



Plan Year 2027

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

April 1, 2026



🔗 Agenda

- **Call to Order**
- **Public Comment**
- **Vote: Meeting Minutes (March 25, 2026)**
- **Follow up items**
- **Wakely Consulting – Standard Health Plans**
- **Access Health CT – Standard Dental Plans**
- **Next Steps/Adjournment**

Public Comment

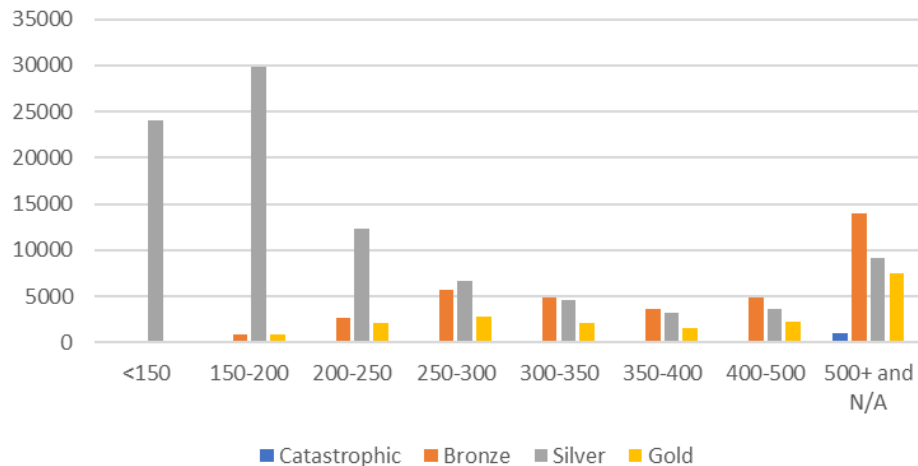
Vote

Review and Approval of Minutes

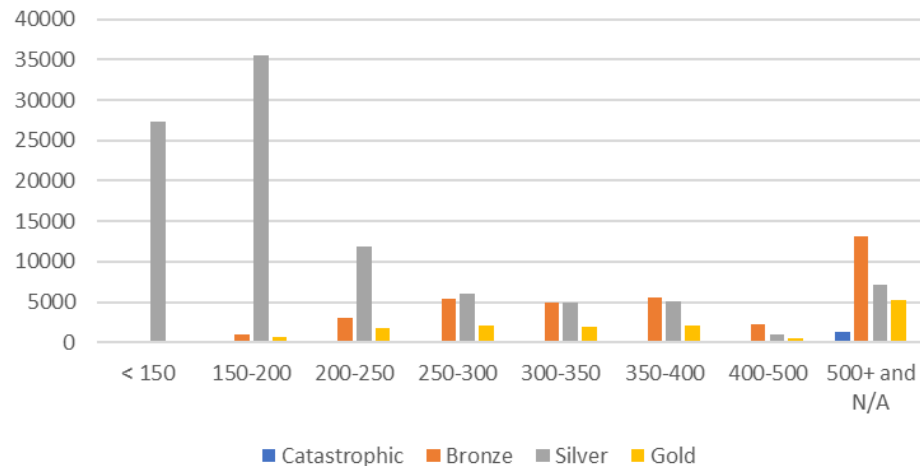
**HPBQ AC Meeting
March 25, 2026**

🔗 Metal Tier Enrollment by FPL

Plan Year 2025



Plan Year 2026



Wakely Consulting Ren Zhong, Consulting Actuary

2027 Individual Market Standard Plan Designs

April 1, 2026

PRESENTED BY:

Ksenia Whittal, FSA, MAAA
ksenia.whittal@wakely.com

Ren Zhong, ASA, MAAA
ren.zhong@wakely.com

Going Beyond the Numbers



2027 Plan Design Overview

Notes and Caveats

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

In-Network Services
Other Services
Mammography Ultrasound
Chiropractic Services (up to 20 visits per calendar year)
Diabetic Supplies & Equipment
Durable Medical Equipment
Home Health Care Services (up to 100 visits per calendar year)
Ambulance Services
Urgent Care Center or Facility
Pediatric Dental Care (for children under age 26)
Diagnostic & Preventive
Basic Services
Major Services
Orthodontia Services (medically necessary)
Pediatric Vision Care (for children under age 26)
Out-of-Network Services
All services, deductible and maximum out-of-pocket

Notes and Caveats

Plan Features

- The cost sharing shown on the following slides represents costs for in-network services only.
- The deductible and MOOP limits shown are for individuals. The family limits are 2x the individual limit for all plans except where noted.
- Preventive care is covered at no cost to the member for all plans.
- Mental Health cost sharing is the same as Primary Care for all plans.
- Silver loading for defunded cost-sharing reduction plans will persist in 2027.
- All plans include 'embedded' deductible approach (not aggregate).

Gold Plan AV Options

Gold Standard Benefit Category	Approved - Final			
	2026 Individual Market Gold Plan	2027 Option 1 Gold High	2027 Option 2 Gold High	2027 Option 3 Gold Medium
Medical Deductible	\$1,200	\$1,500	\$2,000	\$3,000
Rx Deductible	\$50	\$50	\$50	\$50
Coinsurance	30%	30%	30%	30%
Out-of-pocket Maximum	\$7,375	\$8,500	\$8,500	\$8,500
Primary Care, Mental Health	\$20	\$35	\$30	\$40
Specialist Care	\$40	\$70	\$60	\$80
Urgent Care	\$50	\$80	\$70	\$90
Emergency Room	\$400	\$500	\$500	\$500
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 Services (hospital or ambulatory facility)	\$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) (Max \$75 copay)	\$65	\$75	\$75	\$75
Non-Advanced Radiology (X-ray, Diagnostic)	\$40 (after ded.)	\$40 (after ded.)	\$40 (after ded.)	\$40 (after ded.)
Laboratory Services	\$10	\$25	\$25	\$25
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type (Max \$30 copay)	\$20	\$30	\$30	\$30
Chiropractic Care 20 visit calendar maximum	\$40	\$70	\$60	\$80
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
All Other Medical	30%	30%	30%	30%
Tier 1: Generic	Tier 1: \$5 ded not apply	Tier 1: \$5 ded not apply	Tier 1: \$5 ded not apply	Tier 1: \$5 ded not apply
Tier 2: Preferred Brand	Tier 2: \$35 ded not apply	Tier 2: \$35 ded not apply	Tier 2: \$35 ded not apply	Tier 2: \$35 ded not apply
Tier 3: Non-Preferred Brand	Tier 3: \$60 ded not apply	Tier 3: \$60 ded not apply	Tier 3: \$60 ded not apply	Tier 3: \$60 ded not apply
Tier 4: Specialty Rx	Tier 4: 20% coinsurance up to \$100 max after ded.)	Tier 4: 20% coinsurance up to \$100 max after ded.)	Tier 4: 20% coinsurance up to \$100 max after ded.)	Tier 4: 20% coinsurance up to \$100 max after ded.)
2027 AVC Results	85.28%	80.9%	81.1%	79.7%
2027 AVC Compliant (Yes/No)		Yes	Yes	Yes
2027 MHP Compliance (Yes/No)		Yes	Yes	Yes
Carrier AV Ranges			79.35% to 81.06%	

Silver Plan AV Options

Silver Standard	2026 Individual Market	2027 Option 1	2027 Option 2	2027 Option 3	2027 Option 4
Benefit Category	Silver Plan	Silver Plan	Silver Plan	Silver Plan	Silver Plan
Medical Deductible	\$5,000	\$5,000	\$6,000	\$6,000	\$5,500
Rx Deductible	\$250	\$250	\$250	\$250	\$250
Coinsurance	40%	40%	40%	40%	40%
Out-of-pocket Maximum	\$9,400	\$10,000	\$12,000	\$11,000	\$10,550
Primary Care, Mental Health	\$45	\$65	\$45	\$43	\$45
Specialist Care	\$60	\$100	\$60	\$60	\$80
Urgent Care	\$75	\$120	\$75	\$75	\$100
Emergency Room	\$450 (after ded.)	\$450 (after ded.)	\$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)	\$500 per day (after ded., \$2,000 max. per admission)	\$500 per day (after ded., \$2,000 max. per admission)
Outpatient Services (hospital or ambulatory facility)	\$300 ASC/\$500 otherwise (after ded.)	\$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) (Max \$75 copay)	\$75	\$75	\$75	\$75	\$75
Non-Advanced Radiology (X-ray, Diagnostic)	\$40 (after ded.)	\$50 (after ded.)	\$50 (after ded.)	\$50 (after ded.)	\$50 (after ded.)
Laboratory Services	\$25	\$40	\$40	\$40	\$40
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type (Max \$30 copay)	\$30	\$30	\$30	\$30	\$30
Chiropractic Care 20 visit calendar maximum	\$50	\$80	\$50	\$50	\$50
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
All Other Medical	40%	40%	40%	40%	40%
Tier 1: Generic	Tier 1: \$10 ded not apply	Tier 1: \$10 ded not apply	Tier 1: \$10 ded not apply	Tier 1: \$10 ded not apply	Tier 1: \$10 ded not apply
Tier 2: Preferred Brand	Tier 2: \$50 after ded.	Tier 2: \$50 after ded.	Tier 2: \$50 after ded.	Tier 2: \$50 after ded.	Tier 2: \$50 after ded.
Tier 3: Non-Preferred Brand	Tier 3: \$75 after ded.	Tier 3: \$75 after ded.	Tier 3: \$75 after ded.	Tier 3: \$75 after ded.	Tier 3: \$75 after ded.
Tier 4: Specialty Rx	Tier 4: 20% coinsurance up to \$200 max after ded.)	Tier 4: 20% coinsurance up to \$200 max after ded.)	Tier 4: 20% coinsurance up to \$200 max after ded.)	Tier 4: 20% coinsurance up to \$200 max after ded.)	Tier 4: 20% coinsurance up to \$200 max after ded.)
2027 AVC Results	74.73%	71.20%	70.85%	71.80%	71.73%
2027 AVC Compliant (Yes/No)		Yes	Yes	Yes	Yes
2027 MHP Compliance (Yes/No)		Yes	Yes	Yes	Yes
Carrier AV Ranges		70.37% to 71.25%	70.37% to 70.84%	70.47% to 71.77%	70.48% to 71.76%

