Access Health Connecticut

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

February 5, 2024

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Agenda

- **Call to Order**
- **Public Comment**
- **Vote: Meeting Minutes (January 25, 2024)**
- **Plan Management**
  - 2025 Stand-Alone Dental Plan - Standard Plan Design
    - Potential Vote
- **Wakely Consulting**
  - 2025 Qualified Health Plan - Standard Plan Design
    - Review Plan Alternatives
    - Potential Vote
- **Next Steps**

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Public Comment

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Vote

Review and Approval of Minutes
HPBQ AC Meeting
January 25, 2024

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Our Mission, Vision and Values

Our **Mission** is 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.

Our **Vision** is to provide Connecticut residents with access to the most equitable, simple and affordable health insurance products to foster healthier communities.

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

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

CMS Annual Limitation on Cost Sharing

Stand-Alone Dental Plans (SADP)

- **Plan Year 2024**
  - Amounts increased to $400 for one covered child and $800 for two or more covered children
  - HPBQ recommended amounts remain at $350/$700
  - Amounts were last modified for Plan Year 2016
- **Plan Year 2025**
  - Amounts increased to $425 for one covered child and $850 for two or more covered children for in-network coverage

Impact to Rates would be less than $0.75 Per Member Per Month (PMPM)

Individual Rate (All Counties)	Age 25 & Under	Age 26 & Over
Anthem Dental Family Preventive	28.87	20.62
Anthem Family Dental Value	28.87	25.97
Anthem Dental Family	28.87	38.76
Anthem Dental Family Enhanced	32.73	62.34
ConnectiCare Basic Dental Plan	24.17	24.17
ConnectiCare Standard Dental Plan	69.31	69.31

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2025 Standardized Plan Design - SADP

Proposed

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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2025 Individual Market Standard Plan Designs

February 5, 2024

PRESENTED BY:

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Resource Material Status

2025 Plan Design Review

Proposed Regulatory Changes

Proposed Federal Actuarial Value Calculator (AVC) Changes

Preliminary 2025 Calculator Results

Proposed 2025 Plan Designs

Summary of 2025 Proposed AV Changes

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.

Individual Market	Gold	Silver	Bronze	Bronze HSA
2025 Proposed AV Ranges	78.0% - 82.0%	70.0%-72.0%	58.0%-65.0%	58.0%-65.0%
2024 AV (Final)	**81.8%-82.0%**	**71.3%-71.8%**	**64.8%-65.0%**	**64.8%-64.9%**
2025 Draft AV Approx. Chg.	79.6%-80.5%	70.6%-71.0%	62.5%-62.8%	63.8%-64.0%

Individual Market - CSR Plan Variations: Silver	73% AV CSR	87% AV CSR	94% AV CSR
2025 Proposed AV Ranges	73.0%-74.0%	87.0%-88.0%	94.0%-95.0%
2024 AV (Final)	**73.4%- 74.0%**	**87.0%-87.4%**	**94.8%-95.0%**
2025 Draft AV Approx. Chg.	73.1%-73.4%	86.2%-87.2%	94.6%-95.1%

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

2025 Plan Design Overview

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

2025 Plan Options

Additional Cost-sharing Variations

- The current Gold and Non-HSA Bronze plans have AVs based on the proposed 2025 Federal AVC that are below the top of the metal range.
- Wakely developed additional scenarios with the following guidance:
  - Gold: reduce deductible, have Lab services not subject to deductible
  - Bronze Non-HSA: reduce PCP copay, move drug coinsurance amounts to copays, remove drugs from subject to deductible, reduce deductible, reduce MOOP

Summary of 2025 Gold Plan AV Options

Benefit Category	2024/2025 Individual Market Gold Plan	2025 Individual Market Gold Plan Option 1	2025 Individual Market Gold Plan Option 2
Medical Deductible	$1,300 (INN)/$3,000 (OON)	$1,300 (INN)/$3,000 (OON)	$1,200 (INN)
Rx Deductible	$50 (INN)/$350 (OON)	$50 (INN)/$350 (OON)	$50 (INN)/$350 (OON)
Coinsurance	30%	30%	30%
Out-of-pocket Maximum	$7,375 (INN)/$14,750 (OON)	$7,375 (INN)/$14,750 (OON)	$7,375 (INN)/$14,750 (OON)
Primary Care	$20	$20	$20
Specialist Care	$40	$40	$40
Urgent Care	$50	$50	$50
Emergency Room	$400	$400	$400
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)	$65	$65	$65
Non-Advanced Radiology (X-ray, Diagnostic)	$40 (after ded.)	$40 (after ded.)	$40 (after ded.)
Laboratory Services	$10 (after ded.)	$10	$10
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	$20	$20	$20
Chiropractic Care 20 visit calendar maximum	$40	$40	$40
All Other Medical	30%	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)	$5 / $35 / $60 / 20% (spec. after ded., $100 max per spec. script)
2024 AVC Results	**81.8%-82.0%**	**NA**	**NA**
2025 Draft AVC Approximate Change	79.6%-80.5%	80.2%-81.1%	80.3%-81.2%

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Summary of 2025 Silver Plan AV

