Town of Manchester, Connecticut

BENEFIT	High Deductible Health Plan/		BENEFIT	High Deductible Health Plan/
Costshares	**Health Savings Account**		**Inpatient Hospital**	**Health Savings Account**
	Deductible - $2,000/$4,000		General/Medical/Surgical/	**Pre-cert only for Out-of-Network**
	Coinsurance - 100% after plan deductible met		Maternity (Semi-private)	Covered 100% after plan deductible met
	for in network services			
	$4,000/$8,000 out of pocket maximum		Ancillary Services	Covered 100% after plan deductible met
	Coinsurance - 80% after plan deductible met		Medication, Supplies	
	for out of network services			
			Psychiatric	Covered 100% after plan deductible met
				Unlimited days
			Skilled Nursing/Rehabilitation	Covered 100% after plan deductible met
			Facility	Covered up to 180 days per calendar year
	Lifetime Maximum In-Network - Unlimited		Hospice	Covered 100% after plan deductible met
	Lifetime Maximum Out-Of-Network - Unlimited			
Preventive Care			**Outpatient Hospital**	
Pediatric	Covered		Outpatient Surgery	Covered 100% after plan deductible met
			Facility Charges	(Prior Authorization Required)
Adult	Covered		Diagnostic Lab & X-ray	Covered 100% after plan deductible met
Hearing	Covered		Pre-Admission Testing	Covered 100% after plan deductible met
	Screening part of physical exam			
Gynecological	Covered		**Other Services**	
			Durable Medical Equipment	Covered 100% after plan deductible met
Medical Services				
Medical Office Visit	Covered 100% after plan deductible met		Prosthetics	Covered 100% after plan deductible met
Outpatient PT/OT/ST/Chiro.	Covered 100% after plan deductible met		Home Health Care	Covered 100% after plan deductible met
	60 Combined Days			Unlimited days
	per calendar year per member			(Prior Authorization Required)
			Vision	Covered 100% after plan deductible met
Allergy Services	Covered 100% after plan deductible met			Covered once every 24 months
			Prescriptions	After plan deductible is met
Diagnostic Lab & X-ray	Covered 100% after plan deductible met			applicable Rx copays $5/$10/$20
				Three Tier Formulary RX Rider
Inpatient Medical Services	Covered 100% after plan deductible met			
			*** All benefits listed are for In-Network. For Out-of-Network benefits,**	
			please refer to your Employee Benefit Summary.	
Surgery Fees	Covered 100% after plan deductible met			
			**** Plan is Non-Gatekeeper. No referrals are required. No primary**	
			care physician is required.	
Office Surgery	Covered 100% after plan deductible met			
			STATE MANDATES enacted prior to 1/1/15 are included.	
Outpatient MH/SA	Covered 100% after plan deductible met		**ELIGIBILITY: 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.	
Emergency Care				
Emergency Room	Covered 100% after plan deductible met			
Urgent Care	Covered 100% after plan deductible met			
Ambulance	Covered 100% after plan deductible met			