Silver 73% CSR Plan AV Options

	Approved - Preliminary		
Silver CSR	2026 Individual Market	2027 Option 1	2027 Option 2
Benefit Category	Silver Plan (73%)	Silver Plan (73%)	Silver Plan (73%)
Medical Deductible	\$5,000	\$5,000	\$5,000
Rx Deductible	\$250	\$250	\$250
Coinsurance	40%	40%	40%
Out-of-pocket Maximum	\$7,675	\$9,600	\$9,600
Primary Care, Mental Health	\$45	\$50	\$48
Specialist Care	\$60	\$80	\$80
Urgent Care	\$75	\$100	\$100
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 Services (hospital or ambulatory facility)	\$300@ASC/\$500 otherwise (after ded.)	\$300@ASC/\$500 otherwise (after ded.)	\$100@ASC/\$200 otherwise (after ded.)
Advanced Radiology (CT/PET Scan, MRI) (Max \$75 copay)	\$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 (Max \$30 copay)	\$30	\$30	\$30
Chiropractic Care 20 visit calendar maximum	\$50	\$50	\$50
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
All Other Medical	40%	40%	40%
Tier 1: Generic	Tier 1: \$10 ded not apply	Tier 1: \$10 ded not apply	Tier 1: \$10 ded not apply
Tier 2: Preferred Brand	Tier 2: \$50 after ded.	Tier 2: \$50 after ded.	Tier 2: \$50 after ded.
Tier 3: Non-Preferred Brand	Tier 3: \$75 after ded.	Tier 3: \$75 after ded.	Tier 3: \$75 after ded.
Tier 4: Specialty Rx	Tier 4: 20% coinsurance up to \$100 max after ded.)	Tier 4: 20% coinsurance up to \$100 max after ded.)	Tier 4: 20% coinsurance up to \$100 max after ded.)
2027 AVC Results	76.83%	73.43%	73.93%
2027 AVC Compliant (Yes/No)		No	Yes
2027 MHP Compliance (Yes/No)		Yes	Yes
Carrier AV Ranges		72.27% to 73.16%	73.47% to 73.78%

Silver 87% CSR Plan AV Option

Silver CSR		Approved - Preliminary	
Benefit Category	2026 Individual Market Silver Plan (87%)	2027 Option 1 Silver Plan (87%)	
Medical Deductible	\$415	\$415	
Rx Deductible	\$50	\$50	
Coinsurance	40%	40%	
Out-of-pocket Maximum	\$2,950	\$3,500	
Primary Care, Mental Health	\$35	\$35	
Specialist Care	\$50	\$50	
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 Services (hospital or ambulatory facility)	\$60@ASC/\$100 otherwise (after ded.)	\$60@ASC/\$100 otherwise (after ded.)	
Advanced Radiology (CT/PET Scan, MRI) (Max \$75 copay)	\$60	\$60	
Non-Advanced Radiology (X-ray, Diagnostic)	\$30 (after ded.)	\$30 (after ded.)	
Laboratory Services	\$15	\$25	
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type (Max \$30 copay)	\$20	\$20	
Chiropractic Care 20 visit calendar maximum	\$35	\$35	
Home Health Care Services (up to 100 visits per calendar year)	\$0 copayment, deductible does not apply	\$0 copayment, deductible does not apply	
All Other Medical	40%	40%	
Tier 1: Generic	Tier 1: \$10 ded not apply	Tier 1: \$10 ded not apply	
Tier 2: Preferred Brand	Tier 2: \$25 ded not apply	Tier 2: \$25 ded not apply	
Tier 3: Non-Preferred Brand	Tier 3: \$40 after ded.	Tier 3: \$40 after ded.	
Tier 4: Specialty Rx	Tier 4: 20% coinsurance up to \$60 max after ded.)	Tier 4: 20% coinsurance up to \$60 max after ded.)	
2027 AVC Results	88.63%	87.34%	
2027 AVC Compliant (Yes/No)		Yes	
2027 MHP Compliance (Yes/No)		Yes	
Carrier AV Ranges		87.22% to 87.39%	

Silver 94% CSR Plan AV Options

Silver CSR	2026 Individual Market	2027 Option 1	2027 Option 2
Benefit Category	Silver Plan (94%)	Silver Plan (94%)	Silver Plan (94%)
Medical Deductible	\$0	\$0	\$0
Rx Deductible	\$0	\$0	\$0
Coinsurance	40%	40%	40%
Out-of-pocket Maximum	\$1,350	\$2,500	\$1,800
Primary Care, Mental Health	\$15	\$15	\$25
Specialist Care	\$30	\$30	\$50
Urgent Care	\$25	\$25	\$35
Emergency Room	\$50	\$50	\$50
Inpatient Hospital	\$75 per day (\$300 max. per admission)	\$75 per day (\$300 max. per admission)	\$75 per day (\$300 max. per admission)
Outpatient Hospital	\$45@ASC/\$75 otherwise	\$45@ASC/\$75 otherwise	\$45@ASC/\$75 otherwise
Advanced Radiology (CT/PET Scan, MRI)	\$50	\$50	\$55
Non-Advanced Radiology (X-ray, Diagnostic)	\$25	\$25	\$35
Laboratory Services	\$10	\$20	\$25
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	\$30	\$30	\$30
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
All Other Medical	40%	40%	40%
Tier 1: Generic	Tier 1: \$5	Tier 1: \$5	Tier 1: \$5
Tier 2: Preferred Brand	Tier 2: \$10	Tier 2: \$15	Tier 2: \$15
Tier 3: Non-Preferred Brand	Tier 3: \$30	Tier 3: \$35	Tier 3: \$35
Tier 4: Specialty Rx	Tier 4: 20% coinsurance up to \$60 max	Tier 4: 20% coinsurance up to \$60 max	Tier 4: 20% coinsurance up to \$60 max
2027 AVC Results	96.53%	94.27%	94.65%
2027 AVC Compliant (Yes/No)		Yes	Yes
2027 MHP Compliance (Yes/No)		Yes	Yes
Carrier AV Ranges		94.65% to 94.87%	94.74% to 94.8%

Bronze Plan AV Options (Formerly Bronze Non-HSA)

