Town of Manchester, Connecticut

BENEFIT	OAP Plus	OAP Basic
Costshares		
	In-Network services subject to copays	In-Network services subject to copays
	Out-of-Network services subject to deductible	
	and coinsurance; balance billing allowed	
	\$10 Office Visit Copay Effective 7/1/2016	\$10 Office Visit Copay Effective 7/1/2016
	\$15 Office Visit Copay Effective 7/1/2017	\$15 Office Visit Copay Effective 7/1/2017
	\$75 Emergency Room Copay	\$75 Emergency Room Copay
	Deductible - \$250/\$750	
	Coinsurance - 80%	
	\$1,500/\$4,500 OOP Max	
	\$1,000,\$1,000 CO. Max	
	Lifetime Maximum In-Network - Unlimited	Lifetime Maximum In-Network - Unlimited
	Lifetime Maximum Out-Of-Network - Unlimited	
Preventive Care		
Pediatric	No Copay	No Copay
-		
Adult	No Copay	No Copay
Vision	No Copay	No Copay
	Covered once every 24 months	Covered once every 24 months
II. and a	N- C	No. C
Hearing	No Copay	No Copay
	Screening part of physical exam	Screening part of physical exam
Cymanalagiaal	No Conov	No Consu
Gynecological	No Copay	No Copay
Medical Services		
Medical Office Visit	Copay based on date of service	Copay based on date of service
Wedical Office visit	oopay based on date or service	oopay based on date of service
Outpatient PT/OT/ST/Chiro.	Copay based on date of service	Copay based on date of service
	60 Combined Days	60 Combined Days
	per calendar year per member	per calendar year per member
Allergy Services	Copay based on date of service for office visits and testing	Copay based on date of service for office visits and testing
	No copay for injections	No copay for injections
Diagnostic Lab & X-ray	Covered	Covered
Inpatient Medical Services	Covered	Covered
C	0	Coursed
Surgery Fees	Covered	Covered
Office Surgery	Covered	Covered
omice surgery	Covereu	Covereu
Outpatient MH/SA	Copay based on date of service	Copay based on date of service
•		
,		
Emergency Care		
	\$75 Copay (waived if admitted)	\$75 Copay (waived if admitted)
Emergency Care	\$75 Copay (waived if admitted) Sudden & Serious Guidelines	\$75 Copay (waived if admitted) Sudden & Serious Guidelines
Emergency Care		
Emergency Care		
Emergency Care Emergency Room	Sudden & Serious Guidelines	Sudden & Serious Guidelines
Emergency Care Emergency Room Urgent Care	Sudden & Serious Guidelines \$25 Copay	Sudden & Serious Guidelines \$25 Copay
Emergency Care Emergency Room	Sudden & Serious Guidelines	Sudden & Serious Guidelines

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BENEFIT	OAP Plus	OAP Basic
Inpatient Hospital		
General/Medical/Surgical/	Pre-cert only for Out-of-Network	
Maternity (Semi-private)		
	\$100 Copay Effective 7/1/2016	\$100 Copay Effective 7/1/2016
	\$200 Copay Effective 7/1/2017	\$200 Copay Effective 7/1/2017
Ancillary Services	Covered	Covered
Medication, Supplies	Covered	Covered
wedication, supplies		
Psychiatric	Unlimited days	Unlimited days
Substance Abuse/Detox	Unlimited days	Unlimited days
Skilled Nursing/Rehabilitation	Covered up to 180 days per calendar year	Covered up to 180 days per calendar year
Facility	Sovered up to 100 days per calcinal year	oovered up to 100 days per calendar year
Hospice	Covered	Covered
Outpatient Hospital		
Outpatient Surgery	AFO 0 FM 11 7 14 1004 /	450.0 500 11 7/4/004/
Facility Charges	\$50 Copay Effective 7/1/2016 \$100 Copay Effective 7/1/2017	\$50 Copay Effective 7/1/2016 \$100 Copay Effective 7/1/2017
	(Prior Authorization Required)	(Prior Authorization Required)
	(PHOLAUTIONZATION Required)	(Prior Authorization Required)
Diagnostic Lab & X-ray	Covered	Covered
g	1 111111	
Pre-Admission Testing	Covered	Covered
Other Services		
Durable Medical Equipment	Covered	Covered
Prosthetics	Covered	Covered
TOSTICUES	Covered	Covercu
Home Health Care	Unlimited days	Unlimited days
	(Prior Authorization Required)	(Prior Authorization Required)
		·
Express Scripts		
Prescriptions	\$5/\$20/\$30 effective 7/1/2016	\$5/\$20/\$30 effective 7/1/2016
	\$5/\$20/\$35 effective 7/1/2017	\$5/\$20/\$35 Effective 7/1/2017
	Unlimited maximum	Unlimited maximum
		Three Tier Formulary RX Rider
	Three Tier Formulary RX Rider	Three Her Formulary to titues
	Three tier Formulary KX Rider	Three Herrormany Kritical
* All honofits listed are for I		
	In-Network. For Out-of-Network benefits, please refer to	
* All benefits listed are for I plan has no Out-of-Network	In-Network. For Out-of-Network benefits, please refer to	
plan has no Out-of-Network	In-Network. For Out-of-Network benefits, please refer to	your Employee Benefit Summary. OAP Basic
plan has no Out-of-Network ** All plans are Non-Gateke	In-Network. For Out-of-Network benefits, please refer to benefit. 	your Employee Benefit Summary. OAP Basic an is required.
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plan has no Out-of-Network ** All plans are Non-Gateke STATE MANDATES are exclud INFERTILITY: Coverage exclu ELIGIBILITY: Dependent chil	In-Network. For Out-of-Network benefits, please refer to benefit. Deper. No referrals are required. No primary care physicial led from the OAP Plus plan but are included in the OAP Budes GIFT, ZIFT and is subject to a \$5,000 lifetime maximal ldren to age 25 for ALL plans; effective July 1, 2010 deperts to a \$2,000 lifetime maximal ldren to age 25 for ALL plans; effective July 1, 2010 deperts benefits.	o your Employee Benefit Summary. OAP Basic an is required. lastic plan. mum for OAP Plus and OAP Basic plans.
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