Access Health CT

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

February 13, 2025

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Agenda

- **Call to Order**
- **Public Comment**
- **Vote: Meeting Minutes (January 29, 2025)**
- **Wakely Consulting:**
  - 2026 Qualified Health Plan - Standard Plan Design
    - Review Plan Alternatives
    - Potential Vote
- **Next Steps**

Public Comment

Vote

Review and Approval of Minutes
HPBQ AC Meeting
January 29, 2025

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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.

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2026 Individual Market Standard Plan Designs

February 13, 2025

PRESENTED BY:

Julie Andrews, FSA, MAAA
Julie.andrews@wakely.com

2026 Plan Design Overview

2026 Plan Design Options	Plans Under Review
*The plans **have been** reviewed for Mental Health Parity compliance and **have been** reviewed by Carriers* *(except for 87% CSR Options)*	• Gold (Note: Change not required) • Silver (Standard) • Silver (73% CSR) • Silver (87% CSR) – Still researching passing plan design • Silver (94% CSR) • Bronze non-HSA

2026 Approved Plan Designs	• Bronze HSA

***Federal Poverty Level*

2026 Gold Plan AV Options

Benefit Category	2025 Individual Market Gold Plan	Option 4 2026 Individual Market Gold Plan	Option 5 2026 Individual Market Gold Plan
Medical Deductible	$1,200 (INN)/$3,000 (OON)	**$1,250 (INN)**/$3,000 (OON)	$1,200 (INN)/$3,000 (OON)
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)	**$8,000 (INN**)/$14,750 (OON)	$7,375 (INN)/$14,750 (OON)
Primary Care	$20	**$25**	$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	$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 **/ $45 / $60** / 20% (spec. after ded., $100 max per spec. script)	**$10** / $35 / $60 / 20% (spec. after ded., $100 max per spec. script)
2025 AVC Results	79.6%-80.5%	NA	NA
2026 AVC Results	81.4%-81.5%	80.5%-80.7%	80.5%-80.7%

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2026 Silver Plan AV Options

Benefit Category	2025 Individual Market Silver Plan	Option 4 2026 Individual Market Silver Plan	Option 5 2026 Individual Market Silver Plan
Medical Deductible	$5,000 (INN)/ $10,000 (OON)	$5,000 (INN)/ $10,000 (OON)	$5,000 (INN)/ $10,000 (OON)
Rx Deductible	$250 (INN)/ $500 (OON)	$250 (INN)/ $500 (OON)	$250 (INN)/ $500 (OON)
Coinsurance	40%	40%	40%
Out-of-pocket Maximum	$9,100 (INN)/ $18,200 (OON)	**$9,400 (INN)/** $18,200 (OON)	$9,100 (INN)/ $18,200 (OON)
Primary Care	$40	**$45**	$40
Specialist Care	$60	$60	$60
Urgent Care	$75	$75	$75
Emergency Room	$450 (after ded.)	$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)	$500 per day (after ded., $2,000 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	$75	$75
Non-Advanced Radiology (X-ray, Diagnostic)	$40 (after ded.)	$40 (after ded.)	$40 (after ded.)
Laboratory Services	$25	$25	$25
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	$30	$30	$30
Chiropractic Care (20 visit calendar maximum)	$50	$50	$50
All Other Medical	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 **/ $50 / $75** / 20% (all but generic after ded., $200 max per spec. script)	**$15 / $50 / $75** / 20% (all but generic after ded., $200 max per spec. script)
2025 AVC Results	70.3%-70.7%	NA	NA
2026 AVC Results	**71.7%-72.01%**	71.2%-71.6%	71.1%-71.4%

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2026 Silver 73% CSR Plan AV Options

Benefit Category	2025 Individual Market Silver Plan (73%)	Option 4 2026 Individual Market Silver Plan (73%)	Option 5 2026 Individual Market Silver Plan (73%)
Medical Deductible	$5,000	$5,000	**$5,850**
Rx Deductible	$250	$250	$250
Coinsurance	40%	40%	40%
Out-of-pocket Maximum	$7,350	**$7,675**	**$7,675**
Primary Care	$40	**$45**	$40
Specialist Care	$60	$60	$60
Urgent Care	$75	$75	$75
Emergency Room	$450 (after ded.)	$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)	$500 per day (after ded., $2,000 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	$75	$75
Non-Advanced Radiology (X-ray, Diagnostic)	$40 (after ded.)	$40 (after ded.)	$40 (after ded.)
Laboratory Services	$25	$25	$25
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	$30	$30	$30
Chiropractic Care (20 visit calendar maximum)	$50	$50	$50
All Other Medical	40%	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 / $50 / $75** / 20% (all but generic after ded., $100 max per spec. script)	**$15 / $50 / $75** / 20% (all but generic after ded., **$200** max per spec. script)
2025 AVC Results	73.0%-73.3%	NA	NA
2026 AVC Results	**74.3%-74.6%**	73.7%-73.98%	73.3%-73.5%

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2026 Silver 87% CSR Plan AV Options (to be Reviewed)

Benefit Category	2025 Individual Market Silver Plan (87%)	2026 Option 3 Individual Market Silver Plan (87%)
Medical Deductible	$475	$500
Rx Deductible	$50	$50
Coinsurance	40%	40%
Out-of-pocket Maximum	$2,725	$3,000
Primary Care	$20	$25
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)
2025 AVC Results	**87.0%-88.0%**	**NA**
2026 AVC Results	**87.7%-88.7%**	**TBD**

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

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2026 Silver 94% CSR Plan AV Options

Benefit Category	2025 Individual Market Silver Plan (94%)	2026 Option 2 Individual Market Silver Plan (94%)
Medical Deductible	$0	$0
Rx Deductible	$0	$0
Coinsurance	40%	40%
Out-of-pocket Maximum	$1,150	$1,350
Primary Care	$10	$15
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)
2025 AVC Results	**94.3%-94.9%**	**NA**
2026 AVC Results	**94.6%-95.3%**	**94.1%-94.8%**

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

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2026 Bronze Non-HSA Plan AV Options

Benefit Category	2025 Bronze Non-HSA Plan	Option 1 2026 Bronze Non-HSA Plan	Option 2 2026 Bronze Non-HSA Plan	Option 3 2026 Bronze Non-HSA Plan
Combined Medical & Rx Deductible	$6,550 (INN)/$13,100 (OON)	$6,550 (INN)/$13,100 (OON)	**$8,000 (INN)**/$13,100 (OON)	**$7,000 (INN)**/$13,100 (OON)
Coinsurance	40%	40%	40%	40%
Out-of-pocket Maximum	$9,100 (INN) /$18,200 (OON)	$9,100 (INN) /$18,200 (OON)	**$10,000 (INN)** /$18,200 (OON)	**$10,000 (INN)** /$18,200 (OON)
Primary Care	$40	**$50**	$40	**$50**
Specialist Care	$70 (after ded.)	$70 (after ded.)	$70 (after ded.)	$70 (after ded.)
Urgent Care	$75	$75	$75	$75
Emergency Room	$450 (after ded.)	$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)	$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.)	$300@ASC/$500 otherwise (after ded.)
Advanced Radiology (CT/PET Scan, MRI)	$75 (after ded.)	$75 (after ded.)	$75 (after ded.)	$75 (after ded.)
Non-Advanced Radiology (X-ray, Diagnostic)	$40 (after ded.)	$40 (after ded.)	$40 (after ded.)	$40 (after ded.)
Laboratory Services	$20	**$30**	$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.)	$30 (after ded.)
Chiropractic Care (20 visit calendar maximum)	$50 (after ded.)	$50 (after ded.)	$50 (after ded.)	$50 (after ded.)
All Other Medical	40% (after ded.)	40% (after ded.)	40% (after ded.)	40% (after ded.)
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	$15 / $50 / 50% / 50% (all but generic and preferred brand after ded., $500 max per spec. script)	**$25 / $60** / 50% / 50% (all but generic and preferred brand after ded., $500 max per spec. script)	$15 / $50 / 50% / 50% (all but generic and preferred brand after ded., $500 max per spec. script)	$15 / $50 / 50% / 50% (all but generic and preferred brand after ded., $500 max per spec. script)
2025 AVC Results	63.9%-64.3%	NA	NA	NA
2026 AVC Results	**65.3%-65.6%**	63.7%-64.%	63.8%-64.1%	63.8%-64.1%

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2026 Bronze HSA Plan AV Option

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	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)
2025 AVC Results	63.8%-64.0%
2026 AVC Results	64.96%-64.97%

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*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)

Potential Vote

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Reference Materials

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Reference Materials

HPBQ AC Meeting Date	Exhibit Title	Exhibit Number
1/15/2025	Summary of Plan Year 2025 Changes	1.0
1/15/2025	AHCT 2025 Standardized Plans (QHP & SADP)	2.0 - 2.4
1/15/2025	2025 Actuarial Values (AV)	3.0
1/15/2025	2025 Individual Rates – QHP & SADP	4.0 - 4.1
1/15/2025	Average Marketplace Premiums - Bronze, Silver & Gold	5.0 - 5.2
1/15/2025	ARPA - Contribution Rates	6.0
1/15/2025	State Regulation: Imaging Services, PT & OT, Diabetic Coverage, Home Health Care, Breast & Ovarian Screenings	7.0 - 7.4
1/15/2025	Internal Revenue Code: Health Savings Accounts (HSA) Definition	8.0
1/15/2025	CMS Coverage Map	9.0
1/29/2025	2026 Plan Mix - On Exchange SADP	10.0
1/29/2025	CMS Annual Limitation on Cost Sharing	11.0
1/29/2025	2025 Permitted Plans	12.0
1/29/2025	2025 On and Off Exchange Landscapes	13.0
1/29/2025	Certfification Timeline	14.0
2/13/2025	Plan Changes - 5 Year Historical Look Back	15.0 -15.12

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Exhibit 1.0

Summary of QHP Plan Changes

Plan Year 2025

Qualified Health Plans

Metal Level	Medical Deductible	Out-Of-Pocket Maximum	Primary Care	Pharmacy	Laboratory Services
Gold	$1,300 → **$1,200**				$10 after ded → **$10 no ded**
Silver (70%)					$20 → **$25**
Silver (73% CSR)	$4,750 → **$5,000**	$7,475 → **$7,350**			$20 → **$25**
Silver (87% CSR)	$675 → **$475**	$2,925 → **$2,725**			
Silver (94% CSR)		$1,050 → **$1,150**			
Bronze			$50 → **$40**	Generics - $20 → **$15** Pref Brand - 50% after ded → **$50 no ded**	
Bronze HSA					

HSA = Health Savings Account
CSR = Cost Sharing Reduction

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2025 Standardized Plan Design - QHP

