Exhibit A–1
CITY OF MANCHESTER
EMPLOYEE BENEFIT PLAN
SUMMARY OF BENEFITS –RFP Quote Request
EFFECTIVE JULY 1, 2024

The following is a summary of benefits to be quoted for 2024. Eligible Expenses under this plan are charges that have first been applied to the deductible and/or coinsurance of your fully-insured high deductible health plan. All Benefits shown below are subject to precertification requirements, limitations and exclusions as outlined in your fully-insured high deductible health plan, unless otherwise stated.

For a detailed explanation of how your employer helps share a portion of your costs of your fully-insured high deductible plan, see the section called "HOW THIS PLAN WORKS!"

The following benefits are per Participant per Calendar Year. All benefits are subject to the Maximum Allowable Charge.

PPO Plan

Type of Expense	In-Network Amounts	Out-of-Network Amounts
Embedded Deductible, per Calendar Year		
Employee Only	$2,000	$4,000
Employee + Spouse	$2,500	$8,000
Employee + Children	$2,500	$8,000
Family Unit	$3,000	$8,000
Payment Level (unless otherwise stated)	70%	50%
Maximum Out-of-Pocket, per Calendar Year		
Employee Only	$4,500	$13,500
Employee + Spouse	$9,000	$27,000
Employee + Children	$9,000	$27,000
Family Unit	$9,000	$27,000

- The Deductible and Coinsurance are applied to and included in the maximum out-of-pocket amount. Any penalties or non-covered services do not apply towards the maximum-out-pocket amount.

- The In-Network and Out-of-Network Deductible and out-of-pocket amounts do not credit or reduce each other.

- This is an embedded plan.
  - Individual Deductibles are tracked and applied to the individual and the family when an embedded plan is utilized. Once an individual has met the individual Deductible, their claims will be paid at the next level of benefits even though the family Deductible has not been met. Other individuals in the family must continue to pay their individual Deductible amount until either their own individual Deductible is met, or the family Deductible is met, whichever occurs first.
  - Out-of-Pocket amounts are tracked and applied to the individual and the family. Once an individual has met the individual maximum out-of-pocket, their claims will be paid at 100% even though the family maximum out-of-pocket as not been met. Other individuals in the family continue to pay toward their individual maximum out-of-pocket until either their individual maximum is met, or the family maximum is met, whichever occurs first.

PPO Copay Plan			
Covered Medical Expenses (Subject to Fully-Insured Plan Precertification Requirements, Limitations and Exclusions, unless otherwise stated)	**In-Network Amounts**	**Out-of-Network Amounts**	**Limits**
Acupuncture	Visits 1 – 20: $30 copay then 100%, deductible waived Visits 21 – 50: $50 copay then 100%, deductible waived	Visits 1 – 20: $55 copay then 100%, deductible waived Visits 21 – 50: $80 copay then 100%, deductible waived	Limited to 50 visits per Calendar Year
Advanced Imaging – Includes, but not limited to, MRI/MRA/CT/PET	70% after deductible	50% after deductible	
Allergy Services Office Visit	$30 PCP or $50 Specialist copay then 100%, deductible waived	$55 PCP or $80 Specialist copay then 100%, deductible waived	
Testing/Injections	100%, deductible waived	100%, deductible waived	
Ambulance	70% after deductible	70% after in-network deductible	
Ambulatory Surgical Center	70% after deductible	50% after deductible	
Anesthesia	Office Services: 100%, deductible waived Other: 70% after deductible	Office Services: 100%, deductible waived Other: 70% after deductible	
Chiropractic Care (Spinal Manipulations)	Visits 1 – 20: $30 copay then 100%, deductible waived Visits 21 – 50: $50 copay then 100%, deductible waived	Visits 1 – 20: $55 copay then 100%, deductible waived Visits 21 – 50: $80 copay then 100%, deductible waived	Limited to 50 visits per Calendar Year
Telehealth Services	Covered 100% under your Plan	Covered 100^ under your Plan	
Dialysis (Outpatient)	70% after deductible	50% after deductible	
Durable Medical Equipment	70% after deductible	50% after deductible	
Hearing Aids	70% after deductible	50% after deductible	
Home Health Care	70% after deductible	50% after deductible	

