Town of Manchester, Connecticut

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BENEFIT	OAP Preferred	OAP Plus	OAP Basic
Costshares	Only employees hired prior to 7/1/2004	In National condess with the const	In National complete with the trans-
	In-Network services subject to copays	In-Network services subject to copays	In-Network services subject to copays
	Out-of-Network services subject to deductible and coinsurance; balance billing allowed	Out-of-Network services subject to deductible and coinsurance; balance billing allowed	
	and comsurance, balance billing allowed	and comsurance, balance billing allowed	
	\$20 Office Visit Copay	\$10 Office Visit Copay Effective 7/1/2016	\$10 Office Visit Copay Effective 7/1/2016
	\$75 Emergency Room Copay	\$15 Office Visit Copay Effective 7/1/2017	\$15 Office Visit Copay Effective 7/1/2017
	tro Emergency Room copay	\$75 Emergency Room Copay	\$75 Emergency Room Copay
		The same game, mean cape,	tre amangamay maami aapay
	Deductible - \$250/\$750	Deductible - \$250/\$750	
	Coinsurance - 70%	Coinsurance - 80%	
	\$1,750/\$5,250 OOP Max	\$1,500/\$4,500 OOP Max	
	Lifetime Maximum In-Network - Unlimited Lifetime Maximum Out-of-Network- Unlimited	Lifetime Maximum In-Network - Unlimited Lifetime Maximum Out-Of-Network - Unlimited	Lifetime Maximum In-Network - Unlimited
	Lifetime Maximum Out-or-Network- Orinimited	Lifetime Maximum Out-Of-NetWork - Offilimited	
Preventive Care			
Pediatric	No Copay	No Copay	No Copay
- odiati io	no copay	nie copu)	110 0000
Adult	No Copay	No Copay	No Copay
Vision	\$20 Copay	No Copay	No Copay
	Covered once every two years	Covered once every 24 months	Covered once every 24 months
I I a andre or	000 0	No Course	N. Communication
Hearing	\$20 Copay	No Copay Screening part of physical exam	No Copay Screening part of physical exam
	Covered once every two years	Screening part or physical exam	Screening part or physical exam
Gynecological	No Copay	No Copay	No Copay
Cynecological	ivo copay	ive copay	No oopay
Medical Services			
Medical Office Visit	\$20 Copay	Copay based on date of service	Copay based on date of service
Outpatient PT/OT/ST/Chiro.	No Charge	Copay based on date of service	Copay based on date of service
	60 Combined Days	60 Combined Days	60 Combined Days
	per calendar year per member	per calendar year per member	per calendar year per member
Alleray Condess	Office visits/testing: \$20 Copay	Office visits/testing: Copay based on date of service	Office visits/testing: Copay based on date of service
Allergy Services	No copay for injections	No copay for injections	No copay for injections
	No copay for injections	No copay for injections	No copay for injections
Diagnostic Lab & X-ray	Covered	Covered	Covered
Blagnostic Lab a X ray	3373734	0010104	3070.00
Inpatient Medical Services	Covered	Covered	Covered
Cumanu Face	Course	Conversed	Construct
Surgery Fees	Covered	Covered	Covered
		+	
Office Surgery	Covered	Covered	Covered
office ourgery	Govered	OOVERED	oovered
Outpatient MH/SA	\$20 Copay	Copay based on date of service	Copay based on date of service
· · · · · · · · · · · · · · · · · · ·			
Emergency Care	, , , , , , , ,		
Emergency Room	\$75 Copay (waived if admitted)	\$75 Copay (waived if admitted)	\$75 Copay (waived if admitted)
	Sudden and Serious guidelines	Sudden & Serious Guidelines	Sudden & Serious Guidelines
Urgant Cara	¢2E Camari	¢2E Camani	¢2E Camari
Urgent Care	\$25 Copay	\$25 Copay	\$25 Copay
Ambulance	Covered	Covered	Covered
	2275.00	2230.00	22.0.00

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Town of Manchester, Connecticut