Exhibit 2.0

Access Health CT Plan Year 2025 Standard Plans for the Individual Market

All Metal Levels & In-Network Benefits Only

	Bronze (Non-HSA)	Bronze HSA	Silver - 70%	Silver - 73%	Silver - 87%	Silver - 94%	Gold
Provider Office Visits							
Preventive Visit (Adult/Pediatric)	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$40 copayment per visit, deductible does not apply	20% coinsurance per visit after INET deductible	$40 copayment per visit, deductible does not apply	$40 copayment per visit, deductible does not apply	$20 copayment per visit, deductible does not apply	$10 copayment per visit, deductible does not apply	$20 copayment per visit, deductible does not apply
Specialist Office Visits	$70 copayment per visit after INET deductible	20% coinsurance per visit after INET deductible	$60 copayment per visit, deductible does not apply	$60 copayment per visit, deductible does not apply	$45 copayment per visit, deductible does not apply	$30 copayment per visit, deductible does not apply	$40 copayment per visit, deductible does not apply
Mental Health and Substance Use Disorder Office Visit	$40 copayment per visit, deductible does not apply	20% coinsurance per visit after INET deductible	$40 copayment per visit, deductible does not apply	$40 copayment per visit, deductible does not apply	$20 copayment per visit, deductible does not apply	$10 copayment per visit, deductible does not apply	$20 copayment per visit, deductible does not apply
Outpatient Diagnostic Services							
Advanced Radiology (CT/PET Scan, MRI)	$75 copayment per service after INET deductible up to a combined annual maximum of $375 for MRI and CT scans; $400 for PET scans	20% coinsurance per service after INET deductible	$75 copayment per service, deductible does not apply, up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans	$75 copayment per service, deductible does not apply, up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans	$60 copayment per service, deductible does not apply, up to a combined annual maximum of $360 for MRI and CAT scans; $400 for PET scans	$50 copayment per service, deductible does not apply, up to a combined annual maximum of $350 for MRI and CAT scans; $400 for PET scans	$65 copayment per service, deductible does not apply, up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans
Laboratory Services	$20 copayment per service, deductible does not apply	20% coinsurance per service after INET deductible	$25 copayment per service, deductible does not apply	$25 copayment per service, deductible does not apply	$10 copayment per service, deductible does not apply	$10 copayment per service, deductible does not apply	$10 copayment per service, deductible does not apply
Non-Advanced Radiology (X-ray, Diagnostic)	$40 copayment per service after INET deductible	20% coinsurance per service after INET deductible	$40 copayment per service after INET deductible	$40 copayment per service after INET deductible	$30 copayment per service after INET deductible	$25 copayment per service, deductible does not apply	$40 copayment per service after INET deductible
Mammography Ultrasound/MRI (no cost for screening and diagnostic if within Federal and/or State regulations)	$20 copayment per service after INET deductible	20% coinsurance per service after INET deductible	$20 copayment per service, deductible does not apply	$20 copayment per service, deductible does not apply	$20 copayment per service, deductible does not apply	$20 copayment per service, deductible does not apply	$20 copayment per service, deductible does not apply

Green shading represents change from 2024 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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2025 Standardized Plan Design - QHP

Exhibit 2.1

	Bronze (Non-HSA)	Bronze HSA	Silver - 70%	Silver - 73%	Silver - 87%	Silver - 94%	Gold
Prescription Drugs - Retail Pharmacy (30 day supply per prescription)							
Tier 1	$15 copayment per prescription, deductible does not apply	20% coinsurance per prescription after INET deductible	$10 copayment per prescription, deductible does not apply	$10 copayment per prescription, deductible does not apply	$10 copayment per prescription, deductible does not apply	$5 copayment per prescription, deductible does not apply	$5 copayment per prescription, deductible does not apply
Tier 2	$50 copayment per prescription, deductible does not apply	25% coinsurance per prescription after INET deductible	$45 copayment per prescription after INET prescription drug deductible	$45 copayment per prescription after INET prescription drug deductible	$25 copayment per prescription, deductible does not apply	$10 copayment per prescription, deductible does not apply	$35 copayment per prescription, deductible does not apply
Tier 3	50% coinsurance per prescription after INET deductible	30% coinsurance per prescription after INET deductible	$70 copayment per prescription after INET prescription drug deductible	$70 copayment per prescription after INET prescription drug deductible	$40 copayment per prescription after INET prescription drug deductible	$30 copayment per prescription, deductible does not apply	$60 copayment per prescription, deductible does not apply
Tier 4	50% coinsurance up to a maximum of $500 per prescription after INET deductible	30% coinsurance up to a maximum of $500 per prescription after INET deductible	20% coinsurance up to a maximum of $200 per prescription after INET prescription drug deductible	20% coinsurance up to a maximum of $100 per prescription after INET prescription drug deductible	20% coinsurance up to a maximum of $60 per prescription after INET prescription drug deductible	20% coinsurance up to a maximum of $60 per prescription, deductible does not apply	20% coinsurance up to a maximum of $100 per prescription after INET prescription drug deductible
Outpatient Rehabilitative and Habilitative Services							
Speech Therapy	$30 copayment per visit after INET deductible	20% coinsurance per visit after INET deductible	$30 copayment per visit, deductible does not apply	$30 copayment per visit, deductible does not apply	$20 copayment per visit, deductible does not apply	$20 copayment per visit, deductible does not apply	$20 copayment per visit, deductible does not apply
Physical and Occupational Therapy	$30 copayment per visit after INET deductible	20% coinsurance per visit after INET deductible	$30 copayment per visit, deductible does not apply	$30 copayment per visit, deductible does not apply	$20 copayment per visit, deductible does not apply	$20 copayment per visit, deductible does not apply	$20 copayment per visit, deductible does not apply

Green shading represents change from 2024 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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2025 Standardized Plan Design - QHP

Exhibit 2.2

	Bronze (Non-HSA)	Bronze HSA	Silver - 70%	Silver - 73%	Silver - 87%	Silver - 94%	Gold
Other Services							
Chiropractic Services (up to 20 visits per calendar year)	$50 copayment per visit after INET deductible	20% coinsurance per visit after INET deductible	$50 copayment per visit, deductible does not apply	$50 copayment per visit, deductible does not apply	$35 copayment per visit, deductible does not apply	$30 copayment per visit, deductible does not apply	$40 copayment per visit, deductible does not apply
Diabetic Equipment and Supplies	40% coinsurance per equipment/supply after INET deductible	20% coinsurance per equipment/supply after INET deductible	40% coinsurance per equipment/supply, deductible does not apply	40% coinsurance per equipment/supply, deductible does not apply	40% coinsurance per equipment/supply, deductible does not apply	40% coinsurance per equipment/supply, deductible does not apply	30% coinsurance per equipment/supply, deductible does not apply
Durable Medical Equipment (DME)	40% coinsurance per DME item after INET deductible	20% coinsurance per DME item after INET deductible	40% coinsurance per DME item, deductible does not apply	40% coinsurance per DME item, deductible does not apply	40% coinsurance per DME item, deductible does not apply	40% coinsurance per DME item, deductible does not apply	30% coinsurance per DME item, deductible does not apply
Home Health Care Services (up to 100 visits per calendar year)	25% coinsurance per visit after separate $50 deductible	20% coinsurance per visit after INET deductible	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply
Outpatient Services (in a hospital or ambulatory facility)	$500 copayment per visit after INET deductible at an Outpatient Hospital Facility $300 copayment per visit after INET deductible at an Ambulatory Surgery Center	20% coinsurance per visit after INET deductible	$500 copayment per visit after INET deductible at an Outpatient Hospital Facility $300 copayment per visit after INET deductible at an Ambulatory Surgery Center	$500 copayment per visit after INET deductible at an Outpatient Hospital Facility $300 copayment per visit after INET deductible at an Ambulatory Surgery Center	$100 copayment per visit after INET deductible at an Outpatient Hospital Facility $60 copayment per visit after INET deductible at an Ambulatory Surgery Center	$75 copayment per visit at an Outpatient Hospital Facility, deductible does not apply $45 copayment per visit at an Ambulatory Surgery Center, deductible does not apply	$500 copayment per visit after INET deductible at an Outpatient Hospital Facility $300 copayment per visit after INET deductible at an Ambulatory Surgery Center
Inpatient Hospital Services							
Inpatient Hospital Services (Including mental health, substance use disorder, maternity, hospice, skilled nursing facility*, and all IP settings) *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	20% coinsurance per admission after INET deductible	$500 copayment per day to a maximum of $2,000 per admission after INET deductible	$500 copayment per day to a maximum of $2,000 per admission after INET deductible	$100 copayment per day to a maximum of $400 per admission after INET deductible	$75 copayment per day to a maximum of $300 per admission, deductible does not apply	$500 copayment per day to a maximum of $1,000 per admission after INET deductible
Emergency and Urgent Care							
Ambulance Services	$0 copayment per service after INET deductible	20% coinsurance per service after INET deductible	$0 copayment per service, deductible does not apply	$0 copayment per service, deductible does not apply	$0 copayment per service, deductible does not apply	$0 copayment per service, deductible does not apply	$0 copayment per service, deductible does not apply
Emergency Room	$450 copayment per visit after INET deductible	20% coinsurance per visit after INET deductible	$450 copayment per visit after INET deductible	$450 copayment per visit after INET deductible	$150 copayment per visit after INET deductible	$50 copayment per visit, deductible does not apply	$400 copayment per visit, deductible does not apply
Urgent Care Center	$75 copayment per visit, deductible does not apply	20% coinsurance per visit after INET deductible	$75 copayment per visit, deductible does not apply	$75 copayment per visit, deductible does not apply	$35 copayment per visit, deductible does not apply	$25 copayment per visit, deductible does not apply	$50 copayment per visit, deductible does not apply

Green shading represents change from 2024 Plan Year

Blue italic font signifies field included in Actuarial Value Calculator

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2025 Standardized Plan Design - QHP

Exhibit 2.3

	Bronze (Non-HSA)	Bronze HSA	Silver - 70%	Silver - 73%	Silver - 87%	Silver - 94%	Gold
Pediatric Dental Care (covered persons up to age 26)							
Diagnostic & Preventive	$0 copayment, deductible does not apply	$0, deductible does not apply	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply
Basic Services	45% coinsurance per visit after INET deductible	40% coinsurance per visit after INET deductible	40% coinsurance per visit, deductible does not apply	40% coinsurance per visit, deductible does not apply	40% coinsurance per visit, deductible does not apply	40% coinsurance per visit, deductible does not apply	20% coinsurance per visit, deductible does not apply
Major Services	50% coinsurance per visit after INET deductible	50% coinsurance per visit after INET deductible	50% coinsurance per visit, deductible does not apply	50% coinsurance per visit, deductible does not apply	50% coinsurance per visit, deductible does not apply	50% coinsurance per visit, deductible does not apply	40% coinsurance per visit, deductible does not apply
Orthodontia Services (medically necessary only)	50% coinsurance per visit after INET deductible	50% coinsurance per visit after INET deductible	50% coinsurance per visit, deductible does not apply	50% coinsurance per visit, deductible does not apply	50% coinsurance per visit, deductible does not apply	50% coinsurance per visit, deductible does not apply	50% coinsurance per visit, deductible does not apply
Pediatric Vision Care (covered persons up to age 26)							
Prescription Eye Glasses (one pair of frames & lenses or contact lens per calendar year)	Lenses: $0; Collection frame: $0; 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.	Lenses: $0 after INET deductible; Collection frame: $0 after INET deductible; 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.	Lenses: $0; Collection frame: $0; 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.	Lenses: $0; Collection frame: $0; 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.	Lenses: $0; Collection frame: $0; 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.	Lenses: $0; Collection frame: $0; 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.	Lenses: $0; Collection frame: $0; 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.
Routine Eye Exam by Specialist (one exam per calendar year)	$70 copayment per visit after INET deductible	20% coinsurance per visit after INET deductible	$60 copayment per visit, deductible does not apply	$60 copayment per visit, deductible does not apply	$45 copayment per visit, deductible does not apply	$30 copayment per visit, deductible does not apply	$40 copayment per visit, deductible does not apply
Plan Deductibles and Maximum Out of Pocket							
Plan Deductible: Individual	$6,550	$6,500	$5,000	$5,000	$475	$0	$1,200
Plan Deductible: Family	$13,100	$13,000	$10,000	$10,000	$950	$0	$2,400
Separate Prescription Drug Deductible: Individual	N/A	N/A	$250	$250	$50	$0	$50
Separate Prescription Drug Deductible: Family	N/A	N/A	$500	$500	$100	$0	$100
Out-of-Pocket Maximum: Individual	$9,100	$7,225	$9,100	$7,350	$2,725	$1,150	$7,375
Out-of-Pocket Maximum: Family	$18,200	$14,450	$18,200	$14,700	$5,450	$2,300	$14,750