Benefit Category	2024 Individual Market Silver Plan	2025 Individual Market Silver Plan Option 1
Medical Deductible	$5,000 (INN)/ $10,000 (OON)	$5,000 (INN)/ $10,000 (OON)
Rx Deductible	$250 (INN)/ $500 (OON)	$250 (INN)/ $500 (OON)
Coinsurance	40%	40%
Out-of-pocket Maximum	$9,100 (INN)/ $18,200 (OON)	$9,100 (INN)/ $18,200 (OON)
Primary Care	$40	$40
Specialist Care	$60	$60
Urgent Care	$75	$75
Emergency Room	$450 (after ded.)	$450 (after ded.)
Inpatient Hospital	$500 per day (after ded., $2,000 max. per admission)	$500 per day (after ded., $2,000 max. per admission)
Outpatient Hospital	$300@ASC/$500 otherwise (after ded.)	$300@ASC/$500 otherwise (after ded.)
Advanced Radiology (CT/PET Scan, MRI)	$75	$75
Non-Advanced Radiology (X-ray, Diagnostic)	$40 (after ded.)	$40 (after ded.)
Laboratory Services	$20	**$25**
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	$30	$30
Chiropractic Care (20 visit calendar maximum)	$50	$50
All Other Medical	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., $200 max per spec. script)
2024 AVC Results	**71.3%-71.8%**	**NA**
2025 Draft AVC Approximate Change	70.6%-71.0%	70.3%-70.7%

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Summary of 2025 Silver 73% CSR Plan AV

Benefit Category	2024 Individual Market Silver Plan (73%)	2025 Individual Market Silver Plan (73%) Option 1
Medical Deductible	$4,750	**$5,000**
Rx Deductible	$250	$250
Coinsurance	40%	40%
Out-of-pocket Maximum	$7,475	**$7,350**
Primary Care	$40	$40
Specialist Care	$60	$60
Urgent Care	$75	$75
Emergency Room	$450 (after ded.)	$450 (after ded.)
Inpatient Hospital	$500 per day (after ded., $2,000 max. per admission)	$500 per day (after ded., $2,000 max. per admission)
Outpatient Hospital	$300@ASC/$500 otherwise (after ded.)	$300@ASC/$500 otherwise (after ded.)
Advanced Radiology (CT/PET Scan, MRI)	$75	$75
Non-Advanced Radiology (X-ray, Diagnostic)	$40 (after ded.)	$40 (after ded.)
Laboratory Services	$20	$25
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	$30	$30
Chiropractic Care (20 visit calendar maximum)	$50	$50
All Other Medical	40%	40%
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	$10 / $45 / $70 / 20% (all but generic after ded., $100 max per spec. script)	$10 / $45 / $70 / 20% (all but generic after ded., $100 max per spec. script)
2024 AVC Results	**73.4%- 74.0%**	**NA**
2025 Draft AVC Approximate Change	73.1%-73.4%	73.0%-73.3%

2025 MOOP exceeded

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Summary of 2025 Silver 87% CSR Plan AV Options

Benefit Category	2024 Individual Market Silver Plan (87%)	2025 Individual Market Silver Plan (87%) Option 1
Medical Deductible	$675	**$475**
Rx Deductible	$50	$50
Coinsurance	40%	40%
Out-of-pocket Maximum	$2,925	**$2,725**
Primary Care	$20	$20
Specialist Care	$45	$45
Urgent Care	$35	$35
Emergency Room	$150 (after ded.)	$150 (after ded.)
Inpatient Hospital	$100 per day (after ded., $400 max. per admission)	$100 per day (after ded., $400 max. per admission)
Outpatient Hospital	$60@ASC/$100 otherwise (after ded.)	$60@ASC/$100 otherwise (after ded.)
Advanced Radiology (CT/PET Scan, MRI)	$60	$60
Non-Advanced Radiology (X-ray, Diagnostic)	$30 (after ded.)	$30 (after ded.)
Laboratory Services	$10	$10
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	$20	$20
Chiropractic Care (20 visit calendar maximum)	$35	$35
All Other Medical	40%	40%
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	$10 / $25 / $40 / 20% (non-preferred brand and spec. after ded., $60 max per spec. script)	$10 / $25 / $40 / 20% (non-preferred brand and spec. after ded., $60 max per spec. script)
2024 AVC Results	**87.0%-87.4%**	**NA**
2025 Draft AVC Approximate Change	**86.2%-87.2%**	**87.0%-88.0%**

CSR OON MOOP aligns with standard (70%) plan at $18,200.

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Summary of 2025 Silver 94% CSR Plan AV Options

Benefit Category	2024 Individual Market Silver Plan (94%)	2025 Individual Market Silver Plan (94%) Option 1
Medical Deductible	$0	$0
Rx Deductible	$0	$0
Coinsurance	40%	40%
Out-of-pocket Maximum	$1,050	**$1,150**
Primary Care	$10	$10
Specialist Care	$30	$30
Urgent Care	$25	$25
Emergency Room	$50	$50
Inpatient Hospital	$75 ($300 max. per admission)	$75 ($300 max. per admission)
Outpatient Hospital	$45@ASC/$75 otherwise	$45@ASC/$75 otherwise
Advanced Radiology (CT/PET Scan, MRI)	$50	$50
Non-Advanced Radiology (X-ray, Diagnostic)	$25	$25
Laboratory Services	$10	$10
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	$20	$20
Chiropractic Care (20 visit calendar maximum)	$30	$30
All Other Medical	40%	40%
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	$5 / $10 / $30 / 20% ($60 max per spec. script)	$5 / $10 / $30 / 20% ($60 max per spec. script)
2024 AVC Results	**94.8%-95.0%**	**NA**
2025 Draft AVC Approximate Change	94.6%-95.1%	**94.3%-94.9%**

CSR OON MOOP aligns with standard (70%) plan at $18,200.

