

DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

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LIFE, ACCIDENT AND HEALTH

Amended Regulation 4-2-81

CONCERNING COLORADO OPTION STANDARDIZED HEALTH BENEFIT PLANS

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Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-108(7), 10-1-109(1), 10-16-109, and 10-16-1312, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish rules for the required bronze, silver, and gold Standardized plans to be offered by all carriers offering individual and small group health benefits plans issued or renewed on or after January 1, 2026.

Section 3 Applicability

This regulation applies to all carriers offering individual and small group health benefit plans subject to the individual and small group laws of Colorado and the requirements of federal law.

Section 4 Definitions

- A. "Actuarial value" or "AV" means, for the purposes of this regulation, the percentage of total average costs for covered benefits that a plan will cover, with calculations based on the provision of essential health benefits to a standard population.
- B. "Behavioral, mental health, and substance use disorder" shall have the same meaning as found at § 10-16-104(5.5)(d), C.R.S.

- C. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.
- D. "Colorado Option Standardized Plan" or "Standardized plan" shall have the same meaning as found at § 10-16-1303(14), C.R.S.
- E. "Colorado Plans and Benefits Template" or "Colorado PBT" means, for the purposes of this regulation, the Colorado-specific modified version of the Federal PBT for submission of plans offered through the Public Benefit Corporation.
- F. "Colorado Supplement to the Summary of Benefits and Coverage Form" or "COSSBC" shall have the same meaning as found at Colorado Insurance Regulation 4-2-20.
- G. "Consumer Facing Materials" means, for the purposes of this regulation, plan-specific policy forms including the Summary of Benefits and Coverage Form, Colorado Supplement to the Summary of Benefits and Coverage Form, Evidence of Coverage, Certificate of Coverage, and plan-specific marketing materials including brochures, direct mail, website landing page, broker website portal landing page, welcome kit, newsletters, advertisements, and shopping portals on-exchange and off-exchange through the Public Benefit Corporation.
- H. "Covered person" shall have the same meaning as found at § 10-16-102(15), C.R.S.
- I. "Embedded deductible" means, for the purposes of this regulation, a cost-sharing provision within family policies where a covered person may satisfy their own individual deductible before the overall family deductible is satisfied.
- J. "Embedded out-of-pocket maximum" means, for the purposes of this regulation, a cost-sharing provision within family policies where a covered person may satisfy their own individual out-of-pocket maximum before the overall family out-of-pocket maximum is satisfied.
- K. "Essential health benefits" or "EHB" shall have the same meaning as found at § 10-16-102(22), C.R.S.
- L. "Exchange" shall have the same meaning as found at § 10-16-102(26), C.R.S.
- M. "Federal law" shall have the same meaning as found at § 10-16-102(29), C.R.S.
- N. "Federal Plans and Benefits Template" or "Federal PBT" means, for the purposes of this regulation, the Plans & Benefits Template created by the Centers for Medicare & Medicaid Services.
- O. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.
- P. "Network" shall have the same meaning as found at § 10-16-102(45), C.R.S.
- Q. "Preventive drug" shall have the same meaning as found at Colorado Insurance Regulation 4-2-58.
- R. "Provider" shall have the same meaning as found at § 10-16-102(56), C.R.S.
- S. "Public Benefit Corporation" shall have the same meaning as found at § 10-16-1303(12), C.R.S.

- T. “Silver Enhanced Plan” means, for the purposes of this regulation, the standardized silver plan offered by Connect for Health Colorado on the Colorado Public Benefit Corporation with an increase in the plan’s actuarial value to 73% and a \$0 premium containing the same plan design and cost sharing as the Colorado Option On-Exchange Silver (73% AV) Standardized Plan.
- U. “Summary of Benefits and Coverage Form” or “SBC” means, for the purposes of this regulation, the Summary of Benefits and Coverage Form created by the Centers for Medicare & Medicaid Services.