Bronze Standard	2026 Individual Market	2027 Option 1	2027 Option 2
Benefit Category	Bronze Plan	Bronze Plan	Bronze Plan
Medical Deductible	\$7,000	\$7,000	\$8,000
Rx Deductible			
Coinsurance	40%	40%	40%
Out-of-pocket Maximum	\$10,000	\$11,000	\$12,000
Primary Care, Mental Health	\$50	\$60	\$60
Specialist Care	\$70 (after ded.)	\$80 (after ded.)	\$120 (ded not apply)
Urgent Care	\$75	\$85	\$120
Emergency Room	\$450 (after ded.)	\$450 (after ded.)	\$450 (after ded.)
Inpatient Hospital	\$500 per day (after ded., \$1,000 max. per admission)	\$500 per day (after ded., \$1,000 max. per admission)	\$500 per day (after ded., \$1,000 max. per admission)
Outpatient Services (hospital or ambulatory facility)	\$300@ASC/\$500 otherwise (after ded.)	\$300@ASC/\$500 otherwise (after ded.)	\$300@ASC/\$500 otherwise (after ded.)
Advanced Radiology (CT/PET Scan, MRI) (Max \$75 copay)	\$75 (after ded.)	\$75 (after ded.)	\$75 (after ded.)
Non-Advanced Radiology (X-ray, Diagnostic)	\$40 (after ded.)	\$40 (after ded.)	\$40 (after ded.)
Laboratory Services	\$20	\$40	\$40
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type (Max \$30 copay)	\$30 (after ded.)	\$30 (after ded.)	\$30 (after ded.)
Chiropractic Care 20 visit calendar maximum	\$50 (after ded.)	\$50 (after ded.)	\$50 (after ded.)
Home Health Care Services (up to 100 visits per calendar year)	25% coinsurance per visit after separate \$50	25% coinsurance per visit after separate \$50	25% coinsurance per visit after separate \$50
All Other Medical	40% (after ded.)	40% (after ded.)	40% (after ded.)
Tier 1: Generic	Tier 1: \$15 ded not apply	Tier 1: \$15 ded not apply	Tier 1: \$15 ded not apply
Tier 2: Preferred Brand	Tier 2: \$50 ded not apply	Tier 2: \$50 ded not apply	Tier 2: \$50 ded not apply
Tier 3: Non-Preferred Brand	Tier 3: 50% after ded.	Tier 3: 50% after ded.	Tier 3: 50% after ded.
Tier 4: Specialty Rx	Tier 4: 50% up to \$500 max after ded.)	Tier 4: 50% up to \$500 max after ded.)	Tier 4: 50% up to \$500 max after ded.)
2027 AVC Compliant (Yes/No)		Yes	Yes
2027 MHP Compliance (Yes/No)		Yes	Yes
Carrier AV Ranges		63.09% to 63.92%	63.29% to 64.06%

Bronze HDHP Plan Legislation

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

Bronze HDHP (formerly Bronze HSA) & (New) Bronze Lite Options

		Approved - Final				
Bronze Standard HDHP	2026 Individual Market	2027 Option 1	2027 Option 1	2027 Option 2	All Issuers	All Issuers
Benefit Category	Bronze HDHP Plan	Bronze HDHP Plan	(New) Bronze Lite	(New) Bronze Lite	2026 Catastrophic Plan	Potential 2027 Plan
Combined Medical & Rx Deductible	\$6,500	\$6,500	\$8,000	\$8,000	\$10,600	\$12,000
Coinsurance	20%	20%	20%	50%	0%	0%
Out-of-pocket Maximum	\$7,225	\$8,500	\$12,000	\$12,000	\$10,600	\$12,000
Primary Care, Specialist Care, Urgent Care, Emergency Room, Inpatient Hospital, Outpatient Hospital, Advanced Radiology (CT/PET Scan, MRI), Non-Advanced Radiology (X-ray, Diagnostic), Laboratory Services, Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational), Chiropractic Care	20% (after ded.)	20% (after ded.)	20% (after ded.)	20% (after ded.)	For primary care/mental health/SUD, (\$30 or \$40) copay for visit for the first 3 visits, then 0% coinsurance per visit (after ded.)	For primary care/mental health/SUD, (\$30 or \$40) copay for visit for the first 3 visits, then 0% coinsurance per visit (after ded.)
Diabetic Supplies	*20% (after ded.)	*20% (after ded.)	*20% (after ded.)	*50% (after ded.)	0% coinsurance per visit (after ded.)	0% coinsurance per visit (after ded.)
All Other Medical	*20% (after ded.)	*20% (after ded.)	*20% (after ded.)	*50% (after ded.)	0% coinsurance per visit (after ded.)	0% coinsurance per visit (after ded.)
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	Tier 1: 20% after ded.	Tier 1: 20% after ded.	*20% (after ded.)	*50% (after ded.)	0% coinsurance per visit (after ded.)	0% coinsurance per visit (after ded.)
	Tier 2: 25% after ded.	Tier 2: 25% after ded.				
	Tier 3: 30% after ded.	Tier 3: 30% after ded.				
	Tier 4: 30% up to \$500 max after ded.)	Tier 4: 30% up to \$500 max after ded.)				
2027 AVC Results	66.4%	64.7% - 64.8%	60.1% - 60.2%	58.9% - 59.0%		Around 59%

*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)

Thank You

Stand-Alone Dental Plan

2026 Enrollment by Coverage Level

Coverage Level	Enrolled	%
Preventive Only	3,851	20%
Preventive & Basic	4,336	23%
Preventive, Basic & Major	10,942	57%
Totals	19,129	

Non-Standard Plans	Standard Plan
3,851	
4,336	
7,994	2,948
16,181	2,948

Standard Plan enrollment makes up 15% of total dental enrollment and 27% of full coverage enrollment.

Full Coverage = Plans that cover Preventive, Basic & Major Services.

2026 Rates Pediatric & Adult

Anthem		
Preventive	31.76	17.07
Value	31.76	23.56
Family	31.76	34.01
Standard	36.00	57.98
CICI		
Basic	58.72	26.95
Standard	60.17	62.53
Guardian		
Preventive Plus	33.46	21.34
Preventive	33.46	23.71
Essentials	33.46	31.61
Standard	43.56	68.27

⚡ CMS Annual Limitation on Cost Sharing Stand-Alone Dental Plan (SADP)

Plan Year 2026

Amounts increased:

- \$425 for one child
- \$850 for two or more children

HPBQ recommended amounts
remain at \$350/\$700

No plan modifications implemented
since Plan Year 2016

Plan Year 2027

Amounts increased:

- \$450 for one child
- \$900 for two or more children

Stand-Alone Dental Plan Options

	2026 Plan	Option 1	Option 2
Deductible - Individual/Family	\$60/\$180 max	\$60/\$180 max	\$60/\$180 max
Out-of-Pocket Maximum - Pediatric only	\$350/\$700	\$450/\$900	\$450/\$900
Plan Maximum - Adult only	\$2,000	\$2,000	\$2,000
Pediatric and Adult Services			
Diagnostic and Preventive Services	\$0 copay. Deductible does not apply.	\$0 copay, after deductible	\$0 copay, after deductible
Basic Services	20% coinsurance after deductible	25% coinsurance after deductible	30% coinsurance after deductible
Major Services	40% coinsurance after deductible	40% coinsurance after deductible	40% coinsurance after deductible
Medically Necessary Orthodontic Services	50% coinsurance after deductible; No coverage for adults	50% coinsurance after deductible; No coverage for adults	50% coinsurance after deductible; No coverage for adults

**Tentative Meeting Scheduled
April 9, 2026 at 1:00**

Adjournment

Reference Materials

Summary of Plan Changes – Plan Year 2026

Metal Level	Medical Deductible	Out-Of-Pocket Maximum	Primary Care Office Visits	Specialist	Laboratory Services	Pharmacy Tier 2*	Pharmacy Tier 3**
Gold	No plan changes for 2026						
Silver 70%		\$9,100 → \$9,400	\$40 → \$45			\$45 → \$50	\$70 → \$75
Silver 73%		\$7,350 → \$7,675	\$40 → \$45			\$45 → \$50	\$70 → \$75
Silver 87%	\$475 → \$415	\$2,725 → \$2,950	\$20 → \$35	\$45 → \$50	\$10 → \$15		
Silver 94%		\$1,150 → \$1,350	\$10 → \$15				
Bronze	\$6,550 → \$7,000	\$9,100 → \$10,000	\$40 → \$50				
Bronze HSA	No plan changes for 2026						

*Preferred Brand Drugs

**Non-Preferred Brand Drugs

	Bronze	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% coinsurance, 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)	\$50 copayment per visit, deductible does not apply	20% coinsurance per visit after INET deductible	\$45 copayment per visit, deductible does not apply	\$45 copayment per visit, deductible does not apply	\$35 copayment per visit, deductible does not apply	\$15 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	\$50 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	\$50 copayment per visit, deductible does not apply	20% coinsurance per visit after INET deductible	\$45 copayment per visit, deductible does not apply	\$45 copayment per visit, deductible does not apply	\$35 copayment per visit, deductible does not apply	\$15 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 CAT 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	\$15 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
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	\$50 copayment per prescription after INET prescription drug deductible	\$50 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	\$75 copayment per prescription after INET prescription drug deductible	\$75 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

Blue font signifies field included in Actuarial Value Calculator

Indicates change from prior year.