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Summary of 2025 Bronze Non-HSA Plan AV Options

Benefit Category	2024/2025 Bronze Non-HSA Plan	2025 Bronze Non-HSA Plan Option 1	2025 Bronze Non-HSA Plan Option 2
Combined Medical & Rx Deductible	$6,550 (INN)/$13,100 (OON)	$6,550 (INN)/$13,100 (OON)	$6,400 (INN)
Coinsurance	40%	40%	40%
Out-of-pocket Maximum	$9,100 (INN) /$18,200 (OON)	$9,100 (INN) /$18,200 (OON)	$8,000 (INN)
Primary Care	$50	$40	$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	$20	$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% / 50% (all but generic after ded., $500 max per spec. script)	$15 / $50 / 50% / 50% (all but generic and preferred brand after ded., $500 max per spec. script)	$20 / 50% / 50% / 50% (all but generic after ded., $500 max per spec. script)
2024 AVC Results	**64.8%-65.0%**	**NA**	**NA**
2025 Draft AVC Approximate Change	62.5%-62.8%	63.9%-64.3%	64.4%-64.8%

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Summary of 2025 Bronze HSA Plan AV Options

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

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

Benefit Category	2024/2025 Bronze HSA Plan
Combined Medical & Rx Deductible	$6,500 (INN)/ $13,000 (OON)
Coinsurance	20%
Out-of-pocket Maximum	**$7,225 (INN) /$14,450 (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.)
Diabetic Supplies	*20% (after ded.)
All Other Medical	20% (after ded.)
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	*20% / 25% / 30% / 30% (all after ded., $500 max per spec. script)
2024 AVC Results	**64.8%-64.9%**
2025 Draft AVC Approximate Change	63.8%-64.0%

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)

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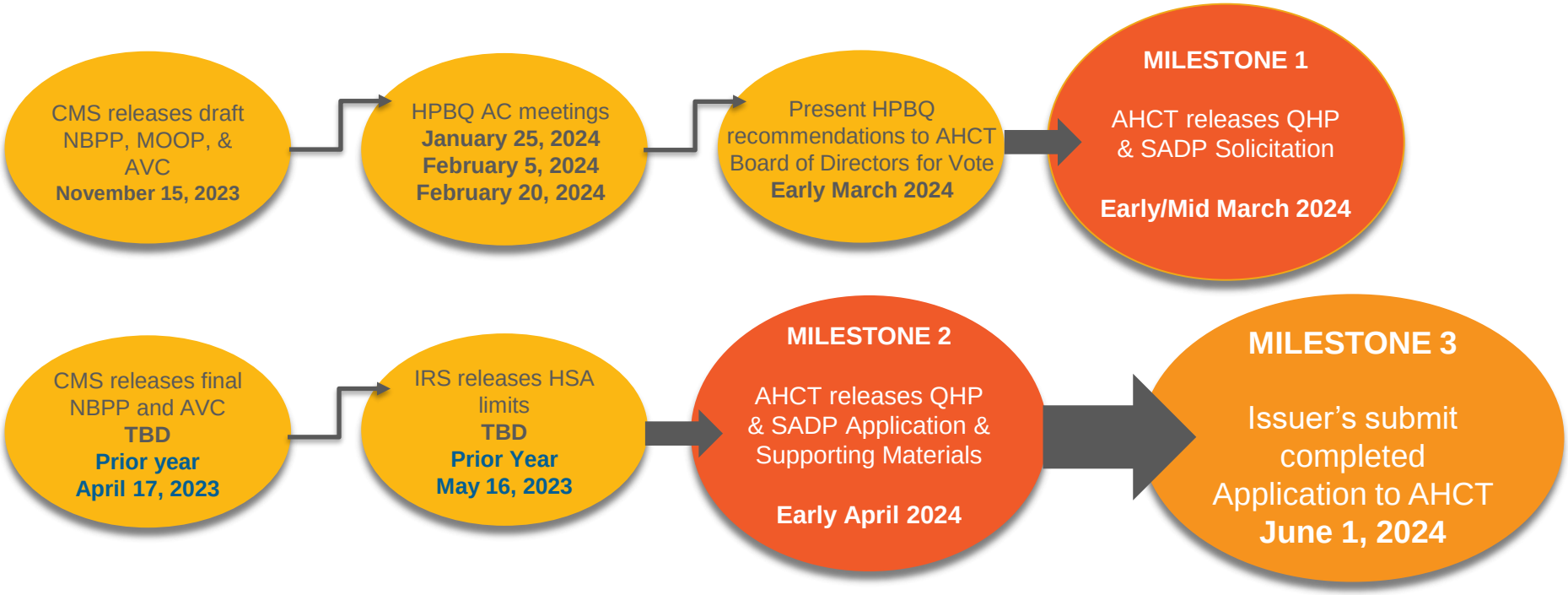
Thank You

Timeline and Key Milestones

Plan Year 2025



Notice of Benefit & Payment Parameters (NBPP)
Actuarial Value Calculator (AVC)
Maximum Out-Of-Pocket (MOOP)