Section 5 Standardized Health Benefit Plan

- A. Carriers shall offer a Standardized plan at the bronze, silver, and gold metal level tiers, as required under § 10-16-1304, C.R.S., and shall:
 - 1. Offer the individual market Standardized plans on-Exchange and off-Exchange through the Public Benefit Corporation.
 - 2. Use the following naming conventions in the Federal PBT and Colorado PBT as well as on consumer facing materials.
 - a. For all metal tier plans: “[Name of Carrier] Colorado Option [Metal Tier].” The name of the carrier may be shortened to an easily identifiable acronym that is commonly used by the carrier in consumer facing publications.
 - b. For silver cost-sharing reduction variant plans: “[Name of Carrier] Colorado Option Silver [% AV value].” The name of the carrier may be shortened to an easily identifiable acronym that is commonly used by the carrier in consumer facing publications.
 - 3. Use the following naming conventions on identification cards:
 - a. For all metal tier plans: “CO Option [Metal Tier].”
 - b. For silver cost-sharing reduction variant plans: “CO Option Silver [% AV value].”
 - 4. Use a Division approved, co-branded logo in individual and small group Standardized plan consumer facing materials. A co-branded logo will use both the Colorado Option logo and the carrier’s logo, to form a dual logo that is a single image.
 - 5. Include a service area or network identifier in the plan name if the plan is not offered on a statewide basis with a statewide network.
- B. Coverage must be provided in a manner consistent with the requirements of:
 - 1. Federal law.
 - 2. Article 16 of Title 10 of the Colorado Revised Statutes, as applicable to individual and small group health benefit plans, including but not limited to:
 - a. §§ 10-16-1304, 10-16-1305, 10-16-1306, C.R.S.

- b. §§ 10-16-104(5.5) and 10-16-147, C.R.S. and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) as defined at § 10-16-102(43.5), C.R.S.
 - (1) Carriers shall submit the CO Financial Requirement and Quantitative Treatment Limitation Classification Template and the Financial Requirements Attestation Template for Standardized Plans, required by Colorado Insurance Regulation 4-2-64, no later than March 1 of each year.
 - (2) If it is determined that a carrier's Standardized plan does not comply with MHPAEA financial requirements and quantitative treatment limitations, the Division will make the minimum adjustments necessary to the cost sharing structure in the Standardized plan to meet these requirements.
- 3. United States Preventive Services Task Force A and B recommendations, Advisory Committee on Immunization Practices age-appropriate immunization and vaccine schedules, and the Women's Preventive Services Guidelines published by the Health Resources and Services Administration (HRSA).
- C. As part of the annual filings process, Standardized plans must be consistent with Colorado Insurance Regulations and guidance regarding rate and form filings, including but not limited to Colorado Insurance Regulations 4-2-39, 4-2-41, 4-2-58 and 4-2-64.
- D. Individual market carriers must file all Standardized plans, except bronze plans, on Benefits Package 1 and bronze plans on Benefits Package 2 of the federal Plans and Benefits Template. Individual market carriers must file the Standardized bronze, off-Exchange silver, silver enhanced, and gold plans on the Colorado Plans and Benefits Template. Small group market carriers must file all Standardized plans, except bronze plans, on Benefits Package 1 and bronze plans on Benefits Package 2 of the federal Plans and Benefits Template.
- E. Coverage must provide essential health benefits as defined in Colorado Insurance Regulation 4-2-42. Carriers are not permitted to add benefits outside of those outlined in Colorado Insurance Regulation 4-2-42 except that carriers may include reproductive health services in addition to the benefits in Colorado Insurance Regulation 4-2-42, subject to approval by the Division of Insurance. Carriers must follow the defined cost-sharing requirements for the benefits listed in Appendix A. Carriers may vary cost-sharing amounts for essential health benefits not listed in Appendix A.
- F. The bronze, silver, and gold Standardized plans must include the following coverage:
 - 1. Mental health, behavioral health and substance use disorder visits and primary care visits in accordance with the cost-sharing requirements contained in Appendix A.
 - 2. Prenatal and postnatal visits in accordance with the cost-sharing requirements contained in Appendix A.
 - a. Carriers utilizing a global billing structure for pregnancy-related care shall account for the cost sharing outlined in the Standardized plan in the global billing fee structure.

