[COMPANY NAME]
INDIVIDUAL MARKET
[Standard Bronze 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*	$6,550 per member $13,100 per family	$13,100 per member $26,200 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)	$8,700 per member $17,400 per family	$17,400 per member $34,800 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)	$50 copayment per visit	50% coinsurance per visit after OON plan deductible is met
Specialist Office 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	$50 copayment per visit	50% coinsurance per visit after OON plan deductible is met
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	$75 copay per service after INET plan deductible is met up to a combined annual 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

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Benefits	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
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	$20 copayment 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 copayment per prescription	50% coinsurance per prescription after OON plan deductible is met
Tier 2	50% coinsurance per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Tier 3	50% coinsurance per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Tier 4	50% 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.)	$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.)	$30 copayment 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)	$50 copayment per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Diabetic Equipment and Supplies *	40% 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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Benefits	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)	25% 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)	$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 (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)	$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	No Cost after INET plan deductible is met
Emergency Room	$450 copayment per visit after INET plan deductible is met	$450 copayment per visit after INET plan deductible is met
Urgent Care Centers	$75 copayment per visit	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	45% 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; Collection frame: $0; Non–collection frame: members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	Not Covered
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

[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.]