Filing at a Glance

Company:	Anthem Health Plans, Inc dba Anthem Blue Cross and Blue Shield of Connecticut
Product Name:	Individual 2026
State:	Connecticut
TOI:	HOrg02I Individual Health Organizations - Health Maintenance (HMO)
Sub-TOI:	HOrg02I.005D Individual - HMO
Filing Type:	Rate
Date Submitted:	05/30/2025
SERFF Tr Num:	AWLP-134549275
SERFF Status:	Assigned
State Tr Num:	202502662
State Status:	
Co Tr Num:	
Effective Date Requested:	01/01/2026
Author(s):	Tu Nguyen, Kayla Hall, Josiah Smith
Reviewer(s):	Tricia Dave (primary), Paul Lombardo, Sarah Mu
Disposition Date:	
Disposition Status:	
Effective Date:	

State Filing Description:

State: *Connecticut* ***Filing Company:*** *Anthem Health Plans, Inc dba Anthem Blue Cross and Blue Shield of Connecticut*

TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*

Product Name: *Individual 2026*

Project Name/Number: */*

General Information

Project Name:

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact: 14.2%

Deemer Date:

Submitted By: Kayla Hall

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 06/01/2025

State Status Changed:

Created By: Kayla Hall

Corresponding Filing Tracking Number:

Filing Description:

State: *Connecticut* **Filing Company:** *Anthem Health Plans, Inc dba Anthem Blue Cross and Blue Shield of Connecticut*

TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*

Product Name: *Individual 2026*

Project Name/Number: */*

May 30, 2025

Ms. Tricia Dave, FSA, MAAA
Actuary, Life & Health Division
State of Connecticut Insurance Department
P.O. Box 816
Hartford, CT 06142-0816

Re: Anthem BCBS 2026 Individual Rate Filing
SERFF Tracking Number AWLP-134549275

Dear Ms. Dave:

For your approval, Anthem Blue Cross and Blue Shield (ABCBS) is submitting proposed premium rates for its new and renewing Individual Products for both On & Off the Connecticut Exchange, effective January 1, 2026. The following policy forms are affected by the requested rate change.

CT_ONHIX_PPO_01-26
CT_OFFHIX_PPO_01-26
CT_ONHIX_HMO_01-26
CT_OFFHIX_HMO_01-26

Please see the enclosed files for the scope of changes and the supporting documents:

•Anthem Individual State - Actuarial Memorandum (20250530CT86545IndvStateActuarialMemorandum)
•Anthem 2026 Individual Actuarial Certification (20250530CT86545IndvAnthemActuarialCertification)
•Anthem Individual Federal – Actuarial Memorandum (20250530CT86545IndvFederalActuarialMemorandum)
•Anthem 2026 Unified Rate Review Template (20250530CT86545IndvUnifiedRateReviewTemplate)
•Unique Plan Design Supporting Documentation (20250530CT86545IndvOnOffUniquePlanJustifications)
•Actuarial Value Screenshot for each Individual Plan (20250530CT86545IndvAVPlanScreenshots)
•Anthem 2026 Rate Tables (20250530CT86545IndvOnOffRateTables)
•Anthem 2026 Schedule of Benefits (20250530CT86545IndvSOBs)
•Anthem 2026 Appendix A (20250530CT86545IndvAppendixA)
•Anthem 2026 Exhibit A (20250530CT86545IndvExhibitA)
•Anthem 2026 Part II Written Justification (20250530CT86545IndvPartIIWrittenJustification)
•Anthem 2026 Federal Mental Health Parity Results and Attestation (20250530CT86545IndvFMHPResults&Attestation)

The Individual Rates are developed from the 2024 Individual ACA experience and this same experience data is used for the Claim Lag Triangle exhibit.

The data paid through March 2025 for Exhibit Q within the actuarial memorandum was not available in time for this rate filing. Exhibit Q will be submitted by end of day, June 13th.

Thank you for your attention to this filing. If you have any questions regarding this matter, please feel free to contact me at tu.nguyen@elevancehealth.com.

Sincerely,

Tu Nguyen, FSA, MAAA
Actuarial Strategic Planning Leader

Attachments

Company and Contact

Filing Contact Information

Tu Nguyen, Actuarial Strategic Planning Leader
108 Leigus Road
Wallingford, CT 06492

tu.nguyen@elevancehealth.com

860-794-2449 [Phone]

Filing Company Information

Anthem Health Plans, Inc dba Anthem Blue Cross and Blue Shield of Connecticut
108 Leigus Road
Wallingford, CT 06492
(203) 677-4000 ext. [Phone]

CoCode: 60217
Group Code: 671
Group Name: WellPoint Inc Group
FEIN Number: 06-1475928

State of Domicile: Connecticut
Company Type: Life, Accident, Health
State ID Number:

State: *Connecticut* **Filing Company:** *Anthem Health Plans, Inc dba Anthem Blue Cross and Blue Shield of Connecticut*

TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*

Product Name: *Individual 2026*

Project Name/Number: */*

Filing Fees

State Fees

Fee Required? No

Retaliatory? No

Fee Explanation:

State Specific

Individual, Small group and non-employer group health filings require rates to be filed. Does this filing comply with the requirements of item 17 of the general instructions?: Yes

A number of long standing Department positions have been reviewed and modified. As a result, some checklists have been amended, for your convenience we have summarized all of these modifications under General Instructions entitled "Amended Department Positions", have you reviewed this attachment at the bottom of the General Instructions?: Yes

SERFF Tracking #:	*AWLP-134549275*	***State Tracking #:***	*202502662*	***Company Tracking #:***	

State:	*Connecticut*	***Filing Company:***	*Anthem Health Plans, Inc dba Anthem Blue Cross and Blue Shield of Connecticut*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*		
Product Name:	*Individual 2026*		
Project Name/Number:	*/*		

Rate Information

Rate data applies to filing.

Filing Method:	Review & Approval
Rate Change Type:	Increase
Overall Percentage of Last Rate Revision:	6.400%
Effective Date of Last Rate Revision:	01/01/2025
Filing Method of Last Filing:	Review & Approval
SERFF Tracking Number of Last Filing:	AWLP-134125233

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	Number of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Anthem Health Plans, Inc dba Anthem Blue Cross and Blue Shield of Connecticut	14.200%	14.200%	$124,256,188	59,438	$1,005,604,151	22.800%	6.400%

SERFF Tracking #:	*AWLP-134549275*	***State Tracking #:***	*202502662*	***Company Tracking #:***

State:	*Connecticut*	***Filing Company:***	*Anthem Health Plans, Inc dba Anthem Blue Cross and Blue Shield of Connecticut*

TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*
Product Name: *Individual 2026*
Project Name/Number: */*

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		Exhibit A	CT_ONHIX_PPO_01-26, CT_OFFHIX_PPO_01-26, CT_ONHIX_HMO_01-26, and CT_OFFHIX_HMO_01-26	New		20250530CT86545IndvExhibitA.pdf,
2		Rate Table	CT_ONHIX_PPO_01-26, CT_OFFHIX_PPO_01-26, CT_ONHIX_HMO_01-26, and CT_OFFHIX_HMO_01-26	New		20250530CT86545IndvOnOffRateTables.pdf, 20250530CT86545IndvOnOffRateTables.xlsm,
3		Appendix A	CT_ONHIX_PPO_01-26, CT_OFFHIX_PPO_01-26, CT_ONHIX_HMO_01-26, and CT_OFFHIX_HMO_01-26	New		20250530CT86545IndvAppendixA.pdf,

SERFF Tracking #:	AWLP-134549275	**State Tracking #:**	202502662	**Company Tracking #:**	

State:	Connecticut	**Filing Company:**	Anthem Health Plans, Inc dba Anthem Blue Cross and Blue Shield of Connecticut
TOI/Sub-TOI:	HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO		
Product Name:	Individual 2026		
Project Name/Number:	/		

Attachment 20250530CT86545IndvOnOffRateTables.xlsm is not a PDF document and cannot be reproduced here.

Exhibit A - Non-Grandfathered Rate Changes

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2026

HIOS Plan Name	2026 HIOS Plan ID	On/Off Exchange	Metal Level	Network Name	Area(s) Offered	Plan Category	Plan Specific Rate Change (excluding aging) {1},{2}
Catastrophic HMO Pathway Enhanced	86545CT1230005	On	Catastrophic	Pathway Enhanced	All	Renewing	7.4%
Bronze HMO Pathway Enhanced with Adult Dental and Vision Benefits	86545CT1230025	On	Bronze	Pathway Enhanced	All	Renewing	8.5%
Gold HMO Pathway Enhanced with Adult Dental and Vision Benefits	86545CT1230027	On	Gold	Pathway Enhanced	All	Renewing	11.6%
Anthem Catastrophic HMO Pathway Enhanced	86545CT1310033	Off	Catastrophic	Pathway Enhanced	All	Renewing	7.1%
Anthem Bronze HMO Pathway Enhanced 6000/12000/40% HSA	86545CT1310019	Off	Bronze	Pathway Enhanced	All	Renewing	8.8%
Anthem Bronze HMO Pathway Enhanced 8500/50%	86545CT1310055	Off	Bronze	Pathway Enhanced	All	Renewing	7.3%
Anthem Silver HMO Pathway Enhanced 4000/30%	86545CT1310056	Off	Silver	Pathway Enhanced	All	Renewing	8.7%
Anthem Gold HMO Pathway Enhanced 2000/10%	86545CT1310060	Off	Gold	Pathway Enhanced	All	Renewing	13.8%
Bronze PPO Standard Pathway HSA	86545CT1330009	On	Bronze	Pathway	All	Renewing	13.6%
Bronze PPO Standard Pathway	86545CT1330002	On	Bronze	Pathway	All	Renewing	15.0%
Silver PPO Standard Pathway	86545CT1330001	On	Silver	Pathway	All	Renewing	15.9%
Gold PPO Pathway with Adult Dental and Vision Benefits	86545CT1330020	On	Gold	Pathway	All	Renewing	12.1%
Gold PPO Standard Pathway	86545CT1330003	On	Gold	Pathway	All	Renewing	6.4%
Anthem Bronze PPO Pathway 8000/0% HSA	86545CT1340020	Off	Bronze	Pathway	All	Renewing	22.8%
Anthem Silver PPO Pathway 4000/20% HSA	86545CT1340021	Off	Silver	Pathway	All	Renewing	20.7%
Bronze PPO Pathway with PreventiveRx HSA	86545CT1570001	On	Bronze	Pathway	All	New	N/A
Gold PPO Pathway	86545CT1570002	On	Gold	Pathway	All	New	N/A
Bronze HMO Pathway Enhanced	86545CT1580001	On	Bronze	Pathway Enhanced	All	New	N/A

NOTES:

{1} Plan level increases in rates do not include demographic changes in the population.

{2} Plan level rate increases were developed in accordance to URR Instructions.

2026 Rates Table Template v15.0	*All fields with an asterisk (*) are required. To validate press Validate button or Ctrl + Shift + I. To finalize, press Finalize button or Ctrl + Shift + F.*			
	If you are in a community rating state, select Family-Tier Rates under Rating Method and fill in all columns.			
	If you are not in a community rating state, select Age-Based Rates under Rating Method and provide an Individual Rate for every age band.			
	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.			
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + H. All plans must have the same dates on a sheet.			
HIOS Issuer ID*	86545			
Rate Effective Date*	1/1/2026			
Rate Expiration Date*	12/31/2026			
Rating Method*	Age-Based Rates			

Plan ID*	Rating Area ID*	Tobacco*	Age*	Individual Rate*
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Required:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan
86545CT1230005	Rating Area 1	No Preference	0-14	238.24
86545CT1230005	Rating Area 1	No Preference	15	259.42
86545CT1230005	Rating Area 1	No Preference	16	267.52
86545CT1230005	Rating Area 1	No Preference	17	275.62
86545CT1230005	Rating Area 1	No Preference	18	284.34
86545CT1230005	Rating Area 1	No Preference	19	293.06
86545CT1230005	Rating Area 1	No Preference	20	302.09
86545CT1230005	Rating Area 1	No Preference	21	311.43
86545CT1230005	Rating Area 1	No Preference	22	311.43
86545CT1230005	Rating Area 1	No Preference	23	311.43
86545CT1230005	Rating Area 1	No Preference	24	311.43
86545CT1230005	Rating Area 1	No Preference	25	312.68
86545CT1230005	Rating Area 1	No Preference	26	318.90
86545CT1230005	Rating Area 1	No Preference	27	326.38
86545CT1230005	Rating Area 1	No Preference	28	338.52
86545CT1230005	Rating Area 1	No Preference	29	348.49
86545CT1230005	Rating Area 1	No Preference	30	353.47
86545CT1230005	Rating Area 1	No Preference	31	360.95
86545CT1230005	Rating Area 1	No Preference	32	368.42
86545CT1230005	Rating Area 1	No Preference	33	373.09
86545CT1230005	Rating Area 1	No Preference	34	378.08
86545CT1230005	Rating Area 1	No Preference	35	380.57
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86545CT1230005	Rating Area 1	No Preference	53	635.32
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86545CT1230005	Rating Area 4	No Preference		53	577.56
86545CT1230005	Rating Area 4	No Preference		54	604.46
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86545CT1580001	Rating Area 7	No Preference	25	438.49
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86545CT1580001	Rating Area 7	No Preference	27	457.70
86545CT1580001	Rating Area 7	No Preference	28	474.74
86545CT1580001	Rating Area 7	No Preference	29	488.71
86545CT1580001	Rating Area 7	No Preference	30	495.70
86545CT1580001	Rating Area 7	No Preference	31	506.18
86545CT1580001	Rating Area 7	No Preference	32	516.66
86545CT1580001	Rating Area 7	No Preference	33	523.21
86545CT1580001	Rating Area 7	No Preference	34	530.20
86545CT1580001	Rating Area 7	No Preference	35	533.70
86545CT1580001	Rating Area 7	No Preference	36	537.19
86545CT1580001	Rating Area 7	No Preference	37	540.68
86545CT1580001	Rating Area 7	No Preference	38	544.18
86545CT1580001	Rating Area 7	No Preference	39	551.17
86545CT1580001	Rating Area 7	No Preference	40	558.15
86545CT1580001	Rating Area 7	No Preference	41	568.64
86545CT1580001	Rating Area 7	No Preference	42	578.68
86545CT1580001	Rating Area 7	No Preference	43	592.66
86545CT1580001	Rating Area 7	No Preference	44	610.13
86545CT1580001	Rating Area 7	No Preference	45	630.65
86545CT1580001	Rating Area 7	No Preference	46	655.11
86545CT1580001	Rating Area 7	No Preference	47	682.62
86545CT1580001	Rating Area 7	No Preference	48	714.07

86545CT1580001	Rating Area 7	No Preference	49	745.08
86545CT1580001	Rating Area 7	No Preference	50	780.02
86545CT1580001	Rating Area 7	No Preference	51	814.52
86545CT1580001	Rating Area 7	No Preference	52	852.52
86545CT1580001	Rating Area 7	No Preference	53	890.95
86545CT1580001	Rating Area 7	No Preference	54	932.44
86545CT1580001	Rating Area 7	No Preference	55	973.93
86545CT1580001	Rating Area 7	No Preference	56	1018.91
86545CT1580001	Rating Area 7	No Preference	57	1064.34
86545CT1580001	Rating Area 7	No Preference	58	1112.81
86545CT1580001	Rating Area 7	No Preference	59	1136.83
86545CT1580001	Rating Area 7	No Preference	60	1185.31
86545CT1580001	Rating Area 7	No Preference	61	1227.24
86545CT1580001	Rating Area 7	No Preference	62	1254.75
86545CT1580001	Rating Area 7	No Preference	63	1289.26
86545CT1580001	Rating Area 7	No Preference	64 and over	1310.22
86545CT1580001	Rating Area 8	No Preference	0-14	334.11
86545CT1580001	Rating Area 8	No Preference	15	363.80
86545CT1580001	Rating Area 8	No Preference	16	375.16
86545CT1580001	Rating Area 8	No Preference	17	386.51
86545CT1580001	Rating Area 8	No Preference	18	398.74
86545CT1580001	Rating Area 8	No Preference	19	410.97
86545CT1580001	Rating Area 8	No Preference	20	423.64
86545CT1580001	Rating Area 8	No Preference	21	436.74
86545CT1580001	Rating Area 8	No Preference	22	436.74
86545CT1580001	Rating Area 8	No Preference	23	436.74
86545CT1580001	Rating Area 8	No Preference	24	436.74
86545CT1580001	Rating Area 8	No Preference	25	438.49
86545CT1580001	Rating Area 8	No Preference	26	447.22
86545CT1580001	Rating Area 8	No Preference	27	457.70
86545CT1580001	Rating Area 8	No Preference	28	474.74
86545CT1580001	Rating Area 8	No Preference	29	488.71
86545CT1580001	Rating Area 8	No Preference	30	495.70
86545CT1580001	Rating Area 8	No Preference	31	506.18
86545CT1580001	Rating Area 8	No Preference	32	516.66
86545CT1580001	Rating Area 8	No Preference	33	523.21
86545CT1580001	Rating Area 8	No Preference	34	530.20
86545CT1580001	Rating Area 8	No Preference	35	533.70
86545CT1580001	Rating Area 8	No Preference	36	537.19
86545CT1580001	Rating Area 8	No Preference	37	540.68
86545CT1580001	Rating Area 8	No Preference	38	544.18
86545CT1580001	Rating Area 8	No Preference	39	551.17
86545CT1580001	Rating Area 8	No Preference	40	558.15
86545CT1580001	Rating Area 8	No Preference	41	568.64
86545CT1580001	Rating Area 8	No Preference	42	578.68
86545CT1580001	Rating Area 8	No Preference	43	592.66
86545CT1580001	Rating Area 8	No Preference	44	610.13
86545CT1580001	Rating Area 8	No Preference	45	630.65
86545CT1580001	Rating Area 8	No Preference	46	655.11
86545CT1580001	Rating Area 8	No Preference	47	682.62
86545CT1580001	Rating Area 8	No Preference	48	714.07
86545CT1580001	Rating Area 8	No Preference	49	745.08
86545CT1580001	Rating Area 8	No Preference	50	780.02
86545CT1580001	Rating Area 8	No Preference	51	814.52
86545CT1580001	Rating Area 8	No Preference	52	852.52
86545CT1580001	Rating Area 8	No Preference	53	890.95
86545CT1580001	Rating Area 8	No Preference	54	932.44
86545CT1580001	Rating Area 8	No Preference	55	973.93
86545CT1580001	Rating Area 8	No Preference	56	1018.91
86545CT1580001	Rating Area 8	No Preference	57	1064.34
86545CT1580001	Rating Area 8	No Preference	58	1112.81
86545CT1580001	Rating Area 8	No Preference	59	1136.83
86545CT1580001	Rating Area 8	No Preference	60	1185.31
86545CT1580001	Rating Area 8	No Preference	61	1227.24
86545CT1580001	Rating Area 8	No Preference	62	1254.75
86545CT1580001	Rating Area 8	No Preference	63	1289.26
86545CT1580001	Rating Area 8	No Preference	64 and over	1310.22

Appendix A

Anthem Health Plans, Inc. - Connecticut
Individual Plans Effective January 1, 2026
Summary of Requested Rate Changes

- The requested rate change for each product can be found in Exhibit A: Non-Grandfathered Rate Changes.

- The percentage of Anthem's total projected Individual ACA membership for each plan is shown in the table below.

HIOS Plan Name	2026 HIOS Plan ID	On/Off Exchange	Metal Level	2026 Projected Membership Distribution	2025 HIOS Plan ID Mapping
Catastrophic HMO Pathway Enhanced	86545CT1230005	On	Catastrophic	0.4%	86545CT1230005
Bronze HMO Pathway Enhanced with Adult Dental and Vision Benefit	86545CT1230025	On	Bronze	8.7%	86545CT1230025
Gold HMO Pathway Enhanced with Adult Dental and Vision Benefits	86545CT1230027	On	Gold	4.7%	86545CT1230027
Anthem Catastrophic HMO Pathway Enhanced	86545CT1310033	Off	Catastrophic	0.3%	86545CT1310033
Anthem Bronze HMO Pathway Enhanced 6000/12000/40% HSA	86545CT1310019	Off	Bronze	1.2%	86545CT1310019
Anthem Bronze HMO Pathway Enhanced 8500/50%	86545CT1310055	Off	Bronze	0.7%	86545CT1310055
Anthem Silver HMO Pathway Enhanced 4000/30%	86545CT1310056	Off	Silver	0.7%	86545CT1310056
Anthem Gold HMO Pathway Enhanced 2000/10%	86545CT1310060	Off	Gold	1.8%	86545CT1310060
Bronze PPO Standard Pathway HSA	86545CT1330009	On	Bronze	3.4%	86545CT1330009
Bronze PPO Standard Pathway	86545CT1330002	On	Bronze	2.6%	86545CT1330002
Silver PPO Standard Pathway	86545CT1330001	On	Silver	55.4%	86545CT1330001
Gold PPO Pathway with Adult Dental and Vision Benefits	86545CT1330020	On	Gold	7.6%	86545CT1330020
Gold PPO Standard Pathway	86545CT1330003	On	Gold	0.4%	86545CT1330003
Anthem Bronze PPO Pathway 8000/0% HSA	86545CT1340020	Off	Bronze	0.3%	None
Anthem Silver PPO Pathway 4000/20% HSA	86545CT1340021	Off	Silver	0.2%	None
Bronze PPO Pathway with PreventiveRx HSA	86545CT1570001	On	Bronze	7.9%	86545CT1330023
Gold PPO Pathway	86545CT1570002	On	Gold	2.1%	86545CT1330024
Bronze HMO Pathway Enhanced	86545CT1580001	On	Bronze	1.5%	None

Components of Average Rate Increase	
Trend	10.3%
Risk Adjustment	0.1%
Induced Demand due to CSRs	0.7%
CSR Silver Load	2.2%
Other	0.5%
Overall Average Rate Increase	14.2%

SERFF Tracking #:	*AWLP-134549275*	***State Tracking #:***	*202502662*	***Company Tracking #:***	

State:	*Connecticut*	***Filing Company:***	*Anthem Health Plans, Inc dba Anthem Blue Cross and Blue Shield of Connecticut*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*		
Product Name:	*Individual 2026*		
Project Name/Number:	*/*		

URRT

State Determination

Review Status:	Incomplete

SERFF Tracking #:	*AWLP-134549275*	***State Tracking #:***	*202502662*	***Company Tracking #:***	

State:	*Connecticut*	***Filing Company:***	*Anthem Health Plans, Inc dba Anthem Blue Cross and Blue Shield of Connecticut*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*		
Product Name:	*Individual 2026*		
Project Name/Number:	*/*		

URRT Items

Item Name	Attachment(s)
Unified Rate Review Template	*20250530CT86545IndvUnifiedRateReviewTemplate.xml*
Actuarial Memorandum	*20250530CT86545IndvStateActuarialMemorandum.pdf*
Actuarial Memorandum - Redacted	*20250530CT86545IndvFederalActuarialMemorandum.pdf*
Consumer Justification Narrative	*20250530CT86545IndvPartIIWrittenJustification.pdf*

SERFF Tracking #:	AWLP-134549275	**State Tracking #:**	202502662	**Company Tracking #:**	

State:	Connecticut	**Filing Company:**	Anthem Health Plans, Inc dba Anthem Blue Cross and Blue Shield of Connecticut
TOI/Sub-TOI:	HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO		
Product Name:	Individual 2026		
Project Name/Number:	/		

Attachment 20250530CT86545IndvUnifiedRateReviewTemplate.xml is not a PDF document and cannot be reproduced here.

ACTUARIAL MEMORANDUM

1. General Information

- Company Identifying Information

Company Legal Name:	Anthem Health Plans, Inc.
State:	Connecticut
HIOS Issuer ID:	86545
NAIC Company Code:	60217
Market:	Individual
Effective Date:	January 1, 2026

- Company Contact Information

Primary Contact Name:	Tu Nguyen
Primary Contact Email Address:	Tu.Nguyen@elevancehealth.com

2. Scope and Purpose of the Filing

This is a rate filing for the Individual market ACA-compliant plans offered by Anthem Health Plans, Inc., also referred to as Anthem. The policy forms associated with these plans are listed below. The proposed rates in this filing will be effective for the 2026 plan year beginning January 1, 2026, and apply to plans both On-Exchange and Off-Exchange.

The Memorandum provides support to the rate development and demonstrates that rates are established in compliance with state laws and provisions of the Affordable Care Act. The rates proposed in this submission reflect the regulatory framework and insurer participation in the market as of May 30, 2025. If the regulatory framework or insurer participation in the market changes after this date, proposed rates may no longer be appropriate and should be reevaluated for revision and resubmission. Due to the timing of the 2025 legislative session, bills passed during the session have not been accounted for in this rate filing. Anthem requests that the Connecticut Insurance Department allows carriers to reflect the impacts of bills passed that affect 2026. Examples of such bills include, but are not limited to, proposed Senate Bill 10 (SB 10) and proposed Senate Bill 11 (SB 11). This rate filing is not intended to be used for other purposes.

Under the American Rescue Plan Act, Advanced Premium Tax Credits (also referred to as APTCs or premium subsidies) provided by the federal government were increased, and these enhancements to the subsidies are set to expire at the end of 2025. Per the filing requirements from Connecticut Bulletin HC-81-25, "carriers must submit their filings for 2026 Rates with the assumption that the subsidies will be extended through 2026." The rates submitted in this filing are in accordance with that guidance rather than the current regulated expiration. If these enhanced subsidies do expire, then the rates included in this rate filing will need to be revised and resubmitted. Anthem has included a 3.7% morbidity impact that will need to be applied to the rates in the event of enhanced subsidy expiration in Section 6 of this actuarial memorandum. In the event that no decision is made on the extension of the enhanced subsidies prior to the Connecticut Insurance Department's final decision on this rate filing, Anthem assumes that the inactivity indicates that the enhanced subsidies will expire and that the morbidity impact outlined in Section 6 will be included within the final rate development submitted to the Connecticut Insurance Department in August or September. Only in the event that the federal government gives final guidance that the enhanced subsidies will be extended will this rate filing hold and the rates not need to be revised to reflect the morbidity impact provided.

Through the Covered Connecticut bill, various cohorts of individuals with income between 138% FPL and 175% FPL were eligible to be covered without cost share and at no premium paid by the member in the Individual ACA market at different times since July 1, 2021. The members of these cohorts have been included in the 2024 base experience to comply with the single risk pool ACA requirement. This rate development does not include the induced utilization impact of members being placed on the 87% or 94% CSR variant and moving to a 100% AV plan based upon the state paying for the member's applicable cost shares. This induced utilization impact is handled outside of this rate filing with the state of Connecticut funding it through a utilization fee on the Covered Connecticut population. Anthem has seen increased utilization from the Covered Connecticut cohort above and beyond what it has seen on the rest of the 87% and 94% CSR population and will work with the state for 2026 to adjust the utilization fee to the appropriate level. More details about the Covered Connecticut population are included in Section 6 of this actuarial memorandum.

Anthem performed an area factor study and is proposing changes to the area rating factors for 2026. These factors are shown in Exhibit M. Justification for the area factor development is shown in Appendix B. No changes were made to the age rating factors, which can be found in Exhibit L. Tobacco rating factors are not used for this filing.

Policy Form Number(s):

CT_ONHIX_PPO_01-26
CT_OFFHIX_PPO_01-26
CT_ONHIX_HMO_01-26
CT_OFFHIX_HMO_01-26

3. Proposed Rate Increase(s)

The proposed rates have been developed from 2024 ACA experience.

The proposed annual rate changes by product in this filing range from 10.04% to 21.89%, with rate changes by plan from 6.40% to 22.77%. These ranges are based on the renewing plans and are consistent with what is reported in the Unified Rate Review Template. Exhibit A shows the rate change for each plan.

The overall average annual rate increase for this filing is 14.2% as shown in Appendix A.

Factors that affect the rate changes for all plans include:

- Trend: This includes the impact of inflation, provider contracting changes, and changes in utilization of services.
- Morbidity: If the enhanced subsidies expire, there are anticipated changes in the market-wide morbidity of the covered population in the projection period. This morbidity impact is not currently reflected in the rate development but will be included within the final rate filing submitted to the Connecticut Insurance Department in August or September unless there is final guidance from the federal government of extension of the enhanced subsidies through 2026.
- Benefit modifications, including changes made to comply with updated AV requirements.
- Changes in taxes, fees, and some non-benefit expenses.

Although rates are based on the same claims experience, the rate changes vary by plan due to the following factors:

- Changes in benefit design that vary by plan.
- Updates in benefit relativity factors among plans.
- Updated adjustment factors for catastrophic plans.
- Changes in some non-benefit expenses that are applied on a PMPM basis.
- Changes in the claim cost relativity by area.

4. Experience and Current Period Premium, Claims, and Enrollment

The experience period premium and claims reported in Worksheet 1, Section I of the Unified Rate Review Template (URRT) are for the non-grandfathered, single risk pool compliant policies of the identified legal entity in the Individual market.

• Paid Through Date

The experience reported in Worksheet 1, Section I of the URRT reflects the incurred claims from January 1, 2024 through December 31, 2024 based on claims paid through February 28, 2025.

• Current Date

The Current Date for Current Enrollment and Current Premium PMPM in Worksheet 2, Section II of the URRT is February 28, 2025.

• Experience Period Premium

The earned premium prior to MLR rebate is $638,247,731. The earned premium reflects the pro-rata share of premium based on policy coverage dates.

The current MLR rebate estimate is $0 for experience period ending December 31, 2024, which is consistent with Anthem's current general ledger estimate allocated to the non-grandfathered portion of Individual business. This is an estimated amount and will not be final until 7/31/2025. The earned premium is $638,247,731 for the legal entity as reported in cell E18 of Worksheet 1, Section I of the URRT.

• Allowed and Incurred Claims Incurred During the Experience Period

The allowed claims are determined by subtracting non-covered benefits, provider discounts, and coordination of benefits amounts from the billed amount.

Allowed and incurred claims are completed using the chain ladder method, an industry standard, by using historic paid vs. incurred claims patterns. The method calculates historic completion percentages, representing the percent of cumulative claims paid of the ultimate incurred amounts for each lag month. Claim backlog files are reviewed on a monthly basis and are accounted for in the historical completion factor estimates.

Allowed and incurred claims reported in Worksheet 1, Section I of the URRT are $637,858,829 and $531,964,086, respectively. These amounts differ from those shown in Exhibit B due to the URRT including Rx Rebates.

Exhibit S details historical experience for the policy forms included in this filing.

5. Benefit Categories

The methodology used to determine benefit categories in Worksheet 1, Section II of the URRT is as follows:

- Inpatient Hospital: Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.
- Outpatient Hospital: Includes non-capitated facility services for surgery, emergency room, lab, radiology, therapy, observation and other services provided in an outpatient facility setting and billed by the facility.

- Professional: Includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, and other professional services, other than hospital-based professionals whose payments are included in facility fees.
- Other Medical: Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, and dental services.
- Capitation: Includes all services provided under one or more capitated arrangements.
- Prescription Drug: Includes drugs dispensed by a pharmacy and rebates received from drug manufacturers.

6. Projection Factors

The experience period claims in Worksheet 1, Section I of the URRT are projected to the projection period using the factors described below. Exhibit C provides a summary of the factors.

• Trend Factors (cost/utilization)

- The annual pricing trend used in the development of proposed rates is 10.3%. This annual pricing trend is applied for 12.0 months to both Years 1 and 2 in Worksheet 1 of the URRT. The trend is developed by normalizing historical benefit expense for changes in the underlying population and known cost drivers, which are then projected forward to develop the pricing trend. Examples of such changes or cost drivers include contracting, cost of care initiatives, workdays, average wholesale price, expected introduction of new brand or generic drugs, changes in medical and pharmacy utilization and other changes in practice patterns. For projection, the experience period claims are trended 24.0 months from the member-weighted endpoint of the experience period, which is December 31, 2024, to the member-weighted endpoint of the projection period, which is December 31, 2026. Exhibit E has details.
  - Anthem's historical trend experience for 2023 and 2024 is included within Exhibit Q. The exhibit details Anthem's unit cost trend, utilization trend, technology trend, and other trend components.
  - Reasons that the pricing trend will differ from historical trends can include, but are not limited to, emerging experience, uncertainty within the federal economic and healthcare environment, and legislation in Connecticut that restricts carriers to be able to contain costs. For example in Connecticut, constraints on mid-year formulary changes enable drug manufacturers to raise the price of prescription drugs, driving significant cost growth, while restricting payers' abilities to contain costs. Additionally, proposed legislation, if passed, could restrict carriers' abilities to contain costs through prior authorization processes. Without these processes in place, medically unnecessary utilization is likely to increase, which will result in increased healthcare costs and premiums.

- The annual pricing trend of 10.3% reflects the forward pricing trend from 2024 to 2026 for the rate development. To develop this assumption, Anthem started with observed allowed historical trends at the total medical and Rx splits. The observed trends were then normalized to remove the impact of aging, workdays, flu, etc. After normalization, the projected future allowed trends were set by a regression model, an industry standard, and explicit assumptions on more known trend drivers, such as contracting. A leveraging assumption of 0.8% was then applied to the projected allowed trend to arrive at a 10.3% paid pricing trend assumption.
- The formula for the trend factor of 1.2163, as shown in Exhibit E, is developed by taking the 10.3% annual pricing trend assumption and trending it forward by 24 months: (1+0.103)^(24/12)=1.2166. The difference between 1.2163 and 1.2166 is due to rounding.
- Anthem does not account for benefit buy-downs within trend. Anthem uses allowed PMPMs to develop the pricing trend assumption, so paid PMPM trends with and without the impact of benefit buy-down are not reviewed.
- Anthem does not include pharmacy rebates in trend. Pharmacy rebates are accounted for separately in the rate development as outlined in Exhibit C and described in Other Adjustments in this section below.

➢ The Office of Health Strategy's (OHS) healthcare cost growth benchmark should not be used to evaluate Anthem's pricing trend. The OHS Benchmark is calculated, in advance of the reporting year, as a blending of the forecasted growth in the CT Potential Gross State Product and the forecasted growth in CT Median Income. The state's gross product and median income are not reliable predictors of healthcare costs since the metrics do not fully account for several factors which are driving up health care costs, including high cost specialty drugs and treatments, increases in healthcare labor costs due to clinical workforce shortages, inflationary pressure, and provider consolidation. The OHS Benchmark also does not account for annual changes that impact an issuer's pricing trend assumption, including but not limited to:

- changes in the demographic and gender mix of the enrollees,
- movement of members between markets (such as individuals disenrolling from Medicaid due to ineligibility and shifting to the Individual market or gaining coverage through an employer),
- anti-selective behaviors by individuals who are more likely to use health care services, and
- induced utilization due to changes in the plan's cost sharing design.

Additionally, the Benchmark is calculated as the cost growth target for the combined commercial market, including Individual, Small Group, and Large Group markets, whereas the pricing trend in this rate filing applies only to the Individual market. OHS sets the benchmarks well in advance of the measurement period based on forecasted growth, but unforeseen circumstances, such as the expiration of enhanced subsidies in the Individual market, could have a significant impact on cost growth from year to year. For all of these reasons, the OHS Benchmark should not be used to evaluate the pricing trend.

- Morbidity Adjustment

As described in Section 2 of this actuarial memorandum, the Connecticut Insurance Department has required that carriers submit their rate filings under the assumption that the enhanced premium subsidies from the American Rescue Plan Act are extended through 2026. The rates within this rate development are in accordance with that guidance rather than the current regulated expiration. If these enhanced subsidies do expire or if there is no federal decision to extend the subsidies prior to the Connecticut Insurance Department's final decision on this rate filing, then a 3.7% morbidity impact will be applied to the rates within this rate filing. Only in the event that the federal government gives final guidance that the enhanced subsidies will be extended will the rates not need to be revised to reflect this impact.

The morbidity impact accounts for the differences between the average morbidity of the experience period population from 2024 and that of the anticipated population in the projection period for 2026. The morbidity adjustment reflects the projected market changes in morbidity due to the expiration of the enhanced ACA premium tax credits on December 31, 2025. Selective lapsation is expected to increase the morbidity of the risk pool as a disproportionate number of healthy enrollees is expected to leave the market due to the increases in their net premiums. The morbidity impact of 3.7% will be applied to the claims in the final rate development submitted to the Connecticut Insurance Department in August or September unless there is final guidance from the federal government extending the enhanced subsidies through 2026.

- Changes in Demographics (Normalization)

The experience period claims are normalized to reflect anticipated changes in age/gender, area, network, and benefit plan in the projection period. Exhibit D provides detail of each normalization factor below:

- Age/Gender: The assumed claims cost is applied by age and gender to the experience period membership distribution and the projection period membership distribution.
- Area/Network: The area claims factors are developed based on an analysis of allowed claims by network, mapped to the prescribed rating areas using the subscriber's 5-digit zip code.
- Benefit Plan: The experience period claims are normalized to reflect the average benefit level in the projection period using benefit relativities. The benefit relativities include the value of cost shares and anticipated changes in utilization due to the difference in average cost share requirements.

- Other Adjustments

Other adjustments to the experience claims data include the following items. Exhibit C has the Covered CT adjustment factor. Exhibit E and Exhibit F show the factors used for each of the other adjustments.

- Covered CT Adjustment: Through the Covered Connecticut bill, various cohorts of individuals with income between 138% FPL and 175% FPL were eligible to be covered without cost share and at no premium paid by the member in the Individual ACA market at different times since July 1, 2021. The members of these cohorts have been included in the 2024 base experience to comply with the single risk pool ACA requirement. As part of the Covered Connecticut program, members are assigned to the Standard Silver plan on the 87% or 94% CSR variant, depending on their FPL. The carrier pays each Covered Connecticut member's cost shares for the respective benefit design upfront, and the state reimburses the carrier for the cost shares. The paid cost shares are reflected within Anthem's starting paid claims. Since the state reimburses these amounts, an adjustment was applied to remove the total amount reimbursed by the state.

  Anthem received $10,466,037.04 in reimbursement from the state for the paid cost shares for 2024. The adjustment factor is one minus the reimbursement divided by the 2024 base experience claims.

2024 Cost Shares for Covered CT Reimbursed by the State	$10,466,037.04
2024 Experience Total Paid Completed Claims	$583,274,756.27
2024 Covered CT Impacts to Experience Claims	0.9821

  This adjustment only accounts for the state's reimbursement of member cost shares.

  The state also pays for the net premium that the member would traditionally be responsible for after accounting for federal premium subsidies. These are not included in the rate development, because this does not change the premium PMPM. The state is just covering the member's portion of the premium.

  The state also pays an induced utilization fee for the Covered Connecticut members that accounts for the members induced utilization impact of being covered at 100% AV with no cost shares from their actual plan design, which is either the 87% or the 94% CSR variant of the Standard Silver plan. The state is not reimbursing for these members moving from 70% AV to 87%/94% AV. The induced utilization impact of the members moving from 70% AV to 87%/94% AV is reflected in the Induced Demand for CSR factor described below with the rest of the non-Covered Connecticut 87% and 94% CSR population. The utilization fee that the state pays to reimburse for the impact of the members moving from 87%/94% AV to 100% AV is not included within this rate development, since the state is paying for this separately. The guidance from the Connecticut Insurance Department when the Covered Connecticut program began was that this additional cost would be funded outside of the normal rate development process. As described in Section 2 of this actuarial memorandum, Anthem has seen increased utilization from the Covered Connecticut cohort above and beyond what it has seen on the rest of the 87% and 94% CSR population and will work with the state for 2026 to adjust the utilization fee to the appropriate level.

- Other Benefit Expense: This adjustment accounts for the cost of benefit expenses that do not flow through the starting paid claims. NY HCRA surcharges and provider settlements are included in this adjustment.

- Induced Demand Due to Cost Share Reductions: Individuals who fall below 250% of the Federal Poverty Level and enroll in On-Exchange silver plans will be eligible for cost share reductions. When members have these richer benefits, they are more likely to utilize services. This is referred to as induced demand. The Induced Demand for CSR factor accounts for the induced utilization that the CSR members have due to having much richer benefts than the Standard Silver 70% plan. This adjustment does not account for the induced demand of Covered Connecticut members moving from 87%/94% AV to 100% AV, which is covered outside of this rate filing as described above in the Covered Connecticut Adjustment section. The Induced Demand for CSR factor does account for the induced demand of Covered Connecticut members moving from 70% to 87%/94% AV, because the state does not reimburse carriers for this amount. The factor is developed by taking the percentage of enrollment in CSR Plans in the experience period and comparing it to that of the projection period to adjust for the different induced demand level due to CSR between the two periods.
- Grace Period: The claims experience has been adjusted to account for incidences of enrollees not paying premiums due during the first month of the 90-day grace period when the QHP is liable for paying claims. Based on Anthem's CT 2024 experience, 6.09% of the total Individual population lapsed in their last month's premium, resulting in 13.42% of their total annual premiums not being paid. The member portion of the premium (total premium – APTC portion) was 16.87%. The Grace Period Factor is calculated through the following method: 1 + (% of members lapsed last month's premium × % premium unpaid in last month × % of member portion premium to total premium), i.e, 1 + (6.09% x 13.42% x 16.87%). This equation results in the 1.0014 factor as shown in Exhibit E.
- Rx Rebates: The projected claims cost is adjusted to reflect anticipated Rx rebates. These projections were developed from 2024 actual experience trended to the rating period at the pricing trend. All anticipated Rx rebates are accounted for in this rate development.
- Projected costs of pediatric dental and vision benefits are included.
- S.B. No 376 (Public Act No. 18-69), an act concerning health insurance coverage for prosthetic devices, was passed. Substitute S.B. No 1 (Public Act No. 24-19), an act concerning the health and safety of Connecticut residents that included a mandate for the coverage of coronary calcium scans, was passed. These claims have been excluded from the experience data, since they are to be defrayed by the state per 45 CFR 155.170. The impact is $0.04 PMPM. This can be calculated by removing the $0.62 PMPM impact from Elective Abortion, as shown in Exhibit F, from the $0.66 PMPM impact of the line labeled "Non-EHBs Embedded in Line Item 1) Above" in Exhibit C.

7. Manual Rate Adjustments

The experience period claims are 100% credible based on the credibility method used. Therefore, a manual rate was not used in the rate development.

8. Credibility of Experience

• Credibility Method Used

Based on an analysis of historical data, the standard for fully credible experience is 5,299 members.

To determine credibility, the following formula was used:

$$\sqrt{\frac{\text{Experience Period Members}}{5{,}299}}$$

- Resulting Credibility Level Assigned to Base Period Experience

With 63,707 members, the credibility level assigned to the experience period claims is 100%.

9. Establishing the Index Rate

- Experience Period Index Rate

The experience period Index Rate is equal to the allowed claims PMPM for the essential health benefits of Anthem's non-grandfathered business in the Individual market. The experience period Index Rate is $834.17. No benefits in excess of the essential health benefits have been included in this amount.

- Projection Period Index Rate

The projection period Index Rate is equal to projected allowed claims PMPM for the essential health benefits of Anthem's non-grandfathered business in the Individual market. It reflects the anticipated claim level of the projection period including impact from trend, benefit and demographics as described in Section 6 of this memo.

The projected Index Rate is reported in Worksheet 1, Section II, cell F42 of the URRT and is also shown in Exhibit C. No benefits in excess of the essential health benefits have been included in this amount.

10. Development of the Market-wide Adjusted Index Rate

The Market-wide Adjusted Index Rate is calculated as the Index Rate adjusted for all allowable market-wide modifiers defined in the market rating rules. The three market-wide adjustments - Risk Adjustment, Reinsurance, and Exchange User Fee adjustment - are described below. In compliance with URR Instructions, these adjustments were applied on an allowed basis in the development of the Market-wide Adjusted Index Rate. Exhibit C illustrates the development of the Market-wide Adjusted Index Rate.

- Projected Risk Adjustments PMPM

CMS will not release final 2024 risk adjustment transfer amounts until June 30, 2025. Since this rate filing is due on June 1, 2025, Anthem is filing a projection of the 2026 risk adjustment transfer amount based upon an estimate of the 2024 amount. An independent consultant's study of 2024 risk adjustment transfers is used to develop the projection for the company's 2026 relative risk to the market. The impact of high-cost risk pooling is also included.

The projected risk adjustment PMPMs reported in Worksheet 2 of the URRT are on a paid claim basis, while the projected amount applied to the development of Market-wide Adjusted Index Rate is on an allowed claim basis. Exhibit C and Exhibit G provide details.

The Risk Adjustment Net Transfer amount from Exhibit G breaks down into 2 components.

- 1. Risk Adjustment Transfer and High-Cost Risk Pool Recovery: $18.88 PMPM. For the Risk Adjustment Transfer amount, an independent consultant's study on 2024 and projected 2026 membership distributions among the metal levels were used to develop the estimate. For the High-Cost Risk Pool Recovery, the experience from prior years was used to develop the estimate.

- 2. High-Cost Risk Pool Assessment: -$4.05 PMPM. This is charged as a percent of premium. Based on an independent consultant's study of historical assessment patterns, Anthem estimated this to be 0.41% of 2026 premium.

Below are the RADV adjustment amounts for the Anthem Individual market that were released by CMS.

Anthem Final Individual RADV					
Year	**2017**	**2018**	**2019/2020**	**2021**	**2022**
Date Released	1/15/2021	1/20/2022	11/16/2022	7/18/2023	5/29/2024
Non-Catastrophic	-$61,590	$1,569,670	$0	-$985,178	$0
Catastrophic Table	$0	$0	$0	-$5,267	$0
Total Individual	-$61,590	$1,569,670	$0	-$990,446	$0

At the time of the writing of this rate filing, CMS has not released final 2023 RADV adjustment amounts.

• Projected ACA Reinsurance Recoveries Net of Reinsurance Premium

Beginning in 2017, the Federal reinsurance program is no longer in effect. The projected reinsurance amount is $0.

• Exchange User Fees

The expected charge is estimated at 1.85% of premium. The fee is applied evenly to all plans in the risk pool, both On and Off Exchange.

The Exchange User Fee is applied as an adjustment to the Market-wide Adjusted Index Rate at the market level as shown in Exhibit C.

11. Plan Adjusted Index Rate

The Plan Adjusted Index Rate is calculated as the Market-wide Adjusted Index Rate adjusted for all allowable plan level modifiers defined in the market rating rules. Exhibit J shows the development. The plan level modifiers are described below:

- Induced Utilization/Cost Sharing Adjustments: This is a multiplicative factor that adjusts for the projected paid/allowed ratio of each plan with an adjustment for induced utilization differences due to differences in cost sharing.
- Adjustments for Benefits in Addition to the Essential Health Benefits: This multiplicative factor adjusts for additional non-EHB benefits shown in Exhibit F.
- Catastrophic Plan Adjustment: This adjustment reflects the projected costs of the population eligible for catastrophic plans. The catastrophic adjustment factor is applied to catastrophic plans only; all other plans have an adjustment factor of 1.0.
- Adjustments for Distribution and Administrative Cost: This is an additive adjustment that includes all the selling expense, administration and retention Items shown in Exhibit H, with the exception of the Exchange User Fee. The Exchange User Fee has been included in the Market-wide Adjusted Index Rate at the market level. The Profit and Risk Margin item is split into 0.95% post-tax profit and 3% post-tax risk margin.

12. Calibration

The Plan Adjusted Index Rate is calibrated by the Age and Geographic factors so that the schedule of premium rates for each plan can be further developed. Exhibit K shows both calibration factors.

• Age Curve Calibration

The age factors are based on the Default Federal Standard Age Curve. The age calibration adjustment is calculated as the member weighted average of the age factors, using the projected membership distribution by age, with an adjustment for the maximum of 3 child dependents under age 21. Under this methodology, the approximate average age rounded to the nearest whole number for the risk pool is 49.

• Geographic Factor Calibration

The geographic factors are developed from historical claims experience. The geographic calibration adjustment is calculated as the member weighted average of the geographic factors, using the projected membership distribution by area.

13. Consumer Adjusted Premium Rate Development

The Consumer Adjusted Premium Rate is calculated by calibrating the Plan Adjusted Index Rate by the Age and Geographic calibration factors described above, and applying consumer specific age and geographic rating factors. Exhibit N has the sample rate calculations.

14. Projected Loss Ratio

- Projected Federal MLR

  Exhibit I shows the projected Federal MLR for the products in this filing. The calculation is an estimate and is not meant to be a true measure for Federal or State MLR rebate purposes. The MLR for Anthem's entire book of Individual business will be compared to the minimum Federal benchmark for purposes of determining regulation-related premium refunds. Also note that the projected Federal MLR presented here does not capture all adjustments, including but not limited to: three-year averaging, credibility, dual option, and deductible. Anthem's projected MLR is expected to meet or exceed the minimum MLR standards at the market level after including all adjustments.

15. Actuarial Value Metal Values

The Actuarial Value (AV) Metal Values reported in Worksheet 2, Section I of the URRT are based on the AV Calculator. To the extent a component of the benefit design was not accommodated by an available input within the AV Calculator, the benefit characteristic was adjusted to be actuarially equivalent to an available input within the AV Calculator for purposes of utilizing the AV Calculator as the basis for the AV Metal Values. When applicable, benefits for plans that are not compatible with the parameters of the AV Calculator have been separately identified and documented in the Unique Plan Design Supporting Documentation and Justification that supports the Plan & Benefits Template.

16. Membership Projections

Membership projections are reported in Worksheet 2, Section IV of the URRT. They are based on historical and current enrollment, and expected new sales and lapses.

For Silver level plans in the Individual market, the portion of projected membership that will be eligible for cost-sharing reduction subsidies at each subsidy level are estimated from the enrollment data in the experience period. Exhibit O provides projected distributions for each plan.

17. Terminated Plans and Products

Exhibit P provides a listing of 2024 and 2025 plans that will be terminated prior to January 1, 2026. The mapping of terminated plans to the new plans is also included.

18. Plan Type

The plan type for each plan reported in Worksheet 2, Section I of the URRT is consistent with the option chosen from the drop-down box.

19. Effective Rate Review Information

The RBC Ratio for Anthem Health Plans, Inc. is 300.08% as of 12/31/2024.

Current capital and surplus for Anthem Health Plans, Inc. is $303,295,221 as shown on page 6, line 49 of the 2024 Annual Statement.

20. State Actuarial Memorandum Requirements

This section contains supplemental material to satisfy the filing requirements from Bulletin HC-90-25 and Bulletin HC-81-25 that is not addressed elsewhere within this actuarial memorandum.

The proposed retention charge in the rate development is 15.4%. This is comprised of both fixed and variable expenses and includes selling expense, administrative expense, federal fees, federal income tax, exchange fees, and risk and net profit margin.

The December 31, 2024 Annual Statement for Anthem Health Plans, Inc. has a retention amount of 16.1%. This amount is calculated from the Analysis of Operations by Lines of Business exhibit (for both Group and Individual) on page 8: 1 – [line 17, column 2 $1,192,970,146 / line 7, column 2 $1,421,493,824] = 16.1%.

Exhibit R shows the claim lag triangle for the experience data.

Exhibit S shows historical experience data for Anthem's Individual ACA business.

The Annual Certification for substituting non-dollar limits on an essential health benefit can be found in Exhibit T.

The Annual Certification for compliance with Federal Mental Health Parity can be found in Exhibit U.

Exhibit A in conjunction with Appendix A show a summary of the requested rate changes.

Individuals who fall below 250% of the Federal Poverty Level and enroll in On-Exchange silver plans will be eligible for cost share reductions. These 73%, 87%, and 94% CSR variant plans have richer benefits (lower cost shares to the members) than the Standard Silver plan, but the premium cost to the member is the same. After the federal government discontinued funding the difference in these cost shares between the Standard Silver plan and the CSR variant plans, carriers must pay for the difference for the CSR members. The carriers fund this additional cost in a process referred to as the CSR Silver Load. For the 2026 rate filing, Anthem's CSR load is 9.3%. The derivation of the CSR load started with claims including CSR costs spread across all plans. The CSR costs were then estimated using historical data. The CSR costs were removed from all plans and loaded to the Standard Silver plan.

21. Reliance

In support of this rate development, various data and analyses were provided by other members of Anthem's actuarial staff, including data and analysis related to cost of care, valuation, trend, and pricing. I have reviewed the data and analyses for reasonableness and consistency. I have also relied on Wayne Rosen, FSA, MAAA to provide the actuarial certification for the Unique Plan Design Supporting Documentation and Justification for plans included in this filing.

22. Actuarial Certification

I, Tu Nguyen, FSA, MAAA, am an actuary for Elevance Health, the holding company of Anthem. I am a member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein. I hereby certify that the following statements are true to the best of my knowledge with regards to this filing:

(1) The projected Index Rate is:

- In compliance with all applicable state and Federal statutes and regulations (45 CFR 156.80 and 147.102)
- Developed in compliance with the applicable Actuarial Standards of Practice
- Reasonable in relation to the benefits provided and the population anticipated to be covered
- Not excessive nor deficient

(2) The Index Rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 156.80(d)(2) were used to generate plan level rates.

(3) The geographic rating factors reflect differences in the costs of delivery (which can include unit cost and provider practice pattern differences) and do not include differences for population morbidity by geographic area.

(4) The most recent approved AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans.

The Part I Unified Rate Review Template does not demonstrate the process used by the issuer to develop the rates. Rather it represents information required by Federal regulation to be provided in support of the review of rate changes, for certification of Qualified Health Plans for Federally-Facilitated Exchanges, and for certification that the Index Rate is developed in accordance with Federal regulation, used consistently, and only adjusted by the allowable modifiers. However, this Actuarial Memorandum does accurately describe the process used by the issuer to develop the rates.

The rates proposed in this submission reflect the regulatory framework and insurer participation in the market as of May 30, 2025. If the regulatory framework or insurer participation in the market change after this date, proposed rates may no longer be appropriate and should be reevaluated for revision and resubmission. Due to the timing of the 2025 legislative session, bills passed during the session have not been accounted for in this rate filing. Anthem requests that the Connecticut Insurance Department allows carriers to reflect the impacts of bills passed that affect 2026. Examples of such bills include, but are not limited to, proposed Senate Bill 10 (SB 10) and proposed Senate Bill 11 (SB 11). Additionally, the Connecticut Insurance Department has required carriers to file under the assumption that the enhanced premium subsidies from the American Rescue Plan Act are extended through 2026. The rates submitted in this filing are in accordance with that guidance rather than the current regulated expiration. Only in the event that the federal government issues final guidance that the enhanced subsidies will be extended through 2026 will this rate filing hold and the rates not need to be revised to reflect a 3.7% morbidity impact, as provided in Section 6 of this actuarial memorandum. The morbidity impact will be applied to the claims in this rate development if the federal government does not give final guidance that the enhanced subsidies are extended through 2026 prior to the final rate filing submission to the Connecticut Insurance Department in August or September. Issuer market entry and exit can have a significant impact on rates through the risk adjuster mechanisms in the ACA and create a need for reconsideration and revision of proposed premium rates. This rate filing is not intended to be used for other purposes.

Tu Nguyen, FSA, MAAA
Actuarial Strategic Planning Leader

5/30/2025
Date

Exhibit A - Non-Grandfathered Rate Changes

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2026

HIOS Plan Name	2026 HIOS Plan ID	On/Off Exchange	Metal Level	Network Name	Area(s) Offered	Plan Category	Plan Specific Rate Change (excluding aging) {1},{2}
Catastrophic HMO Pathway Enhanced	86545CT1230005	On	Catastrophic	Pathway Enhanced	All	Renewing	7.4%
Bronze HMO Pathway Enhanced with Adult Dental and Vision Benefits	86545CT1230025	On	Bronze	Pathway Enhanced	All	Renewing	8.5%
Gold HMO Pathway Enhanced with Adult Dental and Vision Benefits	86545CT1230027	On	Gold	Pathway Enhanced	All	Renewing	11.6%
Anthem Catastrophic HMO Pathway Enhanced	86545CT1310033	Off	Catastrophic	Pathway Enhanced	All	Renewing	7.1%
Anthem Bronze HMO Pathway Enhanced 6000/12000/40% HSA	86545CT1310019	Off	Bronze	Pathway Enhanced	All	Renewing	8.8%
Anthem Bronze HMO Pathway Enhanced 8500/50%	86545CT1310055	Off	Bronze	Pathway Enhanced	All	Renewing	7.3%
Anthem Silver HMO Pathway Enhanced 4000/30%	86545CT1310056	Off	Silver	Pathway Enhanced	All	Renewing	8.7%
Anthem Gold HMO Pathway Enhanced 2000/10%	86545CT1310060	Off	Gold	Pathway Enhanced	All	Renewing	13.8%
Bronze PPO Standard Pathway HSA	86545CT1330009	On	Bronze	Pathway	All	Renewing	13.6%
Bronze PPO Standard Pathway	86545CT1330002	On	Bronze	Pathway	All	Renewing	15.0%
Silver PPO Standard Pathway	86545CT1330001	On	Silver	Pathway	All	Renewing	15.9%
Gold PPO Pathway with Adult Dental and Vision Benefits	86545CT1330020	On	Gold	Pathway	All	Renewing	12.1%
Gold PPO Standard Pathway	86545CT1330003	On	Gold	Pathway	All	Renewing	6.4%
Anthem Bronze PPO Pathway 8000/0% HSA	86545CT1340020	Off	Bronze	Pathway	All	Renewing	22.8%
Anthem Silver PPO Pathway 4000/20% HSA	86545CT1340021	Off	Silver	Pathway	All	Renewing	20.7%
Bronze PPO Pathway with PreventiveRx HSA	86545CT1570001	On	Bronze	Pathway	All	New	N/A
Gold PPO Pathway	86545CT1570002	On	Gold	Pathway	All	New	N/A
Bronze HMO Pathway Enhanced	86545CT1580001	On	Bronze	Pathway Enhanced	All	New	N/A

NOTES:

{1} Plan level increases in rates do not include demographic changes in the population.

{2} Plan level rate increases were developed in accordance to URR Instructions.

Exhibit B - Claims Experience for Rate Developments

Anthem Health Plans, Inc.
Individual

Experience Rate Claims Experience

Incurred January 1, 2024 through December 31, 2024
Paid through February 28, 2025

PAID CLAIMS:									
Incurred and Paid Claims:		IBNR:		Fully Incurred Claims:			Total	Member	Total
Medical	Drug	Medical	Drug	Medical	Drug	Capitation	Benefit Expense	Months	PMPM
$412,209,806	$148,950,659	$22,039,865	$72,685	$434,249,671	$149,023,344	$1,741	$583,274,756	764,485	**$762.96**

ALLOWED CLAIMS:									
Incurred and Paid Claims:		IBNR:		Fully Incurred Claims:			Total	Member	Total
Medical	Drug	Medical	Drug	Medical	Drug	Capitation	Benefit Expense	Months	PMPM
$491,542,187	$161,090,417	$25,986,792	$82,370	$517,528,979	$161,172,788	$1,741	$678,703,508	764,485	**$887.79**

Note

{1} The 'Experience Rate Claims Experience' above does not account for Transitional Plans, Rx Rebates, or Reinsurance in 'Paid Claims', whereas the claims shown in Worksheet 1, Section 1 of the URRT include them, if present.

Exhibit C - Market-wide Adjusted Index Rate Development

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2026

		Experience Rate	
1)	Starting Paid Claims PMPM	$762.96	Exhibit B
2)	x Covered CT Adjustment	0.9821	
3)	= Mature Claims PMPM	$749.30	= (1) x (2)
4)	x Normalization Factor	0.9937	Exhibit D
5)	= Normalized Claims	$744.58	= (3) x (4)
6)	x Plan Design Changes	1.0000	Exhibit E
7)	x Morbidity Changes	1.0000	Exhibit E
8)	x Trend Factor	1.2163	Exhibit E
9)	x Other Adjustments	1.0129	Exhibit E
10)	= Projected Paid Claim Cost	**$917.31**	= (5) x (6) x (7) x (8) x (9)
11)	Credibility Weight	100.00%	
12)	Blended Paid Claims	$917.31	
13)	- Non-EHBs Embedded in Line Item 1) Above	$0.66	
14)	= Projected Paid Claims, Excluding ALL Non-EHBs	$916.65	= (12) - (13)
15)	+ Rx Rebates	-$69.85	Exhibit F
16)	+ CSR Receivable	$0.00	Exhibit F
17)	+ Additional EHBs	$1.62	Exhibit F
18)	= Projected Paid Claims for EHBs	$848.42	= (14) + (15) + (16) + (17)
19)	÷ Paid to Allowed Ratio	0.8551	
20)	**= Index Rate** {2}	**$992.19**	= (18) / (19)
21)	Reinsurance Contribution	$0.00	Exhibit G
22)	Expected Reinsurance Payments	$0.00	Exhibit G
23)	Risk Adjustment Net Transfer	-$14.83	Exhibit G
24)	Marketplace User Fee	$18.28	Exhibit H
25)	**= Market-wide Adjusted Index Rate** {3}	$996.22	= (20)+[(21)+(22)+(23)+(24)] ÷ (19)

NOTE:

{1} Factors above are detailed in subsequent exhibits

{2} Claims covered under S.B. No. 376 & Sub. S.B. No. 1 have been excluded from the experience data, since they are to be defrayed by the state per 45 CFR 155.170. Please see Section 6 of the Actuarial Memorandum for additional details.

{3} Index Rate is Projected Allowed Claims for EHBs only

{4} The Market-wide Adjusted Index Rate is the same for all plans in the single risk pool

Exhibit D - Normalization Factors

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2026

	Average Claim Factors - Experience Rate		
	Experience Period Population	Future Population	Normalization Factor [1]
Age/Gender	1.0272	1.0222	0.9952
Area/Network	0.9932	0.9947	1.0015
Benefit Plan	0.7818	0.7794	0.9970
Total			**0.9937**

Note

{1} Normalization Factor = Future Population Factor / Experience Period Population Factor

Exhibit E - Projection Period Adjustments

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2026

Impact of Changes Between Experience Period and Projection Period:		
		Experience Rate
Plan Design Changes		
	Total Benefit Changes	1.0000
Morbidity Changes		
	Total Morbidity Changes	1.0000
Trend & Other Adjustments		
	Annual Medical/Rx Trend Rate	10.3%
	# Months of Projection	24.0
	Trend Factor	1.2163
	Other Benefit Expense	1.0015
	Induced Demand for CSR	1.0100
	Grace Period	1.0014
	Total Other Adjustments	1.0129

Note

{1} Explanation of the factors above is provided in the Actuarial Memorandum

Exhibit F - Other Claim Adjustments

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2026

Other Claim Adjustments	
	PMPM
Rx Rebates	($69.85)
CSR Receivable	$0.00
Additional EHBs	
Pediatric Dental	$1.55
Pediatric Vision	$0.07
Total - Additional EHBs	$1.62
Additional non-EHBs	
CCP, Adult Dental, Adult Vision	$1.37
Elective Abortion (if Non-EHB)	$0.62
Total - Additional Non-EHBs	$1.99

NOTES:

{1} This exhibit includes projected claims from lines 15, 16, and 17 of Exhibit C and additional non EHBs.

Exhibit G - Risk Adjustment and Reinsurance - Contributions and Payments

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2026

Risk Adjustment:		
PMPM		**Net Transfer{1}**
Federal Program		($14.83)
Reinsurance: {2}		
PMPM	**Contributions Made**	**Expected Receipts**
Federal Program	$0.00	$0.00
Grand Total of All Risk Mitigation Programs		($14.83)

NOTES:

{1} Projected risk adjustment transfer amount is explained in the Memorandum "Development of the Market-wide Adjusted Index Rate" Section. The net transfer for the High Cost Risk Pool is also included in the risk adjustment transfer amount shown.

{2} Federal Reinsurance Program is no longer applicable starting in 2017.

Exhibit H - Non-Benefit Expenses and Profit & Risk

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2026

	Expenses Applied As a PMPM Cost	Expenses Applied as a % of Premium [1]	Expenses Expressed as a PMPM [5]
Administrative Expenses			
Administrative Costs	$38.49		$38.49
Quality Improvement Expense	$5.58		$5.58
Selling Expense	$8.53		$8.53
Selling Expense		0.50%	$4.94
Specialty Expenses	$0.68		$0.68
Total Administrative Expenses	**$53.28**	**0.50%**	**$58.22**
Taxes and Fees			
PCORI Fee	$0.32		$0.32
ACA Insurer Fee		0.00%	$0.00
Risk Adjustment Fee [2]	$0.20		$0.20
Marketplace User Fee		1.85%	$18.28
Premium Tax		1.50%	$14.82
MLR-Deductible Federal/State Income Taxes [3]		1.05%	$10.37
Misc Taxes & Fees - PMPM	$4.30		$4.30
Misc Taxes & Fees - %-of-Premium		0.70%	$6.92
Total Taxes and Fees	**$4.82**	**5.10%**	**$55.21**
Profit and Risk Margin [4]		3.95%	$39.03
Total Non-Benefit Expenses, Profit, and Risk	**$58.10**	**9.55%**	**$152.46**

NOTES:

{1} The sum of the rounded percentages shown may not equal the total at the bottom of the table due to rounding.