PPO CopayPlan			
Covered Medical Expenses (Subject to Fully-Insured Plan Precertification Requirements, Limitations and Exclusions, unless otherwise stated)	**In-Network Amounts**	**Out-of-Network Amounts**	**Limits**
Hospice Care			
Inpatient/Outpatient Treatment	70% after deductible	50% after deductible	
Family Bereavement Counseling	70% after deductible	50% after deductible	
Hospital			
Inpatient	70% after deductible	50% after deductible	
Outpatient	70% after deductible	50% after deductible	
Mental Health/Substance Abuse			
Residential Treatment	70% after deductible	50% after deductible	
Inpatient Treatment	70% after deductible	50% after deductible	
Partial Day Program	70% after deductible	50% after deductible	
Outpatient Physician	$30 copay then 100%, deductible waived	$55 copay then 100%, deductible waived	
Newborn Care	70% after deductible	50% after deductible	
Outpatient Diagnostic X-ray and Lab Services	70%, deductible waived	70%, deductible waived	
Outpatient Emergency Services			
Physician/Facility	$300 copay then 100%, deductible waived	$300 copay then 100%, deductible waived	Copay waived if admitted
Physician Services			
Primary Care Office Visit	$30copay then 100%, deductible waived	$55 copay then 100%, deductible waived	
Specialist Office Visit	$50 copay then 100%, deductible waived	$80 copay then 100%, deductible waived	
Lab, X-rays	100%, deductible waived	100%, deductible waived	
Surgery	$30 PCP or $50 Specialist copay then 100%, deductible waived	$55 PCP or $80 Specialist copay then 100%, deductible waived	
• Primary Care Providers include: Family Practitioners, General Practitioners, Internists, OBGYNs and Pediatricians. Benefits for Nurse Practitioners and Physician's Assistants are considered PCPs or Specialists based on the Provider they are working under.			
Preventive Care as defined under the Patient Protection and Affordable Care Act of 2010	100% deductible waived	Office Services: $50 copay then 100%, deductible waived Outpatient Services: 50% after deductible	

PPO Copay Plan			
Covered Medical Expenses (Subject to Fully-Insured Plan Precertification Requirements, Limitations and Exclusions, unless otherwise stated)	**In-Network Amounts**	**Out-of-Network Amounts**	**Limits**
Prosthetics and Orthotics	70% after deductible	50% after deductible	
Skilled Nursing Facility	70% after deductible	50% after deductible	
Temporomandibular Joint Disorder (TMJ)	70% after deductible	50% after deductible	
Therapy (Outpatient) – Rehabilitative & Habilitative			
Autism Therapy	Benefit Based Upon Service Rendered	Benefit Based Upon Service Rendered	
Cognitive Therapy	70% after deductible	50% after deductible	
Cardiac Therapy	70% after deductible	50% after deductible	
Massage Therapy	70% after deductible	50% after deductible	
Occupational Therapy	70%, deductible waived	50% after deductible	
Physical Therapy	70%, deductible waived	50% after deductible	
Pulmonary Therapy	70% after deductible	50% after deductible	
Speech Therapy	70%, deductible waived	50% after deductible	
Vision Therapy	70% after deductible	50% after deductible	
Transplants	70% after deductible	50% after deductible	
Travel & Lodging	70% after deductible	50% after deductible	
Urgent Care	$55 copay then 100%, deductible waived	$80 copay then 100%, deductible waived	
Wigs	70% after deductible	50% after deductible	
All Other Covered Services	70% after deductible	50% after deductible	

PPO Prescription Drug Benefits		
Covered Prescription Drug Expenses	**Participating Pharmacy**	
Pharmacy Option: 90-day maximum	**30-day supply**	**90-day supply**
Copayment, per prescription or refill, for generic:	$15 copay	$30 copay
Copayment, per prescription or refill, for preferred name brands:	$50 copay	$100 copay
Copayment, per prescription or refill, for non-preferred name brands:	$90 copay	$180 copay
Maintenance Medications: 90-day maximum	**90-day supply**	
Copayment, per prescription or refill, for generic:	$15 copay	
Copayment, per prescription or refill, for preferred name brands:	$50 copay	
Copayment, per prescription or refill, for non-preferred name brands:	$180 copay	
Mail Order Option: 90-day maximum	**90-day supply**	
Copayment, per prescription or refill, for generic:	30 copay	
Copayment, per prescription or refill, for preferred name brands:	$100 copay	
Copayment, per prescription or refill, for non-preferred name brands:	$180 copay	
Specialty Drug Option: 30-day maximum	**30-day supply**	
Coinsurance, per prescription or refill, for generic:	10% coinsurance after deductible; Minimum $50; Maximum $150	
Coinsurance, per prescription or refill, for preferred name brands:	10% coinsurance after deductible; Minimum $50; Maximum $150	
Coinsurance, per prescription or refill, for non-preferred name brands:	10% coinsurance after deductible; Minimum $50; Maximum $150	