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Next Steps

Next Scheduled Meeting
February 20, 2024

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Reference Materials

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Reference Materials

HPBQ AC Meeting Date	Exhibit Title	Exhibit Number
1/25/2024	AHCT 2024 Standardized Plans (QHP & SADP)	1.0 - 8.0
1/25/2024	2024 Actuarial Values (AV)	9.0
1/25/2024	2024 Individual Rates – QHP & SADP	10.0 - 11.0
1/25/2024	Average Marketplace Premiums - Bronze, Silver & Gold	12.0 - 14.0
1/25/2024	ARPA - Contribution Rates	15.0
1/25/2024	Population Estimates - Connecticut Counties	16.0
1/25/2024	State Regulation: Imaging Services, PT & OT, Diabetic Coverage, Home Health Care, Breast & Ovarian Screenings	17.0 - 21.0
1/25/2024	Internal Revenue Code: Health Savings Accounts (HSA) Definition	22.0
1/25/2024	CMS Coverage Map	23.0
2/5/2024	2024 Permitted Plans - On-Exchange QHP	24.0
2/5/2024	2024 On & Off Exchange Landscape	25.0
2/5/2024	2024 Plan Mix - On Exchange SADP	26.0

2024 Standardized Plan Design - QHP

Exhibit 1.0

2024 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	$9,100	$18,200
Out-of-Pocket Maximum: Family	$18,200	$36,400
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, Diagnotic)	$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

2024 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

Green shading represents change from 2023 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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2024 Standardized Plan Design - QHP

Exhibit 2.0

2024 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	$7,225	$14,450
Out-of-Pocket Maximum: Family	$14,450	$28,900
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

2024 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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2024 Standardized Plan Design - QHP

Exhibit 3.0

2024 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

2024 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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2024 Standardized Plan Design - QHP

Exhibit 4.0

2024 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	$7,475	$18,200
Out-of-Pocket Maximum: Family	$14,950	$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

2024 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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2024 Standardized Plan Design - QHP

Exhibit 5.0

2024 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	$2,925	$18,200
Out-of-Pocket Maximum: Family	$5,850	$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

2024 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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2024 Standardized Plan Design - QHP

Exhibit 6.0

2024 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	$1,050	$18,200
Out-of-Pocket Maximum: Family	$2,100	$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

2024 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

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2024 Standardized Plan Design - QHP

Exhibit 7.0

2024 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	$7,375	$14,750
Out-of-Pocket Maximum: Family	$14,750	$29,500
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

2024 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

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2024 Standardized Plan Design - SADP

Exhibit 8.0

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 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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2024 Actuarial Value (AV)

‘On- Exchange’ Plans by Market

Market	New Plan	Carrier	Plan Marketing Name				AV
Ind		CBI	Choice Catastrophic POS with Dental				60.3%
Ind		Anthem	Catastrophic HMO Pathway Enhanced				62.2%
Ind		CBI	Choice Bronze Alternative POS with Dental				62.7%
Ind		Anthem	Bronze PPO Standard Pathway				64.6%
Ind		Anthem	Bronze HMO Pathway Enhanced with Added Dental and Vision Benefits				64.8%
Ind		Anthem	Bronze PPO Standard Pathway for HSA				64.8%
Ind		Anthem	Bronze PPO Pathway				64.8%
Ind	X	Anthem	Bronze PPO Pathway with Added Dental and Vision Benefits				64.8%
Ind		CBI	Choice Bronze Standard POS HSA				64.9%
Ind	X	CICI	Value Bronze Standard POS HSA				64.9%
Ind	X	CICI	Value Bronze Standard POS				65.0%
Ind		CBI	Choice Bronze Standard POS				65.0%
Ind		Anthem	Silver PPO Standard Pathway	71.3%	73.4%	87.4%	95.0%
Ind		CBI	Choice Silver Standard POS	71.8%	74.0%	87.0%	94.8%
Ind	X	CICI	Value Silver Standard POS	71.8%	74.0%	87.0%	94.8%
Ind		Anthem	Gold HMO Pathway Enhanced with Added Dental and Vision Benefits				78.0%
Ind		Anthem	Gold PPO Pathway with Added Dental and Vision Benefits				78.0%
Ind		CBI	Choice Gold Alternative POS				78.2%
Ind	X	Anthem	Gold PPO Pathway				78.7%
Ind		Anthem	Gold PPO Standard Pathway				81.3%
Ind	X	CICI	Value Gold Standard POS				82.0%
Ind		CBI	Choice Gold Standard POS				82.0%
SG		Anthem	Bronze Pathway CT PPO				61.6%
SG		Anthem	Bronze Pathway CT PPO w/HSA				64.2%
SG		Anthem	Silver Pathway CT PPO				71.4%
SG		Anthem	Silver Pathway CT PPO w/HSA				71.5%
SG		Anthem	Gold Pathway CT PPO				81.5%

Exhibit 9.0

AV data is collected from PBT & URRT data submitted during the certification process.

