HealthyCT

Individual

Silver Enhanced PPO 7

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*	 $2,000 per member $4,000 per family	 $6,000 per member $12,000 per family
Separate Prescription Drug Deductible *Individual* *Family*	 Not Applicable Not Applicable	 Not Applicable Not Applicable
Out-of-Pocket Maximum *Individual* *Family* (Includes deductible, copayments and coinsurance)	 $6,000 per member $12,000 per family	 $18,000 per member $36,000 per family
Benefits	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	50% coinsurance per visit
Infant / Pediatric Preventive Visit	No Cost	50% coinsurance per visit
Primary Care Provider Office Visits (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
Mammography Ultrasound	20% coinsurance per service after INET plan deductible is met	50% coinsurance per service after OON plan deductible is met
Prescription Drugs - Retail Pharmacy		

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Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
(30 day supply per prescription)		
Tier 1 Prescription Drugs	$5 copayment per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Tier 2 Prescription Drugs	$30 copayment per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Tier 3 Prescription Drugs	50% coinsurance per prescription to a maximum of $100 per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Tier 4 Prescription Drugs	50% coinsurance per prescription to a maximum of $250 per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Prescription Drugs - Mail Order or Retail Pharmacy ***(90 day supply per prescription)***		
Tier 1 Prescription Drugs	$10 copayment per prescription after INET plan deductible is met	Not Covered
Tier 2 Prescription Drugs	$60 copayment per prescription after INET plan deductible is met	Not Covered
Tier 3 Prescription Drugs	50% coinsurance per prescription to a maximum of $200 per prescription after INET plan deductible is met	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy (40 visits per calendar year limit combined for physical, speech, and occupational therapy)	20% coinsurance per visit after INET plan deductible is met	50% 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% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Other Services		
Chiropractic Services (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	50% coinsurance per equipment/supply after INET plan deductible is met	50% coinsurance per equipment/supply after OON plan deductible is met
Durable Medical Equipment (DME)	50% 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)	$0 copayment per visit after $50 deductible is met	25% coinsurance per visit after $50 deductible is met
Outpatient Surgery (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		

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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)	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	No Cost after INET plan deductible is met	No Cost 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 19)		
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
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 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 from to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to an discount negotiated by the carrier with the retailer.	Not Covered
Routine Eye Exam by Specialist (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
Adult Vision Care		
Routine Adult Vision Exam	20% coinsurance per visit after INET plan deductible is met	50% 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.