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
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	20% coinsurance per visit after INET deductible	\$500 copayment per visit after INET deductible at an Outpatient Hospital Facility	\$500 copayment per visit after INET deductible at an Outpatient Hospital Facility	\$100 copayment per visit after INET deductible at an Outpatient Hospital Facility	\$75 copayment per visit at an Outpatient Hospital Facility, 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		\$300 copayment per visit after INET deductible at an Ambulatory Surgery Center	\$300 copayment per visit after INET deductible at an Ambulatory Surgery Center	\$60 copayment per visit after INET deductible at an Ambulatory Surgery Center	\$45 copayment per visit at an Ambulatory Surgery Center, deductible does not apply	\$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

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	\$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
Deductibles and Maximum Out of Pocket							
Plan Deductible: Individual	\$7,000	\$6,500	\$5,000	\$5,000	\$415	\$0	\$1,200
Plan Deductible: Family	\$14,000	\$13,000	\$10,000	\$10,000	\$830	\$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	\$10,000	\$7,225	\$9,400	\$7,675	\$2,950	\$1,350	\$7,375
Out-of-Pocket Maximum: Family	\$20,000	\$14,450	\$18,800	\$15,350	\$5,900	\$2,700	\$14,750

2026 Standard Stand-Alone Dental Plan

SCHEDULE OF BENEFITS

Plan Overview		In-Network Member Pays	Out-of-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			
<i>Out-of-Pocket Maximum - Out-of-Pocket Maximums do not apply to adult benefits.</i>			
For one child		\$350	None
Two or more children		\$700	None
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			
<i>Plan Maximum – Plan Maximums do not apply to pediatric benefits.</i>			
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		
ADULT BENEFITS (continued) – For adults aged 26 or above			
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	[]
<i>Waiting Periods – Waiting periods do not apply to pediatric benefits.</i>			
Diagnostic and Preventive Services		No waiting period	
Basic Services		6 months ^A	
Major Services		12 months ^A	
^A 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.			

2026 'On & Off Exchange' Landscape

Qualified Health Plans

Individual Market

Metal Level								Product Type				
Carrier	Exchange Status	Catastrophic	Bronze	Silver	Gold	Platinum	Total	HMO	POS	EPO	PPO	Total
Anthem	Off	1	3	2	1		7	5			2	7
Anthem	On	1	5	1	4		11	4			7	11
CBI	On	1	3	1	2		7		7			7
CICI	On		2	1	1		4		4			4
CCI	Off		2	1			3	2	1			3
Total		3	15	6	8	0	32	11	12	0	9	32

Small Group Market

Metal Level								Product Type				
Carrier	Exchange Status	Catastrophic	Bronze	Silver	Gold	Platinum	Total	HMO	POS	EPO	PPO	Total
Anthem	Off	N/A	1	6	11	2	20				20	20
Anthem	On	N/A	2	2	1	1	6				6	6
OHI	Off	N/A	2	8	15	6	31				31	31
OHP	Off	N/A	8	32	60	24	124	124				124
United	Off	N/A	3	8	11	4	26		15	11		26
Total		0	16	56	98	37	207	124	15	11	57	207

2026 Actuarial Value (AV) 'On-Exchange' Plans by Market

Market	New Plan	Carrier	Plan Marketing Name	AV
Ind		CBI	Choice Catastrophic POS with Dental and Vision	60.7%
Ind		Anthem	Catastrophic HMO Pathway Enhanced	59.8%

Ind		CBI	Choice Bronze Alternative POS with Dental and Vision	62.4%
Ind		Anthem	Bronze HMO Pathway Enhanced with Adult Dental and Vision Benefits	62.3%
Ind	X	Anthem	Bronze HMO Pathway Enhanced	62.3%
Ind		Anthem	Bronze PPO Standard Pathway HSA	65.0%
Ind		Anthem	Bronze PPO Standard Pathway	63.8%
Ind		CBI	Choice Bronze Standard POS HSA	65.0%
Ind		CICI	Value Bronze Standard POS HSA	65.0%
Ind		CBI	Choice Bronze Standard POS	63.9%
Ind		CICI	Value Bronze Standard POS	63.9%
Ind	X	Anthem	Bronze PPO Pathway with PreventiveRx HSA	65.0%

Ind		Anthem	Silver PPO Standard Pathway	71.2%	73.7%	87.8%	94.8%
Ind		CBI	Choice Silver Standard POS	71.4%	73.9%	87.4%	94.5%
Ind		CICI	Value Silver Standard POS	71.4%	73.9%	87.4%	94.5%

Ind		Anthem	Gold HMO Pathway Enhanced with Adult Dental and Vision Benefits	79.1%
Ind		Anthem	Gold PPO Pathway with Adult Dental and Vision Benefits	79.1%
Ind		CBI	Choice Gold Alternative POS	78.7%
Ind	X	Anthem	Gold PPO Pathway	79.6%
Ind		Anthem	Gold PPO Standard Pathway	81.2%
Ind		CBI	Choice Gold Standard POS	81.4%
Ind		CICI	Value Gold Standard POS	81.4%

Market	New Plan	Carrier	Plan Marketing Name	AV
SG		Anthem	Bronze Pathway CT PPO	59.5%
SG		Anthem	Bronze Pathway CT PPO w/HSA	63.9%
SG		Anthem	Silver Pathway CT PPO	70.5%
SG		Anthem	Silver Pathway CT PPO w/HSA	70.9%
SG		Anthem	Gold Pathway CT PPO	80.2%
SG		Anthem	Platinum Pathway CT PPO	90.2%

2026 Individual QHP Rates

CID Approved Rates – Age 21

Carrier	Exch	Plan Marketing Name	Fairfield County		Hartford County		Litchfield County		Middlesex County		New Haven County		New London County		Tolland County		Windham County	
			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 and Vision	290.42	1	248.16	1	268.32	1	268.14	1	268.14	1	268.32	3	268.32	3	268.32	3
Anthem	On	Catastrophic HMO Pathway Enhanced	310.69	2	265.50	2	273.97	2	282.44	2	282.44	2	265.50	1	254.20	1	254.20	1
Anthem	Off	Anthem Catastrophic HMO Pathway Enhanced	310.69	2	265.50	2	273.97	2	282.44	2	282.44	2	265.50	1	254.20	1	254.20	1
Anthem	On	Bronze HMO Pathway Enhanced	532.48	4	455.03	4	469.55	4	484.07	4	484.07	4	455.03	6	435.67	4	435.67	4
Anthem	On	Bronze HMO Pathway Enhanced with Adult Dental and Vision Benefits	537.88	5	459.64	5	474.31	5	488.98	5	488.98	5	459.64	4	440.08	5	440.08	5
Anthem	Off	Anthem Bronze HMO Pathway Enhanced 8500/50%	540.80	6	462.14	6	476.89	6	491.64	6	491.64	6	462.14	5	442.47	6	442.47	6
CBI	On	Choice Bronze Standard POS	561.28	7	479.62	7	518.58	10	518.21	8	518.21	8	518.58	9	518.58	11	518.58	11
CBI	On	Choice Bronze Alternative POS with Dental and Vision	562.65	8	480.78	8	519.84	12	519.48	9	519.48	9	519.84	10	519.84	12	519.84	12
Anthem	On	Bronze PPO Pathway with PreventiveRx HSA	563.78	9	481.78	9	497.16	7	512.53	7	512.53	7	481.78	10	461.28	7	461.28	7
Anthem	On	Bronze PPO Standard Pathway HSA	572.48	10	489.21	10	504.83	8	520.44	10	520.44	10	489.21	11	468.40	8	468.40	8
Anthem	Off	Anthem Bronze HMO Pathway Enhanced 6000/12000/40% HSA	575.09	11	491.44	11	507.12	9	522.81	11	522.81	11	491.44	7	470.53	9	470.53	9
CBI	On	Choice Bronze Standard POS HSA	589.98	12	504.13	12	545.09	15	544.70	12	544.70	12	545.09	13	545.09	17	545.09	17
Anthem	On	Bronze PPO Standard Pathway	610.39	13	521.61	14	538.25	13	554.90	13	554.90	13	521.61	12	499.41	10	499.41	10
CCI	Off	Choice SOLO HMO HSA \$7,500 ded.	612.37	14	520.87	13	518.73	11	570.82	14	570.82	15	522.52	15	522.52	13	522.52	13
CICI	On	Value Bronze Standard POS	620.46	15	548.29	16	604.76	20	607.02	18	556.40	14	549.03	14	621.88	24	611.33	24
CCI	Off	Choice SOLO HMO Copay/Coins. \$7,700 ded.	637.71	16	542.43	15	540.20	14	594.44	16	594.44	18	544.14	18	544.14	16	544.14	16
Anthem	On	Silver PPO Standard Pathway	647.47	17	553.29	17	570.95	17	588.61	15	588.61	17	553.29	15	529.75	14	529.75	14
CICI	On	Value Bronze Standard POS HSA	652.26	18	576.39	20	635.76	23	638.14	22	584.92	16	577.17	19	653.75	26	642.67	26
Anthem	Off	Anthem Silver HMO Pathway Enhanced 4000/30%	654.39	19	559.21	18	577.06	18	594.90	17	594.90	19	559.21	17	535.41	15	535.41	15
CCI	Off	Choice SOLO POS HSA Coins. \$6,500 ded.	667.34	20	567.63	19	565.30	16	622.06	20	622.06	21	569.43	22	569.43	20	569.43	20
Anthem	Off	Anthem Bronze PPO Pathway 8000/0% HSA	680.74	21	581.73	21	600.29	19	618.86	19	618.86	20	581.73	23	556.97	18	556.97	18
Anthem	On	Gold HMO Pathway Enhanced with Adult Dental and Vision Benefits	688.05	22	587.97	22	606.73	21	625.50	21	625.50	22	587.97	20	562.95	19	562.95	19
Anthem	On	Gold PPO Pathway with Adult Dental and Vision Benefits	714.78	23	610.81	23	630.31	22	649.80	23	649.80	23	610.81	26	584.82	21	584.82	21
Anthem	Off	Anthem Gold HMO Pathway Enhanced 2000/10%	721.95	24	616.94	24	636.63	24	656.32	24	656.32	24	616.94	24	590.69	22	590.69	22
CBI	On	Choice Gold Alternative POS	725.80	25	620.19	25	670.57	26	670.10	26	670.10	26	670.57	30	670.57	27	670.57	27
Anthem	On	Gold PPO Pathway	728.43	26	622.48	26	642.34	25	662.21	25	662.21	25	622.48	28	595.99	23	595.99	23
CBI	On	Choice Silver Standard POS	731.52	27	625.08	27	675.86	28	675.38	27	675.38	27	675.86	31	675.86	28	675.86	28
Anthem	Off	Anthem Silver PPO Pathway 4000/20% HSA	765.20	28	653.89	28	674.76	27	695.63	28	695.63	28	653.89	31	626.07	25	626.07	25
CICI	On	Value Silver Standard POS	810.99	29	716.66	30	790.47	30	793.43	30	727.26	29	717.62	33	812.85	30	799.06	30
CBI	On	Choice Gold Standard POS	817.87	30	698.87	29	755.64	29	755.11	29	755.11	30	755.64	34	755.64	29	755.64	29
CICI	On	Value Gold Standard POS	905.24	31	799.94	31	882.32	31	885.63	31	811.77	31	801.02	35	907.30	31	891.92	31
Anthem	On	Gold PPO Standard Pathway	1,188.97	32	1,016.03	32	1,048.46	32	1,080.88	32	1,080.88	32	1,016.03	36	972.79	32	972.79	32

