[COMPANY NAME]
INDIVIDUAL MARKET
[Standard Silver Plan - 70%]
SCHEDULE OF BENEFITS

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible		
Individual	$5,000	$10,000
Family	$10,000	$20,000
Separate Prescription Drug Deductible		
Individual	$250	$500
Family	$500	$1,000
Out-of-Pocket Maximum (Includes deductible, copayment and coinsurance)		
Individual	$9,400	$18,200
Family	$18,800	$36,400
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	40% coinsurance, deductible does not apply
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$45 copayment per visit, deductible does not apply	40% coinsurance per visit after OON deductible
Specialist Office Visits	$60 copayment per visit, deductible does not apply	40% coinsurance per visit after OON deductible
Mental Health and Substance Use Disorder Office Visit	$45 copayment per visit, deductible does not apply	40% coinsurance per visit after OON deductible
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	$75 copayment per service, deductible does not apply, up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans	40% coinsurance per service after OON deductible
Laboratory Services	$25 copayment per service, deductible does not apply	40% coinsurance per service after OON deductible
Non-Advanced Radiology (X-ray, Diagnostic)	$40 copayment per service after INET deductible	40% 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, deductible does not apply	40% coinsurance per service after OON deductible
Prescription Drugs - Retail Pharmacy (30 day supply per prescription)		
Tier 1	$10 copayment per prescription, deductible does not apply	40% coinsurance per prescription after OON prescription drug deductible
Tier 2	$50 copayment per prescription after INET prescription drug deductible	40% coinsurance per prescription after OON prescription drug deductible
Tier 3	$75 copayment per prescription after INET prescription drug deductible	40% coinsurance per prescription after OON prescription drug deductible
Tier 4	20% coinsurance up to a maximum of $200 per prescription after INET prescription drug deductible	40% coinsurance per prescription after OON prescription drug 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, deductible does not apply	40% coinsurance per visit after OON deductible
Physical and Occupational Therapy	$30 copayment per visit, deductible does not apply	40% coinsurance per visit after OON deductible
Other Services		
Chiropractic Services (up to 20 visits per calendar year)	$50 copayment per visit, deductible does not apply	40% coinsurance per visit after OON deductible

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Diabetic Equipment and Supplies	40% coinsurance per equipment/supply, deductible does not apply	40% coinsurance per equipment/supply after OON deductible
Durable Medical Equipment (DME)	40% coinsurance per DME item, deductible does not apply	40% coinsurance per DME item after OON deductible
Home Health Care Services (up to 100 visits per calendar year)	$0 copayment, deductible does not apply	25% coinsurance per visit after separate $50 deductible
Outpatient Services (in a hospital or ambulatory facility)	$500 copayment per visit after INET deductible at an Outpatient Hospital Facility $300 copayment per visit after INET deductible at an Ambulatory Surgery Center	40% 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	$500 copayment per day to a maximum of $2,000 per admission after INET deductible	40% coinsurance per admission after OON deductible
Emergency and Urgent Care		
Ambulance Services	$0 copayment per service, deductible does not apply	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	40% 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, deductible does not apply	50% coinsurance per visit after OON deductible
Major Services	50% coinsurance per visit, deductible does not apply	50% coinsurance per visit after OON deductible
Orthodontia Services (medically necessary only)	50% coinsurance per visit, deductible does not apply	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; 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 (one exam per calendar year)	$60 copayment per visit, deductible does not apply	40% 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.]