22 Plans were offered in the Individual Market and 5 in Small Group Market.

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Exhibit 10.0

2024 Individual QHP Rates

CID Approved Rates – Age 21

			Fairfield County		Hartford County		Litchfield County		Middlesex County		New Haven County		New London County		Tolland County		Windham County	
Carrier	Exch	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	262.42	1	224.23	1	242.45	3	242.28	1	242.28	1	242.45	3	242.45	3	242.45	3
Anthem	On	Catastrophic HMO Pathway Enhanced	274.81	2	229.84	2	239.83	1	252.32	2	252.32	2	229.84	1	219.85	1	219.85	1
Anthem	Off	HMO Catastrophic Pathway Enhanced 9450/0%	274.81	2	229.84	2	239.83	1	252.32	2	252.32	2	229.84	1	219.85	1	219.85	1
Anthem	Off	Bronze HMO Pathway Enhanced 8500/50%	473.77	4	396.25	4	413.48	4	435.01	4	435.01	4	396.25	4	379.02	4	379.02	4
CBI	On	Choice Bronze Standard POS HSA	482.21	5	412.03	7	445.51	10	445.20	5	445.20	5	445.51	11	445.51	14	445.51	14
CBI	On	Choice Bronze Alternative POS with Dental	484.25	6	413.77	8	447.39	11	447.08	6	447.08	6	447.39	12	447.39	16	447.39	16
Anthem	On	Bronze HMO Pathway Enhanced with Added Dental and Vision Benefits	489.52	7	409.41	5	427.22	5	449.47	7	449.47	7	409.41	5	391.61	5	391.61	5
Anthem	On	Bronze PPO Standard Pathway for HSA	491.80	8	411.32	6	429.21	6	451.56	8	451.56	8	411.32	6	393.44	6	393.44	6
Anthem	Off	Bronze HMO Pathway Enhanced 6200/12400/40% for HSA	498.26	9	416.72	9	434.84	7	457.49	9	457.49	9	416.72	7	398.61	7	398.61	7
CBI	On	Choice Bronze Standard POS	499.26	10	426.59	12	461.26	14	460.94	11	460.94	11	461.26	16	461.26	19	461.26	19
Anthem	On	Bronze PPO Pathway	500.86	11	418.90	10	437.12	8	459.88	10	459.88	10	418.90	8	400.69	8	400.69	8
Anthem	On	Bronze PPO Pathway with Added Dental and Vision Benefits	505.42	12	422.72	11	441.10	9	464.07	12	464.07	12	422.72	9	404.34	9	404.34	9
CICI	On	Value Bronze Standard POS HSA	521.62	13	460.95	17	508.43	23	510.32	18	467.79	13	461.57	17	522.81	25	513.94	25
Anthem	On	Bronze PPO Standard Pathway	525.95	14	439.88	13	459.01	13	482.91	13	482.91	14	439.88	10	420.76	10	420.76	10
CCI	Off	Passage SOLO HMO Copay/Coins. $7,500 ded	529.41	15	450.30	15	448.45	12	493.49	14	493.49	16	451.75	14	451.75	17	451.75	17
Anthem	On	Gold PPO Pathway	537.62	16	449.64	14	469.19	15	493.63	15	493.63	17	449.64	13	430.09	11	430.09	11
CICI	On	Value Bronze Standard POS	540.07	17	477.25	21	526.40	26	528.37	23	484.34	15	477.89	20	541.30	26	532.12	26
Anthem	On	Gold HMO Pathway Enhanced with Added Dental and Vision Benefits	541.63	18	453.00	16	472.70	16	497.32	16	497.32	18	453.00	15	433.31	12	433.31	12
CBI	On	Choice Silver Standard POS	554.82	19	474.06	20	512.59	25	512.23	19	512.23	20	512.59	26	512.59	24	512.59	24
Anthem	On	Silver PPO Standard Pathway	555.59	20	464.67	18	484.88	19	510.13	17	510.13	19	464.67	18	444.47	13	444.47	13
Anthem	On	Gold PPO Pathway with Added Dental and Vision Benefits	559.22	21	467.71	19	488.05	20	513.47	20	513.47	21	467.71	19	447.38	15	447.38	15
CCI	Off	Choice SOLO HMO HSA $6,500 ded.	564.29	22	479.98	23	478.00	17	526.01	22	526.01	23	481.52	22	481.52	21	481.52	21
CCI	Off	Choice SOLO POS HSA Coins. $6,000 ded.	571.18	23	485.83	24	483.83	18	532.43	24	532.43	25	487.39	23	487.39	22	487.39	22
Anthem	Off	Silver HMO Pathways Enhanced 5100/30%	572.69	24	478.97	22	499.80	22	525.83	21	525.83	22	478.97	21	458.15	18	458.15	18
CCI	Off	Choice SOLO HMO Copay/Coins. $8,000 ded.	582.34	25	495.33	26	493.29	21	542.83	26	542.83	27	496.91	25	496.91	23	496.91	23
Anthem	Off	Gold HMO Pathway Enhanced 2000/20%	585.77	26	489.92	25	511.22	24	537.84	25	537.84	26	489.92	24	468.62	20	468.62	20
CICI	On	Value Silver Standard POS	591.27	27	522.49	27	576.31	27	578.46	27	530.26	24	523.20	27	592.62	27	582.57	27
CICI	Off	Choice SOLO POS Coins. $4,000 ded.	636.41	28	562.39	28	620.31	28	622.63	28	570.74	28	563.15	28	637.86	29	627.05	28
CICI	Off	Choice SOLO POS Copay/Coins. $5,500 30% ded.	656.10	29	579.79	29	639.50	30	641.89	30	588.40	29	580.57	29	657.60	30	646.44	30
CICI	Off	Choice SOLO POS HSA Coins. $3,500 ded.	659.18	30	582.50	30	642.50	31	644.90	31	591.15	30	583.29	30	660.68	31	649.47	31
CICI	Off	Choice SOLO POS Copay/Coins. $6,000 ded.	671.20	31	593.12	32	654.22	32	656.66	32	601.93	31	593.93	31	672.73	32	661.32	32
CBI	On	Choice Gold Alternative POS	684.77	32	585.10	31	632.65	29	632.21	29	632.21	32	632.65	32	632.65	28	632.65	29
CBI	On	Choice Gold Standard POS	753.74	33	644.04	33	696.38	33	695.89	33	695.89	33	696.38	33	696.38	33	696.38	33
CICI	On	Value Gold Standard POS	787.34	34	695.76	34	767.42	34	770.28	34	706.09	34	696.70	34	789.13	34	775.75	34
Anthem	On	Gold PPO Standard Pathway	1,069.21	35	894.25	35	933.13	35	981.73	35	981.73	35	894.25	35	855.37	35	855.37	35

