Employee Benefits Study Committee

Suncook Valley Regional Towns Association

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INTRODUCTION

This document is the official report of the Suncook Valley Regional Towns Association (SVRTA), Employee Benefits Study Committee (EBSC). The EBSC was created by the SVRTA in December of 2013.

The rising cost of health, dental and other insurance options for employees continues to increase absorbing a larger portion of the budgets of the seven towns. The provisions of the federal PPACA or Affordable Care Act (ACA) has dramatically impacted the health insurance market. The present rate of cost increase and quality of coverage provided will put the towns in a situation that will result in the imposition of excise taxes under the present law in 2018 for some plans.

The goal of the SVRTA was to study the various options that will allow for effective health care insurance coverage at a reasonable price to the extent possible and avoid the imposition of excise taxes.

The EBSC was charged with the following tasks to accomplish:

1. Study all viable cost effective options available for the provision of health and dental insurance.
2. When studying the options the committee must ensure that the options are in compliance with the provisions of the Affordable Care Act in its present form.
3. Submit a written report with supporting documentation and make a formal presentation to the SVRTA and the respective boards of selectmen. The report shall contain various plan options, how they would be implemented and their respective costs to the towns and their employees.
4. The study must be submitted to the SVRTA no later than October 1st, 2014. It is the intent of the SVRTA to possibly consider changes to the benefits plan that would take effect on January 1st, 2015.
5. It is the intent of the SVRTA for the EBSC to work in conjunction with the Town of Allenstown's EBSC to the extent possible to develop the options.

Committee Members:

Shaun Mulholland- Chairperson, Allenstown Town Administrator

Diane Demers- Vice Chairperson, Allenstown Finance Director

Cindy Baird- Secretary, Allenstown Administrative Assistant

David Jodoin-Pembroke Town Administrator

Jodi Pinard-Chichester Town Administrator

Barbara Clark-Epsom representative

Patty Yoder-Barnstead representative

Gordon Preston-Barnstead Selectman

Michael Williams-Pittsfield Town Administrator

Alyson King-Allenstown Sewer Department representative, Office Assistant

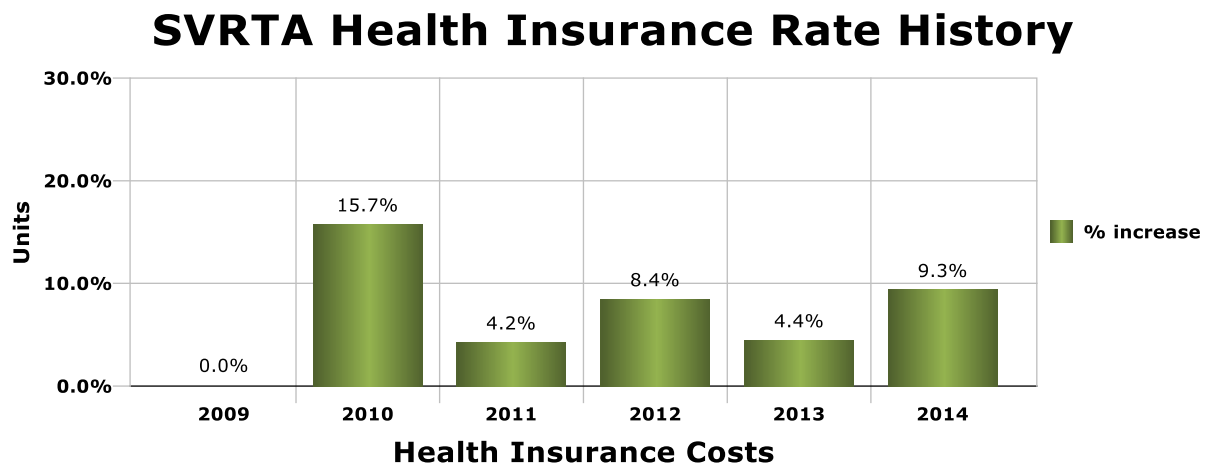
Paul Paquette-Allenstown Police Department representative, Chief of Police

