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	
	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
Hearing	No Copay	No Copay
	Screening part of physical exam	Screening part of physical exam
Gynecological	No Copay	No Copay
Medical Services		
Medical Office Visit	Copay based on date of service	Copay 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
Surgery Fees	Covered	Covered
Office Surgery	Covered	Covered
Outpatient MH/SA	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)
	Sudden & Serious Guidelines	Sudden & Serious Guidelines
Urgent Care	$25 Copay	$25 Copay
Ambulance	Covered	Covered

Town of Manchester, Connecticut

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		
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		
Hospice	Covered	Covered
Outpatient Hospital		
Outpatient Surgery		
Facility Charges	$50 Copay Effective 7/1/2016	$50 Copay Effective 7/1/2016
	$100 Copay Effective 7/1/2017	$100 Copay Effective 7/1/2017
	(Prior Authorization Required)	(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	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
*** All benefits listed are for In-Network. For Out-of-Network benefits, please refer to your Employee Benefit Summary. OAP Basic plan has no Out-of-Network benefit.**		
**** All plans are Non-Gatekeeper. No referrals are required. No primary care physician is required.**		
STATE MANDATES are excluded from the OAP Plus plan but are included in the OAP Basic plan.		
INFERTILITY: Coverage excludes GIFT, ZIFT and is subject to a $5,000 lifetime maximum for OAP Plus and OAP Basic plans.		
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.		