Standard Plans are highlighted in Blue Font

Exhibit sorted in rank order by Fairfield County rates

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Exhibit 11.0

2024 Individual SADP Rates

Age 25 and under	Individual Rate (All Counties)	Rank
Anthem Dental Family Preventive	28.87	2
Anthem Family Dental Value	28.87	2
Anthem Dental Family	28.87	2
Anthem Dental Family Enhanced	32.73	5
ConnectiCare Basic Dental Plan	24.17	1
ConnectiCare Standard Dental Plan	69.31	6

Age 26 and over	Individual Rate (All Counties)	Rank
Anthem Dental Family Preventive	20.62	1
Anthem Family Dental Value	25.97	3
Anthem Dental Family	38.76	4
Anthem Dental Family Enhanced	62.34	5
ConnectiCare Basic Dental Plan	24.17	2
ConnectiCare Standard Dental Plan	69.31	6

BOLD FONT: "Standard Plans"

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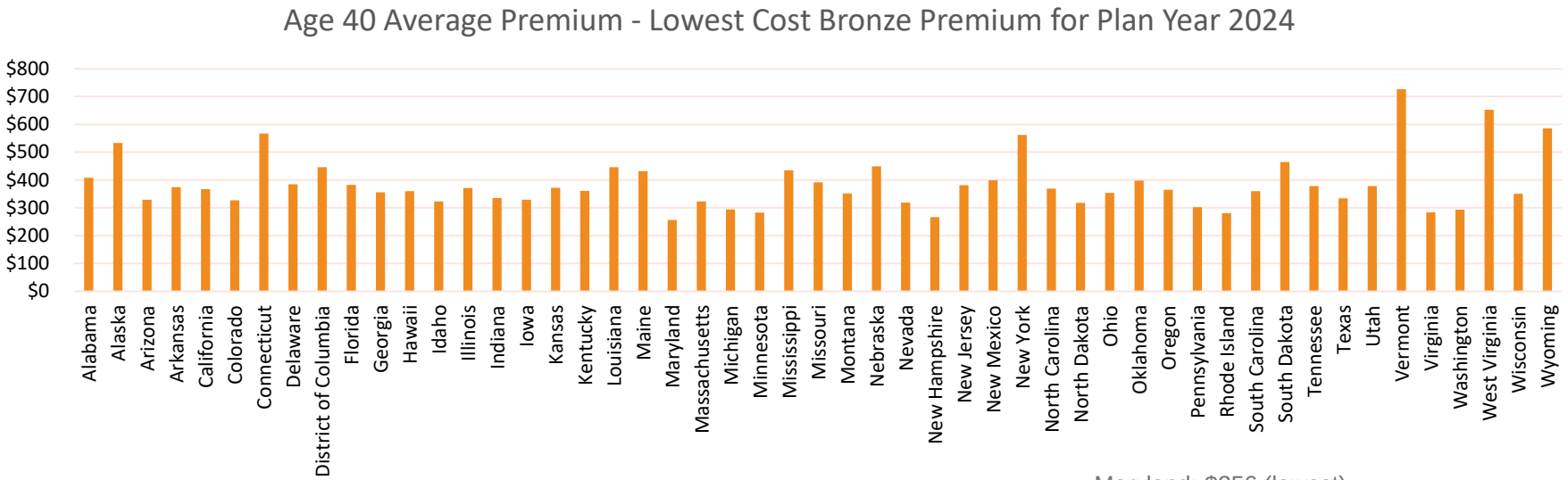
Exhibit 12.0

Average Marketplace Premiums



Maryland: $256 (lowest)

Connecticut: $567 (48th)

Vermont: $726 (highest)

US: $364

- 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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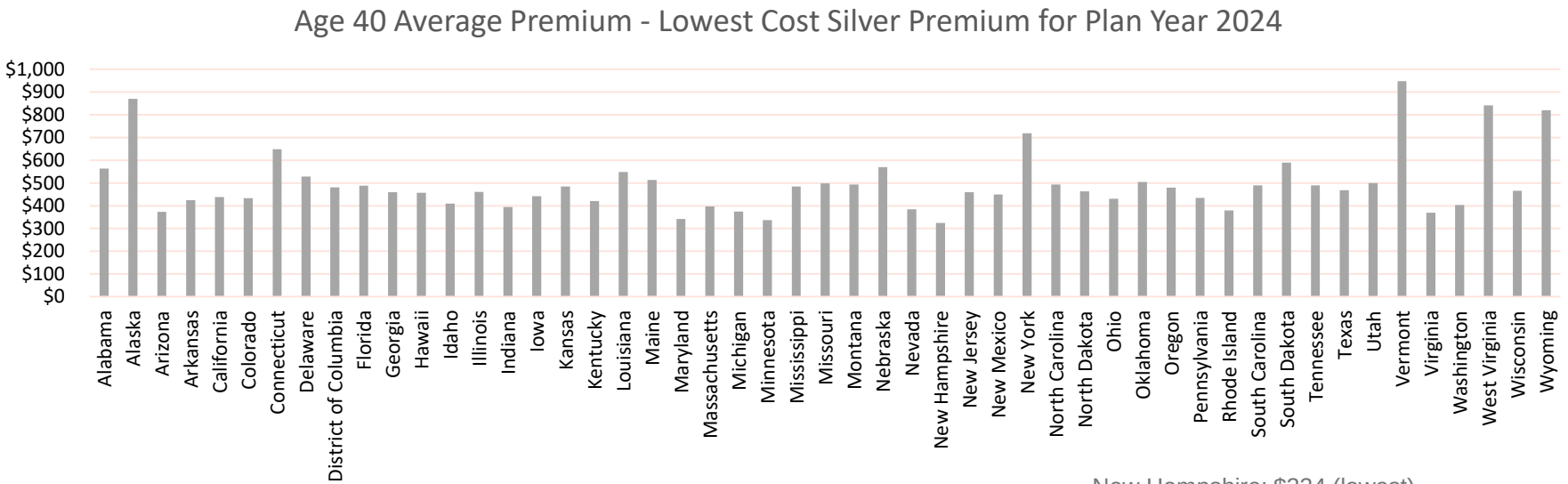
Exhibit 13.0

