Town of Manchester, Connecticut

BENEFIT	High Deductible Health Plan/
Costshares	**Health Savings Account**
	Deductible - $2,000/$4,000
	Coinsurance - 100% after plan deductible met
	for in network services
	$4,000/$8,000 out of pocket maximum
	Coinsurance - 80% after plan deductible met
	for out of network services
	Employer Contribution
	$1,000 single coverage
	$2,000 double or family coverage
	Lifetime Maximum In-Network - Unlimited
	Lifetime Maximum Out-Of-Network - Unlimited
Preventive Care	
Pediatric	Covered
Adult	Covered
Hearing	Covered
	Screening part of physical exam
Gynecological	Covered
Medical Services	
Medical Office Visit	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
Allergy Services	Covered 100% after plan deductible met
Diagnostic Lab & X-ray	Covered 100% after plan deductible met
Inpatient Medical Services	Covered 100% after plan deductible met
Surgery Fees	Covered 100% after plan deductible met
Office Surgery	Covered 100% after plan deductible met
Outpatient MH/SA	Covered 100% after plan deductible met
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

BENEFIT	High Deductible Health Plan/
Inpatient Hospital	**Health Savings Account**
General/Medical/Surgical/	Covered 100% after plan deductible met
Maternity (Semi-private)	
Ancillary Services	Covered 100% after plan deductible met
Medication, Supplies	
Psychiatric	Covered 100% after plan deductible met
	Unlimited days
Substance Abuse/Detox	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
Hospice	Covered 100% after plan deductible met
Outpatient Hospital	
Outpatient Surgery	Covered 100% after plan deductible met
Facility Charges	(Prior Authorization Required)
Diagnostic Lab & X-ray	Covered 100% after plan deductible met
Pre-Admission Testing	Covered 100% after plan deductible met
Other Services	
Durable Medical Equipment	Covered 100% after plan deductible met
Prosthetics	Covered 100% after plan deductible met
Home Health Care	Covered 100% after plan deductible met
	Unlimited days
	(Prior Authorization Required)
Vision	Covered 100% after plan deductible met
	Covered once every 24 months
Prescriptions	Rx copays apply after the deductible is met
	$5/$20/$35 Effective 7/1/2017
	Three Tier Formulary RX Rider

*** All benefits listed are for In-Network. For Out-of-Network benefits, please refer to your Employee Benefit Summary.**

**** Plan is Non-Gatekeeper. No referrals are required. No primary care physician is required.**

INFERTILITY: Coverage is subject to a $5,000 lifetime maximum

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. Dependent children covered to age 25 for dental plans.