{2} The Risk Adjustment User Fee reflects the per capita annual user fee rate established by HHS at the time this filing was prepared: $2.40 per year or $0.20 per-enrollee-per-month.

{3} Includes only those income taxes which are deductible from the MLR denominator; in particular, Federal income taxes on investment income are excluded.

{4} Profit and Risk Margin shown here is post-tax profit, net of those federal and state income taxes which are deductible from the MLR denominator.

{5} Anthem's Non-Benefit Expenses are applied in both PMPM and % of Premium as shown above. The last column expresses all non-benefit Expenses in PMPM only.

Exhibit I - Federal MLR Estimated Calculation

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2026

Numerator:		
Incurred Claims {1}	$850.41	Exhibit C (Line 18) + Exhibit F (Total Non-EHBs)
+ Quality Improvement Expense	$5.58	Exhibit H
+ Risk Corridor Contributions	$0.00	
+ Risk Adjustment Net Transfer	-$14.83	Exhibit G
+ Reinsurance Receipts	$0.00	Exhibit G
+ Risk Corridor Receipts	$0.00	
+ Reduction to Rx Incurred Claims (ACA MLR)	-$11.11	Footnote {3}
= *Estimated* Federal MLR Numerator	$830.05	
Denominator:		
Premiums {2}	$988.04	Incurred Claims + Exhibit G (Total) + Exhibit H (Total)
- Federal and State Taxes	$10.37	Exhibit H (Federal/State Income Taxes)
- Premium Taxes	$14.82	Exhibit H (Premium Tax)
- Risk Adjustment User Fee	$0.20	Exhibit H
- Reinsurance Contributions	$0.00	Exhibit G
- Misc Taxes & Fees (PMPM)	$4.30	Exhibit H
- Misc Taxes & Fees (% of Premium)	$6.92	Exhibit H
- Licensing and Regulatory Fees	$18.60	Exhibit H (PCORI, ACA and Marketplace Fees)
= *Estimated* Federal MLR Denominator	$932.83	
***Estimated* Federal MLR**	**88.98%**	Footnote {4}

NOTES:

{1} Incurred Claims = Projected Paid Claims for EHB (Exhibit C Line 18) + additional non EHBs (Exhibit F Total Non-EHBs)

{2} Premiums = Incurred Claims in this exhibit + Risk Mitigation Programs in Exhibit G + Non-Benefit Expenses and Profit & Risk Margin in Exhibit H

{3} This is the amount of 2026 pharmacy claims that are attributable to Third Party Administrative Expenses (i.e. the 'retail spread' or 'pharmacy claims margin'). It is calculated by applying the third party margin percentage to the 2026 projected Pharmacy claims including projected rebates.

{4} The above calculation is purely an estimate and not meant to be compared to the minimum MLR benchmark for federal/state MLR rebate purposes:

* The above calculation represents only the products in this filing. Federal MLR will be calculated at the legal entity and market level.

* Not all numerator/denominator components are captured above (for example, fraud and prevention program costs, payroll taxes, assessments for state high risk pools etc.).

* Other adjustments may also be applied within the federal MLR calculation such as 3-year averaging, new business, credibility, deductible and dual option. These are ignored in the above calculation.

* Licensing and Regulatory Fees include ACA-related fees as allowed under the MLR Final Rule.

Exhibit J - Plan Adjusted Index Rate and Consumer Adjusted Premium Rates

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2026

HIOS Plan Name	HIOS Plan ID	Market Adjusted Index Rate (Exhibit C)	Induced Utilization/Cost Sharing Adjustment	Provider Network Adjustment	Adjustment for Benefits in Addition to the EHBS	Catastrophic Plan Adjustment {1}	Administrative Costs {2}	Plan Adjusted Index Rate {3}	Calibration Factor {4}	Consumer Adjusted Premium Rate {5}
Catastrophic HMO Pathway Enhanced	86545CT1230005	$996.22	0.5423	1.0000	1.0000	0.7634	$69.79	$482.21	1.7034	$283.09
Bronze HMO Pathway Enhanced with Adult Dental and Vision Benefits	86545CT1230025	$996.22	0.7167	1.0000	1.0059	1.0000	$116.88	$835.07	1.7034	$490.24
Gold HMO Pathway Enhanced with Adult Dental and Vision Benefits	86545CT1230027	$996.22	0.9210	1.0000	1.0047	1.0000	$146.35	$1,068.25	1.7034	$627.13
Anthem Catastrophic HMO Pathway Enhanced	86545CT1310033	$996.22	0.5423	1.0000	1.0000	0.7634	$69.79	$482.21	1.7034	$283.09
Anthem Bronze HMO Pathway Enhanced 6000/12000/40% HSA	86545CT1310019	$996.22	0.7740	1.0000	1.0000	1.0000	$121.68	$892.80	1.7034	$524.13
Anthem Bronze HMO Pathway Enhanced 8500/50%	86545CT1310055	$996.22	0.7274	1.0000	1.0000	1.0000	$114.93	$839.56	1.7034	$492.87
Anthem Silver HMO Pathway Enhanced 4000/30%	86545CT1310056	$996.22	0.8820	1.0000	1.0000	1.0000	$137.30	$1,015.97	1.7034	$596.44
Anthem Gold HMO Pathway Enhanced 2000/10%	86545CT1310060	$996.22	0.9739	1.0000	1.0000	1.0000	$150.60	$1,120.82	1.7034	$657.99
Bronze PPO Standard Pathway HSA	86545CT1330009	$996.22	0.7695	1.0000	1.0003	1.0000	$121.95	$888.73	1.7034	$521.74
Bronze PPO Standard Pathway	86545CT1330002	$996.22	0.8211	1.0000	1.0003	1.0000	$129.40	$947.63	1.7034	$556.32
Silver PPO Standard Pathway	86545CT1330001	$996.22	0.8750	1.0000	1.0002	1.0000	$137.44	$1,009.30	1.7034	$592.52
Gold PPO Pathway with Adult Dental and Vision Benefits	86545CT1330020	$996.22	0.9532	1.0000	1.0085	1.0000	$152.06	$1,109.73	1.7034	$651.48
Gold PPO Standard Pathway	86545CT1330003	$996.22	1.6086	1.0000	1.0001	1.0000	$243.42	$1,846.11	1.7034	$1,083.78
Anthem Bronze PPO Pathway 8000/0% HSA	86545CT1340020	$996.22	0.9178	1.0000	1.0000	1.0000	$142.48	$1,056.81	1.7034	$620.41
Anthem Silver PPO Pathway 4000/20% HSA	86545CT1340021	$996.22	1.0328	1.0000	1.0000	1.0000	$159.12	$1,188.00	1.7034	$697.43
Bronze PPO Pathway with PreventiveRx HSA	86545CT1570001	$996.22	0.7588	1.0000	1.0000	1.0000	$119.26	$875.21	1.7034	$513.80
Gold PPO Pathway	86545CT1570002	$996.22	0.9829	1.0000	1.0000	1.0000	$151.68	$1,130.90	1.7034	$663.90
Bronze HMO Pathway Enhanced	86545CT1580001	$996.22	0.7162	1.0000	1.0000	1.0000	$113.09	$826.55	1.7034	$485.24

Notes:

{1} This adjustment reflects the projected costs of the population eligible for catastrophic plans.

{2} This is an additive adjustment that includes all the selling expense, administration and retention Items shown in Exhibit H, with the exception of the Exchange User Fee. The Exchange User Fee has been included in the Market-wide Adjusted Index Rate at the market level.

{3} The Plan Adjusted Index Rate is calculated by multiplying the Market-wide Adjusted Index Rate by the induced utilization/cost sharing adjustment, provider network, benefits in addition to the EHBs, and catastrophic plan adjustments and then adding the administrative costs. The Plan Adjusted Index Rate can also be described as a Plan Level Required Premium.

{4} See Exhibit K - Calibration.

{5} The Consumer Adjusted Premium Rate is equal to 'Plan Adjusted Index Rate' divided by 'Calibration Factor'.

Exhibit K - Calibration

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2026

Average rating factors for 2026 population:	
	Calibration Factors
Age	1.7125
Tobacco	1.0000
Area	0.9947
Total Calibration Factor{1}	1.7034

NOTES:

{1} Total Calibration factor was used in Exhibit J.

{2} Age calibration includes adjustments for membership that exceeds the three child dependent cap, as permitted by CMS per 2026 Part 3 Instructions.

Exhibit L - Age and Tobacco Factors

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2026

	Age Factors	Tobacco Factors
Age	2026	2026
0-14	0.765	1.000
15	0.833	1.000
16	0.859	1.000
17	0.885	1.000
18	0.913	1.000
19	0.941	1.000
20	0.970	1.000
21	1.000	1.000
22	1.000	1.000
23	1.000	1.000
24	1.000	1.000
25	1.004	1.000
26	1.024	1.000
27	1.048	1.000
28	1.087	1.000
29	1.119	1.000
30	1.135	1.000
31	1.159	1.000
32	1.183	1.000
33	1.198	1.000
34	1.214	1.000
35	1.222	1.000
36	1.230	1.000
37	1.238	1.000
38	1.246	1.000
39	1.262	1.000
40	1.278	1.000
41	1.302	1.000
42	1.325	1.000
43	1.357	1.000
44	1.397	1.000
45	1.444	1.000
46	1.500	1.000
47	1.563	1.000
48	1.635	1.000
49	1.706	1.000
50	1.786	1.000
51	1.865	1.000
52	1.952	1.000
53	2.040	1.000
54	2.135	1.000
55	2.230	1.000
56	2.333	1.000
57	2.437	1.000
58	2.548	1.000
59	2.603	1.000
60	2.714	1.000
61	2.810	1.000
62	2.873	1.000
63	2.952	1.000
64+	3.000	1.000

NOTES:

The weighted average of these factors for the entire risk pool included in this rate filing is provided in Exhibit K.

Exhibit M - Area Factors

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2026

Rating Area Description	2026 Area Rating Factor	2025 Area Rating Factor	Change
Fairfield	1.1000	1.1000	0.0%
Hartford	0.9400	0.9200	2.2%
Litchfield	0.9700	0.9600	1.0%
Middlesex	1.0000	1.0100	-1.0%
New Haven	1.0000	1.0100	-1.0%
New London	0.9400	0.9200	2.2%
Tolland	0.9000	0.8800	2.3%
Windham	0.9000	0.8800	2.3%

NOTES:

{1} The weighted average of these factors for the entire risk pool included in this rate filing is provided in Exhibit K.

Exhibit N - Sample Rate Calculation

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2026

Name: **John Doe**
Effective Date: **1/1/2026**
On/Off Exchange: Off
Metal Level: Bronze
Plan ID: 86545CT1310055
Rating Area: 01

Family Members Covered:

	Age
Subscriber	47
Spouse	42
Child (age 21+)	25
Child #1	20
Child #2	16

Calculation of Monthly Premium:

Consumer Adjusted Premium Rate	$492.87	Exhibit J
x Area Factor	1.1000	Exhibit M
Rate Adjusted for Area =	$542.16	

Age Factors: Exhibit L

	Age Factor
Subscriber	1.563
Spouse	1.325
Child (age 21+)	1.004
Child #1	0.970
Child #2	0.859

Final Monthly Premium PMPM:

	PMPM
Subscriber	$847.40
Spouse	$718.36
Child (age 21+)	$544.33
Child #1	$525.90
Child #2	$465.72
TOTAL	**$3,101.71**

NOTES:

{1} As per the Market Reform Rule, when computing family premiums no more than the three oldest covered children under the age of 21 are taken into account whereas the premiums associated with each child age 21+ are included.

{2} Minor rate variances may occur due to differences in rounding methodology.

Exhibit O - Silver Plan Membership Projections for Cost-Sharing Reductions

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2026

Silver Plan	Projected Membership by Subsidy Level:				
HIOS Standard Component Plan ID	Zero Cost Sharing	100-150%	150%-200%	200%-250%	Standard
86545CT1310056	0	0	0	0	595
86545CT1330001	15	13,083	16,813	5,527	11,682
86545CT1340021	0	0	0	0	194

Exhibit P - Terminated Plans

Anthem Health Plans, Inc.
Individual

Effective January 1, 2026

Following are the plans that will be terminated prior to the effective date:

This includes plans that have experience included in the URRT during the experience period and any plans that were not in effect during the experience period but were made available thereafter.

Pre ACA Terminated Plans

Plan ID	Plan Name	HIOS Product ID	HIOS Product Name	2026 Mapped HIOS Plan ID
N/A	N/A	N/A	N/A	N/A

Post ACA Terminated Plans

Plan ID	Plan Name	HIOS Product ID	HIOS Product Name	2026 Mapped HIOS Plan ID
86545CT1330021	Bronze PPO Pathway HSA	86545CT133	PPO On Exchange	86545CT1570001
86545CT1330023	Bronze PPO Pathway with Adult Dental and Vision Benefits	86545CT133	PPO On Exchange	86545CT1570001
86545CT1330024	Gold PPO Pathway	86545CT133	PPO On Exchange	86545CT1570002
86545CT1340022	Anthem Gold PPO Pathway 2000/10%	86545CT134	PPO Off Exchange	NA

NOTES:

{1} This exhibit may include a greater number of HIOS Plan IDs than the URRT, WS2, as this list additionally includes terminated Plan IDs that were introduced after the experience period.

Exhibit Q - Trend

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2026

The data paid through March 2025 for this exhibit was not available in time for this rate filing. This exhibit will be submitted within SERFF by end of day, June 13th.

Exhibit R - Claims Lag Triangle

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2026

Incurred Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25+
202301	$3,669,936	$10,126,741	$2,739,185	$817,543	$602,161	$177,660	$103,670	$91,417	$2,042	$336	$23,262	$39,472	$43,060	$111,318	$25,456	$1,778	$7,354	$17,921	$63,974	$2,622	-$18,208	$8,114	$560	$13,649	$855
202302	$4,600,949	$13,025,804	$1,353,177	$531,446	$267,737	$64,276	$111,296	-$59,860	$58,462	$32,229	$27,162	$9,175	$16,147	-$49,252	-$43,328	-$2,832	$17,019	$7,529	$2,838	$1,348	$2,647	$21,283	$1,406	$1,121	-$158
202303	$6,597,172	$14,200,524	$2,413,267	$575,701	$481,500	$301,104	-$13,502	$51,876	$17,574	$5,051	$17,393	$24,165	-$2,161	$108,174	-$373,395	$2,721	-$1,322	-$53,526	$185,778	$8,510	$7,075	$21,916	$7,859	-$654	$0
202304	$4,592,625	$15,909,653	$1,736,504	$646,726	$477,040	$40,786	$489,518	$45,325	$18,454	-$30,641	$4,559	$9,298	$5,919	$24,092	-$5,790	$26,463	$10,433	$24,344	$4,074	$6,453	$18,474	$25,101	$1	$0	$0
202305	$7,483,955	$16,950,647	$2,198,773	$294,672	$174,511	$81,934	$147,893	$705,854	$104,452	-$44,385	$68,224	-$6,673	$57,718	-$35,194	-$21,489	$11,670	-$13,141	-$2,630	$9,686	$7,214	$4,125	$17,829	$0	$0	$0
202306	$6,396,630	$16,933,670	$1,554,004	$622,713	$298,454	$76,301	$60,229	$53,122	$37,842	$48,790	$17,898	$24,010	$18,207	$12,434	$8,350	$19,239	$4,415	-$3,189	-$32,478	$2,917	$36,291	$0	$0	$0	$0
202307	$6,975,413	$14,159,065	$1,337,922	$555,822	$153,419	$165,451	-$8,898	$69,459	$18,210	$61,910	-$2,246	$20,528	$41,383	-$22,865	$9,123	$13,084	$98,186	$3,977	$46,288	$14,738	$0	$0	$0	$0	$0
202308	$8,013,997	$15,942,774	$2,291,457	$600,256	$202,267	$93,076	$83,008	$160,974	$168,551	$408,048	$724	$12,827	$26,968	$7,808	$22,576	$37,154	$81,188	$4,890	-$32,813	$0	$0	$0	$0	$0	$0
202309	$5,660,029	$18,345,158	$918,896	$439,226	$349,540	$43,795	$23,578	$205,031	$47,994	$53,651	$27,624	-$287	$8,160	$48,685	$56,858	$3,601	-$2,387	$39,226	$0	$0	$0	$0	$0	$0	$0
202310	$9,195,267	$17,851,558	$2,054,985	$753,909	$328,195	$356,114	$246,730	$96,322	$56,375	$17,416	$46,230	-$28,411	$21,096	$12,286	$12,741	$27,318	$45,322	$0	$0	$0	$0	$0	$0	$0	$0
202311	$6,832,222	$18,518,204	$2,191,186	$320,173	$290,197	$162,030	$42,937	$21,842	$105,464	$63,447	-$100,972	$88,984	$42,244	$59,779	$4,239	$16,286	$0	$0	$0	$0	$0	$0	$0	$0	$0
202312	$5,170,691	$21,116,084	$1,964,360	$371,871	$483,584	$126,988	$283,816	$196,529	$20,019	-$12,533	$20,924	-$73,925	$9,285	$7,775	$29,087	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
202401	$8,113,854	$20,111,673	$2,899,164	$1,274,989	$495,044	$223,360	$216,409	$231,973	$16,125	$38,970	$9,731	$80,448	$36,949	$129,285	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
202402	$9,507,597	$20,035,498	$4,418,663	$1,231,729	$338,805	$216,723	$43,683	$132,493	-$1,962	$37,125	$61,540	$82,138	$107,806	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
202403	$8,824,607	$25,230,235	$3,707,696	$637,114	$533,531	$202,258	$1,293,153	$353,472	$318,859	$69,842	$129,619	$95,677	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
202404	$11,636,770	$26,193,823	$3,479,953	$1,226,110	$334,502	$426,722	$104,700	$37,872	$42,534	$329,421	-$21,554	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
202405	$9,764,268	$29,016,128	$4,285,359	$1,169,951	$599,075	$379,210	$163,231	$21,133	$105,461	$68,682	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
202406	$9,608,405	$29,040,998	$1,816,278	$1,147,577	$573,696	$270,510	$735,397	$86,421	$157,080	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
202407	$13,087,304	$29,033,574	$3,182,508	$1,159,073	$683,269	$272,096	$232,583	$222,087	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
202408	$12,403,388	$31,632,044	$2,233,817	$560,815	$603,475	$347,702	$103,614	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
202409	$14,862,358	$30,150,248	$2,346,918	$757,090	$567,033	$403,695	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
202410	$16,062,595	$33,522,400	$3,936,312	$1,762,160	$1,125,255	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
202411	$12,783,866	$32,093,696	$5,280,327	$1,120,488	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
202412	$7,877,845	$37,899,334	$3,335,359	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

Notes:

{1} As noted in Section 20. State Actuarial Memorandum Requirements, this exhibit displays the claim lag triangle for Individual ACA experience, which was the basis of the Individual ACA rate development.

Exhibit S - Historical Experience

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2026

	CT Individual ACA					
	Member Months	**Premium PMPM**	**Incurred Benefit Expense PMPM**	**Paid Benefit Expense PMPM**	**Incurred Loss Ratio**	**Paid Loss Ratio**
CY 2020	**352,051**	**$785.70**	**$611.75**	**$609.26**	**77.9%**	**77.5%**
CY 2021	**353,435**	**$793.78**	**$711.72**	**$708.19**	**89.7%**	**89.2%**
CY 2022	**357,567**	**$816.38**	**$645.31**	**$641.11**	**79.0%**	**78.5%**
202301	34,835	$797.67	$507.22	$506.79	63.6%	63.5%
202302	37,929	$776.68	$516.58	$516.23	66.5%	66.5%
202303	38,041	$778.55	$623.85	$623.17	80.1%	80.0%
202304	38,025	$774.92	$629.55	$628.86	81.2%	81.2%
202305	38,339	$774.74	$712.71	$711.85	92.0%	91.9%
202306	39,101	$772.85	$644.74	$643.28	83.4%	83.2%
202307	39,761	$777.77	$567.82	$566.34	73.0%	72.8%
202308	40,647	$775.72	$673.23	$668.19	86.8%	86.1%
202309	41,734	$771.09	$604.68	$602.85	78.4%	78.2%
202310	42,307	$765.11	$676.98	$674.88	88.5%	88.2%
202311	42,667	$757.81	$641.06	$638.74	84.6%	84.3%
202312	42,652	$752.68	$672.37	$669.75	89.3%	89.0%
CY 2023	**476,038**	**$772.40**	**$624.56**	**$622.86**	**80.9%**	**80.6%**
202401	52,722	$878.59	$607.95	$604.80	69.2%	68.8%
202402	58,812	$862.32	$585.50	$581.28	67.9%	67.4%
202403	60,393	$859.78	$709.26	$672.58	82.5%	78.2%
202404	61,676	$866.18	$672.11	$665.91	77.6%	76.9%
202405	62,690	$863.92	$685.55	$667.72	79.4%	77.3%
202406	63,689	$864.50	$674.69	$639.18	78.0%	73.9%
202407	64,893	$860.64	$769.09	$758.01	89.4%	88.1%
202408	66,186	$853.24	$712.22	$698.66	83.5%	81.9%
202409	67,428	$845.47	$749.18	$694.52	88.6%	82.1%
202410	68,265	$840.49	$809.76	$776.69	96.3%	92.4%
202411	69,059	$837.56	$746.46	$705.03	89.1%	84.2%
202412	68,672	$830.23	$667.90	$586.99	80.4%	70.7%
CY 2024	**764,485**	**$854.38**	**$702.41**	**$673.15**	**82.2%**	**78.8%**

Notes:

{1} Premium includes expected risk adjustment.

{2} Incurred and Paid benefit expenses include capitation, drug rebates, medical management fees, claims expense reclasses, reinsurance, and other non-core claim accounts.

{3} As noted in Section 4. Experience Period Premium and Claims, this exhibit details historical experience for the policy forms included in this filing.

Exhibit T - Wigs Certification

Anthem Health Plans – Connecticut
Actuarial Certification

I, Tu Nguyen, FSA, MAAA, am an Actuarial Strategic Planning Leader for Anthem Health Plans. I am a member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion herein.

Anthem's historical claims data shows that the allowed cost of wigs range from $230 to $2,370 with an average allowed cost of $466. The data contains low utilization with a few high cost outliers that are currently driving up the average cost beyond $350. However, if outliers in the claims data are excluded, the average allowed cost is $347. Based upon actuarial review, the substitution of 1 wig per year to replace the annual dollar maximum of $350 indicates that the 1 wig per year is a reasonable substitution for a $350 dollar annual limit.

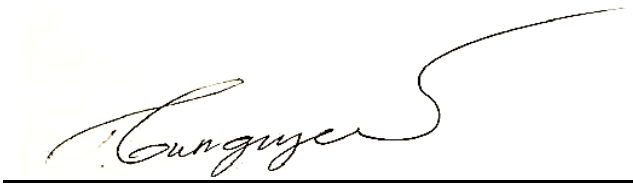
Tu Nguyen, FSA, MAAA
Actuarial Strategic Planning Leader
May 28, 2025

Exhibit U - Mental Health Parity Certification

Anthem Health Plans – Connecticut
Actuarial Certification

The undersigned deposes and says that all policy forms submitted by May 31, 2025, by Anthem Health Plans, Inc. for use in Connecticut sited health insurance contracts subject to the requirements of 42 U.S.C. § 300gg-26, 45 CFR §146.136 and Conn. Gen. Stat. §§38a-488a and 38a-514 provide coverage for parity in mental health and substance abuse disorder benefits in accordance with both state and federal laws as applicable. The undersigned certifies that all such policies issued or renewed will provide coverage for the medical treatment of mental illness and substance abuse provided under the same terms and conditions as coverage that is provided for other illnesses and diseases in connection with financial requirements, quantitative treatment limitations, prescription drug benefits, and non-quantitative treatment limitations.

Tu Nguyen, FSA, MAAA certifies that he is the Actuarial Strategic Planning Leader of such company and that he is authorized to execute and file such instrument. Deponent further says that he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his knowledge, information and belief.



Tu Nguyen, FSA, MAAA
Actuarial Strategic Planning Leader
May 22, 2025

Appendix A

Anthem Health Plans, Inc. - Connecticut
Individual Plans Effective January 1, 2026
Summary of Requested Rate Changes

• The requested rate change for each product can be found in Exhibit A: Non-Grandfathered Rate Changes.

• The percentage of Anthem's total projected Individual ACA membership for each plan is shown in the table below.

HIOS Plan Name	2026 HIOS Plan ID	On/Off Exchange	Metal Level	2026 Projected Membership Distribution	2025 HIOS Plan ID Mapping
Catastrophic HMO Pathway Enhanced	86545CT1230005	On	Catastrophic	0.4%	86545CT1230005
Bronze HMO Pathway Enhanced with Adult Dental and Vision Benefits	86545CT1230025	On	Bronze	8.7%	86545CT1230025
Gold HMO Pathway Enhanced with Adult Dental and Vision Benefits	86545CT1230027	On	Gold	4.7%	86545CT1230027
Anthem Catastrophic HMO Pathway Enhanced	86545CT1310033	Off	Catastrophic	0.3%	86545CT1310033
Anthem Bronze HMO Pathway Enhanced 6000/12000/40% HSA	86545CT1310019	Off	Bronze	1.2%	86545CT1310019
Anthem Bronze HMO Pathway Enhanced 8500/50%	86545CT1310055	Off	Bronze	0.7%	86545CT1310055
Anthem Silver HMO Pathway Enhanced 4000/30%	86545CT1310056	Off	Silver	0.7%	86545CT1310056
Anthem Gold HMO Pathway Enhanced 2000/10%	86545CT1310060	Off	Gold	1.8%	86545CT1310060
Bronze PPO Standard Pathway HSA	86545CT1330009	On	Bronze	3.4%	86545CT1330009
Bronze PPO Standard Pathway	86545CT1330002	On	Bronze	2.6%	86545CT1330002
Silver PPO Standard Pathway	86545CT1330001	On	Silver	55.4%	86545CT1330001
Gold PPO Pathway with Adult Dental and Vision Benefits	86545CT1330020	On	Gold	7.6%	86545CT1330020
Gold PPO Standard Pathway	86545CT1330003	On	Gold	0.4%	86545CT1330003
Anthem Bronze PPO Pathway 8000/0% HSA	86545CT1340020	Off	Bronze	0.3%	None
Anthem Silver PPO Pathway 4000/20% HSA	86545CT1340021	Off	Silver	0.2%	None
Bronze PPO Pathway with PreventiveRx HSA	86545CT1570001	On	Bronze	7.9%	86545CT1330023
Gold PPO Pathway	86545CT1570002	On	Gold	2.1%	86545CT1330024
Bronze HMO Pathway Enhanced	86545CT1580001	On	Bronze	1.5%	None

Components of Average Rate Increase	
Trend	10.3%
Risk Adjustment	0.1%
Induced Demand due to CSRs	0.7%
CSR Silver Load	2.2%
Other	0.5%
Overall Average Rate Increase	14.2%

Appendix B

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2026

	Fairfield	Hartford	Litchfield	Middlesex and New Haven	New London	Tolland and Windham	All Areas
Raw Allowed Claims PMPM	$875.60	$842.60	$770.55	$922.96	$901.05	$834.18	$871.76
Morbidity Factor	1.15	1.24	1.09	1.31	1.25	1.17	1.22
Demographic Factor	0.98	1.01	1.05	1.00	1.06	1.06	1.02
Benefit Induced Utilization Factor	0.94	0.95	0.93	0.94	0.94	0.94	0.94
Normalized Claims PMPM	$827.13	$709.49	$726.63	$744.19	$719.69	$713.92	$750.33
2026 Calculated Area Factors	1.10	0.95	0.97	0.99	0.96	0.95	1.00
2026 Proposed Area Factors	**1.10**	**0.94**	**0.97**	**1.00**	**0.94**	**0.90**	**0.99**
2025 Approved Area Factors	1.10	0.92	0.96	1.01	0.92	0.88	0.99

{1} Anthem performed an area factor study using 2024 experience. Above are the raw allowed and normalized claim PMPMs by county. The calculated area factor shown above was developed by dividing the normalized claim PMPMs for each county by an overall normalized average PMPM of $750.33. Smaller counties are combined for more credible experience.
{2} The proposed area rating factors reflect the calculated area factors with an adjustment made in several counties to minimize market disruption.

ACTUARIAL MEMORANDUM

1. General Information

- Company Identifying Information

Company Legal Name:	Anthem Health Plans, Inc.
State:	Connecticut
HIOS Issuer ID:	86545
NAIC Company Code:	60217
Market:	Individual
Effective Date:	January 1, 2026

- Company Contact Information

Primary Contact Name:	Tu Nguyen
Primary Contact Email Address:	Tu.Nguyen@elevancehealth.com

2. Scope and Purpose of the Filing

This is a rate filing for the Individual market ACA-compliant plans offered by Anthem Health Plans, Inc., also referred to as Anthem. The policy forms associated with these plans are listed below. The proposed rates in this filing will be effective for the 2026 plan year beginning January 1, 2026, and apply to plans both On-Exchange and Off-Exchange.

The Memorandum provides support to the rate development and demonstrates that rates are established in compliance with state laws and provisions of the Affordable Care Act. The rates proposed in this submission reflect the regulatory framework and insurer participation in the market as of May 30, 2025. If the regulatory framework or insurer participation in the market changes after this date, proposed rates may no longer be appropriate and should be reevaluated for revision and resubmission. Due to the timing of the 2025 legislative session, bills passed during the session have not been accounted for in this rate filing. Anthem requests that the Connecticut Insurance Department allows carriers to reflect the impacts of bills passed that affect 2026. Examples of such bills include, but are not limited to, proposed Senate Bill 10 (SB 10) and proposed Senate Bill 11 (SB 11). This rate filing is not intended to be used for other purposes.

Under the American Rescue Plan Act, Advanced Premium Tax Credits (also referred to as APTCs or premium subsidies) provided by the federal government were increased, and these enhancements to the subsidies are set to expire at the end of 2025. Per the filing requirements from Connecticut Bulletin HC-81-25, "carriers must submit their filings for 2026 Rates with the assumption that the subsidies will be extended through 2026." The rates submitted in this filing are in accordance with that guidance rather than the current regulated expiration. If these enhanced subsidies do expire, then the rates included in this rate filing will need to be revised and resubmitted. Anthem has included a 3.7% morbidity impact that will need to be applied to the rates in the event of enhanced subsidy expiration in Section 6 of this actuarial memorandum. In the event that no decision is made on the extension of the enhanced subsidies prior to the Connecticut Insurance Department's final decision on this rate filing, Anthem assumes that the inactivity indicates that the enhanced subsidies will expire and that the morbidity impact outlined in Section 6 will be included within the final rate development submitted to the Connecticut Insurance Department in August or September. Only in the event that the federal government gives final guidance that the enhanced subsidies will be extended will this rate filing hold and the rates not need to be revised to reflect the morbidity impact provided.

Policy Form Number(s):

CT_ONHIX_PPO_01-26
CT_OFFHIX_PPO_01-26
CT_ONHIX_HMO_01-26
CT_OFFHIX_HMO_01-26

3. Proposed Rate Increase(s)

The proposed rates have been developed from 2024 ACA experience.

The proposed annual rate changes by product in this filing range from 10.04% to 21.89%, with rate changes by plan from 6.40% to 22.77%. These ranges are based on the renewing plans and are consistent with what is reported in the Unified Rate Review Template. Exhibit A shows the rate change for each plan.

Factors that affect the rate changes for all plans include:

- Trend: This includes the impact of inflation, provider contracting changes, and changes in utilization of services.
- Morbidity: If the enhanced subsidies expire, there are anticipated changes in the market-wide morbidity of the covered population in the projection period. This morbidity impact is not currently reflected in the rate development but will be included within the final rate filing submitted to the Connecticut Insurance Department in August or September unless there is final guidance from the federal government of extension of the enhanced subsidies through 2026.
- Benefit modifications, including changes made to comply with updated AV requirements.
- Changes in taxes, fees, and some non-benefit expenses.

Although rates are based on the same claims experience, the rate changes vary by plan due to the following factors:

- Changes in benefit design that vary by plan.
- Updates in benefit relativity factors among plans.
- Updated adjustment factors for catastrophic plans.
- Changes in some non-benefit expenses that are applied on a PMPM basis.
- Changes in the claim cost relativity by area.

4. Experience and Current Period Premium, Claims, and Enrollment

The experience period premium and claims reported in Worksheet 1, Section I of the Unified Rate Review Template (URRT) are for the non-grandfathered, single risk pool compliant policies of the identified legal entity in the Individual market.

• Paid Through Date

The experience reported in Worksheet 1, Section I of the URRT reflects the incurred claims from January 1, 2024 through December 31, 2024 based on claims paid through February 28, 2025.

• Current Date

The Current Date for Current Enrollment and Current Premium PMPM in Worksheet 2, Section II of the URRT is February 28, 2025.

• Experience Period Premium

The earned premium prior to MLR rebate is $638,247,731. The earned premium reflects the pro-rata share of premium based on policy coverage dates.

The current MLR rebate estimate is $0 for experience period ending December 31, 2024, which is consistent with Anthem's current general ledger estimate allocated to the non-grandfathered portion of Individual business. This is an estimated amount and will not be final until 7/31/2025. The earned premium is $638,247,731 for the legal entity as reported in cell E18 of Worksheet 1, Section I of the URRT.

• Allowed and Incurred Claims Incurred During the Experience Period

The allowed claims are determined by subtracting non-covered benefits, provider discounts, and coordination of benefits amounts from the billed amount.

Allowed and incurred claims are completed using the chain ladder method, an industry standard, by using historic paid vs. incurred claims patterns. The method calculates historic completion percentages, representing the percent of cumulative claims paid of the ultimate incurred amounts for each lag month. Claim backlog files are reviewed on a monthly basis and are accounted for in the historical completion factor estimates.

Allowed and incurred claims reported in Worksheet 1, Section I of the URRT are $637,858,829 and $531,964,086, respectively. These amounts differ from those shown in Exhibit B due to the URRT including Rx Rebates.

5. Benefit Categories

The methodology used to determine benefit categories in Worksheet 1, Section II of the URRT is as follows:

- Inpatient Hospital: Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.
- Outpatient Hospital: Includes non-capitated facility services for surgery, emergency room, lab, radiology, therapy, observation and other services provided in an outpatient facility setting and billed by the facility.
- Professional: Includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, and other professional services, other than hospital-based professionals whose payments are included in facility fees.
- Other Medical: Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, and dental services.
- Capitation: Includes all services provided under one or more capitated arrangements.
- Prescription Drug: Includes drugs dispensed by a pharmacy and rebates received from drug manufacturers.

6. Projection Factors

The experience period claims in Worksheet 1, Section I of the URRT are projected to the projection period using the factors described below. Exhibit C provides a summary of the factors.

- Trend Factors (cost/utilization)

  - The annual pricing trend used in the development of proposed rates is 10.3%. This annual pricing trend is applied for 12.0 months to both Years 1 and 2 in Worksheet 1 of the URRT. The trend is developed by normalizing historical benefit expense for changes in the underlying population and known cost drivers, which are then projected forward to develop the pricing trend. Examples of such changes or cost drivers include contracting, cost of care initiatives, workdays, average wholesale price, expected introduction of new brand or generic drugs, changes in medical and pharmacy utilization and other changes in practice patterns. For projection, the experience period claims are trended 24.0 months from the member-weighted endpoint of the experience period, which is December 31, 2024, to the member-weighted endpoint of the projection period, which is December 31, 2026. Exhibit E has details.

- Morbidity Adjustment

  As described in Section 2 of this actuarial memorandum, the Connecticut Insurance Department has required that carriers submit their rate filings under the assumption that the enhanced premium subsidies from the American Rescue Plan Act are extended through 2026. The rates within this rate development are in accordance with that guidance rather than the current regulated expiration. If these enhanced subsidies do expire or if there is no federal decision to extend the subsidies prior to the Connecticut Insurance Department's final decision on this rate filing, then a 3.7% morbidity impact will be applied to the rates within this rate filing. Only in the event that the federal government gives final guidance that the enhanced subsidies will be extended will the rates not need to be revised to reflect this impact.

  The morbidity impact accounts for the differences between the average morbidity of the experience period population from 2024 and that of the anticipated population in the projection period for 2026. The morbidity adjustment reflects the projected market changes in morbidity due to the expiration of the enhanced ACA premium tax credits on December 31, 2025. Selective lapsation is expected to increase the morbidity of the risk pool as a disproportionate number of healthy enrollees is expected to leave the market due to the increases in their net premiums. The morbidity impact of 3.7% will be applied to the claims in the final rate development submitted to the Connecticut Insurance Department in August or September unless there is final guidance from the federal government extending the enhanced subsidies through 2026.

- Changes in Demographics (Normalization)

  The experience period claims are normalized to reflect anticipated changes in age/gender, area, network, and benefit plan in the projection period. Exhibit D provides detail of each normalization factor below:

  - Age/Gender: The assumed claims cost is applied by age and gender to the experience period membership distribution and the projection period membership distribution.

- Area/Network: The area claims factors are developed based on an analysis of allowed claims by network, mapped to the prescribed rating areas using the subscriber's 5-digit zip code.
- Benefit Plan: The experience period claims are normalized to reflect the average benefit level in the projection period using benefit relativities. The benefit relativities include the value of cost shares and anticipated changes in utilization due to the difference in average cost share requirements.

• Other Adjustments

Other adjustments to the experience claims data include the following items. Exhibit C has the Covered CT adjustment factor. Exhibit E and Exhibit F show the factors used for each of the other adjustments.

- Covered CT Adjustment: Through the Covered Connecticut bill, various cohorts of individuals with income between 138% FPL and 175% FPL were eligible to be covered without cost share and at no premium paid by the member in the Individual ACA market at different times since July 1, 2021. The members of these cohorts have been included in the 2024 base experience to comply with the single risk pool ACA requirement. As part of the Covered Connecticut program, members are assigned to the Standard Silver plan on the 87% or 94% CSR variant, depending on their FPL. The carrier pays each Covered Connecticut member's cost shares for the respective benefit design upfront, and the state reimburses the carrier for the cost shares. The paid cost shares are reflected within Anthem's starting paid claims. Since the state reimburses these amounts, an adjustment was applied to remove the total amount reimbursed by the state.

  Anthem received $10,466,037.04 in reimbursement from the state for the paid cost shares for 2024. The adjustment factor is one minus the reimbursement divided by the 2024 base experience claims.

2024 Cost Shares for Covered CT Reimbursed by the State	$10,466,037.04
2024 Experience Total Paid Completed Claims	$583,274,756.27
2024 Covered CT Impacts to Experience Claims	0.9821

  This adjustment only accounts for the state's reimbursement of member cost shares.

  The state also pays for the net premium that the member would traditionally be responsible for after accounting for federal premium subsidies. These are not included in the rate development, because this does not change the premium PMPM. The state is just covering the member's portion of the premium.

The state also pays an induced utilization fee for the Covered Connecticut members that accounts for the members induced utilization impact of being covered at 100% AV with no cost shares from their actual plan design, which is either the 87% or the 94% CSR variant of the Standard Silver plan. The state is not reimbursing for these members moving from 70% AV to 87%/94% AV. The induced utilization impact of the members moving from 70% AV to 87%/94% AV is reflected in the Induced Demand for CSR factor described below with the rest of the non-Covered Connecticut 87% and 94% CSR population. The utilization fee that the state pays to reimburse for the impact of the members moving from 87%/94% AV to 100% AV is not included within this rate development, since the state is paying for this separately. The guidance from the Connecticut Insurance Department when the Covered Connecticut program began was that this additional cost would be funded outside of the normal rate development process. As described in Section 2 of this actuarial memorandum, Anthem has seen increased utilization from the Covered Connecticut cohort above and beyond what it has seen on the rest of the 87% and 94% CSR population and will work with the state for 2026 to adjust the utilization fee to the appropriate level.

- Other Benefit Expense: This adjustment accounts for the cost of benefit expenses that do not flow through the starting paid claims. NY HCRA surcharges and provider settlements are included in this adjustment.
- Induced Demand Due to Cost Share Reductions: Individuals who fall below 250% of the Federal Poverty Level and enroll in On-Exchange silver plans will be eligible for cost share reductions. When members have these richer benefits, they are more likely to utilize services. This is referred to as induced demand. The Induced Demand for CSR factor accounts for the induced utilization that the CSR members have due to having much richer benefts than the Standard Silver 70% plan. This adjustment does not account for the induced demand of Covered Connecticut members moving from 87%/94% AV to 100% AV, which is covered outside of this rate filing as described above in the Covered Connecticut Adjustment section. The Induced Demand for CSR factor does account for the induced demand of Covered Connecticut members moving from 70% to 87%/94% AV, because the state does not reimburse carriers for this amount. The factor is developed by taking the percentage of enrollment in CSR Plans in the experience period and comparing it to that of the projection period to adjust for the different induced demand level due to CSR between the two periods.
- Grace Period: The claims experience has been adjusted to account for incidences of enrollees not paying premiums due during the first month of the 90-day grace period when the QHP is liable for paying claims. Based on Anthem's CT 2024 experience, 6.09% of the total Individual population lapsed in their last month's premium, resulting in 13.42% of their total annual premiums not being paid. The member portion of the premium (total premium – APTC portion) was 16.87%. The Grace Period Factor is calculated through the following method: 1 + (% of members lapsed last month's premium × % premium unpaid in last month × % of member portion premium to total premium), i.e, 1 + (6.09% x 13.42% x 16.87%). This equation results in the 1.0014 factor as shown in Exhibit E.
- Rx Rebates: The projected claims cost is adjusted to reflect anticipated Rx rebates. These projections were developed from 2024 actual experience trended to the rating period at the pricing trend. All anticipated Rx rebates are accounted for in this rate development.
- Projected costs of pediatric dental and vision benefits are included.

- S.B. No 376 (Public Act No. 18-69), an act concerning health insurance coverage for prosthetic devices, was passed. Substitute S.B. No 1 (Public Act No. 24-19), an act concerning the health and safety of Connecticut residents that included a mandate for the coverage of coronary calcium scans, was passed. These claims have been excluded from the experience data, since they are to be defrayed by the state per 45 CFR 155.170. The impact is $0.04 PMPM. This can be calculated by removing the $0.62 PMPM impact from Elective Abortion, as shown in Exhibit F, from the $0.66 PMPM impact of the line labeled "Non-EHBs Embedded in Line Item 1) Above" in Exhibit C.

7. Manual Rate Adjustments

The experience period claims are 100% credible based on the credibility method used. Therefore, a manual rate was not used in the rate development.

8. Credibility of Experience

• Credibility Method Used

Based on an analysis of historical data, the standard for fully credible experience is 5,299 members.

To determine credibility, the following formula was used:

$$\sqrt{\frac{\text{Experience Period Members}}{5{,}299}}$$

• Resulting Credibility Level Assigned to Base Period Experience

With 63,707 members, the credibility level assigned to the experience period claims is 100%.

9. Establishing the Index Rate

• Experience Period Index Rate

The experience period Index Rate is equal to the allowed claims PMPM for the essential health benefits of Anthem's non-grandfathered business in the Individual market. The experience period Index Rate is $834.17. No benefits in excess of the essential health benefits have been included in this amount.

• Projection Period Index Rate

The projection period Index Rate is equal to projected allowed claims PMPM for the essential health benefits of Anthem's non-grandfathered business in the Individual market. It reflects the anticipated claim level of the projection period including impact from trend, benefit and demographics as described in Section 6 of this memo.

The projected Index Rate is reported in Worksheet 1, Section II, cell F42 of the URRT and is also shown in Exhibit C. No benefits in excess of the essential health benefits have been included in this amount.

10. Development of the Market-wide Adjusted Index Rate

The Market-wide Adjusted Index Rate is calculated as the Index Rate adjusted for all allowable market-wide modifiers defined in the market rating rules. The three market-wide adjustments - Risk Adjustment, Reinsurance, and Exchange User Fee adjustment - are described below. In compliance with URR Instructions, these adjustments were applied on an allowed basis in the development of the Market-wide Adjusted Index Rate. Exhibit C illustrates the development of the Market-wide Adjusted Index Rate.

- Projected Risk Adjustments PMPM

  CMS will not release final 2024 risk adjustment transfer amounts until June 30, 2025. Since this rate filing is due on June 1, 2025, Anthem is filing a projection of the 2026 risk adjustment transfer amount based upon an estimate of the 2024 amount. An independent consultant's study of 2024 risk adjustment transfers is used to develop the projection for the company's 2026 relative risk to the market. The impact of high-cost risk pooling is also included.

  The projected risk adjustment PMPMs reported in Worksheet 2 of the URRT are on a paid claim basis, while the projected amount applied to the development of Market-wide Adjusted Index Rate is on an allowed claim basis. Exhibit C and Exhibit G provide details.

- Projected ACA Reinsurance Recoveries Net of Reinsurance Premium

  Beginning in 2017, the Federal reinsurance program is no longer in effect. The projected reinsurance amount is $0.

- Exchange User Fees

  The expected charge is estimated at 1.85% of premium. The fee is applied evenly to all plans in the risk pool, both On and Off Exchange.

  The Exchange User Fee is applied as an adjustment to the Market-wide Adjusted Index Rate at the market level as shown in Exhibit C.

11. Plan Adjusted Index Rate

The Plan Adjusted Index Rate is calculated as the Market-wide Adjusted Index Rate adjusted for all allowable plan level modifiers defined in the market rating rules. Exhibit J shows the development. The plan level modifiers are described below:

- Induced Utilization/Cost Sharing Adjustments: This is a multiplicative factor that adjusts for the projected paid/allowed ratio of each plan with an adjustment for induced utilization differences due to differences in cost sharing.

- Adjustments for Benefits in Addition to the Essential Health Benefits: This multiplicative factor adjusts for additional non-EHB benefits shown in Exhibit F.
- Catastrophic Plan Adjustment: This adjustment reflects the projected costs of the population eligible for catastrophic plans. The catastrophic adjustment factor is applied to catastrophic plans only; all other plans have an adjustment factor of 1.0.
- Adjustments for Distribution and Administrative Cost: This is an additive adjustment that includes all the selling expense, administration and retention Items shown in Exhibit H, with the exception of the Exchange User Fee. The Exchange User Fee has been included in the Market-wide Adjusted Index Rate at the market level. The Profit and Risk Margin item is split into 0.95% post-tax profit and 3% post-tax risk margin.

12. Calibration

The Plan Adjusted Index Rate is calibrated by the Age and Geographic factors so that the schedule of premium rates for each plan can be further developed. Exhibit K shows both calibration factors.

• Age Curve Calibration

The age factors are based on the Default Federal Standard Age Curve. The age calibration adjustment is calculated as the member weighted average of the age factors, using the projected membership distribution by age, with an adjustment for the maximum of 3 child dependents under age 21. Under this methodology, the approximate average age rounded to the nearest whole number for the risk pool is 49.

• Geographic Factor Calibration

The geographic factors are developed from historical claims experience. The geographic calibration adjustment is calculated as the member weighted average of the geographic factors, using the projected membership distribution by area.

13. Consumer Adjusted Premium Rate Development

The Consumer Adjusted Premium Rate is calculated by calibrating the Plan Adjusted Index Rate by the Age and Geographic calibration factors described above, and applying consumer specific age and geographic rating factors. Exhibit N has the sample rate calculations.

14. Projected Loss Ratio

- Projected Federal MLR

  Exhibit I shows the projected Federal MLR for the products in this filing. The calculation is an estimate and is not meant to be a true measure for Federal or State MLR rebate purposes. The MLR for Anthem's entire book of Individual business will be compared to the minimum Federal benchmark for purposes of determining regulation-related premium refunds. Also note that the projected Federal MLR presented here does not capture all adjustments, including but not limited to: three-year averaging, credibility, dual option, and deductible. Anthem's projected MLR is expected to meet or exceed the minimum MLR standards at the market level after including all adjustments.

15. Actuarial Value Metal Values

The Actuarial Value (AV) Metal Values reported in Worksheet 2, Section I of the URRT are based on the AV Calculator. To the extent a component of the benefit design was not accommodated by an available input within the AV Calculator, the benefit characteristic was adjusted to be actuarially equivalent to an available input within the AV Calculator for purposes of utilizing the AV Calculator as the basis for the AV Metal Values. When applicable, benefits for plans that are not compatible with the parameters of the AV Calculator have been separately identified and documented in the Unique Plan Design Supporting Documentation and Justification that supports the Plan & Benefits Template.

16. Membership Projections

Membership projections are reported in Worksheet 2, Section IV of the URRT. They are based on historical and current enrollment, and expected new sales and lapses.

For Silver level plans in the Individual market, the portion of projected membership that will be eligible for cost-sharing reduction subsidies at each subsidy level are estimated from the enrollment data in the experience period. Exhibit O provides projected distributions for each plan.

17. Terminated Plans and Products

Exhibit P provides a listing of products from 2024 and 2025 that will be terminated prior to January 1, 2026.

18. Plan Type

The plan type for each plan reported in Worksheet 2, Section I of the URRT is consistent with the option chosen from the drop-down box.

19. Reliance

In support of this rate development, various data and analyses were provided by other members of Anthem's actuarial staff, including data and analysis related to cost of care, valuation, trend, and pricing. I have reviewed the data and analyses for reasonableness and consistency. I have also relied on Wayne Rosen, FSA, MAAA to provide the actuarial certification for the Unique Plan Design Supporting Documentation and Justification for plans included in this filing.

20. Actuarial Certification

I, Tu Nguyen, FSA, MAAA, am an actuary for Elevance Health, the holding company of Anthem. I am a member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein. I hereby certify that the following statements are true to the best of my knowledge with regards to this filing:

(1) The projected Index Rate is:

- In compliance with all applicable state and Federal statutes and regulations (45 CFR 156.80 and 147.102)
- Developed in compliance with the applicable Actuarial Standards of Practice
- Reasonable in relation to the benefits provided and the population anticipated to be covered
- Not excessive nor deficient

(2) The Index Rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 156.80(d)(2) were used to generate plan level rates.

(3) The geographic rating factors reflect differences in the costs of delivery (which can include unit cost and provider practice pattern differences) and do not include differences for population morbidity by geographic area.

(4) The most recent approved AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans.

The Part I Unified Rate Review Template does not demonstrate the process used by the issuer to develop the rates. Rather it represents information required by Federal regulation to be provided in support of the review of rate changes, for certification of Qualified Health Plans for Federally-Facilitated Exchanges, and for certification that the Index Rate is developed in accordance with Federal regulation, used consistently, and only adjusted by the allowable modifiers. However, this Actuarial Memorandum does accurately describe the process used by the issuer to develop the rates.

The rates proposed in this submission reflect the regulatory framework and insurer participation in the market as of May 30, 2025. If the regulatory framework or insurer participation in the market change after this date, proposed rates may no longer be appropriate and should be reevaluated for revision and resubmission. Due to the timing of the 2025 legislative session, bills passed during the session have not been accounted for in this rate filing. Anthem requests that the Connecticut Insurance Department allows carriers to reflect the impacts of bills passed that affect 2026. Examples of such bills include, but are not limited to, proposed Senate Bill 10 (SB 10) and proposed Senate Bill 11 (SB 11). Additionally, the Connecticut Insurance Department has required carriers to file under the assumption that the enhanced premium subsidies from the American Rescue Plan Act are extended through 2026. The rates submitted in this filing are in accordance with that guidance rather than the current regulated expiration. Only in the event that the federal government issues final guidance that the enhanced subsidies will be extended through 2026 will this rate filing hold and the rates not need to be revised to reflect a 3.7% morbidity impact, as provided in Section 6 of this actuarial memorandum. The morbidity impact will be applied to the claims in this rate development if the federal government does not give final guidance that the enhanced subsidies are extended through 2026 prior to the final rate filing submission to the Connecticut Insurance Department in August or September. Issuer market entry and exit can have a significant impact on rates through the risk adjuster mechanisms in the ACA and create a need for reconsideration and revision of proposed premium rates. This rate filing is not intended to be used for other purposes.

Tu Nguyen, FSA, MAAA
Actuarial Strategic Planning Leader

5/30/2025
Date

Exhibit A - Non-Grandfathered Rate Changes

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2026

HIOS Plan Name	2026 HIOS Plan ID	On/Off Exchange	Metal Level	Network Name	Area(s) Offered	Plan Category	Plan Specific Rate Change (excluding aging) {1},{2}
Catastrophic HMO Pathway Enhanced	86545CT1230005	On	Catastrophic	Pathway Enhanced	All	Renewing	7.4%
Bronze HMO Pathway Enhanced with Adult Dental and Vision Benefits	86545CT1230025	On	Bronze	Pathway Enhanced	All	Renewing	8.5%
Gold HMO Pathway Enhanced with Adult Dental and Vision Benefits	86545CT1230027	On	Gold	Pathway Enhanced	All	Renewing	11.6%
Anthem Catastrophic HMO Pathway Enhanced	86545CT1310033	Off	Catastrophic	Pathway Enhanced	All	Renewing	7.1%
Anthem Bronze HMO Pathway Enhanced 6000/12000/40% HSA	86545CT1310019	Off	Bronze	Pathway Enhanced	All	Renewing	8.8%
Anthem Bronze HMO Pathway Enhanced 8500/50%	86545CT1310055	Off	Bronze	Pathway Enhanced	All	Renewing	7.3%
Anthem Silver HMO Pathway Enhanced 4000/30%	86545CT1310056	Off	Silver	Pathway Enhanced	All	Renewing	8.7%
Anthem Gold HMO Pathway Enhanced 2000/10%	86545CT1310060	Off	Gold	Pathway Enhanced	All	Renewing	13.8%
Bronze PPO Standard Pathway HSA	86545CT1330009	On	Bronze	Pathway	All	Renewing	13.6%
Bronze PPO Standard Pathway	86545CT1330002	On	Bronze	Pathway	All	Renewing	15.0%
Silver PPO Standard Pathway	86545CT1330001	On	Silver	Pathway	All	Renewing	15.9%
Gold PPO Pathway with Adult Dental and Vision Benefits	86545CT1330020	On	Gold	Pathway	All	Renewing	12.1%
Gold PPO Standard Pathway	86545CT1330003	On	Gold	Pathway	All	Renewing	6.4%
Anthem Bronze PPO Pathway 8000/0% HSA	86545CT1340020	Off	Bronze	Pathway	All	Renewing	22.8%
Anthem Silver PPO Pathway 4000/20% HSA	86545CT1340021	Off	Silver	Pathway	All	Renewing	20.7%
Bronze PPO Pathway with PreventiveRx HSA	86545CT1570001	On	Bronze	Pathway	All	New	N/A
Gold PPO Pathway	86545CT1570002	On	Gold	Pathway	All	New	N/A
Bronze HMO Pathway Enhanced	86545CT1580001	On	Bronze	Pathway Enhanced	All	New	N/A

NOTES:

{1} Plan level increases in rates do not include demographic changes in the population.

{2} Plan level rate increases were developed in accordance to URR Instructions.

Exhibit B - Claims Experience for Rate Developments

Anthem Health Plans, Inc.
Individual

Experience Rate Claims Experience

Incurred January 1, 2024 through December 31, 2024
Paid through February 28, 2025

PAID CLAIMS:									
Incurred and Paid Claims:		IBNR:		Fully Incurred Claims:			Total	Member	Total
Medical	Drug	Medical	Drug	Medical	Drug	Capitation	Benefit Expense	Months	PMPM
$412,209,806	$148,950,659	$22,039,865	$72,685	$434,249,671	$149,023,344	$1,741	$583,274,756	764,485	**$762.96**

ALLOWED CLAIMS:									
Incurred and Paid Claims:		IBNR:		Fully Incurred Claims:			Total	Member	Total
Medical	Drug	Medical	Drug	Medical	Drug	Capitation	Benefit Expense	Months	PMPM
$491,542,187	$161,090,417	$25,986,792	$82,370	$517,528,979	$161,172,788	$1,741	$678,703,508	764,485	**$887.79**

Note

{1} The 'Experience Rate Claims Experience' above does not account for Transitional Plans, Rx Rebates, or Reinsurance in 'Paid Claims', whereas the claims shown in Worksheet 1, Section 1 of the URRT include them, if present.

Exhibit C - Market-wide Adjusted Index Rate Development

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2026

		Experience Rate	
1)	Starting Paid Claims PMPM	$762.96	Exhibit B
2)	x Covered CT Adjustment	0.9821	
3)	= Mature Claims PMPM	$749.30	= (1) x (2)
4)	x Normalization Factor	0.9937	Exhibit D
5)	= Normalized Claims	$744.58	= (3) x (4)
6)	x Plan Design Changes	1.0000	Exhibit E
7)	x Morbidity Changes	1.0000	Exhibit E
8)	x Trend Factor	1.2163	Exhibit E
9)	x Other Adjustments	1.0129	Exhibit E
10)	= Projected Paid Claim Cost	**$917.31**	= (5) x (6) x (7) x (8) x (9)
11)	Credibility Weight	100.00%	
12)	Blended Paid Claims	$917.31	
13)	- Non-EHBs Embedded in Line Item 1) Above	$0.66	
14)	= Projected Paid Claims, Excluding ALL Non-EHBs	$916.65	= (12) - (13)
15)	+ Rx Rebates	-$69.85	Exhibit F
16)	+ CSR Receivable	$0.00	Exhibit F
17)	+ Additional EHBs	$1.62	Exhibit F
18)	= Projected Paid Claims for EHBs	$848.42	= (14) + (15) + (16) + (17)
19)	÷ Paid to Allowed Ratio	0.8551	
20)	**= Index Rate** {2}	**$992.19**	= (18) / (19)
21)	Reinsurance Contribution	$0.00	Exhibit G
22)	Expected Reinsurance Payments	$0.00	Exhibit G
23)	Risk Adjustment Net Transfer	-$14.83	Exhibit G
24)	Marketplace User Fee	$18.28	Exhibit H
25)	**= Market-wide Adjusted Index Rate** {3}	$996.22	= (20)+[(21)+(22)+(23)+(24)] ÷ (19)

NOTE:

{1} Factors above are detailed in subsequent exhibits

{2} Claims covered under S.B. No. 376 & Sub. S.B. No. 1 have been excluded from the experience data, since they are to be defrayed by the state per 45 CFR 155.170. Please see Section 6 of the Actuarial Memorandum for additional details.

{3} Index Rate is Projected Allowed Claims for EHBs only

{4} The Market-wide Adjusted Index Rate is the same for all plans in the single risk pool

Exhibit D - Normalization Factors

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2026

	Average Claim Factors - Experience Rate		
	Experience Period Population	Future Population	Normalization Factor [1]
Age/Gender	1.0272	1.0222	0.9952
Area/Network	0.9932	0.9947	1.0015
Benefit Plan	0.7818	0.7794	0.9970
Total			**0.9937**

Note

{1} Normalization Factor = Future Population Factor / Experience Period Population Factor

Exhibit E - Projection Period Adjustments

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2026

Impact of Changes Between Experience Period and Projection Period:		
		Experience Rate
Plan Design Changes		
	Total Benefit Changes	1.0000
Morbidity Changes		
	Total Morbidity Changes	1.0000
Trend & Other Adjustments		
	Annual Medical/Rx Trend Rate	10.3%
	# Months of Projection	24.0
	Trend Factor	1.2163
	Other Benefit Expense	1.0015
	Induced Demand for CSR	1.0100
	Grace Period	1.0014
	Total Other Adjustments	1.0129

Note

{1} Explanation of the factors above is provided in the Actuarial Memorandum

Exhibit F - Other Claim Adjustments

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2026

Other Claim Adjustments	
	PMPM
Rx Rebates	($69.85)
CSR Receivable	$0.00
Additional EHBs	
Pediatric Dental	$1.55
Pediatric Vision	$0.07
Total - Additional EHBs	$1.62
Additional non-EHBs	
CCP, Adult Dental, Adult Vision	$1.37
Elective Abortion (if Non-EHB)	$0.62
Total - Additional Non-EHBs	$1.99

NOTES:

{1} This exhibit includes projected claims from lines 15, 16, and 17 of Exhibit C and additional non EHBs.

Exhibit G - Risk Adjustment and Reinsurance - Contributions and Payments

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2026

Risk Adjustment:		
PMPM		**Net Transfer{1}**
Federal Program		($14.83)
Reinsurance: {2}		
PMPM	**Contributions Made**	**Expected Receipts**
Federal Program	$0.00	$0.00
Grand Total of All Risk Mitigation Programs		($14.83)

NOTES:

{1} Projected risk adjustment transfer amount is explained in the Memorandum "Development of the Market-wide Adjusted Index Rate" Section. The net transfer for the High Cost Risk Pool is also included in the risk adjustment transfer amount shown.

{2} Federal Reinsurance Program is no longer applicable starting in 2017.

Exhibit H - Non-Benefit Expenses and Profit & Risk

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2026

	Expenses Applied As a PMPM Cost	Expenses Applied as a % of Premium [1]	Expenses Expressed as a PMPM [5]
Administrative Expenses			
Administrative Costs	$38.49		$38.49
Quality Improvement Expense	$5.58		$5.58
Selling Expense	$8.53		$8.53
Selling Expense		0.50%	$4.94
Specialty Expenses	$0.68		$0.68
Total Administrative Expenses	**$53.28**	**0.50%**	**$58.22**
Taxes and Fees			
PCORI Fee	$0.32		$0.32
ACA Insurer Fee		0.00%	$0.00
Risk Adjustment Fee [2]	$0.20		$0.20
Marketplace User Fee		1.85%	$18.28
Premium Tax		1.50%	$14.82
MLR-Deductible Federal/State Income Taxes [3]		1.05%	$10.37
Misc Taxes & Fees - PMPM	$4.30		$4.30
Misc Taxes & Fees - %-of-Premium		0.70%	$6.92
Total Taxes and Fees	**$4.82**	**5.10%**	**$55.21**
Profit and Risk Margin [4]		3.95%	$39.03
Total Non-Benefit Expenses, Profit, and Risk	**$58.10**	**9.55%**	**$152.46**

NOTES:

{1} The sum of the rounded percentages shown may not equal the total at the bottom of the table due to rounding.

{2} The Risk Adjustment User Fee reflects the per capita annual user fee rate established by HHS at the time this filing was prepared: $2.40 per year or $0.20 per-enrollee-per-month.

{3} Includes only those income taxes which are deductible from the MLR denominator; in particular, Federal income taxes on investment income are excluded.

{4} Profit and Risk Margin shown here is post-tax profit, net of those federal and state income taxes which are deductible from the MLR denominator.

{5} Anthem's Non-Benefit Expenses are applied in both PMPM and % of Premium as shown above. The last column expresses all non-benefit Expenses in PMPM only.

Exhibit I - Federal MLR Estimated Calculation

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2026

Numerator:		
Incurred Claims {1}	$850.41	Exhibit C (Line 18) + Exhibit F (Total Non-EHBs)
+ Quality Improvement Expense	$5.58	Exhibit H
+ Risk Corridor Contributions	$0.00	
+ Risk Adjustment Net Transfer	-$14.83	Exhibit G
+ Reinsurance Receipts	$0.00	Exhibit G
+ Risk Corridor Receipts	$0.00	
+ Reduction to Rx Incurred Claims (ACA MLR)	-$11.11	Footnote {3}
= *Estimated* Federal MLR Numerator	$830.05	
Denominator:		
Premiums {2}	$988.04	Incurred Claims + Exhibit G (Total) + Exhibit H (Total)
- Federal and State Taxes	$10.37	Exhibit H (Federal/State Income Taxes)
- Premium Taxes	$14.82	Exhibit H (Premium Tax)
- Risk Adjustment User Fee	$0.20	Exhibit H
- Reinsurance Contributions	$0.00	Exhibit G
- Misc Taxes & Fees (PMPM)	$4.30	Exhibit H
- Misc Taxes & Fees (% of Premium)	$6.92	Exhibit H
- Licensing and Regulatory Fees	$18.60	Exhibit H (PCORI, ACA and Marketplace Fees)
= *Estimated* Federal MLR Denominator	$932.83	
***Estimated* Federal MLR**	**88.98%**	Footnote {4}

NOTES:

{1} Incurred Claims = Projected Paid Claims for EHB (Exhibit C Line 18) + additional non EHBs (Exhibit F Total Non-EHBs)

{2} Premiums = Incurred Claims in this exhibit + Risk Mitigation Programs in Exhibit G + Non-Benefit Expenses and Profit & Risk Margin in Exhibit H

{3} This is the amount of 2026 pharmacy claims that are attributable to Third Party Administrative Expenses (i.e. the 'retail spread' or 'pharmacy claims margin'). It is calculated by applying the third party margin percentage to the 2026 projected Pharmacy claims including projected rebates.

{4} The above calculation is purely an estimate and not meant to be compared to the minimum MLR benchmark for federal/state MLR rebate purposes:

* The above calculation represents only the products in this filing. Federal MLR will be calculated at the legal entity and market level.