2026 Small Group QHP Rates

CID Approved Rates – Age 21

Carrier	Exch	Plan Marketing Name	Fairfield County		Hartford County		Litchfield County		Middlesex County		New Haven County		New London County		Tolland County		Windham County	
			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
Anthem	On	Bronze Pathway CT PPO	517.55	1	445.67	1	450.46	1	479.21	1	479.21	1	479.21	1	479.21	1	479.21	1
Anthem	On	Bronze Pathway CT PPO w/HSA	568.82	2	489.82	2	495.09	2	526.69	2	526.69	2	526.69	2	526.69	2	526.69	2
Anthem	Off	Anthem Bronze Century Preferred PPO 8000/0%/8000 w/HSA	599.85	3	516.54	3	522.10	3	555.42	3	555.42	3	555.42	3	555.42	3	555.42	3
Anthem	Off	Anthem Silver Pathway CT PPO 4500/20%/7500 w/HSA	604.45	4	520.50	4	526.09	4	559.67	4	559.67	4	559.67	4	559.67	4	559.67	4
Anthem	Off	Anthem Silver Pathway CT PPO 4000/20%/9000 Value	609.39	5	524.75	5	530.39	5	564.25	5	564.25	5	564.25	5	564.25	5	564.25	5
Anthem	On	Silver Pathway CT PPO w/HSA	613.91	6	528.64	6	534.33	6	568.43	6	568.43	6	568.43	6	568.43	6	568.43	6
Anthem	Off	Anthem Silver Century Preferred PPO 4500/20%/7500 w/HSA	637.28	7	548.77	7	554.67	7	590.08	7	590.08	7	590.08	7	590.08	7	590.08	7
Anthem	Off	Anthem Silver Century Preferred PPO 4000/20%/9000 Value	642.43	8	553.21	8	559.15	8	594.85	8	594.85	8	594.85	8	594.85	8	594.85	8
Anthem	Off	Anthem Silver Century Preferred PPO 3500/20%/7500 w/HSA	647.16	9	557.28	9	563.27	9	599.23	9	599.23	9	599.23	9	599.23	9	599.23	9
Anthem	On	Silver Pathway CT PPO	659.27	10	567.70	10	573.81	10	610.43	10	610.43	10	610.43	10	610.43	10	610.43	10
Anthem	Off	Anthem Gold Pathway CT PPO 2000NE/20%/6000 w/HSA	689.95	11	594.12	11	600.51	11	638.84	11	638.84	11	638.84	11	638.84	11	638.84	11
Anthem	Off	Anthem Silver Century Preferred PPO 4500/9000	694.82	12	598.32	12	604.75	12	643.35	12	643.35	12	643.35	12	643.35	12	643.35	12
Anthem	Off	Anthem Gold Pathway CT PPO 2000/20%/5000 Value	698.16	13	601.19	13	607.66	13	646.44	13	646.44	13	646.44	13	646.44	13	646.44	13
Anthem	Off	Anthem Gold Pathway CT PPO 2500/5500	713.33	14	614.25	14	620.86	14	660.49	14	660.49	14	660.49	14	660.49	14	660.49	14
Anthem	Off	Anthem Gold Century Preferred PPO 2000NE/20%/6000 w/HSA	727.03	15	626.06	15	632.79	15	673.18	15	673.18	15	673.18	15	673.18	15	673.18	15
Anthem	On	Gold Pathway CT PPO	727.31	16	626.30	16	633.03	16	673.44	16	673.44	16	673.44	16	673.44	16	673.44	16
Anthem	Off	Anthem Gold Century Preferred PPO 2000/20%/5000 Value	735.66	17	633.48	17	640.30	17	681.17	17	681.17	17	681.17	17	681.17	17	681.17	17
Anthem	Off	Anthem Gold Century Preferred PPO 2500/5500	751.59	18	647.20	18	654.16	18	695.92	18	695.92	18	695.92	18	695.92	18	695.92	18
Anthem	Off	Anthem Gold Pathway CT PPO 30/8000	765.30	19	659.01	19	666.09	19	708.61	19	708.61	19	708.61	19	708.61	19	708.61	19
Anthem	Off	Anthem Gold Century Preferred PPO 1500/5500	766.20	20	659.79	20	666.88	20	709.45	20	709.45	20	709.45	20	709.45	20	709.45	20
Anthem	On	Platinum Pathway CT PPO	773.23	21	665.84	21	673.00	21	715.95	21	715.95	21	715.95	21	715.95	21	715.95	21
Anthem	Off	Anthem Gold Century Preferred PPO 30/8000	806.07	22	694.11	22	701.58	22	746.36	22	746.36	22	746.36	22	746.36	22	746.36	22
Anthem	Off	Anthem Platinum Century Preferred PPO 25/2500	814.42	23	701.30	23	708.84	23	754.09	23	754.09	23	754.09	23	754.09	23	754.09	23
Anthem	Off	Anthem Virtual Access Plus Gold Century Preferred PPO 50/9000	832.92	24	717.24	24	724.95	24	771.22	24	771.22	24	771.22	24	771.22	24	771.22	24
Anthem	Off	Anthem Virtual Access Plus Gold Century Preferred PPO 30/8000	867.92	25	747.37	25	755.41	25	803.63	25	803.63	25	803.63	25	803.63	25	803.63	25
Anthem	Off	Anthem Virtual Access Plus Platinum Century Preferred PPO 25/2500	901.38	26	776.19	26	784.54	26	834.61	26	834.61	26	834.61	26	834.61	26	834.61	26

2026 Individual SADP Rates

Age 25 and under

	Individual Rate (All Counties)	Rank
Anthem Dental Family Preventive	31.76	1
Anthem Family Dental Value	31.76	1
Anthem Dental Family	31.76	1
Anthem Dental Family Enhanced	36.00	4
ConnectiCare Basic Dental Plan	58.72	5
ConnectiCare Standard Dental Plan	60.17	6
Guardian Essentials for Families and Individuals	33.46	4
Guardian Preventive Plus for Families and Individuals	33.46	4
Guardian Preventive for Families and Individuals	33.46	4
Guardian Standard for Families and Individuals	43.56	8

Age 26 and over

	Individual Rate (All Counties)	Rank
Anthem Dental Family Preventive	17.07	1
Anthem Family Dental Value	23.56	3
Anthem Dental Family	34.01	7
Anthem Dental Family Enhanced	57.98	8
ConnectiCare Basic Dental Plan	26.95	5
ConnectiCare Standard Dental Plan	62.53	9
Guardian Essentials for Families and Individuals	31.61	6
Guardian Preventive Plus for Families and Individuals	21.34	2
Guardian Preventive for Families and Individuals	23.71	4
Guardian Standard for Families and Individuals	68.27	10