Average Marketplace Premiums



New Hampshire: $324 (lowest)

Connecticut: $648 (46th)

Vermont: $948 (highest)

US: $468

- 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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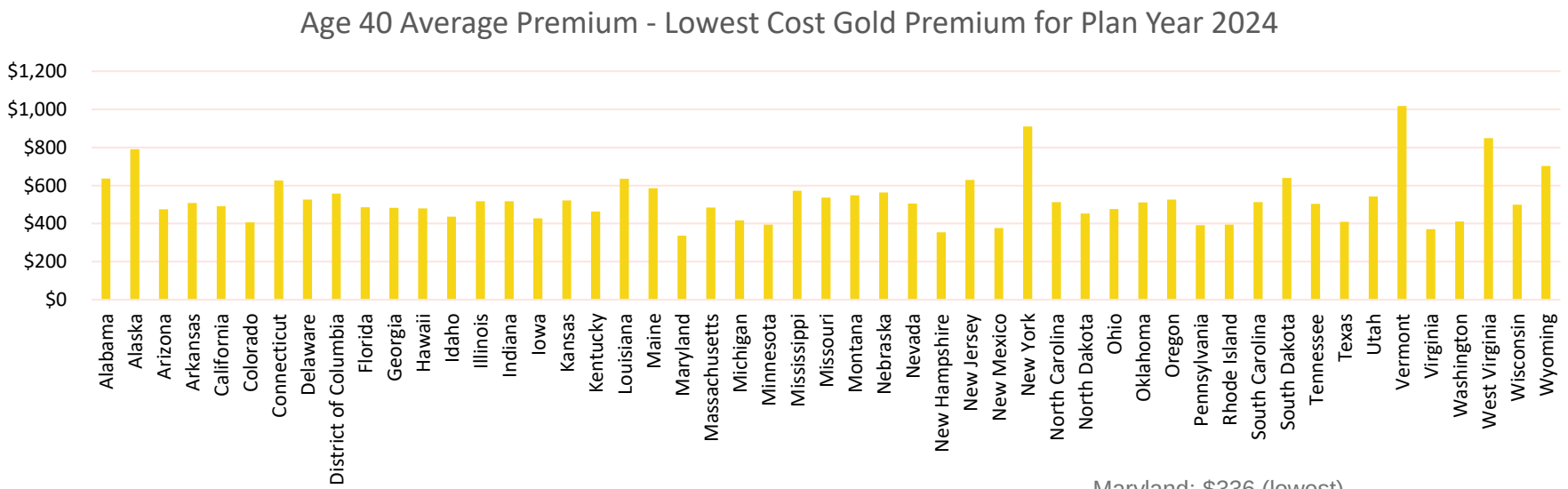
Exhibit 14.0

Average Marketplace Premiums



Maryland: $336 (lowest)

Connecticut: $627 (42nd)

Vermont: $1,018 (highest)

US: $488

- 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 15.0

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 16.0

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 17.0

Cost Sharing Maximums

State Regulation: 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 18.0

Cost Sharing Maximums

State Regulation: In-Network Physical Therapy and Occupational Therapy

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 19.0

Cost Sharing Maximums

State Regulation: Diabetic Coverage - State of Connecticut Public Act No. 20-4

Connecticut General Statute (CGS)

- 38a-492d (individual health insurance policy)
- 38a-518d (group health insurance policy)

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. These provisions apply to a high deductible health plan to the maximum extent permitted by federal law.

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.

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Exhibit 20.0

Cost Sharing Maximums

State Regulation: 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 21.0

Expansion of Coverage

State Regulation: Breast and Ovarian Cancer Screening Expansion of Coverage

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.

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Exhibit 22.0

United States Code (USC)

