

Value Silver Standard POS (CSR 87%)

If you are eligible for automatic renewal, **you'll be enrolled in the 2025 plan unless you take action to change or cancel your plan.** Renewal information you received from Access Health CT had information on automatic renewals and how they work. You can contact **your broker, ConnectiCare, or Access Health CT** for information on other plans and help enrolling in one.

Plan Overview	2024 Plan Year	2025 Plan Year
Plan Name	Value Silver Standard POS (CSR 87%)	Value Silver Standard POS (CSR 87%)
Plan Metal Level	Silver	Silver
Product Type	POS	POS
Deductible		
Individual In-Network (INET)	\$675 per member	\$475 per member
Family In-Network	\$1,350 per family	\$950 per family
Individual Out-of-Network (OON)	\$10,000 per member	No change
Family Out-of-Network	\$20,000 per family	No change
Prescription Drug Deductible		
Individual In-Network	\$50 per member	No change
Family In-Network	\$100 per family	No change
Individual Out-of-Network	\$500 per member	No change
Family Out-of-Network	\$1,000 per family	No change
Out-of-Pocket Maximum		
Individual In-Network	\$2,925 per member	\$2,725 per member
Family In-Network	\$5,850 per family	\$5,450 per family
Individual Out-of-Network	\$18,200 per member	No change
Family Out-of-Network	\$36,400 per family	No change
Physician Office Visits		
Preventive Care/Screenings/ Immunizations	In-network: No cost	No change
	Out-of-network: 40% coinsurance per visit; deductible waived	No change
Primary Care (injury or illness)	In-network: \$20 copayment per visit; deductible waived	No change
	Out-of-network: 40% coinsurance per visit after OON plan deductible is met	No change
Telemedicine Visits Through Teladoc® Primary Care – members must be age 18 or older	In-network: Primary care, mental health, and general medical services: No cost Dermatologist: \$45 copayment/visit; deductible waived	No change
	Out-of-network: 40% coinsurance per visit after OON plan deductible is met	No change
Specialist	In-network: \$45 copayment per visit; deductible waived	No change
	Out-of-network: 40% coinsurance per visit after OON plan deductible is met	No change
Mental Health and Substance Use	In-network: \$20 copayment per visit; deductible waived	No change
	Out-of-network: 40% coinsurance per visit after OON plan deductible is met	No change
Emergency/Urgent Care		
Urgent Care Center or Facility	In-network: \$35 copayment per visit; deductible waived	No change
	Out-of-network: 40% coinsurance per visit after OON plan deductible is met	No change
Emergency Room (copay waived if admitted)	In-network: \$150 copayment per visit after INET plan deductible is met	No change
	Out-of-network: same as in-network	No change

Plan Overview	2024 Plan Year	2025 Plan Year
Pediatric Dental Care (for members under age 26)		
Diagnostic and Preventive	In-network: No cost	No change
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	No change
Basic Services	In-network: 40% coinsurance per visit; deductible waived	No change
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	No change
Major Services	In-network: 50% coinsurance per visit; deductible waived	No change
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	No change
Orthodontia Services (medically necessary only)	In-network: 50% coinsurance per visit; deductible waived	No change
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	No change
Pediatric Vision Care (for members under age 26)		
Routine Eye Exam by Specialist (one exam per calendar year)	In-network: \$45 copayment per visit; deductible waived	No change
	Out-of-network: 40% coinsurance per visit after OON plan deductible is met	No change
Prescription Eyeglasses (one pair of frames and lenses or contact lenses per calendar year)	In-network: Lenses: \$0 Collection frame: \$0	No change
	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.	No change
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	No change
Hospital Services		
Inpatient (including mental health, substance use, maternity, hospice, and skilled nursing facility; skilled nursing facility stay is limited to 90 days per calendar year)	In-network: \$100 copayment per day up to a maximum of \$400 per admission after INET plan deductible is met	No change
	Out-of-network: 40% coinsurance per admission after OON plan deductible is met	No change
Outpatient (performed at an outpatient hospital facility)	In-network: \$100 copayment per visit after INET plan deductible is met	No change
	Out-of-network: 40% coinsurance per visit after OON plan deductible is met	No change
Outpatient (performed at an ambulatory surgery center)	In-network: \$60 copayment per visit after INET plan deductible is met	No change
	Out-of-network: 40% coinsurance per visit after OON plan deductible is met	No change
Outpatient Services		
Home Health Care (100-visit calendar-year maximum)	In-network: No cost	No change
	Out-of-network: 25% coinsurance per visit after separate \$50 deductible is met	No change
Advanced Radiology (CT/PET scan, MRI)	In-network: \$60 copayment per service up to a combined annual maximum of \$360 for MRI and CAT scans; \$400 for PET scans; deductible waived	No change
	Out-of-network: 40% coinsurance per service after OON plan deductible is met	No change

Plan Overview	2024 Plan Year	2025 Plan Year
Outpatient Services		
Non-Advanced Radiology (x-ray, diagnostic)	In-network: \$30 copayment per service after INET plan deductible is met	No change
	Out-of-network: 40% coinsurance per service after OON plan deductible is met	No change
Laboratory Services	In-network: \$10 copayment per service; deductible waived	No change
	Out-of-network: 40% coinsurance per service after OON plan deductible is met	No change
Physical and Occupational Therapy (40 visits per calendar-year limit combined for rehabilitative physical, speech, and occupational therapies. Separate 40 visits per calendar-year limit combined for habilitative speech, physical, and occupational therapies.)	In-network: \$20 copayment per visit; deductible waived	No change
	Out-of-network: 40% coinsurance per visit after OON plan deductible is met	No change
Speech Therapy (40 visits per calendar-year limit combined for rehabilitative physical, speech, and occupational therapies. Separate 40 visits per calendar-year limit combined for habilitative speech, physical, and occupational therapies.)	In-network: \$20 copayment per visit; deductible waived	No change
	Out-of-network: 40% coinsurance per visit after OON plan deductible is met	No change
Prescription Drugs		
Tier 1	In-network: \$10 copayment per prescription; deductible waived	No change
	Out-of-network: 40% coinsurance per prescription after OON prescription drug deductible is met	No change
Tier 2	In-network: \$25 copayment per prescription; deductible waived	No change
	Out-of-network: 40% coinsurance per prescription after OON prescription drug deductible is met	No change
Tier 3	In-network: \$40 copayment per prescription after INET prescription drug deductible is met	No change
	Out-of-network: 40% coinsurance per prescription after OON prescription drug deductible is met	No change
Tier 4	In-network: 20% coinsurance up to a maximum of \$60 per prescription after INET prescription drug deductible is met	No change
	Out-of-network: 40% coinsurance per prescription after OON prescription drug deductible is met	No change

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