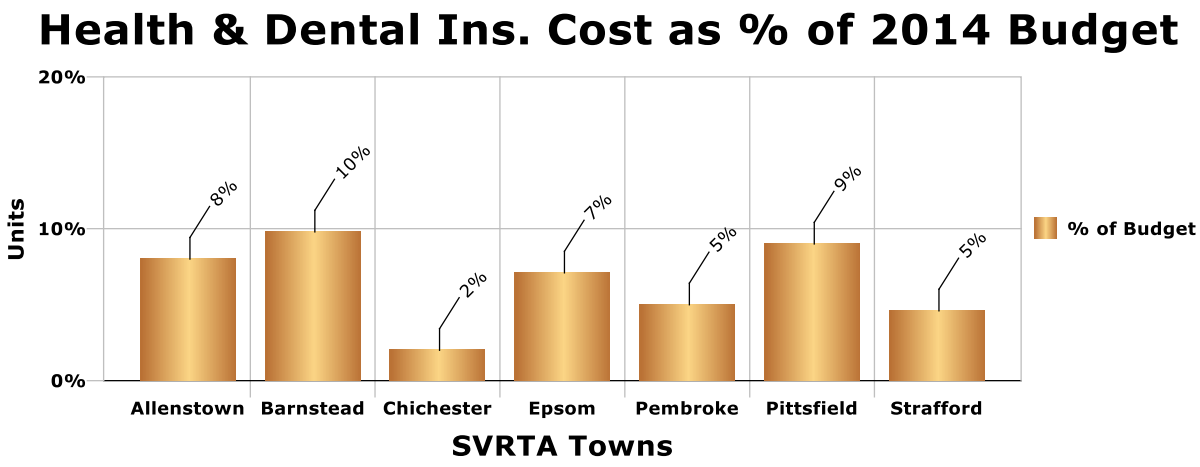
Chad Pelissier-Allenstown Highway Department representative, Truck Driver

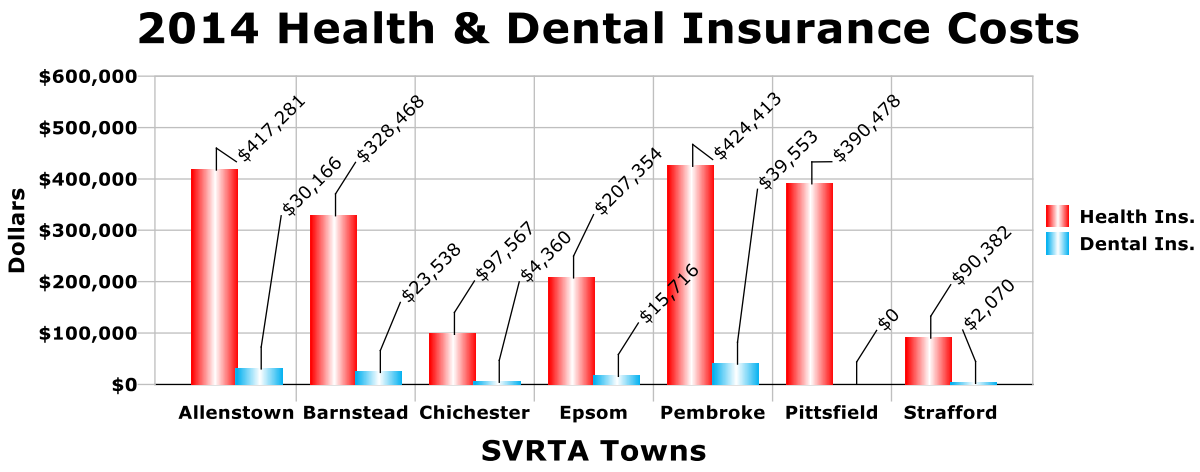
Richard Daughen-Allenstown Fire Department representative, Fire Fighter

EXECUTIVE SUMMARY

The cost to the SVRTA towns to provide health insurance coverage to its employees has increased an average of 7% each year for the last 6 years. The Suncook Valley Regional Town Association has a pool of 134 employees combined.

