[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	$6,500	$13,000
Family	$13,000	$26,000
Separate Prescription Drug Deductible		
Individual	N/A	N/A
Family	N/A	N/A
Out-of-Pocket Maximum (Includes deductible, copayment and coinsurance)		
Individual	$7,225	$14,450
Family	$14,450	$28,900
Benefits	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Provider Office Visits		
Preventive Visit (Adult/Pediatric)	$0 copayment, deductible does not apply	50% coinsurance, deductible does not apply
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	20% coinsurance per visit after INET deductible	50% coinsurance per visit after OON deductible
Specialist Office Visits	20% coinsurance per visit after INET deductible	50% coinsurance per visit after OON deductible
Mental Health and Substance Use Disorder Office Visit	20% coinsurance per visit after INET deductible	50% coinsurance per visit after OON deductible
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	20% coinsurance per service after INET deductible	50% coinsurance per service after OON deductible
Laboratory Services	20% coinsurance per service after INET deductible	50% coinsurance per service after OON deductible
Non-Advanced Radiology (X-ray, Diagnostic)	20% coinsurance per service after INET deductible	50% coinsurance per service after OON deductible
Mammography Ultrasound/MRI (no cost for screening and diagnostic if within Federal and/or State regulations)	20% coinsurance per service after INET deductible	50% coinsurance per service after OON deductible
Prescription Drugs - Retail Pharmacy (30 day supply per prescription)		
Tier 1	20% coinsurance per prescription after INET deductible	50% coinsurance per prescription after OON deductible
Tier 2	25% coinsurance per prescription after INET deductible	50% coinsurance per prescription after OON deductible
Tier 3	30% coinsurance per prescription after INET deductible	50% coinsurance per prescription after OON deductible
Tier 4	30% coinsurance up to a maximum of $500 per prescription after INET deductible	50% coinsurance per prescription after OON deductible
Outpatient Rehabilitative and Habilitative Services (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)		
Speech Therapy	20% coinsurance per visit after INET deductible	50% coinsurance per visit after OON deductible
Physical and Occupational Therapy	20% coinsurance per visit after INET deductible	50% coinsurance per visit after OON deductible
Other Services		
Chiropractic Services (up to 20 visits per calendar year)	20% coinsurance per visit after INET deductible	50% coinsurance per visit after OON deductible
Diabetic Equipment and Supplies	20% coinsurance per equipment/supply after INET deductible	50% coinsurance per equipment/supply after OON deductible

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Durable Medical Equipment (DME)	20% coinsurance per DME item after INET deductible	50% coinsurance per DME item after OON deductible
Home Health Care Services (up to 100 visits per calendar year)	20% coinsurance per visit after INET deductible	25% coinsurance per visit after OON deductible
Outpatient Services (in a hospital or ambulatory facility)	20% coinsurance per visit after INET deductible	50% coinsurance per visit after OON deductible
Inpatient Hospital Services		
Inpatient Hospital Services (Including mental health, substance use disorder, maternity, hospice, skilled nursing facility*, and all IP settings) *skilled nursing facility stay is limited to 90 days per calendar year	20% coinsurance per admission after INET deductible	50% coinsurance per admission after OON deductible
Emergency and Urgent Care		
Ambulance Services	20% coinsurance per service after INET deductible	Same as In-Network
Emergency Room	20% coinsurance per visit after INET deductible	Same as In-Network
Urgent Care Center	20% coinsurance per visit after INET deductible	50% coinsurance per visit after OON deductible
Pediatric Dental Care (covered persons up to age 26)		
Diagnostic & Preventive	$0 copayment, deductible does not apply	50% coinsurance per visit after OON deductible
Basic Services	40% coinsurance per visit after INET deductible	50% coinsurance per visit after OON deductible
Major Services	50% coinsurance per visit after INET deductible	50% coinsurance per visit after OON deductible
Orthodontia Services (medically necessary only)	50% coinsurance per visit after INET deductible	50% coinsurance per visit after OON deductible
Pediatric Vision Care (covered persons up to age 26)		
Prescription Eye Glasses (one pair of frames & lenses or contact lens per calendar year)	Lenses: $0 after INET deductible; Collection frame: $0 after INET deductible; Non–collection frame: members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	50% coinsurance per visit after OON deductible
Routine Eye Exam by Specialist (one exam per calendar year)	20% coinsurance per visit after INET deductible	50% coinsurance per visit after OON deductible

[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 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, including any applicable state regulations.]