Out-of-Network (OON) Coinsurance	50%	50%	40%	40%	40%	40%	30%

Green shading represents change from 2024 Plan Year

Blue italic font signifies field included in Actuarial Value Calculator

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2025 Standardized Plan Design - SADP

Exhibit 2.4

Plan Overview		In-Network Member Pays
Deductible		
Per covered person		$60
Per Family (up to 3 family members)		$180 max
PEDIATRIC BENEFITS - For covered dependents under age 26		
Out-of-Pocket Maximum - *Out-of-Pocket Maximums do not apply to adult benefits.*		
For one child		$350
Two or more children		$700
Diagnostic and Preventive Services	Limitations	
Oral Exams	Twice every 12 months	$0 copay. Deductible does not apply.
Periapical X-Ray		
Bitewing X-Ray Series	Once every 12 months	
Panoramic X-Ray or Complete Series	Once every 36 months	
Cleanings	Twice every 12 months	
Fluoride		
Sealants	Once per 36 months. Ages 5-14 on 1st and 2nd molars	
Basic Services	Limitations	
Fillings		20% coinsurance after deductible
Simple Extractions		
Major Services	Limitations	
Surgical Extractions		40% coinsurance after deductible
Endodontic Therapy (Root Canal Treatment)		
Periodontal Therapy		
Periodontal Scaling and Root Planing	Once per quadrant per 36 months	
Periodontal Maintenance	Twice every 12 months	
Crowns and Cast Restorations		
Prosthodontics (Complete and Partial Dentures; Fixed Bridgework)		
Other Services	Limitations	
Medically Necessary Orthodontic Services		50% coinsurance after deductible

ADULT BENEFITS – For covered persons aged 26 or above		
Plan Maximum – *Plan Maximums do not apply to pediatric benefits.*		
Plan Maximum per covered person – Combined for In-Network and Out-of-Network Services)		$2,000
Diagnostic and Preventive Services	Limitations	
Oral Exams	Twice every 12 months	$0 copay. Deductible does not apply.
Periapical X-Ray	Four every 12 months	
Bitewing X-Ray Series	Once every 12 months	
Panoramic X-Ray or Complete Series	Once every 36 months	
Cleanings	Twice every 12 months	
Fluoride	Not Covered	
Sealants	Not Covered	
Basic Services	Limitations	
Fillings		20% coinsurance after deductible
Simple Extractions		
Major Services	Limitations	
Surgical Extractions		40% coinsurance after deductible
Endodontic Therapy (Root Canal Treatment)		
Periodontal Scaling and Root Planing	Once per quadrant per 36 months	
Periodontal Maintenance	Twice every 12 months	
Periodontal Therapy		
Crowns and Cast Restorations		
Prosthodontics (Complete and Partial Dentures; Fixed Bridgework)		
Other Services	Limitations	
Medically Necessary Orthodontic Services		Not Covered. 100% member cost share
Waiting Periods – *Waiting periods do not apply to pediatric benefits.*		
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.		

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2025 Actuarial Value (AV)

‘On- Exchange’ Plans by Market

Market	New Plan	Carrier	Plan Marketing Name				AV
Ind		CBI	Choice Catastrophic POS with Dental				59.8%
Ind		Anthem	Catastrophic HMO Pathway Enhanced				60.9%
Ind		CBI	Choice Bronze Alternative POS with Dental				61.6%
Ind		Anthem	Bronze HMO Pathway Enhanced with Adult Dental and Vision Benefits				62.3%
Ind		Anthem	Bronze PPO Pathway with Adult Dental and Vision Benefits				62.3%
Ind		Anthem	Bronze PPO Standard Pathway HSA				63.9%
Ind		Anthem	Bronze PPO Standard Pathway				63.9%
Ind		CBI	Choice Bronze Standard POS HSA				64.0%
Ind		CICI	Value Bronze Standard POS HSA				64.0%
Ind		CBI	Choice Bronze Standard POS				64.3%
Ind		CICI	Value Bronze Standard POS				64.3%
Ind		Anthem	Bronze PPO Pathway HSA				64.5%
Ind		Anthem	Silver PPO Standard Pathway	70.3%	73.0%	88.0%	94.9%
Ind		CBI	Choice Silver Standard POS	70.7%	73.3%	87.0%	94.3%
Ind		CICI	Value Silver Standard POS	70.7%	73.3%	87.0%	94.3%
Ind		Anthem	Gold HMO Pathway Enhanced with Adult Dental and Vision Benefits				78.0%
Ind		Anthem	Gold PPO Pathway with Adult Dental and Vision Benefits				78.0%
Ind		CBI	Choice Gold Alternative POS				78.1%
Ind		Anthem	Gold PPO Pathway				78.8%
Ind		Anthem	Gold PPO Standard Pathway				80.3%
Ind		CBI	Choice Gold Standard POS				80.6%
Ind		CICI	Value Gold Standard POS				80.6%
SG		Anthem	Bronze Pathway CT PPO				60.9%
SG		Anthem	Bronze Pathway CT PPO w/HSA				62.7%
SG		Anthem	Silver Pathway CT PPO				69.1%
SG		Anthem	Silver Pathway CT PPO w/HSA				69.7%
SG		Anthem	Gold Pathway CT PPO				79.2%
SG	X	Anthem	Platinum Pathway CT PPO				88.9%

Exhibit 3.0

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

22 Plans were offered in the Individual Market and 6 in Small Group Market.

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Exhibit 4.0

2025 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	273.30	1	233.52	1	252.50	1	252.32	1	252.32	1	252.50	3	252.50	3	252.50	3
Anthem	On	Catastrophic HMO Pathway Enhanced	292.39	2	244.54	2	255.17	2	268.46	2	268.46	2	244.54	1	233.91	1	233.91	1
Anthem	Off	Anthem Catastrophic HMO Pathway Enhanced 9200/0%	292.39	2	244.54	2	255.17	2	268.46	2	268.46	2	244.54	1	233.91	1	233.91	1
Anthem	On	Bronze HMO Pathway Enhanced with Adult Dental and Vision Benefits	500.36	4	418.48	4	436.68	4	459.42	4	459.42	4	418.48	4	400.29	4	400.29	4
CBI	On	Choice Bronze Standard POS HSA	504.02	5	430.66	8	465.66	10	465.34	5	465.34	5	465.66	11	465.66	13	465.66	13
Anthem	Off	Anthem Bronze HMO Pathway Enhanced 8500/50%	507.24	6	424.24	5	442.69	5	465.74	6	465.74	6	424.24	5	405.79	5	405.79	5
Anthem	On	Bronze PPO Pathway HSA	508.62	7	425.39	6	443.89	6	467.01	7	467.01	7	425.39	6	406.90	6	406.90	6
CBI	On	Choice Bronze Alternative POS with Dental	509.60	8	435.43	10	470.82	12	470.49	9	470.49	9	470.82	13	470.82	14	470.82	14
Anthem	On	Bronze PPO Standard Pathway HSA	510.00	9	426.54	7	445.09	7	468.27	8	468.27	8	426.54	7	408.00	7	408.00	7
Anthem	On	Bronze PPO Pathway with Adult Dental and Vision Benefits	516.94	10	432.35	9	451.15	8	474.65	10	474.65	10	432.35	8	413.55	8	413.55	8
CBI	On	Choice Bronze Standard POS	532.32	11	454.84	13	491.80	14	491.46	12	491.46	12	491.80	15	491.80	16	491.80	16
Anthem	Off	Anthem Bronze HMO Pathway Enhanced 6000/12000/40% HSA	532.95	12	445.74	11	465.12	9	489.35	11	489.35	11	445.74	9	426.36	9	426.36	9
Anthem	On	Bronze PPO Standard Pathway	535.77	13	448.09	12	467.58	11	491.93	13	491.93	13	448.09	10	428.61	10	428.61	10
Anthem	Off	Anthem Bronze PPO Pathway 8000/0% HSA	558.32	14	466.96	14	487.26	13	512.64	14	512.64	14	466.96	12	446.65	11	446.65	11
Anthem	On	Silver PPO Standard Pathway	566.47	15	473.77	15	494.37	15	520.12	15	520.12	15	473.77	14	453.17	12	453.17	12
CICI	On	Value Bronze Standard POS HSA	580.91	16	513.34	18	566.21	26	568.33	19	520.96	16	514.04	17	582.23	27	572.36	27
CBI	On	Choice Silver Standard POS	582.19	17	497.46	16	537.88	20	537.51	16	537.51	17	537.88	24	537.88	24	537.88	24
Anthem	Off	Anthem Silver HMO Pathway Enhanced 4000/30%	606.12	18	506.94	17	528.98	18	556.53	17	556.53	19	506.94	16	484.90	15	484.90	15
CCI	Off	Choice SOLO HMO HSA $6,500 ded.	607.70	19	516.90	19	514.77	16	566.48	18	566.48	20	518.56	18	518.56	22	518.56	22
CICI	On	Value Bronze Standard POS	613.43	20	542.07	27	597.91	27	600.14	27	550.13	18	542.81	27	614.82	28	604.40	28
CCI	Off	Choice SOLO POS HSA Coins. $6,000 ded.	615.09	21	523.18	22	521.03	17	573.36	22	573.36	23	524.86	21	524.86	23	524.86	23
Anthem	On	Gold PPO Pathway	620.30	22	518.79	20	541.35	21	569.54	20	569.54	21	518.79	19	496.24	17	496.24	17
Anthem	On	Gold HMO Pathway Enhanced with Adult Dental and Vision Benefits	623.11	23	521.14	21	543.80	22	572.13	21	572.13	22	521.14	20	498.49	18	498.49	18
CCI	Off	Choice SOLO HMO Copay/Coins. $7,700 ded.	633.76	24	539.07	26	536.85	19	590.77	25	590.77	26	540.79	26	540.79	25	540.79	25
Anthem	Off	Anthem Silver PPO Pathway 4000/20% HSA	638.66	25	534.15	23	557.38	23	586.41	23	586.41	24	534.15	22	510.93	19	510.93	19
Anthem	Off	Anthem Gold HMO Pathway Enhanced 2000/10%	639.52	26	534.87	24	558.13	24	587.20	24	587.20	25	534.87	23	511.62	20	511.62	20
Anthem	On	Gold PPO Pathway with Adult Dental and Vision Benefits	643.77	27	538.42	25	561.83	25	591.10	26	591.10	27	538.42	25	515.01	21	515.01	21
CICI	On	Value Silver Standard POS	661.06	28	584.17	28	644.34	29	646.74	29	592.85	28	584.96	28	662.57	29	651.33	29
Anthem	Off	Anthem Gold PPO Pathway 2000/10%	700.81	29	586.13	29	611.62	28	643.47	28	643.47	29	586.13	29	560.65	26	560.65	26
CBI	On	Choice Gold Alternative POS	718.73	30	614.12	30	664.03	30	663.57	30	663.57	32	664.03	34	664.03	30	664.03	30
CICI	Off	Choice SOLO POS HSA Coins. $3,500 ded.	726.33	31	641.84	31	707.95	31	710.60	31	651.38	30	642.71	30	727.98	31	715.64	31
CICI	Off	Choice SOLO POS Coins. $4,000 ded.	728.47	32	643.74	32	710.04	32	712.69	32	653.30	31	644.61	31	730.13	32	717.75	32
CICI	Off	Choice SOLO POS Copay/Coins. $5,500 30% ded.	742.49	33	656.12	33	723.70	33	726.41	33	665.87	33	657.01	32	744.18	34	731.56	34
CICI	Off	Choice SOLO POS Copay/Coins. $6,000 ded.	745.53	34	658.81	34	726.67	34	729.38	34	668.60	34	659.71	33	747.23	35	734.56	35
CBI	On	Choice Gold Standard POS	790.45	35	675.40	35	730.29	35	729.78	35	729.78	35	730.29	35	730.29	33	730.29	33
CICI	On	Value Gold Standard POS	879.74	36	777.41	36	857.48	36	860.68	36	788.96	36	778.47	36	881.74	36	866.79	36
Anthem	On	Gold PPO Standard Pathway	1125.07	37	940.97	37	981.88	37	1033.02	37	1033.02	37	940.97	37	900.06	37	900.06	37