BENEFIT	OAP Preferred	OAP Plus	OAP Basic		
Inpatient Hospital	OAF FIEIEITEU	OAF Flus	OAF Basic		
General/Medical/Surgical/	Dro cort only for Out of Notwork	Dro cort only for Out of Notwork			
Maternity (Semi-private)	Pre-cert only for Out-of-Network	Pre-cert only for Out-of-Network			
Maternity (Semi-private)	¢FO Conou Effective 7/1/201/	¢50 Conou Effective 7/1/201/	¢FO Comput Effortisto 7/1/201/		
	\$50 Copay Effective 7/1/2016 \$100 Copay Effective 7/1/2017	\$50 Copay Effective 7/1/2016 \$100 Copay Effective 7/1/2017	\$50 Copay Effective 7/1/2016 \$100 Copay Effective 7/1/2017		
	\$200 Copay Effective 7/1/2017	\$200 Copay Effective 7/1/2017			
	\$200 Copay Effective 7/1/2018	\$200 Copay Effective 7/1/2018	\$200 Copay Effective 7/1/2018		
Anaillant Candasa	Coulomad	Covered	Carrana		
Ancillary Services	Covered	Covered	Covered		
Medication, Supplies					
5 11 11			11 11 11 11		
Psychiatric	Unlimited days	Unlimited days	Unlimited days		
	11 11 11 11	11 11 15 1 1			
Substance Abuse/Detox	Unlimited days	Unlimited days	Unlimited days		
Skilled Nursing/Rehabilitation	Covered up to 180 days per calendar year	Covered up to 180 days per calendar year	Covered up to 180 days per calendar year		
Facility					
Hospice	Covered	Covered	Covered		
Outpatient Hospital					
Outpatient Surgery	\$50 Copay	\$50 Copay Effective 7/1/2016	\$50 Copay Effective 7/1/2016		
Facility Charges	\$100 Copay Effective 7/1/2017	\$100 Copay Effective 7/1/2017	\$100 Copay Effective 7/1/2017		
	(Prior Authorization Required)	(Prior Authorization Required)	(Prior Authorization Required)		
Diagnostic Lab & X-ray	Covered	Covered	Covered		
Pre-Admission Testing	Covered	Covered	Covered		
110 Mannesien 100 king	3010.04	3373.34	3070.04		
Other Services					
Durable Medical Equipment	Covered	Covered	Covered		
Durable Medical Equipment	Covered	Covered	Covered		
Prosthetics	Covered	Covered	Covered		
1 TOSTRICTICS	Covered	Covered	Covered		
Home Health Care	200 days per calendar year	Unlimited days	Unlimited days		
Tiome ricaitir care	200 days per calendar year	(Prior Authorization Required)	(Prior Authorization Required)		
		(Filor AdditionZation Required)	(Filor Adtriorization Required)		
Express Scripts					
Prescriptions	\$5/\$20/\$30 effective 7/1/2016	\$5/\$20/\$30 effective 7/1/2016	\$5/\$20/\$30 effective 7/1/2016		
1 1 COOLIDATIONS	\$5/\$20/\$35 effective 7/1/2017	\$5/\$20/\$30 effective 7/1/2010 \$5/\$20/\$35 effective 7/1/2017	\$5/\$20/\$30 effective 7/1/2010 \$5/\$20/\$35 effective 7/1/2017		
	\$1,000 maximum	Unlimited maximum	Unlimited maximum		
	Three Tier Formulary RX Rider	Three Tier Formulary RX Rider	Three Tier Formulary RX Rider		
	Excess covered Out-of-Network	THEE HEI FOITHUIDLY KA KIUEL	THEE HELFOITHUIDLY KA KIUEL		
	Excess covered Out-or-Metwork				
* All honofits listed surface	In Notwork For Out of Nationals handile inter-	no refer to your Employee Benefit Comme			
All benefits listed are for	In-Network. For Out-of-Network benefits, pleas	e refer to your Employee Benefit Summary.			
** All plans are New Cottol	sonor No referrale are required. No puls	a physician is required			
All plans are Non-Gatek	eeper. No referrals are required. No primary car	e priysician is required.			
*** OAP Rasic plan has no	Out of Nationals homefit				
UAP Basic plan has no	Out-of-Network benefit.				
CTATE MANDATEC	ded from the OAR Books and OAR St	and the dead of the Alex CAR Results			
STATE MANDATES are exclu	ded from the OAP Preferred and OAP Plus, but a	re included in the UAP Basic.			
INTERPRETATION OF THE PROPERTY	11 11 AF 000 He H	10100 1 11 11 11 11 11 11 11			
INFERTILITY: Coverage is s	ubject to a \$5,000 lifetime maximum for OAP Pl	us and OAP Basic: Unlimited for OAP Preferred.			
ELIGIBILITY: Effective July 1, 2010 dependent children covered to age 26 for medical and prescription plans due to the passing of the Health Care Reform Act of					
		or medical and prescription plans due to the pass	sing of the Health Care Reform Act of		
March 30, 2010. Dependent	children covered to age 25 for dental plans.				

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