- b. Home visits shall be considered a covered postnatal care visit, subject to the cost-sharing for “prenatal and postnatal visits” contained in Appendix A.
 - c. Prenatal and postnatal visits shall be combined in instances where a number of visits is specified in Appendix A.
- 3. Diabetes supplies, including but not limited to Continuous Glucose Monitors and all associated components with automated insulin delivery systems, must be provided with no cost sharing.
 - a. Carriers must maintain an easy-to-understand, transparent, and searchable page on the carrier’s website titled “Covered Diabetic Supplies for Colorado Option Plan” that includes the following information, updated for each plan year:
 - (1) A clear statement that Colorado Option plans provide coverage of diabetic supplies at \$0 cost-sharing and not subject to a deductible, copayments, or coinsurance.
 - (2) A complete list of all diabetic supplies, organized by category of items or supplies, that are covered at \$0 cost-sharing and not subject to a deductible, copayment, or coinsurance under the Colorado Option Standardized Health Benefit Plan.
 - (a) At a minimum, the list must include the following categories: “Continuous Glucose Monitors and Components”, “Insulin Pumps”, “Blood Glucose Monitors and Test Strips”, “Syringes and Needles,” and “Other Covered Diabetic Supplies”.
 - (b) For the categories “Continuous Glucose Monitors and Components,” “Insulin Pumps,” and “Blood Glucose Monitors and Test Strips,” the carrier must list the names of all items or supplies that are covered. For the categories “Syringes and Needles” and “Other Covered Diabetic Supplies,” the carrier may list general types of supplies (e.g., alcohol swabs, test strips) on the website but must have the name of the covered products listed in the carrier’s formulary.
 - (3) At all times, the list shall include all of the diabetic supplies that are covered for the current plan year. If a carrier has a change in the covered items and supplies, the carrier shall update the public-facing list within 10 business days of the change becoming effective. If a carrier has a change in the covered items and supplies, the carrier shall update the public-facing list within 10 business days of the change becoming effective.
 - (4) During the annual Open Enrollment Period, the website shall also display the diabetic supplies covered for the upcoming plan year.

- b. If the carrier offers multiple Colorado Option plans that cover different diabetic supplies, a different list should be included for each plan, and clearly marked with the marketing name(s) of the Colorado Option plan(s) that cover the specific supplies listed.
- c. Next to each item or supply, the carrier must clearly indicate whether it is covered under the medical benefit, including durable medical equipment (DME), or prescription drug benefit.
 - (1) If an item or supply is covered as DME, the carrier must include clear instructions for how a consumer may obtain the diabetic supply through the covered DME supplier, including where to find the contact information for the carrier's covered DME supplier.
 - (2) If an item or supply is covered under the prescription drug benefit, the carrier must include clear instructions on how a consumer can access the carrier's most recent prescription drug formulary and the carrier's provider directory.

4. Carrier formularies:

- a. Formularies shall have five drug tiers that allow copay only cost sharing:
 - (1) Tier 1: The prescription drug tier which consists of drugs used for preventive purposes.
 - (2) Tier 2: The prescription drug tier which consists of the lowest cost tier of prescription drugs, most are generic.
 - (3) Tier 3: The prescription drug tier which consists of medium-cost prescription drugs, most are generic, and some brand-name prescription drugs.
 - (4) Tier 4: The prescription drug tier which consists of the higher-cost prescription drugs, most are brand-name prescription drugs, and some specialty drugs.
 - (5) Tier 5: The prescription drug tier which consists of the highest-cost prescription drugs, most are specialty drugs.
- b. Carriers may assign prescription drugs to one of the five tiers based on drug usage, cost and clinical effectiveness so long as such classification remains in compliance with applicable Federal and Colorado state law requirements.
- c. The cost-share amounts in Appendix A are for a 30-day supply of a prescription drug. A carrier may apply up to three times the cost-share amount for a 90-day supply.