Standard Plans are highlighted in Blue Font

Exhibit sorted in rank order by Fairfield County rates

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Exhibit 4.1

2025 Individual SADP Rates

Age 25 and under	Individual Rate (All Counties)	Rank
Anthem Dental Family Preventive	31.76	2
Anthem Family Dental Value	31.76	2
Anthem Dental Family	31.76	2
Anthem Dental Family Enhanced	36.00	5
ConnectiCare Basic Dental Plan	24.82	1
ConnectiCare Standard Dental Plan	71.32	6

Age 26 and over	Individual Rate (All Counties)	Rank
Anthem Dental Family Preventive	18.97	1
Anthem Family Dental Value	24.80	2
Anthem Dental Family	34.88	4
Anthem Dental Family Enhanced	57.98	5
ConnectiCare Basic Dental Plan	24.82	3
ConnectiCare Standard Dental Plan	71.32	6

BOLD FONT: "Standard Plans"

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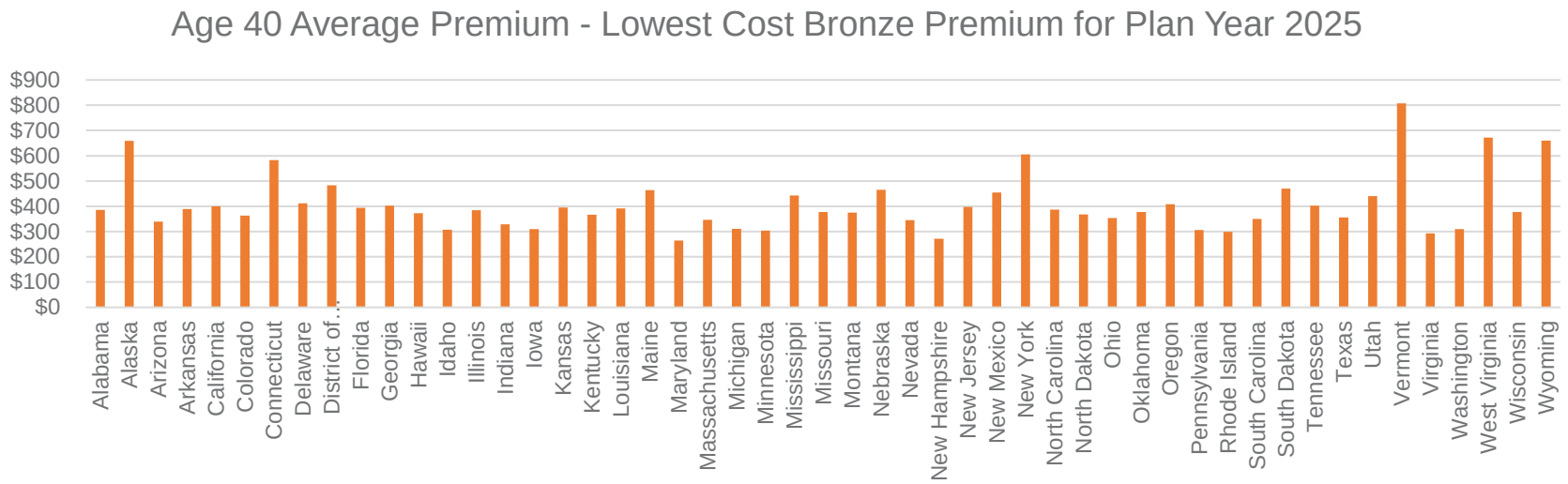
Exhibit 5.0

Average Marketplace Premiums



Maryland: $265 (lowest)

Connecticut: $583 (46th)

Wyoming: $660 (highest)

US: $381

- 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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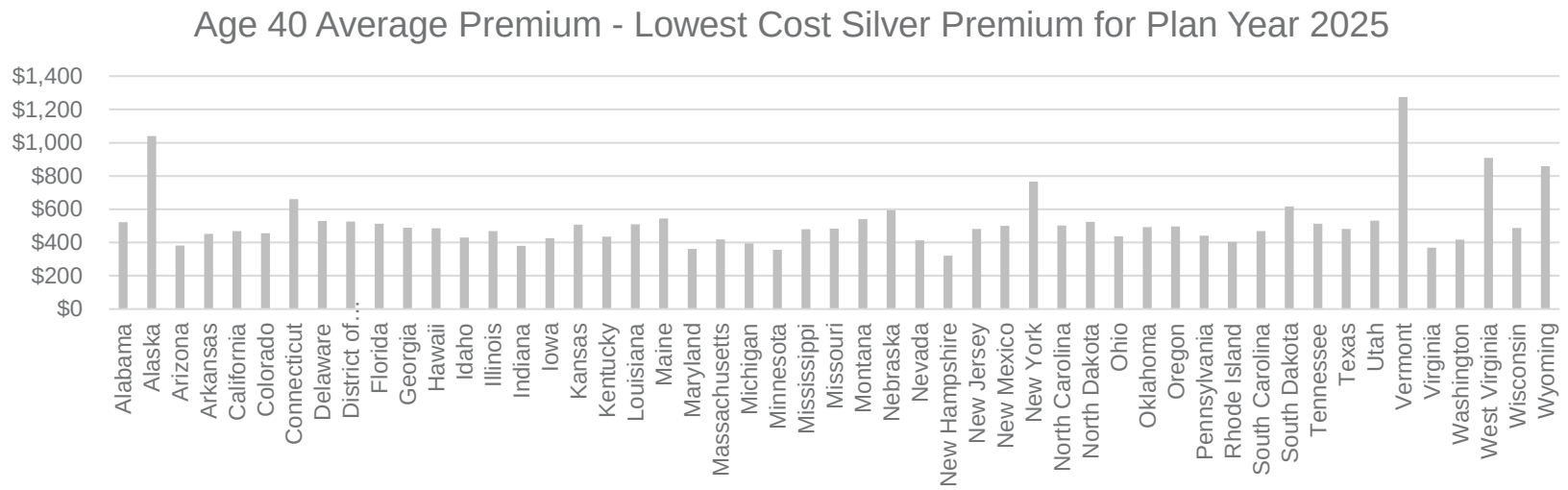
Exhibit 5.1

Average Marketplace Premiums



New Hampshire: $320 (lowest)

Connecticut: $660 (46th)

Vermont: $1275 (highest)

US: $486

- 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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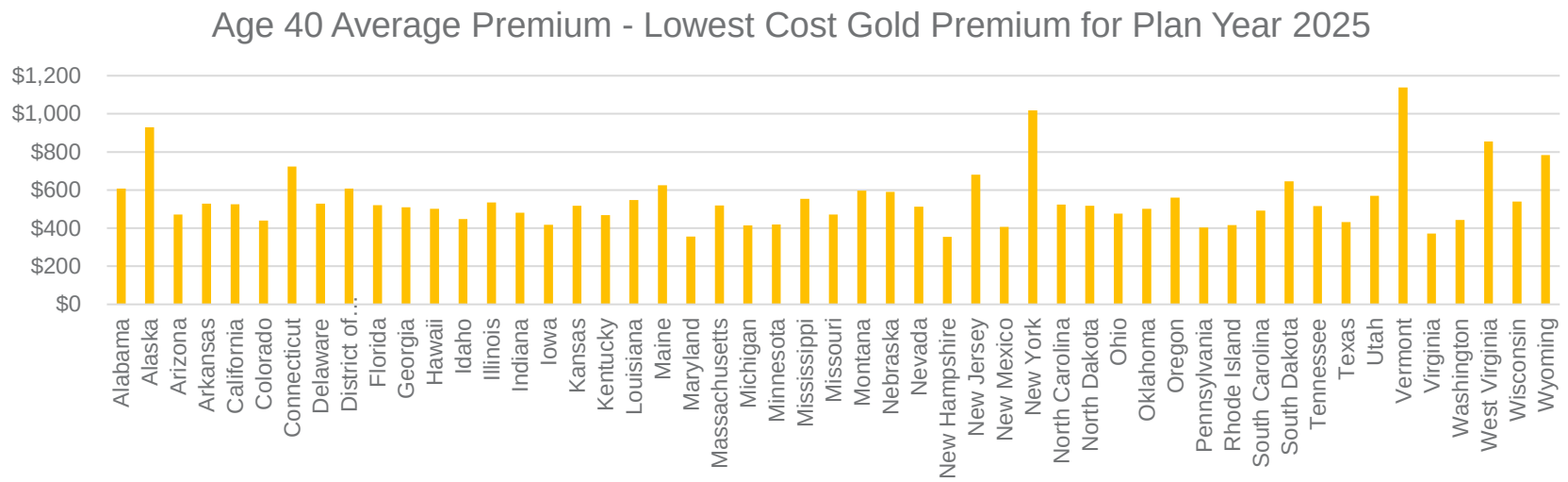
Exhibit 5.2

Average Marketplace Premiums



New Hampshire: $354 (lowest)

Connecticut: $723 (46th)

Vermont: $1,139 (highest)

US: $507

- 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 6.0

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 7.0

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 7.1

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 7.2

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 7.3

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 7.4

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 8.0

United States Code (USC)

