APPENDIX C

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/	Covered 100% after plan deductible met
	Coinsurance - 100% after plan deductible met		Maternity (Semi-private)	
	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
	Employer Contribution			Unlimited days
	$1,000 single coverage			
	$2,000 double or family coverage		Substance Abuse/Detox	Covered 100% after plan deductible met
				Unlimited days
	Lifetime Maximum In-Network - Unlimited		Skilled Nursing/Rehabilitation	Covered 100% after plan deductible met
	Lifetime Maximum Out-Of-Network - Unlimited		Facility	Covered up to 180 days per calendar year
Preventive Care			Hospice	Covered 100% after plan deductible met
Pediatric	Covered			
			Outpatient Hospital	
Adult	Covered		Outpatient Surgery	Covered 100% after plan deductible met
			Facility Charges	(Prior Authorization Required)
Hearing	Covered		Diagnostic Lab & X-ray	Covered 100% after plan deductible met
	Screening part of physical exam			
Gynecological	Covered		Pre-Admission Testing	Covered 100% after plan deductible met
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		Prosthetics	Covered 100% after plan deductible met
	60 Combined Days			
	per calendar year per member			
			Home Health Care	Covered 100% after plan deductible met
Allergy Services	Covered 100% after plan deductible met			Unlimited days
				(Prior Authorization Required)
			Vision	Covered 100% after plan deductible met
Diagnostic Lab & X-ray	Covered 100% after plan deductible met			Covered once every 24 months
			Prescriptions	Rx copays apply after the deductible is met
				$5/$20/$35
				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.	
			INFERTILITY: Coverage is subject to a $5,000 lifetime maximum.	
Emergency Care			**ELIGIBILITY: Dependent children covered to age 26 for medical and**	
Emergency Room	Covered 100% after plan deductible met		**prescription plans.**	
Urgent Care	Covered 100% after plan deductible met			
Ambulance	Covered 100% after plan deductible met			