* Not all numerator/denominator components are captured above (for example, fraud and prevention program costs, payroll taxes, assessments for state high risk pools etc.).

* Other adjustments may also be applied within the federal MLR calculation such as 3-year averaging, new business, credibility, deductible and dual option. These are ignored in the above calculation.

* Licensing and Regulatory Fees include ACA-related fees as allowed under the MLR Final Rule.

Exhibit J - Plan Adjusted Index Rate and Consumer Adjusted Premium Rates

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2026

HIOS Plan Name	HIOS Plan ID	Market Adjusted Index Rate (Exhibit C)	Induced Utilization/Cost Sharing Adjustment	Provider Network Adjustment	Adjustment for Benefits in Addition to the EHBS	Catastrophic Plan Adjustment {1}	Administrative Costs {2}	Plan Adjusted Index Rate {3}	Calibration Factor {4}	Consumer Adjusted Premium Rate {5}
Catastrophic HMO Pathway Enhanced	86545CT1230005	$996.22	0.5423	1.0000	1.0000	0.7634	$69.79	$482.21	1.7034	$283.09
Bronze HMO Pathway Enhanced with Adult Dental and Vision Benefits	86545CT1230025	$996.22	0.7167	1.0000	1.0059	1.0000	$116.88	$835.07	1.7034	$490.24
Gold HMO Pathway Enhanced with Adult Dental and Vision Benefits	86545CT1230027	$996.22	0.9210	1.0000	1.0047	1.0000	$146.35	$1,068.25	1.7034	$627.13
Anthem Catastrophic HMO Pathway Enhanced	86545CT1310033	$996.22	0.5423	1.0000	1.0000	0.7634	$69.79	$482.21	1.7034	$283.09
Anthem Bronze HMO Pathway Enhanced 6000/12000/40% HSA	86545CT1310019	$996.22	0.7740	1.0000	1.0000	1.0000	$121.68	$892.80	1.7034	$524.13
Anthem Bronze HMO Pathway Enhanced 8500/50%	86545CT1310055	$996.22	0.7274	1.0000	1.0000	1.0000	$114.93	$839.56	1.7034	$492.87
Anthem Silver HMO Pathway Enhanced 4000/30%	86545CT1310056	$996.22	0.8820	1.0000	1.0000	1.0000	$137.30	$1,015.97	1.7034	$596.44
Anthem Gold HMO Pathway Enhanced 2000/10%	86545CT1310060	$996.22	0.9739	1.0000	1.0000	1.0000	$150.60	$1,120.82	1.7034	$657.99
Bronze PPO Standard Pathway HSA	86545CT1330009	$996.22	0.7695	1.0000	1.0003	1.0000	$121.95	$888.73	1.7034	$521.74
Bronze PPO Standard Pathway	86545CT1330002	$996.22	0.8211	1.0000	1.0003	1.0000	$129.40	$947.63	1.7034	$556.32
Silver PPO Standard Pathway	86545CT1330001	$996.22	0.8750	1.0000	1.0002	1.0000	$137.44	$1,009.30	1.7034	$592.52
Gold PPO Pathway with Adult Dental and Vision Benefits	86545CT1330020	$996.22	0.9532	1.0000	1.0085	1.0000	$152.06	$1,109.73	1.7034	$651.48
Gold PPO Standard Pathway	86545CT1330003	$996.22	1.6086	1.0000	1.0001	1.0000	$243.42	$1,846.11	1.7034	$1,083.78
Anthem Bronze PPO Pathway 8000/0% HSA	86545CT1340020	$996.22	0.9178	1.0000	1.0000	1.0000	$142.48	$1,056.81	1.7034	$620.41
Anthem Silver PPO Pathway 4000/20% HSA	86545CT1340021	$996.22	1.0328	1.0000	1.0000	1.0000	$159.12	$1,188.00	1.7034	$697.43
Bronze PPO Pathway with PreventiveRx HSA	86545CT1570001	$996.22	0.7588	1.0000	1.0000	1.0000	$119.26	$875.21	1.7034	$513.80
Gold PPO Pathway	86545CT1570002	$996.22	0.9829	1.0000	1.0000	1.0000	$151.68	$1,130.90	1.7034	$663.90
Bronze HMO Pathway Enhanced	86545CT1580001	$996.22	0.7162	1.0000	1.0000	1.0000	$113.09	$826.55	1.7034	$485.24

Notes:

{1} This adjustment reflects the projected costs of the population eligible for catastrophic plans.

{2} This is an additive adjustment that includes all the selling expense, administration and retention Items shown in Exhibit H, with the exception of the Exchange User Fee. The Exchange User Fee has been included in the Market-wide Adjusted Index Rate at the market level.

{3} The Plan Adjusted Index Rate is calculated by multiplying the Market-wide Adjusted Index Rate by the induced utilization/cost sharing adjustment, provider network, benefits in addition to the EHBs, and catastrophic plan adjustments and then adding the administrative costs. The Plan Adjusted Index Rate can also be described as a Plan Level Required Premium.

{4} See Exhibit K - Calibration.

{5} The Consumer Adjusted Premium Rate is equal to 'Plan Adjusted Index Rate' divided by 'Calibration Factor'.

Exhibit K - Calibration

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2026

Average rating factors for 2026 population:	
	Calibration Factors
Age	1.7125
Tobacco	1.0000
Area	0.9947
Total Calibration Factor{1}	1.7034

NOTES:

{1} Total Calibration factor was used in Exhibit J.

{2} Age calibration includes adjustments for membership that exceeds the three child dependent cap, as permitted by CMS per 2026 Part 3 Instructions.

Exhibit L - Age and Tobacco Factors

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2026

	Age Factors	Tobacco Factors
Age	2026	2026
0-14	0.765	1.000
15	0.833	1.000
16	0.859	1.000
17	0.885	1.000
18	0.913	1.000
19	0.941	1.000
20	0.970	1.000
21	1.000	1.000
22	1.000	1.000
23	1.000	1.000
24	1.000	1.000
25	1.004	1.000
26	1.024	1.000
27	1.048	1.000
28	1.087	1.000
29	1.119	1.000
30	1.135	1.000
31	1.159	1.000
32	1.183	1.000
33	1.198	1.000
34	1.214	1.000
35	1.222	1.000
36	1.230	1.000
37	1.238	1.000
38	1.246	1.000
39	1.262	1.000
40	1.278	1.000
41	1.302	1.000
42	1.325	1.000
43	1.357	1.000
44	1.397	1.000
45	1.444	1.000
46	1.500	1.000
47	1.563	1.000
48	1.635	1.000
49	1.706	1.000
50	1.786	1.000
51	1.865	1.000
52	1.952	1.000
53	2.040	1.000
54	2.135	1.000
55	2.230	1.000
56	2.333	1.000
57	2.437	1.000
58	2.548	1.000
59	2.603	1.000
60	2.714	1.000
61	2.810	1.000
62	2.873	1.000
63	2.952	1.000
64+	3.000	1.000

NOTES:

The weighted average of these factors for the entire risk pool included in this rate filing is provided in Exhibit K.

Exhibit M - Area Factors

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2026

Rating Area Description	2026 Area Rating Factor	2025 Area Rating Factor	Change
Fairfield	1.1000	1.1000	0.0%
Hartford	0.9400	0.9200	2.2%
Litchfield	0.9700	0.9600	1.0%
Middlesex	1.0000	1.0100	-1.0%
New Haven	1.0000	1.0100	-1.0%
New London	0.9400	0.9200	2.2%
Tolland	0.9000	0.8800	2.3%
Windham	0.9000	0.8800	2.3%

NOTES:

{1} The weighted average of these factors for the entire risk pool included in this rate filing is provided in Exhibit K.

Exhibit N - Sample Rate Calculation

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2026

Name: **John Doe**
Effective Date: **1/1/2026**
On/Off Exchange: Off
Metal Level: Bronze
Plan ID: 86545CT1310055
Rating Area: 01

Family Members Covered:

	Age
Subscriber	47
Spouse	42
Child (age 21+)	25
Child #1	20
Child #2	16

Calculation of Monthly Premium:

Consumer Adjusted Premium Rate	$492.87	Exhibit J
x Area Factor	1.1000	Exhibit M
Rate Adjusted for Area =	$542.16	

Age Factors: Exhibit L

	Age Factor
Subscriber	1.563
Spouse	1.325
Child (age 21+)	1.004
Child #1	0.970
Child #2	0.859

Final Monthly Premium PMPM:

	PMPM
Subscriber	$847.40
Spouse	$718.36
Child (age 21+)	$544.33
Child #1	$525.90
Child #2	$465.72
TOTAL	**$3,101.71**

NOTES:

{1} As per the Market Reform Rule, when computing family premiums no more than the three oldest covered children under the age of 21 are taken into account whereas the premiums associated with each child age 21+ are included.

{2} Minor rate variances may occur due to differences in rounding methodology.

Exhibit O - Silver Plan Membership Projections for Cost-Sharing Reductions

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2026

Silver Plan	Projected Membership by Subsidy Level:				
HIOS Standard Component Plan ID	Zero Cost Sharing	100-150%	150%-200%	200%-250%	Standard
86545CT1310056	0	0	0	0	595
86545CT1330001	15	13,083	16,813	5,527	11,682
86545CT1340021	0	0	0	0	194

Exhibit P - Terminated Products

Anthem Health Plans, Inc.
Individual

Effective January 1, 2026

Following are the products that will be terminated prior to the effective date:

This includes products that have experience included in the URRT during the experience period and any products that were not in effect during the experience period but were made available thereafter.

Pre ACA Terminated Products	
HIOS Product ID	**HIOS Product Name**
N/A	N/A

Post ACA Terminated Products	
HIOS Product ID	**HIOS Product Name**
N/A	N/A

NOTES:

{1} This exhibit may include a greater number of HIOS Product IDs than the URRT, WS2, as this list additionally includes terminated Product IDs that were introduced after the experience period.

PART II -- Written Description Justifying the Rate Increase

Consumer Disclosure for Proposed Health Insurance Rate Increase
Anthem Blue Cross and Blue Shield of Connecticut
Connecticut Individual ACA Plans
Rate Change Effective January 1, 2026

Scope and Range of the Rate Increase

Anthem Blue Cross and Blue Shield of Connecticut (Anthem) has made an application to the Connecticut Department of Insurance for premium rate changes for its fully ACA-compliant Individual health plan products. This increase will impact approximately 84,000 Connecticut insured members renewing on 1/1/2026 with Anthem. At the individual plan level, rate increases range from 6.4% to 22.8%. A subscriber's actual rate could be higher or lower depending on the geographic location, age characteristics, dependent coverage, and other factors. Anthem expects some members to have an increase over 15%.

Financial Experience

Anthem expects the proposed rate increase will cover projected medical trends and yield a medical loss ratio of 84.6%, meaning more than eighty-four cents of each premium dollar are expected to go to covering our members' medical expenses and improving health care quality. This projected MLR of 84.6% exceeds the minimum MLR requirement of 80% as defined in the Affordable Care Act (ACA). In the event Anthem's MLR is less than the Federal required minimum for a three year period, Anthem will refund the difference to policyholders, consistent with federal regulations.

Drivers of Rate Increase

The primary drivers of premium increases are associated with increased cost of benefit expense for this ACA-compliant block. Increased cost of benefit expense is driven by increases in the price of services primarily from hospitals, physicians, and pharmacies, coupled with members increasing their use of health care services, also called "utilization". Increases in the price of services are driven by technological advances, new specialty medications, and a variety of other factors. Increased utilization is driven by member level utilization and selection patterns in the Guaranteed Issue ACA market.

The proposed rates reflect the regulatory framework and insurer participation in the market as of May 30, 2025. If the regulatory framework or insurer participation in the market changes after this date, proposed rates may no longer be appropriate and should be reevaluated for revision and resubmission.

Efforts to Control Costs

Anthem is committed to working to hold down the cost of insurance and price the Individual ACA market for long term sustainability. We continue to explore innovative collaboration with providers and negotiate deeper discounts at our hospitals. We provide members with tools to make informed decisions about where and how to receive treatment. Despite these efforts to moderate the cost of insurance, the cost of benefit expense in the Individual ACA market has continued to outpace premium on a large scale due to the drivers described above. In light of emerging costs, 2026 premium increases are needed to price Anthem's ACA-compliant Individual health plan products for long term sustainability.

SERFF Tracking #:	*AWLP-134549275*	***State Tracking #:***	*202502662*	***Company Tracking #:***	

State:	*Connecticut*	***Filing Company:***	*Anthem Health Plans, Inc dba Anthem Blue Cross and Blue Shield of Connecticut*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*		
Product Name:	*Individual 2026*		
Project Name/Number:	*/*		

Supporting Document Schedules

Satisfied - Item:	Unique Plan Justifications
Comments:	Unique Plan Justifications are attached.
Attachment(s):	20250530CT86545IndvOnOffUniquePlanJustifications.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Value Screenshots
Comments:	Actuarial Value Screenshots are attached.
Attachment(s):	20250530CT86545IndvAVPlanScreenshots.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Federal Mental Health Parity Testing
Comments:	Federal Mental Health Parity Results and Attestation are attached.
Attachment(s):	20250530CT86545IndvFMHPResults&Attestation.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Summary of Benefits
Comments:	Summary of Benefits are attached.
Attachment(s):	20250530CT86545IndvSOBs.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Certification
Comments:	Actuarial Certification is attached.
Attachment(s):	20250530CT86545IndvAnthemActuarialCertification.pdf
Item Status:	
Status Date:	

Satisfied - Item:	URRT PDF Form
Comments:	URRT in PDF form attached.
Attachment(s):	20250530CT86545IndvUnifiedRateReviewTemplate.pdf
Item Status:	
Status Date:	

SERFF Tracking #:	*AWLP-134549275*	***State Tracking #:***	*202502662*	***Company Tracking #:***	

State:	*Connecticut*	***Filing Company:***	*Anthem Health Plans, Inc dba Anthem Blue Cross and Blue Shield of Connecticut*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*		
Product Name:	*Individual 2026*		
Project Name/Number:	*/*		

Unique Plan Design Supporting Documentation and Justification

Please fill in the following information.

HIOS Issuer ID: 86545

HIOS Product IDs: 86545CT131

Applicable HIOS Plan IDs (Standard Component): **1**

86545CT1310019-00

Reasons the plan design is unique (benefits that are not compatible with the parameters of the AV Calculator and the materiality of those benefits):

1 The AV Calculator does not support plan designs where the cost share varies by site of service and/or by preferred versus non-preferred providers. These plan designs can impact one or more of the following AV service categories:

1. Primary Care Visits to Treat an Injury or Illness (exc. Preventive, and X-rays)
2. Imaging (CT/PET Scans, MRIs)
3. Occupational and Physical Therapy
4. Laboratory Outpatient and Professional Services
5. X-rays and Diagnostic Imaging
6. Outpatient Facility Fee (e.g. Ambulatory Surgery Center)
7. Outpatient Surgery Physician/Surgical Services
8. All drug categories

6 The AV Calculator has five service types (mental/behavioral health and substance use disorder outpatient services; imaging; speech therapy; occupational therapy and physical therapy; and laboratory outpatient and professional services) that include services also classified as outpatient-facility and outpatient-professional. If special cost-sharing provisions are indicated for outpatient - facility and/or outpatient - professional claims and no special cost sharing is indicated for the service type, then the service(s) including both an outpatient-facility and outpatient-professional component will be split into their component parts and the outpatient facility and outpatient-professional relevant cost sharing applied when calculating the plan AV.

9 Plan designs have a member coinsurance payment on one or more of the drugs benefit categories that is either floored or capped at a set amount per script. This functionality in the AV Calculator is limited to a maximum on specialty drugs (i.e. high-cost) coinsurance. The impacted drug member cost shares fall into one of the following categories:

1. Greater of copay or coinsurance percentage
2. Coinsurance with maximum copay per script
3. Coinsurance with minimum and maximum copays per script

Acceptable alternate method used per 156.135(b)(2) or 156.135(b)(3):

1 Per 156.135(b)(2), a weighted average of the two or more member cost shares are calculated when applicable.

6 Per 156.135(b)(2), the AV Calculator (AVC) user guide notes that service specific cost-sharing features are always primary to any input in the outpatient facility fee and/or outpatient surgical physician/surgical service fields. Therefore, a small adjustment factor is multiplied by the specific service coinsurance, only when the coinsurance equals the plan coinsurance as loaded into cell D11 and H11 of the AVC. While not materially impacting the plan's AV, this adjustment prevents the outpatient facility fee and outpatient surgery physician/surgical service fee override methodology from being invoked which Anthem believes is not appropriate for our benefit plans.

9 Per 156.135(b)(3), the actual Rx cost shares are converted into plan effective coinsurance percentages.

Confirmation that only in-network cost sharing, including multitier networks, was considered: Yes

Description of the standardized plan population data used: Used AV Calculator population data.

If the method described in 156.135(b)(2) was used, a description of how the benefits were modified to fit the parameters of the AV Calculator:

1 Using proprietary claims data, weightings between each site of service and/or between preferred and non-preferred providers were developed for each of the listed benefit categories. The weightings were used to calculate a weighted average cost share for each benefit category using the following formula.
Weighted Average Cost Share (example) = (Cost Share 1 Weight) * (Cost Share 1) + (Cost Share 2 Weight) * (Cost Share 2) + (1 - Cost Share 1 Weight - Cost Share 2 Weight) * (Cost Share 3).

6 Method Used: For each of the five specific service categories, the final coinsurance is checked to see if it equals the plan coinsurance. If the service specific coinsurance equals the plan coinsurance then a factor of 0.9999 is multiplied by the service specific coinsurance and the result is loaded into the coinsurance row of the specific service category of the AV Calculator. An example of the calculation for speech therapy services where the service specific coinsurance is 90% and the plan coinsurance is 90%. The adjusted speech therapy coinsurance is calculated as (90% * 0.9999 = 89.99%). The 89.99% adjusted speech therapy coinsurance is loaded into cell D24 and cell H24, where applicable, of the AV calculator.

If the method described in 156.135(b)(3) was used, a description of the data and method used to develop the adjustments:

9 Data used: In addition to the AV Calculator (AVC) continuance tables, we used Rx cost and utilization data from a nationally recognized consulting firm.
Method Used: We calculated an effective coinsurance for each impacted Rx benefit category outside the AVC. We input our calculated effective coinsurance(s) into the AVC.
Description: It is common for the allowed cost of a drug to be less than an Rx copay, therefore, we used proprietary Rx data from a nationally known consulting firm to calculate the effective copay for each of the impacted Rx tiers and then converted the effective copay into an effective coinsurance. The Rx claims data was calibrated at each charge level bucket and cost per script for each Rx tier, based on the AVC average allowed cost per script. The AVC average allowed cost per script was determined by taking the plan charge level Rx average cost PMPY and dividing by the corresponding Rx average scripts PMPY.
Greater of copay or coinsurance: For each calibrated cost per script bucket, the member cost share with only the copay was calculated and the member cost share with only the coinsurance was calculated. The maximum of the two was the final member cost share, expressed as a copay. The weighted average member copay and the weighted average allowed cost per script were both calculated using the distribution of scripts by cost per script bucket. The effective coinsurance was calculated by dividing the weighted average member copay by the weighted average allowed cost per script and input into the AVC.
Coinsurance with minimum and/or maximum copay per script: For each calibrated cost per script bucket, the member cost share with only the coinsurance was calculated, expressed as a copay. The member cost share in each cost per script bucket was replaced with either the minimum copay per script or the maximum copay per script when applicable. The weighted average member copay and the weighted average allowed cost per script were both calculated using the distribution of scripts by cost per script bucket. The effective coinsurance was calculated by dividing the weighted average member copay by the weighted average allowed cost per script and input into the AVC.

Certification Language:

The development of the actuarial value is based on one of the acceptable alternative methods outlined in 156.135(b)(2) or 156.135(b)(3) for those benefits that deviate substantially from the parameters of the AV Calculator and have a material impact on the AV

The analysis was
(i) conducted by a member of the American Academy of Actuaries;
(ii) performed in accordance with generally accepted actuarial principles and methodologies;

Actuary signature: Wayne Rosen

Actuary Printed Name: Wayne Rosen, FSA, MAAA

Date: 4/24/2025

Unique Plan Design Supporting Documentation and Justification

Please fill in the following information.

HIOS Issuer ID: 86545

HIOS Product IDs: 86545CT131

Applicable HIOS Plan IDs (Standard Component): **1**

86545CT1310056-00

Reasons the plan design is unique (benefits that are not compatible with the parameters of the AV Calculator and the materiality of those benefits):

2 The functionality of the AV Calculator does not support plan designs with a flat dollar copayment and percentage coinsurance both applying after deductible for the same medical or Rx benefit category.

3 The AV Calculator does not support plan designs with member cost shares that differ by site of service for outpatient mental/behavioral health and substance use disorders (MH), specifically MH office visits versus other outpatient MH facility and professional visits.

9 Plan designs have a member coinsurance payment on one or more of the drugs benefit categories that is either floored or capped at a set amount per script. This functionality in the AV Calculator is limited to a maximum on specialty drugs (i.e. high-cost) coinsurance. The impacted drug member cost shares fall into one of the following categories:

1. Greater of copay or coinsurance percentage
2. Coinsurance with maximum copay per script
3. Coinsurance with minimum and maximum copays per script

Acceptable alternate method used per 156.135(b)(2) or 156.135(b)(3):

2 Per 156.135(b)(2), the actual cost shares are converted into plan effective coinsurance percentages.

3 Per 156.135(b)(2), a weighted average of the member cost shares for mental health office visits and the member cost shares for outpatient mental health facility and outpatient professional other visits are calculated and converted to an actuarially equivalent effective coinsurance/copay.

9 Per 156.135(b)(3), the actual Rx cost shares are converted into plan effective coinsurance percentages.

Confirmation that only in-network cost sharing, including multitier networks, was considered: Yes

Description of the standardized plan population data used: Used AV Calculator population data.

If the method described in 156.135(b)(2) was used, a description of how the benefits were modified to fit the parameters of the AV Calculator:

2 For all categories, used the cost and frequency data from the AV calculator continuance tables at the appropriate charge level associated with the OOP limit. Used linear interpolation when the exact level was not available in the continuance table. The charge level associated with the OOP was considered "unlimited" when the plan overall (medical or Rx, as applicable) coinsurance was 100%. When the plan overall coinsurance was less than 100%, the following formula was used to calculate the charge level associated with the OOP.

$$\text{Stop Loss} = \frac{(\text{OOP Max} - \text{Deductible})}{1 - \text{Plan Coinsurance}} + \text{Deductible}$$

where Stop Loss = charge level associated with OOP

The effective coinsurance was calculated using the following formula:

$$\text{Plan Eff Coins} = \text{Min}\left(1, \text{Max}\left(0, \frac{(\text{Ben Cost} - \text{Ben Copay} \bullet \text{Ben Freq}) \times (1 - \text{Ben Coins})}{\text{Ben Cost}}\right)\right)$$

where:
Ben Cost = average benefit cost PMPY
Ben Freq = average benefit frequency PMPY
Ben Copay = member copayment for the benefit category
Ben Coins = member coinsurance for the benefit category

3 The Interim Final Rule 45 CFR Part 146 under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHP) and EHB guidance allows separation of cost share types between outpatient other and office visits as allowed under the MHPAEA July 1, 2010 Enforcement Safe Harbor guidance. The Final Rule released on November 13, 2013 retained the sub-classification provision. These plan designs have been tested and meet the regulatory QTL testing methodology requirements. Using proprietary claims data, allocation weightings were calculated and applied to the member cost shares for MH/SA services in an office based setting and in a hospital/facility setting to calculate an effective coinsurance/copay.

If the method described in 156.135(b)(3) was used, a description of the data and method used to develop the adjustments:

9 Data used: In addition to the AV Calculator (AVC) continuance tables, we used Rx cost and utilization data from a nationally recognized consulting firm.
Method Used: We calculated an effective coinsurance for each impacted Rx benefit category outside the AVC. We input our calculated effective coinsurance(s) into the AVC.
Description: It is common for the allowed cost of a drug to be less than an Rx copay, therefore, we used proprietary Rx data from a nationally known consulting firm to calculate the effective copay for each of the impacted Rx tiers and then converted the effective copay into an effective coinsurance. The Rx claims data was calibrated at each charge level bucket and cost per script for each Rx tier, based on the AVC average allowed cost per script. The AVC average allowed cost per script was determined by taking the plan charge level Rx average cost PMPY and dividing by the corresponding Rx average scripts PMPY.
Greater of copay or coinsurance: For each calibrated cost per script bucket, the member cost share with only the copay was calculated and the member cost share with only the coinsurance was calculated. The maximum of the two was the final member cost share, expressed as a copay. The weighted average member copay and the weighted average allowed cost per script were both calculated using the distribution of scripts by cost per script bucket. The effective coinsurance was calculated by dividing the weighted average member copay by the weighted average allowed cost per script and input into the AVC.
Coinsurance with minimum and/or maximum copay per script: For each calibrated cost per script bucket, the member cost share with only the coinsurance was calculated, expressed as a copay. The member cost share in each cost per script bucket was replaced with either the minimum copay per script or the maximum copay per script when applicable. The weighted average member copay and the weighted average allowed cost per script were both calculated using the distribution of scripts by cost per script bucket. The effective coinsurance was calculated by dividing the weighted average member copay by the weighted average allowed cost per script and input into the AVC.

Certification Language:

The development of the actuarial value is based on one of the acceptable alternative methods outlined in 156.135(b)(2) or 156.135(b)(3) for those benefits that deviate substantially from the parameters of the AV Calculator and have a material impact on the AV

The analysis was
(i) conducted by a member of the American Academy of Actuaries;
(ii) performed in accordance with generally accepted actuarial principles and methodologies;

Actuary signature: Wayne Rosen

Actuary Printed Name: Wayne Rosen, FSA, MAAA

Date: 4/24/2025

Unique Plan Design Supporting Documentation and Justification

Please fill in the following information.

HIOS Issuer ID: 86545

HIOS Product IDs: 86545CT134

Applicable HIOS Plan IDs (Standard Component): **1**

86545CT1340020-00

Reasons the plan design is unique (benefits that are not compatible with the parameters of the AV Calculator and the materiality of those benefits):

1 The AV Calculator does not support plan designs where the cost share varies by site of service and/or by preferred versus non-preferred providers. These plan designs can impact one or more of the following AV service categories:

1. Primary Care Visits to Treat an Injury or Illness (exc. Preventive, and X-rays)
2. Imaging (CT/PET Scans, MRIs)
3. Occupational and Physical Therapy
4. Laboratory Outpatient and Professional Services
5. X-rays and Diagnostic Imaging
6. Outpatient Facility Fee (e.g. Ambulatory Surgery Center)
7. Outpatient Surgery Physician/Surgical Services
8. All drug categories

6 The AV Calculator has five service types (mental/behavioral health and substance use disorder outpatient services; imaging; speech therapy; occupational therapy and physical therapy; and laboratory outpatient and professional services) that include services also classified as outpatient-facility and outpatient-professional. If special cost-sharing provisions are indicated for outpatient - facility and/or outpatient - professional claims and no special cost sharing is indicated for the service type, then the service(s) including both an outpatient-facility and outpatient-professional component will be split into their component parts and the outpatient facility and outpatient-professional relevant cost sharing applied when calculating the plan AV.

Acceptable alternate method used per 156.135(b)(2) or 156.135(b)(3):

1 Per 156.135(b)(2), a weighted average of the two or more member cost shares are calculated when applicable.

6 Per 156.135(b)(2), the AV Calculator (AVC) user guide notes that service specific cost-sharing features are always primary to any input in the outpatient facility fee and/or outpatient surgical physician/surgical service fields. Therefore, a small adjustment factor is multiplied by the specific service coinsurance, only when the coinsurance equals the plan coinsurance as loaded into cell D11 and H11 of the AVC. While not materially impacting the plan's AV, this adjustment prevents the outpatient facility fee and outpatient surgery physician/surgical service fee override methodology from being invoked which Anthem believes is not appropriate for our benefit plans.

Confirmation that only in-network cost sharing, including multitier networks, was considered: Yes

Description of the standardized plan population data used: Used AV Calculator population data.

If the method described in 156.135(b)(2) was used, a description of how the benefits were modified to fit the parameters of the AV Calculator:

1 Using proprietary claims data, weightings between each site of service and/or between preferred and non-preferred providers were developed for each of the listed benefit categories. The weightings were used to calculate a weighted average cost share for each benefit category using the following formula.
Weighted Average Cost Share (example) = (Cost Share 1 Weight) * (Cost Share 1) + (Cost Share 2 Weight) * (Cost Share 2) + (1 - Cost Share 1 Weight - Cost Share 2 Weight) * (Cost Share 3).

6 Method Used: For each of the five specific service categories, the final coinsurance is checked to see if it equals the plan coinsurance. If the service specific coinsurance equals the plan coinsurance then a factor of 0.9999 is multiplied by the service specific coinsurance and the result is loaded into the coinsurance row of the specific service category of the AV Calculator. An example of the calculation for speech therapy services where the service specific coinsurance is 90% and the plan coinsurance is 90%. The adjusted speech therapy coinsurance is calculated as (90% * 0.9999 = 89.99%). The 89.99% adjusted speech therapy coinsurance is loaded into cell D24 and cell H24, where applicable, of the AV calculator.

If the method described in 156.135(b)(3) was used, a description of the data and method used to develop the adjustments: This method was not used.

Certification Language:

The development of the actuarial value is based on one of the acceptable alternative methods outlined in 156.135(b)(2) or 156.135(b)(3) for those benefits that deviate substantially from the parameters of the AV Calculator and have a material impact on the AV

The analysis was
(i) conducted by a member of the American Academy of Actuaries;
(ii) performed in accordance with generally accepted actuarial principles and methodologies;

Actuary signature: Wayne Rosen

Actuary Printed Name: Wayne Rosen, FSA, MAAA

Date: 4/24/2025

Unique Plan Design Supporting Documentation and Justification

Please fill in the following information.

HIOS Issuer ID: 86545

HIOS Product IDs: 86545CT131, 86545CT134

Applicable HIOS Plan IDs (Standard Component): **3**
86545CT1310060-00, 86545CT1310055-00, 86545CT1340021-00

Reasons the plan design is unique (benefits that are not compatible with the parameters of the AV Calculator and the materiality of those benefits):

2 The functionality of the AV Calculator does not support plan designs with a flat dollar copayment and percentage coinsurance both applying after deductible for the same medical or Rx benefit category.

6 The AV Calculator has five service types (mental/behavioral health and substance use disorder outpatient services; imaging; speech therapy; occupational therapy and physical therapy; and laboratory outpatient and professional services) that include services also classified as outpatient-facility and outpatient-professional. If special cost-sharing provisions are indicated for outpatient - facility and/or outpatient - professional claims and no special cost sharing is indicated for the service type, then the service(s) including both an outpatient-facility and outpatient-professional component will be split into their component parts and the outpatient facility and outpatient-professional relevant cost sharing applied when calculating the plan AV.

9 Plan designs have a member coinsurance payment on one or more of the drugs benefit categories that is either floored or capped at a set amount per script. This functionality in the AV Calculator is limited to a maximum on specialty drugs (i.e. high-cost) coinsurance. The impacted drug member cost shares fall into one of the following categories:

1. Greater of copay or coinsurance percentage
2. Coinsurance with maximum copay per script
3. Coinsurance with minimum and maximum copays per script

Acceptable alternate method used per 156.135(b)(2) or 156.135(b)(3):

2 Per 156.135(b)(2), the actual cost shares are converted into plan effective coinsurance percentages.

6 Per 156.135(b)(2), the AV Calculator (AVC) user guide notes that service specific cost-sharing features are always primary to any input in the outpatient facility fee and/or outpatient surgical physician/surgical service fields. Therefore, a small adjustment factor is multiplied by the specific service coinsurance, only when the coinsurance equals the plan coinsurance as loaded into cell D11 and H11 of the AVC. While not materially impacting the plan's AV, this adjustment prevents the outpatient facility fee and outpatient surgery physician/surgical service fee override methodology from being invoked which Anthem believes is not appropriate for our benefit plans.

9 Per 156.135(b)(3), the actual Rx cost shares are converted into plan effective coinsurance percentages.

Confirmation that only in-network cost sharing, including multitier networks, was considered: Yes

Description of the standardized plan population data used: Used AV Calculator population data.

If the method described in 156.135(b)(2) was used, a description of how the benefits were modified to fit the parameters of the AV Calculator:

2 For all categories, used the cost and frequency data from the AV calculator continuance tables at the appropriate charge level associated with the OOP limit. Used linear interpolation when the exact level was not available in the continuance table. The charge level associated with the OOP was considered "unlimited" when the plan overall (medical or Rx, as applicable) coinsurance was 100%. When the plan overall coinsurance was less than 100%, the following formula was used to calculate the charge level associated with the OOP.

$$\text{Stop Loss} = \frac{(\text{OOP Max} - \text{Deductible})}{1 - \text{Plan Coinsurance}} + \text{Deductible}$$

where Stop Loss = charge level associated with OOP

The effective coinsurance was calculated using the following formula:

$$\text{Plan Eff Coins} = \text{Min}\left(1, \text{Max}\left(0, \frac{(\text{Ben Cost} - \text{Ben Copay} \bullet \text{Ben Freq}) \times (1 - \text{Ben Coins})}{\text{Ben Cost}}\right)\right)$$

where:
Ben Cost = average benefit cost PMPY
Ben Freq = average benefit frequency PMPY
Ben Copay = member copayment for the benefit category
Ben Coins = member coinsurance for the benefit category

6 Method Used: For each of the five specific service categories, the final coinsurance is checked to see if it equals the plan coinsurance. If the service specific coinsurance equals the plan coinsurance then a factor of 0.9999 is multiplied by the service specific coinsurance and the result is loaded into the coinsurance row of the specific service category of the AV Calculator. An example of the calculation for speech therapy services where the service specific coinsurance is 90% and the plan coinsurance is 90%. The adjusted speech therapy coinsurance is calculated as (90% * 0.9999 = 89.99%). The 89.99% adjusted speech therapy coinsurance is loaded into cell D24 and cell H24, where applicable, of the AV calculator.

If the method described in 156.135(b)(3) was used, a description of the data and method used to develop the adjustments:

9 Data used: In addition to the AV Calculator (AVC) continuance tables, we used Rx cost and utilization data from a nationally recognized consulting firm.
Method Used: We calculated an effective coinsurance for each impacted Rx benefit category outside the AVC. We input our calculated effective coinsurance(s) into the AVC.
Description: It is common for the allowed cost of a drug to be less than an Rx copay, therefore, we used proprietary Rx data from a nationally known consulting firm to calculate the effective copay for each of the impacted Rx tiers and then converted the effective copay into an effective coinsurance. The Rx claims data was calibrated at each charge level bucket and cost per script for each Rx tier, based on the AVC average allowed cost per script. The AVC average allowed cost per script was determined by taking the plan charge level Rx average cost PMPY and dividing by the corresponding Rx average scripts PMPY.
Greater of copay or coinsurance: For each calibrated cost per script bucket, the member cost share with only the copay was calculated and the member cost share with only the coinsurance was calculated. The maximum of the two was the final member cost share, expressed as a copay. The weighted average member copay and the weighted average allowed cost per script were both calculated using the distribution of scripts by cost per script bucket. The effective coinsurance was calculated by dividing the weighted average member copay by the weighted average allowed cost per script and input into the AVC.
Coinsurance with minimum and/or maximum copay per script: For each calibrated cost per script bucket, the member cost share with only the coinsurance was calculated, expressed as a copay. The member cost share in each cost per script bucket was replaced with either the minimum copay per script or the maximum copay per script when applicable. The weighted average member copay and the weighted average allowed cost per script were both calculated using the distribution of scripts by cost per script bucket. The effective coinsurance was calculated by dividing the weighted average member copay by the weighted average allowed cost per script and input into the AVC.

Certification Language:

The development of the actuarial value is based on one of the acceptable alternative methods outlined in 156.135(b)(2) or 156.135(b)(3) for those benefits that deviate substantially from the parameters of the AV Calculator and have a material impact on the AV

The analysis was
(i) conducted by a member of the American Academy of Actuaries;
(ii) performed in accordance with generally accepted actuarial principles and methodologies;

Actuary signature: Wayne Rosen

Actuary Printed Name: Wayne Rosen, FSA, MAAA

Date: 4/24/2025

Unique Plan Design Supporting Documentation and Justification

Please fill in the following information.

HIOS Issuer ID: 86545

HIOS Product IDs: 86545CT131

Applicable HIOS Plan IDs (Standard Component): **1**

86545CT1310033-00

Reasons the plan design is unique (benefits that are not compatible with the parameters of the AV Calculator and the materiality of those benefits):

2 The functionality of the AV Calculator does not support plan designs with a flat dollar copayment and percentage coinsurance both applying after deductible for the same medical or Rx benefit category.

4 Plan designs either cover office visits at no member cost sharing or apply a member copay prior to deductible for a limited number of office visits with remaining office visits subject to a copayment or deductible and then copayment or coinsurance. The limited visits can be separate or combined across multiple benefit categories as defined in the contracts. In addition to primary care visits, limits can apply for specialist visits, outpatient mental/behavioral health and substance use disorder office visits, speech therapy, and/or physical and occupational therapies, urgent care. The limited visits covered in full or at copays prior to deductible functionality in the AV Calculator is only applicable to the primary care visits benefit category. Additional cost adjustments must be made to waive deductible on other listed services for a set number of visits.

6 The AV Calculator has five service types (mental/behavioral health and substance use disorder outpatient services; imaging; speech therapy; occupational therapy and physical therapy; and laboratory outpatient and professional services) that include services also classified as outpatient-facility and outpatient-professional. If special cost-sharing provisions are indicated for outpatient - facility and/or outpatient - professional claims and no special cost sharing is indicated for the service type, then the service(s) including both an outpatient-facility and outpatient-professional component will be split into their component parts and the outpatient facility and outpatient-professional relevant cost sharing applied when calculating the plan AV.

Acceptable alternate method used per 156.135(b)(2) or 156.135(b)(3):

2 Per 156.135(b)(2), the actual cost shares are converted into plan effective coinsurance percentages.

4 Per 156.135(b)(2), When limited visits are combined across services a weighted average of the member cost shares for visits subject to copays and the member cost shares for visits subject to plan deductible and coinsurance are calculated and converted to an effective coinsurance. When separate visit limits apply to services, an adjustment is made for visits covered in full by the plan and then added to the plan cost within the AV Calculator.

6 Per 156.135(b)(2), the AV Calculator (AVC) user guide notes that service specific cost-sharing features are always primary to any input in the outpatient facility fee and/or outpatient surgical physician/surgical service fields. Therefore, a small adjustment factor is multiplied by the specific service coinsurance, only when the coinsurance equals the plan coinsurance as loaded into cell D11 and H11 of the AVC. While not materially impacting the plan's AV, this adjustment prevents the outpatient facility fee and outpatient surgery physician/surgical service fee override methodology from being invoked which Anthem believes is not appropriate for our benefit plans.

Confirmation that only in-network cost sharing, including multitier networks, was considered: Yes

Description of the standardized plan population data used: Used AV Calculator population data.

If the method described in 156.135(b)(2) was used, a description of how the benefits were modified to fit the parameters of the AV Calculator:

2 For all categories, used the cost and frequency data from the AV calculator continuance tables at the appropriate charge level associated with the OOP limit. Used linear interpolation when the exact level was not available in the continuance table. The charge level associated with the OOP was considered "unlimited" when the plan overall (medical or Rx, as applicable) coinsurance was 100%. When the plan overall coinsurance was less than 100%, the following formula was used to calculate the charge level associated with the OOP.

$$\text{Stop Loss} = \frac{\text{(OOP Max - Deductible)}}{\text{1 - Plan Coinsurance}} + \text{Deductible}$$

where Stop Loss = charge level associated with OOP

The effective coinsurance was calculated using the following formula:

$$\text{Plan Eff Coins} = \text{Min}\left(1, \text{Max}\left(0, \frac{\text{(Ben Cost - Ben Copay • Ben Freq) x (1-Ben Coins)}}{\text{Ben Cost}}\right)\right)$$

where:
Ben Cost = average benefit cost PMPY
Ben Freq = average benefit frequency PMPY
Ben Copay = member copayment for the benefit category
Ben Coins = member coinsurance for the benefit category

4 Using proprietary claims data, weightings were determined to model the number of office visit services that would be subject to a limited copayment or the plan deductible and coinsurance.
1) For structures where there are a limited number of visits specific to Provider Specialty categories the following steps were performed:
a) Where there are a specified number of visits covered at no member cost sharing, the AV Calculator can handle that structure with no special adjustments made for primary care services by loading the visits into the "Begin Primary Care Cost-Sharing After a Set Number of Visit?". For other services, such as Mental/Behavioral Health and Substance Use Disorder Outpatient Services, an adjustment must be made to the plan AV.
i) Determine the average charge at the plan deductible level using the medical only CPD within the AV Calculator based on target metal.
ii) Multiply that average charge by the probability of X visits covered at no member cost sharing weighted by office visits as a proportion of the total and add that amount to the net plan pay amount, or numerator, of the AV Calculation.
b) Where there is 1 visit at no member cost sharing and X visits at a copayment with subsequent visits at deductible and coinsurance the following adjustments must be made:
i) For Primary Care load X + 1 visits into the "Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?"
ii) Multiply the copayment times the probability of 1 visit times the weighting of office visits based on total utilization of all included categories on the covered EHB category of the AV Calculator. Add that amount to the net plan pay amount within the AV Calculator. This represents the plan paying the 1 copayment for a member.

6 Method Used: For each of the five specific service categories, the final coinsurance is checked to see if it equals the plan coinsurance. If the service specific coinsurance equals the plan coinsurance then a factor of 0.9999 is multiplied by the service specific coinsurance and the result is loaded into the coinsurance row of the specific service category of the AV Calculator. An example of the calculation for speech therapy services where the service specific coinsurance is 90% and the plan coinsurance is 90%. The adjusted speech therapy coinsurance is calculated as (90% * 0.9999 = 89.99%). The 89.99% adjusted speech therapy coinsurance is loaded into cell D24 and cell H24, where applicable, of the AV calculator.

If the method described in 156.135(b)(3) was used, a description of the data and method used to develop the adjustments: This method was not used.

Certification Language:

The development of the actuarial value is based on one of the acceptable alternative methods outlined in 156.135(b)(2) or 156.135(b)(3) for those benefits that deviate substantially from the parameters of the AV Calculator and have a material impact on the AV

The analysis was
(i) conducted by a member of the American Academy of Actuaries;
(ii) performed in accordance with generally accepted actuarial principles and methodologies;

Actuary signature: Wayne Rosen

Actuary Printed Name: Wayne Rosen, FSA, MAAA

Date: 4/24/2025

Unique Plan Design Supporting Documentation and Justification

Please fill in the following information.

HIOS Issuer ID: 86545

HIOS Product IDs: 86545CT133, 86545CT157

Applicable HIOS Plan IDs (Standard Component): **4**
86545CT1330009-03, 86545CT1570002-03, 86545CT1330009-01, 86545CT1570002-01

Reasons the plan design is unique (benefits that are not compatible with the parameters of the AV Calculator and the materiality of those benefits):

1 The AV Calculator does not support plan designs where the cost share varies by site of service and/or by preferred versus non-preferred providers. These plan designs can impact one or more of the following AV service categories:

1. Primary Care Visits to Treat an Injury or Illness (exc. Preventive, and X-rays)
2. Imaging (CT/PET Scans, MRIs)
3. Occupational and Physical Therapy
4. Laboratory Outpatient and Professional Services
5. X-rays and Diagnostic Imaging
6. Outpatient Facility Fee (e.g. Ambulatory Surgery Center)
7. Outpatient Surgery Physician/Surgical Services
8. All drug categories

6 The AV Calculator has five service types (mental/behavioral health and substance use disorder outpatient services; imaging; speech therapy; occupational therapy and physical therapy; and laboratory outpatient and professional services) that include services also classified as outpatient-facility and outpatient-professional. If special cost-sharing provisions are indicated for outpatient - facility and/or outpatient - professional claims and no special cost sharing is indicated for the service type, then the service(s) including both an outpatient-facility and outpatient-professional component will be split into their component parts and the outpatient facility and outpatient-professional relevant cost sharing applied when calculating the plan AV.

9 Plan designs have a member coinsurance payment on one or more of the drugs benefit categories that is either floored or capped at a set amount per script. This functionality in the AV Calculator is limited to a maximum on specialty drugs (i.e. high-cost) coinsurance. The impacted drug member cost shares fall into one of the following categories:

1. Greater of copay or coinsurance percentage
2. Coinsurance with maximum copay per script
3. Coinsurance with minimum and maximum copays per script

Acceptable alternate method used per 156.135(b)(2) or 156.135(b)(3):

1 Per 156.135(b)(2), a weighted average of the two or more member cost shares are calculated when applicable.

6 Per 156.135(b)(2), the AV Calculator (AVC) user guide notes that service specific cost-sharing features are always primary to any input in the outpatient facility fee and/or outpatient surgical physician/surgical service fields. Therefore, a small adjustment factor is multiplied by the specific service coinsurance, only when the coinsurance equals the plan coinsurance as loaded into cell D11 and H11 of the AVC. While not materially impacting the plan's AV, this adjustment prevents the outpatient facility fee and outpatient surgery physician/surgical service fee override methodology from being invoked which Anthem believes is not appropriate for our benefit plans.

9 Per 156.135(b)(3), the actual Rx cost shares are converted into plan effective coinsurance percentages.

Confirmation that only in-network cost sharing, including multitier networks, was considered: Yes

Description of the standardized plan population data used: Used AV Calculator population data.

If the method described in 156.135(b)(2) was used, a description of how the benefits were modified to fit the parameters of the AV Calculator:

1 Using proprietary claims data, weightings between each site of service and/or between preferred and non-preferred providers were developed for each of the listed benefit categories. The weightings were used to calculate a weighted average cost share for each benefit category using the following formula.
Weighted Average Cost Share (example) = (Cost Share 1 Weight) * (Cost Share 1) + (Cost Share 2 Weight) * (Cost Share 2) + (1 - Cost Share 1 Weight - Cost Share 2 Weight) * (Cost Share 3).

6 Method Used: For each of the five specific service categories, the final coinsurance is checked to see if it equals the plan coinsurance. If the service specific coinsurance equals the plan coinsurance then a factor of 0.9999 is multiplied by the service specific coinsurance and the result is loaded into the coinsurance row of the specific service category of the AV Calculator. An example of the calculation for speech therapy services where the service specific coinsurance is 90% and the plan coinsurance is 90%. The adjusted speech therapy coinsurance is calculated as (90% * 0.9999 = 89.99%). The 89.99% adjusted speech therapy coinsurance is loaded into cell D24 and cell H24, where applicable, of the AV calculator.

If the method described in 156.135(b)(3) was used, a description of the data and method used to develop the adjustments:

9 Data used: In addition to the AV Calculator (AVC) continuance tables, we used Rx cost and utilization data from a nationally recognized consulting firm.
Method Used: We calculated an effective coinsurance for each impacted Rx benefit category outside the AVC. We input our calculated effective coinsurance(s) into the AVC.
Description: It is common for the allowed cost of a drug to be less than an Rx copay, therefore, we used proprietary Rx data from a nationally known consulting firm to calculate the effective copay for each of the impacted Rx tiers and then converted the effective copay into an effective coinsurance. The Rx claims data was calibrated at each charge level bucket and cost per script for each Rx tier, based on the AVC average allowed cost per script. The AVC average allowed cost per script was determined by taking the plan charge level Rx average cost PMPY and dividing by the corresponding Rx average scripts PMPY.
Greater of copay or coinsurance: For each calibrated cost per script bucket, the member cost share with only the copay was calculated and the member cost share with only the coinsurance was calculated. The maximum of the two was the final member cost share, expressed as a copay. The weighted average member copay and the weighted average allowed cost per script were both calculated using the distribution of scripts by cost per script bucket. The effective coinsurance was calculated by dividing the weighted average member copay by the weighted average allowed cost per script and input into the AVC.
Coinsurance with minimum and/or maximum copay per script: For each calibrated cost per script bucket, the member cost share with only the coinsurance was calculated, expressed as a copay. The member cost share in each cost per script bucket was replaced with either the minimum copay per script or the maximum copay per script when applicable. The weighted average member copay and the weighted average allowed cost per script were both calculated using the distribution of scripts by cost per script bucket. The effective coinsurance was calculated by dividing the weighted average member copay by the weighted average allowed cost per script and input into the AVC.

Certification Language:

The development of the actuarial value is based on one of the acceptable alternative methods outlined in 156.135(b)(2) or 156.135(b)(3) for those benefits that deviate substantially from the parameters of the AV Calculator and have a material impact on the AV

The analysis was
(i) conducted by a member of the American Academy of Actuaries;
(ii) performed in accordance with generally accepted actuarial principles and methodologies;

Actuary signature: Wayne Rosen

Actuary Printed Name: Wayne Rosen, FSA, MAAA

Date: 4/24/2025

Unique Plan Design Supporting Documentation and Justification

Please fill in the following information.

HIOS Issuer ID: 86545

HIOS Product IDs: 86545CT133, 86545CT123

Applicable HIOS Plan IDs (Standard Component): **4**
86545CT1330020-03, 86545CT1230027-03, 86545CT1330020-01, 86545CT1230027-01

Reasons the plan design is unique (benefits that are not compatible with the parameters of the AV Calculator and the materiality of those benefits):

2 The functionality of the AV Calculator does not support plan designs with a flat dollar copayment and percentage coinsurance both applying after deductible for the same medical or Rx benefit category.

6 The AV Calculator has five service types (mental/behavioral health and substance use disorder outpatient services; imaging; speech therapy; occupational therapy and physical therapy; and laboratory outpatient and professional services) that include services also classified as outpatient-facility and outpatient-professional. If special cost-sharing provisions are indicated for outpatient - facility and/or outpatient - professional claims and no special cost sharing is indicated for the service type, then the service(s) including both an outpatient-facility and outpatient-professional component will be split into their component parts and the outpatient facility and outpatient-professional relevant cost sharing applied when calculating the plan AV.

9 Plan designs have a member coinsurance payment on one or more of the drugs benefit categories that is either floored or capped at a set amount per script. This functionality in the AV Calculator is limited to a maximum on specialty drugs (i.e. high-cost) coinsurance. The impacted drug member cost shares fall into one of the following categories:

1. Greater of copay or coinsurance percentage
2. Coinsurance with maximum copay per script
3. Coinsurance with minimum and maximum copays per script

Acceptable alternate method used per 156.135(b)(2) or 156.135(b)(3):

2 Per 156.135(b)(2), the actual cost shares are converted into plan effective coinsurance percentages.

6 Per 156.135(b)(2), the AV Calculator (AVC) user guide notes that service specific cost-sharing features are always primary to any input in the outpatient facility fee and/or outpatient surgical physician/surgical service fields. Therefore, a small adjustment factor is multiplied by the specific service coinsurance, only when the coinsurance equals the plan coinsurance as loaded into cell D11 and H11 of the AVC. While not materially impacting the plan's AV, this adjustment prevents the outpatient facility fee and outpatient surgery physician/surgical service fee override methodology from being invoked which Anthem believes is not appropriate for our benefit plans.

9 Per 156.135(b)(3), the actual Rx cost shares are converted into plan effective coinsurance percentages.

Confirmation that only in-network cost sharing, including multitier networks, was considered: Yes

Description of the standardized plan population data used: Used AV Calculator population data.

If the method described in 156.135(b)(2) was used, a description of how the benefits were modified to fit the parameters of the AV Calculator:

2 For all categories, used the cost and frequency data from the AV calculator continuance tables at the appropriate charge level associated with the OOP limit. Used linear interpolation when the exact level was not available in the continuance table. The charge level associated with the OOP was considered "unlimited" when the plan overall (medical or Rx, as applicable) coinsurance was 100%. When the plan overall coinsurance was less than 100%, the following formula was used to calculate the charge level associated with the OOP.

$$\text{Stop Loss} = \frac{(\text{OOP Max} - \text{Deductible})}{1 - \text{Plan Coinsurance}} + \text{Deductible}$$

where Stop Loss = charge level associated with OOP

The effective coinsurance was calculated using the following formula:

$$\text{Plan Eff Coins} = \text{Min}\left(1, \text{Max}\left(0, \frac{(\text{Ben Cost} - \text{Ben Copay} \bullet \text{Ben Freq}) \times (1 - \text{Ben Coins})}{\text{Ben Cost}}\right)\right)$$

where:
Ben Cost = average benefit cost PMPY
Ben Freq = average benefit frequency PMPY
Ben Copay = member copayment for the benefit category
Ben Coins = member coinsurance for the benefit category

6 Method Used: For each of the five specific service categories, the final coinsurance is checked to see if it equals the plan coinsurance. If the service specific coinsurance equals the plan coinsurance then a factor of 0.9999 is multiplied by the service specific coinsurance and the result is loaded into the coinsurance row of the specific service category of the AV Calculator. An example of the calculation for speech therapy services where the service specific coinsurance is 90% and the plan coinsurance is 90%. The adjusted speech therapy coinsurance is calculated as (90% * 0.9999 = 89.99%). The 89.99% adjusted speech therapy coinsurance is loaded into cell D24 and cell H24, where applicable, of the AV calculator.

If the method described in 156.135(b)(3) was used, a description of the data and method used to develop the adjustments:

9 Data used: In addition to the AV Calculator (AVC) continuance tables, we used Rx cost and utilization data from a nationally recognized consulting firm.
Method Used: We calculated an effective coinsurance for each impacted Rx benefit category outside the AVC. We input our calculated effective coinsurance(s) into the AVC.
Description: It is common for the allowed cost of a drug to be less than an Rx copay, therefore, we used proprietary Rx data from a nationally known consulting firm to calculate the effective copay for each of the impacted Rx tiers and then converted the effective copay into an effective coinsurance. The Rx claims data was calibrated at each charge level bucket and cost per script for each Rx tier, based on the AVC average allowed cost per script. The AVC average allowed cost per script was determined by taking the plan charge level Rx average cost PMPY and dividing by the corresponding Rx average scripts PMPY.
Greater of copay or coinsurance: For each calibrated cost per script bucket, the member cost share with only the copay was calculated and the member cost share with only the coinsurance was calculated. The maximum of the two was the final member cost share, expressed as a copay. The weighted average member copay and the weighted average allowed cost per script were both calculated using the distribution of scripts by cost per script bucket. The effective coinsurance was calculated by dividing the weighted average member copay by the weighted average allowed cost per script and input into the AVC.
Coinsurance with minimum and/or maximum copay per script: For each calibrated cost per script bucket, the member cost share with only the coinsurance was calculated, expressed as a copay. The member cost share in each cost per script bucket was replaced with either the minimum copay per script or the maximum copay per script when applicable. The weighted average member copay and the weighted average allowed cost per script were both calculated using the distribution of scripts by cost per script bucket. The effective coinsurance was calculated by dividing the weighted average member copay by the weighted average allowed cost per script and input into the AVC.

Certification Language:

The development of the actuarial value is based on one of the acceptable alternative methods outlined in 156.135(b)(2) or 156.135(b)(3) for those benefits that deviate substantially from the parameters of the AV Calculator and have a material impact on the AV

The analysis was
(i) conducted by a member of the American Academy of Actuaries;
(ii) performed in accordance with generally accepted actuarial principles and methodologies;

Actuary signature: Wayne Rosen

Actuary Printed Name: Wayne Rosen, FSA, MAAA

Date: 4/24/2025

Unique Plan Design Supporting Documentation and Justification

Please fill in the following information.

HIOS Issuer ID: 86545

HIOS Product IDs: 86545CT157

Applicable HIOS Plan IDs (Standard Component): **2**
86545CT1570001-03, 86545CT1570001-01

Reasons the plan design is unique (benefits that are not compatible with the parameters of the AV Calculator and the materiality of those benefits):

1 The AV Calculator does not support plan designs where the cost share varies by site of service and/or by preferred versus non-preferred providers. These plan designs can impact one or more of the following AV service categories:

1. Primary Care Visits to Treat an Injury or Illness (exc. Preventive, and X-rays)
2. Imaging (CT/PET Scans, MRIs)
3. Occupational and Physical Therapy
4. Laboratory Outpatient and Professional Services
5. X-rays and Diagnostic Imaging
6. Outpatient Facility Fee (e.g. Ambulatory Surgery Center)
7. Outpatient Surgery Physician/Surgical Services
8. All drug categories

6 The AV Calculator has five service types (mental/behavioral health and substance use disorder outpatient services; imaging; speech therapy; occupational therapy and physical therapy; and laboratory outpatient and professional services) that include services also classified as outpatient-facility and outpatient-professional. If special cost-sharing provisions are indicated for outpatient - facility and/or outpatient - professional claims and no special cost sharing is indicated for the service type, then the service(s) including both an outpatient-facility and outpatient-professional component will be split into their component parts and the outpatient facility and outpatient-professional relevant cost sharing applied when calculating the plan AV.

9 Plan designs have a member coinsurance payment on one or more of the drugs benefit categories that is either floored or capped at a set amount per script. This functionality in the AV Calculator is limited to a maximum on specialty drugs (i.e. high-cost) coinsurance. The impacted drug member cost shares fall into one of the following categories:

1. Greater of copay or coinsurance percentage
2. Coinsurance with maximum copay per script
3. Coinsurance with minimum and maximum copays per script

10 The AV Calculator does not support more than one cost share within a single drug benefit category. HSA plans with preventive drug benefits offer pre-deductible coverage for preventive drugs in the generics and the preferred brand drugs benefit categories. These preventive drug benefits are compliant with IRS HSA regulations.

Acceptable alternate method used per 156.135(b)(2) or 156.135(b)(3):

1 Per 156.135(b)(2), a weighted average of the two or more member cost shares are calculated when applicable.

6 Per 156.135(b)(2), the AV Calculator (AVC) user guide notes that service specific cost-sharing features are always primary to any input in the outpatient facility fee and/or outpatient surgical physician/surgical service fields. Therefore, a small adjustment factor is multiplied by the specific service coinsurance, only when the coinsurance equals the plan coinsurance as loaded into cell D11 and H11 of the AVC. While not materially impacting the plan's AV, this adjustment prevents the outpatient facility fee and outpatient surgery physician/surgical service fee override methodology from being invoked which Anthem believes is not appropriate for our benefit plans.

9 Per 156.135(b)(3), the actual Rx cost shares are converted into plan effective coinsurance percentages.

10 Per 156.135(b)(3), an adjustment factor is developed by using the AV calculator "Rx Only" continuance tables to calculate pharmacy specific AVs for the plan with and without pre-deductible preventive drug benefits.

Confirmation that only in-network cost sharing, including multitier networks, was considered: Yes

Description of the standardized plan population data used: Used AV Calculator population data.

If the method described in 156.135(b)(2) was used, a description of how the benefits were modified to fit the parameters of the AV Calculator:

1 Using proprietary claims data, weightings between each site of service and/or between preferred and non-preferred providers were developed for each of the listed benefit categories. The weightings were used to calculate a weighted average cost share for each benefit category using the following formula.
Weighted Average Cost Share (example) = (Cost Share 1 Weight) * (Cost Share 1) + (Cost Share 2 Weight) * (Cost Share 2) + (1 - Cost Share 1 Weight - Cost Share 2 Weight) * (Cost Share 3).

6 Method Used: For each of the five specific service categories, the final coinsurance is checked to see if it equals the plan coinsurance. If the service specific coinsurance equals the plan coinsurance then a factor of 0.9999 is multiplied by the service specific coinsurance and the result is loaded into the coinsurance row of the specific service category of the AV Calculator. An example of the calculation for speech therapy services where the service specific coinsurance is 90% and the plan coinsurance is 90%. The adjusted speech therapy coinsurance is calculated as (90% * 0.9999 = 89.99%). The 89.99% adjusted speech therapy coinsurance is loaded into cell D24 and cell H24, where applicable, of the AV calculator.

If the method described in 156.135(b)(3) was used, a description of the data and method used to develop the adjustments:

9 Data used: In addition to the AV Calculator (AVC) continuance tables, we used Rx cost and utilization data from a nationally recognized consulting firm.
Method Used: We calculated an effective coinsurance for each impacted Rx benefit category outside the AVC. We input our calculated effective coinsurance(s) into the AVC.
Description: It is common for the allowed cost of a drug to be less than an Rx copay, therefore, we used proprietary Rx data from a nationally known consulting firm to calculate the effective copay for each of the impacted Rx tiers and then converted the effective copay into an effective coinsurance. The Rx claims data was calibrated at each charge level bucket and cost per script for each Rx tier, based on the AVC average allowed cost per script. The AVC average allowed cost per script was determined by taking the plan charge level Rx average cost PMPY and dividing by the corresponding Rx average scripts PMPY.
Greater of copay or coinsurance: For each calibrated cost per script bucket, the member cost share with only the copay was calculated and the member cost share with only the coinsurance was calculated. The maximum of the two was the final member cost share, expressed as a copay. The weighted average member copay and the weighted average allowed cost per script were both calculated using the distribution of scripts by cost per script bucket. The effective coinsurance was calculated by dividing the weighted average member copay by the weighted average allowed cost per script and input into the AVC.
Coinsurance with minimum and/or maximum copay per script: For each calibrated cost per script bucket, the member cost share with only the coinsurance was calculated, expressed as a copay. The member cost share in each cost per script bucket was replaced with either the minimum copay per script or the maximum copay per script when applicable. The weighted average member copay and the weighted average allowed cost per script were both calculated using the distribution of scripts by cost per script bucket. The effective coinsurance was calculated by dividing the weighted average member copay by the weighted average allowed cost per script and input into the AVC.

10 Data used: In addition to the AV Calculator (AVC) continuance tables, we used Rx cost and utilization data from a nationally recognized consulting firm.
Method used: We calculated the Rx only AV, both with and without pre-deductible preventive Rx benefits, outside of the AVC. We adjusted the difference between the two AVs using the Rx percent of total claims and added the adjusted difference to the AV calculated by the AVC for the plan without pre-deductible preventive Rx coverage.
Step 1: We calculated the percent of allowed claims that are Rx (%Rx) using the "Rx Only" and "Combined" AVC continuance tables. We calculated the percent of Rx claims that are preventive (Prev%RxGen and Prev%RxPrefBrnd) using proprietary Rx claims data.
Step 2: We determined the benefit parameters to use in the Rx only AV calculations. The plan OOP is combined for medical and Rx; therefore we calculated the Rx only OOP (RxOnlyOOP) as %Rx * Plan OOP. It is common for the allowed cost of a drug to be less than a given Rx tiered copay, therefore, we used proprietary drug claims cost data from a nationally known consulting firm to calculate the effective copay for each of the four Rx tiers. The Rx claims data is calibrated at each charge level bucket and cost per script for each Rx tier, based on the AVC average allowed cost per script. The AVC average allowed cost per script is determined by taking the plan charge level Rx average cost PMPY and dividing by the corresponding Rx average scripts PMPY.
Step 3: We calculated the Rx only AV (EstRxPrevAV) using the "Rx Only" AVC continuance tables, the plan Rx deductible, our calculated effective copays, and our calculated RxOnlyOOP. For each claims bucket in the continuance table, we followed these steps: 1) the cumulative allowed dollars and cumulative scripts for each drug tier were calculated by multiplying the cumulative members by the cumulative PMPM and the cumulative average scripts respectively; 2) the allowed dollars and scripts for each drug tier were calculated by subtracting the next lower bucket's cumulative amounts from the bucket's cumulative amounts; 3) the plan's Rx deductible was allocated among the tiers to which the deductible applied based on allowed claims per tier; 4) the members' deductible claims for each drug tier were calculated by taking the minimum of the allowed claims and the members times the allocated deductible; 5) the members' preventive Rx savings was calculated as the plan's preventive coinsurance percentage * members' deductible claims * Prev%RxGen or Prev%RxPrefBrnd for each of the two tiers that contain preventive drugs; these amounts were set aside until the OOP calculation; 6) the members' copay claims for each drug tier were calculated as the percent of allowed dollars remaining after the deductible * scripts * effective copay; 7) the members' portion of allowed claims (deductible claims + copay claims - preventive savings) was summed for the four tiers and compared to RxOnlyOOP; 8) the final members' portion of allowed claims per member was the minimum of the pre-OOP members' portion of allowed claims per member and the RxOnlyOOP. The AV was calculated as total Rx allowed claims less (members multiplied by final members' portion of allowed claims per member).
Step 4: We calculated the Rx only AV (EstRxNoPrev) using the methodology in Step 3, excluding the preventive Rx calculations.
Step 5: We used the AVC to calculate the AV (ActTotNoPrevAV) with the plan's benefits excluding the pre-deductible preventive Rx benefits.
Step 6: We calculated our issuer AV as FinalActAV = ActTotNoPrevAV - Rx% * (EstRxPrevAV - EstRxNoPrevAV).