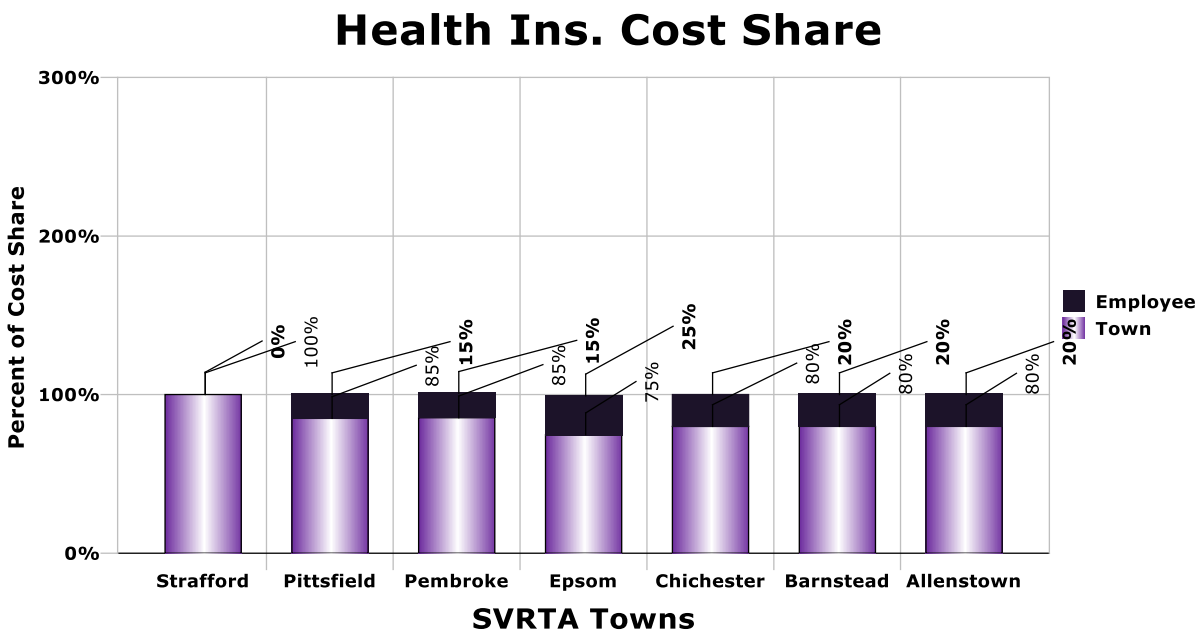






NOTE: Pittsfield does not provide dental insurance.

The Towns provide health and dental insurance for their full time employees. The Towns (except for Strafford) split the cost of the health and dental insurance premium with the employees. Part-time employees who are scheduled to work for more than 30 hours per week may participate in the respective Town's health or dental insurance plan; however the employee pays 100% of the premiums in accordance with provisions of the ACA where applicable. Retirees are also eligible to participate in their Town's health and dental insurance plans in accordance with the provisions of N.H. RSA 100-A:50; however the Towns are not required to contribute toward the cost of these premiums.



Note: Barnstead and Epsom provide 100% of the cost of a single person plan.

The provisions of the ACA in the present federal code will impose a 40% excise tax on certain high-cost health care plans. The tax is scheduled to take effect on 1/1/2018. The tax is imposed on the "excess benefit" provision of Internal Revenue Code 4980I. This is a tax based on the total cost of the premium (both employer and employee) for each covered employee over the annual limit. Only the amount over the limit is subject to the tax. The annual limits are **$10,200** for single coverage and **$27,500** for 2-person and family plans. There is limited guidance from the IRS as to how this law will be enforced. The tax is imposed on the "Coverage Provider". It is unclear whether this is the Town or the insurance provider. There has been some discussion in regards to increasing these threshold amounts based upon actual medical inflation, age and gender adjustments. Starting in 2019 the limits will be indexed for inflation (medical inflation or CPI inflation?).

The health insurance plans of several of the SVRTA communities would be subject to the excise tax at present projected rates. The federal government is relying upon $80 billion in revenue from the excise tax to fund the subsidies for those who qualify. This tax is already in place. It may be difficult for the next administration to repeal this tax, should it wish to, with so many citizens relying upon it for the subsidy. Additionally as more employers change to plans that are not subject to the excise tax the federal government will need to somehow generate the revenue needed for the subsidies. This may very well add to the changing landscape of healthcare in the future.

