

Town of Manchester, Connecticut

| BENEFIT | High Deductible Health Plan/ Health Savings Account | BENEFIT | High Deductible Health Plan/ Health Savings Account |
|----------------------------|--|--|--|
| Costshares | | Inpatient Hospital | |
| | Deductible - \$2,000/\$4,000 | General/Medical/Surgical/ | Covered 100% after plan deductible met |
| | Coinsurance - 100% after plan deductible met for in network services | Maternity (Semi-private) | |
| | \$4,000/\$8,000 out of pocket maximum | Ancillary Services | Covered 100% after plan deductible met |
| | Coinsurance - 80% after plan deductible met for out of network services | Medication, Supplies | |
| | Employer Contribution | Psychiatric | Covered 100% after plan deductible met Unlimited days |
| | \$1,000 single coverage | Substance Abuse/Detox | Covered 100% after plan deductible met Unlimited days |
| | \$2,000 double or family coverage | Skilled Nursing/Rehabilitation Facility | Covered 100% after plan deductible met 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 (Prior Authorization Required) |
| | | Facility Charges | |
| Adult | Covered | Diagnostic Lab & X-ray | Covered 100% after plan deductible met |
| | | Pre-Admission Testing | Covered 100% after plan deductible met |
| Hearing | Covered Screening part of physical exam | | |
| Gynecological | Covered | | |
| Medical Services | | Other Services | |
| Medical Office Visit | Covered 100% after plan deductible met | Durable Medical Equipment | Covered 100% after plan deductible met |
| Outpatient PT/OT/ST/Chiro. | Covered 100% after plan deductible met 60 Combined Days per calendar year per member | Prosthetics | Covered 100% after plan deductible met |
| Allergy Services | Covered 100% after plan deductible met | Home Health Care | Covered 100% after plan deductible met Unlimited days (Prior Authorization Required) |
| Diagnostic Lab & X-ray | Covered 100% after plan deductible met | Vision | Covered 100% after plan deductible met Covered once every 24 months |
| Inpatient Medical Services | Covered 100% after plan deductible met | Prescriptions | Rx copays apply after the deductible is met \$5/\$20/\$30 effective 7/1/2016 \$5/\$20/\$35 Effective 7/1/2017 Three Tier Formulary RX Rider |
| Surgery Fees | 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. | |
| Office Surgery | Covered 100% after plan deductible met | INFERTILITY: Coverage is subject to a \$5,000 lifetime maximum | |
| Emergency Room | 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. | |
| Ambulance | Covered 100% after plan deductible met | | |