Certification Language:

The development of the actuarial value is based on one of the acceptable alternative methods outlined in 156.135(b)(2) or 156.135(b)(3) for those benefits that deviate substantially from the parameters of the AV Calculator and have a material impact on the AV

The analysis was
(i) conducted by a member of the American Academy of Actuaries;
(ii) performed in accordance with generally accepted actuarial principles and methodologies;

Actuary signature: Wayne Rosen

Actuary Printed Name: Wayne Rosen, FSA, MAAA

Date: 4/24/2025

Unique Plan Design Supporting Documentation and Justification

Please fill in the following information.

HIOS Issuer ID: 86545

HIOS Product IDs: 86545CT123, 86545CT133, 86545CT158

Applicable HIOS Plan IDs (Standard Component): **10**

86545CT1230025-03, 86545CT1330001-03, 86545CT1330003-03, 86545CT1330002-03, 86545CT1230025-01, 86545CT1330001-01, 86545CT1330003-01, 86545CT1330002-01, 86545CT1580001-01, 86545CT1580001-03

Reasons the plan design is unique (benefits that are not compatible with the parameters of the AV Calculator and the materiality of those benefits):

1 The AV Calculator does not support plan designs where the cost share varies by site of service and/or by preferred versus non-preferred providers. These plan designs can impact one or more of the following AV service categories:

1. Primary Care Visits to Treat an Injury or Illness (exc. Preventive, and X-rays)
2. Imaging (CT/PET Scans, MRIs)
3. Occupational and Physical Therapy
4. Laboratory Outpatient and Professional Services
5. X-rays and Diagnostic Imaging
6. Outpatient Facility Fee (e.g. Ambulatory Surgery Center)
7. Outpatient Surgery Physician/Surgical Services
8. All drug categories

3 The AV Calculator does not support plan designs with member cost shares that differ by site of service for outpatient mental/behavioral health and substance use disorders (MH), specifically MH office visits versus other outpatient MH facility and professional visits.

9 Plan designs have a member coinsurance payment on one or more of the drugs benefit categories that is either floored or capped at a set amount per script. This functionality in the AV Calculator is limited to a maximum on specialty drugs (i.e. high-cost) coinsurance. The impacted drug member cost shares fall into one of the following categories:

1. Greater of copay or coinsurance percentage
2. Coinsurance with maximum copay per script
3. Coinsurance with minimum and maximum copays per script

Acceptable alternate method used per 156.135(b)(2) or 156.135(b)(3):

1 Per 156.135(b)(2), a weighted average of the two or more member cost shares are calculated when applicable.

3 Per 156.135(b)(2), a weighted average of the member cost shares for mental health office visits and the member cost shares for outpatient mental health facility and outpatient professional other visits are calculated and converted to an actuarially equivalent effective coinsurance/copay.

9 Per 156.135(b)(3), the actual Rx cost shares are converted into plan effective coinsurance percentages.

Confirmation that only in-network cost sharing, including multitier networks, was considered: Yes

Description of the standardized plan population data used: Used AV Calculator population data.

If the method described in 156.135(b)(2) was used, a description of how the benefits were modified to fit the parameters of the AV Calculator:

1 Using proprietary claims data, weightings between each site of service and/or between preferred and non-preferred providers were developed for each of the listed benefit categories. The weightings were used to calculate a weighted average cost share for each benefit category using the following formula.
Weighted Average Cost Share (example) = (Cost Share 1 Weight) * (Cost Share 1) + (Cost Share 2 Weight) * (Cost Share 2) + (1 - Cost Share 1 Weight - Cost Share 2 Weight) * (Cost Share 3).

3 The Interim Final Rule 45 CFR Part 146 under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHP) and EHB guidance allows separation of cost share types between outpatient other and office visits as allowed under the MHPAEA July 1, 2010 Enforcement Safe Harbor guidance. The Final Rule released on November 13, 2013 retained the sub-classification provision. These plan designs have been tested and meet the regulatory QTL testing methodology requirements. Using proprietary claims data, allocation weightings were calculated and applied to the member cost shares for MH/SA services in an office based setting and in a hospital/facility setting to calculate an effective coinsurance/copay.

If the method described in 156.135(b)(3) was used, a description of the data and method used to develop the adjustments:

9 Data used: In addition to the AV Calculator (AVC) continuance tables, we used Rx cost and utilization data from a nationally recognized consulting firm.
Method Used: We calculated an effective coinsurance for each impacted Rx benefit category outside the AVC. We input our calculated effective coinsurance(s) into the AVC.
Description: It is common for the allowed cost of a drug to be less than an Rx copay, therefore, we used proprietary Rx data from a nationally known consulting firm to calculate the effective copay for each of the impacted Rx tiers and then converted the effective copay into an effective coinsurance. The Rx claims data was calibrated at each charge level bucket and cost per script for each Rx tier, based on the AVC average allowed cost per script. The AVC average allowed cost per script was determined by taking the plan charge level Rx average cost PMPY and dividing by the corresponding Rx average scripts PMPY.
Greater of copay or coinsurance: For each calibrated cost per script bucket, the member cost share with only the copay was calculated and the member cost share with only the coinsurance was calculated. The maximum of the two was the final member cost share, expressed as a copay. The weighted average member copay and the weighted average allowed cost per script were both calculated using the distribution of scripts by cost per script bucket. The effective coinsurance was calculated by dividing the weighted average member copay by the weighted average allowed cost per script and input into the AVC.
Coinsurance with minimum and/or maximum copay per script: For each calibrated cost per script bucket, the member cost share with only the coinsurance was calculated, expressed as a copay. The member cost share in each cost per script bucket was replaced with either the minimum copay per script or the maximum copay per script when applicable. The weighted average member copay and the weighted average allowed cost per script were both calculated using the distribution of scripts by cost per script bucket. The effective coinsurance was calculated by dividing the weighted average member copay by the weighted average allowed cost per script and input into the AVC.

Certification Language:

The development of the actuarial value is based on one of the acceptable alternative methods outlined in 156.135(b)(2) or 156.135(b)(3) for those benefits that deviate substantially from the parameters of the AV Calculator and have a material impact on the AV

The analysis was
(i) conducted by a member of the American Academy of Actuaries;
(ii) performed in accordance with generally accepted actuarial principles and methodologies;

Actuary signature: Wayne Rosen

Actuary Printed Name: Wayne Rosen, FSA, MAAA

Date: 4/24/2025

Unique Plan Design Supporting Documentation and Justification

Please fill in the following information.

HIOS Issuer ID: 86545

HIOS Product IDs: 86545CT123

Applicable HIOS Plan IDs (Standard Component): **1**

86545CT1230005-01

Reasons the plan design is unique (benefits that are not compatible with the parameters of the AV Calculator and the materiality of those benefits):

2 The functionality of the AV Calculator does not support plan designs with a flat dollar copayment and percentage coinsurance both applying after deductible for the same medical or Rx benefit category.

4 Plan designs either cover office visits at no member cost sharing or apply a member copay prior to deductible for a limited number of office visits with remaining office visits subject to a copayment or deductible and then copayment or coinsurance. The limited visits can be separate or combined across multiple benefit categories as defined in the contracts. In addition to primary care visits, limits can apply for specialist visits, outpatient mental/behavioral health and substance use disorder office visits, speech therapy, and/or physical and occupational therapies, urgent care. The limited visits covered in full or at copays prior to deductible functionality in the AV Calculator is only applicable to the primary care visits benefit category. Additional cost adjustments must be made to waive deductible on other listed services for a set number of visits.

6 The AV Calculator has five service types (mental/behavioral health and substance use disorder outpatient services; imaging; speech therapy; occupational therapy and physical therapy; and laboratory outpatient and professional services) that include services also classified as outpatient-facility and outpatient-professional. If special cost-sharing provisions are indicated for outpatient - facility and/or outpatient - professional claims and no special cost sharing is indicated for the service type, then the service(s) including both an outpatient-facility and outpatient-professional component will be split into their component parts and the outpatient facility and outpatient-professional relevant cost sharing applied when calculating the plan AV.

Acceptable alternate method used per 156.135(b)(2) or 156.135(b)(3):

2 Per 156.135(b)(2), the actual cost shares are converted into plan effective coinsurance percentages.

4 Per 156.135(b)(2), When limited visits are combined across services a weighted average of the member cost shares for visits subject to copays and the member cost shares for visits subject to plan deductible and coinsurance are calculated and converted to an effective coinsurance. When separate visit limits apply to services, an adjustment is made for visits covered in full by the plan and then added to the plan cost within the AV Calculator.

6 Per 156.135(b)(2), the AV Calculator (AVC) user guide notes that service specific cost-sharing features are always primary to any input in the outpatient facility fee and/or outpatient surgical physician/surgical service fields. Therefore, a small adjustment factor is multiplied by the specific service coinsurance, only when the coinsurance equals the plan coinsurance as loaded into cell D11 and H11 of the AVC. While not materially impacting the plan's AV, this adjustment prevents the outpatient facility fee and outpatient surgery physician/surgical service fee override methodology from being invoked which Anthem believes is not appropriate for our benefit plans.

Confirmation that only in-network cost sharing, including multitier networks, was considered: Yes

Description of the standardized plan population data used: Used AV Calculator population data.

If the method described in 156.135(b)(2) was used, a description of how the benefits were modified to fit the parameters of the AV Calculator:

2 For all categories, used the cost and frequency data from the AV calculator continuance tables at the appropriate charge level associated with the OOP limit. Used linear interpolation when the exact level was not available in the continuance table. The charge level associated with the OOP was considered "unlimited" when the plan overall (medical or Rx, as applicable) coinsurance was 100%. When the plan overall coinsurance was less than 100%, the following formula was used to calculate the charge level associated with the OOP.

$$\text{Stop Loss} = \frac{\text{(OOP Max - Deductible)}}{\text{1 - Plan Coinsurance}} + \text{Deductible}$$

where Stop Loss = charge level associated with OOP

The effective coinsurance was calculated using the following formula:

$$\text{Plan Eff Coins} = \text{Min}\left(1, \text{Max}\left(0, \frac{\text{(Ben Cost - Ben Copay • Ben Freq) x (1-Ben Coins)}}{\text{Ben Cost}}\right)\right)$$

where:
Ben Cost = average benefit cost PMPY
Ben Freq = average benefit frequency PMPY
Ben Copay = member copayment for the benefit category
Ben Coins = member coinsurance for the benefit category

4 Using proprietary claims data, weightings were determined to model the number of office visit services that would be subject to a limited copayment or the plan deductible and coinsurance.
1) For structures where there are a limited number of visits specific to Provider Specialty categories the following steps were performed:
a) Where there are a specified number of visits covered at no member cost sharing, the AV Calculator can handle that structure with no special adjustments made for primary care services by loading the visits into the "Begin Primary Care Cost-Sharing After a Set Number of Visit?". For other services, such as Mental/Behavioral Health and Substance Use Disorder Outpatient Services, an adjustment must be made to the plan AV.
i) Determine the average charge at the plan deductible level using the medical only CPD within the AV Calculator based on target metal.
ii) Multiply that average charge by the probability of X visits covered at no member cost sharing weighted by office visits as a proportion of the total and add that amount to the net plan pay amount, or numerator, of the AV Calculation.
b) Where there is 1 visit at no member cost sharing and X visits at a copayment with subsequent visits at deductible and coinsurance the following adjustments must be made:
i) For Primary Care load X + 1 visits into the "Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?"
ii) Multiply the copayment times the probability of 1 visit times the weighting of office visits based on total utilization of all included categories on the covered EHB category of the AV Calculator. Add that amount to the net plan pay amount within the AV Calculator. This represents the plan paying the 1 copayment for a member.

6 Method Used: For each of the five specific service categories, the final coinsurance is checked to see if it equals the plan coinsurance. If the service specific coinsurance equals the plan coinsurance then a factor of 0.9999 is multiplied by the service specific coinsurance and the result is loaded into the coinsurance row of the specific service category of the AV Calculator. An example of the calculation for speech therapy services where the service specific coinsurance is 90% and the plan coinsurance is 90%. The adjusted speech therapy coinsurance is calculated as (90% * 0.9999 = 89.99%). The 89.99% adjusted speech therapy coinsurance is loaded into cell D24 and cell H24, where applicable, of the AV calculator.

If the method described in 156.135(b)(3) was used, a description of the data and method used to develop the adjustments: This method was not used.

Certification Language:

The development of the actuarial value is based on one of the acceptable alternative methods outlined in 156.135(b)(2) or 156.135(b)(3) for those benefits that deviate substantially from the parameters of the AV Calculator and have a material impact on the AV

The analysis was
(i) conducted by a member of the American Academy of Actuaries;
(ii) performed in accordance with generally accepted actuarial principles and methodologies;

Actuary signature: Wayne Rosen

Actuary Printed Name: Wayne Rosen, FSA, MAAA

Date: 4/24/2025

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☑
Apply Skilled Nursing Facility Copay per Day?	☑
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$0.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
MOOP ($)			$1,350.00			
MOOP if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical										
Emergency Room Services	☐ All	☐ All		$50.00	☐ All	☐ All			☐ All	☐ All
All Inpatient Hospital Services (inc. MH/SUD)	☐	☐		$75.00	☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				$14.72						
Specialist Visit				$29.89						
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$30.54	☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☐	☐		$50.00	☐	☐			☐	☐
Speech Therapy	☐	☐		$20.00	☐	☐			☐	☐
Occupational and Physical Therapy	☐	☐		$20.00	☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☐	☐		$10.00	☐	☐			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$25.00	☐	☐			☐	☐
Skilled Nursing Facility	☐	☐		$75.00	☐	☐			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☐	☐		$67.83	☐	☐			☐	☐
Outpatient Surgery Physician/Surgical Services	☐	☐		$0.00	☐	☐			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$5.00	☐	☐			☐	☐
Preferred Brand Drugs	☐	☐		$10.00	☐	☐			☐	☐
Non-Preferred Brand Drugs	☐	☐		$30.00	☐	☐			☐	☐
Specialty Drugs (i.e. high-cost)	☐	☑	80%		☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$60
Set a Maximum Number of Days for Charging an IP Copay?	☑
# Days (1-10):	4
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT133
HIOS Plan ID: 86545CT1330001-06
AVC Version: 2026_1d

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	94.80%
Metal Tier:	Platinum
	NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).
Additional Notes:	
Calculation Time:	0.038 seconds

Revised Final 2026 AV Calculator

$8,749.90
$9,230.19

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,500.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
MOOP ($)			$7,225.00			
MOOP if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Copay applies only after deductible?**	
Medical										
Emergency Room Services	☑ All	☑ All			☐ All	☐ All			☐ All	☐ All
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)			80%							
Specialist Visit	☑	☑	80%						☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑	80%		☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑	80%		☐	☐			☐	☐
Speech Therapy	☑	☑	80%		☐	☐			☐	☐
Occupational and Physical Therapy	☑	☑	80%		☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑	80%		☐	☐			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☐	☐			☐	☐
Skilled Nursing Facility	☑	☑			☐	☐			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☑			☐	☐			☐	☐
Preferred Brand Drugs	☑	☑	75%		☐	☐			☐	☐
Non-Preferred Brand Drugs	☑	☑	70%		☐	☐			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$500
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT133
HIOS Plan ID: 86545CT1330009-03
AVC Version: 2026_1d

Output

Status/Error Messages: Error: Result is outside of [-4, +2] percent de minimis variation.
Actuarial Value: 64.97%
Metal Tier:

NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.

Additional Notes:

Calculation Time: 0.0391 seconds

Revised Final 2026 AV Calculator

$3,372.18
$5,190.48

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
MOOP ($)			$8,000.00			
MOOP if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Copay applies only after deductible?**	
Medical										
Emergency Room Services	☑ All	☑ All			☐ All	☐ All			☐ All	☐ All
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				$19.62						
Specialist Visit				$79.72						
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑	90%		☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑	89%		☐	☐			☐	☐
Speech Therapy	☐	☐		$30.00	☐	☐			☐	☐
Occupational and Physical Therapy	☐	☐		$30.00	☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑	51%		☐	☐			☐	☐
X-rays and Diagnostic Imaging	☑	☑	78%		☐	☐			☐	☐
Skilled Nursing Facility	☑	☑			☐	☐			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$5.00	☐	☐			☐	☐
Preferred Brand Drugs	☐	☐		$40.00	☐	☐			☐	☐
Non-Preferred Brand Drugs	☐	☐		$127.67	☐	☐			☐	☐
Specialty Drugs (i.e. high-cost)	☐	☐		$623.22	☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT133
HIOS Plan ID: 86545CT1330020-03
AVC Version: 2026_1d

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	79.05%
Metal Tier:	Gold
Additional Notes:	
Calculation Time:	0.049 seconds

Revised Final 2026 AV Calculator

$7,141.36
$9,034.31

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,000.00			
Coinsurance (%, Insurer's Cost Share)			75.00%			
MOOP ($)			$8,000.00			
MOOP if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical										
Emergency Room Services	☑ All	☑ All			☐ All	☐ All			☐ All	☐ All
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$68.67					☑	☐
Specialist Visit	☑	☐		$99.65					☑	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑	75%		☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑	75%		☐	☐			☐	☐
Speech Therapy	☑	☑	75%		☐	☐			☐	☐
Occupational and Physical Therapy	☑	☑	75%		☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑	75%		☐	☐			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☐	☐			☐	☐
Skilled Nursing Facility	☑	☑			☐	☐			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☐		$30.00	☐	☐			☑	☐
Preferred Brand Drugs	☑	☑			☐	☐			☐	☐
Non-Preferred Brand Drugs	☑	☑	70%		☐	☐			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	60%		☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$500
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT157
HIOS Plan ID: 86545CT1570001-03
AVC Version: 2026_1d

Output

Status/Error Messages: Error: Result is outside of [-4, +2] percent de minimis variation.
Actuarial Value: 64.01%
Metal Tier:

NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.

Additional Notes:

Calculation Time: 0.067 seconds

Revised Final 2026 AV Calculator

$3,322.27
$5,190.48

Pursuant to section 156.135 (b) (2) or 156.135 (b) (3), alternative methods were used to calculate AV for this HIOS Plan ID. Reference the Unique Plan Design Supporting Documentation and Justification forms for additional details on the methods used for this HIOS Plan ID.
Adjusted Actuarial Value: 64.99%

$3,373.45

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☑
Apply Skilled Nursing Facility Copay per Day?	☑
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Bronze

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$7,000.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
MOOP ($)			$10,000.00			
MOOP if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Copay applies only after deductible?**	
Medical										
Emergency Room Services	☑ All	☑ All		$500.00	☐ All	☐ All			☐ All	☐ All
All Inpatient Hospital Services (inc. MH/SUD)	☑	☐		$500.00	☐	☐			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				$68.67						
Specialist Visit	☑	☐		$89.68	☐	☐			☑	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☐		$196.19	☐	☐			☑	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$61.05	☐	☐			☑	☐
Speech Therapy	☑	☐		$30.00	☐	☐			☑	☐
Occupational and Physical Therapy	☑	☐		$30.00	☐	☐			☑	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☐		$34.13	☐	☐			☑	☐
X-rays and Diagnostic Imaging	☑	☐		$28.76	☐	☐			☑	☐
Skilled Nursing Facility	☑	☐		$500.00	☐	☐			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$452.20	☐	☐			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$20.00	☐	☐			☐	☐
Preferred Brand Drugs	☐	☐		$75.00	☐	☐			☐	☐
Non-Preferred Brand Drugs	☐	☐		$205.69	☐	☐			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$1,000
Set a Maximum Number of Days for Charging an IP Copay?	☑
# Days (1-10):	2
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT123
HIOS Plan ID: 86545CT1230025-03
AVC Version: 2026_1d

Output

Status/Error Messages: Expanded Bronze Standard (56% to 65%), Calculation Successful.
Actuarial Value: 62.33%
Metal Tier: Bronze
NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).

Additional Notes:

Calculation Time: 0.0481 seconds

Revised Final 2026 AV Calculator

$3,235.10
$5,190.48

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
MOOP ($)			$8,000.00			
MOOP if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Copay applies only after deductible?**	
Medical										
Emergency Room Services	☑ All	☑ All			☐ All	☐ All			☐ All	☐ All
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				$19.62						
Specialist Visit				$79.72						
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑	90%		☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑	89%		☐	☐			☐	☐
Speech Therapy	☐	☐		$30.00	☐	☐			☐	☐
Occupational and Physical Therapy	☐	☐		$30.00	☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑	51%		☐	☐			☐	☐
X-rays and Diagnostic Imaging	☑	☑	78%		☐	☐			☐	☐
Skilled Nursing Facility	☑	☑			☐	☐			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$5.00	☐	☐			☐	☐
Preferred Brand Drugs	☐	☐		$40.00	☐	☐			☐	☐
Non-Preferred Brand Drugs	☐	☐		$127.67	☐	☐			☐	☐
Specialty Drugs (i.e. high-cost)	☐	☐		$623.22	☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT123
HIOS Plan ID: 86545CT1230027-03
AVC Version: 2026_1d

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	79.05%
Metal Tier:	Gold
Additional Notes:	
Calculation Time:	0.04 seconds

Revised Final 2026 AV Calculator

$7,141.36
$9,034.31

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☑
Apply Skilled Nursing Facility Copay per Day?	☑
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$5,000.00	$250.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	80.00%				
MOOP ($)	$7,675.00					
MOOP if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
Medical										
Emergency Room Services	☑ All	☑ All		$450.00	☐ All	☐ All			☑ All	☐ All
All Inpatient Hospital Services (inc. MH/SUD)	☑	☐		$500.00	☐	☐			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				$44.15						
Specialist Visit				$59.79						
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$162.85	☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☐	☐		$75.00	☐	☐			☐	☐
Speech Therapy	☐	☐		$30.00	☐	☐			☐	☐
Occupational and Physical Therapy	☐	☐		$30.00	☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☐	☐		$25.00	☐	☐			☐	☐
X-rays and Diagnostic Imaging	☑	☐		$40.00	☐	☐			☑	☐
Skilled Nursing Facility	☑	☐		$500.00	☐	☐			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$452.20	☐	☐			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$10.00	☐	☐			☐	☐
Preferred Brand Drugs	☑	☐		$50.00	☐	☐			☑	☐
Non-Preferred Brand Drugs	☑	☐		$75.00	☐	☐			☑	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$100
Set a Maximum Number of Days for Charging an IP Copay?	☑
# Days (1-10):	4
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT133
HIOS Plan ID: 86545CT1330001-04
AVC Version: 2026_1d

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.70%
Metal Tier:	Silver
	NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).
Additional Notes:	
Calculation Time:	0.1111 seconds

Revised Final 2026 AV Calculator

$5,443.45
$7,386.31

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☑
Apply Skilled Nursing Facility Copay per Day?	☑
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$5,000.00	$250.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	80.00%				
MOOP ($)	$9,400.00					
MOOP if Separate ($)						

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Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical										
Emergency Room Services	☑ All	☑ All		$450.00	☑ All	☑ All			☑ All	☐ All
All Inpatient Hospital Services (inc. MH/SUD)	☑	☐		$500.00	☐	☐			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				$44.15						
Specialist Visit				$59.79						
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$162.85	☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☐	☐		$75.00	☐	☐			☐	☐
Speech Therapy	☐	☐		$30.00	☐	☐			☐	☐
Occupational and Physical Therapy	☐	☐		$30.00	☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☐	☐		$25.00	☐	☐			☐	☐
X-rays and Diagnostic Imaging	☑	☐		$40.00	☐	☐			☑	☐
Skilled Nursing Facility	☑	☐		$500.00	☐	☐			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$452.20	☐	☐			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$10.00	☐	☐			☐	☐
Preferred Brand Drugs	☑	☐		$50.00	☐	☐			☑	☐
Non-Preferred Brand Drugs	☑	☐		$75.00	☐	☐			☑	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$200
Set a Maximum Number of Days for Charging an IP Copay?	☑
# Days (1-10):	4
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT133
HIOS Plan ID: 86545CT1330001-03
AVC Version: 2026_1d

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.21%
Metal Tier:	Silver
	NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).
Additional Notes:	
Calculation Time:	0.101 seconds

Revised Final 2026 AV Calculator

$5,260.12
$7,386.31

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☑
Apply Skilled Nursing Facility Copay per Day?	☑
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$1,200.00	$50.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	80.00%				
MOOP ($)	$7,375.00					
MOOP if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical										
Emergency Room Services	☐ All	☑ All		$400.00	☑ All	☑ All			☐ All	☐ All
All Inpatient Hospital Services (inc. MH/SUD)	☑	☐		$500.00	☐	☐			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				$19.62						
Specialist Visit				$39.86						
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$144.32	☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☐	☐		$65.00	☐	☐			☐	☐
Speech Therapy	☐	☐		$20.00	☐	☐			☐	☐
Occupational and Physical Therapy	☐	☐		$20.00	☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☐	☐		$10.00	☐	☐			☐	☐
X-rays and Diagnostic Imaging	☑	☐		$40.00	☐	☐			☑	☐
Skilled Nursing Facility	☑	☐		$500.00	☐	☐			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$452.20	☐	☐			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$5.00	☐	☐			☐	☐
Preferred Brand Drugs	☐	☐		$35.00	☐	☐			☐	☐
Non-Preferred Brand Drugs	☐	☐		$60.00	☐	☐			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$100
Set a Maximum Number of Days for Charging an IP Copay?	☑
# Days (1-10):	2
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT133
HIOS Plan ID: 86545CT1330003-03
AVC Version: 2026_1d

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	81.20%
Metal Tier:	Gold
	NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).
Additional Notes:	
Calculation Time:	0.041 seconds

Revised Final 2026 AV Calculator

$7,335.71
$9,034.31

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☑
Apply Skilled Nursing Facility Copay per Day?	☑
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$415.00	$50.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	80.00%				
MOOP ($)	$2,950.00					
MOOP if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical										
Emergency Room Services	☑ All	☐ All		$150.00	☐ All	☐ All			☑ All	☐ All
All Inpatient Hospital Services (inc. MH/SUD)	☑	☐		$100.00	☐	☐			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				$34.34						
Specialist Visit				$49.82						
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$51.84	☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☐	☐		$60.00	☐	☐			☐	☐
Speech Therapy	☐	☐		$20.00	☐	☐			☐	☐
Occupational and Physical Therapy	☐	☐		$20.00	☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☐	☐		$13.48	☐	☐			☐	☐
X-rays and Diagnostic Imaging	☑	☐		$30.00	☐	☐			☑	☐
Skilled Nursing Facility	☑	☐		$100.00	☐	☐			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$90.44	☐	☐			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$10.00	☐	☐			☐	☐
Preferred Brand Drugs	☐	☐		$25.00	☐	☐			☐	☐
Non-Preferred Brand Drugs	☑	☐		$40.00	☐	☐			☑	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$60
Set a Maximum Number of Days for Charging an IP Copay?	☑
# Days (1-10):	4
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT133
HIOS Plan ID: 86545CT1330001-05
AVC Version: 2026_1d

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	87.81%
Metal Tier:	Gold
	NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).
Additional Notes:	
Calculation Time:	0.0569 seconds

Revised Final 2026 AV Calculator

$7,933.22
$9,034.31

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☑
Apply Skilled Nursing Facility Copay per Day?	☑
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Bronze

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$7,000.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
MOOP ($)			$10,000.00			
MOOP if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Copay applies only after deductible?**	
Medical										
Emergency Room Services	☑ All	☑ All		$450.00	☑ All	☑ All			☑ All	☐ All
All Inpatient Hospital Services (inc. MH/SUD)	☑	☐		$500.00	☐	☐			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				$49.05						
Specialist Visit	☑	☐		$69.75	☐	☐			☑	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$166.55	☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$75.00	☐	☐			☑	☐
Speech Therapy	☑	☐		$30.00	☐	☐			☑	☐
Occupational and Physical Therapy	☑	☐		$30.00	☐	☐			☑	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☐	☐		$20.00	☐	☐			☐	☐
X-rays and Diagnostic Imaging	☑	☐		$40.00	☐	☐			☑	☐
Skilled Nursing Facility	☑	☐		$500.00	☐	☐			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$452.20	☐	☐			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$15.00	☐	☐			☐	☐
Preferred Brand Drugs	☐	☐		$50.00	☐	☐			☐	☐
Non-Preferred Brand Drugs	☑	☑	50%		☐	☐			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$500
Set a Maximum Number of Days for Charging an IP Copay?	☑
# Days (1-10):	2
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT133
HIOS Plan ID: 86545CT1330002-03
AVC Version: 2026_1d

Output

Status/Error Messages:	Expanded Bronze Standard (56% to 65%), Calculation Successful.
Actuarial Value:	63.77%
Metal Tier:	Bronze
	NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).
Additional Notes:	
Calculation Time:	0.0349 seconds

Revised Final 2026 AV Calculator

$3,309.94
$5,190.48

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
MOOP ($)			$9,000.00			
MOOP if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical										
Emergency Room Services	☑ All	☑ All			☐ All	☐ All			☐ All	☐ All
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)			90%							
Specialist Visit	☑	☑	90%						☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑	90%		☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑	90%		☐	☐			☐	☐
Speech Therapy	☑	☑	90%		☐	☐			☐	☐
Occupational and Physical Therapy	☑	☑	90%		☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑	90%		☐	☐			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☐	☐			☐	☐
Skilled Nursing Facility	☑	☑			☐	☐			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$3.42	☐	☐			☐	☐
Preferred Brand Drugs	☐	☐		$141.46	☐	☐			☐	☐
Non-Preferred Brand Drugs	☐	☐		$133.19	☐	☐			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$1,000
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT157
HIOS Plan ID: 86545CT1570002-03
AVC Version: 2026_1d

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	79.62%
Metal Tier:	Gold
	NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.
Additional Notes:	
Calculation Time:	0.036 seconds

Revised Final 2026 AV Calculator

$7,193.49
$9,034.31

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
MOOP ($)			$8,000.00			
MOOP if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Copay applies only after deductible?**	
Medical										
Emergency Room Services	☑ All	☑ All			☐ All	☐ All			☐ All	☐ All
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				$19.62						
Specialist Visit				$79.72						
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑	90%		☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑	89%		☐	☐			☐	☐
Speech Therapy	☐	☐		$30.00	☐	☐			☐	☐
Occupational and Physical Therapy	☐	☐		$30.00	☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑	51%		☐	☐			☐	☐
X-rays and Diagnostic Imaging	☑	☑	78%		☐	☐			☐	☐
Skilled Nursing Facility	☑	☑			☐	☐			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$5.00	☐	☐			☐	☐
Preferred Brand Drugs	☐	☐		$40.00	☐	☐			☐	☐
Non-Preferred Brand Drugs	☐	☐		$127.67	☐	☐			☐	☐
Specialty Drugs (i.e. high-cost)	☐	☐		$623.22	☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT133
HIOS Plan ID: 86545CT1330020-01
AVC Version: 2026_1d

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	79.05%
Metal Tier:	Gold
Additional Notes:	
Calculation Time:	0.042 seconds

Revised Final 2026 AV Calculator

$7,141.36
$9,034.31

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Bronze

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,000.00			
Coinsurance (%, Insurer's Cost Share)			75.00%			
MOOP ($)			$8,000.00			
MOOP if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical										
Emergency Room Services	☑ All	☑ All			☐ All	☐ All			☐ All	☐ All
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$68.67	☐	☐			☑	☐
Specialist Visit	☑	☐		$99.65	☐	☐			☑	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑	75%		☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑	75%		☐	☐			☐	☐
Speech Therapy	☑	☑	75%		☐	☐			☐	☐
Occupational and Physical Therapy	☑	☑	75%		☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑	75%		☐	☐			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☐	☐			☐	☐
Skilled Nursing Facility	☑	☑			☐	☐			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☐		$30.00	☐	☐			☑	☐
Preferred Brand Drugs	☑	☑			☐	☐			☐	☐
Non-Preferred Brand Drugs	☑	☑	70%		☐	☐			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	60%		☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$500
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT157
HIOS Plan ID: 86545CT1570001-01
AVC Version: 2026_1d

Output

Status/Error Messages: Expanded Bronze Standard (56% to 65%), Calculation Successful.
Actuarial Value: 64.01%
Metal Tier: Bronze
NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.

Additional Notes:

Calculation Time: 0.033 seconds

Revised Final 2026 AV Calculator

$3,322.27
$5,190.48

Pursuant to section 156.135 (b) (2) or 156.135 (b) (3), alternative methods were used to calculate AV for this HIOS Plan ID. Reference the Unique Plan Design Supporting Documentation and Justification forms for additional details on the methods used for this HIOS Plan ID.
Adjusted Actuarial Value: 64.99%

$3,373.45

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☑
Apply Skilled Nursing Facility Copay per Day?	☑
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Bronze

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$7,000.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
MOOP ($)			$10,000.00			
MOOP if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Copay applies only after deductible?**	
Medical										
Emergency Room Services	☑ All	☑ All		$500.00	☐ All	☐ All			☐ All	☐ All
All Inpatient Hospital Services (inc. MH/SUD)	☑	☐		$500.00	☐	☐			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				$68.67						
Specialist Visit	☑	☐		$89.68	☐	☐			☑	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☐		$196.19	☐	☐			☑	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$61.05	☐	☐			☑	☐
Speech Therapy	☑	☐		$30.00	☐	☐			☑	☐
Occupational and Physical Therapy	☑	☐		$30.00	☐	☐			☑	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☐		$34.13	☐	☐			☑	☐
X-rays and Diagnostic Imaging	☑	☐		$28.76	☐	☐			☑	☐
Skilled Nursing Facility	☑	☐		$500.00	☐	☐			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$452.20	☐	☐			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$20.00	☐	☐			☐	☐
Preferred Brand Drugs	☐	☐		$75.00	☐	☐			☐	☐
Non-Preferred Brand Drugs	☐	☐		$205.69	☐	☐			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$1,000
Set a Maximum Number of Days for Charging an IP Copay?	☑
# Days (1-10):	2
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT123
HIOS Plan ID: 86545CT1230025-01
AVC Version: 2026_1d

Output

Status/Error Messages: Expanded Bronze Standard (56% to 65%), Calculation Successful.
Actuarial Value: 62.33%
Metal Tier: Bronze
NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).

Additional Notes:

Calculation Time: 0.0389 seconds

Revised Final 2026 AV Calculator

$3,235.10
$5,190.48

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
MOOP ($)			$8,000.00			
MOOP if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Copay applies only after deductible?**	
Medical										
Emergency Room Services	☑ All	☑ All			☐ All	☐ All			☐ All	☐ All
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				$19.62						
Specialist Visit				$79.72						
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑	90%		☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑	89%		☐	☐			☐	☐
Speech Therapy	☐	☐		$30.00	☐	☐			☐	☐
Occupational and Physical Therapy	☐	☐		$30.00	☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑	51%		☐	☐			☐	☐
X-rays and Diagnostic Imaging	☑	☑	78%		☐	☐			☐	☐
Skilled Nursing Facility	☑	☑			☐	☐			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$5.00	☐	☐			☐	☐
Preferred Brand Drugs	☐	☐		$40.00	☐	☐			☐	☐
Non-Preferred Brand Drugs	☐	☐		$127.67	☐	☐			☐	☐
Specialty Drugs (i.e. high-cost)	☐	☐		$623.22	☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT123
HIOS Plan ID: 86545CT1230027-01
AVC Version: 2026_1d

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	79.05%
Metal Tier:	Gold
Additional Notes:	
Calculation Time:	0.093 seconds

Revised Final 2026 AV Calculator

$7,141.36
$9,034.31

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☑
Apply Skilled Nursing Facility Copay per Day?	☑
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$5,000.00	$250.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	80.00%				
MOOP ($)	$9,400.00					
MOOP if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical										
Emergency Room Services	☑ All	☑ All		$450.00	☑ All	☑ All			☑ All	☐ All
All Inpatient Hospital Services (inc. MH/SUD)	☑	☐		$500.00	☐	☐			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				$44.15						
Specialist Visit				$59.79						
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$162.85	☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☐	☐		$75.00	☐	☐			☐	☐
Speech Therapy	☐	☐		$30.00	☐	☐			☐	☐
Occupational and Physical Therapy	☐	☐		$30.00	☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☐	☐		$25.00	☐	☐			☐	☐
X-rays and Diagnostic Imaging	☑	☐		$40.00	☐	☐			☑	☐
Skilled Nursing Facility	☑	☐		$500.00	☐	☐			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$452.20	☐	☐			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$10.00	☐	☐			☐	☐
Preferred Brand Drugs	☑	☐		$50.00	☐	☐			☑	☐
Non-Preferred Brand Drugs	☑	☐		$75.00	☐	☐			☑	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$200
Set a Maximum Number of Days for Charging an IP Copay?	☑
# Days (1-10):	4
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT133
HIOS Plan ID: 86545CT1330001-01
AVC Version: 2026_1d

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.21%
Metal Tier:	Silver
	NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).
Additional Notes:	
Calculation Time:	0.046 seconds

Revised Final 2026 AV Calculator

$5,260.12
$7,386.31

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☑
Apply Skilled Nursing Facility Copay per Day?	☑
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$1,200.00	$50.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	80.00%				
MOOP ($)	$7,375.00					
MOOP if Separate ($)						

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Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical										
Emergency Room Services	☐ All	☑ All		$400.00	☑ All	☑ All			☐ All	☐ All
All Inpatient Hospital Services (inc. MH/SUD)	☑	☐		$500.00	☐	☐			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				$19.62						
Specialist Visit				$39.86						
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$144.32	☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☐	☐		$65.00	☐	☐			☐	☐
Speech Therapy	☐	☐		$20.00	☐	☐			☐	☐
Occupational and Physical Therapy	☐	☐		$20.00	☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☐	☐		$10.00	☐	☐			☐	☐
X-rays and Diagnostic Imaging	☑	☐		$40.00	☐	☐			☑	☐
Skilled Nursing Facility	☑	☐		$500.00	☐	☐			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$452.20	☐	☐			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$5.00	☐	☐			☐	☐
Preferred Brand Drugs	☐	☐		$35.00	☐	☐			☐	☐
Non-Preferred Brand Drugs	☐	☐		$60.00	☐	☐			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$100
Set a Maximum Number of Days for Charging an IP Copay?	☑
# Days (1-10):	2
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT133
HIOS Plan ID: 86545CT1330003-01
AVC Version: 2026_1d

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	81.20%
Metal Tier:	Gold
	NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).
Additional Notes:	
Calculation Time:	0.106 seconds

Revised Final 2026 AV Calculator

$7,335.71
$9,034.31

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Bronze

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,500.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
MOOP ($)			$7,225.00			
MOOP if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Copay applies only after deductible?**	
Medical										
Emergency Room Services	☑ All	☑ All			☐ All	☐ All			☐ All	☐ All
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)			80%							
Specialist Visit	☑	☑	80%						☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑	80%		☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑	80%		☐	☐			☐	☐
Speech Therapy	☑	☑	80%		☐	☐			☐	☐
Occupational and Physical Therapy	☑	☑	80%		☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑	80%		☐	☐			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☐	☐			☐	☐
Skilled Nursing Facility	☑	☑			☐	☐			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☑			☐	☐			☐	☐
Preferred Brand Drugs	☑	☑	75%		☐	☐			☐	☐
Non-Preferred Brand Drugs	☑	☑	70%		☐	☐			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$500
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT133
HIOS Plan ID: 86545CT1330009-01
AVC Version: 2026_1d

Output

Status/Error Messages:	Expanded Bronze Standard (56% to 65%), Calculation Successful.
Actuarial Value:	64.97%
Metal Tier:	Bronze
	NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.
Additional Notes:	
Calculation Time:	0.037 seconds

Revised Final 2026 AV Calculator

$3,372.18
$5,190.48

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☑
Apply Skilled Nursing Facility Copay per Day?	☑
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Bronze

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$7,000.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
MOOP ($)			$10,000.00			
MOOP if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
Medical										
Emergency Room Services	☑ All	☐ All		$450.00	☐ All	☐ All			☑ All	☐ All
All Inpatient Hospital Services (inc. MH/SUD)	☑	☐		$500.00	☐	☐			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				$49.05						
Specialist Visit	☑	☐		$69.75					☑	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$166.55	☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$75.00	☐	☐			☑	☐
Speech Therapy	☑	☐		$30.00	☐	☐			☑	☐
Occupational and Physical Therapy	☑	☐		$30.00	☐	☐			☑	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☐	☐		$20.00	☐	☐			☐	☐
X-rays and Diagnostic Imaging	☑	☐		$40.00	☐	☐			☑	☐
Skilled Nursing Facility	☑	☐		$500.00	☐	☐			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$452.20	☐	☐			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$15.00	☐	☐			☐	☐
Preferred Brand Drugs	☐	☐		$50.00	☐	☐			☐	☐
Non-Preferred Brand Drugs	☑	☑	50%		☐	☐			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$500
Set a Maximum Number of Days for Charging an IP Copay?	☑
# Days (1-10):	2
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT133
HIOS Plan ID: 86545CT1330002-01
AVC Version: 2026_1d

Output

Status/Error Messages: Expanded Bronze Standard (56% to 65%), Calculation Successful.
Actuarial Value: 63.77%
Metal Tier: Bronze
NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).

Additional Notes:

Calculation Time: 0.047 seconds

Revised Final 2026 AV Calculator

$3,309.94
$5,190.48

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$10,600.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
MOOP ($)			$10,600.00			
MOOP if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical										
Emergency Room Services	☑ All	☑ All			☐ All	☐ All			☐ All	☐ All
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				$39.24						
Specialist Visit	☑	☑			☐	☐			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑	100%		☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑	100%		☐	☐			☐	☐
Speech Therapy	☑	☑	100%		☐	☐			☐	☐
Occupational and Physical Therapy	☑	☑	100%		☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑	100%		☐	☐			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☐	☐			☐	☐
Skilled Nursing Facility	☑	☑			☐	☐			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☑			☐	☐			☐	☐
Preferred Brand Drugs	☑	☑			☐	☐			☐	☐
Non-Preferred Brand Drugs	☑	☑			☐	☐			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	3

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT123
HIOS Plan ID: 86545CT1230005-01
AVC Version: 2026_1d

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.80%
Metal Tier:	Bronze
	NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.
Additional Notes:	
Calculation Time:	0.198 seconds

Revised Final 2026 AV Calculator

$3,104.05
$5,190.48

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
MOOP ($)			$9,000.00			
MOOP if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical										
Emergency Room Services	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	90%		☐	☐			☐	☐
Specialist Visit	☑	☑	90%		☐	☐			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑	90%		☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑	90%		☐	☐			☐	☐
Speech Therapy	☑	☑	90%		☐	☐			☐	☐
Occupational and Physical Therapy	☑	☑	90%		☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑	90%		☐	☐			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☐	☐			☐	☐
Skilled Nursing Facility	☑	☑			☐	☐			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$3.42	☐	☐			☐	☐
Preferred Brand Drugs	☐	☐		$141.46	☐	☐			☐	☐
Non-Preferred Brand Drugs	☐	☐		$133.19	☐	☐			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$1,000
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT157
HIOS Plan ID: 86545CT1570002-01
AVC Version: 2026_1d

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	79.62%
Metal Tier:	Gold
	NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.
Additional Notes:	
Calculation Time:	0.037 seconds

Revised Final 2026 AV Calculator

$7,193.49
$9,034.31

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☑
Apply Skilled Nursing Facility Copay per Day?	☑
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Bronze

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$7,000.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
MOOP ($)			$10,000.00			
MOOP if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
Medical										
Emergency Room Services	☑ All	☑ All		$500.00	☐ All	☐ All			☐ All	☐ All
All Inpatient Hospital Services (inc. MH/SUD)	☑	☐		$500.00	☐	☐			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				$68.67						
Specialist Visit	☑	☐		$89.68	☐	☐			☑	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☐		$196.19	☐	☐			☑	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$61.05	☐	☐			☑	☐
Speech Therapy	☑	☐		$30.00	☐	☐			☑	☐
Occupational and Physical Therapy	☑	☐		$30.00	☐	☐			☑	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☐		$34.13	☐	☐			☑	☐
X-rays and Diagnostic Imaging	☑	☐		$28.76	☐	☐			☑	☐
Skilled Nursing Facility	☑	☐		$500.00	☐	☐			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$452.20	☐	☐			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$20.00	☐	☐			☐	☐
Preferred Brand Drugs	☐	☐		$75.00	☐	☐			☐	☐
Non-Preferred Brand Drugs	☐	☐		$205.69	☐	☐			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$1,000
Set a Maximum Number of Days for Charging an IP Copay?	☑
# Days (1-10):	2
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT158
HIOS Plan ID: 86545CT1580001-01
AVC Version: 2026_1d

Output

Status/Error Messages: Expanded Bronze Standard (56% to 65%), Calculation Successful.
Actuarial Value: 62.33%
Metal Tier: Bronze
NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).

Additional Notes:

Calculation Time: 0.0439 seconds

Revised Final 2026 AV Calculator

$3,235.10
$5,190.48

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☑
Apply Skilled Nursing Facility Copay per Day?	☑
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Bronze

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$7,000.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
MOOP ($)			$10,000.00			
MOOP if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
Medical										
Emergency Room Services	☑ All	☑ All		$500.00	☐ All	☐ All			☐ All	☐ All
All Inpatient Hospital Services (inc. MH/SUD)	☑	☐		$500.00	☐	☐			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				$68.67						
Specialist Visit	☑	☐		$89.68	☐	☐			☑	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☐		$196.19	☐	☐			☑	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$61.05	☐	☐			☑	☐
Speech Therapy	☑	☐		$30.00	☐	☐			☑	☐
Occupational and Physical Therapy	☑	☐		$30.00	☐	☐			☑	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☐		$34.13	☐	☐			☑	☐
X-rays and Diagnostic Imaging	☑	☐		$28.76	☐	☐			☑	☐
Skilled Nursing Facility	☑	☐		$500.00	☐	☐			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$452.20	☐	☐			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$20.00	☐	☐			☐	☐
Preferred Brand Drugs	☐	☐		$75.00	☐	☐			☐	☐
Non-Preferred Brand Drugs	☐	☐		$205.69	☐	☐			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$1,000
Set a Maximum Number of Days for Charging an IP Copay?	☑
# Days (1-10):	2
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT158
HIOS Plan ID: 86545CT1580001-03
AVC Version: 2026_1d

Output

Status/Error Messages: Expanded Bronze Standard (56% to 65%), Calculation Successful.
Actuarial Value: 62.33%
Metal Tier: Bronze
NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).

Additional Notes:

Calculation Time: 0.0459 seconds

Revised Final 2026 AV Calculator

$3,235.10
$5,190.48

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
MOOP ($)			$9,000.00			
MOOP if Separate ($)						

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Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical										
Emergency Room Services	☑ All	☑ All			☐ All	☐ All			☐ All	☐ All
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				$19.62						
Specialist Visit	☑	☑	90%		☐	☐			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑	90%		☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑	91%		☐	☐			☐	☐
Speech Therapy	☑	☑	90%		☐	☐			☐	☐
Occupational and Physical Therapy	☑	☑	90%		☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑	90%		☐	☐			☐	☐
X-rays and Diagnostic Imaging	☑	☑	89%		☐	☐			☐	☐
Skilled Nursing Facility	☑	☑			☐	☐			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$10.00	☐	☐			☐	☐
Preferred Brand Drugs	☐	☐		$60.00	☐	☐			☐	☐
Non-Preferred Brand Drugs	☑	☑	63%		☐	☐			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT131
HIOS Plan ID: 86545CT1310060-00
AVC Version: 2026_1d

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	79.56%
Metal Tier:	Gold
Additional Notes:	
Calculation Time:	0.03 seconds

Revised Final 2026 AV Calculator

$7,187.96
$9,034.31

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$10,600.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
MOOP ($)			$10,600.00			
MOOP if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Copay applies only after deductible?**	
Medical										
Emergency Room Services	☑ All	☑ All			☐ All	☐ All			☐ All	☐ All
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				$39.24						
Specialist Visit	☑	☑			☐	☐			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑	100%		☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑	100%		☐	☐			☐	☐
Speech Therapy	☑	☑	100%		☐	☐			☐	☐
Occupational and Physical Therapy	☑	☑	100%		☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑	100%		☐	☐			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☐	☐			☐	☐
Skilled Nursing Facility	☑	☑			☐	☐			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☑			☐	☐			☐	☐
Preferred Brand Drugs	☑	☑			☐	☐			☐	☐
Non-Preferred Brand Drugs	☑	☑			☐	☐			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	3

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT131
HIOS Plan ID: 86545CT1310033-00
AVC Version: 2026_1d

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.80%
Metal Tier:	Bronze
	NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.
Additional Notes:	
Calculation Time:	0.3979 seconds

Revised Final 2026 AV Calculator

$3,104.05
$5,190.48

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Bronze

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,000.00			
Coinsurance (%, Insurer's Cost Share)			60.00%			
MOOP ($)			$8,000.00			
MOOP if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Copay applies only after deductible?**	
Medical										
Emergency Room Services	☑ All	☑ All			☐ All	☐ All			☐ All	☐ All
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)			61%							
Specialist Visit	☑	☑	60%						☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑	60%		☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑	64%		☐	☐			☐	☐
Speech Therapy	☑	☑	60%		☐	☐			☐	☐
Occupational and Physical Therapy	☑	☑	60%		☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑	60%		☐	☐			☐	☐
X-rays and Diagnostic Imaging	☑	☑	66%		☐	☐			☐	☐
Skilled Nursing Facility	☑	☑			☐	☐			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☑			☐	☐			☐	☐
Preferred Brand Drugs	☑	☑			☐	☐			☐	☐
Non-Preferred Brand Drugs	☑	☑			☐	☐			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT131
HIOS Plan ID: 86545CT1310019-00
AVC Version: 2026_1d

Output

Status/Error Messages:	Expanded Bronze Standard (56% to 65%), Calculation Successful.
Actuarial Value:	63.84%
Metal Tier:	Bronze
Additional Notes:	
Calculation Time:	0.1121 seconds

Revised Final 2026 AV Calculator

$3,313.35
$5,190.48

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$4,000.00			
Coinsurance (%, Insurer's Cost Share)			70.00%			
MOOP ($)			$10,000.00			
MOOP if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
Medical										
Emergency Room Services	☑ All	☑ All			☐ All	☐ All			☐ All	☐ All
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				$29.43						
Specialist Visit	☑			$69.75					☑	
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☐		$181.37	☐	☐			☑	☐
Imaging (CT/PET Scans, MRIs)	☑	☑	75%		☐	☐			☐	☐
Speech Therapy	☑	☐		$50.00	☐	☐			☑	☐
Occupational and Physical Therapy	☑	☐		$30.00	☐	☐			☑	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑	74%		☐	☐			☐	☐
X-rays and Diagnostic Imaging	☑	☑	76%		☐	☐			☐	☐
Skilled Nursing Facility	☑	☑			☐	☐			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$500.00	☐	☐			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☐		$22.40	☐	☐			☑	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$5.00	☐	☐			☐	☐
Preferred Brand Drugs	☑	☑	50%		☐	☐			☐	☐
Non-Preferred Brand Drugs	☑	☑	60%		☐	☐			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT131
HIOS Plan ID: 86545CT1310056-00
AVC Version: 2026_1d

Output

Status/Error Messages: Calculation Successful.
Actuarial Value: 67.80%
Metal Tier: Silver
NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).

Additional Notes:

Calculation Time: 0.0341 seconds

Revised Final 2026 AV Calculator

$5,008.27
$7,386.31

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Bronze

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$8,500.00			
Coinsurance (%, Insurer's Cost Share)			50.00%			
MOOP ($)			$10,000.00			
MOOP if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical										
Emergency Room Services	☑ All	☑ All			☐ All	☐ All			☐ All	☐ All
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				$39.24						
Specialist Visit	☑	☑	50%		☐	☐			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑	50%		☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑	60%		☐	☐			☐	☐
Speech Therapy	☑	☐		$50.00	☐	☐			☑	☐
Occupational and Physical Therapy	☑	☐		$30.00	☐	☐			☑	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑	50%		☐	☐			☐	☐
X-rays and Diagnostic Imaging	☑	☑	63%		☐	☐			☐	☐
Skilled Nursing Facility	☑	☑			☐	☐			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$15.00	☐	☐			☐	☐
Preferred Brand Drugs	☑	☐		$50.00	☐	☐			☑	☐
Non-Preferred Brand Drugs	☑	☑	60%		☐	☐			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$750
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT131
HIOS Plan ID: 86545CT1310055-00
AVC Version: 2026_1d

Output

Status/Error Messages:	Expanded Bronze Standard (56% to 65%), Calculation Successful.
Actuarial Value:	62.15%
Metal Tier:	Bronze
Additional Notes:	
Calculation Time:	0.0341 seconds

Revised Final 2026 AV Calculator

$3,225.98
$5,190.48

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Bronze

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$8,000.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
MOOP ($)			$8,000.00			
MOOP if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Copay applies only after deductible?**	
Medical										
Emergency Room Services	☑ All	☑ All			☐ All	☐ All			☐ All	☐ All
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)										
Specialist Visit	☑	☑			☐	☐			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑	100%		☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑	100%		☐	☐			☐	☐
Speech Therapy	☑	☑	100%		☐	☐			☐	☐
Occupational and Physical Therapy	☑	☑	100%		☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑	100%		☐	☐			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☐	☐			☐	☐
Skilled Nursing Facility	☑	☑			☐	☐			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☑			☐	☐			☐	☐
Preferred Brand Drugs	☑	☑			☐	☐			☐	☐
Non-Preferred Brand Drugs	☑	☑			☐	☐			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT134
HIOS Plan ID: 86545CT1340020-00
AVC Version: 2026_1d

Output

Status/Error Messages:	Expanded Bronze Standard (56% to 65%), Calculation Successful.
Actuarial Value:	63.11%
Metal Tier:	Bronze
Additional Notes:	
Calculation Time:	0.146 seconds

Revised Final 2026 AV Calculator

$3,275.46
$5,190.48

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$4,000.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
MOOP ($)			$8,000.00			
MOOP if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Copay applies only after deductible?**	
Medical										
Emergency Room Services	☑ All	☑ All			☐ All	☐ All			☐ All	☐ All
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				$49.05						
Specialist Visit	☑	☐		$99.65					☑	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑	80%		☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑	84%		☐	☐			☐	☐
Speech Therapy	☑	☑	80%		☐	☐			☐	☐
Occupational and Physical Therapy	☑	☑	80%		☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑	34%		☐	☐			☐	☐
X-rays and Diagnostic Imaging	☑	☑	76%		☐	☐			☐	☐
Skilled Nursing Facility	☑	☑			☐	☐			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☐		$5.00	☐	☐			☑	☐
Preferred Brand Drugs	☑	☐		$60.00	☐	☐			☑	☐
Non-Preferred Brand Drugs	☑	☑	75%		☐	☐			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$1,000
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT134
HIOS Plan ID: 86545CT1340021-00
AVC Version: 2026_1d

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	69.40%
Metal Tier:	Silver
Additional Notes:	
Calculation Time:	0.053 seconds

Revised Final 2026 AV Calculator

$5,126.03
$7,386.31

Federal Mental Health Parity Quantitative Testing Results

State	CT
HIOS Plan ID	**86545CT1310060-00**
Plan Effective Date	**1/1/2026**
Plan Name	Anthem Gold HMO Pathway Enhanced 2000/10%
Product Type	**HMO**
MHP Final Testing Results	**Pass**

MHP Parity Testing Classifications:

Inpatient In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	100.0%	$2,000	$2,000	$2,000
OOP Max	100.0%	$9,000	$9,000	$9,000
Copays	0.0%	No Copay	No Copay	No Copay
Coins	100.0%	10%	10%	10%

Inpatient Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Other In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	90.7%	$2,000	$2,000	$2,000
OOP Max	95.5%	$9,000	$9,000	$9,000
Copays	5.7%	No Copay	No Copay	No Copay
Coins	90.6%	10%	10%	10%

Outpatient Other Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Office In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	90.7%	$2,000	$2,000
OOP Max	95.5%	$9,000	$9,000
Copays	5.7%	No Copay	No Copay
Coins	90.6%	10%	10%

Outpatient Office Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A
Copays	N/A	N/A	N/A
Coins	N/A	N/A	N/A

Emergency Services	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	93.9%	$2,000	$2,000	$2,000
OOP Max	93.9%	$9,000	$9,000	$9,000
Copays	0.0%	No Copay	No Copay	No Copay
Coins	100.0%	10%	10%	10%

Medical/Surgical	INN = OON
Deductible	True
OOP Max	True
Copays	True
Coins	True

Federal Mental Health Parity Quantitative Testing Results

State	CT
HIOS Plan ID	**86545CT1330001-06**
Plan Effective Date	**1/1/2026**
Plan Name	Silver PPO Standard Pathway 94% CSR
Product Type	**PPO**
MHP Final Testing Results	**Pass**

MHP Parity Testing Classifications:

Inpatient In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	0.0%	No Deductible	No Deductible	No Deductible
OOP Max	100.0%	$1,350	$1,350	$1,350
Copays	79.5%	$75	$75	No Copay
Coins	0.0%	No Coins	No Coins	No Coins

Inpatient Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Other In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	0.0%	No Deductible	No Deductible	No Deductible
OOP Max	95.8%	$1,350	$1,350	$1,350
Copays	71.7%	$75	$75	$15
Coins	1.4%	No Coins	No Coins	No Coins

Outpatient Other Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Office In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	0.0%	No Deductible	No Deductible
OOP Max	95.8%	$1,350	$1,350
Copays	71.7%	$75	$15
Coins	1.4%	No Coins	No Coins

Outpatient Office Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A
Copays	N/A	N/A	N/A
Coins	N/A	N/A	N/A

Emergency Services	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	0.0%	No Deductible	No Deductible	No Deductible
OOP Max	94.0%	$1,350	$1,350	$1,350
Copays	86.8%	$50	$50	No Copay
Coins	0.0%	No Coins	No Coins	No Coins

Medical/Surgical	INN = OON
Deductible	True
OOP Max	True
Copays	True
Coins	True

Federal Mental Health Parity Quantitative Testing Results

State	CT
HIOS Plan ID	**86545CT1330009-03**
Plan Effective Date	**1/1/2026**
Plan Name	Bronze PPO Standard Pathway LCSR
Product Type	**PPO**
MHP Final Testing Results	**Pass**

MHP Parity Testing Classifications:

Inpatient In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	100.0%	$6,500	$6,500	$6,500
OOP Max	100.0%	$7,225	$7,225	$7,225
Copays	0.0%	No Copay	No Copay	No Copay
Coins	100.0%	20%	20%	20%

Inpatient Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Other In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	95.3%	$6,500	$6,500	$6,500
OOP Max	95.3%	$7,225	$7,225	$7,225
Copays	0.0%	No Copay	No Copay	No Copay
Coins	95.2%	20%	20%	20%

Outpatient Other Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Office In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	95.3%	$6,500	$6,500
OOP Max	95.3%	$7,225	$7,225
Copays	0.0%	No Copay	No Copay
Coins	95.2%	20%	20%

Outpatient Office Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A
Copays	N/A	N/A	N/A
Coins	N/A	N/A	N/A

Emergency Services	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	93.6%	$6,500	$6,500	$6,500
OOP Max	93.6%	$7,225	$7,225	$7,225
Copays	0.0%	No Copay	No Copay	No Copay
Coins	100.0%	20%	20%	20%

Medical/Surgical	INN = OON
Deductible	True
OOP Max	True
Copays	True
Coins	True

Federal Mental Health Parity Quantitative Testing Results

State	CT
HIOS Plan ID	**86545CT1310033-00**
Plan Effective Date	**1/1/2026**
Plan Name	Anthem Catastrophic HMO Pathway Enhanced
Product Type	**HMO**
MHP Final Testing Results	**Pass**

MHP Parity Testing Classifications:

Inpatient In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	100.0%	$10,600	$10,600	$10,600
OOP Max	100.0%	$10,600	$10,600	$10,600
Copays	0.0%	No Copay	No Copay	No Copay
Coins	0.0%	No Coins	No Coins	No Coins

Inpatient Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Other In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	97.4%	$10,600	$10,600	$10,600
OOP Max	97.4%	$10,600	$10,600	$10,600
Copays	1.1%	No Copay	No Copay	No Copay
Coins	0.0%	No Coins	No Coins	No Coins

Outpatient Other Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Office In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	85.1%	$10,600	$10,600
OOP Max	85.1%	$10,600	$10,600
Copays	25.3%	No Copay	No Copay
Coins	0.0%	No Coins	No Coins

Outpatient Office Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A
Copays	N/A	N/A	N/A
Coins	N/A	N/A	N/A

Emergency Services	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	93.6%	$10,600	$10,600	$10,600
OOP Max	93.6%	$10,600	$10,600	$10,600
Copays	0.0%	No Copay	No Copay	No Copay
Coins	0.0%	No Coins	No Coins	No Coins

Medical/Surgical	INN = OON
Deductible	True
OOP Max	True
Copays	True
Coins	True

Federal Mental Health Parity Quantitative Testing Results

State	CT
HIOS Plan ID	**86545CT1330020-03**
Plan Effective Date	**1/1/2026**
Plan Name	Gold PPO Pathway LCSR with Adult Dental and Vision Benefits
Product Type	**PPO**
MHP Final Testing Results	**Pass**

MHP Parity Testing Classifications:

Inpatient In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	100.0%	$2,000	$2,000	$2,000
OOP Max	100.0%	$8,000	$8,000	$8,000
Copays	0.0%	No Copay	No Copay	No Copay
Coins	100.0%	10%	10%	10%

Inpatient Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Other In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	71.7%	$2,000	$2,000	$2,000
OOP Max	95.5%	$8,000	$8,000	$8,000
Copays	22.9%	No Copay	No Copay	No Copay
Coins	72.8%	10%	10%	10%

Outpatient Other Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Office In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	71.7%	$2,000	$2,000
OOP Max	95.5%	$8,000	$8,000
Copays	22.9%	No Copay	No Copay
Coins	72.8%	10%	10%

Outpatient Office Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A
Copays	N/A	N/A	N/A
Coins	N/A	N/A	N/A

Emergency Services	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	93.8%	$2,000	$2,000	$2,000
OOP Max	93.8%	$8,000	$8,000	$8,000
Copays	0.0%	No Copay	No Copay	No Copay
Coins	100.0%	10%	10%	10%

Medical/Surgical	INN = OON
Deductible	True
OOP Max	True
Copays	True
Coins	True

Federal Mental Health Parity Quantitative Testing Results

State	CT
HIOS Plan ID	**86545CT1570001-03**
Plan Effective Date	**1/1/2026**
Plan Name	Bronze PPO Pathway with PreventiveRx LCSR
Product Type	**PPO**
MHP Final Testing Results	**Pass**

MHP Parity Testing Classifications:

Inpatient In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	100.0%	$6,000	$6,000	$6,000
OOP Max	100.0%	$8,000	$8,000	$8,000
Copays	0.0%	No Copay	No Copay	No Copay
Coins	100.0%	25%	25%	25%

Inpatient Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Other In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	95.2%	$6,000	$6,000	$6,000
OOP Max	95.2%	$8,000	$8,000	$8,000
Copays	13.5%	No Copay	No Copay	No Copay
Coins	81.6%	25%	25%	25%

Outpatient Other Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Office In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	95.2%	$6,000	$6,000
OOP Max	95.2%	$8,000	$8,000
Copays	13.5%	No Copay	No Copay
Coins	81.6%	25%	25%

Outpatient Office Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A
Copays	N/A	N/A	N/A
Coins	N/A	N/A	N/A

Emergency Services	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	93.6%	$6,000	$6,000	$6,000
OOP Max	93.6%	$8,000	$8,000	$8,000
Copays	0.0%	No Copay	No Copay	No Copay
Coins	100.0%	25%	25%	25%

Medical/Surgical	INN = OON
Deductible	True
OOP Max	True
Copays	True
Coins	True

Federal Mental Health Parity Quantitative Testing Results

State	CT
HIOS Plan ID	**86545CT1310019-00**
Plan Effective Date	**1/1/2026**
Plan Name	Anthem Bronze HMO Pathway Enhanced 6000/12000/40% HSA
Product Type	**HMO**
MHP Final Testing Results	**Pass**

MHP Parity Testing Classifications:

Inpatient In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	100.0%	$6,000	$6,000	$6,000
OOP Max	100.0%	$8,000	$8,000	$8,000
Copays	0.0%	No Copay	No Copay	No Copay
Coins	100.0%	40%	40%	40%

Inpatient Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Other In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	95.2%	$6,000	$6,000	$6,000
OOP Max	95.3%	$8,000	$8,000	$8,000
Copays	0.0%	No Copay	No Copay	No Copay
Coins	95.2%	40%	40%	40%

Outpatient Other Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Office In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	95.2%	$6,000	$6,000
OOP Max	95.3%	$8,000	$8,000
Copays	0.0%	No Copay	No Copay
Coins	95.2%	40%	40%

Outpatient Office Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A
Copays	N/A	N/A	N/A
Coins	N/A	N/A	N/A

Emergency Services	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	93.7%	$6,000	$6,000	$6,000
OOP Max	93.7%	$8,000	$8,000	$8,000
Copays	0.0%	No Copay	No Copay	No Copay
Coins	100.0%	40%	40%	40%