The primary cost drivers for health insurance are as follows:

1. Increased utilization of services and growing consumer demand

    a. Desire for new expensive treatments
    b. Unhealthy lifestyles and more chronic diseases
    c. Aging population
2. Rising provider prices-increasing physician and hospital prices, nursing salaries and malpractice costs.
3. More expensive new technologies and prescription drugs-significant growth in new drugs, diagnostic tests and treatments.
4. Lack of incentives for providers
    a. Providers lack financial incentives to deliver care more effectively and efficiently.
    b. Consumers lack of incentives to select the most efficient, high quality providers.
5. Cost shifting causing employers to pay substantially more to make up the shortfall
    a. Medicare and Medicaid
    b. Uncompensated care
6. Healthcare reform is causing more cost shifting and added costs.

STUDY METHODOLOGY

The committee requested proposals be submitted from the three quasi-governmental entities that provide health insurance plans to municipalities. The three entities are:

Health Trust (SVRTA present provider)

NH Interlocal Trust

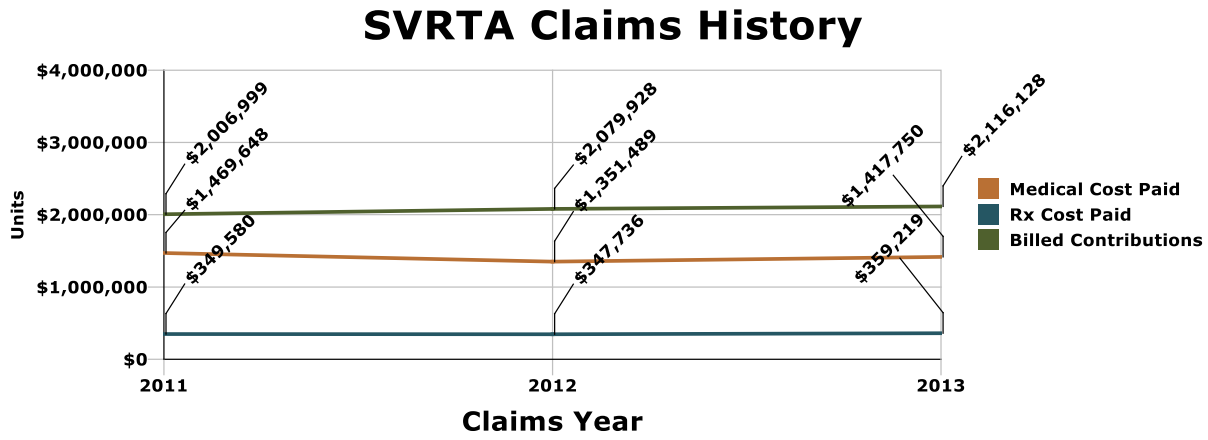
School Care

The three entities determined costs based upon data that we provided containing census data and claims history. The Towns at present have the following health care plans and the annotated number of employees enrolled in each type of plan.

Town	BC2T10+	BC3T10	MTB20	MTB5		Medicare
Allenstown	10S,10F,5T					5
Barnstead			6S,10F,3T			5
Chichester	4S,3F, 1T					
Epsom		3S,2F,1T		5S,1F,2T		2
Pembroke		2S,1T		9S,13F,11T		4
Pittsfield	1S,8F,2T		3F			1
Strafford		3S,2F,2T				

S-Single, F-Family, T-2-Person The BC2T10+ and BC3T10 are Point of Service Plans. The MTB plans are HMO plans.

The SVRTA group claims data for the last three years is detailed below.



Representatives of each of the entities made presentations before the committee. Each one of the entities provide a range of plans that in terms of comparison are slightly different. However the plans of all three entities fall into three general categories.

