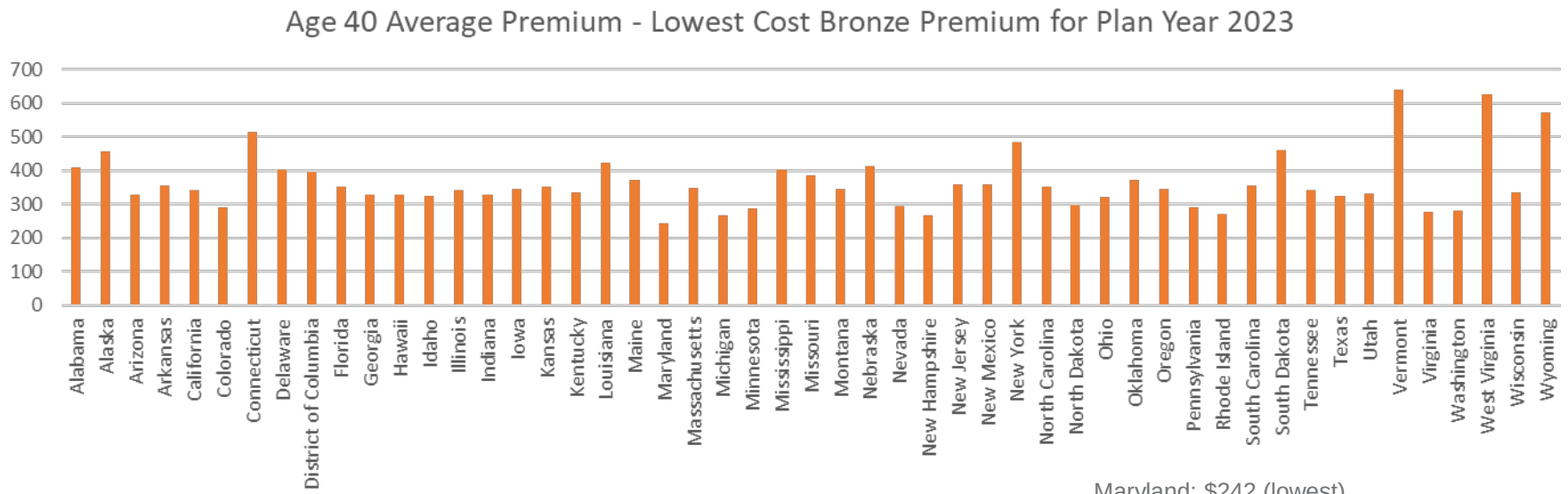
EXHIBIT 13.0

Average Marketplace Premiums



Maryland: $242 (lowest)

Connecticut: $515 (48th)

Vermont: $641 (highest)

US: $342

- 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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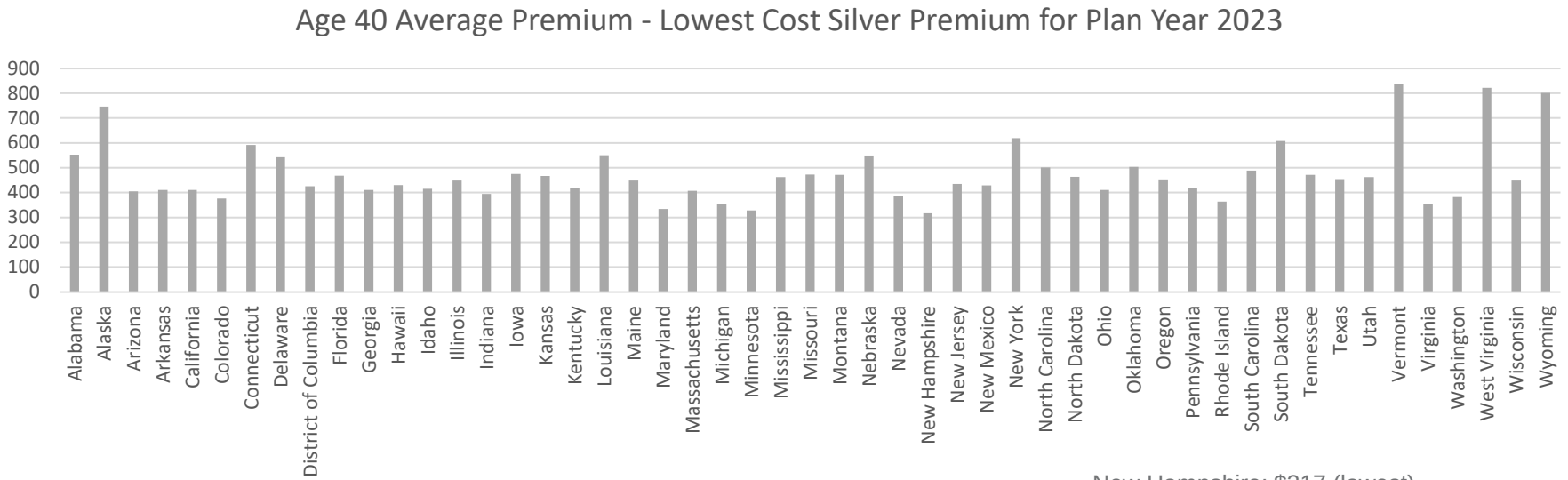
EXHIBIT 13.1

Average Marketplace Premiums



New Hampshire: $317 (lowest)

Connecticut: $540 (45th)

Vermont: $837 (highest)