Medical/Surgical	INN = OON
Deductible	True
OOP Max	True
Copays	True
Coins	True

Federal Mental Health Parity Quantitative Testing Results

State	CT
HIOS Plan ID	**86545CT1230025-03**
Plan Effective Date	**1/1/2026**
Plan Name	Bronze HMO Pathway Enhanced LCSR with Adult Dental and Vision Benefits
Product Type	**HMO**
MHP Final Testing Results	**Pass**

MHP Parity Testing Classifications:

Inpatient In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	100.0%	$7,000	$7,000	$7,000
OOP Max	100.0%	$10,000	$10,000	$10,000
Copays	78.6%	$500	$500	No Copay
Coins	0.0%	No Coins	No Coins	No Coins

Inpatient Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Other In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	88.9%	$7,000	$7,000	$7,000
OOP Max	95.2%	$10,000	$10,000	$10,000
Copays	74.7%	$500	$500	No Copay
Coins	1.6%	No Coins	No Coins	No Coins

Outpatient Other Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Office In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	88.9%	$7,000	$7,000
OOP Max	95.2%	$10,000	$10,000
Copays	74.7%	$500	$90
Coins	1.6%	No Coins	No Coins

Outpatient Office Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A
Copays	N/A	N/A	N/A
Coins	N/A	N/A	N/A

Emergency Services	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	93.7%	$7,000	$7,000	$7,000
OOP Max	93.7%	$10,000	$10,000	$10,000
Copays	87.6%	$500	$500	No Copay
Coins	6.3%	No Coins	No Coins	No Coins

Medical/Surgical	INN = OON
Deductible	True
OOP Max	True
Copays	True
Coins	True

Federal Mental Health Parity Quantitative Testing Results

State	CT
HIOS Plan ID	**86545CT1310056-00**
Plan Effective Date	**1/1/2026**
Plan Name	Anthem Silver HMO Pathway Enhanced 4000/30%
Product Type	**HMO**
MHP Final Testing Results	**Pass**

MHP Parity Testing Classifications:

Inpatient In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	100.0%	$4,000	$4,000	$4,000
OOP Max	100.0%	$10,000	$10,000	$10,000
Copays	0.0%	No Copay	No Copay	No Copay
Coins	100.0%	30%	30%	30%

Inpatient Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Other In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	90.0%	$4,000	$4,000	$4,000
OOP Max	95.3%	$10,000	$10,000	$10,000
Copays	71.4%	$500	$500	No Copay
Coins	9.4%	No Coins	No Coins	No Coins

Outpatient Other Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Office In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	90.0%	$4,000	$4,000
OOP Max	95.3%	$10,000	$10,000
Copays	71.4%	$500	$70
Coins	9.4%	No Coins	No Coins

Outpatient Office Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A
Copays	N/A	N/A	N/A
Coins	N/A	N/A	N/A

Emergency Services	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	93.8%	$4,000	$4,000	$4,000
OOP Max	93.8%	$10,000	$10,000	$10,000
Copays	0.0%	No Copay	No Copay	No Copay
Coins	100.0%	30%	30%	30%

Medical/Surgical	INN = OON
Deductible	True
OOP Max	True
Copays	True
Coins	True

Federal Mental Health Parity Quantitative Testing Results

State	CT
HIOS Plan ID	**86545CT1310055-00**
Plan Effective Date	**1/1/2026**
Plan Name	Anthem Bronze HMO Pathway Enhanced 8500/50%
Product Type	**HMO**
MHP Final Testing Results	**Pass**

MHP Parity Testing Classifications:

Inpatient In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	100.0%	$8,500	$8,500	$8,500
OOP Max	100.0%	$10,000	$10,000	$10,000
Copays	0.0%	No Copay	No Copay	No Copay
Coins	100.0%	50%	50%	50%

Inpatient Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Other In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	89.8%	$8,500	$8,500	$8,500
OOP Max	95.2%	$10,000	$10,000	$10,000
Copays	10.3%	No Copay	No Copay	No Copay
Coins	85.5%	50%	50%	No Coins

Outpatient Other Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Office In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	89.8%	$8,500	$8,500
OOP Max	95.2%	$10,000	$10,000
Copays	10.3%	No Copay	No Copay
Coins	85.5%	50%	50%

Outpatient Office Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A
Copays	N/A	N/A	N/A
Coins	N/A	N/A	N/A

Emergency Services	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	93.6%	$8,500	$8,500	$8,500
OOP Max	93.6%	$10,000	$10,000	$10,000
Copays	0.0%	No Copay	No Copay	No Copay
Coins	100.0%	50%	50%	50%

Medical/Surgical	INN = OON
Deductible	True
OOP Max	True
Copays	True
Coins	True

Federal Mental Health Parity Quantitative Testing Results

State	CT
HIOS Plan ID	**86545CT1230027-03**
Plan Effective Date	**1/1/2026**
Plan Name	Gold HMO Pathway Enhanced LCSR with Adult Dental and Vision Benefits
Product Type	**HMO**
MHP Final Testing Results	**Pass**

MHP Parity Testing Classifications:

Inpatient In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	100.0%	$2,000	$2,000	$2,000
OOP Max	100.0%	$8,000	$8,000	$8,000
Copays	0.0%	No Copay	No Copay	No Copay
Coins	100.0%	10%	10%	10%

Inpatient Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Other In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	72.3%	$2,000	$2,000	$2,000
OOP Max	95.5%	$8,000	$8,000	$8,000
Copays	22.4%	No Copay	No Copay	No Copay
Coins	73.4%	10%	10%	10%

Outpatient Other Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Office In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	72.3%	$2,000	$2,000
OOP Max	95.5%	$8,000	$8,000
Copays	22.4%	No Copay	No Copay
Coins	73.4%	10%	10%

Outpatient Office Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A
Copays	N/A	N/A	N/A
Coins	N/A	N/A	N/A

Emergency Services	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	94.0%	$2,000	$2,000	$2,000
OOP Max	94.0%	$8,000	$8,000	$8,000
Copays	0.0%	No Copay	No Copay	No Copay
Coins	100.0%	10%	10%	10%

Medical/Surgical	INN = OON
Deductible	True
OOP Max	True
Copays	True
Coins	True

Federal Mental Health Parity Quantitative Testing Results

State	CT
HIOS Plan ID	**86545CT1330001-04**
Plan Effective Date	**1/1/2026**
Plan Name	Silver PPO Standard Pathway 73% CSR
Product Type	**PPO**
MHP Final Testing Results	**Pass**

MHP Parity Testing Classifications:

Inpatient In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	100.0%	$5,000	$5,000	$5,000
OOP Max	100.0%	$7,675	$7,675	$7,675
Copays	78.6%	$500	$500	No Copay
Coins	0.0%	No Coins	No Coins	No Coins

Inpatient Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Other In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	67.4%	$5,000	$5,000	No Deductible
OOP Max	95.4%	$7,675	$7,675	$7,675
Copays	72.2%	$500	$500	$45
Coins	1.4%	No Coins	No Coins	No Coins

Outpatient Other Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Office In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	67.4%	$5,000	No Deductible
OOP Max	95.4%	$7,675	$7,675
Copays	72.2%	$500	$45
Coins	1.4%	No Coins	No Coins

Outpatient Office Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A
Copays	N/A	N/A	N/A
Coins	N/A	N/A	N/A

Emergency Services	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	87.7%	$5,000	$5,000	No Deductible
OOP Max	93.9%	$7,675	$7,675	$7,675
Copays	87.7%	$450	$450	No Copay
Coins	0.0%	No Coins	No Coins	No Coins

Medical/Surgical	INN = OON
Deductible	True
OOP Max	True
Copays	True
Coins	True

Federal Mental Health Parity Quantitative Testing Results

State	CT
HIOS Plan ID	**86545CT1330001-03**
Plan Effective Date	**1/1/2026**
Plan Name	Silver PPO Standard Pathway LCSR
Product Type	**PPO**
MHP Final Testing Results	**Pass**

MHP Parity Testing Classifications:

Inpatient In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	100.0%	$5,000	$5,000	$5,000
OOP Max	100.0%	$9,400	$9,400	$9,400
Copays	78.6%	$500	$500	No Copay
Coins	0.0%	No Coins	No Coins	No Coins

Inpatient Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Other In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	67.4%	$5,000	$5,000	No Deductible
OOP Max	95.4%	$9,400	$9,400	$9,400
Copays	72.1%	$500	$500	$45
Coins	1.4%	No Coins	No Coins	No Coins

Outpatient Other Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Office In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	67.4%	$5,000	No Deductible
OOP Max	95.4%	$9,400	$9,400
Copays	72.1%	$500	$45
Coins	1.4%	No Coins	No Coins

Outpatient Office Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A
Copays	N/A	N/A	N/A
Coins	N/A	N/A	N/A

Emergency Services	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	87.6%	$5,000	$5,000	No Deductible
OOP Max	93.8%	$9,400	$9,400	$9,400
Copays	87.6%	$450	$450	No Copay
Coins	0.0%	No Coins	No Coins	No Coins

Medical/Surgical	INN = OON
Deductible	True
OOP Max	True
Copays	True
Coins	True

Federal Mental Health Parity Quantitative Testing Results

State	CT
HIOS Plan ID	**86545CT1330003-03**
Plan Effective Date	**1/1/2026**
Plan Name	Gold PPO Standard Pathway LCSR
Product Type	**PPO**
MHP Final Testing Results	**Pass**

MHP Parity Testing Classifications:

Inpatient In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	100.0%	$1,200	$1,200	$1,200
OOP Max	100.0%	$7,375	$7,375	$7,375
Copays	78.7%	$500	$500	No Copay
Coins	0.0%	No Coins	No Coins	No Coins

Inpatient Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Other In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	63.2%	No Deductible	No Deductible	No Deductible
OOP Max	95.6%	$7,375	$7,375	$7,375
Copays	71.8%	$500	$500	$20
Coins	1.4%	No Coins	No Coins	No Coins

Outpatient Other Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Office In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	63.2%	No Deductible	No Deductible
OOP Max	95.6%	$7,375	$7,375
Copays	71.8%	$500	$20
Coins	1.4%	No Coins	No Coins

Outpatient Office Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A
Copays	N/A	N/A	N/A
Coins	N/A	N/A	N/A

Emergency Services	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	0.0%	No Deductible	No Deductible	No Deductible
OOP Max	93.9%	$7,375	$7,375	$7,375
Copays	87.7%	$400	$400	No Copay
Coins	0.0%	No Coins	No Coins	No Coins

Medical/Surgical	INN = OON
Deductible	True
OOP Max	True
Copays	True
Coins	True

Federal Mental Health Parity Quantitative Testing Results

State	CT
HIOS Plan ID	**86545CT1330001-05**
Plan Effective Date	**1/1/2026**
Plan Name	Silver PPO Standard Pathway 87% CSR
Product Type	**PPO**
MHP Final Testing Results	**Pass**

MHP Parity Testing Classifications:

Inpatient In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	100.0%	$415	$415	$415
OOP Max	100.0%	$2,950	$2,950	$2,950
Copays	79.3%	$100	$100	No Copay
Coins	0.0%	No Coins	No Coins	No Coins

Inpatient Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Other In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	68.5%	$415	$415	No Deductible
OOP Max	95.7%	$2,950	$2,950	$2,950
Copays	71.4%	$100	$100	$35
Coins	1.4%	No Coins	No Coins	No Coins

Outpatient Other Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Office In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	68.5%	$415	No Deductible
OOP Max	95.7%	$2,950	$2,950
Copays	71.4%	$100	$35
Coins	1.4%	No Coins	No Coins

Outpatient Office Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A
Copays	N/A	N/A	N/A
Coins	N/A	N/A	N/A

Emergency Services	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	87.5%	$415	$415	No Deductible
OOP Max	93.9%	$2,950	$2,950	$2,950
Copays	87.5%	$150	$150	No Copay
Coins	0.0%	No Coins	No Coins	No Coins

Medical/Surgical	INN = OON
Deductible	True
OOP Max	True
Copays	True
Coins	True

Federal Mental Health Parity Quantitative Testing Results

State	CT
HIOS Plan ID	**86545CT1330002-03**
Plan Effective Date	**1/1/2026**
Plan Name	Bronze PPO Standard Pathway LCSR
Product Type	**PPO**
MHP Final Testing Results	**Pass**

MHP Parity Testing Classifications:

Inpatient In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	100.0%	$7,000	$7,000	$7,000
OOP Max	100.0%	$10,000	$10,000	$10,000
Copays	78.4%	$500	$500	No Copay
Coins	0.0%	No Coins	No Coins	No Coins

Inpatient Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Other In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	85.1%	$7,000	$7,000	No Deductible
OOP Max	95.2%	$10,000	$10,000	$10,000
Copays	72.1%	$500	$500	$50
Coins	1.6%	No Coins	No Coins	No Coins

Outpatient Other Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Office In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	85.1%	$7,000	No Deductible
OOP Max	95.2%	$10,000	$10,000
Copays	72.1%	$500	$50
Coins	1.6%	No Coins	No Coins

Outpatient Office Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A
Copays	N/A	N/A	N/A
Coins	N/A	N/A	N/A

Emergency Services	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	93.5%	$7,000	$7,000	$7,000
OOP Max	93.5%	$10,000	$10,000	$10,000
Copays	87.1%	$450	$450	No Copay
Coins	0.0%	No Coins	No Coins	No Coins

Medical/Surgical	INN = OON
Deductible	True
OOP Max	True
Copays	True
Coins	True

Federal Mental Health Parity Quantitative Testing Results

State	CT
HIOS Plan ID	**86545CT1570002-03**
Plan Effective Date	**1/1/2026**
Plan Name	Gold PPO Pathway LCSR
Product Type	**PPO**
MHP Final Testing Results	**Pass**

MHP Parity Testing Classifications:

Inpatient In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	100.0%	$2,000	$2,000	$2,000
OOP Max	100.0%	$9,000	$9,000	$9,000
Copays	0.0%	No Copay	No Copay	No Copay
Coins	100.0%	10%	10%	10%

Inpatient Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Other In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	95.4%	$2,000	$2,000	$2,000
OOP Max	95.5%	$9,000	$9,000	$9,000
Copays	0.0%	No Copay	No Copay	No Copay
Coins	95.4%	10%	10%	10%

Outpatient Other Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Office In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	95.4%	$2,000	$2,000
OOP Max	95.5%	$9,000	$9,000
Copays	0.0%	No Copay	No Copay
Coins	95.4%	10%	10%

Outpatient Office Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A
Copays	N/A	N/A	N/A
Coins	N/A	N/A	N/A

Emergency Services	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	93.8%	$2,000	$2,000	$2,000
OOP Max	93.8%	$9,000	$9,000	$9,000
Copays	0.0%	No Copay	No Copay	No Copay
Coins	100.0%	10%	10%	10%

Medical/Surgical	INN = OON
Deductible	True
OOP Max	True
Copays	True
Coins	True

Federal Mental Health Parity Quantitative Testing Results

State	CT
HIOS Plan ID	**86545CT1330020-01**
Plan Effective Date	**1/1/2026**
Plan Name	Gold PPO Pathway with Adult Dental and Vision Benefits
Product Type	**PPO**
MHP Final Testing Results	**Pass**

MHP Parity Testing Classifications:

Inpatient In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	100.0%	$2,000	$2,000	$2,000
OOP Max	100.0%	$8,000	$8,000	$8,000
Copays	0.0%	No Copay	No Copay	No Copay
Coins	100.0%	10%	10%	10%

Inpatient Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Other In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	71.7%	$2,000	$2,000	$2,000
OOP Max	95.5%	$8,000	$8,000	$8,000
Copays	22.9%	No Copay	No Copay	No Copay
Coins	72.8%	10%	10%	10%

Outpatient Other Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Office In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	71.7%	$2,000	$2,000
OOP Max	95.5%	$8,000	$8,000
Copays	22.9%	No Copay	No Copay
Coins	72.8%	10%	10%

Outpatient Office Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A
Copays	N/A	N/A	N/A
Coins	N/A	N/A	N/A

Emergency Services	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	93.8%	$2,000	$2,000	$2,000
OOP Max	93.8%	$8,000	$8,000	$8,000
Copays	0.0%	No Copay	No Copay	No Copay
Coins	100.0%	10%	10%	10%

Medical/Surgical	INN = OON
Deductible	True
OOP Max	True
Copays	True
Coins	True

Federal Mental Health Parity Quantitative Testing Results

State	CT
HIOS Plan ID	**86545CT1570001-01**
Plan Effective Date	**1/1/2026**
Plan Name	Bronze PPO Pathway with PreventiveRx HSA
Product Type	**PPO**
MHP Final Testing Results	**Pass**

MHP Parity Testing Classifications:

Inpatient In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	100.0%	$6,000	$6,000	$6,000
OOP Max	100.0%	$8,000	$8,000	$8,000
Copays	0.0%	No Copay	No Copay	No Copay
Coins	100.0%	25%	25%	25%

Inpatient Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Other In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	95.2%	$6,000	$6,000	$6,000
OOP Max	95.2%	$8,000	$8,000	$8,000
Copays	13.5%	No Copay	No Copay	No Copay
Coins	81.6%	25%	25%	25%

Outpatient Other Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Office In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	95.2%	$6,000	$6,000
OOP Max	95.2%	$8,000	$8,000
Copays	13.5%	No Copay	No Copay
Coins	81.6%	25%	25%

Outpatient Office Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A
Copays	N/A	N/A	N/A
Coins	N/A	N/A	N/A

Emergency Services	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	93.6%	$6,000	$6,000	$6,000
OOP Max	93.6%	$8,000	$8,000	$8,000
Copays	0.0%	No Copay	No Copay	No Copay
Coins	100.0%	25%	25%	25%

Medical/Surgical	INN = OON
Deductible	True
OOP Max	True
Copays	True
Coins	True

Federal Mental Health Parity Quantitative Testing Results

State	CT
HIOS Plan ID	**86545CT1230025-01**
Plan Effective Date	**1/1/2026**
Plan Name	Bronze HMO Pathway Enhanced with Adult Dental and Vision Benefits
Product Type	**HMO**
MHP Final Testing Results	**Pass**

MHP Parity Testing Classifications:

Inpatient In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	100.0%	$7,000	$7,000	$7,000
OOP Max	100.0%	$10,000	$10,000	$10,000
Copays	78.6%	$500	$500	No Copay
Coins	0.0%	No Coins	No Coins	No Coins

Inpatient Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Other In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	88.9%	$7,000	$7,000	$7,000
OOP Max	95.2%	$10,000	$10,000	$10,000
Copays	74.7%	$500	$500	No Copay
Coins	1.6%	No Coins	No Coins	No Coins

Outpatient Other Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Office In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	88.9%	$7,000	$7,000
OOP Max	95.2%	$10,000	$10,000
Copays	74.7%	$500	$90
Coins	1.6%	No Coins	No Coins

Outpatient Office Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A
Copays	N/A	N/A	N/A
Coins	N/A	N/A	N/A

Emergency Services	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	93.7%	$7,000	$7,000	$7,000
OOP Max	93.7%	$10,000	$10,000	$10,000
Copays	87.6%	$500	$500	No Copay
Coins	6.3%	No Coins	No Coins	No Coins

Medical/Surgical	INN = OON
Deductible	True
OOP Max	True
Copays	True
Coins	True

Federal Mental Health Parity Quantitative Testing Results

State	CT
HIOS Plan ID	**86545CT1230027-01**
Plan Effective Date	**1/1/2026**
Plan Name	Gold HMO Pathway Enhanced with Adult Dental and Vision Benefits
Product Type	**HMO**
MHP Final Testing Results	**Pass**

MHP Parity Testing Classifications:

Inpatient In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	100.0%	$2,000	$2,000	$2,000
OOP Max	100.0%	$8,000	$8,000	$8,000
Copays	0.0%	No Copay	No Copay	No Copay
Coins	100.0%	10%	10%	10%

Inpatient Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Other In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	72.3%	$2,000	$2,000	$2,000
OOP Max	95.5%	$8,000	$8,000	$8,000
Copays	22.4%	No Copay	No Copay	No Copay
Coins	73.4%	10%	10%	10%

Outpatient Other Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Office In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	72.3%	$2,000	$2,000
OOP Max	95.5%	$8,000	$8,000
Copays	22.4%	No Copay	No Copay
Coins	73.4%	10%	10%

Outpatient Office Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A
Copays	N/A	N/A	N/A
Coins	N/A	N/A	N/A

Emergency Services	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	94.0%	$2,000	$2,000	$2,000
OOP Max	94.0%	$8,000	$8,000	$8,000
Copays	0.0%	No Copay	No Copay	No Copay
Coins	100.0%	10%	10%	10%

Medical/Surgical	INN = OON
Deductible	True
OOP Max	True
Copays	True
Coins	True

Federal Mental Health Parity Quantitative Testing Results

State	CT
HIOS Plan ID	**86545CT1330001-01**
Plan Effective Date	**1/1/2026**
Plan Name	Silver PPO Standard Pathway
Product Type	**PPO**
MHP Final Testing Results	**Pass**

MHP Parity Testing Classifications:

Inpatient In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	100.0%	$5,000	$5,000	$5,000
OOP Max	100.0%	$9,400	$9,400	$9,400
Copays	78.6%	$500	$500	No Copay
Coins	0.0%	No Coins	No Coins	No Coins

Inpatient Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Other In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	67.4%	$5,000	$5,000	No Deductible
OOP Max	95.4%	$9,400	$9,400	$9,400
Copays	72.1%	$500	$500	$45
Coins	1.4%	No Coins	No Coins	No Coins

Outpatient Other Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Office In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	67.4%	$5,000	No Deductible
OOP Max	95.4%	$9,400	$9,400
Copays	72.1%	$500	$45
Coins	1.4%	No Coins	No Coins

Outpatient Office Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A
Copays	N/A	N/A	N/A
Coins	N/A	N/A	N/A

Emergency Services	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	87.6%	$5,000	$5,000	No Deductible
OOP Max	93.8%	$9,400	$9,400	$9,400
Copays	87.6%	$450	$450	No Copay
Coins	0.0%	No Coins	No Coins	No Coins

Medical/Surgical	INN = OON
Deductible	True
OOP Max	True
Copays	True
Coins	True

Federal Mental Health Parity Quantitative Testing Results

State	CT
HIOS Plan ID	**86545CT1330003-01**
Plan Effective Date	**1/1/2026**
Plan Name	Gold PPO Standard Pathway
Product Type	**PPO**
MHP Final Testing Results	**Pass**

MHP Parity Testing Classifications:

Inpatient In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	100.0%	$1,200	$1,200	$1,200
OOP Max	100.0%	$7,375	$7,375	$7,375
Copays	78.7%	$500	$500	No Copay
Coins	0.0%	No Coins	No Coins	No Coins

Inpatient Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Other In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	63.2%	No Deductible	No Deductible	No Deductible
OOP Max	95.6%	$7,375	$7,375	$7,375
Copays	71.8%	$500	$500	$20
Coins	1.4%	No Coins	No Coins	No Coins

Outpatient Other Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Office In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	63.2%	No Deductible	No Deductible
OOP Max	95.6%	$7,375	$7,375
Copays	71.8%	$500	$20
Coins	1.4%	No Coins	No Coins

Outpatient Office Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A
Copays	N/A	N/A	N/A
Coins	N/A	N/A	N/A

Emergency Services	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	0.0%	No Deductible	No Deductible	No Deductible
OOP Max	93.9%	$7,375	$7,375	$7,375
Copays	87.7%	$400	$400	No Copay
Coins	0.0%	No Coins	No Coins	No Coins

Medical/Surgical	INN = OON
Deductible	True
OOP Max	True
Copays	True
Coins	True

Federal Mental Health Parity Quantitative Testing Results

State	CT
HIOS Plan ID	**86545CT1330009-01**
Plan Effective Date	**1/1/2026**
Plan Name	Bronze PPO Standard Pathway HSA
Product Type	**PPO**
MHP Final Testing Results	**Pass**

MHP Parity Testing Classifications:

Inpatient In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	100.0%	$6,500	$6,500	$6,500
OOP Max	100.0%	$7,225	$7,225	$7,225
Copays	0.0%	No Copay	No Copay	No Copay
Coins	100.0%	20%	20%	20%

Inpatient Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Other In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	95.3%	$6,500	$6,500	$6,500
OOP Max	95.3%	$7,225	$7,225	$7,225
Copays	0.0%	No Copay	No Copay	No Copay
Coins	95.2%	20%	20%	20%

Outpatient Other Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Office In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	95.3%	$6,500	$6,500
OOP Max	95.3%	$7,225	$7,225
Copays	0.0%	No Copay	No Copay
Coins	95.2%	20%	20%

Outpatient Office Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A
Copays	N/A	N/A	N/A
Coins	N/A	N/A	N/A

Emergency Services	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	93.6%	$6,500	$6,500	$6,500
OOP Max	93.6%	$7,225	$7,225	$7,225
Copays	0.0%	No Copay	No Copay	No Copay
Coins	100.0%	20%	20%	20%

Medical/Surgical	INN = OON
Deductible	True
OOP Max	True
Copays	True
Coins	True

Federal Mental Health Parity Quantitative Testing Results

State	CT
HIOS Plan ID	**86545CT1330002-01**
Plan Effective Date	**1/1/2026**
Plan Name	Bronze PPO Standard Pathway
Product Type	**PPO**
MHP Final Testing Results	**Pass**

MHP Parity Testing Classifications:

Inpatient In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	100.0%	$7,000	$7,000	$7,000
OOP Max	100.0%	$10,000	$10,000	$10,000
Copays	78.4%	$500	$500	No Copay
Coins	0.0%	No Coins	No Coins	No Coins

Inpatient Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Other In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	85.1%	$7,000	$7,000	No Deductible
OOP Max	95.2%	$10,000	$10,000	$10,000
Copays	72.1%	$500	$500	$50
Coins	1.6%	No Coins	No Coins	No Coins

Outpatient Other Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Office In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	85.1%	$7,000	No Deductible
OOP Max	95.2%	$10,000	$10,000
Copays	72.1%	$500	$50
Coins	1.6%	No Coins	No Coins

Outpatient Office Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A
Copays	N/A	N/A	N/A
Coins	N/A	N/A	N/A

Emergency Services	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	93.5%	$7,000	$7,000	$7,000
OOP Max	93.5%	$10,000	$10,000	$10,000
Copays	87.1%	$450	$450	No Copay
Coins	0.0%	No Coins	No Coins	No Coins

Medical/Surgical	INN = OON
Deductible	True
OOP Max	True
Copays	True
Coins	True

Federal Mental Health Parity Quantitative Testing Results

State	CT
HIOS Plan ID	**86545CT1230005-01**
Plan Effective Date	**1/1/2026**
Plan Name	Catastrophic HMO Pathway Enhanced
Product Type	**HMO**
MHP Final Testing Results	**Pass**

MHP Parity Testing Classifications:

Inpatient In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	100.0%	$10,600	$10,600	$10,600
OOP Max	100.0%	$10,600	$10,600	$10,600
Copays	0.0%	No Copay	No Copay	No Copay
Coins	0.0%	No Coins	No Coins	No Coins

Inpatient Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Other In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	97.4%	$10,600	$10,600	$10,600
OOP Max	97.4%	$10,600	$10,600	$10,600
Copays	1.1%	No Copay	No Copay	No Copay
Coins	0.0%	No Coins	No Coins	No Coins

Outpatient Other Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Office In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	85.1%	$10,600	$10,600
OOP Max	85.1%	$10,600	$10,600
Copays	25.3%	No Copay	No Copay
Coins	0.0%	No Coins	No Coins

Outpatient Office Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A
Copays	N/A	N/A	N/A
Coins	N/A	N/A	N/A

Emergency Services	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	93.6%	$10,600	$10,600	$10,600
OOP Max	93.6%	$10,600	$10,600	$10,600
Copays	0.0%	No Copay	No Copay	No Copay
Coins	0.0%	No Coins	No Coins	No Coins

Medical/Surgical	INN = OON
Deductible	True
OOP Max	True
Copays	True
Coins	True

Federal Mental Health Parity Quantitative Testing Results

State	CT
HIOS Plan ID	**86545CT1570002-01**
Plan Effective Date	**1/1/2026**
Plan Name	Gold PPO Pathway
Product Type	**PPO**
MHP Final Testing Results	**Pass**

MHP Parity Testing Classifications:

Inpatient In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	100.0%	$2,000	$2,000	$2,000
OOP Max	100.0%	$9,000	$9,000	$9,000
Copays	0.0%	No Copay	No Copay	No Copay
Coins	100.0%	10%	10%	10%

Inpatient Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Other In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	95.4%	$2,000	$2,000	$2,000
OOP Max	95.5%	$9,000	$9,000	$9,000
Copays	0.0%	No Copay	No Copay	No Copay
Coins	95.4%	10%	10%	10%

Outpatient Other Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Office In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	95.4%	$2,000	$2,000
OOP Max	95.5%	$9,000	$9,000
Copays	0.0%	No Copay	No Copay
Coins	95.4%	10%	10%

Outpatient Office Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A
Copays	N/A	N/A	N/A
Coins	N/A	N/A	N/A

Emergency Services	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	93.8%	$2,000	$2,000	$2,000
OOP Max	93.8%	$9,000	$9,000	$9,000
Copays	0.0%	No Copay	No Copay	No Copay
Coins	100.0%	10%	10%	10%

Medical/Surgical	INN = OON
Deductible	True
OOP Max	True
Copays	True
Coins	True

Federal Mental Health Parity Quantitative Testing Results

State	CT
HIOS Plan ID	**86545CT1340020-00**
Plan Effective Date	**1/1/2026**
Plan Name	Anthem Bronze PPO Pathway 8000/0% HSA
Product Type	**PPO**
MHP Final Testing Results	**Pass**

MHP Parity Testing Classifications:

Inpatient In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	100.0%	$8,000	$8,000	$8,000
OOP Max	100.0%	$8,000	$8,000	$8,000
Copays	0.0%	No Copay	No Copay	No Copay
Coins	0.0%	No Coins	No Coins	No Coins

Inpatient Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Other In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	95.2%	$8,000	$8,000	$8,000
OOP Max	95.2%	$8,000	$8,000	$8,000
Copays	0.0%	No Copay	No Copay	No Copay
Coins	0.0%	No Coins	No Coins	No Coins

Outpatient Other Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Office In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	95.2%	$8,000	$8,000
OOP Max	95.2%	$8,000	$8,000
Copays	0.0%	No Copay	No Copay
Coins	0.0%	No Coins	No Coins

Outpatient Office Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A
Copays	N/A	N/A	N/A
Coins	N/A	N/A	N/A

Emergency Services	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	93.5%	$8,000	$8,000	$8,000
OOP Max	93.5%	$8,000	$8,000	$8,000
Copays	0.0%	No Copay	No Copay	No Copay
Coins	0.0%	No Coins	No Coins	No Coins

Medical/Surgical	INN = OON
Deductible	True
OOP Max	True
Copays	True
Coins	True

Federal Mental Health Parity Quantitative Testing Results

State	CT
HIOS Plan ID	**86545CT1340021-00**
Plan Effective Date	**1/1/2026**
Plan Name	Anthem Silver PPO Pathway 4000/20% HSA
Product Type	**PPO**
MHP Final Testing Results	**Pass**

MHP Parity Testing Classifications:

Inpatient In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	100.0%	$4,000	$4,000	$4,000
OOP Max	100.0%	$8,000	$8,000	$8,000
Copays	0.0%	No Copay	No Copay	No Copay
Coins	100.0%	20%	20%	20%

Inpatient Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Other In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	95.2%	$4,000	$4,000	$4,000
OOP Max	95.2%	$8,000	$8,000	$8,000
Copays	18.4%	No Copay	No Copay	No Copay
Coins	77.4%	20%	20%	20%

Outpatient Other Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Office In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	95.2%	$4,000	$4,000
OOP Max	95.2%	$8,000	$8,000
Copays	18.4%	No Copay	No Copay
Coins	77.4%	20%	20%

Outpatient Office Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A
Copays	N/A	N/A	N/A
Coins	N/A	N/A	N/A

Emergency Services	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	93.6%	$4,000	$4,000	$4,000
OOP Max	93.6%	$8,000	$8,000	$8,000
Copays	0.0%	No Copay	No Copay	No Copay
Coins	100.0%	20%	20%	20%

Medical/Surgical	INN = OON
Deductible	True
OOP Max	True
Copays	True
Coins	True

Federal Mental Health Parity Quantitative Testing Results

State	CT
HIOS Plan ID	**86545CT1580001-01**
Plan Effective Date	**1/1/2026**
Plan Name	Bronze HMO Pathway Enhanced
Product Type	**HMO**
MHP Final Testing Results	**Pass**

MHP Parity Testing Classifications:

Inpatient In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	100.0%	$7,000	$7,000	$7,000
OOP Max	100.0%	$10,000	$10,000	$10,000
Copays	78.6%	$500	$500	No Copay
Coins	0.0%	No Coins	No Coins	No Coins

Inpatient Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Other In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	88.9%	$7,000	$7,000	$7,000
OOP Max	95.2%	$10,000	$10,000	$10,000
Copays	74.7%	$500	$500	No Copay
Coins	1.6%	No Coins	No Coins	No Coins

Outpatient Other Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Office In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	88.9%	$7,000	$7,000
OOP Max	95.2%	$10,000	$10,000
Copays	74.7%	$500	$90
Coins	1.6%	No Coins	No Coins

Outpatient Office Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A
Copays	N/A	N/A	N/A
Coins	N/A	N/A	N/A

Emergency Services	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	93.7%	$7,000	$7,000	$7,000
OOP Max	93.7%	$10,000	$10,000	$10,000
Copays	87.6%	$500	$500	No Copay
Coins	6.3%	No Coins	No Coins	No Coins

Medical/Surgical	INN = OON
Deductible	True
OOP Max	True
Copays	True
Coins	True

Federal Mental Health Parity Quantitative Testing Results

State	CT
HIOS Plan ID	**86545CT1580001-03**
Plan Effective Date	**1/1/2026**
Plan Name	Bronze HMO Pathway Enhanced LCSR
Product Type	**HMO**
MHP Final Testing Results	**Pass**

MHP Parity Testing Classifications:

Inpatient In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	100.0%	$7,000	$7,000	$7,000
OOP Max	100.0%	$10,000	$10,000	$10,000
Copays	78.6%	$500	$500	No Copay
Coins	0.0%	No Coins	No Coins	No Coins

Inpatient Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Other In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	88.9%	$7,000	$7,000	$7,000
OOP Max	95.2%	$10,000	$10,000	$10,000
Copays	74.7%	$500	$500	No Copay
Coins	1.6%	No Coins	No Coins	No Coins

Outpatient Other Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A	N/A
Copays	N/A	N/A	N/A	N/A
Coins	N/A	N/A	N/A	N/A

Outpatient Office In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	88.9%	$7,000	$7,000
OOP Max	95.2%	$10,000	$10,000
Copays	74.7%	$500	$90
Coins	1.6%	No Coins	No Coins

Outpatient Office Out-of-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share
Deductible	N/A	N/A	N/A
OOP Max	N/A	N/A	N/A
Copays	N/A	N/A	N/A
Coins	N/A	N/A	N/A

Emergency Services	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	93.7%	$7,000	$7,000	$7,000
OOP Max	93.7%	$10,000	$10,000	$10,000
Copays	87.6%	$500	$500	No Copay
Coins	6.3%	No Coins	No Coins	No Coins

Medical/Surgical	INN = OON
Deductible	True
OOP Max	True
Copays	True
Coins	True

Actuarial Attestation

HIOS Product ID(s): 86545CT123

HIOS Plan ID(s): 86545CT1230005, 86545CT1230025, 86545CT1230027

Effective Date of Plan Design(s): 1/1/2026

Description of data used for substantially all and predominant analyses if sufficient claims data available for analysis:

Sufficient claims data for these plans not available for analysis.

Description of data used for substantially all and predominant analyses if sufficient claims data not available for analysis, following guidance provided for question 3 in ACA FAQ 34 issued 10/27/2016 by the Department of Labor (DOL), Health and Human Services (HHS), and the Treasury:

Allowed claims for individual on and off exchange HMO and PPO plans offered by Anthem Blue Cross and Blue Shield in Connecticut paid between 7/1/2023 and 6/30/2024 trended to the effective date of 1/1/2026. Claims for members with less than 12 months of exposure were removed from the claims data set. Utilization adjustments from Anthem's proprietary benefit relativity model were applied to the data set to reflect each plan design to which substantially all and predominant quantitative analyses were applied. Demographic and area adjustments were not applied because the data set is representative of the demographics for individual plans in Connecticut. Final data set reflected claims for approximately 50,813 members.

Confirmation whether or not the office visit sub-classification of outpatient benefits allowed under 54.9812-1(c)(3)(iii)(C) was used for substantially all and predominant analyses:

The office visit sub-classification provision for outpatient benefits was not used.

Certification Language:

The analysis was performed in accordance with 54.9812-1(c)(3) of MHPAEA as amended by the ACA.
The analysis was performed in accordance with the guidance provided for question 3 in ACA FAQ 34.
The analysis was performed in accordance with the ASOPs established by the Actuarial Standards Board (ASB).

The analysis was performed by an actuary who is a member of the American Academy of Actuaries, meets the Qualification Standards for actuaries who issue statements of actuarial opinion in the United States, and has the education and experience necessary to perform the analysis.

Actuary signature: Wayne Rosen

Actuary Printed Name: Wayne, Rosen, FSA, MAAA

Date: 5/22/2025

Actuarial Attestation

HIOS Product ID(s): 86545CT131

HIOS Plan ID(s): 86545CT1310019, 86545CT1310033, 86545CT1310055, 86545CT1310056, 86545CT1310060

Effective Date of Plan Design(s): 1/1/2026

Description of data used for substantially all and predominant analyses if sufficient claims data available for analysis:

Sufficient claims data for these plans not available for analysis.

Description of data used for substantially all and predominant analyses if sufficient claims data not available for analysis, following guidance provided for question 3 in ACA FAQ 34 issued 10/27/2016 by the Department of Labor (DOL), Health and Human Services (HHS), and the Treasury:

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Confirmation whether or not the office visit sub-classification of outpatient benefits allowed under 54.9812-1(c)(3)(iii)(C) was used for substantially all and predominant analyses:

The office visit sub-classification provision for outpatient benefits was not used.

Certification Language:

The analysis was performed in accordance with 54.9812-1(c)(3) of MHPAEA as amended by the ACA.
The analysis was performed in accordance with the guidance provided for question 3 in ACA FAQ 34.
The analysis was performed in accordance with the ASOPs established by the Actuarial Standards Board (ASB).

The analysis was performed by an actuary who is a member of the American Academy of Actuaries, meets the Qualification Standards for actuaries who issue statements of actuarial opinion in the United States, and has the education and experience necessary to perform the analysis.

Actuary signature: Wayne Rosen

Actuary Printed Name: Wayne, Rosen, FSA, MAAA

Date: 5/22/2025

Actuarial Attestation

HIOS Product ID(s): 86545CT133

HIOS Plan ID(s): 86545CT1330001, 86545CT1330002, 86545CT1330003, 86545CT1330009, 86545CT1330020

Effective Date of Plan Design(s): 1/1/2026

Description of data used for substantially all and predominant analyses if sufficient claims data available for analysis:

Sufficient claims data for these plans not available for analysis.

Description of data used for substantially all and predominant analyses if sufficient claims data not available for analysis, following guidance provided for question 3 in ACA FAQ 34 issued 10/27/2016 by the Department of Labor (DOL), Health and Human Services (HHS), and the Treasury:

Allowed claims for individual on and off exchange HMO and PPO plans offered by Anthem Blue Cross and Blue Shield in Connecticut paid between 7/1/2023 and 6/30/2024 trended to the effective date of 1/1/2026. Claims for members with less than 12 months of exposure were removed from the claims data set. Utilization adjustments from Anthem's proprietary benefit relativity model were applied to the data set to reflect each plan design to which substantially all and predominant quantitative analyses were applied. Demographic and area adjustments were not applied because the data set is representative of the demographics for individual plans in Connecticut. Final data set reflected claims for approximately 50,813 members.

Confirmation whether or not the office visit sub-classification of outpatient benefits allowed under 54.9812-1(c)(3)(iii)(C) was used for substantially all and predominant analyses:

The office visit sub-classification provision for outpatient benefits was not used.

Certification Language:

The analysis was performed in accordance with 54.9812-1(c)(3) of MHPAEA as amended by the ACA.
The analysis was performed in accordance with the guidance provided for question 3 in ACA FAQ 34.
The analysis was performed in accordance with the ASOPs established by the Actuarial Standards Board (ASB).

The analysis was performed by an actuary who is a member of the American Academy of Actuaries, meets the Qualification Standards for actuaries who issue statements of actuarial opinion in the United States, and has the education and experience necessary to perform the analysis.

Actuary signature: Wayne Rosen

Actuary Printed Name: Wayne, Rosen, FSA, MAAA

Date: 5/22/2025

Actuarial Attestation

HIOS Product ID(s): 86545CT134

HIOS Plan ID(s): 86545CT1340020, 86545CT1340021

Effective Date of Plan Design(s): 1/1/2026

Description of data used for substantially all and predominant analyses if sufficient claims data available for analysis:

Sufficient claims data for these plans not available for analysis.

Description of data used for substantially all and predominant analyses if sufficient claims data not available for analysis, following guidance provided for question 3 in ACA FAQ 34 issued 10/27/2016 by the Department of Labor (DOL), Health and Human Services (HHS), and the Treasury:

Allowed claims for individual on and off exchange HMO and PPO plans offered by Anthem Blue Cross and Blue Shield in Connecticut paid between 7/1/2023 and 6/30/2024 trended to the effective date of 1/1/2026. Claims for members with less than 12 months of exposure were removed from the claims data set. Utilization adjustments from Anthem's proprietary benefit relativity model were applied to the data set to reflect each plan design to which substantially all and predominant quantitative analyses were applied. Demographic and area adjustments were not applied because the data set is representative of the demographics for individual plans in Connecticut. Final data set reflected claims for approximately 50,813 members.

Confirmation whether or not the office visit sub-classification of outpatient benefits allowed under 54.9812-1(c)(3)(iii)(C) was used for substantially all and predominant analyses:

The office visit sub-classification provision for outpatient benefits was not used.

Certification Language:

The analysis was performed in accordance with 54.9812-1(c)(3) of MHPAEA as amended by the ACA.
The analysis was performed in accordance with the guidance provided for question 3 in ACA FAQ 34.
The analysis was performed in accordance with the ASOPs established by the Actuarial Standards Board (ASB).

The analysis was performed by an actuary who is a member of the American Academy of Actuaries, meets the Qualification Standards for actuaries who issue statements of actuarial opinion in the United States, and has the education and experience necessary to perform the analysis.

Actuary signature: Wayne Rosen

Actuary Printed Name: Wayne, Rosen, FSA, MAAA

Date: 5/22/2025

Actuarial Attestation

HIOS Product ID(s): 86545CT157

HIOS Plan ID(s): 86545CT1570001, 86545CT1570002

Effective Date of Plan Design(s): 1/1/2026

Description of data used for substantially all and predominant analyses if sufficient claims data available for analysis:

Sufficient claims data for these plans not available for analysis.

Description of data used for substantially all and predominant analyses if sufficient claims data not available for analysis, following guidance provided for question 3 in ACA FAQ 34 issued 10/27/2016 by the Department of Labor (DOL), Health and Human Services (HHS), and the Treasury:

Allowed claims for individual on and off exchange HMO and PPO plans offered by Anthem Blue Cross and Blue Shield in Connecticut paid between 7/1/2023 and 6/30/2024 trended to the effective date of 1/1/2026. Claims for members with less than 12 months of exposure were removed from the claims data set. Utilization adjustments from Anthem's proprietary benefit relativity model were applied to the data set to reflect each plan design to which substantially all and predominant quantitative analyses were applied. Demographic and area adjustments were not applied because the data set is representative of the demographics for individual plans in Connecticut. Final data set reflected claims for approximately 50,813 members.

Confirmation whether or not the office visit sub-classification of outpatient benefits allowed under 54.9812-1(c)(3)(iii)(C) was used for substantially all and predominant analyses:

The office visit sub-classification provision for outpatient benefits was not used.

Certification Language:

The analysis was performed in accordance with 54.9812-1(c)(3) of MHPAEA as amended by the ACA.
The analysis was performed in accordance with the guidance provided for question 3 in ACA FAQ 34.
The analysis was performed in accordance with the ASOPs established by the Actuarial Standards Board (ASB).

The analysis was performed by an actuary who is a member of the American Academy of Actuaries, meets the Qualification Standards for actuaries who issue statements of actuarial opinion in the United States, and has the education and experience necessary to perform the analysis.

Actuary signature: Wayne Rosen

Actuary Printed Name: Wayne, Rosen, FSA, MAAA

Date: 5/22/2025

Actuarial Attestation

HIOS Product ID(s): 86545CT158

HIOS Plan ID(s): 86545CT1580001

Effective Date of Plan Design(s): 1/1/2026

Description of data used for substantially all and predominant analyses if sufficient claims data available for analysis:

Sufficient claims data for these plans not available for analysis.

Description of data used for substantially all and predominant analyses if sufficient claims data not available for analysis, following guidance provided for question 3 in ACA FAQ 34 issued 10/27/2016 by the Department of Labor (DOL), Health and Human Services (HHS), and the Treasury:

Allowed claims for individual on and off exchange HMO and PPO plans offered by Anthem Blue Cross and Blue Shield in Connecticut paid between 7/1/2023 and 6/30/2024 trended to the effective date of 1/1/2026. Claims for members with less than 12 months of exposure were removed from the claims data set. Utilization adjustments from Anthem's proprietary benefit relativity model were applied to the data set to reflect each plan design to which substantially all and predominant quantitative analyses were applied. Demographic and area adjustments were not applied because the data set is representative of the demographics for individual plans in Connecticut. Final data set reflected claims for approximately 50,813 members.

Confirmation whether or not the office visit sub-classification of outpatient benefits allowed under 54.9812-1(c)(3)(iii)(C) was used for substantially all and predominant analyses:

The office visit sub-classification provision for outpatient benefits was not used.

Certification Language:

The analysis was performed in accordance with 54.9812-1(c)(3) of MHPAEA as amended by the ACA.
The analysis was performed in accordance with the guidance provided for question 3 in ACA FAQ 34.
The analysis was performed in accordance with the ASOPs established by the Actuarial Standards Board (ASB).

The analysis was performed by an actuary who is a member of the American Academy of Actuaries, meets the Qualification Standards for actuaries who issue statements of actuarial opinion in the United States, and has the education and experience necessary to perform the analysis.

Actuary signature: Wayne Rosen

Actuary Printed Name: Wayne, Rosen, FSA, MAAA

Date: 5/22/2025

Anthem
Individual Market

Anthem Gold HMO Pathway Enhanced 2000/10% with Adult Dental and Vision Benefits

Schedule of Benefits
Non-Tiered Network Plan

Your plan provides You with the option to lower Your Out-of-Pocket costs for certain services by going to Site of Service Providers. These Providers may have lower cost shares and Maximum Allowed Amounts, reducing Your Out-of-Pocket costs for certain services. When You use the "Find a Doctor" tool on anthem.com, look for the "SOS" indicator under the Provider's name, and when applicable, the tool will automatically sort and show these Providers first in Your results.

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$2,000 per Member	Not Covered per Member
Family	$4,000 per family	Not Covered per family
Out-of-Pocket Maximum **Individual**	$8,000 per Member	Not Covered per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$16,000 per family	Not Covered per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	Not Covered
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$20 Copayment per visit	Not Covered
Virtual Visits with PCP	$20 Copayment per visit	Not Covered
Virtual Visits from PCP Virtual Care-Only Provider through Our mobile app and website	$0 Copayment per visit	Not Applicable
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	$80 Copayment per visit	Not Covered
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	10% Coinsurance per visit after INET plan Deductible is met	Not Covered
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	10% Coinsurance per service after INET plan Deductible is met	Not Covered
Site of Service Provider	$75 Copayment per service after INET plan Deductible is met up to a combined maximum of $375 for MRI and CAT scans; $400 for PET scans	Not Covered
Laboratory Services	10% Coinsurance per service after INET plan Deductible is met	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Non-Advanced Radiology (X-ray, Diagnostic)	10% Coinsurance per service after INET plan Deductible is met	Not Covered
Site of Service Provider	$40 Copayment per service after INET plan Deductible is met	Not Covered
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	10% Coinsurance per service after INET plan Deductible is met	Not Covered
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$5 Copayment per prescription	Not Covered
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$40 Copayment per prescription	Not Covered
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription up to a maximum of $500 per prescription	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	30% Coinsurance per prescription up to a maximum of $1000 per prescription	Not Covered
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$15 Copayment per prescription	Not Covered
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$120 Copayment per prescription	Not Covered
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	30% Coinsurance per prescription up to a maximum of $1000 per prescription	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit	Not Covered
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit	Not Covered
Other Services		
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	$30 Copayment per visit	Not Covered
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	40% Coinsurance per equipment/supply	Not Covered
Durable Medical Equipment (DME)	40% Coinsurance per equipment/supply	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Home Health Care Services **(up to 100 visits per Calendar Year)**	10% Coinsurance per visit after separate $50 Deductible is met	Not Covered
Outpatient Services **(in a Hospital or ambulatory Facility)**	10% Coinsurance per visit after INET plan Deductible is met	Not Covered
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	10% Coinsurance per Admission after INET plan Deductible is met	Not Covered
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	10% Coinsurance per Admission after INET plan Deductible is met	Not Covered
Emergency and Urgent Care		
Ambulance Services	10% Coinsurance per service after INET plan Deductible is met	Same as In-Network
Emergency Room	10% Coinsurance per visit after INET plan Deductible is met	Same as In-Network
Urgent Care Centers	$100 Copayment per visit	Same as In-Network
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	0% Coinsurance per visit	Not Covered
Basic Services	40% Coinsurance per visit after INET plan Deductible is met	Not Covered
Major Services	50% Coinsurance per visit after INET plan Deductible is met	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	Not Covered

Adult Dental Care (for Members age 26 and over)		
Diagnostic & Preventive Exams Cleanings Bitewing X-rays X-rays (full Mouth or Panoramic) Office Visit Copay Note: please see “Adult Dental Care” in the “What is Covered” section for additional information.	20% Coinsurance per visit	Not Covered
Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	$0 Copayment	Not Covered
Single Vision Lenses	$0 Copayment	Not Covered
Bifocal	$0 Copayment	Not Covered
Trifocal	$0 Copayment	Not Covered
Collection Frame	$0 Copayment	Not Covered
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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	Not Covered
Adult Vision Care (for Subscriber and spouse age 19 and older)		
Prescription Eye Glasses Single Vision Lenses	$40 Copayment	Not Covered

Bifocal Lenses	$40 Copayment	Not Covered
Trifocal Lenses	$40 Copayment	Not Covered
Frames One frame every other Calendar Year	Covered up to $100	Not Covered
Contact Lenses Once every other Calendar Year		
Elective (conventional and disposable)	Covered up to $80	Not Covered
Non-Elective	$0 Copayment	Not Covered
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	$40 Copayment per visit	Not Covered
Important Note: Benefits for contact lenses are in lieu of Your eyeglass lens benefit. If You receive contact lenses, no benefit will be available for eyeglass lenses until the next benefit period.		

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Covered Dental Services pediatric dental services are covered for Members until age 26. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see “Pediatric Dental Care” in the “What is Covered” section for more information on pediatric dental services.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the “Preventive Care Services” section of this

Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;
- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem
Individual Market
Silver PPO Standard Pathway 73% CSR
Schedule of Benefits
Non-Tiered Network Plan

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$5,000 per Member	$10,000 per Member
Family	$10,000 per family	$20,000 per family
Separate Prescription Drug Deductible **Individual**	$250 per Member	$500 per Member
Family	$500 per family	$1,000 per family
Out-of-Pocket Maximum **Individual**	$7,675 per Member	$18,200 per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$15,350 per family	$36,400 per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	40% Coinsurance per visit
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$45 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	$60 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	$45 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	$75 Copayment per service up to a combined maximum of $375 for MRI and CAT scans; $400 for PET scans	40% Coinsurance per service after OON plan Deductible is met
Laboratory Services	$25 Copayment per service	40% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	$40 Copayment per service after INET plan Deductible is met	40% Coinsurance per service after OON plan Deductible is met
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	$20 Copayment per service	40% Coinsurance per service after OON plan Deductible is met
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$10 Copayment per prescription	40% per prescription after OON prescription drug Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$50 Copayment per prescription after INET prescription drug Deductible is met	40% per prescription after OON prescription drug Deductible is met
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$75 Copayment per prescription after INET prescription drug Deductible is met	40% per prescription after OON prescription drug Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription after INET prescription drug Deductible is met up to a maximum of $100 per prescription	40% per prescription after OON prescription drug Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$30 Copayment per prescription	40% per prescription after OON prescription drug Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$150 Copayment per prescription after INET prescription drug Deductible is met	40% per prescription after OON prescription drug Deductible is met
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$225 Copayment per prescription after INET prescription drug Deductible is met	40% per prescription after OON prescription drug Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription after INET prescription drug Deductible is met up to a maximum of $100 per prescription	40% per prescription after OON prescription drug Deductible is met
Outpatient Rehabilitative and Habilitative Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	$50 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	40% Coinsurance per equipment/supply	40% Coinsurance per equipment/supply after OON plan Deductible is met
Durable Medical Equipment (DME)	40% Coinsurance per equipment/supply	40% Coinsurance per equipment/supply after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	No Cost	25% Coinsurance per visit after separate $50 Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Outpatient Services **(in a Hospital or ambulatory Facility)**	$500 Copayment per visit after INET plan Deductible is met at an Outpatient Hospital Facility $300 Copayment per visit after INET plan Deductible is met at an Ambulatory Surgery Center	40% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	$500 Copayment per day to a maximum of $2,000 per Admission after INET plan Deductible is met	40% Coinsurance per admission after OON plan Deductible is met
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	$500 Copayment per day to a maximum of $2,000 per Admission after INET plan Deductible is met	40% Coinsurance per admission after OON plan Deductible is met
Emergency and Urgent Care		
Ambulance Services	No Cost	Same as In-Network
Emergency Room	$450 Copayment per visit after INET plan Deductible is met	Same as In-Network
Urgent Care Centers	$75 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	No Cost	50% Coinsurance per visit after OON plan Deductible is met
Basic Services	40% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Major Services	50% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	$0 Copayment per visit	50% Coinsurance per visit after the OON plan Deductible is met
Single Vision Lenses	$0 Copayment per visit	50% Coinsurance per visit after the OON plan Deductible is met
Bifocal	$0 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Trifocal	$0 Copayment per visit	50% Coinsurance per visit after the OON plan Deductible is met
Collection Frame	$0 Copayment per visit	50% Coinsurance per visit after the OON plan Deductible is met
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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	40% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Covered Dental Services pediatric dental services are covered for Members until age 26. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see “Pediatric Dental Care” in the “What is Covered” section for more information on pediatric dental services.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the “Preventive Care Services” section of this

Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;
- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Urgent Care Center services received from a BlueCard® Provider will be covered at the In-Network level.

Urgent Care Center services received from a non-BlueCard® Provider will be covered at the Out-of-Network level.

All non-urgent services (BlueCard® or non-BlueCard®) will be covered at the Out-of-Network level.

The Home Health Care 100 visit limit is a combined In and Out-of-Network visit limit.

Anthem
Individual Market
Bronze PPO Pathway with PreventiveRx ZCSR
Schedule of Benefits
Non-Tiered Network Plan

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$0 per Member	$0 per Member
Family	$0 per family	$0 per family
Out-of-Pocket Maximum **Individual**	$0 per Member	$0 per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$0 per family	$0 per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	No Cost
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	No Cost	No Cost
Virtual Visits with PCP	No Cost	No Cost
Virtual Visits from PCP Virtual Care-Only Provider through Our mobile app and website	No Cost	No Cost
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	No Cost	No Cost
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	No Cost	No Cost
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	No Cost	No Cost
Laboratory Services	No Cost	No Cost
Non-Advanced Radiology (X-ray, Diagnostic)	No Cost	No Cost
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	No Cost	No Cost

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary). **PreventiveRx Note:** No Copayment, Deductible, or Coinsurance applies to Prescription Drugs on the PreventiveRx Basic List when you use an In-Network Pharmacy		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	No Cost	No Cost
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary). **PreventiveRx Note:** No Copayment, Deductible, or Coinsurance applies to Prescription Drugs on the PreventiveRx Basic List when you use an In-Network Pharmacy		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	No Cost	No Cost
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost
Outpatient Rehabilitative and Habilitative Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	No Cost	No Cost
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	No Cost	No Cost
Other Services		
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	No Cost	No Cost
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	No Cost	No Cost
Durable Medical Equipment (DME)	No Cost	No Cost
Home Health Care Services **(up to 100 visits per Calendar Year)**	No Cost	No Cost
Outpatient Services **(in a Hospital or ambulatory Facility)**	No Cost	No Cost
Inpatient Hospital Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Inpatient Hospital services **(All Inpatient settings)**	No Cost	No Cost
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	No Cost	No Cost
Emergency and Urgent Care		
Ambulance Services	No Cost	Same as In-Network
Emergency Room	No Cost	Same as In-Network
Urgent Care Centers	No Cost	No Cost

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	No Cost	No Cost
Single Vision Lenses	No Cost	No Cost
Bifocal	No Cost	No Cost
Trifocal	No Cost	No Cost
Collection Frame	No Cost	No Cost
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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)	No Cost	No Cost

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the “Preventive Care Services” section of this Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government’s web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;

- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Urgent Care Center services received from a BlueCard® Provider will be covered at the In-Network level.

Urgent Care Center services received from a non-BlueCard® Provider will be covered at the Out-of-Network level.

All non-urgent services (BlueCard® or non-BlueCard®) will be covered at the Out-of-Network level.

The Home Health Care 100 visit limit is a combined In and Out-of-Network visit limit.

Anthem
Individual Market

Gold HMO Pathway Enhanced with Adult Dental and Vision Benefits

Schedule of Benefits
Non-Tiered Network Plan

Your plan provides You with the option to lower Your Out-of-Pocket costs for certain services by going to Site of Service Providers. These Providers may have lower cost shares and Maximum Allowed Amounts, reducing Your Out-of-Pocket costs for certain services. When You use the "Find a Doctor" tool on anthem.com, look for the "SOS" indicator under the Provider's name, and when applicable, the tool will automatically sort and show these Providers first in Your results.

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$2,000 per Member	Not Covered per Member
Family	$4,000 per family	Not Covered per family
Out-of-Pocket Maximum **Individual**	$8,000 per Member	Not Covered per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$16,000 per family	Not Covered per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	Not Covered
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$20 Copayment per visit	Not Covered
Virtual Visits with PCP	$20 Copayment per visit	Not Covered
Virtual Visits from PCP Virtual Care-Only Provider through Our mobile app and website	$0 Copayment per visit	Not Applicable
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	$80 Copayment per visit	Not Covered
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	10% Coinsurance per visit after INET plan Deductible is met	Not Covered
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	10% Coinsurance per service after INET plan Deductible is met	Not Covered
Site of Service Provider	$75 Copayment per service after INET plan Deductible is met up to a combined maximum of $375 for MRI and CAT scans; $400 for PET scans	Not Covered
Laboratory Services	10% Coinsurance per service after INET plan Deductible is met	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Non-Advanced Radiology (X-ray, Diagnostic)	10% Coinsurance per service after INET plan Deductible is met	Not Covered
Site of Service Provider	$40 Copayment per service after INET plan Deductible is met	Not Covered
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	10% Coinsurance per service after INET plan Deductible is met	Not Covered
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$5 Copayment per prescription	Not Covered
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$40 Copayment per prescription	Not Covered
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription up to a maximum of $500 per prescription	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	30% Coinsurance per prescription up to a maximum of $1000 per prescription	Not Covered
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$15 Copayment per prescription	Not Covered
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$120 Copayment per prescription	Not Covered
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	30% Coinsurance per prescription up to a maximum of $1000 per prescription	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit	Not Covered
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit	Not Covered
Other Services		
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	$30 Copayment per visit	Not Covered
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	40% Coinsurance per equipment/supply	Not Covered
Durable Medical Equipment (DME)	40% Coinsurance per equipment/supply	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Home Health Care Services **(up to 100 visits per Calendar Year)**	10% Coinsurance per visit after separate $50 Deductible is met	Not Covered
Outpatient Services **(in a Hospital or ambulatory Facility)**	10% Coinsurance per visit after INET plan Deductible is met	Not Covered
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	10% Coinsurance per Admission after INET plan Deductible is met	Not Covered
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	10% Coinsurance per Admission after INET plan Deductible is met	Not Covered
Emergency and Urgent Care		
Ambulance Services	10% Coinsurance per service after INET plan Deductible is met	Same as In-Network
Emergency Room	10% Coinsurance per visit after INET plan Deductible is met	Same as In-Network
Urgent Care Centers	$100 Copayment per visit	Same as In-Network
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	0% Coinsurance per visit	Not Covered
Basic Services	40% Coinsurance per visit after INET plan Deductible is met	Not Covered
Major Services	50% Coinsurance per visit after INET plan Deductible is met	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	Not Covered

Adult Dental Care (for Members age 26 and over)		
Diagnostic & Preventive Exams Cleanings Bitewing X-rays X-rays (full Mouth or Panoramic) Office Visit Copay Note: please see “Adult Dental Care” in the “What is Covered” section for additional information.	20% Coinsurance per visit	Not Covered
Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	$0 Copayment	Not Covered
Single Vision Lenses	$0 Copayment	Not Covered
Bifocal	$0 Copayment	Not Covered
Trifocal	$0 Copayment	Not Covered
Collection Frame	$0 Copayment	Not Covered
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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	Not Covered
Adult Vision Care (for Subscriber and spouse age 19 and older)		
Prescription Eye Glasses Single Vision Lenses	$40 Copayment	Not Covered

Bifocal Lenses	$40 Copayment	Not Covered
Trifocal Lenses	$40 Copayment	Not Covered
Frames One frame every other Calendar Year	Covered up to $100	Not Covered
Contact Lenses Once every other Calendar Year		
Elective (conventional and disposable)	Covered up to $80	Not Covered
Non-Elective	$0 Copayment	Not Covered
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	$40 Copayment per visit	Not Covered
Important Note: Benefits for contact lenses are in lieu of Your eyeglass lens benefit. If You receive contact lenses, no benefit will be available for eyeglass lenses until the next benefit period.		

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Covered Dental Services pediatric dental services are covered for Members until age 26. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see “Pediatric Dental Care” in the “What is Covered” section for more information on pediatric dental services.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the “Preventive Care Services” section of this

Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;
- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem
Individual Market
Bronze PPO Standard Pathway ZCSR
Schedule of Benefits
Non-Tiered Network Plan

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$0 per Member	$0 per Member
Family	$0 per family	$0 per family
Out-of-Pocket Maximum **Individual**	$0 per Member	$0 per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$0 per family	$0 per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	No Cost
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	No Cost	No Cost
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	No Cost	No Cost
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	No Cost	No Cost
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	No Cost	No Cost
Laboratory Services	No Cost	No Cost
Non-Advanced Radiology (X-ray, Diagnostic)	No Cost	No Cost
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	No Cost	No Cost
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	No Cost	No Cost
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	No Cost	No Cost
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost
Outpatient Rehabilitative and Habilitative Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	No Cost	No Cost
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	No Cost	No Cost
Other Services		
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	No Cost	No Cost
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	No Cost	No Cost
Durable Medical Equipment (DME)	No Cost	No Cost
Home Health Care Services **(up to 100 visits per Calendar Year)**	No Cost	No Cost
Outpatient Services **(in a Hospital or ambulatory Facility)**	No Cost	No Cost
Inpatient Hospital Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Inpatient Hospital services **(All Inpatient settings)**	No Cost	No Cost
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	No Cost	No Cost
Emergency and Urgent Care		
Ambulance Services	No Cost	Same as In-Network
Emergency Room	No Cost	Same as In-Network
Urgent Care Centers	No Cost	No Cost
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	0% Coinsurance per visit after INET plan Deductible is met	0% Coinsurance per visit after OON plan Deductible is met
Basic Services	0% Coinsurance per visit after INET plan Deductible is met	0% Coinsurance per visit after OON plan Deductible is met
Major Services	0% Coinsurance per visit after INET plan Deductible is met	0% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	0% Coinsurance per visit after INET plan Deductible is met	0% Coinsurance per visit after OON plan Deductible is met

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	No Cost	No Cost
Single Vision Lenses	No Cost	No Cost
Bifocal	No Cost	No Cost
Trifocal	No Cost	No Cost
Collection Frame	No Cost	No Cost
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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)	No Cost	No Cost

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Covered Dental Services pediatric dental services are covered for Members until age 26. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see “Pediatric Dental Care” in the “What is Covered” section for more information on pediatric dental services.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the “Preventive Care Services” section of this

Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;
- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Urgent Care Center services received from a BlueCard® Provider will be covered at the In-Network level.

Urgent Care Center services received from a non-BlueCard® Provider will be covered at the Out-of-Network level.