Title 26 Internal Revenue Code

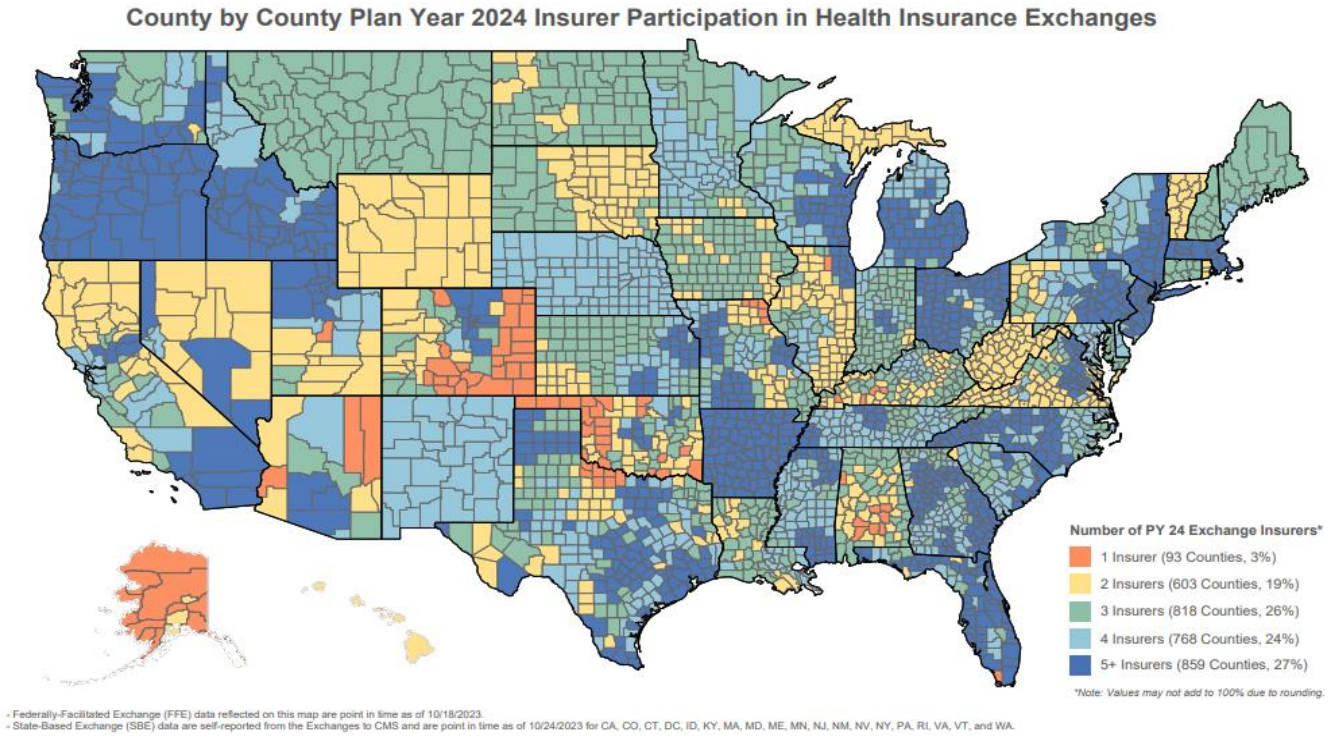
26 USC §223(c)(2): Health Savings Accounts (HSA)

Definition: High Deductible Health Plan (HDHP)

- Shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for preventive care.
- 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).
- 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.
- Coverage outside of plan network is not taken into account.

CMS Coverage Map

Exhibit 23.0



Released by CMS
10/26/2023

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

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Exhibit 24.0

2024 Permitted Plans

‘On-Exchange’ Qualified Health Plans (QHPs)

Metal Level	Individual	
	Standardized	*Non-Standard*
	Required	*Optional*
Catastrophic	*N/A*	*1*
Bronze	*2*	*3*
Silver	*1*	*0*
Gold	*1*	*3*
Platinum	*N/A*	*2*
Total	*4*	*Up to 9*

Small Group	
*Required**	*Optional*
N/A	N/A
2	*2*
2	*4*
1	*5*
N/A	*4*
5	*Up to 15*

* No requirement for "standardized" plans in Small Group.

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

**Actuarial Values for a plan is just the average amount a consumer might pay during the year. A consumer could pay more or less depending on plan selection and which types of services are utilized throughout the year..

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2024 ‘On & Off Exchange’ Landscape

Qualified Health Plan (QHP)

Individual Market

Metal Level								Product Type			
Carrier	Exchange Status	Catastrophic	Bronze	Silver	Gold	Platinum	Total	HMO	POS	EPO	PPO
Anthem	Off	1	2	1	1		5	5			
Anthem	On	1	5	1	4		11	3			8
CBI	On	1	3	1	2		7		7		
CICI	On		2	1	1		4		4		
CICI	Off			4			4		4		
CCI	Off		3	1			4	3	1		
Total		3	15	9	8	0	35	11	16	0	8

Small Group

Metal Level								Product Type			
Carrier	Exchange Status	Catastrophic	Bronze	Silver	Gold	Platinum	Total	HMO	POS	EPO	PPO
Anthem	Off	N/A	1	5	6	1	13				13
Anthem	On	N/A	2	2	1		5				5
Aetna	Off	N/A		1			1			1	
Cigna	Off	N/A	5	8	7	1	21				21
OHI	Off	N/A	3	9	13	4	29				29
OHP	Off	N/A	5	30	19	4	58	58			
United	Off	N/A	3	11	15	3	32		13	19	
Total		0	19	66	61	13	159	58	13	20	68

Information obtained from CID website: [Health Insurance Rates for 2024 (state.ct.us)]

62% of plans filed in the Individual Market to be offered through AHCT

Anthem is the only carrier offering Small Group products on the exchange.

Exhibit 25.0

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Exhibit 26.0

2024 Plan Mix

'On-Exchange' Stand-Alone Dental Plans (SADP)

Market	*Permitted Number of Plans per Carrier*		Submitted Plans		
	Standardized (Required)	*Non-Standard (Optional)*	Anthem	CICI	Total
Individual	*1*	*3*	**4**	**2**	**6**
Small Group	*1*	*3*	**0**	**0**	**0**

All Stand-Alone Dental Plans are PPO based, offering in and out of network coverage.

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