4. Consistent with existing coverage requirements, carriers must provide the following:

- a. Carriers must include the “Colorado QuitLine” as part of covered tobacco cessation programs;
 - b. When outpatient education for prediabetes is recommended by a provider, carriers must include a program recognized by the National Centers for Disease Control and Prevention (CDC) Diabetes Prevention Program as part of diabetes prevention coverage.
- G. The Colorado Option bronze, silver, and gold Standardized plans may not have a tiered network with different copays for different network tiers.
- H. Covered persons in the Standardized plans must receive care at the cost-sharing levels required for the different services in the Standardized plans for any “In-Network” provider. In-network services include services provided by an out-of-network provider, but are approved as in-network by the carrier.
- I. The Standardized bronze, silver, and gold plans do not specify cost-sharing amounts for any out-of-network services except for those services required under state or federal law to have in-network cost-share amounts.
- J. Any copay, coinsurance, and deductible payments for in-network covered services shall apply to the out-of-pocket maximum.
- K. Carriers shall use an embedded deductible.
- L. Carriers shall use an embedded out-of-pocket maximum.
- M. Carriers are not required to submit reasonable modification requests for benefits and/or cost-sharing modifications found in Appendix A of this regulation. Carriers are required to submit any other benefits and/or cost-sharing reasonable modification requests to the Standardized plans, pursuant to Colorado Insurance Regulation 4-2-27.

Section 6 Incorporation by Reference

The age-appropriate immunization and vaccine schedules as recommended by the Advisory Committee on Immunization Practices, as published by the Advisory Committee on Immunization Practices shall mean age-appropriate immunization and vaccine schedules as published on the effective date of this regulation and do not include later amendments to, or editions of, the age-appropriate immunization and vaccine schedules. The age-appropriate immunization and vaccine schedules as recommended by the Advisory Committee on Immunization Practices may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202 or by visiting the Advisory Committee on Immunization Practices website at <http://www.cdc.gov/vaccines/schedules/hcp/index.html>. Certified copies of the age-appropriate immunization and vaccine schedules as recommended by the Advisory Committee on Immunization Practices are available from the Colorado Division of Insurance for a fee.

The United States Preventive Services Task Force A and B Recommendations, published by the United States Preventive Services Task Force, shall mean the United States Preventive Services Task Force A and B Recommendations, as published on the effective date of this regulation and does not include later

amendments to, or editions of, the United States Preventive Services Task Force A and B Recommendations. The United States Preventive Services Task Force A and B Recommendations may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202 or by visiting the United States Preventive Services Task Force website at <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations>. Certified copies of the United States Preventive Services Task Force A and B Recommendations are available from the Colorado Division of Insurance for a fee.

The Women's Preventive Services Guidelines, published by the Health Resources and Services Administration, shall mean the Women's Preventive Services Guidelines published by the Health Resources and Services Administration, as published on the effective date of this regulation and does not include later amendments to, or editions of the Women's Preventive Services Guidelines published by the Health Resources and Services Administration. The Women's Preventive Services Guidelines published by the Health Resources and Services Administration may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202 or by visiting the Health Resources and Services Administration website at <https://www.hrsa.gov/womens-guidelines>. Certified copies of the Women's Preventive Services Guidelines, published by the Health Resources and Services Administration, are available from the Colorado Division of Insurance for a fee.

Section 7 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 8 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 9 Effective Date

This regulation shall become effective on January 1, 2026.

Section 10 History

This regulation shall become effective June 30, 2022.

Amended regulation effective June 14, 2025.

Amended regulation effective January 1, 2026.

Appendix A: 2026 Gold, Silver, and Bronze Standardized Plans

This Appendix outlines the plan designs for the gold, silver, and bronze metal tier standardized plans.

- The column **“Member Cost Share (In Network)”** refers to the cost share amount paid by the covered person after their deductible is met.
- The **“x” in the “Deductible Applies”** column indicates that a covered person is expected to meet their deductible prior to paying the cost share amount listed in the “Member Cost Share (In Network)” column.
- If there is **no “x” in the “Deductible Applies”** column, this indicates that the cost-share is pre-deductible or first dollar coverage.

Standardized Silver Cost Sharing Reduction Plans at 73% AV and 87% AV are only required to be offered in the individual, On-Exchange market. Standardized Silver Cost Sharing Reduction Plans at the 94% AV level are required to be offered in the individual, On-Exchange market, and the individual, Off-Exchange market through the Public Benefit Corporation.