All non-urgent services (BlueCard® or non-BlueCard®) will be covered at the Out-of-Network level.

The Home Health Care 100 visit limit is a combined In and Out-of-Network visit limit.

Anthem
Individual Market
Catastrophic HMO Pathway Enhanced
Schedule of Benefits
Non-Tiered Network Plan

Your plan provides You with the option to lower Your Out-of-Pocket costs for certain services by going to Site of Service Providers. These Providers may have lower cost shares and Maximum Allowed Amounts, reducing Your Out-of-Pocket costs for certain services. When You use the "Find a Doctor" tool on anthem.com, look for the "SOS" indicator under the Provider's name, and when applicable, the tool will automatically sort and show these Providers first in Your results.

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$10,600 per Member	Not Covered per Member
Family	$21,200 per family	Not Covered per family
Out-of-Pocket Maximum **Individual**	$10,600 per Member	Not Covered per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$21,200 per family	Not Covered per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	Not Covered
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$40 Copayment for the first 3 visits (Deductible is waived), then $0 Copayment per visit after INET plan Deductible is met	Not Covered
Virtual Visits with PCP	$40 Copayment for the first 3 visits (Deductible is waived), then $0 Copayment per visit after INET plan Deductible is met	Not Covered
Virtual Visits from PCP Virtual Care-Only Provider through Our mobile app and website	$0 Copayment per visit after INET plan Deductible is met	Not Applicable
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	0% Coinsurance per visit after INET plan Deductible is met	Not Covered
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	0% Coinsurance per visit after INET plan Deductible is met	Not Covered
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	0% Coinsurance per service after INET plan Deductible is met	Not Covered
Laboratory Services	0% Coinsurance per service after INET plan Deductible is met	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Non-Advanced Radiology (X-ray, Diagnostic)	0% Coinsurance per service after INET plan Deductible is met	Not Covered
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	0% Coinsurance per service after INET plan Deductible is met	Not Covered
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	0% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	0% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	0% Coinsurance per prescription after INET plan Deductible is met	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	0% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	0% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	0% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	0% Coinsurance per prescription after INET plan Deductible is met	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	0% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	0% Coinsurance per visit after INET plan Deductible is met	Not Covered
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	0% Coinsurance per visit after INET plan Deductible is met	Not Covered
Other Services		
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	0% Coinsurance per visit after INET plan Deductible is met	Not Covered
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	0% Coinsurance per equipment/supply after INET plan Deductible is met	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Durable Medical Equipment (DME)	0% Coinsurance per equipment/supply after INET plan Deductible is met	Not Covered
Home Health Care Services **(up to 100 visits per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met	Not Covered
Outpatient Services **(in a Hospital or ambulatory Facility)**	0% Coinsurance per visit after INET plan Deductible is met	Not Covered
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	0% Coinsurance per Admission after INET plan Deductible is met	Not Covered
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	0% Coinsurance per Admission after INET plan Deductible is met	Not Covered
Emergency and Urgent Care		
Ambulance Services	0% Coinsurance per service after INET plan Deductible is met	Same as In-Network
Emergency Room	0% Coinsurance per visit after INET plan Deductible is met	Same as In-Network
Urgent Care Centers	0% Coinsurance per visit after INET plan Deductible is met	Same as In-Network
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	0% Coinsurance per visit after INET plan Deductible is met	Not Covered
Basic Services	0% Coinsurance per visit after INET plan Deductible is met	Not Covered
Major Services	0% Coinsurance per visit after INET plan Deductible is met	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Orthodontia Services **(Medically Necessary only)**	0% Coinsurance per visit after INET plan Deductible is met	Not Covered

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	$0 Copayment after INET plan Deductible is met	Not Covered
Single Vision Lenses	$0 Copayment after INET plan Deductible is met	Not Covered
Bifocal	$0 Copayment after INET plan Deductible is met	Not Covered
Trifocal	$0 Copayment after INET plan Deductible is met	Not Covered
Collection Frame	$0 Copayment after INET plan Deductible is met	Not Covered
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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)	$0 Copayment per visit after INET plan Deductible is met	Not Covered

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Covered Dental Services pediatric dental services are covered for Members until age 26. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see “Pediatric Dental Care” in the “What is Covered” section for more information on pediatric dental services.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the “Preventive Care Services” section of this

Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;
- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Primary Care and Mental Health and Substance Abuse Provider Office Visits combined (for non-standard plans) subject to Copayment for the first three visits, not subject to the Deductible. Subsequent Office Visits are subject to medical Deductible.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem
Individual Market
Gold PPO Pathway ZCSR
Schedule of Benefits
Non-Tiered Network Plan

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$0 per Member	$0 per Member
Family	$0 per family	$0 per family
Out-of-Pocket Maximum **Individual**	$0 per Member	$0 per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$0 per family	$0 per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	No Cost
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	No Cost	No Cost
Virtual Visits with PCP	No Cost	No Cost
Virtual Visits from PCP Virtual Care-Only Provider through Our mobile app and website	No Cost	No Cost
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	No Cost	No Cost
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	No Cost	No Cost
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	No Cost	No Cost
Laboratory Services	No Cost	No Cost
Non-Advanced Radiology (X-ray, Diagnostic)	No Cost	No Cost
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	No Cost	No Cost

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	No Cost	No Cost
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	No Cost	No Cost
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost
Outpatient Rehabilitative and Habilitative Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	No Cost	No Cost
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	No Cost	No Cost
Other Services		
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	No Cost	No Cost
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	No Cost	No Cost
Durable Medical Equipment (DME)	No Cost	No Cost
Home Health Care Services **(up to 100 visits per Calendar Year)**	No Cost	No Cost
Outpatient Services **(in a Hospital or ambulatory Facility)**	No Cost	No Cost
Inpatient Hospital Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Inpatient Hospital services **(All Inpatient settings)**	No Cost	No Cost
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	No Cost	No Cost
Emergency and Urgent Care		
Ambulance Services	No Cost	Same as In-Network
Emergency Room	No Cost	Same as In-Network
Urgent Care Centers	No Cost	No Cost

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	No Cost	No Cost
Single Vision Lenses	No Cost	No Cost
Bifocal	No Cost	No Cost
Trifocal	No Cost	No Cost
Collection Frame	No Cost	No Cost
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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)	No Cost	No Cost

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the “Preventive Care Services” section of this Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government’s web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;

- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Urgent Care Center services received from a BlueCard® Provider will be covered at the In-Network level.

Urgent Care Center services received from a non-BlueCard® Provider will be covered at the Out-of-Network level.

All non-urgent services (BlueCard® or non-BlueCard®) will be covered at the Out-of-Network level.

The Home Health Care 100 visit limit is a combined In and Out-of-Network visit limit.

Anthem
Individual Market

Anthem Gold PPO Pathway 2000/10% with Adult Dental and Vision Benefits

Schedule of Benefits
Non-Tiered Network Plan

Your plan provides You with the option to lower Your Out-of-Pocket costs for certain services by going to Site of Service Providers. These Providers may have lower cost shares and Maximum Allowed Amounts, reducing Your Out-of-Pocket costs for certain services. When You use the "Find a Doctor" tool on anthem.com, look for the "SOS" indicator under the Provider's name, and when applicable, the tool will automatically sort and show these Providers first in Your results.

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$2,000 per Member	$4,000 per Member
Family	$4,000 per family	$8,000 per family
Out-of-Pocket Maximum **Individual**	$8,000 per Member	$16,000 per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$16,000 per family	$32,000 per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	50% Coinsurance per visit
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$20 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Virtual Visits with PCP	$20 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Virtual Visits from PCP Virtual Care-Only Provider through Our mobile app and website	$0 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	$80 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	10% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Site of Service Provider	$75 Copayment per service after INET plan Deductible is met up to a combined maximum of $375 for MRI and CAT scans; $400 for PET scans	50% Coinsurance per service after OON plan Deductible is met
Laboratory Services	10% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Non-Advanced Radiology (X-ray, Diagnostic)	10% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Site of Service Provider	$40 Copayment per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	10% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$5 Copayment per prescription	50% per prescription after OON plan Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$40 Copayment per prescription	50% per prescription after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription up to a maximum of $500 per prescription	50% per prescription after OON plan Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	30% Coinsurance per prescription up to a maximum of $1000 per prescription	50% per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$15 Copayment per prescription	50% per prescription after OON plan Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$120 Copayment per prescription	50% per prescription after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription	50% per prescription after OON plan Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	30% Coinsurance per prescription up to a maximum of $1000 per prescription	50% per prescription after OON plan Deductible is met
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Other Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	$30 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the "Prescription Drug" section for details.	40% Coinsurance per equipment/supply	50% Coinsurance per equipment/supply after OON plan Deductible is met
Durable Medical Equipment (DME)	40% Coinsurance per equipment/supply	50% Coinsurance per equipment/supply after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	10% Coinsurance per visit after separate $50 Deductible is met	25% Coinsurance per visit after separate $50 Deductible is met
Outpatient Services **(in a Hospital or ambulatory Facility)**	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	10% Coinsurance per Admission after INET plan Deductible is met	50% Coinsurance per admission after OON plan Deductible is met
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	10% Coinsurance per Admission after INET plan Deductible is met	50% Coinsurance per admission after OON plan Deductible is met
Emergency and Urgent Care		
Ambulance Services	10% Coinsurance per service after INET plan Deductible is met	Same as In-Network
Emergency Room	10% Coinsurance per visit after INET plan Deductible is met	Same as In-Network
Urgent Care Centers	$100 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	No Cost	No Cost
Basic Services	40% Coinsurance per visit after INET plan Deductible is met	40% Coinsurance per visit after OON plan Deductible is met
Major Services	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Adult Dental Care (for Members age 26 and over)		
Diagnostic & Preventive Exams Cleanings Bitewing X-rays X-rays (full Mouth or Panoramic) Office Visit Copay Note: please see “Adult Dental Care” in the “What is Covered” section for additional information.	20% Coinsurance per visit	20% Coinsurance per visit
Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	$0 Copayment	50% Coinsurance
Single Vision Lenses	$0 Copayment	50% Coinsurance
Bifocal	$0 Copayment	50% Coinsurance
Trifocal	$0 Copayment	50% Coinsurance
Collection Frame	$0 Copayment	50% Coinsurance
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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	50% Coinsurance per visit
Adult Vision Care (for Subscriber and spouse age 19 and older)		
Prescription Eye Glasses Single Vision Lenses	$40 Copayment	Reimbursed up to $25

Bifocal Lenses Trifocal Lenses Frames One frame every other Calendar Year	$40 Copayment $40 Copayment Covered up to $100	Reimbursed up to $40 Reimbursed up to $55 Reimbursed up to $45
Contact Lenses Once every other Calendar Year		
Elective (conventional and disposable) **Non-Elective**	Covered up to $80 $0 Copayment	Reimbursed up to $60 Reimbursed up to $210
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	$40 Copayment per visit	Reimbursed up to $30
Important Note: Benefits for contact lenses are in lieu of Your eyeglass lens benefit. If You receive contact lenses, no benefit will be available for eyeglass lenses until the next benefit period.		

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Covered Dental Services pediatric dental services are covered for Members until age 26. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see “Pediatric Dental Care” in the “What is Covered” section for more information on pediatric dental services.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the “Preventive Care Services” section of this

Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;
- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Urgent Care Center services received from a BlueCard® Provider will be covered at the In-Network level.

Urgent Care Center services received from a non-BlueCard® Provider will be covered at the Out-of-Network level.

All non-urgent services (BlueCard® or non-BlueCard®) will be covered at the Out-of-Network level.

The Home Health Care 100 visit limit is a combined In and Out-of-Network visit limit.

Anthem
Individual Market

Anthem Bronze PPO Standard Pathway 6500/13000/20% HSA

Schedule of Benefits
Non-Tiered Network Plan

Your plan provides You with the option to lower Your Out-of-Pocket costs for certain services by going to Site of Service Providers. These Providers may have lower cost shares and Maximum Allowed Amounts, reducing Your Out-of-Pocket costs for certain services. When You use the "Find a Doctor" tool on anthem.com, look for the "SOS" indicator under the Provider's name, and when applicable, the tool will automatically sort and show these Providers first in Your results.

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$6,500 per Member	$13,000 per Member
Family	$13,000 per family	$26,000 per family
Out-of-Pocket Maximum **Individual**	$7,225 per Member	$14,450 per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$14,450 per family	$28,900 per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	50% Coinsurance per visit
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	20% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Site of Service Provider	20% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Laboratory Services	20% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	20% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Site of Service Provider	20% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	20% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	20% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	25% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	30% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	30% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription	50% per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	20% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	25% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	30% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	30% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription	50% per prescription after OON plan Deductible is met
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	20% Coinsurance per equipment/supply after INET plan Deductible is met	50% Coinsurance per equipment/supply after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Durable Medical Equipment (DME)	20% Coinsurance per equipment/supply after INET plan Deductible is met	50% Coinsurance per equipment/supply after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	20% Coinsurance per visit after INET plan Deductible is met	25% Coinsurance per visit after OON plan Deductible is met
Outpatient Services **(in a Hospital or ambulatory Facility)**	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	20% Coinsurance per Admission after INET plan Deductible is met	50% Coinsurance per admission after OON plan Deductible is met
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	20% Coinsurance per Admission after INET plan Deductible is met	50% Coinsurance per admission after OON plan Deductible is met
Emergency and Urgent Care		
Ambulance Services	20% Coinsurance per service after INET plan Deductible is met	Same as In-Network
Emergency Room	20% Coinsurance per visit after INET plan Deductible is met	Same as In-Network
Urgent Care Centers	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	No Cost	50% Coinsurance per visit after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Basic Services	40% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Major Services	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	$0 Copayment after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
Single Vision Lenses	$0 Copayment after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
Bifocal	$0 Copayment after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Trifocal	$0 Copayment after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
Collection Frame	$0 Copayment after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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 plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% Coinsurance after Deductible. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Covered Dental Services pediatric dental services are covered for Members until age 26. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see “Pediatric Dental Care” in the “What is Covered” section for more information on pediatric dental services.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the “Preventive Care Services” section of this

Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;
- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Urgent Care Center services received from a BlueCard® Provider will be covered at the In-Network level.

Urgent Care Center services received from a non-BlueCard® Provider will be covered at the Out-of-Network level.

All non-urgent services (BlueCard® or non-BlueCard®) will be covered at the Out-of-Network level.

The Home Health Care 100 visit limit is a combined In and Out-of-Network visit limit.

Anthem
Individual Market

Gold HMO Pathway Enhanced LCSR with Adult Dental and Vision Benefits

Schedule of Benefits
Non-Tiered Network Plan

Your plan provides You with the option to lower Your Out-of-Pocket costs for certain services by going to Site of Service Providers. These Providers may have lower cost shares and Maximum Allowed Amounts, reducing Your Out-of-Pocket costs for certain services. When You use the "Find a Doctor" tool on anthem.com, look for the "SOS" indicator under the Provider's name, and when applicable, the tool will automatically sort and show these Providers first in Your results.

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$2,000 per Member	Not Covered per Member
Family	$4,000 per family	Not Covered per family
Out-of-Pocket Maximum **Individual**	$8,000 per Member	Not Covered per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$16,000 per family	Not Covered per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	Not Covered
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$20 Copayment per visit	Not Covered
Virtual Visits with PCP	$20 Copayment per visit	Not Covered
Virtual Visits from PCP Virtual Care-Only Provider through Our mobile app and website	$0 Copayment per visit	Not Applicable
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	$80 Copayment per visit	Not Covered
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	10% Coinsurance per visit after INET plan Deductible is met	Not Covered
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	10% Coinsurance per service after INET plan Deductible is met	Not Covered
Site of Service Provider	$75 Copayment per service after INET plan Deductible is met up to a combined maximum of $375 for MRI and CAT scans; $400 for PET scans	Not Covered
Laboratory Services	10% Coinsurance per service after INET plan Deductible is met	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Non-Advanced Radiology (X-ray, Diagnostic)	10% Coinsurance per service after INET plan Deductible is met	Not Covered
Site of Service Provider	$40 Copayment per service after INET plan Deductible is met	Not Covered
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	10% Coinsurance per service after INET plan Deductible is met	Not Covered
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$5 Copayment per prescription	Not Covered
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$40 Copayment per prescription	Not Covered
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription up to a maximum of $500 per prescription	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	30% Coinsurance per prescription up to a maximum of $1000 per prescription	Not Covered
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$15 Copayment per prescription	Not Covered
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$120 Copayment per prescription	Not Covered
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	30% Coinsurance per prescription up to a maximum of $1000 per prescription	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit	Not Covered
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit	Not Covered
Other Services		
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	$30 Copayment per visit	Not Covered
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	40% Coinsurance per equipment/supply	Not Covered
Durable Medical Equipment (DME)	40% Coinsurance per equipment/supply	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Home Health Care Services **(up to 100 visits per Calendar Year)**	10% Coinsurance per visit after separate $50 Deductible is met	Not Covered
Outpatient Services **(in a Hospital or ambulatory Facility)**	10% Coinsurance per visit after INET plan Deductible is met	Not Covered
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	10% Coinsurance per Admission after INET plan Deductible is met	Not Covered
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	10% Coinsurance per Admission after INET plan Deductible is met	Not Covered
Emergency and Urgent Care		
Ambulance Services	10% Coinsurance per service after INET plan Deductible is met	Same as In-Network
Emergency Room	10% Coinsurance per visit after INET plan Deductible is met	Same as In-Network
Urgent Care Centers	$100 Copayment per visit	Same as In-Network
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	0% Coinsurance per visit	Not Covered
Basic Services	40% Coinsurance per visit after INET plan Deductible is met	Not Covered
Major Services	50% Coinsurance per visit after INET plan Deductible is met	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	Not Covered

Adult Dental Care (for Members age 26 and over)		
Diagnostic & Preventive Exams Cleanings Bitewing X-rays X-rays (full Mouth or Panoramic) Office Visit Copay Note: please see “Adult Dental Care” in the “What is Covered” section for additional information.	20% Coinsurance per visit	Not Covered
Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	$0 Copayment	Not Covered
Single Vision Lenses	$0 Copayment	Not Covered
Bifocal	$0 Copayment	Not Covered
Trifocal	$0 Copayment	Not Covered
Collection Frame	$0 Copayment	Not Covered
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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	Not Covered
Adult Vision Care (for Subscriber and spouse age 19 and older)		
Prescription Eye Glasses Single Vision Lenses	$40 Copayment	Not Covered

Bifocal Lenses Trifocal Lenses Frames One frame every other Calendar Year	$40 Copayment $40 Copayment Covered up to $100	Not Covered Not Covered Not Covered
Contact Lenses Once every other Calendar Year		
Elective (conventional and disposable) **Non-Elective**	Covered up to $80 $0 Copayment	Not Covered Not Covered
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	$40 Copayment per visit	Not Covered
Important Note: Benefits for contact lenses are in lieu of Your eyeglass lens benefit. If You receive contact lenses, no benefit will be available for eyeglass lenses until the next benefit period.		

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Covered Dental Services pediatric dental services are covered for Members until age 26. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see “Pediatric Dental Care” in the “What is Covered” section for more information on pediatric dental services.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the “Preventive Care Services” section of this

Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;
- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Eligible American Indians, as determined by the Exchange, enrolled in the Limited Cost Share Reduction plans, are exempt from Cost Sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no member responsibility for American Indians when Covered Services are rendered by one of these Providers.

Anthem
Individual Market
Gold PPO Pathway LCSR
Schedule of Benefits
Non-Tiered Network Plan

Your plan provides You with the option to lower Your Out-of-Pocket costs for certain services by going to Site of Service Providers. These Providers may have lower cost shares and Maximum Allowed Amounts, reducing Your Out-of-Pocket costs for certain services. When You use the "Find a Doctor" tool on anthem.com, look for the "SOS" indicator under the Provider's name, and when applicable, the tool will automatically sort and show these Providers first in Your results.

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$2,000 per Member	$4,000 per Member
Family	$4,000 per family	$8,000 per family
Out-of-Pocket Maximum **Individual**	$9,000 per Member	$18,000 per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$18,000 per family	$36,000 per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	50% Coinsurance per visit
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Virtual Visits with PCP	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Virtual Visits from PCP Virtual Care-Only Provider through Our mobile app and website	0% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	10% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Site of Service Provider	10% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Laboratory Services	10% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Non-Advanced Radiology (X-ray, Diagnostic)	10% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Site of Service Provider	10% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	10% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	10% Coinsurance per prescription	50% per prescription after OON plan Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription	50% per prescription after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription up to a maximum of $500 per prescription	50% per prescription after OON plan Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	30% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $1000 per prescription	50% per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	10% Coinsurance per prescription	50% per prescription after OON plan Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription	50% per prescription after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription	50% per prescription after OON plan Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	30% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $1000 per prescription	50% per prescription after OON plan Deductible is met
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Other Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the "Prescription Drug" section for details.	10% Coinsurance per equipment/supply after INET plan Deductible is met	50% Coinsurance per equipment/supply after OON plan Deductible is met
Durable Medical Equipment (DME)	10% Coinsurance per equipment/supply after INET plan Deductible is met	50% Coinsurance per equipment/supply after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	10% Coinsurance per visit after separate $50 Deductible is met	25% Coinsurance per visit after separate $50 Deductible is met
Outpatient Services **(in a Hospital or ambulatory Facility)**	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	10% Coinsurance per Admission after INET plan Deductible is met	50% Coinsurance per admission after OON plan Deductible is met
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	10% Coinsurance per Admission after INET plan Deductible is met	50% Coinsurance per admission after OON plan Deductible is met
Emergency and Urgent Care		
Ambulance Services	10% Coinsurance per service after INET plan Deductible is met	Same as In-Network
Emergency Room	10% Coinsurance per visit after INET plan Deductible is met	Same as In-Network
Urgent Care Centers	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	$0 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Single Vision Lenses	$0 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Bifocal	$0 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Trifocal	$0 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Collection Frame	$0 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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 per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the “Preventive Care Services” section of this Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government’s web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;

- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Urgent Care Center services received from a BlueCard® Provider will be covered at the In-Network level.

Urgent Care Center services received from a non-BlueCard® Provider will be covered at the Out-of-Network level.

All non-urgent services (BlueCard® or non-BlueCard®) will be covered at the Out-of-Network level.

The Home Health Care 100 visit limit is a combined In and Out-of-Network visit limit.

Eligible American Indians, as determined by the Exchange, enrolled in the Limited Cost Share Reduction plans, are exempt from Cost Sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no member responsibility for American Indians when Covered Services are rendered by one of these Providers.

Anthem
Individual Market

Gold PPO Pathway with Adult Dental and Vision Benefits

Schedule of Benefits
Non-Tiered Network Plan

Your plan provides You with the option to lower Your Out-of-Pocket costs for certain services by going to Site of Service Providers. These Providers may have lower cost shares and Maximum Allowed Amounts, reducing Your Out-of-Pocket costs for certain services. When You use the "Find a Doctor" tool on anthem.com, look for the "SOS" indicator under the Provider's name, and when applicable, the tool will automatically sort and show these Providers first in Your results.

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$2,000 per Member	$4,000 per Member
Family	$4,000 per family	$8,000 per family
Out-of-Pocket Maximum **Individual**	$8,000 per Member	$16,000 per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$16,000 per family	$32,000 per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	50% Coinsurance per visit
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$20 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Virtual Visits with PCP	$20 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Virtual Visits from PCP Virtual Care-Only Provider through Our mobile app and website	$0 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	$80 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	10% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Site of Service Provider	$75 Copayment per service after INET plan Deductible is met up to a combined maximum of $375 for MRI and CAT scans; $400 for PET scans	50% Coinsurance per service after OON plan Deductible is met
Laboratory Services	10% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Non-Advanced Radiology (X-ray, Diagnostic)	10% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Site of Service Provider	$40 Copayment per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	10% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$5 Copayment per prescription	50% per prescription after OON plan Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$40 Copayment per prescription	50% per prescription after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription up to a maximum of $500 per prescription	50% per prescription after OON plan Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	30% Coinsurance per prescription up to a maximum of $1000 per prescription	50% per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$15 Copayment per prescription	50% per prescription after OON plan Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$120 Copayment per prescription	50% per prescription after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription	50% per prescription after OON plan Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	30% Coinsurance per prescription up to a maximum of $1000 per prescription	50% per prescription after OON plan Deductible is met
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Other Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	$30 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the "Prescription Drug" section for details.	40% Coinsurance per equipment/supply	50% Coinsurance per equipment/supply after OON plan Deductible is met
Durable Medical Equipment (DME)	40% Coinsurance per equipment/supply	50% Coinsurance per equipment/supply after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	10% Coinsurance per visit after separate $50 Deductible is met	25% Coinsurance per visit after separate $50 Deductible is met
Outpatient Services **(in a Hospital or ambulatory Facility)**	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	10% Coinsurance per Admission after INET plan Deductible is met	50% Coinsurance per admission after OON plan Deductible is met
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	10% Coinsurance per Admission after INET plan Deductible is met	50% Coinsurance per admission after OON plan Deductible is met
Emergency and Urgent Care		
Ambulance Services	10% Coinsurance per service after INET plan Deductible is met	Same as In-Network
Emergency Room	10% Coinsurance per visit after INET plan Deductible is met	Same as In-Network
Urgent Care Centers	$100 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	No Cost	No Cost
Basic Services	40% Coinsurance per visit after INET plan Deductible is met	40% Coinsurance per visit after OON plan Deductible is met
Major Services	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Adult Dental Care (for Members age 26 and over)		
Diagnostic & Preventive Exams Cleanings Bitewing X-rays X-rays (full Mouth or Panoramic) Office Visit Copay Note: please see “Adult Dental Care” in the “What is Covered” section for additional information.	20% Coinsurance per visit	20% Coinsurance per visit
Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	$0 Copayment	50% Coinsurance
Single Vision Lenses	$0 Copayment	50% Coinsurance
Bifocal	$0 Copayment	50% Coinsurance
Trifocal	$0 Copayment	50% Coinsurance
Collection Frame	$0 Copayment	50% Coinsurance
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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	50% Coinsurance per visit
Adult Vision Care (for Subscriber and spouse age 19 and older)		
Prescription Eye Glasses Single Vision Lenses	$40 Copayment	Reimbursed up to $25

Bifocal Lenses Trifocal Lenses Frames One frame every other Calendar Year	$40 Copayment $40 Copayment Covered up to $100	Reimbursed up to $40 Reimbursed up to $55 Reimbursed up to $45
Contact Lenses Once every other Calendar Year		
Elective (conventional and disposable) **Non-Elective**	Covered up to $80 $0 Copayment	Reimbursed up to $60 Reimbursed up to $210
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	$40 Copayment per visit	Reimbursed up to $30
Important Note: Benefits for contact lenses are in lieu of Your eyeglass lens benefit. If You receive contact lenses, no benefit will be available for eyeglass lenses until the next benefit period.		

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Covered Dental Services pediatric dental services are covered for Members until age 26. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see “Pediatric Dental Care” in the “What is Covered” section for more information on pediatric dental services.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the “Preventive Care Services” section of this

Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;
- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Urgent Care Center services received from a BlueCard® Provider will be covered at the In-Network level.

Urgent Care Center services received from a non-BlueCard® Provider will be covered at the Out-of-Network level.

All non-urgent services (BlueCard® or non-BlueCard®) will be covered at the Out-of-Network level.

The Home Health Care 100 visit limit is a combined In and Out-of-Network visit limit.

Anthem
Individual Market

Anthem Gold PPO Pathway 2000/10%

Schedule of Benefits
Non-Tiered Network Plan

Your plan provides You with the option to lower Your Out-of-Pocket costs for certain services by going to Site of Service Providers. These Providers may have lower cost shares and Maximum Allowed Amounts, reducing Your Out-of-Pocket costs for certain services. When You use the "Find a Doctor" tool on anthem.com, look for the "SOS" indicator under the Provider's name, and when applicable, the tool will automatically sort and show these Providers first in Your results.

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$2,000 per Member	$4,000 per Member
Family	$4,000 per family	$8,000 per family
Out-of-Pocket Maximum **Individual**	$9,000 per Member	$18,000 per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$18,000 per family	$36,000 per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	50% Coinsurance per visit
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Virtual Visits with PCP	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Virtual Visits from PCP Virtual Care-Only Provider through Our mobile app and website	0% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	10% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Site of Service Provider	10% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Laboratory Services	10% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Non-Advanced Radiology (X-ray, Diagnostic)	10% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Site of Service Provider	10% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	10% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	10% Coinsurance per prescription	50% per prescription after OON plan Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription	50% per prescription after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription up to a maximum of $500 per prescription	50% per prescription after OON plan Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	30% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $1000 per prescription	50% per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	10% Coinsurance per prescription	50% per prescription after OON plan Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription	50% per prescription after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription	50% per prescription after OON plan Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	30% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $1000 per prescription	50% per prescription after OON plan Deductible is met
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Other Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the "Prescription Drug" section for details.	10% Coinsurance per equipment/supply after INET plan Deductible is met	50% Coinsurance per equipment/supply after OON plan Deductible is met
Durable Medical Equipment (DME)	10% Coinsurance per equipment/supply after INET plan Deductible is met	50% Coinsurance per equipment/supply after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	10% Coinsurance per visit after separate $50 Deductible is met	25% Coinsurance per visit after separate $50 Deductible is met
Outpatient Services **(in a Hospital or ambulatory Facility)**	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	10% Coinsurance per Admission after INET plan Deductible is met	50% Coinsurance per admission after OON plan Deductible is met
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	10% Coinsurance per Admission after INET plan Deductible is met	50% Coinsurance per admission after OON plan Deductible is met
Emergency and Urgent Care		
Ambulance Services	10% Coinsurance per service after INET plan Deductible is met	Same as In-Network
Emergency Room	10% Coinsurance per visit after INET plan Deductible is met	Same as In-Network
Urgent Care Centers	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	$0 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Single Vision Lenses	$0 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Bifocal	$0 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Trifocal	$0 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Collection Frame	$0 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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 per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the “Preventive Care Services” section of this Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government’s web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;

- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Urgent Care Center services received from a BlueCard® Provider will be covered at the In-Network level.

Urgent Care Center services received from a non-BlueCard® Provider will be covered at the Out-of-Network level.

All non-urgent services (BlueCard® or non-BlueCard®) will be covered at the Out-of-Network level.

The Home Health Care 100 visit limit is a combined In and Out-of-Network visit limit.

Anthem
Individual Market

Anthem Bronze HMO Pathway Enhanced 8500/50%

Schedule of Benefits
Non-Tiered Network Plan

Your plan provides You with the option to lower Your Out-of-Pocket costs for certain services by going to Site of Service Providers. These Providers may have lower cost shares and Maximum Allowed Amounts, reducing Your Out-of-Pocket costs for certain services. When You use the “Find a Doctor” tool on anthem.com, look for the “SOS” indicator under the Provider’s name, and when applicable, the tool will automatically sort and show these Providers first in Your results.

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$8,500 per Member	Not Covered per Member
Family	$17,000 per family	Not Covered per family
Out-of-Pocket Maximum **Individual**	$10,000 per Member	Not Covered per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$20,000 per family	Not Covered per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	Not Covered
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$40 Copayment per visit	Not Covered
Virtual Visits with PCP	$40 Copayment per visit	Not Covered
Virtual Visits from PCP Virtual Care-Only Provider through Our mobile app and website	$0 Copayment per visit	Not Applicable
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	50% Coinsurance per visit after INET plan Deductible is met	Not Covered
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	50% Coinsurance per visit after INET plan Deductible is met	Not Covered
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	50% Coinsurance per service after INET plan Deductible is met	Not Covered
Site of Service Provider	$50 Copayment per service after INET plan Deductible is met up to a combined maximum of $375 for MRI and CAT scans; $400 for PET scans	Not Covered
Laboratory Services	50% Coinsurance per service after INET plan Deductible is met	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Non-Advanced Radiology (X-ray, Diagnostic)	50% Coinsurance per service after INET plan Deductible is met	Not Covered
Site of Service Provider	$40 Copayment per service after INET plan Deductible is met	Not Covered
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	50% Coinsurance per service after INET plan Deductible is met	Not Covered
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$15 Copayment per prescription	Not Covered
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$50 Copayment per prescription after INET plan Deductible is met	Not Covered
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	40% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $750 per prescription	Not Covered
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$45 Copayment per prescription	Not Covered
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$150 Copayment per prescription after INET plan Deductible is met	Not Covered
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	40% Coinsurance per prescription after INET plan Deductible is met	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $750 per prescription	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$50 Copayment per visit after INET plan Deductible is met	Not Covered
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit after INET plan Deductible is met	Not Covered
Other Services		
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	$50 Copayment per visit after INET plan Deductible is met	Not Covered
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	50% Coinsurance per equipment/supply after INET plan Deductible is met	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Durable Medical Equipment (DME)	50% Coinsurance per equipment/supply after INET plan Deductible is met	Not Covered
Home Health Care Services **(up to 100 visits per Calendar Year)**	25% Coinsurance per visit after separate $50 Deductible is met	Not Covered
Outpatient Services **(in a Hospital or ambulatory Facility)**	50% Coinsurance per visit after INET plan Deductible is met	Not Covered
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	50% Coinsurance per Admission after INET plan Deductible is met	Not Covered
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	50% Coinsurance per Admission after INET plan Deductible is met	Not Covered
Emergency and Urgent Care		
Ambulance Services	50% Coinsurance per service after INET plan Deductible is met	Same as In-Network
Emergency Room	50% Coinsurance per visit after INET plan Deductible is met	Same as In-Network
Urgent Care Centers	$50 Copayment per visit	Same as In-Network
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	0% Coinsurance per visit	Not Covered
Basic Services	40% Coinsurance per visit after INET plan Deductible is met	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Major Services	50% Coinsurance per visit after INET plan Deductible is met	Not Covered
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	Not Covered

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	$0 Copayment	Not Covered
Single Vision Lenses	$0 Copayment	Not Covered
Bifocal	$0 Copayment	Not Covered
Trifocal	$0 Copayment	Not Covered
Collection Frame	$0 Copayment	Not Covered
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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	Not Covered

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Covered Dental Services pediatric dental services are covered for Members until age 26. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see “Pediatric Dental Care” in the “What is Covered” section for more information on pediatric dental services.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the “Preventive Care Services” section of this

Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;
- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem
Individual Market
Gold PPO Standard Pathway ZCSR
Schedule of Benefits
Non-Tiered Network Plan

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$0 per Member	$0 per Member
Family	$0 per family	$0 per family
Out-of-Pocket Maximum **Individual**	$0 per Member	$0 per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$0 per family	$0 per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	No Cost
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	No Cost	No Cost
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	No Cost	No Cost
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	No Cost	No Cost
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	No Cost	No Cost
Laboratory Services	No Cost	No Cost
Non-Advanced Radiology (X-ray, Diagnostic)	No Cost	No Cost
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	No Cost	No Cost
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	No Cost	No Cost
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	No Cost	No Cost
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost
Outpatient Rehabilitative and Habilitative Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	No Cost	No Cost
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	No Cost	No Cost
Other Services		
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	No Cost	No Cost
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	No Cost	No Cost
Durable Medical Equipment (DME)	No Cost	No Cost
Home Health Care Services **(up to 100 visits per Calendar Year)**	No Cost	No Cost
Outpatient Services **(in a Hospital or ambulatory Facility)**	No Cost	No Cost
Inpatient Hospital Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Inpatient Hospital services **(All Inpatient settings)**	No Cost	No Cost
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	No Cost	No Cost
Emergency and Urgent Care		
Ambulance Services	No Cost	Same as In-Network
Emergency Room	No Cost	Same as In-Network
Urgent Care Centers	No Cost	No Cost
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	0% Coinsurance per visit after INET plan Deductible is met	0% Coinsurance per visit after OON plan Deductible is met
Basic Services	0% Coinsurance per visit after INET plan Deductible is met	0% Coinsurance per visit after OON plan Deductible is met
Major Services	0% Coinsurance per visit after INET plan Deductible is met	0% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	0% Coinsurance per visit after INET plan Deductible is met	0% Coinsurance per visit after OON plan Deductible is met

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	No Cost	No Cost
Single Vision Lenses	No Cost	No Cost
Bifocal	No Cost	No Cost
Trifocal	No Cost	No Cost
Collection Frame	No Cost	No Cost
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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)	No Cost	No Cost

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Covered Dental Services pediatric dental services are covered for Members until age 26. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see “Pediatric Dental Care” in the “What is Covered” section for more information on pediatric dental services.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the “Preventive Care Services” section of this

Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;
- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Urgent Care Center services received from a BlueCard® Provider will be covered at the In-Network level.

Urgent Care Center services received from a non-BlueCard® Provider will be covered at the Out-of-Network level.

All non-urgent services (BlueCard® or non-BlueCard®) will be covered at the Out-of-Network level.

The Home Health Care 100 visit limit is a combined In and Out-of-Network visit limit.

Anthem
Individual Market

Anthem Silver PPO Pathway 4000/20% HSA

Schedule of Benefits
Non-Tiered Network Plan

Your plan provides You with the option to lower Your Out-of-Pocket costs for certain services by going to Site of Service Providers. These Providers may have lower cost shares and Maximum Allowed Amounts, reducing Your Out-of-Pocket costs for certain services. When You use the "Find a Doctor" tool on anthem.com, look for the "SOS" indicator under the Provider's name, and when applicable, the tool will automatically sort and show these Providers first in Your results.

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$4,000 per Member	$8,000 per Member
Family	$8,000 per family	$16,000 per family
Out-of-Pocket Maximum **Individual**	$8,000 per Member	$16,000 per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$16,000 per family	$32,000 per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	50% Coinsurance per visit
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$50 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	$100 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	20% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Site of Service Provider	$75 Copayment per service after INET plan Deductible is met up to a combined maximum of $375 for MRI and CAT scans; $400 for PET scans	50% Coinsurance per service after OON plan Deductible is met
Laboratory Services	20% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	20% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Site of Service Provider	$50 Copayment per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	20% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$5 Copayment per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$60 Copayment per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	25% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription	50% per prescription after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	30% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $1000 per prescription	50% per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$15 Copayment per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$180 Copayment per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	25% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	30% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $1000 per prescription	50% per prescription after OON plan Deductible is met
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	20% Coinsurance per equipment/supply after INET plan Deductible is met	50% Coinsurance per equipment/supply after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Durable Medical Equipment (DME)	40% Coinsurance per equipment/supply after INET plan Deductible is met	50% Coinsurance per equipment/supply after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	20% Coinsurance per visit after INET plan Deductible is met	25% Coinsurance per visit after OON plan Deductible is met
Outpatient Services **(in a Hospital or ambulatory Facility)**	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	20% Coinsurance per Admission after INET plan Deductible is met	50% Coinsurance per admission after OON plan Deductible is met
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	20% Coinsurance per Admission after INET plan Deductible is met	50% Coinsurance per admission after OON plan Deductible is met
Emergency and Urgent Care		
Ambulance Services	20% Coinsurance per service after INET plan Deductible is met	Same as In-Network
Emergency Room	20% Coinsurance per visit after INET plan Deductible is met	Same as In-Network
Urgent Care Centers	$100 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	No Cost	No Cost
Basic Services	40% Coinsurance per visit after INET plan Deductible is met	40% Coinsurance per visit after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Major Services	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	$0 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
Single Vision Lenses	$0 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
Bifocal	$0 Copayment	50% Coinsurance per visit after OON plan Deductible is met
Trifocal	$0 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
Collection Frame	$0 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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 after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% Coinsurance after Deductible. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Covered Dental Services pediatric dental services are covered for Members until age 26. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see “Pediatric Dental Care” in the “What is Covered” section for more information on pediatric dental services.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the “Preventive Care Services” section of this

Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;
- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Urgent Care Center services received from a BlueCard® Provider will be covered at the In-Network level.

The Home Health Care 100 visit limit is a combined In and Out-of-Network visit limit.

Anthem
Individual Market
Gold PPO Standard Pathway
Schedule of Benefits
Non-Tiered Network Plan

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$1,200 per Member	$3,000 per Member
Family	$2,400 per family	$6,000 per family
Separate Prescription Drug Deductible **Individual**	$50 per Member	$350 per Member
Family	$100 per family	$700 per family
Out-of-Pocket Maximum **Individual**	$7,375 per Member	$14,750 per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$14,750 per family	$29,500 per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	30% Coinsurance per visit
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$20 Copayment per visit	30% Coinsurance per visit after OON plan Deductible is met
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	$40 Copayment per visit	30% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	$20 Copayment per visit	30% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	$65 Copayment per service up to a combined maximum of $375 for MRI and CAT scans; $400 for PET scans	30% Coinsurance per service after OON plan Deductible is met
Laboratory Services	$10 Copayment per service	30% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	$40 Copayment per service after INET plan Deductible is met	30% Coinsurance per service after OON plan Deductible is met
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	$20 Copayment per service	30% Coinsurance per service after OON plan Deductible is met
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$5 Copayment per prescription	30% per prescription after OON prescription drug Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$35 Copayment per prescription	30% per prescription after OON prescription drug Deductible is met
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$60 Copayment per prescription	30% per prescription after OON prescription drug Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription after INET prescription drug Deductible is met up to a maximum of $100 per prescription	30% per prescription after OON prescription drug Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$15 Copayment per prescription	30% per prescription after OON prescription drug Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$105 Copayment per prescription	30% per prescription after OON prescription drug Deductible is met
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$180 Copayment per prescription	30% per prescription after OON prescription drug Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription after INET prescription drug Deductible is met up to a maximum of $100 per prescription	30% per prescription after OON prescription drug Deductible is met
Outpatient Rehabilitative and Habilitative Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$20 Copayment per visit	30% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$20 Copayment per visit	30% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	$40 Copayment per visit	30% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	30% Coinsurance per equipment/supply	30% Coinsurance per equipment/supply after OON plan Deductible is met
Durable Medical Equipment (DME)	30% Coinsurance per equipment/supply	30% Coinsurance per equipment/supply after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	No Cost	25% Coinsurance per visit after separate $50 Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Outpatient Services **(in a Hospital or ambulatory Facility)**	$500 Copayment per visit after INET plan Deductible is met at an Outpatient Hospital Facility $300 Copayment per visit after INET plan Deductible is met at an Ambulatory Surgery Center	30% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	$500 Copayment per day to a maximum of $1,000 per Admission after INET plan Deductible is met	30% Coinsurance per admission after OON plan Deductible is met
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	$500 Copayment per day to a maximum of $1,000 per Admission after INET plan Deductible is met	30% Coinsurance per admission after OON plan Deductible is met
Emergency and Urgent Care		
Ambulance Services	No Cost	Same as In-Network
Emergency Room	$400 Copayment per visit	Same as In-Network
Urgent Care Centers	$50 Copayment per visit	30% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	No Cost	50% Coinsurance per visit after OON plan Deductible is met
Basic Services	20% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met
Major Services	40% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	$0 Copayment	50% Coinsurance per visit after the OON plan Deductible is met
Single Vision Lenses	$0 Copayment	50% Coinsurance per visit after the OON plan Deductible is met
Bifocal	$0 Copayment	50% Coinsurance per visit after OON plan Deductible is met
Trifocal	$0 Copayment	50% Coinsurance per visit after the OON plan Deductible is met
Collection Frame	$0 Copayment	50% Coinsurance per visit after the OON plan Deductible is met
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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	30% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Covered Dental Services pediatric dental services are covered for Members until age 26. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see “Pediatric Dental Care” in the “What is Covered” section for more information on pediatric dental services.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the “Preventive Care Services” section of this

Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;
- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Urgent Care Center services received from a BlueCard® Provider will be covered at the In-Network level.

Urgent Care Center services received from a non-BlueCard® Provider will be covered at the Out-of-Network level.

All non-urgent services (BlueCard® or non-BlueCard®) will be covered at the Out-of-Network level.

The Home Health Care 100 visit limit is a combined In and Out-of-Network visit limit.

Anthem
Individual Market

Gold PPO Pathway LCSR with Adult Dental and Vision Benefits

Schedule of Benefits
Non-Tiered Network Plan

Your plan provides You with the option to lower Your Out-of-Pocket costs for certain services by going to Site of Service Providers. These Providers may have lower cost shares and Maximum Allowed Amounts, reducing Your Out-of-Pocket costs for certain services. When You use the "Find a Doctor" tool on anthem.com, look for the "SOS" indicator under the Provider's name, and when applicable, the tool will automatically sort and show these Providers first in Your results.

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$2,000 per Member	$4,000 per Member
Family	$4,000 per family	$8,000 per family
Out-of-Pocket Maximum **Individual**	$8,000 per Member	$16,000 per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$16,000 per family	$32,000 per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	50% Coinsurance per visit
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$20 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Virtual Visits with PCP	$20 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Virtual Visits from PCP Virtual Care-Only Provider through Our mobile app and website	$0 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	$80 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	10% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Site of Service Provider	$75 Copayment per service after INET plan Deductible is met up to a combined maximum of $375 for MRI and CAT scans; $400 for PET scans	50% Coinsurance per service after OON plan Deductible is met
Laboratory Services	10% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Non-Advanced Radiology (X-ray, Diagnostic)	10% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Site of Service Provider	$40 Copayment per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	10% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$5 Copayment per prescription	50% per prescription after OON plan Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$40 Copayment per prescription	50% per prescription after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription up to a maximum of $500 per prescription	50% per prescription after OON plan Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	30% Coinsurance per prescription up to a maximum of $1000 per prescription	50% per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$15 Copayment per prescription	50% per prescription after OON plan Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$120 Copayment per prescription	50% per prescription after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription	50% per prescription after OON plan Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	30% Coinsurance per prescription up to a maximum of $1000 per prescription	50% per prescription after OON plan Deductible is met
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Other Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	$30 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the "Prescription Drug" section for details.	40% Coinsurance per equipment/supply	50% Coinsurance per equipment/supply after OON plan Deductible is met
Durable Medical Equipment (DME)	40% Coinsurance per equipment/supply	50% Coinsurance per equipment/supply after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	10% Coinsurance per visit after separate $50 Deductible is met	25% Coinsurance per visit after separate $50 Deductible is met
Outpatient Services **(in a Hospital or ambulatory Facility)**	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	10% Coinsurance per Admission after INET plan Deductible is met	50% Coinsurance per admission after OON plan Deductible is met
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	10% Coinsurance per Admission after INET plan Deductible is met	50% Coinsurance per admission after OON plan Deductible is met
Emergency and Urgent Care		
Ambulance Services	10% Coinsurance per service after INET plan Deductible is met	Same as In-Network
Emergency Room	10% Coinsurance per visit after INET plan Deductible is met	Same as In-Network
Urgent Care Centers	$100 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	No Cost	No Cost
Basic Services	40% Coinsurance per visit after INET plan Deductible is met	40% Coinsurance per visit after OON plan Deductible is met
Major Services	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Adult Dental Care (for Members age 26 and over)		
Diagnostic & Preventive Exams Cleanings Bitewing X-rays X-rays (full Mouth or Panoramic) Office Visit Copay Note: please see “Adult Dental Care” in the “What is Covered” section for additional information.	20% Coinsurance per visit	20% Coinsurance per visit
Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	$0 Copayment	50% Coinsurance
Single Vision Lenses	$0 Copayment	50% Coinsurance
Bifocal	$0 Copayment	50% Coinsurance
Trifocal	$0 Copayment	50% Coinsurance
Collection Frame	$0 Copayment	50% Coinsurance
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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	50% Coinsurance per visit
Adult Vision Care (for Subscriber and spouse age 19 and older)		
Prescription Eye Glasses Single Vision Lenses	$40 Copayment	Reimbursed up to $25

Bifocal Lenses Trifocal Lenses Frames One frame every other Calendar Year	$40 Copayment $40 Copayment Covered up to $100	Reimbursed up to $40 Reimbursed up to $55 Reimbursed up to $45
Contact Lenses Once every other Calendar Year		
Elective (conventional and disposable) **Non-Elective**	Covered up to $80 $0 Copayment	Reimbursed up to $60 Reimbursed up to $210
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	$40 Copayment per visit	Reimbursed up to $30
Important Note: Benefits for contact lenses are in lieu of Your eyeglass lens benefit. If You receive contact lenses, no benefit will be available for eyeglass lenses until the next benefit period.		

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Covered Dental Services pediatric dental services are covered for Members until age 26. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see “Pediatric Dental Care” in the “What is Covered” section for more information on pediatric dental services.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the “Preventive Care Services” section of this

Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;
- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Urgent Care Center services received from a BlueCard® Provider will be covered at the In-Network level.

Urgent Care Center services received from a non-BlueCard® Provider will be covered at the Out-of-Network level.

All non-urgent services (BlueCard® or non-BlueCard®) will be covered at the Out-of-Network level.

The Home Health Care 100 visit limit is a combined In and Out-of-Network visit limit.

Eligible American Indians, as determined by the Exchange, enrolled in the Limited Cost Share Reduction plans, are exempt from Cost Sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no member responsibility for American Indians when Covered Services are rendered by one of these Providers.

Anthem
Individual Market
Bronze HMO Pathway Enhanced ZCSR
Schedule of Benefits
Non-Tiered Network Plan

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$0 per Member	Not Covered per Member
Family	$0 per family	Not Covered per family
Out-of-Pocket Maximum **Individual**	$0 per Member	Not Covered per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$0 per family	Not Covered per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	Not Covered
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	No Cost	Not Covered
Virtual Visits with PCP	No Cost	Not Covered
Virtual Visits from PCP Virtual Care-Only Provider through Our mobile app and website	No Cost	Not Applicable
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	No Cost	Not Covered
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	No Cost	Not Covered
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	No Cost	Not Covered
Laboratory Services	No Cost	Not Covered
Non-Advanced Radiology (X-ray, Diagnostic)	No Cost	Not Covered
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	No Cost	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	No Cost	Not Covered
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	Not Covered
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	Not Covered
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	Not Covered
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	No Cost	Not Covered
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	Not Covered
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	Not Covered
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	Not Covered
Outpatient Rehabilitative and Habilitative Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	No Cost	Not Covered
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	No Cost	Not Covered
Other Services		
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	No Cost	Not Covered
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	No Cost	Not Covered
Durable Medical Equipment (DME)	No Cost	Not Covered
Home Health Care Services **(up to 100 visits per Calendar Year)**	No Cost	Not Covered
Outpatient Services **(in a Hospital or ambulatory Facility)**	No Cost	Not Covered
Inpatient Hospital Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Inpatient Hospital services **(All Inpatient settings)**	No Cost	Not Covered
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	No Cost	Not Covered
Emergency and Urgent Care		
Ambulance Services	No Cost	Same as In-Network
Emergency Room	No Cost	Same as In-Network
Urgent Care Centers	No Cost	No Cost

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	No Cost	Not Covered
Single Vision Lenses	No Cost	Not Covered
Bifocal	No Cost	Not Covered
Trifocal	No Cost	Not Covered
Collection Frame	No Cost	Not Covered
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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)	No Cost	Not Covered

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

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Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

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You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

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- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem
Individual Market

Bronze HMO Pathway Enhanced ZCSR with Adult Dental and Vision Benefits

Schedule of Benefits
Non-Tiered Network Plan

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$0 per Member	Not Covered per Member
Family	$0 per family	Not Covered per family
Out-of-Pocket Maximum **Individual**	$0 per Member	Not Covered per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$0 per family	Not Covered per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	Not Covered
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	No Cost	Not Covered
Virtual Visits with PCP	No Cost	Not Covered
Virtual Visits from PCP Virtual Care-Only Provider through Our mobile app and website	No Cost	Not Applicable
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	No Cost	Not Covered
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	No Cost	Not Covered
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	No Cost	Not Covered
Laboratory Services	No Cost	Not Covered
Non-Advanced Radiology (X-ray, Diagnostic)	No Cost	Not Covered
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	No Cost	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	No Cost	Not Covered
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	Not Covered
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	Not Covered
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	Not Covered
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	No Cost	Not Covered
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	Not Covered
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	Not Covered
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	Not Covered
Outpatient Rehabilitative and Habilitative Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	No Cost	Not Covered
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	No Cost	Not Covered
Other Services		
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	No Cost	Not Covered
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	No Cost	Not Covered
Durable Medical Equipment (DME)	No Cost	Not Covered
Home Health Care Services **(up to 100 visits per Calendar Year)**	No Cost	Not Covered
Outpatient Services **(in a Hospital or ambulatory Facility)**	No Cost	Not Covered
Inpatient Hospital Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Inpatient Hospital services **(All Inpatient settings)**	No Cost	Not Covered
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	No Cost	Not Covered
Emergency and Urgent Care		
Ambulance Services	No Cost	Same as In-Network
Emergency Room	No Cost	Same as In-Network
Urgent Care Centers	No Cost	No Cost
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	No Cost	Not Covered
Basic Services	No Cost	Not Covered
Major Services	No Cost	Not Covered
Orthodontia Services **(Medically Necessary only)**	No Cost	Not Covered

Adult Dental Care (for Members age 26 and over)		
Diagnostic & Preventive Exams Cleanings Bitewing X-rays X-rays (full Mouth or Panoramic) Office Visit Copay Note: please see “Adult Dental Care” in the “What is Covered” section for additional information.	No Cost	Not Covered
Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	No Cost	Not Covered
Single Vision Lenses	No Cost	Not Covered
Bifocal	No Cost	Not Covered
Trifocal	No Cost	Not Covered
Collection Frame	No Cost	Not Covered
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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)**	No Cost	Not Covered
Adult Vision Care (for Subscriber and spouse age 19 and older)		
Prescription Eye Glasses Single Vision Lenses	No Cost	Not Covered

Bifocal Lenses	No Cost	Not Covered
Trifocal Lenses	No Cost	Not Covered
Frames One frame every other Calendar Year	Covered up to $100	Not Covered
Contact Lenses Once every other Calendar Year		
Elective (conventional and disposable)	Covered up to $80	Not Covered
Non-Elective	No Cost	Not Covered
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	No Cost	Not Covered
Important Note: Benefits for contact lenses are in lieu of Your eyeglass lens benefit. If You receive contact lenses, no benefit will be available for eyeglass lenses until the next benefit period.		

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
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Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

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Covered Dental Services pediatric dental services are covered for Members until age 26. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see “Pediatric Dental Care” in the “What is Covered” section for more information on pediatric dental services.

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Nutritional Counseling two visits per Calendar Year.

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Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem
Individual Market

Gold PPO Pathway ZCSR with Adult Dental and Vision Benefits

Schedule of Benefits
Non-Tiered Network Plan

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$0 per Member	$0 per Member
Family	$0 per family	$0 per family
Out-of-Pocket Maximum **Individual**	$0 per Member	$0 per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$0 per family	$0 per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	No Cost
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	No Cost	No Cost
Virtual Visits with PCP	No Cost	No Cost
Virtual Visits from PCP Virtual Care-Only Provider through Our mobile app and website	No Cost	No Cost
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	No Cost	No Cost
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	No Cost	No Cost
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	No Cost	No Cost
Laboratory Services	No cost	No Cost
Non-Advanced Radiology (X-ray, Diagnostic)	No Cost	No Cost
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	No Cost	No Cost

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	No Cost	No Cost
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	No Cost	No Cost
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost
Outpatient Rehabilitative and Habilitative Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	No Cost	No Cost
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	No Cost	No Cost
Other Services		
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	No Cost	No Cost
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	No Cost	No Cost
Durable Medical Equipment (DME)	No Cost	No Cost
Home Health Care Services **(up to 100 visits per Calendar Year)**	No Cost	No Cost
Outpatient Services **(in a Hospital or ambulatory Facility)**	No Cost	No Cost
Inpatient Hospital Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Inpatient Hospital services **(All Inpatient settings)**	No Cost	No Cost
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	No Cost	No Cost
Emergency and Urgent Care		
Ambulance Services	No Cost	Same as In-Network
Emergency Room	No Cost	Same as In-Network
Urgent Care Centers	No Cost	No Cost
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	No Cost	No Cost
Basic Services	No Cost	No Cost
Major Services	No Cost	No Cost
Orthodontia Services **(Medically Necessary only)**	No Cost	No Cost

Adult Dental Care (for Members age 26 and over)		
Diagnostic & Preventive Exams Cleanings Bitewing X-rays X-rays (full Mouth or Panoramic) Office Visit Copay Note: please see “Adult Dental Care” in the “What is Covered” section for additional information.	No Cost	No Cost
Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	No Cost	Not Covered
Single Vision Lenses	No Cost	Not Covered
Bifocal	No Cost	Not Covered
Trifocal	No Cost	Not Covered
Collection Frame	No Cost	Not Covered
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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)	No Cost	No Cost
Adult Vision Care (for Subscriber and spouse age 19 and older)		
Prescription Eye Glasses Single Vision Lenses	$0 Copayment	Not Covered

Bifocal Lenses	$0 Copayment	Not Covered
Trifocal Lenses	$0 Copayment	Not Covered
Frames One frame every other Calendar Year	Covered up to $100	Not Covered
Contact Lenses Once every other Calendar Year		
Elective (conventional and disposable)	Covered up to $80	Not Covered
Non-Elective	No Cost	Not Covered
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	No Cost	No Cost
Important Note: Benefits for contact lenses are in lieu of Your eyeglass lens benefit. If You receive contact lenses, no benefit will be available for eyeglass lenses until the next benefit period.		

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Covered Dental Services pediatric dental services are covered for Members until age 26. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see “Pediatric Dental Care” in the “What is Covered” section for more information on pediatric dental services.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the “Preventive Care Services” section of this

Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;
- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Urgent Care Center services received from a BlueCard® Provider will be covered at the In-Network level.

Urgent Care Center services received from a non-BlueCard® Provider will be covered at the Out-of-Network level.

All non-urgent services (BlueCard® or non-BlueCard®) will be covered at the Out-of-Network level.

The Home Health Care 100 visit limit is a combined In and Out-of-Network visit limit.

Anthem
Individual Market

Bronze HMO Pathway Enhanced with Adult Dental and Vision Benefits

Schedule of Benefits
Non-Tiered Network Plan

Your plan provides You with the option to lower Your Out-of-Pocket costs for certain services by going to Site of Service Providers. These Providers may have lower cost shares and Maximum Allowed Amounts, reducing Your Out-of-Pocket costs for certain services. When You use the "Find a Doctor" tool on anthem.com, look for the "SOS" indicator under the Provider's name, and when applicable, the tool will automatically sort and show these Providers first in Your results.

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$7,000 per Member	Not Covered per Member
Family	$14,000 per family	Not Covered per family
Out-of-Pocket Maximum **Individual**	$10,000 per Member	Not Covered per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$20,000 per family	Not Covered per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	Not Covered
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$70 Copayment per visit	Not Covered
Virtual Visits with PCP	$70 Copayment per visit	Not Covered
Virtual Visits from PCP Virtual Care-Only Provider through Our mobile app and website	$0 Copayment per visit	Not Applicable
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	$90 Copayment per visit after INET plan Deductible is met	Not Covered
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	$90 Copayment per visit after INET plan Deductible is met	Not Covered
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	$75 Copayment per service after INET plan Deductible is met up to a combined maximum of $375 for MRI and CAT scans; $400 for PET scans	Not Covered
Site of Service Provider	$75 Copayment per service after INET plan Deductible is met up to a combined maximum of $375 for MRI and CAT scans; $400 for PET scans	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Laboratory Services	$20 Copayment per service after INET plan Deductible is met	Not Covered
Non-Advanced Radiology (X-ray, Diagnostic) **Site of Service Provider**	$40 Copayment per service after INET plan Deductible is met $40 Copayment per service after INET plan Deductible is met	Not Covered Not Covered
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	$20 Copayment per service	Not Covered
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$20 Copayment per prescription	Not Covered
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$75 Copayment per prescription	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	40% Coinsurance per prescription up to a maximum of $500 per prescription	Not Covered
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $1000 per prescription	Not Covered
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$60 Copayment per prescription	Not Covered
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$225 Copayment per prescription	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	40% Coinsurance per prescription	Not Covered
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $1000 per prescription	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit after INET plan Deductible is met	Not Covered
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit after INET plan Deductible is met	Not Covered
Other Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	$50 Copayment per visit after INET plan Deductible is met	Not Covered
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	0% Coinsurance per equipment/supply after INET plan Deductible is met	Not Covered
Durable Medical Equipment (DME)	40% Coinsurance per equipment/supply after INET plan Deductible is met	Not Covered
Home Health Care Services **(up to 100 visits per Calendar Year)**	25% Coinsurance per visit after separate $50 Deductible is met	Not Covered
Outpatient Services **(in a Hospital or ambulatory Facility)**	$500 Copayment per visit after INET plan Deductible is met at an Outpatient Hospital Facility $300 Copayment per visit after INET plan Deductible is met at an Ambulatory Surgery Center	Not Covered
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	$500 Copayment per day to a maximum of $1,000 per Admission after INET plan Deductible is met	Not Covered
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	$500 Copayment per day to a maximum of $1,000 per Admission after INET plan Deductible is met	Not Covered
Emergency and Urgent Care		
Ambulance Services	40% Coinsurance per service after INET plan Deductible is met	Same as In-Network
Emergency Room	$500 Copayment per visit after INET plan Deductible is met	Same as In-Network

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Urgent Care Centers	$100 Copayment per visit after INET plan Deductible is met	Same as In-Network
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	0% Coinsurance per visit	Not Covered
Basic Services	40% Coinsurance per visit after INET plan Deductible is met	Not Covered
Major Services	50% Coinsurance per visit after INET plan Deductible is met	Not Covered
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	Not Covered

Adult Dental Care (for Members age 26 and over)		
Diagnostic & Preventive Exams Cleanings Bitewing X-rays X-rays (full Mouth or Panoramic) Office Visit Copay Note: please see “Adult Dental Care” in the “What is Covered” section for additional information.	20% Coinsurance per visit	Not Covered
Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	$0 Copayment	Not Covered
Single Vision Lenses	$0 Copayment	Not Covered
Bifocal	$0 Copayment	Not Covered
Trifocal	$0 Copayment	Not Covered
Collection Frame	$0 Copayment	Not Covered
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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	Not Covered
Adult Vision Care (for Subscriber and spouse age 19 and older)		
Prescription Eye Glasses Single Vision Lenses	$40 Copayment	Not Covered

Bifocal Lenses	$40 Copayment	Not Covered
Trifocal Lenses	$40 Copayment	Not Covered
Frames One frame every other Calendar Year	Covered up to $100	Not Covered
Contact Lenses Once every other Calendar Year		
Elective (conventional and disposable)	Covered up to $80	Not Covered
Non-Elective	$0 Copayment	Not Covered
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	$40 Copayment per visit	Not Covered
Important Note: Benefits for contact lenses are in lieu of Your eyeglass lens benefit. If You receive contact lenses, no benefit will be available for eyeglass lenses until the next benefit period.		

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Covered Dental Services pediatric dental services are covered for Members until age 26. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see “Pediatric Dental Care” in the “What is Covered” section for more information on pediatric dental services.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the “Preventive Care Services” section of this

Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;
- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem
Individual Market
Bronze PPO Standard Pathway
Schedule of Benefits
Non-Tiered Network Plan

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$7,000 per Member	$13,100 per Member
Family	$14,000 per family	$26,200 per family
Out-of-Pocket Maximum **Individual**	$10,000 per Member	$18,200 per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$20,000 per family	$36,400 per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	50% Coinsurance per visit
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$50 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	$70 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	$50 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	$75 Copayment per service after INET plan Deductible is met up to a combined maximum of $375 for MRI and CAT scans; $400 for PET scans	50% Coinsurance per service after OON plan Deductible is met
Laboratory Services	$20 Copayment per service	50% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	$40 Copayment per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	$20 Copayment per service	50% Coinsurance per service after OON plan Deductible is met
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$15Copayment per prescription	50% per prescription after OON plan Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$50 Copayment per prescription	50% per prescription after OON plan Deductible is met
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	50% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription	50% per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$45 Copayment per prescription	50% per prescription after OON plan Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$150 Copayment per prescription	50% per prescription after OON plan Deductible is met
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	50% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription	50% per prescription after OON plan Deductible is met
Outpatient Rehabilitative and Habilitative Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	$50 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	40% Coinsurance per equipment/supply after INET plan Deductible is met	50% Coinsurance per equipment/supply after OON plan Deductible is met
Durable Medical Equipment (DME)	40% Coinsurance per equipment/supply after INET plan Deductible is met	50% Coinsurance per equipment/supply after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	25% Coinsurance per visit after separate $50 Deductible is met	25% Coinsurance per visit after separate $50 Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Outpatient Services **(in a Hospital or ambulatory Facility)**	$500 Copayment per visit after INET plan Deductible is met at an Outpatient Hospital Facility $300 Copayment per visit after INET plan Deductible is met at an Ambulatory Surgery Center	50% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	$500 Copayment per day to a maximum of $1,000 per Admission after INET plan Deductible is met	50% Coinsurance per admission after OON plan Deductible is met
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	$500 Copayment per day to a maximum of $1,000 per Admission after INET plan Deductible is met	50% Coinsurance per admission after OON plan Deductible is met
Emergency and Urgent Care		
Ambulance Services	No Cost after INET plan Deductible is met	Same as In-Network
Emergency Room	$450 Copayment per visit after INET plan Deductible is met	Same as In-Network
Urgent Care Centers	$75 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	No Cost	50% Coinsurance per visit after OON plan Deductible is met
Basic Services	45% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Major Services	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	$0 Copayment	50% Coinsurance per visit after the OON plan Deductible is met
Single Vision Lenses	$0 Copayment	50% Coinsurance per visit after the OON plan Deductible is met
Bifocal	$0 Copayment	50% Coinsurance per visit after OON plan Deductible is met
Trifocal	$0 Copayment	50% Coinsurance per visit after the OON plan Deductible is met
Collection Frame	$0 Copayment	50% Coinsurance per visit after the OON plan Deductible is met
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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 plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the "Preventive Care Services" section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the "Medical Supplies, Durable Medical Equipment and Appliances" section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Covered Dental Services pediatric dental services are covered for Members until age 26. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see "Pediatric Dental Care" in the "What is Covered" section for more information on pediatric dental services.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the "Preventive Care Services" section of this

Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;
- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Urgent Care Center services received from a BlueCard® Provider will be covered at the In-Network level.

