

Town of Manchester, Connecticut

| BENEFIT | OAP Preferred \$20 | OAP Plus \$5 | OAP \$5/10 | OAP Basic |
|-------------------------------|---|--|---|--|
| Costshares | | | | |
| | In-Network services subject to copays | 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 | Out-of-Network services subject to deductible and coinsurance | Out-of-Network services subject to deductible and coinsurance | |
| | \$20 Office Visit, | \$5 Office Visit Copay | \$5 Office Visit Copay - PCP | \$5 Office Visit Copay - PCP |
| | \$50 Emergency Room, | \$50 Emergency Room Copay; | \$10 Office Visit Copay - Specialist | \$5 Office Visit Copay - Specialist |
| | \$50 Outpatient Surgery | | \$50 Emergency Room Copay; | \$50 Emergency Room Copay; |
| | Deductible - \$250/\$500/\$750 | Deductible - \$250/\$750 | Deductible - \$250/\$750 | |
| | Coinsurance - 70% to \$5000/\$10,000/\$15,000 | Coinsurance - 80% to \$6,250/\$18,750 | Coinsurance - 80% to \$6,250/\$18,750 | |
| | \$1,750/ \$3,500/\$5,250 Oop Max | \$1,500/ \$4,500 OOP Max | \$1,500/ \$4,500 OOP Max | |
| | Lifetime Maximum In-Network - Unlimited | Lifetime Maximum In-Network - Unlimited | Lifetime Maximum In-Network - Unlimited | Lifetime Maximum In-Network - Unlimited |
| | Lifetime max out of network- Unlimited | Lifetime Maximum Out-Of-Network -\$1,000,000 | Lifetime Maximum Out-Of-Network -\$1,000,000 | |
| Preventive Care | | | | |
| Pediatric | In-network \$0 Copay | No Copay | No Copay | No Copay |
| Adult | \$20 Copay (1997 AAP) | No Copay | No Copay | No Copay |
| Vision | \$20 Copay Covered once every two years | No Copay Covered once every 24 months | No Copay Covered once every 24 months | No Copay Covered once every 24 months |
| Hearing | \$20 Copay Covered once every two years | No Copay Screening part of physical exam | No Copay Screening part of physical exam | No Copay Screening part of physical exam |
| Gynecological | \$20 Copay | No Copay | No Copay | No Copay |
| Medical Services | | | | |
| Medical Office Visit | In Network \$20 Copay | \$5 Copay | \$5 Copay - PCP \$10 Copay - Specialist | \$5 Copay |
| Outpatient PT/OT/ST Chiro. | No Charge per member per calendar year 60 Combined Days | \$5 Copay | \$10 Copay | \$5 Copay |
| Allergy Services | \$20 Copay for office visits and testing No copay for injections | \$5 Copay for office visits and testing No copay for injections | \$10 Copay for office visits and testing No copay for injections | \$5 Copay for office visits and testing No copay for injections |
| Diagnostic Lab & X-ray | Covered | Covered | Covered | Covered |
| Inpatient Medical Services | Covered | Covered | Covered | Covered |
| Surgery Fees | Covered | Covered | Covered | Covered |
| Office Surgery | Covered | Covered | Covered | Covered |
| Outpatient MH/SA | \$20 Copay per visit | \$5 copay per visit | \$10 copay per visit | \$5 copay |
| Emergency Care | | | | |
| Emergency Room | \$50 Copay (waived if admitted) Sudden and Serious guidelines | \$50 Copay (waived if admitted) Sudden & Serious Guidelines | \$50 Copay (waived if admitted) Sudden & Serious Guidelines | \$50 Copay (waived if admitted) Sudden & Serious Guidelines |
| Urgent Care | \$25 Copay | \$25 Copay | \$25 Copay | \$25 Copay |
| Ambulance | Covered | Covered | Covered | Covered |