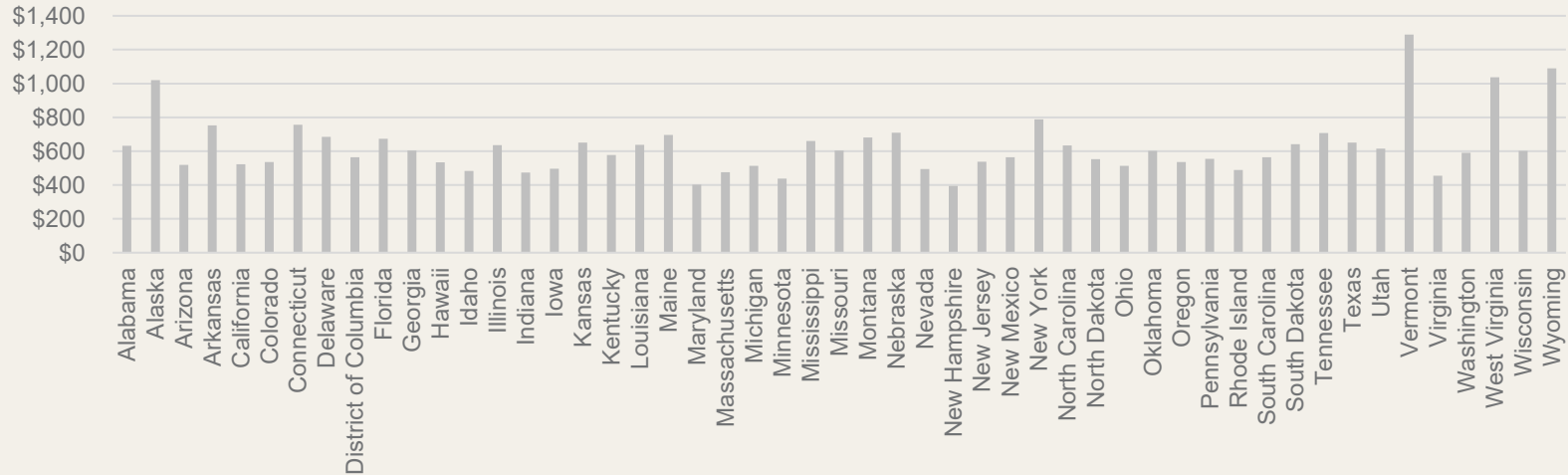
📌 Average Marketplace Premiums

Age 40 Average Premium - Lowest Cost Bronze Premium for Plan Year 2026



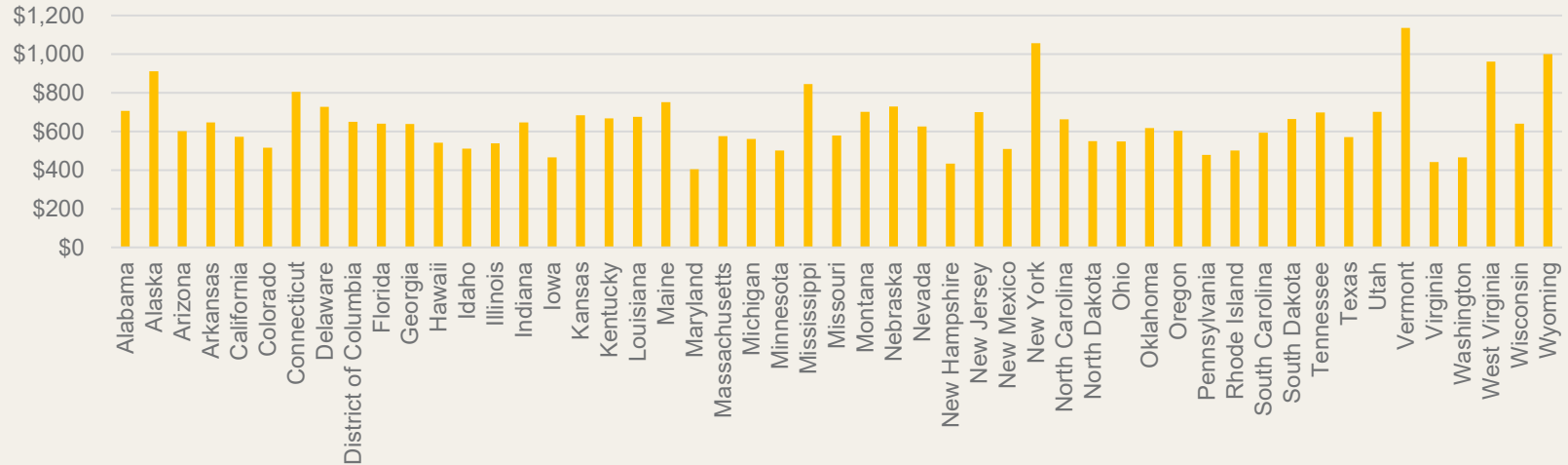
🔗 Average Marketplace Premiums

Age 40 Average Premium - Lowest Cost Silver Premium for Plan Year 2026



🔗 Average Marketplace Premiums

Age 40 Average Premium - Lowest Cost Gold Premium for Plan Year 2026



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

🔗 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.

🔗 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.

⚡ 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.

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.

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.

Expansion of Coverage

State Regulation: Behavioral Therapy

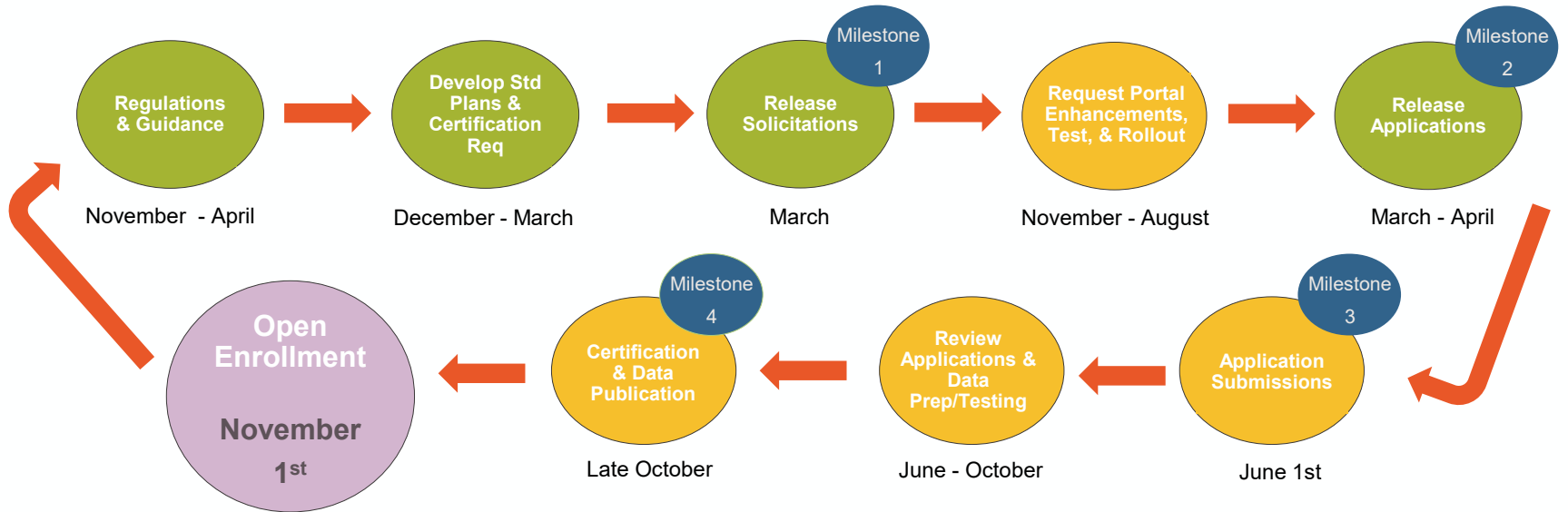
State of Connecticut Public Act No. 25-3 (House Bill No. 8004)

Summary: This Public Act expands insurance coverage of applied behavioral analysis services for individuals diagnosed with autism spectrum disorder, up to age 26.

"Behavioral therapy" means any interactive behavioral therapies derived from evidence-based research and consistent with the services and interventions designated by the Commissioner of Social Services pursuant to subsection (e) of section 17a-215c, including, but not limited to, applied behavior analysis, cognitive behavioral therapy, or other therapies supported by empirical evidence of the effective treatment of individuals diagnosed with autism spectrum disorder, that are: (A) **Provided to [children less than twenty-one] individuals under twenty-six years of age;** and (B) provided or supervised by (i) a licensed behavior analyst, (ii) a licensed physician, or (iii) a licensed psychologist. For the purposes of this subdivision, behavioral therapy is "supervised by" such licensed behavior analyst, licensed physician or licensed psychologist when such supervision entails at least one hour of face-to-face supervision of the autism spectrum disorder services provider by such licensed behavior analyst, licensed physician or licensed psychologist for each ten hours of behavioral therapy provided by the supervised provider.

