# Exhibit A
# CITY OF MANCHESTER
# EMPLOYEE BENEFIT PLAN
# SUMMARY OF BENEFITS – LIMITED PLAN
# EFFECTIVE JULY 1, 2023

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.

| Limited Plan | | |
|---|---|---|
| **Type of Expense** | **In-Network Amounts** | **Out-of-Network Amounts** |
| **Embedded Deductible, per Calendar Year** | | |
| Employee Only | $1,800 | $3,600 |
| Employee + Spouse | $2,800 | $5,500 |
| Employee + Children | $2,500 | $4,800 |
| Family Unit | $3,600 | $7,200 |
| **Payment Level (unless otherwise stated)** | 70% | 50% |
| **Maximum Out-of-Pocket, per Calendar Year** | | |
| Employee Only | $4,665 | $13,600 |
| Employee + Spouse | $8,770 | $27,200 |
| Employee + Children | $8,560 | $27,200 |
| Family Unit | $9,330 | $27,200 |

- 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.

| Limited 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: $35 copay then 100%, deductible waived Visits 21 – 50: $55 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 | $35 PCP or $55 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: $35 copay then 100%, deductible waived Visits 21 – 50: $55 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 |
| **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 | |

| Limited 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** |
| **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 | |
| **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 | $35 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 | $200 copay then 100%, deductible waived | $200 copay then 100%, deductible waived | Copay waived if admitted |
| **Physician Services** | | | |
| Primary Care Office Visit | $35 copay then 100%, deductible waived | $55 copay then 100%, deductible waived | |
| Specialist Office Visit | $55 copay then 100%, deductible waived | $80 copay then 100%, deductible waived | |
| Lab, X-rays | 100%, deductible waived | 100%, deductible waived | |
| Surgery | $35 PCP or $55 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 | Covered under your Fully-Insured Plan | Office Services: $50 copay then 100%, deductible waived Outpatient Services: 50% after deductible | |

| Limited 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 | |

| 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: | $14 copay | $28 copay |
| Copayment, per prescription or refill, for preferred name brands: | $60 copay | $120 copay |
| Copayment, per prescription or refill, for non-preferred name brands: | $110 copay | $220 copay |
| **Maintenance Medications: 90-day maximum** | **90-day supply** | |
| Copayment, per prescription or refill, for generic: | $14 copay | |
| Copayment, per prescription or refill, for preferred name brands: | $60 copay | |
| Copayment, per prescription or refill, for non-preferred name brands: | $200 copay | |
| **Specialty Drugs & Mail Order Prescriptions:** Specialty drugs and mail order prescriptions **must** be ordered through your **fully-insured plan.** After you have paid for your specialty order and mail order prescriptions by presenting your fully insured card and then paying any applicable charges, you may submit your fully-insured plan invoices to LHS for reimbursements as follows: | | |
| **Mail Order Option: 90-day maximum** | **90-day supply** | |
| Copayment, per prescription or refill, for generic: | $28 copay | |
| Copayment, per prescription or refill, for preferred name brands: | $120 copay | |
| Copayment, per prescription or refill, for non-preferred name brands: | $220 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 | |

**Important to remember:** Regardless of the above schedule, in all instances where your fully-insured plan waives the deductible or applies a co-payment to a covered expense, this plan will not pay any additional benefits. In instances where you have questions regarding if a medical expense is considered covered or excluded, please refer to your fully-insured plan.

# CITY OF MANCHESTER
# EMPLOYEE BENEFIT PLAN
# SUMMARY OF BENEFITS – LOCAL CDHP PLAN
# EFFECTIVE JULY 1, 2023

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.

| Local 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 | $4,805 | $10,000 |
| Family Unit | $9,610 | $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.

| Local 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 | |

| Local 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 under your Fully-Insured Plan | 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 | |

| Local 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 | |
| **Specialty Drugs & Mail Order Prescriptions:** Specialty drugs and mail order prescriptions **must** be ordered through your **fully-insured plan.** After you have paid for your specialty order and mail order prescriptions by presenting your fully insured card and then paying any applicable charges, you may submit your fully-insured plan invoices to LHS for reimbursements as follows: | | |
| **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 | |

**Important to remember:** Regardless of the above schedule, in all instances where your fully-insured plan waives the deductible or applies a co-payment to a covered expense, this plan will not pay any additional benefits. In instances where you have questions regarding if a medical expense is considered covered or excluded, please refer to your fully-insured plan.