Point of Service Plan- A health care insurance plan that allows enrollees to seek care from a physician affiliated with the service provider at a fixed co-payment or to choose a nonaffiliated physician and pay more —abbreviation *POS*

Health Maintenance Organization- a health care insurance plan that provides comprehensive health care to voluntarily enrolled individuals and families in a particular geographic area by member physicians with limited referral to outside specialists. – abbreviation *HMO*

High Deductible Health Plan- A plan that features higher deductibles than traditional insurance plans. High deductible health plans (HDHPs) can be combined with a health savings account or a health reimbursement arrangement to allow enrollees to pay for qualified out-of-pocket medical expenses on a pre-tax basis. An HDHP has both a minimum and maximum deductible that must be met to qualify.

2013 Amounts	Self-only coverage	Family coverage
Min. annual deductible	$1,250	$2,500
Max. annual deductible and out of pocket expenses*	$6,250	$12,500

*This limit does not apply to deductibles and expenses for out-of-network services if the plan uses a network of providers. Instead, only deductibles and out-of-pocket expenses for services within the network should be used to figure whether the limit applies.

The committee also explored the three alternative accounts that can be used to partially fund health care. These alternatives are defined by the Internal Revenue Code (Publication 969).

Flexible Spending Accounts- (FSA) allow employees to be pay for qualified medical expenses (IRS Pub. 502). FSAs are usually funded through voluntary payroll deductions. No federal income taxes are withheld from this contribution. Employers may contribute up to $500 per year. The maximum employee contribution cannot exceed $2,500 per year. FSAs have a "use or lose" rule. The Town can allow up to $500 to be carried over into the next year or choose the option of a 2.5 month grace period to utilize the funds. These accounts are not portable and if the employee leaves employment they will no longer have access to the funds.

Health Savings Account- (HSA) is a tax exempt trust that is set up for an individual employee. The account must be set up through the Town and managed by a bank, insurance company or other approved entity. Both employers and employees can contribute to these accounts. Maximum contributions are $3,100 for single coverage and $6,250 for family coverage. The funds can be used only for qualified medical expenses (IRS Pub. 502). You must be covered under a high deductible health plan. The account is portable and can earn interest. Unlike the FSA the funds do not have a "use or lose" rule. HSAs can only be used with a qualified HDHP.

Health Reimbursement Accounts- (HRA) is an employer funded account to be used to pay for qualified medical expenses (IRS Pub. 502). The account is for each individual employee and can be rolled over from one year to the next without penalty. The account stays with the employer when the employee leaves service with the Town. These accounts are managed by a bank, insurance company or other IRS permitted entity.

There are four companies that provide administration of FSAs, HSAs and HRAs for a monthly fee per employee. These companies are;

Benefit Strategies: www.benstrat.com

CGI Employee Benefits Group: www.cgibenefitsgroup.com

Concepts in Benefits, Inc.: www.conceptsinbenefits.com

Group Dynamic, Inc: www.dynamic.com

We contacted all four of these companies to determine what services they provide and at what cost. All four of these companies receive a direct data link with Anthem Blue Cross. They all charge an initial set up fee and a monthly service fee for each employee. When we met with the health insurance plan providers we discovered the following:

HealthTrust- administers an FSA program with no set up fee. There is a monthly fee per employee. They also offer a payment card which works like a credit

card for an additional monthly fee ($75 per year). The Town of Epsom presently provides an option for its employees to utilize an FSA to supplement their health/ dental expenses. Epsom pays the fee for the card. Health Trust does not manage HSAs or HRAs. They recommend that customers coordinate with the four providers listed above.

NH Interlocal Trust- has an arrangement with CGI to manage FSAs, HSAs and HRAs as part of the cost of the insurance premium. In other words, it is built into the premiums of the insurance plan provided.

School Care- manages FSAs, HSAs and HRAs with their own staff internally. The cost of these options is built into the premiums of the insurance plan provided.

We looked at the Concord Beneflex Plan as an example of a "cafeteria style" plan to see the benefits of that concept. The health plan options that some of the SVRTA towns provide offer some options in terms of what plans an employee can participate in. Some SVRTA towns such as Allenstown, Barnstead, Chichester and Strafford only offer one plan. The cafeteria style concept provides some flexibility to employees who might have different needs. These options generally reduce costs to both employees and employers. *See copy of Concord Beneflex Plan*. Individual communities may opt to set an amount for employees to use to purchase one of several health care plans, dental plans, life insurance and short/long term disability insurance. This concept can enhance the level of consumerism that employees develop.

