APPENDIX B

TOWN OF MANCHESTER, CONNECTICUT

IOWN OF MANCHESTER, CONNECTICUT	
BENEFIT Costshares	OAP Basic
Costsilares	In-Network services subject to copays
	OAP Basic plan has no Out-of -Network benefit
	O'AL DUSIE PIGHT HIS THE OUT OF THE CHIEFE
	\$15 Office Visit Copay
	\$75 Emergency Room Copay
	q. c
	Lifetime Maximum In-Network - Unlimited
Preventive Care	
Pediatric	No Copay
Adult	No Copay
Vision	No Copay
	Covered once every 24 months
Hearing	No Copay
-	Screening part of physical exam
Gynecological	No Copay
Medical Services	
Medical Office Visit	Сорау
	i
Outpatient PT/OT/ST/Chiro.	Сорау
	60 Combined Days
	per calendar year per member
Allergy Services	Office visits/testing: Copay
<i>.</i>	No copay for injections
Diagnostic Lab & X-ray	Covered
,	
Inpatient Medical Services	Covered
Surgery Fees	Covered
Office Surgery	Covered
-	
Outpatient MH/SA	Сорау
·	
Emergency Care	
Emergency Room	\$75 Copay (waived if admitted)
5,	Sudden & Serious Guidelines
Urgent Care	\$25 Copay
- 3	yes sopul
Ambulance	Covered
	00.00

APPENDIX B

TOWN OF MANCHESTER, CONNECTICUT

DELLEGE	TOWN OF MANCHESTER, CONNECTION
BENEFIT	OAP Basic
Inpatient Hospital	
General/Medical/Surgical/	
Maternity (Semi-private)	
, , , ,	\$200 Copay Effective 7/1/2018
	4200 Capar ICatar 1, 2, 2020
A: II Ci	Count
Ancillary Services	Covered
Medication, Supplies	
Psychiatric	Unlimited days
Substance Abuse/Detox	Unlimited days
oussiance / isase/ s etex	Onlineas days
Chilled Nameire - /Beleekilitetiere	Country to 100 days are salarday are
Skilled Nursing/Rehabilitation	Covered up to 180 days per calendar year
Facility	
Hospice	Covered
Outpatient Hospital	
Outpatient Surgery	\$100 Copay
Facility Charges	
racility Charges	(Prior Authorization Required)
Diagnostic Lab & X-ray	Covered
Pre-Admission Testing	Covered
Tre Harrission resuing	COTOLCO
Other Services	
Durable Medical Equipment	Covered
Prosthetics	Covered
	30.00
Hama Haalth Care	Linking that day o
Home Health Care	Unlimited days
	(Prior Authorization Required)
Pharmacy Benefits	
Prescriptions	\$5/\$20/\$35
	Unlimited maximum
	Three Tier Formulary RX Rider
	The test of the second of the
w all 1	
 All benefits listed are for 	In-Network. For Out-of-Network benefits, please refer to your Employee Benefit Summary.
** OAP Basic plan has no O	ut-of-Network benefit.
INFERTILITY: Coverage is	subject to a \$5,000 lifetime maximum for OAP Plus, OAP Plan and OAP Basic: Unlimited for OAP Preferred.
ELIGIBILITY: Dependent	hildren to age 25 for All plans; effectgive July 1, 2010 dependent children covered to age 26 for medical and prescription plans
	ealth Care Reform Act of March 30, 2010.
uue to the passing of the H	eatur Care Retorni ACC Of March 30, 2010.
Matrix CIGNA Residual 7/01/23	