[COMPANY NAME]
INDIVIDUAL MARKET
[Standard Bronze HSA Plan – 60%]
SCHEDULE OF BENEFITS

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible *Individual* *Family*	$6,500 per member $13,000 per family	$13,000 per member $26,000 per family
Separate Prescription Drug Deductible *Individual* *Family*	Included in Plan Deductible per member / per family	Included in Plan Deductible per member / per family
Out-of-Pocket Maximum *Individual* *Family* (Includes deductible, copayments and coinsurance)	$7,000 per member $14,000 per family	$14,000 per member $28,000 per family

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult / Pediatric Preventive Visit	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
Specialist Office 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	20% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	20% coinsurance per service after INET plan deductible is met	50% coinsurance per service after OON 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

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Benefits	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
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
Prescription Drugs – Retail Pharmacy** ***(30-day supply per prescription)		
Tier 1	20% coinsurance per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Tier 2	25% coinsurance per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Tier 3	30% coinsurance per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Tier 4	30% coinsurance up to a maximum of $500 per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy (40 visits per calendar year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per calendar year limit combined for Habilitative speech, physical and occupational therapies.)	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.)	20% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Other Services		
Chiropractic Services (up to 20 visits per calendar year)	20% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Diabetic Equipment and Supplies*	20% coinsurance per equipment/supply after INET plan deductible is met	50% coinsurance per equipment/supply after OON plan deductible is met

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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 (including mental health, substance abuse, maternity, hospice and skilled nursing facility* and all IP settings) *(skilled nursing facility stay is limited to 90 days per calendar year)	20% coinsurance per admission after INET plan deductible is met	50% coinsurance per admission after OON plan deductible is met
Emergency and Urgent Care		
Ambulance Services	20% coinsurance per service after INET plan deductible is met	20% coinsurance per service after INET plan deductible is met
Emergency Room	20% coinsurance per visit after INET plan deductible is met	20% coinsurance per visit after INET plan deductible is met
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 19)		
Diagnostic & Preventive	No Cost	50% coinsurance per visit after OON plan deductible is met
Basic Services	40% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Major Services	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Orthodontia Services (medically necessary only)	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met

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Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Pediatric Vision Care		
Prescription Eyeglasses (one pair of frames and lenses or contact lens per calendar year)	Lenses: $0 copayment after INET plan deductible is met; Collection frame: $0 copayment after INET plan deductible is met; Non–collection frame: members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	Not Covered
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

[This is a brief description of the member cost sharing for this plan design. It is intended as a reference for health insurance carriers that will be offering plans through AHCT in the Individual Market for Plan Year 2022 to assist in preparing form filings to the Connecticut Insurance Department (CID). Member documents must be reviewed and approved by the CID, and these will contain a complete description of plan benefits. This includes any applicable state regulations, including maximum copays for insulin and non-insulin medications and diabetes devices, including diabetic ketoacidosis devices, used in the medically necessary treatment of diabetes. This plan includes coverage of four items included in IRS Notice 2019-45 for individuals diagnosed with diabetes not subject to the deductible when in accordance with the IRS guidance. These items are insulin and other glucose lowering agents, glucometer, hemoglobin A1c testing and retinopathy screening. Coverage of insulin and other glucose lowering agents and the glucometer prior to the plan deductible must comply with the maximum cost sharing limits outlined in Connecticut General Statute (CGS) Sec. 38a-492d when applicable. Additionally, once the plan deductible is met, cost sharing limitations for coverage of the treatment of diabetes as outlined in CGS 38a-492d must apply when in accordance with the statute.]