access health CT

Connecticut's Health Insurance Marketplace

Standard Silver Cost Sharing Reduction Plan - 94%

Plan Overview	In-Network Member Pays	Out-of-Network Member Pays
Deductible *Individual* *Family* *(copays are not applied to deductible)*	$0 $0	$6,000 $12,000
Out-of-Pocket Maximum *Individual* *Family*	$2,000 $4,000	$12,500 $25,000
Physician Office Visits		
Preventive Care/Screenings/Immunizations	$0	40% coinsurance
Primary Care (injury or illness)	$5 copay	40% coinsurance*
Specialist	$15 copay	40% coinsurance*
Emergency/Urgent Care		
Urgent Care Center or Facility	$50 copay	40% coinsurance*
Emergency Room	$75 copay	$75 copay
Ambulance	$0	$0
Hospital Services		
Inpatient	$250 copay per day to a maximum of $500 per admission	40% coinsurance*
Outpatient (performed at hospital or ambulatory facility)	$250 copay	40% coinsurance*
Skilled Nursing Facility *90 day calendar year maximum*	$250 copay per day to a maximum of $500 per admission	40% coinsurance*
Mental Health, Substance Abuse & Behavioral Health Services		
Inpatient	$250 copay per day to a maximum of $500 per admission	40% coinsurance*
Outpatient	$5 copay	40% coinsurance*
Hospice Care		
Hospice Services	$0	40% coinsurance*
Outpatient Services		
Home Health Care *100 visit calendar year maximum*	$0	25% coinsurance subject to a $50 deductible
Advanced Radiology (CT/PET Scan, MRI)	$50 copay per service up to a combined calendar year maximum of $375 for MRI and CT scans; $400 for PET scans	40% coinsurance*
Non-Advanced Radiology (X-ray, Diagnostic)	$15 copay	40% coinsurance*

*After out-of-network deductible is met

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.

access health CT

Connecticut's Health Insurance Marketplace

Standard Silver Cost Sharing Reduction Plan - 94%

Plan Overview	In-Network Member Pays	Out-of-Network Member Pays
Outpatient Services		
Laboratory Services	$5 copay	40% coinsurance*
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) *combined 40 visit calendar year maximum*	$5 copay	40% coinsurance*
Chiropractic Care *20 visit calendar maximum*	$15 copay	40% coinsurance*
Other Services		
Durable Medical Equipment	40% coinsurance	40% coinsurance*
Prosthetics	40% coinsurance	40% coinsurance*
Diabetic Supplies & Equipment	40% coinsurance	40% coinsurance*
Prescription Drugs		
Generic Drugs	$5 copay	40% coinsurance*
Preferred Brand Drugs	$15 copay	40% coinsurance*
Non–Preferred Brand Drugs	$30 copay	40% coinsurance*
Specialty Drugs	$40 copay	40% 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)	20% coinsurance	50% coinsurance*
Major Restorative (Endodontic, Crown)	40% coinsurance	50% coinsurance*
Orthodontia Services *medically necessary only*	50% coinsurance	50% coinsurance*
Pediatric Vision Care		
Routine Eye Exam	$5 copay	40% 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 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.