Town of Manchester, Connecticut

BENEFIT	OAP Preferred $20	OAP Plus $5	OAP $5/$10	OAP Basic
Costshares	***Only employees hired prior to 7/1/2000***			
	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	Out-of-Network services subject to deductible	Out-of-Network services subject to deductible	OAP Basic plan has no Out-of-Network benefit
	and coinsurance; balance billing allowed	and coinsurance; balance billing allowed	and coinsurance; balance billing allowed	
	$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	$50 Emergency Room Copay
	$50 Outpatient Surgery		$50 Emergency Room Copay	
	Deductible - $250/$750	Deductible - $250/$750	Deductible - $250/$750	
	Coinsurance - 70%	Coinsurance - 80%	Coinsurance - 80%	
	$1,750/$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 Maximum Out-of-Network- Unlimited	Lifetime Maximum Out-Of-Network - Unlimited	Lifetime Maximum Out-Of-Network - Unlimited	
Preventive Care				
Pediatric	No Copay	No Copay	No Copay	No Copay
Adult	No Copay	No Copay	No Copay	No Copay
Vision	$20 Copay	No Copay	No Copay	No Copay
	Covered once every two years	Covered once every 24 months	Covered once every 24 months	Covered once every 24 months
Hearing	$20 Copay	No Copay	No Copay	No Copay
	Covered once every two years	Screening part of physical exam	Screening part of physical exam	Screening part of physical exam
Gynecological	No Copay	No Copay	No Copay	No Copay
Medical Services				
Medical Office Visit	$20 Copay	$5 Copay	$5 Copay - PCP	$5 Copay
			$10 Copay - Specialist	
Outpatient PT/OT/ST/Chiro.	No Charge	$5 Copay	$10 Copay	$5 Copay
	60 Combined Days	60 Combined Days	60 Combined Days	60 Combined Days
	per calendar year per member	per calendar year per member	per calendar year per member	per calendar year per member
Allergy Services	$20 Copay for office visits and testing	$5 Copay for office visits and testing	$10 Copay for office visits and testing	$5 Copay for office visits and testing
	No copay for injections	No copay for injections	No copay for injections	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	$5 Copay	$10 Copay	$5 Copay
Emergency Care				
Emergency Room	$50 Copay (waived if admitted)	$50 Copay (waived if admitted)	$50 Copay (waived if admitted)	$50 Copay (waived if admitted)
	Sudden and Serious guidelines	Sudden & Serious Guidelines	Sudden & Serious Guidelines	Sudden & Serious Guidelines
Urgent Care	$25 Copay	$25 Copay	$25 Copay	$25 Copay
Ambulance	Covered	Covered	Covered	Covered

Town of Manchester, Connecticut

BENEFIT	OAP Preferred $20	OAP Plus $5	OAP $5/$10	OAP Basic
Inpatient Hospital	***Only employees hired prior to 7/1/2000***			
General/Medical/Surgical/	**Pre-cert only for Out-of-Network**	**Pre-cert only for Out-of-Network**	**Pre-cert only for Out-of-Network**	**Pre-cert only for Out-of-Network**
Maternity (Semi-private)	Covered	Covered	Covered	Covered
Ancillary Services	Covered	Covered	Covered	Covered
Medication, Supplies				
Psychiatric	Unlimited days	Unlimited days	Unlimited days	Unlimited days
Substance Abuse/Detox	Unlimited days	Unlimited days	Unlimited days	Unlimited days
Skilled Nursing/Rehabilitation Facility	Covered up to 180 days per calendar year	Covered up to 180 days per calendar year	Covered up to 180 days per calendar year	Covered up to 180 days per calendar year
Hospice	Covered	Covered	Covered	Covered
Outpatient Hospital				
Outpatient Surgery	$50 Copay	Covered	Covered	Covered
Facility Charges		(Prior Authorization Required)	(Prior Authorization Required)	(Prior Authorization Required)
Diagnostic Lab & X-ray	Covered	Covered	Covered	Covered
Pre-Admission Testing	Covered	Covered	Covered	Covered
Other Services				
Durable Medical Equipment	Covered	Covered	Covered	Covered
Prosthetics	Covered	Covered	Covered	Covered
Home Health Care	200 days per calendar year	Unlimited days	Unlimited days	Unlimited days
		(Prior Authorization Required)	(Prior Authorization Required)	(Prior Authorization Required)
Pharmacy Benefits				
Prescriptions	$5/$15/$25 to $1,000 maximum	$5/$10/$20 to unlimited maximum	$5/$15/$25 to unlimited maximum	$5/$10/$20 to unlimited maximum
	Three Tier Formulary RX Rider	Three Tier Formulary RX Rider	Three Tier Formulary RX Rider	Three Tier Formulary RX Rider
	Excess covered Out-of-Network			

*** 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.**

STATE MANDATES are excluded from the OAP Preferred $20, OAP Plus $5 and OAP $5/10 but are included in the OAP Basic.

INFERTILITY: Coverage is subject to a $5,000 lifetime maximum for OAP Plus $5, OAP$5/10 and OAP Basic; Unlimited for OAP Preferred $20.

ELIGIBILITY: Dependent children to age 25 for ALL plans; effective July 1, 2010 dependent children coveraged to age26 for medical and prescription plans due to the passing of the Health Care Reform Act of March 30, 2010.