

## Town of Manchester, Connecticut

BENEFIT	OAP Plus \$5	OAP Basic
<b>Costshares</b>		
	In-Network services subject to copays	In-Network services subject to copays
	Out-of-Network services subject to deductible and coinsurance; balance billing allowed	
	\$20 Office Visit Copay	\$20 Office Visit Copay - PCP
	\$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	
<b>Preventive Care</b>		
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
<b>Medical Services</b>		
Medical Office Visit	\$20 Copay	\$20 Copay
Outpatient PT/OT/ST/Chiro.	\$20 Copay	\$20 Copay
	60 Combined Days	60 Combined Days
	per calendar year per member	per calendar year per member
Allergy Services	\$20 Copay for office visits and testing	\$20 Copay for office visits and testing
	No copay for injections	No copay for injections
Inpatient Medical Services	\$200 Hospital Admission Copay	\$200 Hospital Admission Copay
Surgery Fees	Inpatient: \$200 Hospital Admission Copay	Inpatient: \$200 Hospital Admission Copay
	Outpatient: \$100 Copay	Outpatient: \$100 Copay
Office Surgery	\$20 Copay	\$20 Copay
Outpatient MH/SA	\$20 Copay	\$20 Copay
<b>Emergency Care</b>		
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

