AccessHealthCT.com
P: 1-855-805-4325

Instructions for Completing the Schedule of Benefits Template
Note: Refer to separate blank templates for non-standard (SHOP & Individual) with/without aggregate Deductible/Out–of–Pocket Maximum

1. Include out-of-network category unless HMO without POS. If HMO without POS, remove this column.
2. Use the designated blank template for non-standardized plans that include an aggregate deductible and/or aggregate MOOP.

   Notes: Select and modify the applicable language for the Plan Deductible and delete the language not applicable.

   Delete the language displayed for Out-of-Pocket Maximum, Family [coverage] if the family OOP is NOT less than the federal individual MOOP.
3. Include the "Separate Prescription Drug Deductible" section immediately below the "Plan Deductible" section if a plan features separate deductibles.
4. All office visits must have the same cost share as the PCP or Specialist with the exception of items in statute such as mammography ultrasound and PT/occupational therapy.
5. "Mammography Ultrasound" benefit must be listed separately if copayment for non-advanced radiology exceeds $20. Insert below "Non-Advanced Radiology (X-ray, Diagnostic)".
6. Include "Prescription Drugs – Mail Order" for plans that feature this benefit. Display immediately under the "Prescription Drugs – Retail Pharmacy" if the plan offers "Mail Order".
7. Separate blank templates exist for SHOP & Individual market with specificity to visit limits reflective of per plan year vs. per calendar year.
8. Include narrative for "Outpatient Services" facility designation if one or both applies:
   - in a hospital based facility including an ambulatory facility
   - in a free-standing facility, not associated with a hospital

   Facility text must appear in the same section under Outpatient Services text.

   Note: providers must be identified as hospital based or free standing in the provider directory if any cost differential
9. Remove "Pediatric Dental Care" section for any non-standard plans that do not offer embedded pediatric dental benefits.
10. Include the following language in American Indian Limited Cost-sharing plan variations: "No Member cost when services are rendered by an Indian Health Service provider" in each benefit category immediately below the cost-sharing for services provided by a non-Indian Health Service provider.
11. Free text area to be completed by the carriers to provide contact information, any disclaimers regarding prior authorization requirements, etc.

12. Insert a footer displaying FORM #, Version # and Product Type: HMO/POS/PPO/HSA] for each plan.