Some communities have chosen to allow buyouts if employees choose not to purchase health insurance through their respective towns. Barnstead and Epsom presently provide a buyout option. Barnstead presently offers $2,500 for a single plan and $3,000 for a 2-person or family plan per year. Epsom offers a $2,000 buyout plan per year. Towns choosing to offer buyouts should consider as a condition of the buyout that the employee certify that they have insurance from another means. This will limit a Town's exposure to the fines under the ACA,which requires employers to provide insurance coverage at a reasonable cost and provides the required coverage.

ANALYSIS OF PLAN TYPES

The Committee reviewed the three plan types (POS,HMO and HDHP) which were offered by the three providers.

- The POS plans had the most expensive premiums with the lowest co-pays and provided the highest level of coverage possible. The Towns of Allenstown and Strafford offer these plans exclusively to their employees. All of the other towns, except for Barnstead, offered POS plans as an option along with other plan options. These plans do little to enhance consumerism the way HMOs and HDHPs do. The cost of the premiums for these plans are between $2,095 and $2,216 per month (2014 plan costs Town of Allenstown). A calculator was used to predict the amount of excise tax that would be levied on these premiums in

2018. Assuming a rate of increase of 6.8% in health insurance costs per year and the same number of employees subscribing to the same plans the Town of Allenstown would be subject to an excise tax of just over $18,000 in 2018.

- The HMO plans offered by the three providers are provided at a lower price. The copays are generally higher. Some of the HMO plans have deductibles . These plans are offered at a lower price as the insurance provider has set agreed upon rates with certain healthcare providers. This along with the higher copays and deductibles entice consumerism on the part of employees who are paying a higher portion of the share of the costs.

For example an employee on a POS plan could go to the Dartmouth Hitchcock Clinic and use their contracted lab for blood work if they chose. If the same employee was on an HMO plan, they would be referred to the Quest lab with whom Anthem has an agreement with. The cost of the lab work is considerably cheaper. The employee could chose to have their lab work done at the Dartmouth Lab however they would have to pay the costs over and above what Anthem would pay for the same lab work to be done at Quest. Both labs are certified to do the same type of lab work.

All of the providers have HMO plan options with deductibles. The deductibles range from $500 to $3,000. Each of the providers has different variations of plan options and costs. See the following example for comparison purposes.

The NH Interlocal Trust Super HMO plan through Harvard Insurance premium costs $1,824 per month for a family plan. The plan has no deductible. They also offer the HMO High plan which as a deductible of $1,000 per family. The premium for this plan is $1,681 or $143 per month less that the Super HMO plan. The savings in premium cost is $1,716. With an 80/20 split (employer/employee) on the payment of the premium the Town saves $1,372. The employee saves $344 on the premium however the employee absorbs the $1,000 deductible, higher prescription costs, a slightly lower copay (from $15 to $10).

Towns, as well as employees (when a ranges of plans are offered), need to consider the costs of the plans, as well as to whom the costs are being shifted. All of the HMO plans proposed by the providers are projected to be below the threshold at which the excise tax would be levied. The same caveats apply in regards to rate of increase of premium costs. This also makes the presumption that the employer would not fund the deductible through an HRA, this will be discussed in greater detail later.

- High Deductible Health Plans are relatively new in the public sector. The high deductible plans differ significantly among the three providers (see benefits comparison spreadsheet). The deductibles range from $1,000 to as much as $10,000 per year. Both Health Trust and NH Interlocal Trust cover in-network costs at 100% once the deductible is met. Routine preventive care is provided at no cost at all times in accordance with the ACA. Generally these deductibles are paid by FSAs, HSAs or HRAs that are managed through the employer. Health

Trust does manage FSA's and recommends one of the third party providers listed in this report to manage HSA's or HRAs. NH Interlocal Trust has an agreement with CGI to provide management of these accounts as an included cost of the premium. School Care manages these accounts through its own organization at no extra charge. There are some caveats and warnings in regards to employers attempting to fund the deductible at 100%. Anthem will only allow the employer to fund at most 50% of the deductible through an HRA or HSA. All of the providers urged caution in regards to an employer funding deductibles. This discourages consumerism which results in higher premium costs as employees are not encouraged to find the lower cost options in the market.

