

APPENDIX B

TOWN OF MANCHESTER, CONNECTICUT

BENEFIT	OAP Plus	OAP Basic
Costshares		
	In-Network services subject to copays Out-of-Network services subject to deductible and coinsurance; balance billing allowed	In-Network services subject to copays OAP Basic plan has no Out-of-Network benefit
	\$15 Office Visit Copay \$75 Emergency Room Copay	\$15 Office Visit Copay \$75 Emergency Room Copay
	Deductible - \$250/\$750 Coinsurance - 80% \$1,500/\$4,500 OOP Max	
	Lifetime Maximum In-Network - Unlimited Lifetime Maximum Out-Of-Network - Unlimited ****OAP Plus not available after June 30, 2021	Lifetime Maximum In-Network - Unlimited
Preventive Care		
Pediatric	No Copay	No Copay
Adult	No Copay	No Copay
Vision	No Copay Covered once every 24 months	No Copay Covered once every 24 months
Hearing	No Copay Screening part of physical exam	No Copay Screening part of physical exam
Gynecological	No Copay	No Copay
Medical Services		
Medical Office Visit	Copay	Copay
Outpatient PT/OT/ST/Chiro.	Copay 60 Combined Days per calendar year per member	Copay 60 Combined Days per calendar year per member
Allergy Services	Office visits/testing: Copay No copay for injections	Office visits/testing: Copay No copay for injections
Diagnostic Lab & X-ray	Covered	Covered
Inpatient Medical Services	Covered	Covered
Surgery Fees	Covered	Covered
Office Surgery	Covered	Covered
Outpatient MH/SA	Copay	Copay
Emergency Care		
Emergency Room	\$75 Copay (waived if admitted) Sudden & Serious Guidelines	\$75 Copay (waived if admitted) Sudden & Serious Guidelines
Urgent Care	\$25 Copay	\$25 Copay
Ambulance	Covered	Covered

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BENEFIT	OAP Plus	OAP Basic
Inpatient Hospital		
General/Medical/Surgical/ Maternity (Semi-private)	Pre-cert only for Out-of-Network	
	\$200 Copay Effective 7/1/2018	\$200 Copay Effective 7/1/2018
Ancillary Services Medication, Supplies	Covered	Covered
Psychiatric	Unlimited days	Unlimited days
Substance Abuse/Detox	Unlimited days	Unlimited days
Skilled Nursing/Rehabilitation Facility	Covered up to 180 days per calendar year	Covered up to 180 days per calendar year
Hospice	Covered	Covered
Outpatient Hospital		
Outpatient Surgery Facility Charges	\$100 Copay (Prior Authorization Required)	\$100 Copay (Prior Authorization Required)
Diagnostic Lab & X-ray	Covered	Covered
Pre-Admission Testing	Covered	Covered
Other Services		
Durable Medical Equipment	Covered	Covered
Prosthetics	Covered	Covered
Home Health Care	Unlimited days (Prior Authorization Required)	Unlimited days (Prior Authorization Required)
Pharmacy Benefits		
Prescriptions	\$5/\$20/\$35 Unlimited maximum Three Tier Formulary RX Rider	\$5/\$20/\$35 Unlimited maximum Three Tier Formulary RX Rider
* All benefits listed are for In-Network. For Out-of-Network benefits, please refer to your Employee Benefit Summary.		
** All plans are Non-Gatekeeper. No referrals are required. No primary care physician is required.		
*** OAP Basic plan has no Out-of-Network benefit.		
**** OAP Plus not available after June 30, 2021		
INFERTILITY: Coverage is subject to a \$5,000 lifetime maximum for OAP Plus, OAP Plan and OAP Basic: Unlimited for OAP Preferred.		
ELIGIBILITY: Dependent children to age 25 for ALL plans; 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 March 30, 2010.		