HealthyCT

Individual

Gold Preferred Standard PPO

SCHEDULE OF BENEFITS

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Deductible – The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		
Plan Deductible *Individual* *Family*	 $1,000 per member $2,000 per family	 $3,000 per member $6,000 per family
Separate Prescription Drug Deductible *Individual* *Family*	 $25 per member $50 per family	 $350 per member $700 per family
Out-of-Pocket Maximum *Individual* *Family* (Includes deductible, copayments and coinsurance)	 $3,000 per member $6,000 per family	 $6,000 per member $12,000 per family
Benefits	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	30% coinsurance per visit
Infant / Pediatric Preventive Visit	No Cost	30% coinsurance per visit
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$20 copayment per visit	30% coinsurance per visit after OON plan deductible is met
Specialist Office Visits	$40 copayment per visit	30% coinsurance per visit after OON plan deductible is met
Mental Health and Substance Abuse Office Visit	$20 copayment per visit	30% coinsurance per visit after OON plan deductible is met
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	$65 copayment per service up to a combined annual maximum of $375 for MRI and CT scans; $400 for PET scans	30% coinsurance per service after OON plan deductible is met
Laboratory Services	$25 copayment per service	30% coinsurance per service after OON plan deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	$40 copayment per service	30% coinsurance per service after OON plan deductible is met
Mammography Ultrasound	$20 copayment per service	30% coinsurance per service after OON plan deductible is met

HealthyCT

Individual

Gold Preferred Standard PPO

SCHEDULE OF BENEFITS

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Prescription Drugs - Retail Pharmacy ***(30 day supply per prescription)***		
Tier 1 Prescription Drugs	$5 copayment per prescription	30% coinsurance per prescription after OON plan prescription drug deductible is met
Tier 2 Prescription Drugs	$25 copayment per prescription	30% coinsurance per prescription after OON plan prescription drug deductible is met
Tier 3 Prescription Drugs	$50 copayment per prescription	30% coinsurance per prescription after OON plan prescription drug deductible is met
Tier 4 Prescription Drugs	20% coinsurance up to maximum of $100 per prescription after INET plan prescription deductible is met	30% coinsurance per prescription after OON plan prescription drug deductible is met
Prescription Drugs - Mail Order or Retail Pharmacy ***(90 day supply per prescription)***		
Tier 1 Prescription Drugs	$10 copayment per prescription	Not Covered
Tier 2 Prescription Drugs	$50 copayment per prescription	Not Covered
Tier 3 Prescription Drugs	$100 copayment per prescription	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy (40 visits per calendar year limit combined for physical, speech, and occupational therapy)	$20 copayment per visit	30% coinsurance per visit after OON plan deductible is met
Physical and Occupational Therapy (40 visits per calendar year limit combined for physical, speech, and occupational therapy)	$20 copayment per visit	30% coinsurance per visit after OON plan deductible is met
Other Services		
Chiropractic Services (up to 20 visits per calendar year)	$40 copayment per visit	30% coinsurance per visit after OON plan deductible is met
Diabetic Equipment and Supplies	30% coinsurance per equipment/supply	30% coinsurance per visit after OON plan deductible is met
Durable Medical Equipment (DME)	30% coinsurance per equipment/supply	30% coinsurance per equipment/supply after OON plan deductible is met
Home Health Care Services (up to 100 visits per calendar year)	No Cost	25% coinsurance per visit after $50 deductible is met
Outpatient Surgery (in a hospital or ambulatory facility)	$500 copayment per visit after INET plan deductible is met	30% coinsurance per visit after OON plan deductible is met
Inpatient Hospital Services		

HealthyCT

Individual

Gold Preferred Standard PPO

SCHEDULE OF BENEFITS

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) *(skilled nursing facility stay is limited to 90 days per calendar year)	$500 copayment per day up to a maximum of $1,000 per admission after INET plan deductible is met	30% coinsurance per admission after OON plan deductible is met
Emergency and Urgent Care		
Ambulance Services	No Cost	No Cost
Emergency Room	$100 copayment per visit	$100 copayment per visit
Urgent Care Centers	$50 copayment per visit	30% coinsurance per visit after OON plan deductible is met
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	50% coinsurance per visit after OON plan deductible is met
Basic Services	20% coinsurance per visit	50% coinsurance per visit after OON plan deductible is met
Major Services	40% coinsurance per visit	50% coinsurance per visit after OON plan deductible is met
Orthodontia Services (medically necessary only)	50% coinsurance per visit	50% coinsurance per visit after OON plan deductible is met
Pediatric Vision Care (for children under age 19)		
Prescription Eye Glasses (one pair of frames and lenses or contact lens per calendar year)	Lenses: $0; Collection frame: $0; 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.	Not Covered
Routine Eye Exam by Specialist (one exam per calendar year)	$40 copayment per visit	30% coinsurance per visit after OON plan deductible is met
Adult Vision Care		
Routine Adult Vision Exam	$40 copayment per visit	30% coinsurance per visit after OON plan deductible is met

This Schedule of Benefits contains only a summary of the benefits offered by this plan. This Schedule of Benefits, alone, is not a contract. Your Certificate of Coverage will have specific and complete information about the benefits and limitations that apply to you.