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

| Deductible and Out-of-Pocket Maximum | In-Network (INET)<br>Member Pays | Out-of-Network (OON)<br>Member Pays |
|---|---|---|
| **Plan Deductible** | | |
| Individual | $7,000 | $13,100 |
| Family | $14,000 | $26,200 |
| **Separate Prescription Drug Deductible** | | |
| Individual | N/A | N/A |
| Family | N/A | N/A |
| **Out-of-Pocket Maximum** (Includes deductible, copayment and coinsurance) | | |
| Individual | $10,000 | $18,200 |
| Family | $20,000 | $36,400 |
| **Benefits** | **In-Network (INET)<br>Member Pays** | **Out-of-Network (OON)<br>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) | $50 copayment per visit, deductible does not apply | 50% coinsurance per visit after OON deductible |
| Specialist Office Visits | $70 copayment per visit after INET deductible | 50% coinsurance per visit after OON deductible |
| Mental Health and Substance Use Disorder Office Visit | $50 copayment per visit, deductible does not apply | 50% coinsurance per visit after OON deductible |
| **Outpatient Diagnostic Services** | | |
| Advanced Radiology (CT/PET Scan, MRI) | $75 copayment per service after INET deductible up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans | 50% coinsurance per service after OON deductible |
| Laboratory Services | $20 copayment per service, deductible does not apply | 50% coinsurance per service after OON deductible |
| Non-Advanced Radiology (X-ray, Diagnostic) | $40 copayment 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 copayment per service after INET deductible | 50% coinsurance per service after OON deductible |
| **Prescription Drugs - Retail Pharmacy (30 day supply per prescription)** | | |
| Tier 1 | $15 copayment per prescription, deductible does not apply | 50% coinsurance per prescription after OON deductible |
| Tier 2 | $50 copayment per prescription, deductible does not apply | 50% coinsurance per prescription after OON deductible |
| Tier 3 | 50% coinsurance per prescription after INET deductible | 50% coinsurance per prescription after OON deductible |
| Tier 4 | 50% 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 | $30 copayment per visit after INET deductible | 50% coinsurance per visit after OON deductible |
| Physical and Occupational Therapy | $30 copayment per visit after INET deductible | 50% coinsurance per visit after OON deductible |
| **Other Services** | | |
| Chiropractic Services (up to 20 visits per calendar year) | $50 copayment per visit after INET deductible | 50% coinsurance per visit after OON deductible |

| Benefits | In-Network (INET)<br>Member Pays | Out-of-Network (OON)<br>Member Pays |
|---|---|---|
| Diabetic Equipment and Supplies | 40% coinsurance per equipment/supply after INET deductible | 50% coinsurance per equipment/supply after OON deductible |
| Durable Medical Equipment (DME) | 40% coinsurance per DME item after INET deductible | 50% coinsurance per DME item after OON deductible |
| Home Health Care Services<br>(up to 100 visits per calendar year) | 25% coinsurance per visit after separate $50 deductible | 25% coinsurance per visit after separate $50 deductible |
| Outpatient Services<br>(in a hospital or ambulatory facility) | $500 copayment per visit after INET deductible at an Outpatient Hospital Facility<br><br>$300 copayment per visit after INET deductible at an Ambulatory Surgery Center | 50% coinsurance per visit after OON deductible |
| **Inpatient Hospital Services** | | |
| Inpatient Hospital Services<br>(Including mental health, substance use disorder, maternity, hospice, skilled nursing facility*, and all IP settings)<br><br>*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 deductible | 50% coinsurance per admission after OON deductible |
| **Emergency and Urgent Care** | | |
| Ambulance Services | $0 copayment per service after INET deductible | Same as In-Network |
| Emergency Room | $450 copayment per visit after INET deductible | Same as In-Network |
| Urgent Care Center | $75 copayment per visit, deductible does not apply | 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 | 45% 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<br>(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<br>(one pair of frames & 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. | 50% coinsurance per visit after OON deductible |
| Routine Eye Exam by Specialist<br>(one exam per calendar year) | $70 copayment 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.]