Urgent Care Center services received from a non-BlueCard® Provider will be covered at the Out-of-Network level.

All non-urgent services (BlueCard® or non-BlueCard®) will be covered at the Out-of-Network level.

The Home Health Care 100 visit limit is a combined In and Out-of-Network visit limit.

Anthem
Individual Market

Anthem Bronze PPO Standard Pathway 7000/14000/0%

Schedule of Benefits
Non-Tiered Network Plan

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$7,000 per Member	$13,100 per Member
Family	$14,000 per family	$26,200 per family
Out-of-Pocket Maximum **Individual**	$10,000 per Member	$18,200 per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$20,000 per family	$36,400 per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	50% Coinsurance per visit
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$50 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	$70 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	$50 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	$75 Copayment per service after INET plan Deductible is met up to a combined maximum of $375 for MRI and CAT scans; $400 for PET scans	50% Coinsurance per service after OON plan Deductible is met
Laboratory Services	$20 Copayment per service	50% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	$40 Copayment per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	$20 Copayment per service	50% Coinsurance per service after OON plan Deductible is met
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$15 Copayment per prescription	50% per prescription after OON plan Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$50 Copayment per prescription	50% per prescription after OON plan Deductible is met
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	50% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription	50% per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$45 Copayment per prescription	50% per prescription after OON plan Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$150 Copayment per prescription	50% per prescription after OON plan Deductible is met
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	50% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription	50% per prescription after OON plan Deductible is met
Outpatient Rehabilitative and Habilitative Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	$50 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	40% Coinsurance per equipment/supply after INET plan Deductible is met	50% Coinsurance per equipment/supply after OON plan Deductible is met
Durable Medical Equipment (DME)	40% Coinsurance per equipment/supply after INET plan Deductible is met	50% Coinsurance per equipment/supply after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	25% Coinsurance per visit after separate $50 Deductible is met	25% Coinsurance per visit after separate $50 Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Outpatient Services **(in a Hospital or ambulatory Facility)**	$500 Copayment per visit after INET plan Deductible is met at an Outpatient Hospital Facility $300 Copayment per visit after INET plan Deductible is met at an Ambulatory Surgery Center	50% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	$500 Copayment per day to a maximum of $1,000 per Admission after INET plan Deductible is met	50% Coinsurance per admission after OON plan Deductible is met
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	$500 Copayment per day to a maximum of $1,000 per Admission after INET plan Deductible is met	50% Coinsurance per admission after OON plan Deductible is met
Emergency and Urgent Care		
Ambulance Services	No Cost after INET plan Deductible is met	Same as In-Network
Emergency Room	$450 Copayment per visit after INET plan Deductible is met	Same as In-Network
Urgent Care Centers	$75 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	No Cost	50% Coinsurance per visit after OON plan Deductible is met
Basic Services	45% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Major Services	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	$0 Copayment	50% Coinsurance per visit after the OON plan Deductible is met
Single Vision Lenses	$0 Copayment	50% Coinsurance per visit after the OON plan Deductible is met
Bifocal	$0 Copayment	50% Coinsurance per visit after OON plan Deductible is met
Trifocal	$0 Copayment	50% Coinsurance per visit after the OON plan Deductible is met
Collection Frame	$0 Copayment	50% Coinsurance per visit after the OON plan Deductible is met
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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 plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Covered Dental Services pediatric dental services are covered for Members until age 26. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see “Pediatric Dental Care” in the “What is Covered” section for more information on pediatric dental services.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the “Preventive Care Services” section of this

Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;
- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Urgent Care Center services received from a BlueCard® Provider will be covered at the In-Network level.

Urgent Care Center services received from a non-BlueCard® Provider will be covered at the Out-of-Network level.

All non-urgent services (BlueCard® or non-BlueCard®) will be covered at the Out-of-Network level.

The Home Health Care 100 visit limit is a combined In and Out-of-Network visit limit.

Anthem
Individual Market
Bronze PPO Standard Pathway LCSR
Schedule of Benefits
Non-Tiered Network Plan

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$7,000 per Member	$13,100 per Member
Family	$14,000 per family	$26,200 per family
Out-of-Pocket Maximum **Individual**	$10,000 per Member	$18,200 per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$20,000 per family	$36,400 per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	50% Coinsurance per visit
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$50 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	$70 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	$50 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	$75 Copayment per service after INET plan Deductible is met up to a combined maximum of $375 for MRI and CAT scans; $400 for PET scans	50% Coinsurance per service after OON plan Deductible is met
Laboratory Services	$20 Copayment per service	50% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	$40 Copayment per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	$20 Copayment per service	50% Coinsurance per service after OON plan Deductible is met
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$15 Copayment per prescription	50% per prescription after OON plan Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$50 Copayment per prescription	50% per prescription after OON plan Deductible is met
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	50% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription	50% per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$45 Copayment per prescription	50% per prescription after OON plan Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$150 Copayment per prescription	50% per prescription after OON plan Deductible is met
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	50% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription	50% per prescription after OON plan Deductible is met
Outpatient Rehabilitative and Habilitative Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	$50 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	40% Coinsurance per equipment/supply after INET plan Deductible is met	50% Coinsurance per equipment/supply after OON plan Deductible is met
Durable Medical Equipment (DME)	40% Coinsurance per equipment/supply after INET plan Deductible is met	50% Coinsurance per equipment/supply after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	25% Coinsurance per visit after separate $50 Deductible is met	25% Coinsurance per visit after separate $50 Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Outpatient Services **(in a Hospital or ambulatory Facility)**	$500 Copayment per visit after INET plan Deductible is met at an Outpatient Hospital Facility $300 Copayment per visit after INET plan Deductible is met at an Ambulatory Surgery Center	50% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	$500 Copayment per day to a maximum of $1,000 per Admission after INET plan Deductible is met	50% Coinsurance per admission after OON plan Deductible is met
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	$500 Copayment per day to a maximum of $1,000 per Admission after INET plan Deductible is met	50% Coinsurance per admission after OON plan Deductible is met
Emergency and Urgent Care		
Ambulance Services	No Cost after INET plan Deductible is met	Same as In-Network
Emergency Room	$450 Copayment per visit after INET plan Deductible is met	Same as In-Network
Urgent Care Centers	$75 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	No Cost	50% Coinsurance per visit after OON plan Deductible is met
Basic Services	45% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Major Services	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	$0 Copayment	50% Coinsurance per visit after the OON plan Deductible is met
Single Vision Lenses	$0 Copayment	50% Coinsurance per visit after the OON plan Deductible is met
Bifocal	$0 Copayment	50% Coinsurance per visit after OON plan Deductible is met
Trifocal	$0 Copayment	50% Coinsurance per visit after the OON plan Deductible is met
Collection Frame	$0 Copayment	50% Coinsurance per visit after the OON plan Deductible is met
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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 plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Covered Dental Services pediatric dental services are covered for Members until age 26. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see “Pediatric Dental Care” in the “What is Covered” section for more information on pediatric dental services.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the “Preventive Care Services” section of this

Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;
- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Urgent Care Center services received from a BlueCard® Provider will be covered at the In-Network level.

Urgent Care Center services received from a non-BlueCard® Provider will be covered at the Out-of-Network level.

All non-urgent services (BlueCard® or non-BlueCard®) will be covered at the Out-of-Network level.

The Home Health Care 100 visit limit is a combined In and Out-of-Network visit limit.

Eligible American Indians, as determined by the Exchange, enrolled in the Limited Cost Share Reduction plans, are exempt from Cost Sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no member responsibility for American Indians when Covered Services are rendered by one of these Providers.

Anthem
Individual Market

Anthem Catastrophic HMO Pathway Enhanced

Schedule of Benefits
Non-Tiered Network Plan

Your plan provides You with the option to lower Your Out-of-Pocket costs for certain services by going to Site of Service Providers. These Providers may have lower cost shares and Maximum Allowed Amounts, reducing Your Out-of-Pocket costs for certain services. When You use the “Find a Doctor” tool on anthem.com, look for the “SOS” indicator under the Provider’s name, and when applicable, the tool will automatically sort and show these Providers first in Your results.

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$10,600 per Member	Not Covered per Member
Family	$21,200 per family	Not Covered per family
Out-of-Pocket Maximum **Individual**	$10,600 per Member	Not Covered per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$21,200 per family	Not Covered per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	Not Covered
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$40 Copayment for the first 3 visits (Deductible is waived), then $0 Copayment per visit after INET plan Deductible is met	Not Covered
Virtual Visits with PCP	$40 Copayment for the first 3 visits (Deductible is waived), then $0 Copayment per visit after INET plan Deductible is met	Not Covered
Virtual Visits from PCP Virtual Care-Only Provider through Our mobile app and website	$0 Copayment per visit after INET plan Deductible is met	Not Applicable
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	0% Coinsurance per visit after INET plan Deductible is met	Not Covered
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	0% Coinsurance per visit after INET plan Deductible is met	Not Covered
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	0% Coinsurance per service after INET plan Deductible is met	Not Covered
Laboratory Services	0% Coinsurance per service after INET plan Deductible is met	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Non-Advanced Radiology (X-ray, Diagnostic)	0% Coinsurance per service after INET plan Deductible is met	Not Covered
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	0% Coinsurance per service after INET plan Deductible is met	Not Covered
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	0% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	0% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	0% Coinsurance per prescription after INET plan Deductible is met	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	0% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	0% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	0% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	0% Coinsurance per prescription after INET plan Deductible is met	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	0% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	0% Coinsurance per visit after INET plan Deductible is met	Not Covered
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	0% Coinsurance per visit after INET plan Deductible is met	Not Covered
Other Services		
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	0% Coinsurance per visit after INET plan Deductible is met	Not Covered
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	0% Coinsurance per equipment/supply after INET plan Deductible is met	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Durable Medical Equipment (DME)	0% Coinsurance per equipment/supply after INET plan Deductible is met	Not Covered
Home Health Care Services **(up to 100 visits per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met	Not Covered
Outpatient Services **(in a Hospital or ambulatory Facility)**	0% Coinsurance per visit after INET plan Deductible is met	Not Covered
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	0% Coinsurance per Admission after INET plan Deductible is met	Not Covered
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	0% Coinsurance per Admission after INET plan Deductible is met	Not Covered
Emergency and Urgent Care		
Ambulance Services	0% Coinsurance per service after INET plan Deductible is met	Same as In-Network
Emergency Room	0% Coinsurance per visit after INET plan Deductible is met	Same as In-Network
Urgent Care Centers	0% Coinsurance per visit after INET plan Deductible is met	Same as In-Network
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	0% Coinsurance per visit after INET plan Deductible is met	Not Covered
Basic Services	0% Coinsurance per visit after INET plan Deductible is met	Not Covered
Major Services	0% Coinsurance per visit after INET plan Deductible is met	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Orthodontia Services **(Medically Necessary only)**	0% Coinsurance per visit after INET plan Deductible is met	Not Covered

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	$0 Copayment after INET plan Deductible is met	Not Covered
Single Vision Lenses	$0 Copayment after INET plan Deductible is met	Not Covered
Bifocal	$0 Copayment after INET plan Deductible is met	Not Covered
Trifocal	$0 Copayment after INET plan Deductible is met	Not Covered
Collection Frame	$0 Copayment after INET plan Deductible is met	Not Covered
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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)	$0 Copayment per visit after INET plan Deductible is met	Not Covered

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Covered Dental Services pediatric dental services are covered for Members until age 26. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see “Pediatric Dental Care” in the “What is Covered” section for more information on pediatric dental services.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the “Preventive Care Services” section of this

Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;
- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Primary Care and Mental Health and Substance Abuse Provider Office Visits combined (for non-standard plans) subject to Copayment for the first three visits, not subject to the Deductible. Subsequent Office Visits are subject to medical Deductible.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem
Individual Market
Bronze HMO Pathway Enhanced
Schedule of Benefits
Non-Tiered Network Plan

Your plan provides You with the option to lower Your Out-of-Pocket costs for certain services by going to Site of Service Providers. These Providers may have lower cost shares and Maximum Allowed Amounts, reducing Your Out-of-Pocket costs for certain services. When You use the "Find a Doctor" tool on anthem.com, look for the "SOS" indicator under the Provider's name, and when applicable, the tool will automatically sort and show these Providers first in Your results.

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$7,000 per Member	Not Covered per Member
Family	$14,000 per family	Not Covered per family
Out-of-Pocket Maximum **Individual**	$10,000 per Member	Not Covered per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$20,000 per family	Not Covered per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	Not Covered
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$70 Copayment per visit	Not Covered
Virtual Visits with PCP	$70 Copayment per visit	Not Covered
Virtual Visits from PCP Virtual Care-Only Provider through Our mobile app and website	$0 Copayment per visit	Not Applicable
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	$90 Copayment per visit after INET plan Deductible is met	Not Covered
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	$90 Copayment per visit after INET plan Deductible is met	Not Covered
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	$75 Copayment per service after INET plan Deductible is met up to a combined maximum of $375 for MRI and CAT scans; $400 for PET scans	Not Covered
Site of Service Provider	$75 Copayment per service after INET plan Deductible is met up to a combined maximum of $375 for MRI and CAT scans; $400 for PET scans	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Laboratory Services	$20 Copayment per service after INET plan Deductible is met	Not Covered
Non-Advanced Radiology (X-ray, Diagnostic)	$40 Copayment per service after INET plan Deductible is met	Not Covered
Site of Service Provider	$40 Copayment per service after INET plan Deductible is met	Not Covered
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	$20 Copayment per service	Not Covered
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$20 Copayment per prescription	Not Covered
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$75 Copayment per prescription	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	40% Coinsurance per prescription up to a maximum of $500 per prescription	Not Covered
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $1000 per prescription	Not Covered
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$60 Copayment per prescription	Not Covered
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$225 Copayment per prescription	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	40% Coinsurance per prescription	Not Covered
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $1000 per prescription	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit after INET plan Deductible is met	Not Covered
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit after INET plan Deductible is met	Not Covered
Other Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	$50 Copayment per visit after INET plan Deductible is met	Not Covered
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	0% Coinsurance per equipment/supply after INET plan Deductible is met	Not Covered
Durable Medical Equipment (DME)	40% Coinsurance per equipment/supply after INET plan Deductible is met	Not Covered
Home Health Care Services **(up to 100 visits per Calendar Year)**	25% Coinsurance per visit after separate $50 Deductible is met	Not Covered
Outpatient Services **(in a Hospital or ambulatory Facility)**	$500 Copayment per visit after INET plan Deductible is met at an Outpatient Hospital Facility $300 Copayment per visit after INET plan Deductible is met at an Ambulatory Surgery Center	Not Covered
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	$500 Copayment per day to a maximum of $1,000 per Admission after INET plan Deductible is met	Not Covered
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	$500 Copayment per day to a maximum of $1,000 per Admission after INET plan Deductible is met	Not Covered
Emergency and Urgent Care		
Ambulance Services	40% Coinsurance per service after INET plan Deductible is met	Same as In-Network
Emergency Room	$500 Copayment per visit after INET plan Deductible is met	Same as In-Network

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Urgent Care Centers	$100 Copayment per visit after INET plan Deductible is met	Same as In-Network

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	$0 Copayment	Not Covered
Single Vision Lenses	$0 Copayment	Not Covered
Bifocal	$0 Copayment	Not Covered
Trifocal	$0 Copayment	Not Covered
Collection Frame	$0 Copayment	Not Covered
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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	Not Covered

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the "Preventive Care Services" section of this Subscriber Agreement for more information.

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Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

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- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the "Preventive Care Services" section of this Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;

- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem
Individual Market

Anthem Silver HMO Pathway Enhanced 4000/30%

Schedule of Benefits
Non-Tiered Network Plan

Your plan provides You with the option to lower Your Out-of-Pocket costs for certain services by going to Site of Service Providers. These Providers may have lower cost shares and Maximum Allowed Amounts, reducing Your Out-of-Pocket costs for certain services. When You use the “Find a Doctor” tool on anthem.com, look for the “SOS” indicator under the Provider’s name, and when applicable, the tool will automatically sort and show these Providers first in Your results.

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$4,000 per Member	Not Covered per Member
Family	$8,000 per family	Not Covered per family
Out-of-Pocket Maximum **Individual**	$10,000 per Member	Not Covered per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$20,000 per family	Not Covered per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	Not Covered
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$30 Copayment per visit	Not Covered
Virtual Visits with PCP	$30 Copayment per visit	Not Covered
Virtual Visits from PCP Virtual Care-Only Provider through Our mobile app and website	$0 Copayment per visit	Not Applicable
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	$70 Copayment per visit after INET plan Deductible is met	Not Covered
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	$70 Copayment per visit after INET plan Deductible is met	Not Covered
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	30% Coinsurance per service after INET plan Deductible is met	Not Covered
Site of Service Provider	$75 Copayment per service after INET plan Deductible is met up to a combined maximum of $375 for MRI and CAT scans; $400 for PET scans	Not Covered
Laboratory Services	30% Coinsurance per service after INET plan Deductible is met	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Non-Advanced Radiology (X-ray, Diagnostic)	30% Coinsurance per service after INET plan Deductible is met	Not Covered
Site of Service Provider	$40 Copayment per service after INET plan Deductible is met	Not Covered
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	30% Coinsurance per service after INET plan Deductible is met	Not Covered
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$5 Copayment per prescription	Not Covered
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	50% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	40% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $750 per prescription	Not Covered
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$15 Copayment per prescription	Not Covered
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	50% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	40% Coinsurance per prescription after INET plan Deductible is met	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $750 per prescription	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$50 Copayment per visit after INET plan Deductible is met	Not Covered
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit after INET plan Deductible is met	Not Covered
Other Services		
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	$50 Copayment per visit after INET plan Deductible is met	Not Covered
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	30% Coinsurance per equipment/supply after INET plan Deductible is met	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Durable Medical Equipment (DME)	30% Coinsurance per equipment/supply after INET plan Deductible is met	Not Covered
Home Health Care Services **(up to 100 visits per Calendar Year)**	25% Coinsurance per visit after separate $50 Deductible is met	Not Covered
Outpatient Services **(in a Hospital or ambulatory Facility)**	$500 Copayment per visit after INET plan Deductible is met	Not Covered
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	30% Coinsurance per Admission after INET plan Deductible is met	Not Covered
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	30% Coinsurance per Admission after INET plan Deductible is met	Not Covered
Emergency and Urgent Care		
Ambulance Services	30% Coinsurance per service after INET plan Deductible is met	Same as In-Network
Emergency Room	30% Coinsurance per visit after INET plan Deductible is met	Same as In-Network
Urgent Care Centers	$75 Copayment per visit	Same as In-Network
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	0% Coinsurance per visit	Not Covered
Basic Services	40% Coinsurance per visit after INET plan Deductible is met	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Major Services	50% Coinsurance per visit after INET plan Deductible is met	Not Covered
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	Not Covered

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	$0 Copayment	Not Covered
Single Vision Lenses	$0 Copayment	Not Covered
Bifocal	$0 Copayment	Not Covered
Trifocal	$0 Copayment	Not Covered
Collection Frame	$0 Copayment	Not Covered
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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	Not Covered

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Covered Dental Services pediatric dental services are covered for Members until age 26. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see “Pediatric Dental Care” in the “What is Covered” section for more information on pediatric dental services.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the “Preventive Care Services” section of this

Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;
- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem
Individual Market

Anthem Gold HMO Pathway Enhanced 2000/10%

Schedule of Benefits
Non-Tiered Network Plan

Your plan provides You with the option to lower Your Out-of-Pocket costs for certain services by going to Site of Service Providers. These Providers may have lower cost shares and Maximum Allowed Amounts, reducing Your Out-of-Pocket costs for certain services. When You use the “Find a Doctor” tool on anthem.com, look for the “SOS” indicator under the Provider’s name, and when applicable, the tool will automatically sort and show these Providers first in Your results.

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$2,000 per Member	Not Covered per Member
Family	$4,000 per family	Not Covered per family
Out-of-Pocket Maximum **Individual**	$9,000 per Member	Not Covered per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$18,000 per family	Not Covered per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	Not Covered
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$20 Copayment per visit	Not Covered
Virtual Visits with PCP	$20 Copayment per visit	Not Covered
Virtual Visits from PCP Virtual Care-Only Provider through Our mobile app and website	$0 Copayment per visit	Not Applicable
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	10% Coinsurance per visit after INET plan Deductible is met	Not Covered
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	10% Coinsurance per visit after INET plan Deductible is met	Not Covered
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	10% Coinsurance per service after INET plan Deductible is met	Not Covered
Site of Service Provider	$75 Copayment per service after INET plan Deductible is met up to a combined maximum of $375 for MRI and CAT scans; $400 for PET scans	Not Covered
Laboratory Services	10% Coinsurance per service after INET plan Deductible is met	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Non-Advanced Radiology (X-ray, Diagnostic)	10% Coinsurance per service after INET plan Deductible is met	Not Covered
Site of Service Provider	$40 Copayment per service after INET plan Deductible is met	Not Covered
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	10% Coinsurance per service after INET plan Deductible is met	Not Covered
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$10 Copayment per prescription	Not Covered
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$60 Copayment per prescription	Not Covered
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	40% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $750 per prescription	Not Covered
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$30 Copayment per prescription	Not Covered
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$180 Copayment per prescription	Not Covered
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	40% Coinsurance per prescription after INET plan Deductible is met	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $750 per prescription	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	10% Coinsurance per visit after INET plan Deductible is met	Not Covered
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	10% Coinsurance per visit after INET plan Deductible is met	Not Covered
Other Services		
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	10% Coinsurance per visit after INET plan Deductible is met	Not Covered
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	10% Coinsurance per equipment/supply after INET plan Deductible is met	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Durable Medical Equipment (DME)	10% Coinsurance per equipment/supply after INET plan Deductible is met	Not Covered
Home Health Care Services **(up to 100 visits per Calendar Year)**	10% Coinsurance per visit after separate $50 Deductible is met	Not Covered
Outpatient Services **(in a Hospital or ambulatory Facility)**	10% Coinsurance per visit after INET plan Deductible is met	Not Covered
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	10% Coinsurance per Admission after INET plan Deductible is met	Not Covered
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	10% Coinsurance per Admission after INET plan Deductible is met	Not Covered
Emergency and Urgent Care		
Ambulance Services	10% Coinsurance per service after INET plan Deductible is met	Same as In-Network
Emergency Room	10% Coinsurance per visit after INET plan Deductible is met	Same as In-Network
Urgent Care Centers	10% Coinsurance per visit after INET plan Deductible is met	Same as In-Network
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	0% Coinsurance per visit	Not Covered
Basic Services	40% Coinsurance per visit after INET plan Deductible is met	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Major Services	50% Coinsurance per visit after INET plan Deductible is met	Not Covered
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	Not Covered

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	$0 Copayment	Not Covered
Single Vision Lenses	$0 Copayment	Not Covered
Bifocal	$0 Copayment	Not Covered
Trifocal	$0 Copayment	Not Covered
Collection Frame	$0 Copayment	Not Covered
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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)	$30 Copayment per visit	Not Covered

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the "Preventive Care Services" section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the "Medical Supplies, Durable Medical Equipment and Appliances" section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Covered Dental Services pediatric dental services are covered for Members until age 26. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see "Pediatric Dental Care" in the "What is Covered" section for more information on pediatric dental services.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the "Preventive Care Services" section of this

Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;
- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem
Individual Market
Silver PPO Standard Pathway ZCSR
Schedule of Benefits
Non-Tiered Network Plan

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$0 per Member	$0 per Member
Family	$0 per family	$0 per family
Out-of-Pocket Maximum **Individual**	$0 per Member	$0 per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$0 per family	$0 per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	No Cost
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	No Cost	No Cost
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	No Cost	No Cost
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	No Cost	No Cost
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	No Cost	No Cost
Laboratory Services	No Cost	No Cost
Non-Advanced Radiology (X-ray, Diagnostic)	No Cost	No Cost
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	No Cost	No Cost
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	No Cost	No Cost
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	No Cost	No Cost
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost
Outpatient Rehabilitative and Habilitative Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	No Cost	No Cost
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	No Cost	No Cost
Other Services		
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	No Cost	No Cost
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	No Cost	No Cost
Durable Medical Equipment (DME)	No Cost	No Cost
Home Health Care Services **(up to 100 visits per Calendar Year)**	No Cost	No Cost
Outpatient Services **(in a Hospital or ambulatory Facility)**	No Cost	No Cost
Inpatient Hospital Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Inpatient Hospital services **(All Inpatient settings)**	No Cost	No Cost
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	No Cost	No Cost
Emergency and Urgent Care		
Ambulance Services	No Cost	Same as In-Network
Emergency Room	No Cost	Same as In-Network
Urgent Care Centers	No Cost	No Cost
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	0% Coinsurance per visit after INET plan Deductible is met	0% Coinsurance per visit after OON plan Deductible is met
Basic Services	0% Coinsurance per visit after INET plan Deductible is met	0% Coinsurance per visit after OON plan Deductible is met
Major Services	0% Coinsurance per visit after INET plan Deductible is met	0% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	0% Coinsurance per visit after INET plan Deductible is met	0% Coinsurance per visit after OON plan Deductible is met

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	No Cost	No Cost
Single Vision Lenses	No Cost	No Cost
Bifocal	No Cost	No Cost
Trifocal	No Cost	No Cost
Collection Frame	No Cost	No Cost
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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)	No Cost	No Cost

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

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Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

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Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

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Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

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- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Urgent Care Center services received from a BlueCard® Provider will be covered at the In-Network level.

Urgent Care Center services received from a non-BlueCard® Provider will be covered at the Out-of-Network level.

All non-urgent services (BlueCard® or non-BlueCard®) will be covered at the Out-of-Network level.

The Home Health Care 100 visit limit is a combined In and Out-of-Network visit limit.

Anthem
Individual Market
Silver PPO Standard Pathway 94% CSR
Schedule of Benefits
Non-Tiered Network Plan

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$0 per Member	$10,000 per Member
Family	$0 per family	$20,000 per family
Separate Prescription Drug Deductible **Individual**	$0 per Member	$500 per Member
Family	$0 per family	$1,000 per family
Out-of-Pocket Maximum **Individual**	$1,350 per Member	$18,200 per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$2,700 per family	$36,400 per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	40% Coinsurance per visit
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$15 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	$30 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	$15 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	$50 Copayment per service up to a combined maximum of $350 for MRI and CAT scans; $400 for PET scans	40% Coinsurance per service after OON plan Deductible is met
Laboratory Services	$10 Copayment per service	40% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	$25 Copayment per service	40% Coinsurance per service after OON plan Deductible is met
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	$20 Copayment per service	40% Coinsurance per service after OON plan Deductible is met
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$5 Copayment per prescription	40% per prescription after OON prescription drug Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$10 Copayment per prescription	40% per prescription after OON prescription drug Deductible is met
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$30 Copayment per prescription	40% per prescription after OON prescription drug Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription up to a maximum of $60 per prescription	40% per prescription after OON prescription drug Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$15 Copayment per prescription	40% per prescription after OON prescription drug Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$30 Copayment per prescription	40% per prescription after OON prescription drug Deductible is met
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$90 Copayment per prescription	40% per prescription after OON prescription drug Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription up to a maximum of $60 per prescription	40% per prescription after OON prescription drug Deductible is met
Outpatient Rehabilitative and Habilitative Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$20 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$20 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	$30 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	40% Coinsurance per equipment/supply	40% Coinsurance per equipment/supply after OON plan Deductible is met
Durable Medical Equipment (DME)	40% Coinsurance per equipment/supply	40% Coinsurance per equipment/supply after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	No cost	25% Coinsurance per visit after separate $50 Deductible is met
Outpatient Services **(in a Hospital or ambulatory Facility)**	$75 Copayment per visit at an Outpatient Hospital Facility $45 Copayment per visit at an Ambulatory Surgery Center	40% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Inpatient Hospital services **(All Inpatient settings)**	$75 Copayment per day to a maximum of $300 per Admission	40% Coinsurance per admission after OON plan Deductible is met
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	$75 Copayment per day to a maximum of $300 per Admission	40% Coinsurance per admission after OON plan Deductible is met
Emergency and Urgent Care		
Ambulance Services	No Cost	Same as In-Network
Emergency Room	$50 Copayment per visit	Same as In-Network
Urgent Care Centers	$25 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	No Cost	50% Coinsurance per visit after OON plan Deductible is met
Basic Services	40% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met
Major Services	50% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	$0 Copayment per visit	50% Coinsurance per visit after the OON plan Deductible is met
Single Vision Lenses	$0 Copayment per visit	50% Coinsurance per visit after the OON plan Deductible is met
Bifocal	$0 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Trifocal	$0 Copayment per visit	50% Coinsurance per visit after the OON plan Deductible is met
Collection Frame	$0 Copayment per visit	50% Coinsurance per visit after the OON plan Deductible is met
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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)	$30 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the "Preventive Care Services" section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the "Medical Supplies, Durable Medical Equipment and Appliances" section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Covered Dental Services pediatric dental services are covered for Members until age 26. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see "Pediatric Dental Care" in the "What is Covered" section for more information on pediatric dental services.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the "Preventive Care Services" section of this

Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;
- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Urgent Care Center services received from a BlueCard® Provider will be covered at the In-Network level.

Urgent Care Center services received from a non-BlueCard® Provider will be covered at the Out-of-Network level.

All non-urgent services (BlueCard® or non-BlueCard®) will be covered at the Out-of-Network level.

The Home Health Care 100 visit limit is a combined In and Out-of-Network visit limit.

Anthem
Individual Market
Bronze PPO Standard Pathway ZCSR
Schedule of Benefits
Non-Tiered Network Plan

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$0 per Member	$0 per Member
Family	$0 per family	$0 per family
Out-of-Pocket Maximum **Individual**	$0 per Member	$0 per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$0 per family	$0 per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	No Cost
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	No Cost	No Cost
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	No Cost	No Cost
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	No Cost	No Cost
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	No Cost	No Cost
Laboratory Services	No Cost	No Cost
Non-Advanced Radiology (X-ray, Diagnostic)	No Cost	No Cost
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	No Cost	No Cost
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	No Cost	No Cost
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	No Cost	No Cost
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	No Cost
Outpatient Rehabilitative and Habilitative Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	No Cost	No Cost
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	No Cost	No Cost
Other Services		
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	No Cost	No Cost
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	No Cost	No Cost
Durable Medical Equipment (DME)	No Cost	No Cost
Home Health Care Services **(up to 100 visits per Calendar Year)**	No Cost	No Cost
Outpatient Services **(in a Hospital or ambulatory Facility)**	No Cost	No Cost
Inpatient Hospital Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Inpatient Hospital services **(All Inpatient settings)**	No Cost	No Cost
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	No Cost	No Cost
Emergency and Urgent Care		
Ambulance Services	No Cost	Same as In-Network
Emergency Room	No Cost	Same as In-Network
Urgent Care Centers	No Cost	No Cost
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	0% Coinsurance per visit after INET plan Deductible is met	0% Coinsurance per visit after OON plan Deductible is met
Basic Services	0% Coinsurance per visit after INET plan Deductible is met	0% Coinsurance per visit after OON plan Deductible is met
Major Services	0% Coinsurance per visit after INET plan Deductible is met	0% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	0% Coinsurance per visit after INET plan Deductible is met	0% Coinsurance per visit after OON plan Deductible is met

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	No Cost	No Cost
Single Vision Lenses	No Cost	No Cost
Bifocal	No Cost	No Cost
Trifocal	No Cost	No Cost
Collection Frame	No Cost	No Cost
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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)	No Cost	No Cost

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Covered Dental Services pediatric dental services are covered for Members until age 26. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see “Pediatric Dental Care” in the “What is Covered” section for more information on pediatric dental services.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

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Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;
- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

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Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Urgent Care Center services received from a BlueCard® Provider will be covered at the In-Network level.

Urgent Care Center services received from a non-BlueCard® Provider will be covered at the Out-of-Network level.

All non-urgent services (BlueCard® or non-BlueCard®) will be covered at the Out-of-Network level.

The Home Health Care 100 visit limit is a combined In and Out-of-Network visit limit.

Anthem
Individual Market
Bronze PPO Standard Pathway HSA
Schedule of Benefits
Non-Tiered Network Plan

Your plan provides You with the option to lower Your Out-of-Pocket costs for certain services by going to Site of Service Providers. These Providers may have lower cost shares and Maximum Allowed Amounts, reducing Your Out-of-Pocket costs for certain services. When You use the "Find a Doctor" tool on anthem.com, look for the "SOS" indicator under the Provider's name, and when applicable, the tool will automatically sort and show these Providers first in Your results.

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$6,500 per Member	$13,000 per Member
Family	$13,000 per family	$26,000 per family
Out-of-Pocket Maximum **Individual**	$7,225 per Member	$14,450 per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$14,450 per family	$28,900 per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	50% Coinsurance per visit
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	20% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Site of Service Provider	20% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Laboratory Services	20% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	20% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Site of Service Provider	20% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	20% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	20% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	25% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	30% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	30% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription	50% per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	20% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	25% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	30% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	30% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription	50% per prescription after OON plan Deductible is met
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	20% Coinsurance per equipment/supply after INET plan Deductible is met	50% Coinsurance per equipment/supply after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Durable Medical Equipment (DME)	20% Coinsurance per equipment/supply after INET plan Deductible is met	50% Coinsurance per equipment/supply after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	20% Coinsurance per visit after INET plan Deductible is met	25% Coinsurance per visit after OON plan Deductible is met
Outpatient Services **(in a Hospital or ambulatory Facility)**	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	20% Coinsurance per Admission after INET plan Deductible is met	50% Coinsurance per admission after OON plan Deductible is met
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	20% Coinsurance per Admission after INET plan Deductible is met	50% Coinsurance per admission after OON plan Deductible is met
Emergency and Urgent Care		
Ambulance Services	20% Coinsurance per service after INET plan Deductible is met	Same as In-Network
Emergency Room	20% Coinsurance per visit after INET plan Deductible is met	Same as In-Network
Urgent Care Centers	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	No Cost	50% Coinsurance per visit after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Basic Services	40% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Major Services	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	$0 Copayment after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
Single Vision Lenses	$0 Copayment after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
Bifocal	$0 Copayment after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Trifocal	$0 Copayment after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
Collection Frame	$0 Copayment after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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 plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% Coinsurance after Deductible. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Covered Dental Services pediatric dental services are covered for Members until age 26. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see “Pediatric Dental Care” in the “What is Covered” section for more information on pediatric dental services.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the “Preventive Care Services” section of this

Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;
- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Urgent Care Center services received from a BlueCard® Provider will be covered at the In-Network level.

Urgent Care Center services received from a non-BlueCard® Provider will be covered at the Out-of-Network level.

All non-urgent services (BlueCard® or non-BlueCard®) will be covered at the Out-of-Network level.

The Home Health Care 100 visit limit is a combined In and Out-of-Network visit limit.

Anthem
Individual Market
Silver PPO Standard Pathway 87% CSR
Schedule of Benefits
Non-Tiered Network Plan

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$415 per Member	$10,000 per Member
Family	$830 per family	$20,000 per family
Separate Prescription Drug Deductible **Individual**	$50 per Member	$500 per Member
Family	$100 per family	$1,000 per family
Out-of-Pocket Maximum **Individual**	$2,950 per Member	$18,200 per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$5,900 per family	$36,400 per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	40% Coinsurance per visit
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$35 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	$50 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	$35 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	$60 Copayment per service up to a combined maximum of $360 for MRI and CAT scans; $400 for PET scans	40% Coinsurance per service after OON plan Deductible is met
Laboratory Services	$15 Copayment per service	40% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	$30 Copayment per service after INET plan Deductible is met	40% Coinsurance per service after OON plan Deductible is met
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	$20 Copayment per service	40% Coinsurance per service after OON plan Deductible is met
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$10 Copayment per prescription	40% per prescription after OON prescription drug Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$25 Copayment per prescription	40% per prescription after OON prescription drug Deductible is met
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$40 Copayment per prescription after INET prescription drug Deductible is met	40% per prescription after OON prescription drug Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription after INET prescription drug Deductible is met up to a maximum of $60 per prescription	40% per prescription after OON prescription drug Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$30 Copayment per prescription	40% per prescription after OON prescription drug Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$75 Copayment per prescription	40% per prescription after OON prescription drug Deductible is met
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$120 Copayment per prescription after INET prescription drug Deductible is met	40% per prescription after OON prescription drug Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription after INET prescription drug Deductible is met up to a maximum of $60 per prescription	40% per prescription after OON prescription drug Deductible is met
Outpatient Rehabilitative and Habilitative Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$20 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$20 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	$35 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	40% Coinsurance per equipment/supply	40% Coinsurance per equipment/supply after OON plan Deductible is met
Durable Medical Equipment (DME)	40% Coinsurance per equipment/supply	40% Coinsurance per equipment/supply after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	No Cost	25% Coinsurance per visit after separate $50 Deductible is met
Outpatient Services **(in a Hospital or ambulatory Facility)**	$100 Copayment per visit after INET plan Deductible is met at an Outpatient Hospital Facility $60 Copayment per visit after INET plan Deductible is met at an Ambulatory Surgery Center	40% Coinsurance per visit after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	$100 Copayment per day to a maximum of $400 per Admission after INET plan Deductible is met	40% Coinsurance per admission after OON plan Deductible is met
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	$100 Copayment per day to a maximum of $400 per Admission after INET plan Deductible is met	40% Coinsurance per admission after OON plan Deductible is met
Emergency and Urgent Care		
Ambulance Services	No Cost	Same as In-Network
Emergency Room	$150 Copayment per visit after INET plan Deductible is met	Same as In-Network
Urgent Care Centers	$35 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	No Cost	50% Coinsurance per visit after OON plan Deductible is met
Basic Services	40% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met
Major Services	50% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	$0 Copayment per visit	50% Coinsurance per visit after the OON plan Deductible is met
Single Vision Lenses	$0 Copayment per visit	50% Coinsurance per visit after the OON plan Deductible is met
Bifocal	$0 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Trifocal	$0 Copayment per visit	50% Coinsurance per visit after the OON plan Deductible is met
Collection Frame	$0 Copayment per visit	50% Coinsurance per visit after the OON plan Deductible is met
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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)	$50 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Covered Dental Services pediatric dental services are covered for Members until age 26. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see “Pediatric Dental Care” in the “What is Covered” section for more information on pediatric dental services.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the “Preventive Care Services” section of this

Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;
- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Urgent Care Center services received from a BlueCard® Provider will be covered at the In-Network level.

Urgent Care Center services received from a non-BlueCard® Provider will be covered at the Out-of-Network level.

All non-urgent services (BlueCard® or non-BlueCard®) will be covered at the Out-of-Network level.

The Home Health Care 100 visit limit is a combined In and Out-of-Network visit limit.

Anthem
Individual Market

Anthem Bronze PPO Pathway with PreventiveRx 6000/25% HSA

Schedule of Benefits
Non-Tiered Network Plan

Your plan provides You with the option to lower Your Out-of-Pocket costs for certain services by going to Site of Service Providers. These Providers may have lower cost shares and Maximum Allowed Amounts, reducing Your Out-of-Pocket costs for certain services. When You use the "Find a Doctor" tool on anthem.com, look for the "SOS" indicator under the Provider's name, and when applicable, the tool will automatically sort and show these Providers first in Your results.

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$6,000 per Member	$12,000 per Member
Family	$12,000 per family	$24,000 per family
Out-of-Pocket Maximum **Individual**	$8,000 per Member	$16,000 per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$16,000 per family	$32,000 per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	50% Coinsurance per visit
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$70 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Virtual Visits with PCP	$70 Copayment per visit after INET plan deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Virtual Visits from PCP Virtual Care-Only Provider through Our mobile app and website	$0 Copayment per visit after INET plan deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	$100 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	25% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Site of Service Provider	25% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Laboratory Services	25% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Non-Advanced Radiology (X-ray, Diagnostic)	25% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Site of Service Provider	25% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	25% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary). **PreventiveRx Note:** No Copayment, Deductible, or Coinsurance applies to Prescription Drugs on the PreventiveRx Basic List when you use an In-Network Pharmacy		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$30 Copayment per prescription after INET plan deductible is met	50% per prescription after OON plan Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	25% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	30% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	40% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription	50% per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary). **PreventiveRx Note:** No Copayment, Deductible, or Coinsurance applies to Prescription Drugs on the PreventiveRx Basic List when you use an In-Network Pharmacy		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$90 Copayment per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	25% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	30% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	40% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription	50% per prescription after OON plan Deductible is met
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Other Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the "Prescription Drug" section for details.	25% Coinsurance per equipment/supply after INET plan Deductible is met	50% Coinsurance per equipment/supply after OON plan Deductible is met
Durable Medical Equipment (DME)	25% Coinsurance per equipment/supply after INET plan Deductible is met	50% Coinsurance per equipment/supply after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	25% Coinsurance per visit after INET plan Deductible is met	25% Coinsurance per visit after OON plan Deductible is met
Outpatient Services **(in a Hospital or ambulatory Facility)**	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	25% Coinsurance per Admission after INET plan Deductible is met	50% Coinsurance per admission after OON plan Deductible is met
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	25% Coinsurance per Admission after INET plan Deductible is met	50% Coinsurance per admission after OON plan Deductible is met
Emergency and Urgent Care		
Ambulance Services	25% Coinsurance per service after INET plan Deductible is met	Same as In-Network
Emergency Room	25% Coinsurance per visit after INET plan Deductible is met	Same as In-Network
Urgent Care Centers	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	0% Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
Single Vision Lenses	$0 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
Bifocal	$0 Copayment	50% Coinsurance per visit after OON plan Deductible is met
Trifocal	$0 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
Collection Frame	$0 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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 after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the "Preventive Care Services" section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the "Medical Supplies, Durable Medical Equipment and Appliances" section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% Coinsurance after Deductible. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the "Preventive Care Services" section of this Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;

- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Urgent Care Center services received from a BlueCard® Provider will be covered at the In-Network level.

Urgent Care Center services received from a non-BlueCard® Provider will be covered at the Out-of-Network level.

All non-urgent services (BlueCard® or non-BlueCard®) will be covered at the Out-of-Network level.

The Home Health Care 100 visit limit is a combined In and Out-of-Network visit limit.

Anthem
Individual Market
Bronze PPO Pathway with PreventiveRx HSA
Schedule of Benefits
Non-Tiered Network Plan

Your plan provides You with the option to lower Your Out-of-Pocket costs for certain services by going to Site of Service Providers. These Providers may have lower cost shares and Maximum Allowed Amounts, reducing Your Out-of-Pocket costs for certain services. When You use the "Find a Doctor" tool on anthem.com, look for the "SOS" indicator under the Provider's name, and when applicable, the tool will automatically sort and show these Providers first in Your results.

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$6,000 per Member	$12,000 per Member
Family	$12,000 per family	$24,000 per family
Out-of-Pocket Maximum **Individual**	$8,000 per Member	$16,000 per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$16,000 per family	$32,000 per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	50% Coinsurance per visit
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$70 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Virtual Visits with PCP	$70 Copayment per visit after INET plan deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Virtual Visits from PCP Virtual Care-Only Provider through Our mobile app and website	$0 Copayment per visit after INET plan deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	$100 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	25% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Site of Service Provider	25% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Laboratory Services	25% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Non-Advanced Radiology (X-ray, Diagnostic)	25% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Site of Service Provider	25% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	25% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary). **PreventiveRx Note:** No Copayment, Deductible, or Coinsurance applies to Prescription Drugs on the PreventiveRx Basic List when you use an In-Network Pharmacy		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$30 Copayment per prescription after INET plan deductible is met	50% per prescription after OON plan Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	25% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	30% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	40% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription	50% per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary). **PreventiveRx Note:** No Copayment, Deductible, or Coinsurance applies to Prescription Drugs on the PreventiveRx Basic List when you use an In-Network Pharmacy		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$90 Copayment per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	25% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	30% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	40% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription	50% per prescription after OON plan Deductible is met
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Other Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the "Prescription Drug" section for details.	25% Coinsurance per equipment/supply after INET plan Deductible is met	50% Coinsurance per equipment/supply after OON plan Deductible is met
Durable Medical Equipment (DME)	25% Coinsurance per equipment/supply after INET plan Deductible is met	50% Coinsurance per equipment/supply after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	25% Coinsurance per visit after INET plan Deductible is met	25% Coinsurance per visit after OON plan Deductible is met
Outpatient Services **(in a Hospital or ambulatory Facility)**	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	25% Coinsurance per Admission after INET plan Deductible is met	50% Coinsurance per admission after OON plan Deductible is met
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	25% Coinsurance per Admission after INET plan Deductible is met	50% Coinsurance per admission after OON plan Deductible is met
Emergency and Urgent Care		
Ambulance Services	25% Coinsurance per service after INET plan Deductible is met	Same as In-Network
Emergency Room	25% Coinsurance per visit after INET plan Deductible is met	Same as In-Network
Urgent Care Centers	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	0% Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
Single Vision Lenses	$0 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
Bifocal	$0 Copayment	50% Coinsurance per visit after OON plan Deductible is met
Trifocal	$0 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
Collection Frame	$0 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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 after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the "Preventive Care Services" section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the "Medical Supplies, Durable Medical Equipment and Appliances" section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% Coinsurance after Deductible. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the "Preventive Care Services" section of this Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;

- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Urgent Care Center services received from a BlueCard® Provider will be covered at the In-Network level.

Urgent Care Center services received from a non-BlueCard® Provider will be covered at the Out-of-Network level.

All non-urgent services (BlueCard® or non-BlueCard®) will be covered at the Out-of-Network level.

The Home Health Care 100 visit limit is a combined In and Out-of-Network visit limit.

Anthem
Individual Market
Anthem Gold PPO Standard Pathway 1200/2400/0%
Schedule of Benefits
Non-Tiered Network Plan

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$1,200 per Member	$3,000 per Member
Family	$2,400 per family	$6,000 per family
Separate Prescription Drug Deductible **Individual**	$50 per Member	$350 per Member
Family	$100 per family	$700 per family
Out-of-Pocket Maximum **Individual**	$7,375 per Member	$14,750 per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$14,750 per family	$29,500 per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	30% Coinsurance per visit
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$20 Copayment per visit	30% Coinsurance per visit after OON plan Deductible is met
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	$40 Copayment per visit	30% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	$20 Copayment per visit	30% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	$65 Copayment per service up to a combined maximum of $375 for MRI and CAT scans; $400 for PET scans	30% Coinsurance per service after OON plan Deductible is met
Laboratory Services	$10 Copayment per service	30% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	$40 Copayment per service after INET plan Deductible is met	30% Coinsurance per service after OON plan Deductible is met
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	$20 Copayment per service	30% Coinsurance per service after OON plan Deductible is met
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$5 Copayment per prescription	30% per prescription after OON prescription drug Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$35 Copayment per prescription	30% per prescription after OON prescription drug Deductible is met
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$60 Copayment per prescription	30% per prescription after OON prescription drug Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription after INET prescription drug Deductible is met up to a maximum of $100 per prescription	30% per prescription after OON prescription drug Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$15 Copayment per prescription	30% per prescription after OON prescription drug Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$105 Copayment per prescription	30% per prescription after OON prescription drug Deductible is met
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$180 Copayment per prescription	30% per prescription after OON prescription drug Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription after INET prescription drug Deductible is met up to a maximum of $100 per prescription	30% per prescription after OON prescription drug Deductible is met
Outpatient Rehabilitative and Habilitative Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$20 Copayment per visit	30% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$20 Copayment per visit	30% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	$40 Copayment per visit	30% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	30% Coinsurance per equipment/supply	30% Coinsurance per equipment/supply after OON plan Deductible is met
Durable Medical Equipment (DME)	30% Coinsurance per equipment/supply	30% Coinsurance per equipment/supply after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	No Cost	25% Coinsurance per visit after separate $50 Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Outpatient Services **(in a Hospital or ambulatory Facility)**	$500 Copayment per visit after INET plan Deductible is met at an Outpatient Hospital Facility $300 Copayment per visit after INET plan Deductible is met at an Ambulatory Surgery Center	30% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	$500 Copayment per day to a maximum of $1,000 per Admission after INET plan Deductible is met	30% Coinsurance per admission after OON plan Deductible is met
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	$500 Copayment per day to a maximum of $1,000 per Admission after INET plan Deductible is met	30% Coinsurance per admission after OON plan Deductible is met
Emergency and Urgent Care		
Ambulance Services	No Cost	Same as In-Network
Emergency Room	$400 Copayment per visit	Same as In-Network
Urgent Care Centers	$50 Copayment per visit	30% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	No Cost	50% Coinsurance per visit after OON plan Deductible is met
Basic Services	20% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met
Major Services	40% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	$0 Copayment	50% Coinsurance per visit after the OON plan Deductible is met
Single Vision Lenses	$0 Copayment	50% Coinsurance per visit after the OON plan Deductible is met
Bifocal	$0 Copayment	50% Coinsurance per visit after OON plan Deductible is met
Trifocal	$0 Copayment	50% Coinsurance per visit after the OON plan Deductible is met
Collection Frame	$0 Copayment	50% Coinsurance per visit after the OON plan Deductible is met
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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	30% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Covered Dental Services pediatric dental services are covered for Members until age 26. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see “Pediatric Dental Care” in the “What is Covered” section for more information on pediatric dental services.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the “Preventive Care Services” section of this

Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;
- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Urgent Care Center services received from a BlueCard® Provider will be covered at the In-Network level.

Urgent Care Center services received from a non-BlueCard® Provider will be covered at the Out-of-Network level.

All non-urgent services (BlueCard® or non-BlueCard®) will be covered at the Out-of-Network level.

The Home Health Care 100 visit limit is a combined In and Out-of-Network visit limit.

Anthem
Individual Market

Anthem Bronze HMO Pathway Enhanced 7000/0% with Adult Dental and Vision Benefits

Schedule of Benefits
Non-Tiered Network Plan

Your plan provides You with the option to lower Your Out-of-Pocket costs for certain services by going to Site of Service Providers. These Providers may have lower cost shares and Maximum Allowed Amounts, reducing Your Out-of-Pocket costs for certain services. When You use the "Find a Doctor" tool on anthem.com, look for the "SOS" indicator under the Provider's name, and when applicable, the tool will automatically sort and show these Providers first in Your results.

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$7,000 per Member	Not Covered per Member
Family	$14,000 per family	Not Covered per family
Out-of-Pocket Maximum **Individual**	$10,000 per Member	Not Covered per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$20,000 per family	Not Covered per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	Not Covered
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$70 Copayment per visit	Not Covered
Virtual Visits with PCP	$70 Copayment per visit	Not Covered
Virtual Visits from PCP Virtual Care-Only Provider through Our mobile app and website	$0 Copayment per visit	Not Applicable
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	$90 Copayment per visit after INET plan Deductible is met	Not Covered
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	$90 Copayment per visit after INET plan Deductible is met	Not Covered
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	$75 Copayment per service after INET plan Deductible is met up to a combined maximum of $375 for MRI and CAT scans; $400 for PET scans	Not Covered
Site of Service Provider	$75 Copayment per service after INET plan Deductible is met up to a combined maximum of $375 for MRI and CAT scans; $400 for PET scans	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Laboratory Services	$20 Copayment per service after INET plan Deductible is met	Not Covered
Non-Advanced Radiology (X-ray, Diagnostic) **Site of Service Provider**	$40 Copayment per service after INET plan Deductible is met $40 Copayment per service after INET plan Deductible is met	Not Covered Not Covered
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	$20 Copayment per service	Not Covered
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$20 Copayment per prescription	Not Covered
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$75 Copayment per prescription	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	40% Coinsurance per prescription up to a maximum of $500 per prescription	Not Covered
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $1000 per prescription	Not Covered
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$60 Copayment per prescription	Not Covered
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$225 Copayment per prescription	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	40% Coinsurance per prescription	Not Covered
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $1000 per prescription	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit after INET plan Deductible is met	Not Covered
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit after INET plan Deductible is met	Not Covered
Other Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	$50 Copayment per visit after INET plan Deductible is met	Not Covered
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	0% Coinsurance per equipment/supply after INET plan Deductible is met	Not Covered
Durable Medical Equipment (DME)	40% Coinsurance per equipment/supply after INET plan Deductible is met	Not Covered
Home Health Care Services **(up to 100 visits per Calendar Year)**	25% Coinsurance per visit after separate $50 Deductible is met	Not Covered
Outpatient Services **(in a Hospital or ambulatory Facility)**	$500 Copayment per visit after INET plan Deductible is met at an Outpatient Hospital Facility $300 Copayment per visit after INET plan Deductible is met at an Ambulatory Surgery Center	Not Covered
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	$500 Copayment per day to a maximum of $1,000 per Admission after INET plan Deductible is met	Not Covered
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	$500 Copayment per day to a maximum of $1,000 per Admission after INET plan Deductible is met	Not Covered
Emergency and Urgent Care		
Ambulance Services	40% Coinsurance per service after INET plan Deductible is met	Same as In-Network
Emergency Room	$500 Copayment per visit after INET plan Deductible is met	Same as In-Network

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Urgent Care Centers	$100 Copayment per visit after INET plan Deductible is met	Same as In-Network
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	0% Coinsurance per visit	Not Covered
Basic Services	40% Coinsurance per visit after INET plan Deductible is met	Not Covered
Major Services	50% Coinsurance per visit after INET plan Deductible is met	Not Covered
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	Not Covered

Adult Dental Care (for Members age 26 and over)		
Diagnostic & Preventive Exams Cleanings Bitewing X-rays X-rays (full Mouth or Panoramic) Office Visit Copay Note: please see “Adult Dental Care” in the “What is Covered” section for additional information.	20% Coinsurance per visit	Not Covered
Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	$0 Copayment	Not Covered
Single Vision Lenses	$0 Copayment	Not Covered
Bifocal	$0 Copayment	Not Covered
Trifocal	$0 Copayment	Not Covered
Collection Frame	$0 Copayment	Not Covered
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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	Not Covered
Adult Vision Care (for Subscriber and spouse age 19 and older)		
Prescription Eye Glasses Single Vision Lenses	$40 Copayment	Not Covered

Bifocal Lenses	$40 Copayment	Not Covered
Trifocal Lenses	$40 Copayment	Not Covered
Frames One frame every other Calendar Year	Covered up to $100	Not Covered
Contact Lenses Once every other Calendar Year		
Elective (conventional and disposable)	Covered up to $80	Not Covered
Non-Elective	$0 Copayment	Not Covered
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	$40 Copayment per visit	Not Covered
Important Note: Benefits for contact lenses are in lieu of Your eyeglass lens benefit. If You receive contact lenses, no benefit will be available for eyeglass lenses until the next benefit period.		

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Covered Dental Services pediatric dental services are covered for Members until age 26. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see “Pediatric Dental Care” in the “What is Covered” section for more information on pediatric dental services.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the “Preventive Care Services” section of this

Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;
- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem
Individual Market

Anthem Bronze HMO Pathway Enhanced 6000/12000/40% HSA

Schedule of Benefits
Non-Tiered Network Plan

Your plan provides You with the option to lower Your Out-of-Pocket costs for certain services by going to Site of Service Providers. These Providers may have lower cost shares and Maximum Allowed Amounts, reducing Your Out-of-Pocket costs for certain services. When You use the "Find a Doctor" tool on anthem.com, look for the "SOS" indicator under the Provider's name, and when applicable, the tool will automatically sort and show these Providers first in Your results.

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$6,000 per Member	Not Covered per Member
Family	$12,000 per family	Not Covered per family
Out-of-Pocket Maximum **Individual**	$8,000 per Member	Not Covered per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$16,000 per family	Not Covered per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	Not Covered
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	40% Coinsurance per visit after INET plan Deductible is met	Not Covered
Virtual Visits with PCP	40% Coinsurance per visit after INET plan Deductible is met	Not Covered
Virtual Visits from PCP Virtual Care-Only Provider through Our mobile app and website	0% Coinsurance per visit after INET plan Deductible is met	Not Applicable
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	40% Coinsurance per visit after INET plan Deductible is met	Not Covered
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	40% Coinsurance per visit after INET plan Deductible is met	Not Covered
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	40% Coinsurance per service after INET plan Deductible is met	Not Covered
Site of Service Provider	20% Coinsurance per service after INET plan Deductible is met	Not Covered
Laboratory Services	40% Coinsurance per service after INET plan Deductible is met	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Non-Advanced Radiology (X-ray, Diagnostic) **Site of Service Provider**	40% Coinsurance per service after INET plan Deductible is met 20% Coinsurance per service after INET plan Deductible is met	Not Covered Not Covered
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	40% Coinsurance per service after INET plan Deductible is met	Not Covered
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	40% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	40% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	40% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $750 per prescription	Not Covered
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	40% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	40% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	40% Coinsurance per prescription after INET plan Deductible is met	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $750 per prescription	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	40% Coinsurance per visit after INET plan Deductible is met	Not Covered
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	40% Coinsurance per visit after INET plan Deductible is met	Not Covered
Other Services		
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	40% Coinsurance per visit after INET plan Deductible is met	Not Covered
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	40% Coinsurance per equipment/supply after INET plan Deductible is met	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Durable Medical Equipment (DME)	40% Coinsurance per equipment/supply after INET plan Deductible is met	Not Covered
Home Health Care Services **(up to 100 visits per Calendar Year)**	25% Coinsurance per visit after INET plan Deductible is met	Not Covered
Outpatient Services **(in a Hospital or ambulatory Facility)**	40% Coinsurance per visit after INET plan Deductible is met	Not Covered
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	40% Coinsurance per Admission after INET plan Deductible is met	Not Covered
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	40% Coinsurance per Admission after INET plan Deductible is met	Not Covered
Emergency and Urgent Care		
Ambulance Services	40% Coinsurance per service after INET plan Deductible is met	Same as In-Network
Emergency Room	40% Coinsurance per visit after INET plan Deductible is met	Same as In-Network
Urgent Care Centers	40% Coinsurance per visit after INET plan Deductible is met	Same as In-Network
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	0% Coinsurance per visit	Not Covered
Basic Services	40% Coinsurance per visit after INET plan Deductible is met	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Major Services	50% Coinsurance per visit after INET plan Deductible is met	Not Covered
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	Not Covered

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	$0 Copayment after INET plan Deductible is met	Not Covered
Single Vision Lenses	$0 Copayment after INET plan Deductible is met	Not Covered
Bifocal	$0 Copayment after INET plan Deductible is met	Not Covered
Trifocal	$0 Copayment after INET plan Deductible is met	Not Covered
Collection Frame	$0 Copayment after INET plan Deductible is met	Not Covered
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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 after INET plan Deductible is met	Not Covered

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% Coinsurance after Deductible. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Covered Dental Services pediatric dental services are covered for Members until age 26. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see “Pediatric Dental Care” in the “What is Covered” section for more information on pediatric dental services.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the “Preventive Care Services” section of this

Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;
- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem
Individual Market

Anthem Silver PPO Standard Pathway 5000/10000/0%

Schedule of Benefits
Non-Tiered Network Plan

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$5,000 per Member	$10,000 per Member
Family	$10,000 per family	$20,000 per family
Separate Prescription Drug Deductible **Individual**	$250 per Member	$500 per Member
Family	$500 per family	$1,000 per family
Out-of-Pocket Maximum **Individual**	$9,400 per Member	$18,200 per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$18,800 per family	$36,400 per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	40% Coinsurance per visit
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$45 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	$60 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	$45 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	$75 Copayment per service up to a combined maximum of $375 for MRI and CAT scans; $400 for PET scans	40% Coinsurance per service after OON plan Deductible is met
Laboratory Services	$25 Copayment per service	40% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	$40 Copayment per service after INET plan Deductible is met	40% Coinsurance per service after OON plan Deductible is met
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	$20 Copayment per service	40% Coinsurance per service after OON plan Deductible is met
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$10 Copayment per prescription	40% per prescription after OON prescription drug Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$50 Copayment per prescription after INET prescription drug Deductible is met	40% per prescription after OON prescription drug Deductible is met
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$75 Copayment per prescription after INET prescription drug Deductible is met	40% per prescription after OON prescription drug Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription after INET prescription drug Deductible is met up to a maximum of $200 per prescription	40% per prescription after OON prescription drug Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$30 Copayment per prescription	40% per prescription after OON prescription drug Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$150 Copayment per prescription after INET prescription drug Deductible is met	40% per prescription after OON prescription drug Deductible is met
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$225 Copayment per prescription after INET prescription drug Deductible is met	40% per prescription after OON prescription drug Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription after INET prescription drug Deductible is met up to a maximum of $200 per prescription	40% per prescription after OON prescription drug Deductible is met
Outpatient Rehabilitative and Habilitative Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	$50 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	40% Coinsurance per equipment/supply	40% Coinsurance per equipment/supply after OON plan Deductible is met
Durable Medical Equipment (DME)	40% Coinsurance per equipment/supply	40% Coinsurance per equipment/supply after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	No Cost	25% Coinsurance per visit after separate $50 Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Outpatient Services **(in a Hospital or ambulatory Facility)**	$500 Copayment per visit after INET plan Deductible is met at an Outpatient Hospital Facility $300 Copayment per visit after INET plan Deductible is met at an Ambulatory Surgery Center	40% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	$500 Copayment per day to a maximum of $2,000 per Admission after INET plan Deductible is met	40% Coinsurance per admission after OON plan Deductible is met
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	$500 Copayment per day to a maximum of $2,000 per Admission after INET plan Deductible is met	40% Coinsurance per admission after OON plan Deductible is met
Emergency and Urgent Care		
Ambulance Services	No Cost	Same as In-Network
Emergency Room	$450 Copayment per visit after INET plan Deductible is met	Same as In-Network
Urgent Care Centers	$75 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	No Cost	50% Coinsurance per visit after OON plan Deductible is met
Basic Services	40% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Major Services	50% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	$0 Copayment per visit	50% Coinsurance per visit after the OON plan Deductible is met
Single Vision Lenses	$0 Copayment per visit	50% Coinsurance per visit after the OON plan Deductible is met
Bifocal	$0 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Trifocal	$0 Copayment per visit	50% Coinsurance per visit after the OON plan Deductible is met
Collection Frame	$0 Copayment per visit	50% Coinsurance per visit after the OON plan Deductible is met
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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	40% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Covered Dental Services pediatric dental services are covered for Members until age 26. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see “Pediatric Dental Care” in the “What is Covered” section for more information on pediatric dental services.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the “Preventive Care Services” section of this

Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;
- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Urgent Care Center services received from a BlueCard® Provider will be covered at the In-Network level.

Urgent Care Center services received from a non-BlueCard® Provider will be covered at the Out-of-Network level.

All non-urgent services (BlueCard® or non-BlueCard®) will be covered at the Out-of-Network level.

The Home Health Care 100 visit limit is a combined In and Out-of-Network visit limit.

Anthem
Individual Market
Bronze HMO Pathway Enhanced LCSR
Schedule of Benefits
Non-Tiered Network Plan

Your plan provides You with the option to lower Your Out-of-Pocket costs for certain services by going to Site of Service Providers. These Providers may have lower cost shares and Maximum Allowed Amounts, reducing Your Out-of-Pocket costs for certain services. When You use the "Find a Doctor" tool on anthem.com, look for the "SOS" indicator under the Provider's name, and when applicable, the tool will automatically sort and show these Providers first in Your results.