US: $448

- 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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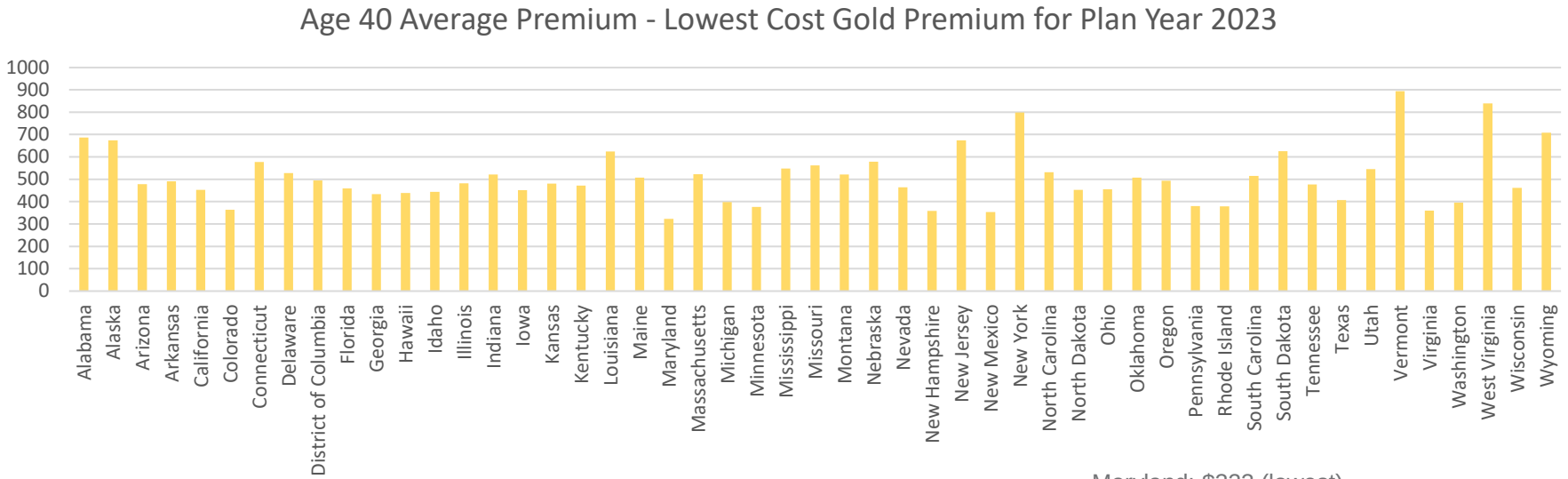
EXHIBIT 13.2

Average Marketplace Premiums



Maryland: $323 (lowest)

Connecticut: $577 (41st)

Vermont: $894 (highest)

US: $472

- 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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EXHIBIT 14.0

2023 Plan Mix

Individual Market QHPs

Individual Market	*'On-Exchange' Permitted Number of Plans per Carrier*		'On-Exchange' Submitted Plans			
Metal Level	*Standardized (Required)*	*Non-Standard (Optional)*	**Anthem**	**CBI**	**CICI**	**Total**
Catastrophic	*N/A*	*1*	**1**	**1**		**2**
Bronze	*2*	*3*	**5**	**3**	**2**	**10**
Silver	*1*	*0*	**1**	**1**	**1**	**3**
Gold	*1*	*3*	**4**	**3**	**2**	**9**
Platinum	*N/A*	*2*			**1**	**1**
Total	*4*	*Up to 9*	**11**	**8**	**6**	**25**

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

	Avg. Amt. Consumer Pays *	Avg. Amt Carrier Pays
Bronze	40%	60%
Silver	30%	70%
Gold	20%	80%
Platinum	10%	90%

Per CMS regulations effective for the 2023 Plan Year, 'de minimis' AV ranges are as follows:

- Standard Bronze, Gold and Platinum: +/-2
- Expanded Bronze: +5/-2 and plan must include at least 1 major service not subject to deductible or is a High Deductible Health Plan
- Standard Silver: +2/-0
- Silver Cost Sharing Reduction Plans (CSR) 73%, CSR 87% & CSR 94%: +1, additionally CSR: 73% must be at least 2 points greater than 'standard' Silver plan

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EXHIBIT 15.0

2023 QHP Individual Market Landscape

Metal Level

Carrier	Exchange Status	Catastrophic	Bronze	Silver	Gold	Platinum	Total
Anthem	Off	1	2	2	2		7
Anthem	On	1	5	1	4		11
CBI	On	1	3	1	3		8
CICI	On		2	1	2	1	6
CICI	Off			4			4
CCI	Off		3	2	1		6
Total		3	15	11	12	1	42

Product Type

Carrier	Exchange Status	HMO	POS	EPO	PPO	Total
Anthem	Off	7				7
Anthem	On	5			6	11
CBI	On		8			8
CICI	On		5	1		6
CICI	Off		4			4
CCI	Off	4	2			6
Total		16	19	1	6	42

Information obtained from CID website: https://www.catalog.state.ct.us/cid/portalApps/HCfiling2023.aspx

60% of plans filed in the Individual Market to be offered through AHCT

POS products continue to be the predominant product offered on the exchange.

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EXHIBIT 16.0

2023 Plan Mix

Stand-Alone Dental Plans (SADPs)

Number of Plans Permitted per Issuer	
Individual	
Standardized Plans (Required)	1
Non-Standard Plans (Optional)	3
Total	4

Issuer Plan Submissions 2023 Plan Year	
Anthem	CICI
1	1
3	1
4	2

Standardized plan design and plans permitted per Issuer are the same in both Individual and Small Group Markets

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EXHIBIT 17.0

Value Based Insurance Design

Link to Final Report

http://vbidcenter.org/wp-content/uploads/2019/07/VBID-X-FINAL-REPORT-7.1.19-1.pdf

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