Gold Standardized Plan

Actuarial Value			78.0%
Individual Deductible (Combined Medical & Drug)			\$2,050
Individual Out-of-Pocket Maximum			\$9,600
Family Deductible			\$4,100
Family Out-of-Pocket Maximum			\$19,200
Common Medical Event	Service Type	Member Cost Share (In Network)	Deductible Applies
Health Care Provider's Office or Clinic Visit	Preventive care/screening/immunization	\$0	
	Primary care visit or non-specialist practitioner visit to treat an injury or illness	\$0, unlimited	
	Specialist visit	\$55	
Pregnancy	Prenatal and postnatal visits	\$0, unlimited	

Mental/ Behavioral Health and Substance Use Needs	Mental/Behavioral Health and Substance Use Disorder Office Visit	\$0, unlimited	
	Mental/Behavioral Health and Substance Use Disorder Outpatient services	30%	X
	Mental/Behavioral Health and Substance Use Disorder Inpatient services	30%	X
Tests	Laboratory tests	30%	X
	X-rays and diagnostic imaging	30%	X
	Advanced Imaging/Radiology (CT/PET scans, MRI)	30%	X
Drugs to treat Illness or Condition	Tier 1	\$0	
	Tier 2	\$10	
	Tier 3	\$50	
	Tier 4	\$200	
	Tier 5	\$600	
Outpatient Surgery	Facility Fee (e.g. Ambulatory Surgery Center)	30%	X
	Physician/Surgical Services	30%	X
Need Immediate Attention	Urgent care centers or facilities	\$50	
	Emergency room services	30%	X
	Emergency medical transportation (ambulance)	30%	X
Hospital Stay	Inpatient Hospital services	30%	X

	Inpatient Physician and Surgical Services	30%	X
	Inpatient Rehabilitation Services	30%	X
	Inpatient Habilitation Services	30%	X
Help recovering or other health needs	Speech Therapy	30%	X
	Physical Therapy	30%	X
	Occupational Therapy	30%	X
	Durable medical equipment ¹	30%	X
	Diabetes Self-Management Education ²	\$5	

¹ Diabetes supplies, including Continuous Glucose Monitors, are provided with no-cost sharing

² At a minimum 10 hours of individual or group sessions in the first year of diagnosis, and 6 hours of individual or group sessions every year after diagnosis

Silver Standardized Plan

(On-Exchange Individual Market & On and Off-Exchange Small Group Market)

Actuarial Value			70.0%
Individual Deductible (Combined Medical & Drug)			\$4,400
Individual Out-of-Pocket Maximum			\$9,800
Family Deductible			\$8,800
Family Out-of-Pocket Maximum			\$19,600
Common Medical Event	Service Type	Member Cost Share (In Network)	Deductible Applies
Health Care Provider's Office or Clinic Visit	Preventive care/screening/immunization	\$0	
	Primary care visit or non-specialist practitioner visit to treat an injury or illness	\$0, unlimited	
	Specialist visit	\$90	
Pregnancy	Prenatal and postnatal visits	\$0, unlimited	
Mental/ Behavioral Health and Substance Use Needs	Mental/Behavioral Health and Substance Use Disorder Office Visit	\$0, unlimited	
	Mental/Behavioral Health and Substance Use Disorder Outpatient services	40%	X
	Mental/Behavioral Health and Substance Use Disorder Inpatient services	40%	X
Tests	Laboratory tests	40%	X
	X-rays and diagnostic imaging	40%	X

	Advanced Imaging/Radiology (CT/PET scans, MRI)	40%	X
Drugs to treat Illness or Condition	Tier 1	\$0	
	Tier 2	\$20	
	Tier 3	\$125	
	Tier 4	\$300	
	Tier 5	\$650	
Outpatient Surgery	Facility Fee (e.g. Ambulatory Surgery Center)	40%	X
	Physician/Surgical Services	40%	X
Need Immediate Attention	Urgent care centers or facilities	\$80	
	Emergency room services	40%	X
	Emergency medical transportation (ambulance)	40%	X
Hospital Stay	Inpatient Hospital services	40%	X
	Inpatient Physician and Surgical Services	40%	X
	Inpatient Rehabilitation Services	40%	X
	Inpatient Habilitation Services	40%	X
Help recovering or other health needs	Speech Therapy	40%	X
	Physical Therapy	40%	X
	Occupational Therapy	40%	X
	Durable medical equipment ¹	40%	X

