[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**<br>*Individual*<br>*Family* | $6,500 per member<br>$13,000 per family | $13,000 per member<br>$26,000 per family |
| **Separate Prescription Drug Deductible**<br>*Individual*<br>*Family* | Included in Plan Deductible per member / per family | Included in Plan Deductible per member / per family |
| **Out-of-Pocket Maximum**<br>*Individual*<br>*Family*<br>(Includes deductible, copayments and coinsurance) | $7,225 per member<br>$14,450 per family | $14,450 per member<br>$28,900 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<br>(includes services for illness, injury, follow-up care and consultations) | 20% coinsurance per visit after INET plan deductible is met | 50% coinsurance per visit after OON plan deductible is met |
| Specialist Office Visits | 20% coinsurance 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 | 20% coinsurance per visit after INET plan deductible is met | 50% coinsurance per visit after OON plan deductible is met |
| **Outpatient Diagnostic Services** | | |
| Advanced Radiology (CT/PET Scan, MRI) | 20% coinsurance per service after INET plan deductible is met | 50% coinsurance per service after OON plan deductible is met |
| Laboratory Services | 20% coinsurance per service after INET plan deductible is met | 50% coinsurance per service after OON plan deductible is met |
| Non-Advanced Radiology (X-ray, Diagnostic) | 20% coinsurance per service after INET plan deductible is met | 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 |
|---|---|---|
| Mammography Ultrasound/MRI<br>(No cost for Screening and Diagnostic if within Federal and/or State regulations) | 20% coinsurance per service after INET plan deductible is met | 50% coinsurance per service after OON plan deductible is met |
| ***Prescription Drugs – Retail Pharmacy**<br>***(30-day supply per prescription)*** | | |
| Tier 1 | 20% coinsurance per prescription after INET plan deductible is met | 50% coinsurance per prescription after OON plan deductible is met |
| Tier 2 | 25% coinsurance per prescription after INET plan deductible is met | 50% coinsurance per prescription after OON plan deductible is met |
| Tier 3 | 30% coinsurance per prescription after INET plan deductible is met | 50% coinsurance per prescription after OON plan deductible is met |
| Tier 4 | 30% 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<br>(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.) | 20% coinsurance per visit after INET plan deductible is met | 50% coinsurance per visit after OON plan deductible is met |
| Physical and Occupational Therapy<br>(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.) | 20% coinsurance per visit after INET plan deductible is met | 50% coinsurance per visit after OON plan deductible is met |
| **Other Services** | | |
| Chiropractic Services<br>(up to 20 visits per calendar year) | 20% coinsurance per visit after INET plan deductible is met | 50% coinsurance per visit after OON plan deductible is met |
| Diabetic Equipment and Supplies* | 20% 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) | 20% 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) | 20% coinsurance per visit after INET plan deductible is met | 25% coinsurance per visit after OON plan deductible is met |
| Outpatient Services (in a hospital or ambulatory facility) | 20% coinsurance per visit after INET plan deductible is met | 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)<br>*(skilled nursing facility stay is limited to 90 days per calendar year) | 20% coinsurance per admission after INET plan deductible is met | 50% coinsurance per admission after OON plan deductible is met |
| **Emergency and Urgent Care** | | |
| Ambulance Services | 20% coinsurance per service after INET plan deductible is met | 20% coinsurance per service after INET plan deductible is met |
| Emergency Room | 20% coinsurance per visit after INET plan deductible is met | 20% coinsurance per visit after INET plan deductible is met |
| Urgent Care Centers | 20% coinsurance per visit after INET plan deductible is met | 50% coinsurance per visit after OON plan deductible is met |
| **Pediatric Dental Care (for children under age 26)** | | |
| Diagnostic & Preventive | No Cost | 50% coinsurance per visit after OON plan deductible is met |
| Basic Services | 40% 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)<br>Member Pays | Out-of-Network (OON)<br>Member Pays |
|---|---|---|
| **Pediatric Vision Care (for children under age 26)** | | |
| Prescription Eyeglasses<br>(one pair of frames and lenses or contact lens per calendar year) | Lenses: $0 copayment after INET plan deductible is met; Collection frame: $0 copayment after INET plan deductible is met; 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 plan deductible is met |
| Routine Eye Exam by Specialist<br>(one exam per calendar year) | 20% coinsurance 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 2025 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. This plan includes coverage of four items included in IRS Notice 2019-45 for individuals diagnosed with diabetes not subject to the deductible when in accordance with the IRS guidance. These items are insulin and other glucose lowering agents, glucometer, hemoglobin A1c testing and retinopathy screening. Coverage of insulin and other glucose lowering agents and the glucometer prior to the plan deductible must comply with the maximum cost sharing limits outlined in Connecticut General Statute (CGS) Sec. 38a-492d when applicable. Additionally, once the plan deductible is met, cost sharing limitations for coverage of the treatment of diabetes as outlined in CGS 38a-492d must apply when in accordance with the statute.]*