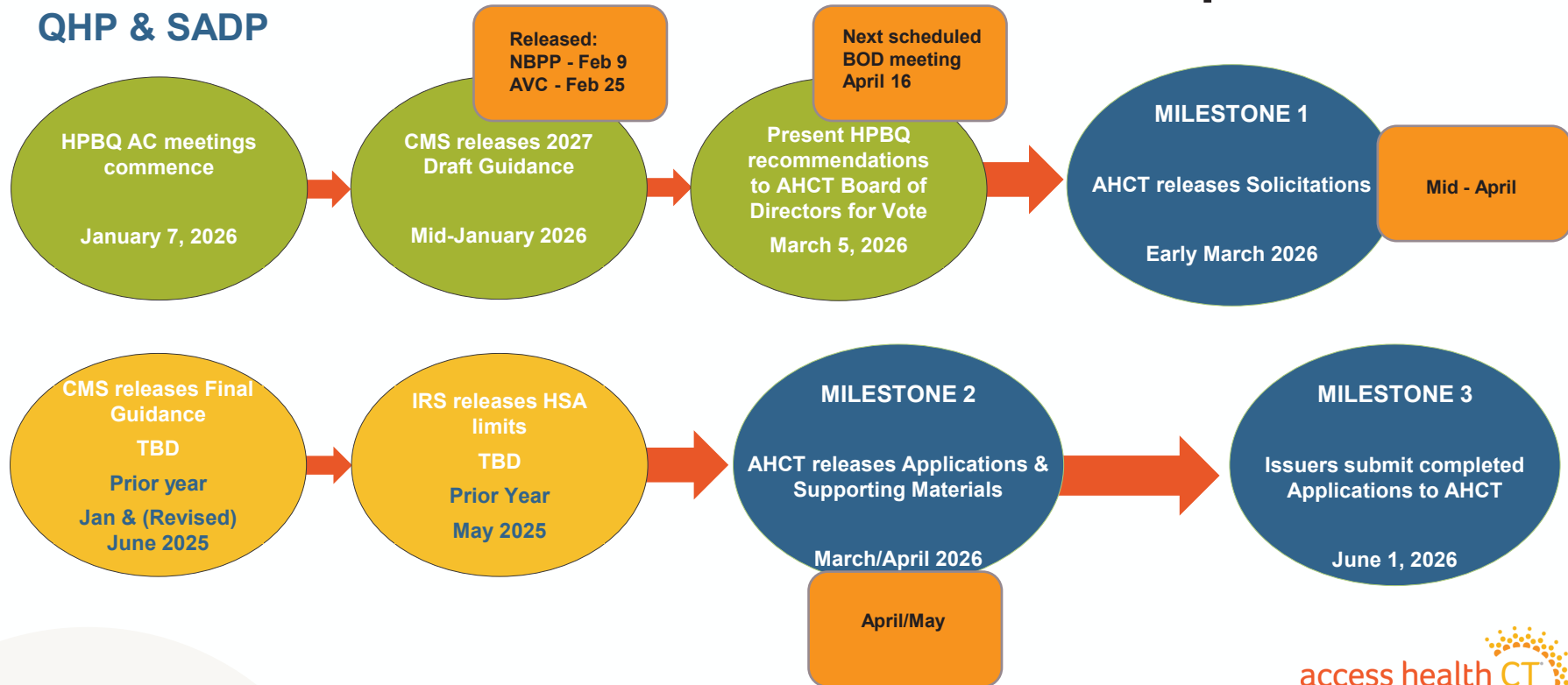
Plan Management Certification Life Cycle

QHP & SADP



🌟 Certification Timeline for Plan Year 2027 - Updated

QHP & SADP



Certification Requirements	Modified in 2026	Suggested Topic for 2027
Essential Health Benefits (EHB) Benchmark Plan: CMS Submission Deadline: May 1, 2026 for PY 2027 (CID)		
Prescription Drug Formulary Review Responsibility (CID)		
Network Adequacy Standards (CID)		
Tobacco Use Premium Surcharge in the Individual Market		
Broker Compensation		●
Essential Community Provider (ECP) Contracting Standards		
Pediatric Dental Coverage in Medical Plans		
Lowest Cost Silver Plan in the Individual Market		
Standardized Plan Development – Individual Medical	●	●
Standardized Plan Development – Individual SADP		●
“Plan Mix”: Individual Medical		
“Plan Mix”: Individual Stand-Alone Dental Plans (SADP)		
“Plan Mix”: Small Group Medical		
“Plan Mix”: Small Group Stand-Alone Dental Plans (SADP)		
New Federal / State Regulations and Guidance		
Suggested Topics by AHCT Board of Directors, HPBQ AC or Other Constituents		

2027 Permitted Plans 'On-Exchange'

Qualified Health Plans

Metal Level	Individual		Small Group	
	Standardized (Required)	Non-Standard (Optional)	Required*	Optional
Catastrophic	N/A	1	N/A	N/A
Bronze	2	3	2	2
Silver	1	0	2	4
Gold	1	3	1	5
Platinum	N/A	2	N/A	4
Total	4	Up to 9	5	Up to 15

Stand-Alone Dental Plans

Individual & Small Group	
Standardized (Required)	Non-Standard (Optional)
1	3

* There is no requirement for "standardized" plans in Small Group.

2026 Individual Gold Health Plans					
Plan Name	Standard Plans (All Issuers)	Anthem Gold PPO Pathway with Adult Dental and Vision	Anthem Gold PPO Pathway	Anthem Gold HMO Pathway Enhanced with Adult Dental and Vision Benefits	CBI Choice Gold Alternative POS
Plan Type	PPO or POS	PPO	PPO	HMO	POS
Preventive Care - (Annual Check Up)	\$0.00 Copay, deductible does not apply				
Primary Care Visit (To Treat an Illness or Injury)	\$20.00 Copay, deductible does not apply	\$20.00 Copay, deductible does not apply	10.00% Coinsurance after deductible	\$20.00 Copay, deductible does not apply	\$40.00 Copay, deductible does not apply
Specialist Visit	\$40.00 Copay, deductible does not apply	\$80.00 Copay, deductible does not apply	10.00% Coinsurance after deductible	\$80.00 Copay, deductible does not apply	\$50.00 Copay, deductible does not apply
Mental/Behavioral Health Office Visit	\$20.00 Copay, deductible does not apply	10.00% Coinsurance after deductible	10.00% Coinsurance after deductible	10.00% Coinsurance after deductible	\$40.00 Copay, deductible does not apply
Substance Use Disorder Office Visit	\$20.00 Copay, deductible does not apply	10.00% Coinsurance after deductible	10.00% Coinsurance after deductible	10.00% Coinsurance after deductible	\$40.00 Copay, deductible does not apply
Advanced Radiology (CT/PET Scans, MRIs)	\$65.00 Copay, deductible does not apply	10.00% Coinsurance after deductible	10.00% Coinsurance after deductible	10.00% Coinsurance after deductible	30.00% Coinsurance after deductible
Laboratory Services	\$10.00 Copay, deductible does not apply	10.00% Coinsurance after deductible	10.00% Coinsurance after deductible	10.00% Coinsurance after deductible	\$10.00 Copay, deductible does not apply
Non-Advanced Radiology (X-rays and Diagnostic)	\$40.00 Copay after deductible	10.00% Coinsurance after deductible	10.00% Coinsurance after deductible	10.00% Coinsurance after deductible	30.00% Coinsurance after deductible
Mammography Ultrasound (Non-preventive)	\$20.00 Copay, deductible does not apply	10.00% Coinsurance after deductible	10.00% Coinsurance after deductible	10.00% Coinsurance after deductible	30.00% Coinsurance after deductible
Tier 1 - Generic Drugs	\$5.00 Copay, deductible does not apply	\$5.00 Copay, deductible does not apply	10.00% Coinsurance, deductible does not apply	\$5.00 Copay, deductible does not apply	\$10.00 Copay, deductible does not apply
Tier 2 - Preferred Brand Drugs	\$35.00 Copay, deductible does not apply	\$40.00 Copay, deductible does not apply	20.00% Coinsurance, deductible does not apply	\$40.00 Copay, deductible does not apply	\$40.00 Copay, deductible does not apply
Tier 3 - Non-Preferred Brand Drugs	\$60.00 Copay, deductible does not apply	20.00% Coinsurance, deductible does not apply to a maximum of \$500 per prescription	20.00% Coinsurance, deductible does not apply to a maximum of \$500 per prescription	20.00% Coinsurance, deductible does not apply to a maximum of \$500 per prescription	20.00% Coinsurance after Prescription Drug deductible
Tier 4 - Specialty Drugs	20.00% Coinsurance after Prescription Drug deductible to a maximum of \$100 per prescription	30.00% Coinsurance, deductible does not apply to a maximum of \$1,000 per prescription	30.00% Coinsurance after deductible to a maximum of \$1,000 per prescription	30.00% Coinsurance, deductible does not apply to a maximum of \$1,000 per prescription	20.00% Coinsurance after Prescription Drug deductible to a maximum of \$750 per prescription
Speech Therapy	\$20.00 Copay, deductible does not apply	\$30.00 Copay, deductible does not apply	10.00% Coinsurance after deductible	\$30.00 Copay, deductible does not apply	30.00% Coinsurance after deductible
Physical and Occupational Therapy	\$20.00 Copay, deductible does not apply	\$30.00 Copay, deductible does not apply	10.00% Coinsurance after deductible	\$30.00 Copay, deductible does not apply	30.00% Coinsurance after deductible
Chiropractic Care	\$40.00 Copay, deductible does not apply	\$30.00 Copay, deductible does not apply	10.00% Coinsurance after deductible	\$30.00 Copay, deductible does not apply	30.00% Coinsurance after deductible
Diabetic Equipment and Supplies	30.00% Coinsurance, deductible does not apply	40.00% Coinsurance, deductible does not apply	10.00% Coinsurance after deductible	40.00% Coinsurance, deductible does not apply	30.00% Coinsurance after deductible
Durable Medical Equipment	30.00% Coinsurance, deductible does not apply	40.00% Coinsurance, deductible does not apply	10.00% Coinsurance after deductible	40.00% Coinsurance, deductible does not apply	30.00% Coinsurance after deductible
Home Health Care Services	\$0.00 Copay, deductible does not apply	10.00% Coinsurance after separate \$50 deductible	10.00% Coinsurance after separate \$50 deductible	10.00% Coinsurance after separate \$50 deductible	25.00% Coinsurance after separate \$50 deductible
Outpatient Facility	\$500.00 Copay after deductible	10.00% Coinsurance after deductible	10.00% Coinsurance after deductible	10.00% Coinsurance after deductible	30.00% Coinsurance after deductible
Inpatient Hospital Services (all Inpatient settings)	\$500.00 Copay per Day after deductible to a maximum of \$1,000.00 per admission	10.00% Coinsurance after deductible	10.00% Coinsurance after deductible	10.00% Coinsurance after deductible	30.00% Coinsurance after deductible
Ambulance	\$0.00 Copay, deductible does not apply	10.00% Coinsurance after deductible	10.00% Coinsurance after deductible	10.00% Coinsurance after deductible	30.00% Coinsurance after deductible
Emergency Room Services	\$400.00 Copay, deductible does not apply	10.00% Coinsurance after deductible	10.00% Coinsurance after deductible	10.00% Coinsurance after deductible	30.00% Coinsurance after deductible
Urgent Care Centers or Facilities	\$50.00 Copay, deductible does not apply	\$100.00 Copay, deductible does not apply	10.00% Coinsurance after deductible	\$100.00 Copay, deductible does not apply	30.00% Coinsurance, deductible does not apply