	Diabetes Self-Management Education ²	\$5	
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¹ Diabetes supplies, including Continuous Glucose Monitors, are provided with no-cost sharing

² At a minimum 10 hours of individual or group sessions in the first year of diagnosis, and 6 hours of individual or group sessions every year after diagnosis

Silver (73% AV) Standardized Plan

(On-Exchange Individual Market and Off-Exchange Individual Market through the Public Benefit Corporation)

Actuarial Value			73.0%
Individual Deductible (Combined Medical & Drug)			\$2,850
Individual Out-of-Pocket Maximum			\$8,000
Family Deductible			\$5,700
Family Out-of-Pocket Maximum			\$16,000
Common Medical Event	Service Type	Member Cost Share (In Network)	Deductible Applies
Health Care Provider's Office or Clinic Visit	Preventive care/screening/immunization	\$0	
	Primary care visit or non-specialist practitioner visit to treat an injury or illness	\$0, unlimited	
	Specialist visit	\$90	
Pregnancy	Prenatal and postnatal visits	\$0, unlimited	
Mental/ Behavioral Health and Substance Use Needs	Mental/Behavioral Health and Substance Use Disorder Office Visit	\$0, unlimited	
	Mental/Behavioral Health and Substance Use Disorder Outpatient services	40%	X
	Mental/Behavioral Health and Substance Use Disorder Inpatient services	40%	X
Tests	Laboratory tests	40%	X
	X-rays and diagnostic imaging	40%	X

	Advanced Imaging/Radiology (CT/PET scans, MRI)	40%	X
Drugs to treat Illness or Condition	Tier 1	\$0	
	Tier 2	\$20	
	Tier 3	\$125	
	Tier 4	\$300	
	Tier 5	\$600	
Outpatient Surgery	Facility Fee (e.g. Ambulatory Surgery Center)	40%	X
	Physician/Surgical Services	40%	X
Need Immediate Attention	Urgent care centers or facilities	\$80	
	Emergency room services	40%	X
	Emergency medical transportation (ambulance)	40%	X
Hospital Stay	Inpatient Hospital services	40%	X
	Inpatient Physician and Surgical Services	40%	X
	Inpatient Rehabilitation Services	40%	X
	Inpatient Habilitation Services	40%	X
Help recovering or other health needs	Speech Therapy	40%	X
	Physical Therapy	40%	X
	Occupational Therapy	40%	X
	Durable medical equipment ¹	40%	X

	Diabetes Self-Management Education ²	\$5	
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¹ Diabetes supplies, including Continuous Glucose Monitors, are provided with no-cost sharing

² At a minimum 10 hours of individual or group sessions in the first year of diagnosis, and 6 hours of individual or group sessions every year after diagnosis

Silver (87% AV) Standardized Plan
(On-Exchange Individual Market)

Actuarial Value			87.0%
Individual Deductible (Combined Medical & Drug)			\$950
Individual Out-of-Pocket Maximum			\$3,350
Family Deductible			\$1,900
Family Out-of-Pocket Maximum			\$6,700
Common Medical Event	Service Type	Member Cost Share (In Network)	Deductible Applies
Health Care Provider's Office or Clinic Visit	Preventive care/screening/immunization	\$0	
	Primary care visit or non-specialist practitioner visit to treat an injury or illness	\$0, unlimited	
	Specialist visit	\$65	
Pregnancy	Prenatal and postnatal visits	\$0, unlimited	
Mental/ Behavioral Health and Substance Use Needs	Mental/Behavioral Health and Substance Use Disorder Office Visit	\$0, unlimited	
	Mental/Behavioral Health and Substance Use Disorder Outpatient services	30%	X
	Mental/Behavioral Health and Substance Use Disorder Inpatient services	30%	X
Tests	Laboratory tests	30%	X
	X-rays and diagnostic imaging	30%	X