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$7,000 per Member	Not Covered per Member
Family	$14,000 per family	Not Covered per family
Out-of-Pocket Maximum **Individual**	$10,000 per Member	Not Covered per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$20,000 per family	Not Covered per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	Not Covered
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$70 Copayment per visit	Not Covered
Virtual Visits with PCP	$70 Copayment per visit	Not Covered
Virtual Visits from PCP Virtual Care-Only Provider through Our mobile app and website	$0 Copayment per visit	Not Applicable
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	$90 Copayment per visit after INET plan Deductible is met	Not Covered
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	$90 Copayment per visit after INET plan Deductible is met	Not Covered
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	$75 Copayment per service after INET plan Deductible is met up to a combined maximum of $375 for MRI and CAT scans; $400 for PET scans	Not Covered
Site of Service Provider	$75 Copayment per service after INET plan Deductible is met up to a combined maximum of $375 for MRI and CAT scans; $400 for PET scans	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Laboratory Services	$20 Copayment per service after INET plan Deductible is met	Not Covered
Non-Advanced Radiology (X-ray, Diagnostic)	$40 Copayment per service after INET plan Deductible is met	Not Covered
Site of Service Provider	$40 Copayment per service after INET plan Deductible is met	Not Covered
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	$20 Copayment per service	Not Covered
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$20 Copayment per prescription	Not Covered
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$75 Copayment per prescription	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	40% Coinsurance per prescription up to a maximum of $500 per prescription	Not Covered
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $1000 per prescription	Not Covered
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$60 Copayment per prescription	Not Covered
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$225 Copayment per prescription	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	40% Coinsurance per prescription	Not Covered
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $1000 per prescription	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit after INET plan Deductible is met	Not Covered
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit after INET plan Deductible is met	Not Covered
Other Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	$50 Copayment per visit after INET plan Deductible is met	Not Covered
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	0% Coinsurance per equipment/supply after INET plan Deductible is met	Not Covered
Durable Medical Equipment (DME)	40% Coinsurance per equipment/supply after INET plan Deductible is met	Not Covered
Home Health Care Services **(up to 100 visits per Calendar Year)**	25% Coinsurance per visit after separate $50 Deductible is met	Not Covered
Outpatient Services **(in a Hospital or ambulatory Facility)**	$500 Copayment per visit after INET plan Deductible is met at an Outpatient Hospital Facility $300 Copayment per visit after INET plan Deductible is met at an Ambulatory Surgery Center	Not Covered
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	$500 Copayment per day to a maximum of $1,000 per Admission after INET plan Deductible is met	Not Covered
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	$500 Copayment per day to a maximum of $1,000 per Admission after INET plan Deductible is met	Not Covered
Emergency and Urgent Care		
Ambulance Services	40% Coinsurance per service after INET plan Deductible is met	Same as In-Network
Emergency Room	$500 Copayment per visit after INET plan Deductible is met	Same as In-Network

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Urgent Care Centers	$100 Copayment per visit after INET plan Deductible is met	Same as In-Network

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	$0 Copayment	Not Covered
Single Vision Lenses	$0 Copayment	Not Covered
Bifocal	$0 Copayment	Not Covered
Trifocal	$0 Copayment	Not Covered
Collection Frame	$0 Copayment	Not Covered
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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	Not Covered

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the "Preventive Care Services" section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the "Medical Supplies, Durable Medical Equipment and Appliances" section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the "Preventive Care Services" section of this Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;

- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Eligible American Indians, as determined by the Exchange, enrolled in the Limited Cost Share Reduction plans, are exempt from Cost Sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no member responsibility for American Indians when Covered Services are rendered by one of these Providers.

Anthem
Individual Market

Anthem Bronze HMO Pathway Enhanced 7000/0%

Schedule of Benefits
Non-Tiered Network Plan

Your plan provides You with the option to lower Your Out-of-Pocket costs for certain services by going to Site of Service Providers. These Providers may have lower cost shares and Maximum Allowed Amounts, reducing Your Out-of-Pocket costs for certain services. When You use the “Find a Doctor” tool on anthem.com, look for the “SOS” indicator under the Provider’s name, and when applicable, the tool will automatically sort and show these Providers first in Your results.

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$7,000 per Member	Not Covered per Member
Family	$14,000 per family	Not Covered per family
Out-of-Pocket Maximum **Individual**	$10,000 per Member	Not Covered per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$20,000 per family	Not Covered per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	Not Covered
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$70 Copayment per visit	Not Covered
Virtual Visits with PCP	$70 Copayment per visit	Not Covered
Virtual Visits from PCP Virtual Care-Only Provider through Our mobile app and website	$0 Copayment per visit	Not Applicable
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	$90 Copayment per visit after INET plan Deductible is met	Not Covered
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	$90 Copayment per visit after INET plan Deductible is met	Not Covered
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	$75 Copayment per service after INET plan Deductible is met up to a combined maximum of $375 for MRI and CAT scans; $400 for PET scans	Not Covered
Site of Service Provider	$75 Copayment per service after INET plan Deductible is met up to a combined maximum of $375 for MRI and CAT scans; $400 for PET scans	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Laboratory Services	$20 Copayment per service after INET plan Deductible is met	Not Covered
Non-Advanced Radiology (X-ray, Diagnostic)	$40 Copayment per service after INET plan Deductible is met	Not Covered
Site of Service Provider	$40 Copayment per service after INET plan Deductible is met	Not Covered
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	$20 Copayment per service	Not Covered
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$20 Copayment per prescription	Not Covered
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$75 Copayment per prescription	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	40% Coinsurance per prescription up to a maximum of $500 per prescription	Not Covered
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $1000 per prescription	Not Covered
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$60 Copayment per prescription	Not Covered
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$225 Copayment per prescription	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	40% Coinsurance per prescription	Not Covered
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $1000 per prescription	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit after INET plan Deductible is met	Not Covered
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit after INET plan Deductible is met	Not Covered
Other Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	$50 Copayment per visit after INET plan Deductible is met	Not Covered
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	0% Coinsurance per equipment/supply after INET plan Deductible is met	Not Covered
Durable Medical Equipment (DME)	40% Coinsurance per equipment/supply after INET plan Deductible is met	Not Covered
Home Health Care Services **(up to 100 visits per Calendar Year)**	25% Coinsurance per visit after separate $50 Deductible is met	Not Covered
Outpatient Services **(in a Hospital or ambulatory Facility)**	$500 Copayment per visit after INET plan Deductible is met at an Outpatient Hospital Facility $300 Copayment per visit after INET plan Deductible is met at an Ambulatory Surgery Center	Not Covered
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	$500 Copayment per day to a maximum of $1,000 per Admission after INET plan Deductible is met	Not Covered
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	$500 Copayment per day to a maximum of $1,000 per Admission after INET plan Deductible is met	Not Covered
Emergency and Urgent Care		
Ambulance Services	40% Coinsurance per service after INET plan Deductible is met	Same as In-Network
Emergency Room	$500 Copayment per visit after INET plan Deductible is met	Same as In-Network

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Urgent Care Centers	$100 Copayment per visit after INET plan Deductible is met	Same as In-Network

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	$0 Copayment	Not Covered
Single Vision Lenses	$0 Copayment	Not Covered
Bifocal	$0 Copayment	Not Covered
Trifocal	$0 Copayment	Not Covered
Collection Frame	$0 Copayment	Not Covered
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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	Not Covered

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the "Preventive Care Services" section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the "Medical Supplies, Durable Medical Equipment and Appliances" section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the "Preventive Care Services" section of this Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;

- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem
Individual Market
Gold PPO Pathway
Schedule of Benefits
Non-Tiered Network Plan

Your plan provides You with the option to lower Your Out-of-Pocket costs for certain services by going to Site of Service Providers. These Providers may have lower cost shares and Maximum Allowed Amounts, reducing Your Out-of-Pocket costs for certain services. When You use the "Find a Doctor" tool on anthem.com, look for the "SOS" indicator under the Provider's name, and when applicable, the tool will automatically sort and show these Providers first in Your results.

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$2,000 per Member	$4,000 per Member
Family	$4,000 per family	$8,000 per family
Out-of-Pocket Maximum **Individual**	$9,000 per Member	$18,000 per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$18,000 per family	$36,000 per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	50% Coinsurance per visit
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Virtual Visits with PCP	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Virtual Visits from PCP Virtual Care-Only Provider through Our mobile app and website	0% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	10% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Site of Service Provider	10% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Laboratory Services	10% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Non-Advanced Radiology (X-ray, Diagnostic)	10% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Site of Service Provider	10% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	10% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	10% Coinsurance per prescription	50% per prescription after OON plan Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription	50% per prescription after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription up to a maximum of $500 per prescription	50% per prescription after OON plan Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	30% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $1000 per prescription	50% per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	10% Coinsurance per prescription	50% per prescription after OON plan Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription	50% per prescription after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription	50% per prescription after OON plan Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	30% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $1000 per prescription	50% per prescription after OON plan Deductible is met
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Other Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the "Prescription Drug" section for details.	10% Coinsurance per equipment/supply after INET plan Deductible is met	50% Coinsurance per equipment/supply after OON plan Deductible is met
Durable Medical Equipment (DME)	10% Coinsurance per equipment/supply after INET plan Deductible is met	50% Coinsurance per equipment/supply after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	10% Coinsurance per visit after separate $50 Deductible is met	25% Coinsurance per visit after separate $50 Deductible is met
Outpatient Services **(in a Hospital or ambulatory Facility)**	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	10% Coinsurance per Admission after INET plan Deductible is met	50% Coinsurance per admission after OON plan Deductible is met
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	10% Coinsurance per Admission after INET plan Deductible is met	50% Coinsurance per admission after OON plan Deductible is met
Emergency and Urgent Care		
Ambulance Services	10% Coinsurance per service after INET plan Deductible is met	Same as In-Network
Emergency Room	10% Coinsurance per visit after INET plan Deductible is met	Same as In-Network
Urgent Care Centers	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	$0 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Single Vision Lenses	$0 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Bifocal	$0 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Trifocal	$0 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Collection Frame	$0 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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 per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

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Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the “Preventive Care Services” section of this Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government’s web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;

- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Urgent Care Center services received from a BlueCard® Provider will be covered at the In-Network level.

Urgent Care Center services received from a non-BlueCard® Provider will be covered at the Out-of-Network level.

All non-urgent services (BlueCard® or non-BlueCard®) will be covered at the Out-of-Network level.

The Home Health Care 100 visit limit is a combined In and Out-of-Network visit limit.

Anthem
Individual Market

Anthem Catastrophic HMO Pathway Enhanced

Schedule of Benefits
Non-Tiered Network Plan

Your plan provides You with the option to lower Your Out-of-Pocket costs for certain services by going to Site of Service Providers. These Providers may have lower cost shares and Maximum Allowed Amounts, reducing Your Out-of-Pocket costs for certain services. When You use the “Find a Doctor” tool on anthem.com, look for the “SOS” indicator under the Provider’s name, and when applicable, the tool will automatically sort and show these Providers first in Your results.

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$10,600 per Member	Not Covered per Member
Family	$21,200 per family	Not Covered per family
Out-of-Pocket Maximum **Individual**	$10,600 per Member	Not Covered per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$21,200 per family	Not Covered per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	Not Covered
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$40 Copayment for the first 3 visits (Deductible is waived), then $0 Copayment per visit after INET plan Deductible is met	Not Covered
Virtual Visits with PCP	$40 Copayment for the first 3 visits (Deductible is waived), then $0 Copayment per visit after INET plan Deductible is met	Not Covered
Virtual Visits from PCP Virtual Care-Only Provider through Our mobile app and website	$0 Copayment per visit after INET plan Deductible is met	Not Applicable
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	0% Coinsurance per visit after INET plan Deductible is met	Not Covered
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	0% Coinsurance per visit after INET plan Deductible is met	Not Covered
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	0% Coinsurance per service after INET plan Deductible is met	Not Covered
Laboratory Services	0% Coinsurance per service after INET plan Deductible is met	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Non-Advanced Radiology (X-ray, Diagnostic)	0% Coinsurance per service after INET plan Deductible is met	Not Covered
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	0% Coinsurance per service after INET plan Deductible is met	Not Covered
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	0% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	0% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	0% Coinsurance per prescription after INET plan Deductible is met	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	0% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	0% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	0% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	0% Coinsurance per prescription after INET plan Deductible is met	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	0% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	0% Coinsurance per visit after INET plan Deductible is met	Not Covered
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	0% Coinsurance per visit after INET plan Deductible is met	Not Covered
Other Services		
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	0% Coinsurance per visit after INET plan Deductible is met	Not Covered
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	0% Coinsurance per equipment/supply after INET plan Deductible is met	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Durable Medical Equipment (DME)	0% Coinsurance per equipment/supply after INET plan Deductible is met	Not Covered
Home Health Care Services **(up to 100 visits per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met	Not Covered
Outpatient Services **(in a Hospital or ambulatory Facility)**	0% Coinsurance per visit after INET plan Deductible is met	Not Covered
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	0% Coinsurance per Admission after INET plan Deductible is met	Not Covered
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	0% Coinsurance per Admission after INET plan Deductible is met	Not Covered
Emergency and Urgent Care		
Ambulance Services	0% Coinsurance per service after INET plan Deductible is met	Same as In-Network
Emergency Room	0% Coinsurance per visit after INET plan Deductible is met	Same as In-Network
Urgent Care Centers	0% Coinsurance per visit after INET plan Deductible is met	Same as In-Network
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	0% Coinsurance per visit after INET plan Deductible is met	Not Covered
Basic Services	0% Coinsurance per visit after INET plan Deductible is met	Not Covered
Major Services	0% Coinsurance per visit after INET plan Deductible is met	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Orthodontia Services **(Medically Necessary only)**	0% Coinsurance per visit after INET plan Deductible is met	Not Covered

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	$0 Copayment after INET plan Deductible is met	Not Covered
Single Vision Lenses	$0 Copayment after INET plan Deductible is met	Not Covered
Bifocal	$0 Copayment after INET plan Deductible is met	Not Covered
Trifocal	$0 Copayment after INET plan Deductible is met	Not Covered
Collection Frame	$0 Copayment after INET plan Deductible is met	Not Covered
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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)	$0 Copayment per visit after INET plan Deductible is met	Not Covered

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Covered Dental Services pediatric dental services are covered for Members until age 26. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see “Pediatric Dental Care” in the “What is Covered” section for more information on pediatric dental services.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the “Preventive Care Services” section of this

Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;
- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Primary Care and Mental Health and Substance Abuse Provider Office Visits combined (for non-standard plans) subject to Copayment for the first three visits, not subject to the Deductible. Subsequent Office Visits are subject to medical Deductible.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem
Individual Market

Bronze HMO Pathway Enhanced LCSR with Adult Dental and Vision Benefits

Schedule of Benefits
Non-Tiered Network Plan

Your plan provides You with the option to lower Your Out-of-Pocket costs for certain services by going to Site of Service Providers. These Providers may have lower cost shares and Maximum Allowed Amounts, reducing Your Out-of-Pocket costs for certain services. When You use the "Find a Doctor" tool on anthem.com, look for the "SOS" indicator under the Provider's name, and when applicable, the tool will automatically sort and show these Providers first in Your results.

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$7,000 per Member	Not Covered per Member
Family	$14,000 per family	Not Covered per family
Out-of-Pocket Maximum **Individual**	$10,000 per Member	Not Covered per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$20,000 per family	Not Covered per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	Not Covered
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$70 Copayment per visit	Not Covered
Virtual Visits with PCP	$70 Copayment per visit	Not Covered
Virtual Visits from PCP Virtual Care-Only Provider through Our mobile app and website	$0 Copayment per visit	Not Applicable
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	$90 Copayment per visit after INET plan Deductible is met	Not Covered
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	$90 Copayment per visit after INET plan Deductible is met	Not Covered
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	$75 Copayment per service after INET plan Deductible is met up to a combined maximum of $375 for MRI and CAT scans; $400 for PET scans	Not Covered
Site of Service Provider	$75 Copayment per service after INET plan Deductible is met up to a combined maximum of $375 for MRI and CAT scans; $400 for PET scans	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Laboratory Services	$20 Copayment per service after INET plan Deductible is met	Not Covered
Non-Advanced Radiology (X-ray, Diagnostic)	$40 Copayment per service after INET plan Deductible is met	Not Covered
Site of Service Provider	$40 Copayment per service after INET plan Deductible is met	Not Covered
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	$20 Copayment per service	Not Covered
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$20 Copayment per prescription	Not Covered
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$75 Copayment per prescription	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	40% Coinsurance per prescription up to a maximum of $500 per prescription	Not Covered
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $1000 per prescription	Not Covered
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$60 Copayment per prescription	Not Covered
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$225 Copayment per prescription	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	40% Coinsurance per prescription	Not Covered
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $1000 per prescription	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit after INET plan Deductible is met	Not Covered
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit after INET plan Deductible is met	Not Covered
Other Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	$50 Copayment per visit after INET plan Deductible is met	Not Covered
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	0% Coinsurance per equipment/supply after INET plan Deductible is met	Not Covered
Durable Medical Equipment (DME)	40% Coinsurance per equipment/supply after INET plan Deductible is met	Not Covered
Home Health Care Services **(up to 100 visits per Calendar Year)**	25% Coinsurance per visit after separate $50 Deductible is met	Not Covered
Outpatient Services **(in a Hospital or ambulatory Facility)**	$500 Copayment per visit after INET plan Deductible is met at an Outpatient Hospital Facility $300 Copayment per visit after INET plan Deductible is met at an Ambulatory Surgery Center	Not Covered
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	$500 Copayment per day to a maximum of $1,000 per Admission after INET plan Deductible is met	Not Covered
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	$500 Copayment per day to a maximum of $1,000 per Admission after INET plan Deductible is met	Not Covered
Emergency and Urgent Care		
Ambulance Services	40% Coinsurance per service after INET plan Deductible is met	Same as In-Network
Emergency Room	$500 Copayment per visit after INET plan Deductible is met	Same as In-Network

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Urgent Care Centers	$100 Copayment per visit after INET plan Deductible is met	Same as In-Network
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	0% Coinsurance per visit	Not Covered
Basic Services	40% Coinsurance per visit after INET plan Deductible is met	Not Covered
Major Services	50% Coinsurance per visit after INET plan Deductible is met	Not Covered
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	Not Covered

Adult Dental Care (for Members age 26 and over)		
Diagnostic & Preventive Exams Cleanings Bitewing X-rays X-rays (full Mouth or Panoramic) Office Visit Copay Note: please see “Adult Dental Care” in the “What is Covered” section for additional information.	20% Coinsurance per visit	Not Covered
Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	$0 Copayment	Not Covered
Single Vision Lenses	$0 Copayment	Not Covered
Bifocal	$0 Copayment	Not Covered
Trifocal	$0 Copayment	Not Covered
Collection Frame	$0 Copayment	Not Covered
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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	Not Covered
Adult Vision Care (for Subscriber and spouse age 19 and older)		
Prescription Eye Glasses Single Vision Lenses	$40 Copayment	Not Covered

Bifocal Lenses Trifocal Lenses Frames One frame every other Calendar Year	$40 Copayment $40 Copayment Covered up to $100	Not Covered Not Covered Not Covered
Contact Lenses Once every other Calendar Year		
Elective (conventional and disposable) **Non-Elective**	Covered up to $80 $0 Copayment	Not Covered Not Covered
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	$40 Copayment per visit	Not Covered
Important Note: Benefits for contact lenses are in lieu of Your eyeglass lens benefit. If You receive contact lenses, no benefit will be available for eyeglass lenses until the next benefit period.		

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Covered Dental Services pediatric dental services are covered for Members until age 26. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see “Pediatric Dental Care” in the “What is Covered” section for more information on pediatric dental services.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the “Preventive Care Services” section of this

Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;
- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Eligible American Indians, as determined by the Exchange, enrolled in the Limited Cost Share Reduction plans, are exempt from Cost Sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no member responsibility for American Indians when Covered Services are rendered by one of these Providers.

Anthem
Individual Market
Silver PPO Standard Pathway
Schedule of Benefits
Non-Tiered Network Plan

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$5,000 per Member	$10,000 per Member
Family	$10,000 per family	$20,000 per family
Separate Prescription Drug Deductible **Individual**	$250 per Member	$500 per Member
Family	$500 per family	$1,000 per family
Out-of-Pocket Maximum **Individual**	$9,400 per Member	$18,200 per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$18,800 per family	$36,400 per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	40% Coinsurance per visit
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$45 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	$60 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	$45 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	$75 Copayment per service up to a combined maximum of $375 for MRI and CAT scans; $400 for PET scans	40% Coinsurance per service after OON plan Deductible is met
Laboratory Services	$25 Copayment per service	40% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	$40 Copayment per service after INET plan Deductible is met	40% Coinsurance per service after OON plan Deductible is met
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	$20 Copayment per service	40% Coinsurance per service after OON plan Deductible is met
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$10 Copayment per prescription	40% per prescription after OON prescription drug Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$50 Copayment per prescription after INET prescription drug Deductible is met	40% per prescription after OON prescription drug Deductible is met
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$75 Copayment per prescription after INET prescription drug Deductible is met	40% per prescription after OON prescription drug Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription after INET prescription drug Deductible is met up to a maximum of $200 per prescription	40% per prescription after OON prescription drug Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$30 Copayment per prescription	40% per prescription after OON prescription drug Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$150 Copayment per prescription after INET prescription drug Deductible is met	40% per prescription after OON prescription drug Deductible is met
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$225 Copayment per prescription after INET prescription drug Deductible is met	40% per prescription after OON prescription drug Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription after INET prescription drug Deductible is met up to a maximum of $200 per prescription	40% per prescription after OON prescription drug Deductible is met
Outpatient Rehabilitative and Habilitative Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	$50 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	40% Coinsurance per equipment/supply	40% Coinsurance per equipment/supply after OON plan Deductible is met
Durable Medical Equipment (DME)	40% Coinsurance per equipment/supply	40% Coinsurance per equipment/supply after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	No Cost	25% Coinsurance per visit after separate $50 Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Outpatient Services **(in a Hospital or ambulatory Facility)**	$500 Copayment per visit after INET plan Deductible is met at an Outpatient Hospital Facility $300 Copayment per visit after INET plan Deductible is met at an Ambulatory Surgery Center	40% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	$500 Copayment per day to a maximum of $2,000 per Admission after INET plan Deductible is met	40% Coinsurance per admission after OON plan Deductible is met
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	$500 Copayment per day to a maximum of $2,000 per Admission after INET plan Deductible is met	40% Coinsurance per admission after OON plan Deductible is met
Emergency and Urgent Care		
Ambulance Services	No Cost	Same as In-Network
Emergency Room	$450 Copayment per visit after INET plan Deductible is met	Same as In-Network
Urgent Care Centers	$75 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	No Cost	50% Coinsurance per visit after OON plan Deductible is met
Basic Services	40% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Major Services	50% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	$0 Copayment per visit	50% Coinsurance per visit after the OON plan Deductible is met
Single Vision Lenses	$0 Copayment per visit	50% Coinsurance per visit after the OON plan Deductible is met
Bifocal	$0 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Trifocal	$0 Copayment per visit	50% Coinsurance per visit after the OON plan Deductible is met
Collection Frame	$0 Copayment per visit	50% Coinsurance per visit after the OON plan Deductible is met
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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	40% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Covered Dental Services pediatric dental services are covered for Members until age 26. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see “Pediatric Dental Care” in the “What is Covered” section for more information on pediatric dental services.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the “Preventive Care Services” section of this

Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;
- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Urgent Care Center services received from a BlueCard® Provider will be covered at the In-Network level.

Urgent Care Center services received from a non-BlueCard® Provider will be covered at the Out-of-Network level.

All non-urgent services (BlueCard® or non-BlueCard®) will be covered at the Out-of-Network level.

The Home Health Care 100 visit limit is a combined In and Out-of-Network visit limit.

Anthem
Individual Market

Gold HMO Pathway Enhanced ZCSR with Adult Dental and Vision Benefits

Schedule of Benefits
Non-Tiered Network Plan

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$0 per Member	Not Covered per Member
Family	$0 per family	Not Covered per family
Out-of-Pocket Maximum **Individual**	$0 per Member	Not Covered per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$0 per family	Not Covered per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	Not Covered
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	No Cost	Not Covered
Virtual Visits with PCP	No Cost	Not Covered
Virtual Visits from PCP Virtual Care-Only Provider through Our mobile app and website	No Cost	Not Applicable
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	No Cost	Not Covered
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	No Cost	Not Covered
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	No Cost	Not Covered
Laboratory Services	No Cost	Not Covered
Non-Advanced Radiology (X-ray, Diagnostic)	No Cost	Not Covered
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	No Cost	Not Covered

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	No Cost	Not Covered
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	Not Covered
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	Not Covered
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	Not Covered
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	No Cost	Not Covered
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	Not Covered
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	Not Covered
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	No Cost	Not Covered
Outpatient Rehabilitative and Habilitative Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	No Cost	Not Covered
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	No Cost	Not Covered
Other Services		
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	No Cost	Not Covered
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	No Cost	Not Covered
Durable Medical Equipment (DME)	No Cost	Not Covered
Home Health Care Services **(up to 100 visits per Calendar Year)**	No Cost	Not Covered
Outpatient Services **(in a Hospital or ambulatory Facility)**	No Cost	Not Covered
Inpatient Hospital Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Inpatient Hospital services **(All Inpatient settings)**	No Cost	Not Covered
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	No Cost	Not Covered
Emergency and Urgent Care		
Ambulance Services	No Cost	Same as In-Network
Emergency Room	No Cost	Same as In-Network
Urgent Care Centers	No Cost	No Cost
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	No Cost	Not Covered
Basic Services	No Cost	Not Covered
Major Services	No Cost	Not Covered
Orthodontia Services **(Medically Necessary only)**	No Cost	Not Covered

Adult Dental Care (for Members age 26 and over)		
Diagnostic & Preventive Exams Cleanings Bitewing X-rays X-rays (full Mouth or Panoramic) Office Visit Copay Note: please see “Adult Dental Care” in the “What is Covered” section for additional information.	No Cost	Not Covered
Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	No Cost	Not Covered
Single Vision Lenses	No Cost	Not Covered
Bifocal	No Cost	Not Covered
Trifocal	No Cost	Not Covered
Collection Frame	No Cost	Not Covered
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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)	No Cost	Not Covered
Adult Vision Care (for Subscriber and spouse age 19 and older)		
Prescription Eye Glasses Single Vision Lenses	No Cost	Not Covered

Bifocal Lenses	No Cost	Not Covered
Trifocal Lenses	No Cost	Not Covered
Frames One frame every other Calendar Year	Covered up to $100	Not Covered
Contact Lenses Once every other Calendar Year		
Elective (conventional and disposable)	Covered up to $80	Not Covered
Non-Elective	No Cost	Not Covered
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	No Cost	Not Covered
Important Note: Benefits for contact lenses are in lieu of Your eyeglass lens benefit. If You receive contact lenses, no benefit will be available for eyeglass lenses until the next benefit period.		

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Covered Dental Services pediatric dental services are covered for Members until age 26. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see “Pediatric Dental Care” in the “What is Covered” section for more information on pediatric dental services.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the “Preventive Care Services” section of this

Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;
- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem
Individual Market

Anthem Bronze PPO Pathway 8000/0% HSA

Schedule of Benefits
Non-Tiered Network Plan

Your plan provides You with the option to lower Your Out-of-Pocket costs for certain services by going to Site of Service Providers. These Providers may have lower cost shares and Maximum Allowed Amounts, reducing Your Out-of-Pocket costs for certain services. When You use the "Find a Doctor" tool on anthem.com, look for the "SOS" indicator under the Provider's name, and when applicable, the tool will automatically sort and show these Providers first in Your results.

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$8,000 per Member	$16,000 per Member
Family	$16,000 per family	$32,000 per family
Out-of-Pocket Maximum **Individual**	$8,000 per Member	$16,000 per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$16,000 per family	$32,000 per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	50% Coinsurance per visit
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	0% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Site of Service Provider	0% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Laboratory Services	0% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	0% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Site of Service Provider	0% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	0% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	0% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	0% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	0% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	0% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	0% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	0% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	0% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	0% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	0% Coinsurance per equipment/supply after INET plan Deductible is met	50% Coinsurance per equipment/supply after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Durable Medical Equipment (DME)	0% Coinsurance per equipment/supply after INET plan Deductible is met	50% Coinsurance per equipment/supply after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met	25% Coinsurance per visit after OON plan Deductible is met
Outpatient Services **(in a Hospital or ambulatory Facility)**	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	0% Coinsurance per Admission after INET plan Deductible is met	50% Coinsurance per admission after OON plan Deductible is met
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	0% Coinsurance per Admission after INET plan Deductible is met	50% Coinsurance per admission after OON plan Deductible is met
Emergency and Urgent Care		
Ambulance Services	0% Coinsurance per service after INET plan Deductible is met	Same as In-Network
Emergency Room	0% Coinsurance per visit after INET plan Deductible is met	Same as In-Network
Urgent Care Centers	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	No Cost	No Cost
Basic Services	0% Coinsurance per visit after INET plan Deductible is met	0% Coinsurance per visit after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Major Services	0% Coinsurance per visit after INET plan Deductible is met	0% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	0% Coinsurance per visit after INET plan Deductible is met	0% Coinsurance per visit after OON plan Deductible is met

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	$0 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
Single Vision Lenses	$0 Copayment after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
Bifocal	$0 Copayment	50% Coinsurance per visit after OON plan Deductible is met
Trifocal	$0 Copayment after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
Collection Frame	$0 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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)	$0 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% Coinsurance after Deductible. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Covered Dental Services pediatric dental services are covered for Members until age 26. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see “Pediatric Dental Care” in the “What is Covered” section for more information on pediatric dental services.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the “Preventive Care Services” section of this

Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;
- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Urgent Care Center services received from a BlueCard® Provider will be covered at the In-Network level.

The Home Health Care 100 visit limit is a combined In and Out-of-Network visit limit.

Anthem
Individual Market
Bronze PPO Pathway with PreventiveRx LCSR
Schedule of Benefits
Non-Tiered Network Plan

Your plan provides You with the option to lower Your Out-of-Pocket costs for certain services by going to Site of Service Providers. These Providers may have lower cost shares and Maximum Allowed Amounts, reducing Your Out-of-Pocket costs for certain services. When You use the "Find a Doctor" tool on anthem.com, look for the "SOS" indicator under the Provider's name, and when applicable, the tool will automatically sort and show these Providers first in Your results.

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$6,000 per Member	$12,000 per Member
Family	$12,000 per family	$24,000 per family
Out-of-Pocket Maximum **Individual**	$8,000 per Member	$16,000 per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$16,000 per family	$32,000 per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	50% Coinsurance per visit
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$70 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Virtual Visits with PCP	$70 Copayment per visit after INET plan deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Virtual Visits from PCP Virtual Care-Only Provider through Our mobile app and website	$0 Copayment per visit after INET plan deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	$100 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	25% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Site of Service Provider	25% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Laboratory Services	25% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Non-Advanced Radiology (X-ray, Diagnostic)	25% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Site of Service Provider	25% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	25% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary). **PreventiveRx Note:** No Copayment, Deductible, or Coinsurance applies to Prescription Drugs on the PreventiveRx Basic List when you use an In-Network Pharmacy		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$30 Copayment per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	25% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	30% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	40% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription	50% per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary). **PreventiveRx Note:** No Copayment, Deductible, or Coinsurance applies to Prescription Drugs on the PreventiveRx Basic List when you use an In-Network Pharmacy		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$90 Copayment per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	25% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	30% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	40% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription	50% per prescription after OON plan Deductible is met
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Other Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the "Prescription Drug" section for details.	25% Coinsurance per equipment/supply after INET plan Deductible is met	50% Coinsurance per equipment/supply after OON plan Deductible is met
Durable Medical Equipment (DME)	25% Coinsurance per equipment/supply after INET plan Deductible is met	50% Coinsurance per equipment/supply after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	25% Coinsurance per visit after INET plan Deductible is met	25% Coinsurance per visit after OON plan Deductible is met
Outpatient Services **(in a Hospital or ambulatory Facility)**	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	25% Coinsurance per Admission after INET plan Deductible is met	50% Coinsurance per admission after OON plan Deductible is met
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	25% Coinsurance per Admission after INET plan Deductible is met	50% Coinsurance per admission after OON plan Deductible is met
Emergency and Urgent Care		
Ambulance Services	25% Coinsurance per service after INET plan Deductible is met	Same as In-Network
Emergency Room	25% Coinsurance per visit after INET plan Deductible is met	Same as In-Network
Urgent Care Centers	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	0% Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
Single Vision Lenses	$0 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
Bifocal	$0 Copayment	50% Coinsurance per visit after OON plan Deductible is met
Trifocal	$0 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
Collection Frame	$0 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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 after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the “Preventive Care Services” section of this Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government’s web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;

- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Urgent Care Center services received from a BlueCard® Provider will be covered at the In-Network level.

Urgent Care Center services received from a non-BlueCard® Provider will be covered at the Out-of-Network level.

All non-urgent services (BlueCard® or non-BlueCard®) will be covered at the Out-of-Network level.

The Home Health Care 100 visit limit is a combined In and Out-of-Network visit limit.

Eligible American Indians, as determined by the Exchange, enrolled in the Limited Cost Share Reduction plans, are exempt from Cost Sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no member responsibility for American Indians when Covered Services are rendered by one of these Providers.

Anthem
Individual Market
Bronze PPO Standard Pathway LCSR
Schedule of Benefits
Non-Tiered Network Plan

Your plan provides You with the option to lower Your Out-of-Pocket costs for certain services by going to Site of Service Providers. These Providers may have lower cost shares and Maximum Allowed Amounts, reducing Your Out-of-Pocket costs for certain services. When You use the "Find a Doctor" tool on anthem.com, look for the "SOS" indicator under the Provider's name, and when applicable, the tool will automatically sort and show these Providers first in Your results.

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$6,500 per Member	$13,000 per Member
Family	$13,000 per family	$26,000 per family
Out-of-Pocket Maximum **Individual**	$7,225 per Member	$14,450 per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$14,450 per family	$28,900 per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	50% Coinsurance per visit
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	20% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Site of Service Provider	20% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Laboratory Services	20% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	20% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Site of Service Provider	20% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	20% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	20% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	25% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	30% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	30% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription	50% per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	20% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	25% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	30% Coinsurance per prescription after INET plan Deductible is met	50% per prescription after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	30% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription	50% per prescription after OON plan Deductible is met
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	20% Coinsurance per equipment/supply after INET plan Deductible is met	50% Coinsurance per equipment/supply after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Durable Medical Equipment (DME)	20% Coinsurance per equipment/supply after INET plan Deductible is met	50% Coinsurance per equipment/supply after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	20% Coinsurance per visit after INET plan Deductible is met	25% Coinsurance per visit after OON plan Deductible is met
Outpatient Services **(in a Hospital or ambulatory Facility)**	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	20% Coinsurance per Admission after INET plan Deductible is met	50% Coinsurance per admission after OON plan Deductible is met
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	20% Coinsurance per Admission after INET plan Deductible is met	50% Coinsurance per admission after OON plan Deductible is met
Emergency and Urgent Care		
Ambulance Services	20% Coinsurance per service after INET plan Deductible is met	Same as In-Network
Emergency Room	20% Coinsurance per visit after INET plan Deductible is met	Same as In-Network
Urgent Care Centers	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	No Cost	50% Coinsurance per visit after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Basic Services	40% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Major Services	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	$0 Copayment after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
Single Vision Lenses	$0 Copayment after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
Bifocal	$0 Copayment after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Trifocal	$0 Copayment after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
Collection Frame	$0 Copayment after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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 plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

Connecticut State Mandate requires that the Coinsurance, Copayment, Deductible or other out-of-pocket expense for Unrelated Donor Testing cannot exceed 20% of the cost per year. See the Unrelated Donor Search under "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" provision.

Covered Dental Services pediatric dental services are covered for Members until age 26. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see “Pediatric Dental Care” in the “What is Covered” section for more information on pediatric dental services.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the “Preventive Care Services” section of this

Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;
- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Urgent Care Center services received from a BlueCard® Provider will be covered at the In-Network level.

Urgent Care Center services received from a non-BlueCard® Provider will be covered at the Out-of-Network level.

All non-urgent services (BlueCard® or non-BlueCard®) will be covered at the Out-of-Network level.

The Home Health Care 100 visit limit is a combined In and Out-of-Network visit limit.

Eligible American Indians, as determined by the Exchange, enrolled in the Limited Cost Share Reduction plans, are exempt from Cost Sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no member responsibility for American Indians when Covered Services are rendered by one of these Providers.

Anthem
Individual Market
Gold PPO Standard Pathway LCSR
Schedule of Benefits
Non-Tiered Network Plan

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$1,200 per Member	$3,000 per Member
Family	$2,400 per family	$6,000 per family
Separate Prescription Drug Deductible **Individual**	$50 per Member	$350 per Member
Family	$100 per family	$700 per family
Out-of-Pocket Maximum **Individual**	$7,375 per Member	$14,750 per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$14,750 per family	$29,500 per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	30% Coinsurance per visit
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$20 Copayment per visit	30% Coinsurance per visit after OON plan Deductible is met
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	$40 Copayment per visit	30% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	$20 Copayment per visit	30% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	$65 Copayment per service up to a combined maximum of $375 for MRI and CAT scans; $400 for PET scans	30% Coinsurance per service after OON plan Deductible is met
Laboratory Services	$10 Copayment per service	30% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	$40 Copayment per service after INET plan Deductible is met	30% Coinsurance per service after OON plan Deductible is met
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	$20 Copayment per service	30% Coinsurance per service after OON plan Deductible is met
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$5 Copayment per prescription	30% per prescription after OON prescription drug Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$35 Copayment per prescription	30% per prescription after OON prescription drug Deductible is met
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$60 Copayment per prescription	30% per prescription after OON prescription drug Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription after INET prescription drug Deductible is met up to a maximum of $100 per prescription	30% per prescription after OON prescription drug Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$15 Copayment per prescription	30% per prescription after OON prescription drug Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$105 Copayment per prescription	30% per prescription after OON prescription drug Deductible is met
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$180 Copayment per prescription	30% per prescription after OON prescription drug Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription after INET prescription drug Deductible is met up to a maximum of $100 per prescription	30% per prescription after OON prescription drug Deductible is met
Outpatient Rehabilitative and Habilitative Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$20 Copayment per visit	30% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$20 Copayment per visit	30% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	$40 Copayment per visit	30% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	30% Coinsurance per equipment/supply	30% Coinsurance per equipment/supply after OON plan Deductible is met
Durable Medical Equipment (DME)	30% Coinsurance per equipment/supply	30% Coinsurance per equipment/supply after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	No Cost	25% Coinsurance per visit after separate $50 Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Outpatient Services **(in a Hospital or ambulatory Facility)**	$500 Copayment per visit after INET plan Deductible is met at an Outpatient Hospital Facility $300 Copayment per visit after INET plan Deductible is met at an Ambulatory Surgery Center	30% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	$500 Copayment per day to a maximum of $1,000 per Admission after INET plan Deductible is met	30% Coinsurance per admission after OON plan Deductible is met
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	$500 Copayment per day to a maximum of $1,000 per Admission after INET plan Deductible is met	30% Coinsurance per admission after OON plan Deductible is met
Emergency and Urgent Care		
Ambulance Services	No Cost	Same as In-Network
Emergency Room	$400 Copayment per visit	Same as In-Network
Urgent Care Centers	$50 Copayment per visit	30% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	No Cost	50% Coinsurance per visit after OON plan Deductible is met
Basic Services	20% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met
Major Services	40% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	$0 Copayment	50% Coinsurance per visit after the OON plan Deductible is met
Single Vision Lenses	$0 Copayment	50% Coinsurance per visit after the OON plan Deductible is met
Bifocal	$0 Copayment	50% Coinsurance per visit after OON plan Deductible is met
Trifocal	$0 Copayment	50% Coinsurance per visit after the OON plan Deductible is met
Collection Frame	$0 Copayment	50% Coinsurance per visit after the OON plan Deductible is met
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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	30% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Connecticut State Mandate requires benefits of two mental health and substance abuse wellness examinations per Member per Calendar Year when performed by a licensed mental health professional or Primary Care Physician/Provider. No Cost-Share will apply to the two visits and Prior Authorization is not required.

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Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for authorized nonemergency ambulance services, except for air ambulance services, will be limited to $50,000 per trip if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

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Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care Services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits;
- http://www.ahrq.gov;
- http://www.cdc.gov/vaccines/acip/index.html.

You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic areas.
- Check with Your Doctor or Provider.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors per transplant, performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To get the In-Network benefit, You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please call the number on the back of Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Urgent Care Center services received from a BlueCard® Provider will be covered at the In-Network level.

Urgent Care Center services received from a non-BlueCard® Provider will be covered at the Out-of-Network level.

All non-urgent services (BlueCard® or non-BlueCard®) will be covered at the Out-of-Network level.

The Home Health Care 100 visit limit is a combined In and Out-of-Network visit limit.

Eligible American Indians, as determined by the Exchange, enrolled in the Limited Cost Share Reduction plans, are exempt from Cost Sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no member responsibility for American Indians when Covered Services are rendered by one of these Providers.

Anthem
Individual Market
Silver PPO Standard Pathway LCSR
Schedule of Benefits
Non-Tiered Network Plan

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$5,000 per Member	$10,000 per Member
Family	$10,000 per family	$20,000 per family
Separate Prescription Drug Deductible **Individual**	$250 per Member	$500 per Member
Family	$500 per family	$1,000 per family
Out-of-Pocket Maximum **Individual**	$9,400 per Member	$18,200 per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$18,800 per family	$36,400 per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	40% Coinsurance per visit
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$45 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	$60 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	$45 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services (Please see the “Diagnostic Services” and “Preventive Care” sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	$75 Copayment per service up to a combined maximum of $375 for MRI and CAT scans; $400 for PET scans	40% Coinsurance per service after OON plan Deductible is met
Laboratory Services	$25 Copayment per service	40% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	$40 Copayment per service after INET plan Deductible is met	40% Coinsurance per service after OON plan Deductible is met
Mammography Ultrasound/MRI (No cost for screening and diagnostic if within Federal and/or State regulations)	$20 Copayment per service	40% Coinsurance per service after OON plan Deductible is met
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$10 Copayment per prescription	40% per prescription after OON prescription drug Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$50 Copayment per prescription after INET prescription drug Deductible is met	40% per prescription after OON prescription drug Deductible is met
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$75 Copayment per prescription after INET prescription drug Deductible is met	40% per prescription after OON prescription drug Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription after INET prescription drug Deductible is met up to a maximum of $200 per prescription	40% per prescription after OON prescription drug Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$30 Copayment per prescription	40% per prescription after OON prescription drug Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$150 Copayment per prescription after INET prescription drug Deductible is met	40% per prescription after OON prescription drug Deductible is met
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$225 Copayment per prescription after INET prescription drug Deductible is met	40% per prescription after OON prescription drug Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription after INET prescription drug Deductible is met up to a maximum of $200 per prescription	40% per prescription after OON prescription drug Deductible is met
Outpatient Rehabilitative and Habilitative Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$30 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services / Manipulative Therapy (up to 20 visits per Calendar Year)	$50 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	40% Coinsurance per equipment/supply	40% Coinsurance per equipment/supply after OON plan Deductible is met
Durable Medical Equipment (DME)	40% Coinsurance per equipment/supply	40% Coinsurance per equipment/supply after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	No Cost	25% Coinsurance per visit after separate $50 Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Outpatient Services **(in a Hospital or ambulatory Facility)**	$500 Copayment per visit after INET plan Deductible is met at an Outpatient Hospital Facility $300 Copayment per visit after INET plan Deductible is met at an Ambulatory Surgery Center	40% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital services **(All Inpatient settings)**	$500 Copayment per day to a maximum of $2,000 per Admission after INET plan Deductible is met	40% Coinsurance per admission after OON plan Deductible is met
Skilled Nursing Facility (stay is limited to 90 days per Calendar Year)	$500 Copayment per day to a maximum of $2,000 per Admission after INET plan Deductible is met	40% Coinsurance per admission after OON plan Deductible is met
Emergency and Urgent Care		
Ambulance Services	No Cost	Same as In-Network
Emergency Room	$450 Copayment per visit after INET plan Deductible is met	Same as In-Network
Urgent Care Centers	$75 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	No Cost	50% Coinsurance per visit after OON plan Deductible is met
Basic Services	40% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Major Services	50% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met

Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses		
Contact Lenses	$0 Copayment per visit	50% Coinsurance per visit after the OON plan Deductible is met
Single Vision Lenses	$0 Copayment per visit	50% Coinsurance per visit after the OON plan Deductible is met
Bifocal	$0 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Trifocal	$0 Copayment per visit	50% Coinsurance per visit after the OON plan Deductible is met
Collection Frame	$0 Copayment per visit	50% Coinsurance per visit after the OON plan Deductible is met
NOTE: one pair of frames and lenses or contact lens per Calendar Year **NOTE:** 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	40% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost Shares

Chiropractic Services Cost Shares are determined by place of service and the Covered Service received. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

Connecticut State Mandate requires benefits for diagnostic and screening services to monitor for breast cancer and other gynecological cancers. Please see the “Preventive Care Services” section of this Subscriber Agreement for more information.

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the “Medical Supplies, Durable Medical Equipment and Appliances” section.

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Anthem

Anthem Health Plans – Connecticut
Actuarial Certification

I, Tu Nguyen, FSA, MAAA, am an Actuarial Strategic Planning Leader for Anthem Health Plans. I am a member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion herein. I certify that to the best of my knowledge and judgment that the enclosed rate filing is in compliance with the applicable laws, regulations and bulletins of the State of Connecticut and is in accordance with generally accepted actuarial principles. Under the American Rescue Plan Act, Advanced Premium Tax Credits (also referred to as APTCs or premium subsidies) provided by the federal government were increased, and these enhancements to the subsidies are set to expire at the end of 2025. Per the filing requirements from Connecticut Bulletin HC-81-25, "carriers must submit their filings for 2026 Rates with the assumption that the subsidies will be extended through 2026." The rates submitted in this filing are in accordance with that guidance rather than the current regulated expiration. If these enhanced subsidies do expire, then the rates included in this rate filing will need to be revised and resubmitted. Anthem has included a morbidity impact that will need to be applied to the rates in the event of enhanced subsidy expiration in this rate filing's actuarial memorandum. In the event that no decision is made on the extension of the enhanced subsidies prior to the Connecticut Insurance Department's final decision on this rate filing, Anthem assumes that the inactivity indicates that the enhanced subsidies will expire and that the morbidity impact will be included within the final rate development submitted to the Connecticut Insurance Department in August or September. Only in the event that the federal government gives final guidance that the enhanced subsidies will be extended will this rate filing hold and the rates not need to be revised to reflect the morbidity impact provided.

In my opinion, these rates are not excessive, inadequate, or unfairly discriminatory. My determination was based on information provided by other employees of Elevance Health, the holding company of Anthem Health Plans, and my own analysis.

Tu Nguyen, FSA, MAAA
Actuarial Strategic Planning Leader
May 30, 2025

Unified Rate Review v6.1

To add a product to Worksheet 2 - Plan Product Info, select the Add Product button or Ctrl + Shift + P.
To add a plan to Worksheet 2 - Plan Product Info, select the Add Plan button or Ctrl + Shift + L.
To validate, select the Validate button or Ctrl + Shift + I.
To finalize, select the Finalize button or Ctrl + Shift + F.

Company Legal Name:	**Anthem Health Plans, Inc.**		
HIOS Issuer ID:	**86545**	State:	**CT**
Effective Date of Rate Change(s):	**1/1/2026**	Market:	**Individual**

Market Level Calculations (Same for all Plans)

Section I: Experience Period Data

Experience Period: 1/1/2024 to 12/31/2024

	Total	PMPM
Allowed Claims	$637,858,829.35	$834.52
Reinsurance	$0.00	$0.00
Incurred Claims in Experience Period	$531,964,085.96	$695.98
Risk Adjustment	$13,016,025.63	$17.03
Experience Period Premium	$638,247,730.60	$835.03
Experience Period Member Months	764,341	

Section II: Projections

Benefit Category	Experience Period Index Rate PMPM	Year 1 Trend		Year 2 Trend		Trended EHB Allowed Claims PMPM
		Cost	Utilization	Cost	Utilization	
Inpatient Hospital	$142.52	1.040	1.049	1.040	1.049	$169.75
Outpatient Hospital	$343.72	1.040	1.049	1.040	1.049	$409.38
Professional	$224.71	1.040	1.049	1.040	1.049	$267.63
Other Medical	$12.59	1.040	1.049	1.040	1.049	$15.00
Capitation	$0.00	1.005	1.000	1.005	1.000	$0.00
Prescription Drug	$110.62	1.046	1.060	1.046	1.060	$135.94
Total	$834.17					**$997.70**

Morbidity Adjustment		1.000
Demographic Shift		0.994
Plan Design Changes		1.000
Other		1.000
Adjusted Trended EHB Allowed Claims PMPM for	**1/1/2026**	**$992.19**

Manual EHB Allowed Claims PMPM	$0.00
Applied Credibility %	100.00%

			Projected Period Totals
Projected Index Rate for	**1/1/2026**	**$992.19**	$1,012,033,800.00
Reinsurance		$0.00	$0.00
Risk Adjustment Payment/Charge		$17.34	$17,689,860.83
Exchange User Fees		2.15%	$21,803,736.29
Market Adjusted Index Rate		**$996.22**	**$1,016,147,675.45**

Projected Member Months	**1,020,000**

Product-Plan Data Collection

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To add a plan to Worksheet 2 - Plan Product Info, select the Add Plan button or Ctrl + Shift + L.
To validate, select the Validate button or Ctrl + Shift + I.
To finalize, select the Finalize button or Ctrl + Shift + F.
To remove a product, navigate to the corresponding Product Name/Product ID field and select the Remove Product button or Ctrl + Shift + Q.
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Company Legal Name: **Anthem Health Plans, Inc.**
HIOS Issuer ID: **86545** State: **CT**
Effective Date of Rate Change(s): **1/1/2026** Market: **Individual**

Product/Plan Level Calculations

Field #	Section I: General Product and Plan Information																				
1.1	Product Name		HMO			HMO - Off Exchange					PPO						PPO - Off Exchange		PPO w/ Pediatric Vision		MO w/ Pediatric Vision
1.2	Product ID		86545CT123			86545CT131					86545CT133						86545CT134		86545CT157		86545CT158
1.3	Plan Name		Pathway	Pathway	Pathway	Catastrophic HMO	HMO Pathway	HMO Pathway	HMO Pathway	HMO Pathway	Standard Pathway	Standard Pathway	Standard Pathway	with Adult Dental	Standard Pathway	Pathway with	PPO Pathway	Pathway	Pathway with	Gold PPO Pathway	Pathway
1.4	Plan ID (Standard Component ID)		86545CT1230005	86545CT1230025	86545CT1230027	86545CT1310033	86545CT1310019	86545CT1310055	86545CT1310056	86545CT1310060	86545CT1330009	86545CT1330002	86545CT1330001	86545CT1330020	86545CT1330003	86545CT1330023	86545CT1340020	86545CT1340021	86545CT1570001	86545CT1570002	86545CT1580001
1.5	Metal		Catastrophic	Bronze	Gold	Catastrophic	Bronze	Bronze	Silver	Gold	Bronze	Bronze	Silver	Gold	Gold	Bronze	Bronze	Silver	Bronze	Gold	Bronze
1.6	AV Metal Value		0.598	0.623	0.790	0.598	0.638	0.622	0.678	0.796	0.650	0.638	0.712	0.790	0.812	0.648	0.631	0.694	0.650	0.796	0.623
1.7	Plan Category		Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Terminated	Renewing	Renewing	New	New	New
1.8	Plan Type		HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	HMO
1.9	Exchange Plan?		Yes	Yes	Yes	No	No	No	No	No	Yes	Yes	Yes	Yes	Yes	No	No	No	Yes	Yes	Yes
1.10	Effective Date of Proposed Rates		1/1/2026	1/1/2026	1/1/2026	1/1/2026	1/1/2026	1/1/2026	1/1/2026	1/1/2026	1/1/2026	1/1/2026	1/1/2026	1/1/2026	1/1/2026	1/1/2026	1/1/2026	1/1/2026	1/1/2026	1/1/2026	1/1/2026
1.11	Cumulative Rate Change % (over 12 mos prior)		7.44%	8.47%	11.55%	7.10%	8.77%	7.27%	8.72%	13.78%	13.57%	15.01%	15.85%	12.13%	6.40%	0.00%	22.77%	20.73%	0.00%	0.00%	0.00%
1.12	Product Rate Increase %		10.04%			10.56%					15.06%						21.89%		0.00%		0.00%
1.13	Submission Level Rate Increase %		14.15%																		

Worksheet 1 Totals		Section II: Experience Period and Current Plan Level Information																		
	2.1 Plan ID (Standard Component ID)	Total	86545CT1230005	86545CT1230025	86545CT1230027	86545CT1310033	86545CT1310019	86545CT1310055	86545CT1310056	86545CT1310060	86545CT1330009	86545CT1330002	86545CT1330001	86545CT1330020	86545CT1330003	86545CT1330023	86545CT1340020	86545CT1340021	86545CT1570001	86545CT1570002	86545CT1580001
$637,858,829	2.2 Allowed Claims	$637,814,744	$726,811	$21,280,999	$57,068,267	$589,742	$9,369,238	$2,763,488	$5,810,916	$19,741,497	$29,717,252	$16,598,579	$318,737,333	$103,600,167	$14,454,727	$5,675,707	$0	$0	$6,831,594	$24,848,427	$0
$0	2.3 Reinsurance	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	2.4 Member Cost Sharing	$95,414,587	$398,754	$7,250,672	$11,091,213	$339,167	$2,585,561	$1,037,719	$1,416,505	$3,246,987	$7,314,002	$3,428,821	$27,606,919	$19,796,020	$953,920	$2,001,369	$0	$0	$2,302,924	$4,644,034	$0
	2.5 Cost Sharing Reduction	$10,465,992	$0	$0	$20	$0	$0	$0	$1,115	$0	$0	$0	$10,464,369	-$58	$546	$0	$0	$0	$0	$0	$0
$531,964,086	2.6 Incurred Claims	$531,934,165	$328,057	$14,030,327	$45,977,034	$250,574	$6,783,677	$1,725,769	$4,393,296	$16,494,510	$22,403,250	$13,169,758	$280,666,046	$83,804,205	$13,500,260	$3,674,339	$0	$0	$4,528,670	$20,204,394	$0
$13,016,026	2.7 Risk Adjustment Transfer Amount	$13,016,026	$8,027	$343,311	$1,125,023	$6,131	$165,991	$42,228	$107,501	$403,608	$548,191	$322,254	$6,867,685	$2,050,625	$330,341	$89,908	$0	$0	$110,813	$494,386	$0
$638,247,731	2.8 Premium	$638,135,218	$955,180	$39,109,064	$66,186,320	$720,391	$11,993,941	$4,792,530	$6,893,852	$14,853,919	$31,519,375	$18,308,992	$294,361,261	$98,882,962	$7,545,396	$9,256,660	$0	$0	$11,349,752	$21,405,621	$0
764,341	2.9 Experience Period Member Months	764,341	3,823	53,494	79,802	2,849	14,319	6,901	7,443	17,433	37,825	21,100	346,917	116,267	4,875	11,957	0	0	14,140	25,196	0
	2.10 Current Enrollment	83,790	320	6,044	5,133	251	1,012	638	604	1,518	2,796	2,122	47,059	8,098	377	0	232	177	5,190	2,219	0
	2.11 Current Premium PMPM	$886.69	$267.31	$754.38	$957.85	$269.31	$909.96	$744.28	$973.08	$923.11	$873.81	$870.32	$867.22	$980.42	$1,639.85	$0.00	$933.90	$925.89	$896.45	$1,167.42	$0.00
	2.12 Loss Ratio	81.69%	34.06%	35.56%	68.31%	34.49%	55.79%	35.70%	62.75%	108.11%	69.86%	70.69%	93.17%	83.03%	171.42%	39.31%	#DIV/0!	#DIV/0!	39.52%	92.26%	#DIV/0!
	Per Member Per Month																				
	2.13 Allowed Claims	$834.46	$190.12	$397.82	$715.12	$207.00	$654.32	$400.45	$780.72	$1,132.42	$785.65	$786.66	$918.77	$891.05	$2,965.07	$474.68	#DIV/0!	#DIV/0!	$483.14	$986.21	#DIV/0!
	2.14 Reinsurance	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
	2.15 Member Cost Sharing	$124.83	$104.30	$135.54	$138.98	$119.05	$180.57	$150.37	$190.31	$186.26	$193.36	$162.50	$79.58	$170.26	$195.68	$167.38	#DIV/0!	#DIV/0!	$162.87	$184.32	#DIV/0!
	2.16 Cost Sharing Reduction	$13.69	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.15	$0.00	$0.00	$0.00	$30.16	$0.00	$0.11	$0.00	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
	2.17 Incurred Claims	$695.94	$85.81	$262.28	$576.14	$87.95	$473.75	$250.08	$590.26	$946.17	$592.29	$624.16	$809.03	$720.79	$2,769.28	$307.30	#DIV/0!	#DIV/0!	$320.27	$801.89	#DIV/0!
	2.18 Risk Adjustment Transfer Amount	$17.03	$2.10	$6.42	$14.10	$2.15	$11.59	$6.12	$14.44	$23.15	$14.49	$15.27	$19.80	$17.64	$67.76	$7.52	#DIV/0!	#DIV/0!	$7.84	$19.62	#DIV/0!
	2.19 Premium	$834.88	$249.85	$731.09	$829.38	$252.86	$837.62	$694.47	$926.22	$852.06	$833.29	$867.72	$848.51	$850.48	$1,547.77	$774.16	#DIV/0!	#DIV/0!	$802.67	$849.56	#DIV/0!

	Section III: Plan Adjustment Factors																				
3.1	Plan ID (Standard Component ID)		86545CT1230005	86545CT1230025	86545CT1230027	86545CT1310033	86545CT1310019	86545CT1310055	86545CT1310056	86545CT1310060	86545CT1330009	86545CT1330002	86545CT1330001	86545CT1330020	86545CT1330003	86545CT1330023	86545CT1340020	86545CT1340021	86545CT1570001	86545CT1570002	86545CT1580001
3.2	Market Adjusted Index Rate		$996.22																		
3.3	AV and Cost Sharing Design of Plan		0.5423	0.7167	0.9210	0.5423	0.7740	0.7274	0.8820	0.9739	0.7695	0.8211	0.8750	0.9532	1.6086	0.0000	0.9178	1.0328	0.7588	0.9829	0.7162
3.4	Provider Network Adjustment		1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	0.0000	1.0000	1.0000	1.0000	1.0000	1.0000
3.5	Benefits in Addition to EHB		1.0000	1.0059	1.0047	1.0000	1.0000	1.0000	1.0000	1.0000	1.0003	1.0003	1.0002	1.0085	1.0001	0.0000	1.0000	1.0000	1.0000	1.0000	1.0000
	Administrative Costs																				
3.6	Administrative Expense		6.78%	6.26%	5.98%	6.78%	5.94%	6.00%	5.83%	5.75%	5.98%	5.92%	5.88%	5.95%	5.47%	0.00%	5.79%	5.71%	5.94%	5.73%	5.99%
3.7	Taxes and Fees		3.74%	3.76%	3.75%	3.74%	3.74%	3.74%	3.74%	3.74%	3.76%	3.76%	3.76%	3.77%	3.75%	0.00%	3.74%	3.74%	3.74%	3.74%	3.74%
3.8	Profit & Risk Load		3.96%	3.98%	3.97%	3.96%	3.95%	3.95%	3.95%	3.95%	3.98%	3.97%	3.97%	3.98%	3.96%	0.00%	3.95%	3.95%	3.95%	3.95%	3.95%
3.9	Catastrophic Adjustment		0.7634	1.0000	1.0000	0.7634	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	0.0000	1.0000	1.0000	1.0000	1.0000	1.0000
3.10	**Plan Adjusted Index Rate**		$482.26	$835.12	$1,068.17	$482.26	$892.76	$839.59	$1,016.04	$1,120.87	$888.76	$947.59	$1,009.23	$1,109.70	$1,845.99	$0.00	$1,056.79	$1,188.11	$875.23	$1,130.96	$826.57
3.11	Age Calibration Factor	0.5839	0.5839																		
3.12	Geographic Calibration Factor	1.0053	1.0053																		
3.13	Tobacco Calibration Factor	1.0000	1.0000																		
3.14	**Calibrated Plan Adjusted Index Rate**		$283.11	$490.26	$627.07	$283.11	$524.10	$492.89	$596.47	$658.01	$521.75	$556.29	$592.47	$651.45	$1,083.69	$0.00	$620.39	$697.48	$513.81	$663.94	$485.24

	Section IV: Projected Plan Level Information																				
4.1	Plan ID (Standard Component ID)	Total	86545CT1230005	86545CT1230025	86545CT1230027	86545CT1310033	86545CT1310019	86545CT1310055	86545CT1310056	86545CT1310060	86545CT1330009	86545CT1330002	86545CT1330001	86545CT1330020	86545CT1330003	86545CT1330023	86545CT1340020	86545CT1340021	86545CT1570001	86545CT1570002	86545CT1580001
4.2	Allowed Claims	$1,014,445,560	$2,349,478	$87,318,121	$52,422,378	$1,840,304	$12,794,414	$7,767,300	$8,209,901	$21,287,845	$36,082,598	$29,560,579	$529,329,924	$87,684,935	$7,950,587	$0	$3,785,166	$3,165,832	$83,082,306	$24,361,743	$15,452,151
4.3	Reinsurance	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
4.4	Member Cost Sharing	$147,021,525	$757,535	$23,913,303	$8,279,623	$593,364	$3,533,238	$2,320,471	$1,962,241	$3,525,209	$9,478,400	$7,644,162	$37,855,728	$13,848,807	$725,258	$0	$1,064,104	$780,196	$22,592,345	$3,915,747	$4,231,796
4.5	Cost Sharing Reduction	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
4.6	Incurred Claims	$867,424,034	$1,591,943	$63,404,819	$44,142,755	$1,246,940	$9,261,177	$5,446,829	$6,247,660	$17,762,636	$26,604,198	$21,916,416	$491,474,195	$73,836,127	$7,225,329	$0	$2,721,063	$2,385,636	$60,489,961	$20,445,996	$11,220,355
4.7	Risk Adjustment Transfer Amount	$15,126,600	$27,764	$1,105,812	$769,872	$21,747	$161,520	$94,995	$108,962	$309,789	$463,926	$382,180	$8,570,368	$1,287,561	$125,996	$0	$47,450	$41,601	$1,054,829	$356,539	$195,689
4.8	Premium	$1,007,800,800	$1,868,845	$73,945,127	$51,321,287	$1,463,833	$10,765,993	$6,336,286	$7,253,180	$20,602,772	$30,928,772	$25,461,559	$570,711,905	$85,789,149	$8,352,022	$0	$3,157,822	$2,765,734	$70,316,361	$23,708,711	$13,051,443
4.9	Projected Member Months	1,020,000	3,876	88,560	48,048	3,036	12,060	7,548	7,140	18,384	34,800	26,868	565,440	77,304	4,524	0	2,988	2,328	80,340	20,964	15,792
4.10	Loss Ratio	84.80%	83.94%	84.48%	84.74%	83.94%	84.75%	84.69%	84.86%	84.94%	84.75%	84.80%	84.84%	84.79%	85.22%	#DIV/0!	84.89%	84.98%	84.75%	84.96%	84.70%
	Per Member Per Month																				
4.11	Allowed Claims	$994.55	$606.16	$985.98	$1,091.04	$606.16	$1,060.90	$1,029.05	$1,149.85	$1,157.96	$1,036.86	$1,100.22	$936.14	$1,134.29	$1,757.42	#DIV/0!	$1,266.79	$1,359.89	$1,034.13	$1,162.08	$978.48
4.12	Reinsurance	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	#DIV/0!	$0.00	$0.00	$0.00	$0.00	$0.00
4.13	Member Cost Sharing	$144.14	$195.44	$270.02	$172.32	$195.44	$292.97	$307.43	$274.82	$191.75	$272.37	$284.51	$66.95	$179.15	$160.31	#DIV/0!	$356.13	$335.14	$281.21	$186.78	$267.97
4.14	Cost Sharing Reduction	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	#DIV/0!	$0.00	$0.00	$0.00	$0.00	$0.00
4.15	Incurred Claims	$850.42	$410.72	$715.95	$918.72	$410.72	$767.93	$721.63	$875.02	$966.20	$764.49	$815.71	$869.19	$955.14	$1,597.11	#DIV/0!	$910.66	$1,024.76	$752.92	$975.29	$710.51
4.16	Risk Adjustment Transfer Amount	$14.83	$7.16	$12.49	$16.02	$7.16	$13.39	$12.59	$15.26	$16.85	$13.33	$14.22	$15.16	$16.66	$27.85	#DIV/0!	$15.88	$17.87	$13.13	$17.01	$12.39
4.17	Premium	$988.04	$482.16	$834.97	$1,068.13	$482.16	$892.70	$839.47	$1,015.85	$1,120.69	$888.76	$947.65	$1,009.32	$1,109.76	$1,846.16	#DIV/0!	$1,056.83	$1,188.03	$875.23	$1,130.92	$826.46

Rating Area Data Collection

Specify the total number of Rating Areas in your State by selecting the Create Rating Areas button or Ctrl + Shift + R.
Select only the Rating Areas you are offering plans within and add a factor for each area.
To validate, select the Validate button or Ctrl + Shift + I.
To finalize, select the Finalize button or Ctrl + Shift + F.

Rating Area	Rating Factor
Rating Area 1	1.1000
Rating Area 2	0.9400
Rating Area 3	0.9700
Rating Area 4	1.0000
Rating Area 5	1.0000
Rating Area 6	0.9400
Rating Area 7	0.9000
Rating Area 8	0.9000