2026 Individual Gold Health Plans					
Plan Name	Standard Plans (All Issuers)	Anthem Gold PPO Pathway with Adult Dental and Vision	Anthem Gold PPO Pathway	Anthem Gold HMO Pathway Enhanced with Adult Dental and Vision Benefits	CBI Choice Gold Alternative POS
Diagnostic and Preventive - Adult	Not Covered	20.00% Coinsurance, deductible does not apply	Not Covered	20.00% Coinsurance, deductible does not apply	Not Covered
Basic Restorative - Adult	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Major Restorative - Adult	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Orthodontic Services - Adult	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Diagnostic and Preventive - Pediatric	\$0.00 Copay, deductible does not apply	\$0.00 Copay, deductible does not apply	Not Covered	0.00% Coinsurance, deductible does not apply	\$0.00 Copay, deductible does not apply
Basic Restorative - Pediatric	20.00% Coinsurance, deductible does not apply	40.00% Coinsurance after deductible	Not Covered	40.00% Coinsurance after deductible	50.00% Coinsurance after deductible
Major Restorative - Pediatric	40.00% Coinsurance, deductible does not apply	50.00% Coinsurance after deductible	Not Covered	50.00% Coinsurance after deductible	50.00% Coinsurance after deductible
Orthodontic Services - Pediatric (When medically necessary)	50.00% Coinsurance, deductible does not apply	50.00% Coinsurance after deductible	Not Covered	50.00% Coinsurance after deductible	50.00% Coinsurance after deductible
Routine Eye Exam - Pediatric	\$40.00 Copay, deductible does not apply	\$40.00 Copay, deductible does not apply	\$40.00 Copay after deductible	\$40.00 Copay, deductible does not apply	\$50.00 Copay, deductible does not apply
Eye Glasses for Children	\$0.00 Copay, deductible does not apply	\$0.00 Copay, deductible does not apply	\$0.00 Copay after deductible	\$0.00 Copay, deductible does not apply	50.00% Coinsurance after deductible
Routine Eye Exam - Adult	**	\$40.00 Copay, deductible does not apply	Not Covered	\$40.00 Copay, deductible does not apply	\$50.00 Copay, deductible does not apply
Deductible-Individual	\$1,200	\$2,000	\$2,000	\$2,000	\$2,000
Deductible-Family	\$2,400	\$4,000	\$4,000	\$4,000	\$4,000
Separate Prescription Drug Deductible - Ind	\$50	Included in deductible	Included in deductible	Included in deductible	\$75
Separate Prescription Drug Deductible - Family	\$100	Included in deductible	Included in deductible	Included in deductible	\$150
Out-of-Pocket Maximum-Individual	\$7,375	\$8,000	\$9,000	\$8,000	\$7,900
Out-of-Pocket Maximum-Family	\$14,750	\$16,000	\$18,000	\$16,000	\$15,800
Gray shading indicates deductible does not apply for that covered service.					
*A standard plan shares the same plan design and member cost share amounts across all Carriers. The difference will be in physician networks, prescription drug formularies, Carrier specific programs, and monthly premiums.					
** This is not defined by Access Health CT as a requirement for a standard plan and can vary by Carrier. Refer to the Carrier specific plan document for plan specifics.					

Silver Plan Comparison

	2027 Option 4	2027 Option 2	2027 Option 1	2027 Option 1	2027 Option 2
Benefit Category	Silver Plan	Silver Plan (73%)	Silver Plan (87%)	Silver Plan (94%)	Silver Plan (94%)
Medical Deductible	\$5,500	\$5,000	\$415	\$0	\$0
Rx Deductible	\$250	\$250	\$50	\$0	\$0
Coinsurance	40%	40%	40%	40%	40%
Out-of-pocket Maximum	\$10,550	\$9,600	\$3,500	\$2,500	\$1,800
Primary Care, Mental Health	\$45	\$48	\$35	\$15	\$25
Specialist Care	\$80	\$80	\$50	\$30	\$50
Urgent Care	\$100	\$100	\$35	\$25	\$35
Emergency Room	\$450 (after ded.)	\$450 (after ded.)	\$150 (after ded.)	\$50	\$50
Inpatient Hospital	\$500 per day (after ded., \$2,000 max. per admission)	\$500 per day (after ded., \$2,000 max. per admission)	\$100 per day (after ded., \$400 max. per admission)	\$75 per day (\$300 max. per admission)	\$75 per day (\$300 max. per admission)
Outpatient Services (hospital or ambulatory facility)	\$300 ASC/\$500 otherwise (after ded.)	\$100@ASC/\$200 otherwise (after ded.)	\$60@ASC/\$100 otherwise (after ded.)	\$45@ASC/\$75 otherwise	\$45@ASC/\$75 otherwise
Advanced Radiology (CT/PET Scan, MRI) (Max \$75 copay)	\$75	\$75	\$60	\$50	\$55
Non-Advanced Radiology (X-ray, Diagnostic)	\$50 (after ded.)	\$40 (after ded.)	\$30 (after ded.)	\$25	\$35
Laboratory Services	\$40	\$25	\$25	\$20	\$25
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type (Max \$30 copay)	\$30	\$30	\$20	\$20	\$20
Chiropractic Care 20 visit calendar maximum	\$50	\$50	\$35	\$30	\$30
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
All Other Medical	40%	40%	40%	40%	40%
Tier 1: Generic	Tier 1: \$10 ded not apply	Tier 1: \$10 ded not apply	Tier 1: \$10 ded not apply	Tier 1: \$5	Tier 1: \$5
Tier 2: Preferred Brand	Tier 2: \$50 after ded.	Tier 2: \$50 after ded.	Tier 2: \$25 ded not apply	Tier 2: \$15	Tier 2: \$15
Tier 3: Non-Preferred Brand	Tier 3: \$75 after ded.	Tier 3: \$75 after ded.	Tier 3: \$40 after ded.	Tier 3: \$35	Tier 3: \$35
Tier 4: Specialty Rx	Tier 4: 20% coinsurance up to \$200 max after ded.)	Tier 4: 20% coinsurance up to \$100 max after ded.)	Tier 4: 20% coinsurance up to \$60 max after ded.)	Tier 4: 20% coinsurance up to \$60 max	Tier 4: 20% coinsurance up to \$60 max