CITY OF MANCHESTER
EMPLOYEE BENEFIT PLAN
SUMMARY OF BENEFITS – LOCAL CDHP PLAN
EFFECTIVE JULY 1, 2024

The following is a summary of benefits under this plan. Eligible Expenses under this plan are charges that have first been applied to the deductible and/or coinsurance of your fully-insured high deductible health plan. All Benefits shown below are subject to precertification requirements, limitations and exclusions as outlined in your fully-insured high deductible health plan, unless otherwise stated.

For a detailed explanation of how your employer helps share a portion of your costs of your fully-insured high deductible plan, see the section called "HOW THIS PLAN WORKS!"

The following benefits are per Participant per Calendar Year. All benefits are subject to the Maximum Allowable Charge.

CDHP Plan		
Type of Expense	**In-Network Amounts**	**Out-of-Network Amounts**
Embedded Deductible, per Calendar Year		
Individual	$2,000	$4,000
Family Unit	$4,000	$8,000
Payment Level (unless otherwise stated)	70%	50%
Maximum Out-of-Pocket, per Calendar Year		
Individual	$4,500	$10,000
Family Unit	$9,000	$20,000

- The Deductible and Coinsurance are applied to and included in the maximum out-of-pocket amount. Any penalties or non-covered services do not apply towards the maximum-out-pocket amount.

- The In-Network and Out-of-Network Deductible and out-of-pocket amounts do not credit or reduce each other.

- This is an embedded plan.
  - Individual Deductibles are tracked and applied to the individual and the family when an embedded plan is utilized. Once an individual has met the individual Deductible, their claims will be paid at the next level of benefits even though the family Deductible has not been met. Other individuals in the family must continue to pay their individual Deductible amount until either their own individual Deductible is met, or the family Deductible is met, whichever occurs first.
  - Out-of-Pocket amounts are tracked and applied to the individual and the family. Once an individual has met the individual maximum out-of-pocket, their claims will be paid at 100% even though the family maximum out-of-pocket as not been met. Other individuals in the family continue to pay toward their individual maximum out-of-pocket until either their individual maximum is met, or the family maximum is met, whichever occurs first.

CDHP Plan			
Covered Medical Expenses (Subject to Fully-Insured Plan Precertification Requirements, Limitations and Exclusions, unless otherwise stated)	**In-Network Amounts**	**Out-of-Network Amounts**	**Limits**
Acupuncture	70% after deductible	50% after deductible	Limited to 50 visits per Calendar Year
Advanced Imaging – Includes, but not limited to, MRI/MRA/CT/PET	70% after deductible	50% after deductible	
Allergy Services			
Office Visit	70% after deductible	50% after deductible	
Testing/Injections	70% after deductible	50% after deductible	
Ambulance	70% after deductible	70% after in-network deductible	
Ambulatory Surgical Center	70% after deductible	50% after deductible	
Anesthesia	70% after deductible	50% after deductible	
Chiropractic Care (Spinal Manipulations)	70% after deductible	50% after deductible	Limited to 50 visits per Calendar Year
COVID-19 Testing	Covered under your Fully-Insured Plan	Covered under your Fully-Insured Plan	
Dialysis (Outpatient)	70% after deductible	50% after deductible	
Durable Medical Equipment	70% after deductible	50% after deductible	
Hearing Aids	70% after deductible	50% after deductible	
Home Health Care	70% after deductible	50% after deductible	
Hospice Care			
Inpatient/Outpatient Treatment	Covered under your Fully-Insured Plan	50% after deductible	
Family Bereavement Counseling	Covered under your Fully-Insured Plan	50% after deductible	
Hospital			
Inpatient	70% after deductible	50% after deductible	
Outpatient	70% after deductible	50% after deductible	