	Advanced Imaging/Radiology (CT/PET scans, MRI)	30%	X
Drugs to treat Illness or Condition	Tier 1	\$0	
	Tier 2	\$0	
	Tier 3	\$60	
	Tier 4	\$120	
	Tier 5	\$180	
Outpatient Surgery	Facility Fee (e.g. Ambulatory Surgery Center)	30%	X
	Physician/Surgical Services	30%	X
Need Immediate Attention	Urgent care centers or facilities	\$60	
	Emergency room services	30%	X
	Emergency medical transportation (ambulance)	30%	X
Hospital Stay	Inpatient Hospital services	30%	X
	Inpatient Physician and Surgical Services	30%	X
	Inpatient Rehabilitation Services	30%	X
	Inpatient Habilitation Services	30%	X
Help recovering or other health needs	Speech Therapy	30%	X
	Physical Therapy	30%	X
	Occupational Therapy	30%	X
	Durable medical equipment ¹	30%	X

	Diabetes Self-Management Education ²	\$5	
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¹ Diabetes supplies, including Continuous Glucose Monitors, are provided with no-cost sharing

² At a minimum 10 hours of individual or group sessions in the first year of diagnosis, and 6 hours of individual or group sessions every year after diagnosis

Silver (94% AV) Standardized Plan
(On-Exchange Individual Market)

Actuarial Value			94.5%
Individual Deductible (Combined Medical & Drug)			\$100
Individual Out-of-Pocket Maximum			\$1,375
Family Deductible			\$200
Family Out-of-Pocket Maximum			\$2,750
Common Medical Event	Service Type	Member Cost Share (In Network)	Deductible Applies
Health Care Provider's Office or Clinic Visit	Preventive care/screening/immunization	\$0	
	Primary care visit or non-specialist practitioner visit to treat an injury or illness	\$0, unlimited	
	Specialist visit	\$40	
Pregnancy	Prenatal and postnatal visits	\$0, unlimited	
Mental/ Behavioral Health and Substance Use Needs	Mental/Behavioral Health and Substance Use Disorder Office Visit	\$0, unlimited	
	Mental/Behavioral Health and Substance Use Disorder Outpatient services	20%	X
	Mental/Behavioral Health and Substance Use Disorder Inpatient services	20%	X
Tests	Laboratory tests	20%	X
	X-rays and diagnostic imaging	20%	X

	Advanced Imaging/Radiology (CT/PET scans, MRI)	20%	X
Drugs to treat Illness or Condition	Tier 1	\$0	
	Tier 2	\$0	
	Tier 3	\$20	
	Tier 4	\$40	
	Tier 5	\$60	
Outpatient Surgery	Facility Fee (e.g. Ambulatory Surgery Center)	20%	X
	Physician/Surgical Services	20%	X
Need Immediate Attention	Urgent care centers or facilities	\$40	
	Emergency room services	20%	X
	Emergency medical transportation (ambulance)	20%	X
Hospital Stay	Inpatient Hospital services	20%	X
	Inpatient Physician and Surgical Services	20%	X
	Inpatient Rehabilitation Services	20%	X
	Inpatient Habilitation Services	20%	X
Help recovering or other health needs	Speech Therapy	20%	X
	Physical Therapy	20%	X
	Occupational Therapy	20%	X
	Durable medical equipment ¹	20%	X

	Diabetes Self-Management Education ²	\$5	
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¹ Diabetes supplies, including Continuous Glucose Monitors, are provided with no-cost sharing

² At a minimum 10 hours of individual or group sessions in the first year of diagnosis, and 6 hours of individual or group sessions every year after diagnosis

Silver Off Exchange Standardized Plan
(Individual Market Off-Exchange)

