access health CT
Connecticut's Health Insurance Marketplace

Standard Silver Cost Sharing Reduction Plan - 73%

Plan Overview	In-Network Member Pays	Out-of-Network Member Pays
Medical Deductible *Individual* *Family* *(copays are not applied to deductible)*	 $2,500 $5,000	 $6,000 $12,000 deductibles are combined
Prescription Drug Deductible *Individual* *Family* *(copays are not applied to deductible)*	 $300 $600	
Out-of-Pocket Maximum *Individual* *Family*	 $5,200 $10,400	 $12,500 $25,000
Physician Office Visits		
Preventive Care/Screenings/Immunizations	$0	40% coinsurance
Primary Care (injury or illness)	$30 copay	40% coinsurance**
Specialist	$45 copay	40% coinsurance**
Emergency/Urgent Care		
Urgent Care Center or Facility	$75 copay	40% coinsurance**
Emergency Room	$150 copay	$150 copay
Ambulance	$0	$0
Hospital Services		
Inpatient	$500 copay per day to a maximum of $1,000 per admission*	40% coinsurance**
Outpatient (performed at hospital or ambulatory facility)	$500 copay*	40% coinsurance**
Skilled Nursing Facility *90 day calendar year maximum*	$500 copay per day to a maximum of $1,000 per admission*	40% coinsurance**
Mental Health, Substance Abuse & Behavioral Health Care		
Mental Health, Substance Abuse & Behavioral Health Services	Covered same as any other illness	Covered same as any other illness
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)	$75 copay per service up to a combined calendar year maximum of $375 for MRI and CT scans; $400 for PET scans	40% coinsurance**

*After in-network medical deductible is met

**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.

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Outpatient Services		
Non-Advanced Radiology (X-ray, Diagnostic)	$45 copay	40% coinsurance**
Laboratory Services	$30 copay	40% coinsurance**
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) *combined 40 visit calendar year maximum*	$30 copay	40% coinsurance**
Chiropractic Care *20 visit calendar maximum*	$45 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	$10 copay	40% coinsurance**
Preferred Brand Drugs	$25 copay***	40% coinsurance**
Non–Preferred Brand Drugs	$40 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)	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	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 in-network medical deductible is met

**After out-of-network deductible is met

***After in-network prescription drug deductible is met