Title 26 Internal Revenue Code

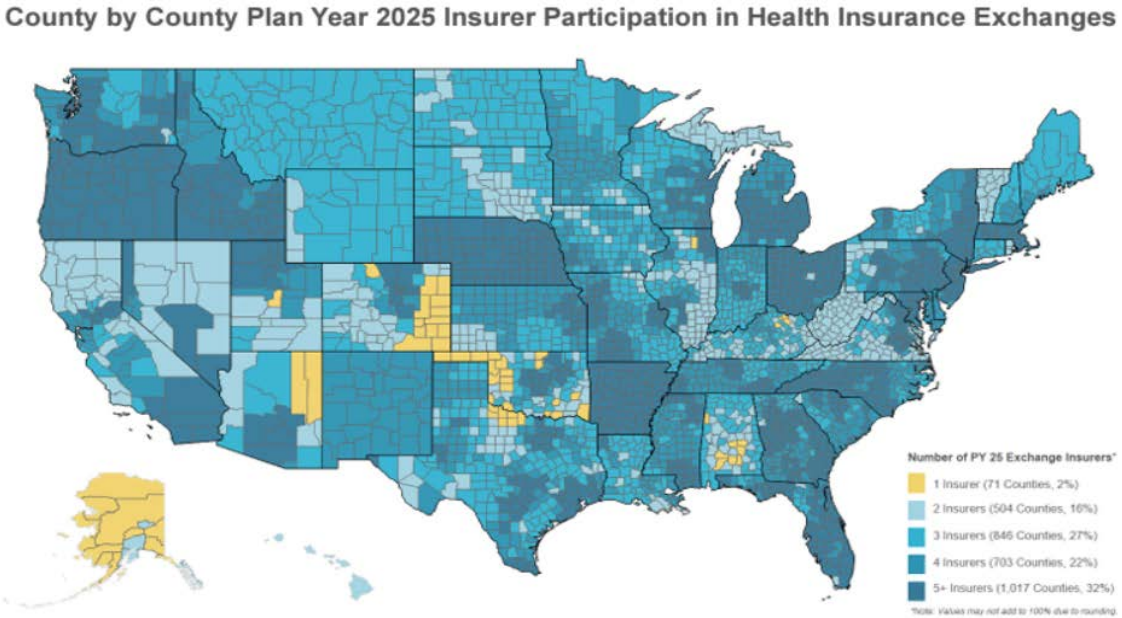
26 USC §223(c)(2): Health Savings Accounts (HSA)

Definition: High Deductible Health Plan (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 9.0



- Federally-Facilitated Exchange (FFE) data reflected on this map are point in time as of 08/18/2024.
- State-Based Exchange (SBE) data are self-reported from the Exchanges to CMS and are point in time as of 10/18/2024 for CA, CO, CT, DC, GA, ID, KY, MA, MD, ME, MN, NM, NV, NY, PA, RI, VA, VT, and WA.
- SBE finalized PY 24 data for NJ are point in time as of 11/03/2023 and will be updated with PY 25 data once it is made available.

Released by CMS 10/25/2024

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

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Exhibit 10.0

2026 Permitted Plans

'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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Exhibit 11.0

CMS Annual Limitation on Cost Sharing

Stand-Alone Dental Plans (SADP)

- **Plan Year 2025**
  - Amounts increased to $425 for one covered child and $850 for two or more covered children
  - HPBQ recommended amounts remain at $350/$700
  - No plan modifications implemented since Plan Year 2016
- **Plan Year 2026**
  - Amounts increased to $450 for one covered child and $900 for two or more covered children for in-network coverage

2025 SADP Rates

Individual Rate (All Counties)	Age 25 & Under	Age 26 & Over
Anthem Dental Family Preventive	31.76	18.97
Anthem Family Dental Value	31.76	24.80
Anthem Dental Family	31.76	34.88
Anthem Dental Family Enhanced	36.00	57.98
ConnectiCare Basic Dental Plan	24.82	24.82
ConnectiCare Standard Dental Plan	71.32	71.32

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Exhibit 12.0

2026 Permitted Plans

‘On-Exchange’ Qualified Health Plans (QHPs)

	Individual	
Metal Level	*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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2025 ‘On & Off Exchange’ Landscape

Qualified Health Plan (QHP)

Exhibit 13.0

Individual Market

Carrier	Exchange Status	Metal Level						Product Type			
		Catastrophic	Bronze	Silver	Gold	Platinum	Total	HMO	POS	EPO	PPO
Anthem	Off	1	3	2	2		8	5			3
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		2	1			3	2	1		
Total		3	15	10	9	0	37	10	16	0	11

Small Group

Carrier	Exchange Status	Metal Level						Product Type			
		Catastrophic	Bronze	Silver	Gold	Platinum	Total	HMO	POS	EPO	PPO
Anthem	Off	N/A	1	6	9	1	17				17
Anthem	On	N/A	2	2	1	1	6				6
OHI	Off	N/A	3	9	13	6	31				31
OHP	Off	N/A	12	36	52	24	124	124			
United	Off	N/A	3	11	12	4	30		13	17	
Total		0	21	64	87	36	208	124	13	17	54

Information obtained from CID website: Health Insurance Rates for 2025

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

Anthem continues to be the only carrier offering Small Group products on the exchange.

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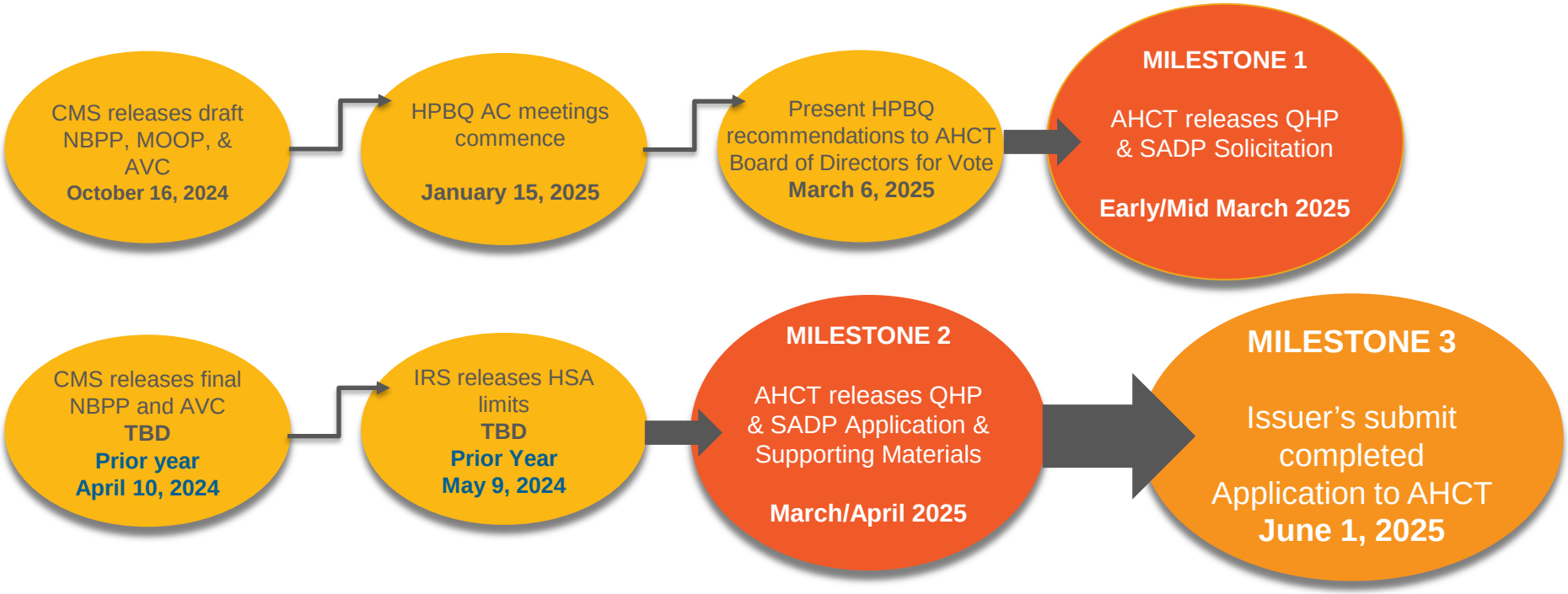
Exhibit 14.0

Certification Timeline

Plan Year 2026



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

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Exhibit 15.0

Standard Bronze Plan Plan Changes - 5 Year Historical Look Back	2021	2022	2023	2024	2025
Provider Office Visits					
Preventive Visit (Adult/Pediatric)	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$50 copayment per visit	$50 copayment per visit	$50 copayment per visit	$50 copayment per visit	$40 copayment per visit, deductible does not apply
Specialist Office Visits	$70 copayment per visit after INET deductible	$70 copayment per visit after INET deductible	$70 copayment per visit after INET deductible	$70 copayment per visit after INET deductible	$70 copayment per visit after INET deductible
Mental Health and Substance Use Disorder Office Visit	$40 copayment per visit, deductible does not apply	$40 copayment per visit, deductible does not apply	$40 copayment per visit, deductible does not apply	$40 copayment per visit, deductible does not apply	$40 copayment per visit, deductible does not apply
Outpatient Diagnostic Services					
Advanced Radiology (CT/PET Scan, MRI)	$75 copayment per service after INET deductible up to a combined annual maximum of $375 for MRI and CT scans; $400 for PET scans	$75 copayment per service after INET deductible up to a combined annual maximum of $375 for MRI and CT scans; $400 for PET scans	$75 copayment per service after INET deductible up to a combined annual maximum of $375 for MRI and CT scans; $400 for PET scans	$75 copayment per service after INET deductible up to a combined annual maximum of $375 for MRI and CT scans; $400 for PET scans	$75 copayment per service after INET deductible up to a combined annual maximum of $375 for MRI and CT scans; $400 for PET scans
Laboratory Services	$10 copayment per service after INET deductible	$20 copayment per service, deductible does not apply	$20 copayment per service, deductible does not apply	$20 copayment per service, deductible does not apply	$20 copayment per service, deductible does not apply
Non-Advanced Radiology (X-ray, Diagnostic)	$40 copayment per service after INET deductible	$40 copayment per service after INET deductible	$40 copayment per service after INET deductible	$40 copayment per service after INET deductible	$40 copayment per service after INET deductible
Mammography Ultrasound/MRI (no cost for screening and diagnostic if within Federal and/or State regulations)	$20 copayment per service after INET deductible	$20 copayment per service after INET deductible	$20 copayment per service after INET deductible	$20 copayment per service after INET deductible	$20 copayment per service after INET deductible
Prescription Drugs - Retail Pharmacy (30 day supply per prescription)					
Tier 1	$20 copayment per prescription	$20 copayment per prescription	$20 copayment per prescription	$20 copayment per prescription	$15 copayment per prescription, deductible does not apply
Tier 2	50% coinsurance per prescription after INET deductible	50% coinsurance per prescription after INET deductible	50% coinsurance per prescription after INET deductible	50% coinsurance per prescription after INET deductible	$50 copayment per prescription, deductible does not apply
Tier 3	50% coinsurance per prescription after INET deductible	50% coinsurance per prescription after INET deductible	50% coinsurance per prescription after INET deductible	50% coinsurance per prescription after INET deductible	50% coinsurance per prescription after INET deductible
Tier 4	50% coinsurance up to a maximum of $500 per prescription after INET deductible	50% coinsurance up to a maximum of $500 per prescription after INET deductible	50% coinsurance up to a maximum of $500 per prescription after INET deductible	50% coinsurance up to a maximum of $500 per prescription after INET deductible	50% coinsurance up to a maximum of $500 per prescription after INET deductible