Actuarial Value			70.0%
Individual Deductible (Combined Medical & Drug)			\$4,400
Individual Out-of-Pocket Maximum			\$9,800
Family Deductible			\$8,800
Family Out-of-Pocket Maximum			\$19,600
Common Medical Event	Service Type	Member Cost Share (In Network)	Deductible Applies
Health Care Provider's Office or Clinic Visit	Preventive care/screening/immunization	\$0	
	Primary care visit or non-specialist practitioner visit to treat an injury or illness	\$0, unlimited	
	Specialist visit	\$90	
Pregnancy	Prenatal and postnatal visits	\$0, unlimited	
Mental/ Behavioral Health and Substance Use Needs	Mental/Behavioral Health and Substance Use Disorder Office Visit	\$0, unlimited	
	Mental/Behavioral Health and Substance Use Disorder Outpatient services	40%	X
	Mental/Behavioral Health and Substance Use Disorder Inpatient services	40%	X
Tests	Laboratory tests	40%	X
	X-rays and diagnostic imaging	40%	X

	Advanced Imaging/Radiology (CT/PET scans, MRI)	40%	X
Drugs to treat Illness or Condition	Tier 1	\$0	
	Tier 2	\$20	
	Tier 3	\$125	
	Tier 4	\$300	
	Tier 5	\$650	
Outpatient Surgery	Facility Fee (e.g. Ambulatory Surgery Center)	40%	X
	Physician/Surgical Services	40%	X
Need Immediate Attention	Urgent care centers or facilities	\$80	
	Emergency room services	40%	X
	Emergency medical transportation (ambulance)	45%	X
Hospital Stay	Inpatient Hospital services	40%	X
	Inpatient Physician and Surgical Services	40%	X
	Inpatient Rehabilitation Services	40%	X
	Inpatient Habilitation Services	40%	X
Help recovering or other health needs	Speech Therapy	40%	X
	Physical Therapy	40%	X
	Occupational Therapy	40%	X
	Durable medical equipment ¹	40%	X

	Diabetes Self-Management Education ²	\$5	
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¹ Diabetes supplies, including Continuous Glucose Monitors, are provided with no-cost sharing

² At a minimum 10 hours of individual or group sessions in the first year of diagnosis, and 6 hours of individual or group sessions every year after diagnosis

Bronze Standardized Plan

Actuarial Value			63.5%
Individual Deductible (Combined Medical & Drug)			\$7,500
Individual Out-of-Pocket Maximum			\$10,000
Family Deductible			\$15,000
Family Out-of-Pocket Maximum			\$20,000
Common Medical Event	Service Type	Member Cost Share (In Network)	Deductible Applies
Health Care Provider's Office or Clinic Visit	Preventive care/screening/immunization	\$0	
	Primary care visit or non-specialist practitioner visit to treat an injury or illness	First 3 visits \$0, then deductible, then \$50	X
	Specialist visit	50%	X
Pregnancy	Prenatal and postnatal visits	First 3 visits \$0, then deductible, then \$50	X
Mental/Behavioral Health and Substance Use Needs	Mental/Behavioral Health and Substance Use Disorder Office Visit	\$0, unlimited	
	Mental/Behavioral Health and Substance Use Disorder Outpatient services	50%	X
	Mental/Behavioral Health and Substance Use Disorder Inpatient services	50%	X
Tests	Laboratory tests	50%	X
	X-rays and diagnostic imaging	50%	X

	Advanced Imaging/Radiology (CT/PET scans, MRI)	50%	X
Drugs to treat Illness or Condition	Tier 1	\$0	
	Tier 2	\$30	
	Tier 3	\$200	
	Tier 4	\$350	
	Tier 5	\$700	
Outpatient Surgery	Facility Fee (e.g. Ambulatory Surgery Center)	50%	X
	Physician/Surgical Services	50%	X
Need Immediate Attention	Urgent care centers or facilities	50%	X
	Emergency room services	50%	X
	Emergency medical transportation (ambulance)	50%	X
Hospital Stay	Inpatient Hospital services	50%	X
	Inpatient Physician and Surgical Services	50%	X
	Inpatient Rehabilitation Services	50%	X
	Inpatient Habilitation Services	50%	X
Help recovering or other health needs	Speech Therapy	50%	X
	Physical Therapy	50%	X
	Occupational Therapy	50%	X

	Durable medical equipment ¹	50%	X
	Diabetes Self-Management Education ²	\$5	

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² At a minimum 10 hours of individual or group sessions in the first year of diagnosis, and 6 hours of individual or group sessions every year after diagnosis