CDHP Plan			
Covered Medical Expenses (Subject to Fully-Insured Plan Precertification Requirements, Limitations and Exclusions, unless otherwise stated)	**In-Network Amounts**	**Out-of-Network Amounts**	**Limits**
Mental Health/Substance Abuse			
Residential Treatment	70% after deductible	50% after deductible	
Inpatient Treatment	70% after deductible	50% after deductible	
Partial Day Program	70% after deductible	50% after deductible	
Outpatient Physician	70% after deductible	50% after deductible	
Newborn Care	70% after deductible	50% after deductible	
Outpatient Diagnostic X-ray and Lab Services	70% after deductible	50% after deductible	
Outpatient Emergency Services			
Physician/Facility	70% after deductible	70% after in-network deductible	
Physician Services			
Primary Care Office Visit	70% after deductible	50% after deductible	
Specialist Office Visit	70% after deductible	50% after deductible	
Lab, X-rays	70% after deductible	50% after deductible	
Surgery	70% after deductible	50% after deductible	
• Primary Care Providers include: Family Practitioners, General Practitioners, Internists, OBGYNs and Pediatricians. Benefits for Nurse Practitioners and Physician's Assistants are considered PCPs or Specialists based on the Provider they are working under.			
Preventive Care as defined under the Patient Protection and Affordable Care Act of 2010	Covered 100% deductible waived	50% after deductible	
Prosthetics and Orthotics	70% after deductible	50% after deductible	
Skilled Nursing Facility	70% after deductible	50% after deductible	
Temporomandibular Joint Disorder (TMJ)	70% after deductible	50% after deductible	
Therapy (Outpatient) – Rehabilitative & Habilitative			
Autism Therapy	Benefit Based Upon Service Rendered	Benefit Based Upon Service Rendered	
Cognitive Therapy	70% after deductible	50% after deductible	

CDHP Plan			
Covered Medical Expenses (Subject to Fully-Insured Plan Precertification Requirements, Limitations and Exclusions, unless otherwise stated)	**In-Network Amounts**	**Out-of-Network Amounts**	**Limits**
Cardiac Therapy	70% after deductible	50% after deductible	
Massage Therapy	70% after deductible	50% after deductible	
Occupational Therapy	70% after deductible	50% after deductible	
Physical Therapy	70% after deductible	50% after deductible	
Pulmonary Therapy	70% after deductible	50% after deductible	
Speech Therapy	70% after deductible	50% after deductible	
Vision Therapy	70% after deductible	50% after deductible	
Transplants	70% after deductible	50% after deductible	
Travel & Lodging	70% after deductible	50% after deductible	
Urgent Care	70% after deductible	50% after deductible	
Wigs	70% after deductible	50% after deductible	
All Other Covered Services	70% after deductible	50% after deductible	

Prescription Drug Benefits		
Covered Prescription Drug Expenses	**Participating Pharmacy**	
Pharmacy Option: 90-day maximum	**30-day supply**	**90-day supply**
Coinsurance, per prescription or refill, for generic:	30% coinsurance after deductible	30% coinsurance after deductible
Coinsurance, per prescription or refill, for preferred name brands:	30% coinsurance after deductible	30% coinsurance after deductible
Coinsurance, per prescription or refill, for non-preferred name brands:	30% coinsurance after deductible	30% coinsurance after deductible
Maintenance Medications: 90-day maximum	**90-day supply**	
Coinsurance, per prescription or refill, for generic:	20% coinsurance, deductible waived	
Coinsurance, per prescription or refill, for preferred name brands:	20% coinsurance, deductible waived	
Coinsurance, per prescription or refill, for non-preferred name brands:	20% coinsurance, deductible waived	
Mail Order Option: 90-day maximum	**90-day supply**	
Coinsurance, per prescription or refill, for generic:	30% coinsurance after deductible	
Coinsurance, per prescription or refill, for preferred name brands:	30% coinsurance after deductible	
Coinsurance, per prescription or refill, for non-preferred name brands:	30% coinsurance after deductible	
Specialty Drug Option: 30-day maximum	**30-day supply**	
Coinsurance, per prescription or refill, for generic:	30% coinsurance after deductible	
Coinsurance, per prescription or refill, for preferred name brands:	30% coinsurance after deductible	
Coinsurance, per prescription or refill, for non-preferred name brands:	30% coinsurance after deductible	