

Town of Manchester, Connecticut

BENEFIT	High Deductible Health Plan/ Health Savings Account	BENEFIT	High Deductible Health Plan/ Health Savings Account
Costshares	Deductible - \$2,000/\$4,000	Inpatient Hospital	Covered 100% after plan deductible met
	Coinsurance - 100% after plan deductible met for in network services	General/Medical/Surgical/ 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		
	\$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 Facility	Covered 100% after plan deductible met Covered up to 180 days per calendar year
	Lifetime Maximum Out-Of-Network - Unlimited		
Preventive Care		Hospice	Covered 100% after plan deductible met
Pediatric	Covered		
		Outpatient Hospital	
Adult	Covered	Outpatient Surgery Facility Charges	Covered 100% after plan deductible met (Prior Authorization Required)
Hearing	Covered Screening part of physical exam	Diagnostic Lab & X-ray	Covered 100% after plan deductible met
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
		Prosthetics	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	Home Health Care	Covered 100% after plan deductible met Unlimited days (Prior Authorization Required)
Allergy Services	Covered 100% after plan deductible met	Vision	Covered 100% after plan deductible met Covered once every 24 months
Diagnostic Lab & X-ray	Covered 100% after plan deductible met	Prescriptions (Coverage through Cigna)	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
Inpatient Medical Services	Covered 100% after plan deductible met		
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		
		** Plan is Non-Gatekeeper. No referrals are required. No primary care physician is required.	
Outpatient MH/SA	Covered 100% after plan deductible met		
		INFERTILITY: Coverage is subject to a \$5,000 lifetime maximum	
Emergency Care		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 Room	Covered 100% after plan deductible met		
Urgent Care	Covered 100% after plan deductible met		
Ambulance	Covered 100% after plan deductible met		