BRONZE

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Exhibit 15.1

Standard Bronze Plan					
Plan Changes - 5 Year Historical Look Back					
	2021	2022	2023	2024	2025
Outpatient Rehabilitative and Habilitative Services					
Speech Therapy	$30 copayment per visit after INET deductible	$30 copayment per visit after INET deductible	$30 copayment per visit after INET deductible	$30 copayment per visit after INET deductible	$30 copayment per visit after INET deductible
Physical and Occupational Therapy	$30 copayment per visit after INET deductible	$30 copayment per visit after INET deductible	$30 copayment per visit after INET deductible	$30 copayment per visit after INET deductible	$30 copayment per visit after INET deductible
Other Services					
Chiropractic Services (up to 20 visits per calendar year)	$50 copayment per visit after INET deductible	$50 copayment per visit after INET deductible	$50 copayment per visit after INET deductible	$50 copayment per visit after INET deductible	$50 copayment per visit after INET deductible
Diabetic Equipment and Supplies	40% coinsurance per equipment/supply after INET deductible	40% coinsurance per equipment/supply after INET deductible	40% coinsurance per equipment/supply after INET deductible	40% coinsurance per equipment/supply after INET deductible	40% coinsurance per equipment/supply after INET deductible
Durable Medical Equipment (DME)	40% coinsurance per DME item after INET deductible	40% coinsurance per DME item after INET deductible	40% coinsurance per DME item after INET deductible	40% coinsurance per DME item after INET deductible	40% coinsurance per DME item after INET 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	25% coinsurance per visit after separate $50 deductible	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 per visit after INET deductible at an Outpatient Hospital Facility $300 copayment per visit after INET deductible at an Ambulatory Surgery Center	$500 copayment per visit after INET deductible at an Outpatient Hospital Facility $300 copayment per visit after INET deductible at an Ambulatory Surgery Center	$500 copayment per visit after INET deductible at an Outpatient Hospital Facility $300 copayment per visit after INET deductible at an Ambulatory Surgery Center	$500 copayment per visit after INET deductible at an Outpatient Hospital Facility $300 copayment per visit after INET deductible at an Ambulatory Surgery Center	$500 copayment per visit after INET deductible at an Outpatient Hospital Facility $300 copayment per visit after INET deductible at an Ambulatory Surgery Center
Inpatient Hospital Services					
Inpatient Hospital Services (Including mental health, substance use disorder, maternity, hospice, skilled nursing facility*, and all IP settings) *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	$500 copayment per day to a maximum of $1,000 per admission after INET deductible	$500 copayment per day to a maximum of $1,000 per admission after INET deductible	$500 copayment per day to a maximum of $1,000 per admission after INET deductible	$500 copayment per day to a maximum of $1,000 per admission after INET deductible
Emergency and Urgent Care					
Ambulance Services	$0 copayment per service after INET deductible	$0 copayment per service after INET deductible	$0 copayment per service after INET deductible	$0 copayment per service after INET deductible	$0 copayment per service after INET deductible
Emergency Room	$450 copayment per visit after INET deductible	$450 copayment per visit after INET deductible	$450 copayment per visit after INET deductible	$450 copayment per visit after INET deductible	$450 copayment per visit after INET deductible
Urgent Care Center	$75 copayment per visit, deductible does not apply	$75 copayment per visit, deductible does not apply	$75 copayment per visit, deductible does not apply	$75 copayment per visit, deductible does not apply	$75 copayment per visit, deductible does not apply

BRONZE

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Exhibit 15.2

Standard Bronze Plan					
Plan Changes - 5 Year Historical Look Back					
	2021	2022	2023	2024	2025
Pediatric Dental Care (covered persons up to age 26)					
Diagnostic & Preventive	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply
Basic Services	45% coinsurance per visit after INET deductible	45% coinsurance per visit after INET deductible	45% coinsurance per visit after INET deductible	45% coinsurance per visit after INET deductible	45% coinsurance per visit after INET deductible
Major Services	50% coinsurance per visit after INET deductible	50% coinsurance per visit after INET deductible	50% coinsurance per visit after INET deductible	50% coinsurance per visit after INET deductible	50% coinsurance per visit after INET deductible
Orthodontia Services (medically necessary only)	50% coinsurance per visit after INET deductible	50% coinsurance per visit after INET deductible	50% coinsurance per visit after INET deductible	50% coinsurance per visit after INET deductible	50% coinsurance per visit after INET deductible
Pediatric Vision Care (covered persons up to age 26)					
Prescription Eye Glasses (one pair of frames & lenses or contact lens per calendar year)	Lenses: $0; Collection frame: $0; 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.	Lenses: $0; Collection frame: $0; 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.	Lenses: $0; Collection frame: $0; 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.	Lenses: $0; Collection frame: $0; 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.	Lenses: $0; Collection frame: $0; 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.
Routine Eye Exam by Specialist (one exam per calendar year)	$70 copayment per visit after INET deductible	$70 copayment per visit after INET deductible	$70 copayment per visit after INET deductible	$70 copayment per visit after INET deductible	$70 copayment per visit after INET deductible
Plan Deductibles and Maximum Out of Pocket					
Plan Deductible: Individual	$6,550	$6,550	$6,550	$6,550	$6,550
Plan Deductible: Family	$13,100	$13,100	$13,100	$13,100	$13,100
Separate Prescription Drug Deductible: Individual	N/A	N/A	N/A	N/A	N/A
Separate Prescription Drug Deductible: Family	N/A	N/A	N/A	N/A	N/A
Out-of-Pocket Maximum: Individual	$8,550	$8,700	$8,800	$9,100	$9,100
Out-of-Pocket Maximum: Family	$17,100	$17,400	$17,600	$18,200	$18,200
Out-of-Network (OON) Coinsurance	50%	50%	50%	50%	50%

BRONZE

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Exhibit 15.3

Standard Bronze HSA Plan Plan Changes - 5 Year Historical Look Back	2021	2022	2023	2024	2025
Provider Office Visits					
Preventive Visit (Adult/Pediatric)	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible
Specialist Office Visits	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible
Mental Health and Substance Use Disorder Office Visit	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible
Outpatient Diagnostic Services					
Advanced Radiology (CT/PET Scan, MRI)	20% coinsurance per service after INET deductible	20% coinsurance per service after INET deductible	20% coinsurance per service after INET deductible	20% coinsurance per service after INET deductible	20% coinsurance per service after INET deductible
Laboratory Services	20% coinsurance per service after INET deductible	20% coinsurance per service after INET deductible	20% coinsurance per service after INET deductible	20% coinsurance per service after INET deductible	20% coinsurance per service after INET deductible
Non-Advanced Radiology (X-ray, Diagnostic)	20% coinsurance per service after INET deductible	20% coinsurance per service after INET deductible	20% coinsurance per service after INET deductible	20% coinsurance per service after INET deductible	20% coinsurance per service after INET deductible
Mammography Ultrasound/MRI (no cost for screening and diagnostic if within Federal and/or State regulations)	20% coinsurance per service after INET deductible	20% coinsurance per service after INET deductible	20% coinsurance per service after INET deductible	20% coinsurance per service after INET deductible	20% coinsurance per service after INET deductible
Prescription Drugs - Retail Pharmacy (30 day supply per prescription)					
Tier 1	20% coinsurance per prescription after INET deductible	20% coinsurance per prescription after INET deductible	20% coinsurance per prescription after INET deductible	20% coinsurance per prescription after INET deductible	20% coinsurance per prescription after INET deductible
Tier 2	25% coinsurance per prescription after INET deductible	25% coinsurance per prescription after INET deductible	25% coinsurance per prescription after INET deductible	25% coinsurance per prescription after INET deductible	25% coinsurance per prescription after INET deductible
Tier 3	30% coinsurance per prescription after INET deductible	30% coinsurance per prescription after INET deductible	30% coinsurance per prescription after INET deductible	30% coinsurance per prescription after INET deductible	30% coinsurance per prescription after INET deductible
Tier 4	30% coinsurance up to a maximum of $500 per prescription after INET deductible	30% coinsurance up to a maximum of $500 per prescription after INET deductible	30% coinsurance up to a maximum of $500 per prescription after INET deductible	30% coinsurance up to a maximum of $500 per prescription after INET deductible	30% coinsurance up to a maximum of $500 per prescription after INET deductible

BRONZE HSA

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Exhibit 15.4

Standard Bronze HSA Plan Plan Changes - 5 Year Historical Look Back	2021	2022	2023	2024	2025
Outpatient Rehabilitative and Habilitative Services					
Speech Therapy	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible
Physical and Occupational Therapy	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible
Other Services					
Chiropractic Services (up to 20 visits per calendar year)	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible
Diabetic Equipment and Supplies	20% coinsurance per equipment/supply after INET deductible	20% coinsurance per equipment/supply after INET deductible	20% coinsurance per equipment/supply after INET deductible	20% coinsurance per equipment/supply after INET deductible	20% coinsurance per equipment/supply after INET deductible
Durable Medical Equipment (DME)	20% coinsurance per DME item after INET deductible	20% coinsurance per DME item after INET deductible	20% coinsurance per DME item after INET deductible	20% coinsurance per DME item after INET deductible	20% coinsurance per DME item after INET deductible
Home Health Care Services (up to 100 visits per calendar year)	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible
Outpatient Services (in a hospital or ambulatory facility)	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible
Inpatient Hospital Services					
Inpatient Hospital Services (Including mental health, substance use disorder, maternity, hospice, skilled nursing facility*, and all IP settings) *skilled nursing facility stay is limited to 90 days per calendar year	20% coinsurance per admission after INET deductible	20% coinsurance per admission after INET deductible	20% coinsurance per admission after INET deductible	20% coinsurance per admission after INET deductible	20% coinsurance per admission after INET deductible
Emergency and Urgent Care					
Ambulance Services	20% coinsurance per service after INET deductible	20% coinsurance per service after INET deductible	20% coinsurance per service after INET deductible	20% coinsurance per service after INET deductible	20% coinsurance per service after INET deductible
Emergency Room	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible
Urgent Care Center	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible

BRONZE HSA

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Exhibit 15.5

BRONZE HSA

Standard Bronze HSA Plan					
	Plan Changes - 5 Year Historical Look Back				
	2021	2022	2023	2024	2025
Pediatric Dental Care (covered persons up to age 26)					
Diagnostic & Preventive	$0, deductible does not apply	$0, deductible does not apply	$0, deductible does not apply	$0, deductible does not apply	$0, deductible does not apply
Basic Services	40% coinsurance per visit after INET deductible	40% coinsurance per visit after INET deductible	40% coinsurance per visit after INET deductible	40% coinsurance per visit after INET deductible	40% coinsurance per visit after INET deductible
Major Services	50% coinsurance per visit after INET deductible	50% coinsurance per visit after INET deductible	50% coinsurance per visit after INET deductible	50% coinsurance per visit after INET deductible	50% coinsurance per visit after INET deductible
Orthodontia Services (medically necessary only)	50% coinsurance per visit after INET deductible	50% coinsurance per visit after INET deductible	50% coinsurance per visit after INET deductible	50% coinsurance per visit after INET deductible	50% coinsurance per visit after INET deductible
Pediatric Vision Care (covered persons up to age 26)					
Prescription Eye Glasses (one pair of frames & lenses or contact lens per calendar year)	Lenses: $0 after INET deductible; Collection frame: $0 after INET deductible; 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.	Lenses: $0 after INET deductible; Collection frame: $0 after INET deductible; 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.	Lenses: $0 after INET deductible; Collection frame: $0 after INET deductible; 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.	Lenses: $0 after INET deductible; Collection frame: $0 after INET deductible; 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.	Lenses: $0 after INET deductible; Collection frame: $0 after INET deductible; 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.
Routine Eye Exam by Specialist (one exam per calendar year)	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible
Plan Deductibles and Maximum Out of Pocket					
Plan Deductible: Individual	$6,350	$6,500	$6,500	$6,500	$6,500
Plan Deductible: Family	$12,700	$13,000	$13,000	$13,000	$13,000
Separate Prescription Drug Deductible: Individual	N/A	N/A	N/A	N/A	N/A
Separate Prescription Drug Deductible: Family	N/A	N/A	N/A	N/A	N/A
Out-of-Pocket Maximum: Individual	$6,900	$7,000	$7,000	$7,225	$7,225
Out-of-Pocket Maximum: Family	$13,800	$14,000	$14,000	$14,450	$14,450
Out-of-Network (OON) Coinsurance	50%	50%	50%	50%	50%

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Exhibit 15.6

Standardized Silver Plan Plan Changes - 5 Year Historical Look Back	2021	2022	2023	2024	2025
Provider Office Visits					
Preventive Visit (Adult/Pediatric)	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$40 copayment per visit, deductible does not apply	$40 copayment per visit, deductible does not apply	$40 copayment per visit, deductible does not apply	$40 copayment per visit, deductible does not apply	$40 copayment per visit, deductible does not apply
Specialist Office Visits	$60 copayment per visit, deductible does not apply	$60 copayment per visit, deductible does not apply	$60 copayment per visit, deductible does not apply	$60 copayment per visit, deductible does not apply	$60 copayment per visit, deductible does not apply
Mental Health and Substance Use Disorder Office Visit	$40 copayment per visit, deductible does not apply	$40 copayment per visit, deductible does not apply	$40 copayment per visit, deductible does not apply	$40 copayment per visit, deductible does not apply	$40 copayment per visit, deductible does not apply
Outpatient Diagnostic Services					
Advanced Radiology (CT/PET Scan, MRI)	$75 copayment per service, deductible does not apply, up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans	$75 copayment per service, deductible does not apply, up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans	$75 copayment per service, deductible does not apply, up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans	$75 copayment per service, deductible does not apply, up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans	$75 copayment per service, deductible does not apply, up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans
Laboratory Services	$10 copayment per service after INET deductible	$20 copayment per service, deductible does not apply	$20 copayment per service, deductible does not apply	$20 copayment per service, deductible does not apply	$25 copayment per service, deductible does not apply
Non-Advanced Radiology (X-ray, Diagnostic)	$40 copayment per service after INET deductible	$40 copayment per service after INET deductible	$40 copayment per service after INET deductible	$40 copayment per service after INET deductible	$40 copayment per service after INET deductible
Mammography Ultrasound/MRI (no cost for screening and diagnostic if within Federal and/or State regulations)	$20 copayment per service, deductible does not apply	$20 copayment per service, deductible does not apply	$20 copayment per service, deductible does not apply	$20 copayment per service, deductible does not apply	$20 copayment per service, deductible does not apply
Prescription Drugs - Retail Pharmacy (30 day supply per prescription)					
Tier 1	$10 copayment per prescription, deductible does not apply	$10 copayment per prescription, deductible does not apply	$10 copayment per prescription, deductible does not apply	$10 copayment per prescription, deductible does not apply	$10 copayment per prescription, deductible does not apply
Tier 2	$45 copayment per prescription after INET prescription drug deductible	$45 copayment per prescription after INET prescription drug deductible	$45 copayment per prescription after INET prescription drug deductible	$45 copayment per prescription after INET prescription drug deductible	$45 copayment per prescription after INET prescription drug deductible
Tier 3	$70 copayment per prescription after INET prescription drug deductible	$70 copayment per prescription after INET prescription drug deductible	$70 copayment per prescription after INET prescription drug deductible	$70 copayment per prescription after INET prescription drug deductible	$70 copayment per prescription after INET prescription drug deductible
Tier 4	20% coinsurance up to a maximum of $200 per prescription after INET prescription drug deductible	20% coinsurance up to a maximum of $200 per prescription after INET prescription drug deductible	20% coinsurance up to a maximum of $200 per prescription after INET prescription drug deductible	20% coinsurance up to a maximum of $200 per prescription after INET prescription drug deductible	20% coinsurance up to a maximum of $200 per prescription after INET prescription drug deductible

S I L V E R

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Exhibit 15.7

Standardized Silver Plan					
Plan Changes - 5 Year Historical Look Back					
	2021	2022	2023	2024	2025
Outpatient Rehabilitative and Habilitative Services					
Speech Therapy	$30 copayment per visit, deductible does not apply	$30 copayment per visit, deductible does not apply	$30 copayment per visit, deductible does not apply	$30 copayment per visit, deductible does not apply	$30 copayment per visit, deductible does not apply
Physical and Occupational Therapy	$30 copayment per visit, deductible does not apply	$30 copayment per visit, deductible does not apply	$30 copayment per visit, deductible does not apply	$30 copayment per visit, deductible does not apply	$30 copayment per visit, deductible does not apply
Other Services					
Chiropractic Services (up to 20 visits per calendar year)	$50 copayment per visit, deductible does not apply	$50 copayment per visit, deductible does not apply	$50 copayment per visit, deductible does not apply	$50 copayment per visit, deductible does not apply	$50 copayment per visit, deductible does not apply
Diabetic Equipment and Supplies	40% coinsurance per equipment/supply, deductible does not apply	40% coinsurance per equipment/supply, deductible does not apply	40% coinsurance per equipment/supply, deductible does not apply	40% coinsurance per equipment/supply, deductible does not apply	40% coinsurance per equipment/supply, deductible does not apply
Durable Medical Equipment (DME)	40% coinsurance per DME item, deductible does not apply	40% coinsurance per DME item, deductible does not apply	40% coinsurance per DME item, deductible does not apply	40% coinsurance per DME item, deductible does not apply	40% coinsurance per DME item, deductible does not apply
Home Health Care Services (up to 100 visits per calendar year)	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply
Outpatient Services (in a hospital or ambulatory facility)	$500 copayment per visit after INET deductible at an Outpatient Hospital Facility $300 copayment per visit after INET deductible at an Ambulatory Surgery Center	$500 copayment per visit after INET deductible at an Outpatient Hospital Facility $300 copayment per visit after INET deductible at an Ambulatory Surgery Center	$500 copayment per visit after INET deductible at an Outpatient Hospital Facility $300 copayment per visit after INET deductible at an Ambulatory Surgery Center	$500 copayment per visit after INET deductible at an Outpatient Hospital Facility $300 copayment per visit after INET deductible at an Ambulatory Surgery Center	$500 copayment per visit after INET deductible at an Outpatient Hospital Facility $300 copayment per visit after INET deductible at an Ambulatory Surgery Center
Inpatient Hospital Services					
Inpatient Hospital Services (Including mental health, substance use disorder, maternity, hospice, skilled nursing facility*, and all IP settings) *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 deductible	$500 copayment per day to a maximum of $2,000 per admission after INET deductible	$500 copayment per day to a maximum of $2,000 per admission after INET deductible	$500 copayment per day to a maximum of $2,000 per admission after INET deductible	$500 copayment per day to a maximum of $2,000 per admission after INET deductible
Emergency and Urgent Care					
Ambulance Services	$0 copayment per service, deductible does not apply	$0 copayment per service, deductible does not apply	$0 copayment per service, deductible does not apply	$0 copayment per service, deductible does not apply	$0 copayment per service, deductible does not apply
Emergency Room	$450 copayment per visit after INET deductible	$450 copayment per visit after INET deductible	$450 copayment per visit after INET deductible	$450 copayment per visit after INET deductible	$450 copayment per visit after INET deductible
Urgent Care Center	$75 copayment per visit, deductible does not apply	$75 copayment per visit, deductible does not apply	$75 copayment per visit, deductible does not apply	$75 copayment per visit, deductible does not apply	$75 copayment per visit, deductible does not apply

SILVER

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Exhibit 15.8

Standardized Silver Plan					
Plan Changes - 5 Year Historical Look Back					
	2021	2022	2023	2024	2025
Pediatric Dental Care (covered persons up to age 26)					
Diagnostic & Preventive	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply
Basic Services	40% coinsurance per visit, deductible does not apply	40% coinsurance per visit, deductible does not apply	40% coinsurance per visit, deductible does not apply	40% coinsurance per visit, deductible does not apply	40% coinsurance per visit, deductible does not apply
Major Services	50% coinsurance per visit, deductible does not apply	50% coinsurance per visit, deductible does not apply	50% coinsurance per visit, deductible does not apply	50% coinsurance per visit, deductible does not apply	50% coinsurance per visit, deductible does not apply
Orthodontia Services (medically necessary only)	50% coinsurance per visit, deductible does not apply	50% coinsurance per visit, deductible does not apply	50% coinsurance per visit, deductible does not apply	50% coinsurance per visit, deductible does not apply	50% coinsurance per visit, deductible does not apply
Pediatric Vision Care (covered persons up to age 26)					
Prescription Eye Glasses (one pair of frames & lenses or contact lens per calendar year)	Lenses: $0; Collection frame: $0; 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.	Lenses: $0; Collection frame: $0; 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.	Lenses: $0; Collection frame: $0; 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.	Lenses: $0; Collection frame: $0; 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.	Lenses: $0; Collection frame: $0; 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.
Routine Eye Exam by Specialist (one exam per calendar year)	$60 copayment per visit, deductible does not apply	$60 copayment per visit, deductible does not apply	$60 copayment per visit, deductible does not apply	$60 copayment per visit, deductible does not apply	$60 copayment per visit, deductible does not apply
Plan Deductibles and Maximum Out of Pocket					
Plan Deductible: Individual	$4,300	$4,300	$5,000	$5,000	$5,000
Plan Deductible: Family	$8,600	$8,600	$10,000	$10,000	$10,000
Separate Prescription Drug Deductible: Individual	$250	$250	$250	$250	$250
Separate Prescription Drug Deductible: Family	$500	$500	$500	$500	$500
Out-of-Pocket Maximum: Individual	$8,150	$8,600	$9,100	$9,100	$9,100
Out-of-Pocket Maximum: Family	$16,300	$17,200	$18,200	$18,200	$18,200
Out-of-Network (OON) Coinsurance	40%	40%	40%	40%	40%

