access health CT

Connecticut's Health Insurance Marketplace

Standard Bronze Plan 1 - 60%

Plan Overview	In-Network Member Pays	Out-of-Network Member Pays
Deductible *Individual* *Family* *(copays are not applied to deductible)*	 $3,250 $6,500	 $6,500 $13,000
Out-of-Pocket Maximum *Individual* *Family*	 $6,250 $12,500	 $12,500 $25,000
Physician Office Visits		
Preventive Care/Screenings/Immunizations	$0	50% coinsurance
Primary Care (injury or illness)	$30 copay*	50% coinsurance**
Specialist	40% coinsurance*	50% coinsurance**
Emergency/Urgent Care		
Urgent Care Center or Facility	40% coinsurance*	50% coinsurance**
Emergency Room	40% coinsurance*	40% coinsurance*
Ambulance	$0*	$0*
Hospital Services		
Inpatient	40% coinsurance*	50% coinsurance**
Outpatient (performed at hospital or ambulatory facility)	40% coinsurance*	50% coinsurance**
Skilled Nursing Facility *90 day calendar year maximum*	40% coinsurance*	50% coinsurance**
Mental Health, Substance Abuse & Behavioral Health Services		
Inpatient	40% coinsurance*	50% coinsurance**
Outpatient	$30 copay*	50% coinsurance**
Hospice Care		
Hospice Services	$0*	50% coinsurance**
Outpatient Services		
Home Health Care *100 visit calendar year maximum*	25% coinsurance subject to a $50 deductible	25% coinsurance subject to a $50 deductible
Advanced Radiology (CT/PET Scan, MRI)	40% coinsurance*	50% coinsurance**
Non-Advanced Radiology (X-ray, Diagnostic)	40% coinsurance*	50% coinsurance**

*After in-network deductible is met

**After out-of-network deductible is met

SAMPLE

This Standard Plan Design sample is representative and is not intended to be a legal contract. Please see the actual plan documents for a full list of benefit coverage, exclusions and the terms of the policy.

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	In-Network Member Pays	Out-of-Network Member Pays
Outpatient Services		
Laboratory Services	40% coinsurance*	50% coinsurance**
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) *combined 40 visit calendar year maximum*	40% coinsurance*	50% coinsurance**
Chiropractic Care *20 visit calendar maximum*	40% coinsurance*	50% coinsurance**
Other Services		
Durable Medical Equipment	40% coinsurance*	50% coinsurance**
Prosthetics	40% coinsurance*	50% coinsurance**
Diabetic Supplies & Equipment	40% coinsurance*	50% coinsurance**
Prescription Drugs		
Generic Drugs	$10 copay*	50% coinsurance**
Preferred Brand Drugs	40% coinsurance*	50% coinsurance**
Non–Preferred Brand Drugs	40% coinsurance*	50% coinsurance**
Specialty Drugs	40% coinsurance*	50% coinsurance**

Pediatric-Only Services (for children under age 19)

Pediatric Dental Care		
Diagnostic & Preventive (Oral Exam, Cleaning, X-ray)	$0*	50% coinsurance**
Basic Restorative (Filling, Simple Extraction)	40% coinsurance*	50% coinsurance**
Major Restorative (Endodontic, Crown)	50% coinsurance*	50% coinsurance**
Orthodontia Services *medically necessary only*	50% coinsurance*	50% coinsurance**
Pediatric Vision Care		
Routine Eye Exam	$30 copay*	50% coinsurance**
Prescription Eye Glasses *one pair of frames & lenses per calendar year*	lenses: $0* collection frames: $0* non-collection frames: $0* up to a $150 allowance; any amount over the $150 allowance is payable by the member minus a 20% discount	lenses: $0** frames: $0** up to a $30 allowance; any amount over the allowance is payable by the member

*After in-network deductible is met

**After out-of-network deductible is met

SAMPLE

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