SILVER

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Exhibit 15.9

Standardized Silver Plan - 73%					
Plan Changes - 5 Year Historical Look Back					
	2021	2022	2023	2024	2025
Laboratory Services	$10 copayment per service after INET deductible	$20 copayment per service, deductible does not apply	$20 copayment per service, deductible does not apply	$20 copayment per service, deductible does not apply	$25 copayment per service, deductible does not apply
Plan Deductible: Individual	$3,950	$3,950	$4,750	$4,750	$5,000
Plan Deductible: Family	$7,900	$7,900	$9,500	$9,500	$10,000
Out-of-Pocket Maximum: Individual	$6,500	$6,800	$7,250	$7,475	$7,350
Out-of-Pocket Maximum: Family	$13,000	$13,600	$14,500	$14,950	$14,700

Standardized Silver Plan - 87%					
Plan Changes - 5 Year Historical Look Back					
	2021	2022	2023	2024	2025
Laboratory Services	$10 copayment per service after INET deductible	$10 copayment per service, deductible does not apply	$10 copayment per service, deductible does not apply	$10 copayment per service, deductible does not apply	$10 copayment per service, deductible does not apply
Plan Deductible: Individual	$650	$650	$675	$675	$475
Plan Deductible: Family	$1,300	$1,300	$1,350	$1,350	$950
Out-of-Pocket Maximum: Individual	$2,500	$2,725	$3,000	$2,925	$2,725
Out-of-Pocket Maximum: Family	$5,000	$5,450	$6,000	$5,850	$5,450

Standardized Silver Plan - 94%					
Plan Changes - 5 Year Historical Look Back					
	2021	2022	2023	2024	2025
Out-of-Pocket Maximum: Individual	$900	$900	$950	$1,050	$1,150
Out-of-Pocket Maximum: Family	$1,800	$1,800	$1,900	$2,100	$2,300

SILVER CSR

For the Silver CSR plans - only member cost share amounts that were modified in the last 5 years are displayed. If the service is not listed, the member cost share has not been changed since plan year 2020.

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Exhibit 15.10

Standardized Gold Plan Plan Changes - 5 Year Historical Look Back	2021	2022	2023	2024	2025
Provider Office Visits					
Preventive Visit (Adult/Pediatric)	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$20 copayment per visit, deductible does not apply	$20 copayment per visit, deductible does not apply	$20 copayment per visit, deductible does not apply	$20 copayment per visit, deductible does not apply	$20 copayment per visit, deductible does not apply
Specialist Office Visits	$40 copayment per visit, deductible does not apply	$40 copayment per visit, deductible does not apply	$40 copayment per visit, deductible does not apply	$40 copayment per visit, deductible does not apply	$40 copayment per visit, deductible does not apply
Mental Health and Substance Use Disorder Office Visit	$20 copayment per visit, deductible does not apply	$20 copayment per visit, deductible does not apply	$20 copayment per visit, deductible does not apply	$20 copayment per visit, deductible does not apply	$20 copayment per visit, deductible does not apply
Outpatient Diagnostic Services					
Advanced Radiology (CT/PET Scan, MRI)	$65 copayment per service, deductible does not apply, up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans	$65 copayment per service, deductible does not apply, up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans	$65 copayment per service, deductible does not apply, up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans	$65 copayment per service, deductible does not apply, up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans	$65 copayment per service, deductible does not apply, up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans
Laboratory Services	$10 copayment per service, after INET deductible	$10 copayment per service, after INET deductible	$10 copayment per service, after INET deductible	$10 copayment per service, after INET deductible	$10 copayment per service, deductible does not apply
Non-Advanced Radiology (X-ray, Diagnostic)	$40 copayment per service after INET deductible	$40 copayment per service after INET deductible	$40 copayment per service after INET deductible	$40 copayment per service after INET deductible	$40 copayment per service after INET deductible
Mammography Ultrasound/MRI (no cost for screening and diagnostic if within Federal and/or State regulations)	$20 copayment per service, deductible does not apply	$20 copayment per service, deductible does not apply	$20 copayment per service, deductible does not apply	$20 copayment per service, deductible does not apply	$20 copayment per service, deductible does not apply
Prescription Drugs - Retail Pharmacy (30 day supply per prescription)					
Tier 1	$5 copayment per prescription, deductible does not apply	$5 copayment per prescription, deductible does not apply	$5 copayment per prescription, deductible does not apply	$5 copayment per prescription, deductible does not apply	$5 copayment per prescription, deductible does not apply
Tier 2	$35 copayment per prescription, deductible does not apply	$35 copayment per prescription, deductible does not apply	$35 copayment per prescription, deductible does not apply	$35 copayment per prescription, deductible does not apply	$35 copayment per prescription, deductible does not apply
Tier 3	$60 copayment per prescription, deductible does not apply	$60 copayment per prescription, deductible does not apply	$60 copayment per prescription, deductible does not apply	$60 copayment per prescription, deductible does not apply	$60 copayment per prescription, deductible does not apply
Tier 4	20% coinsurance up to a maximum of $100 per prescription after INET prescription drug deductible	20% coinsurance up to a maximum of $100 per prescription after INET prescription drug deductible	20% coinsurance up to a maximum of $100 per prescription after INET prescription drug deductible	20% coinsurance up to a maximum of $100 per prescription after INET prescription drug deductible	20% coinsurance up to a maximum of $100 per prescription after INET prescription drug deductible

GOLD

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Exhibit 15.11

GOLD

Standardized Gold Plan					
Plan Changes - 5 Year Historical Look Back					
	2021	2022	2023	2024	2025
Outpatient Rehabilitative and Habilitative Services					
Speech Therapy	$20 copayment per visit, deductible does not apply	$20 copayment per visit, deductible does not apply	$20 copayment per visit, deductible does not apply	$20 copayment per visit, deductible does not apply	$20 copayment per visit, deductible does not apply
Physical and Occupational Therapy	$20 copayment per visit, deductible does not apply	$20 copayment per visit, deductible does not apply	$20 copayment per visit, deductible does not apply	$20 copayment per visit, deductible does not apply	$20 copayment per visit, deductible does not apply
Other Services					
Chiropractic Services (up to 20 visits per calendar year)	$40 copayment per visit, deductible does not apply	$40 copayment per visit, deductible does not apply	$40 copayment per visit, deductible does not apply	$40 copayment per visit, deductible does not apply	$40 copayment per visit, deductible does not apply
Diabetic Equipment and Supplies	30% coinsurance per equipment/supply, deductible does not apply	30% coinsurance per equipment/supply, deductible does not apply	30% coinsurance per equipment/supply, deductible does not apply	30% coinsurance per equipment/supply, deductible does not apply	30% coinsurance per equipment/supply, deductible does not apply
Durable Medical Equipment (DME)	30% coinsurance per DME item, deductible does not apply	30% coinsurance per DME item, deductible does not apply	30% coinsurance per DME item, deductible does not apply	30% coinsurance per DME item, deductible does not apply	30% coinsurance per DME item, deductible does not apply
Home Health Care Services (up to 100 visits per calendar year)	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply
Outpatient Services (in a hospital or ambulatory facility)	$500 copayment per visit after INET deductible at an Outpatient Hospital Facility $300 copayment per visit after INET deductible at an Ambulatory Surgery Center	$500 copayment per visit after INET deductible at an Outpatient Hospital Facility $300 copayment per visit after INET deductible at an Ambulatory Surgery Center	$500 copayment per visit after INET deductible at an Outpatient Hospital Facility $300 copayment per visit after INET deductible at an Ambulatory Surgery Center	$500 copayment per visit after INET deductible at an Outpatient Hospital Facility $300 copayment per visit after INET deductible at an Ambulatory Surgery Center	$500 copayment per visit after INET deductible at an Outpatient Hospital Facility $300 copayment per visit after INET deductible at an Ambulatory Surgery Center
Inpatient Hospital Services					
Inpatient Hospital Services (Including mental health, substance use disorder, maternity, hospice, skilled nursing facility*, and all IP settings) *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	$500 copayment per day to a maximum of $1,000 per admission after INET deductible	$500 copayment per day to a maximum of $1,000 per admission after INET deductible	$500 copayment per day to a maximum of $1,000 per admission after INET deductible	$500 copayment per day to a maximum of $1,000 per admission after INET deductible
Emergency and Urgent Care					
Ambulance Services	$0 copayment per service, deductible does not apply	$0 copayment per service, deductible does not apply	$0 copayment per service, deductible does not apply	$0 copayment per service, deductible does not apply	$0 copayment per service, deductible does not apply
Emergency Room	$400 copayment per visit, deductible does not apply	$400 copayment per visit, deductible does not apply	$400 copayment per visit, deductible does not apply	$400 copayment per visit, deductible does not apply	$400 copayment per visit, deductible does not apply
Urgent Care Center	$50 copayment per visit, deductible does not apply	$50 copayment per visit, deductible does not apply	$50 copayment per visit, deductible does not apply	$50 copayment per visit, deductible does not apply	$50 copayment per visit, deductible does not apply

Exhibit 15.12

Standardized Gold Plan					
Plan Changes - 5 Year Historical Look Back					
	2021	2022	2023	2024	2025
Pediatric Dental Care (covered persons up to age 26)					
Diagnostic & Preventive	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply	$0 copayment, deductible does not apply
Basic Services	20% coinsurance per visit, deductible does not apply	20% coinsurance per visit, deductible does not apply	20% coinsurance per visit, deductible does not apply	20% coinsurance per visit, deductible does not apply	20% coinsurance per visit, deductible does not apply
Major Services	40% coinsurance per visit, deductible does not apply	40% coinsurance per visit, deductible does not apply	40% coinsurance per visit, deductible does not apply	40% coinsurance per visit, deductible does not apply	40% coinsurance per visit, deductible does not apply
Orthodontia Services (medically necessary only)	50% coinsurance per visit, deductible does not apply	50% coinsurance per visit, deductible does not apply	50% coinsurance per visit, deductible does not apply	50% coinsurance per visit, deductible does not apply	50% coinsurance per visit, deductible does not apply
Pediatric Vision Care (covered persons up to age 26)					
Prescription Eye Glasses (one pair of frames & lenses or contact lens per calendar year)	Lenses: $0; Collection frame: $0; 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.	Lenses: $0; Collection frame: $0; 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.	Lenses: $0; Collection frame: $0; 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.	Lenses: $0; Collection frame: $0; 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.	Lenses: $0; Collection frame: $0; 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.
Routine Eye Exam by Specialist (one exam per calendar year)	$40 copayment per visit, deductible does not apply	$40 copayment per visit, deductible does not apply	$40 copayment per visit, deductible does not apply	$40 copayment per visit, deductible does not apply	$40 copayment per visit, deductible does not apply
Plan Deductibles and Maximum Out of Pocket					
Plan Deductible: Individual	$1,300	$1,300	$1,300	$1,300	$1,200
Plan Deductible: Family	$2,600	$2,600	$2,600	$2,600	$2,400
Separate Prescription Drug Deductible: Individual	$50	$50	$50	$50	$50
Separate Prescription Drug Deductible: Family	$100	$100	$100	$100	$100
Out-of-Pocket Maximum: Individual	$5,250	$5,250	$6,000	$7,375	$7,375
Out-of-Pocket Maximum: Family	$10,500	$10,500	$12,000	$14,750	$14,750
Out-of-Network (OON) Coinsurance	30%	30%	30%	30%	30%

GOLD

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