Example- *The Health Trust HMO MTB20 family plan costs $1,707 per month ($20,484 per year). The Health Trust Lumenos 5000 plan costs $1,162 per month ($13,944 per year). This results in a premium reduction of $6,540 (Employer $5,232, Employee $1,308). However the deductible is $10,000. Although preventative care is still provided at no charge to the employee and his family all other medical expenses must be paid by the employee until they reach the $10,000 deductible amount. The employee saves $1,308 on the premium per year; however, they are now exposed to the $10,000 risk depending upon the medical needs of the members of that family.*

This example is the extreme in that the plan discussed above has the highest deductible and the lowest premium cost. All three providers offer lower deductibles. Ratios change and the risk to the employee gets smaller as the cost of the premiums comes closer to the cost of the MTB20 plan, which has no deductible. The HDHPs provide diminished value in terms of coverage with less than appreciable cost savings. The plans are of value in two ways. They shift more costs to the employee and save the employer considerable sums at least in the cost of premiums. If an employee can absorb those risks then HDHPs are of value. However we think those situations are unlikely for the most part. Although the employer may save considerable sums of money on the premiums the cost shifting in essence is a defacto (or can be) pay cut. This would negatively impact a municipality's ability to compete in the job market for many of the positions that are specific to the public sector.

- Prescription Plans are a key component of health insurance coverage. The plans are set up the same in that there are in essence three tiers.

- Generic medications
- Preferred brand-name medications
- Non-Preferred brand-name medications

Most, but not all, have a set copay which the employee is responsible for. The copay may change depending upon whether the medication is purchased directly at a pharmacy (30 day supply) or through a mail service pharmacy (90 day supply).

- Medicare Plans are also offered by all three insurance providers. All three provide Medicare Part A and B for hospital care and doctor visits. All three offer Medicare Part D prescription drug coverage. The programs of all three are very similar and the costs are very comparable across all three. See attached documents.
- Dental Plans are offered by two of the providers (Health Trust and School Care). NH Interlocal Trust does not offer a dental plan at this time. They are in the process of developing a dental plan. The dental plans offered by the two providers are very similar in terms of cost and coverage provided. See attached documents.

RECOMMENDATIONS

The cost of health care will undoubtedly increase in the future. The POS plans under the present provisions of the ACA will result in the Towns paying an excise tax to the federal government. A change in leadership at the federal level could change the face of the ACA. We do know what the law is today. We can only speculate what it might be in the future. It is wise for the SVRTA communities to plan address the impacts of the ACA as they continue to be implemented. Excise taxes will only add to the cost of the health insurance benefits we provide to employees. Additionally we suspect that the prospect of a Town paying a tax to the federal government may not be popular with the citizens of our communities. The SVRTA Employee Benefits Study Committee makes the following recommendations.

1. Offer a range of plans to employees similar to the Concord Beneflex Plan. Most of the Health Trust member customer employees have transitioned to HMO plans and have discontinued the POS plans due to costs.
2. Consider setting a cap as to how much the Town will pay for a health insurance plan. For example, the Town would pay 80% of the cost of the HMO MTB20 plan. The equivalent of that amount of money could also be used to purchase a POS plan if the employee chose to. An example of that for Allenstown would result in the town paying 60% of the premium, with the employee paying the other 40%. If an employee chose a lower cost plan they would still have the same dollar amount to use, which results in a lower employee percentage contribution and a higher employer percentage contribution. *See attached spreadsheet.*
3. Consider offering FSAs to employees. These are funded by pre-tax employee contributions and can be used to pay for deductibles, copays and other uncovered health care costs. Employers could either fund the monthly account management fees or pass them on to employees.
4. Encourage consumerism programs such as the COMPASS program, which is being tested as a pilot by Health Trust and being used by the other providers. Employees receive monetary incentives to shop for lower cost medical providers.

5. Encourage wellness programs to reduce claims by making a healthier workforce. These programs have demonstrated effectiveness. These programs educate employees in regards to unhealthy lifestyles and how to live healthier lifestyles.
6. Excise taxes on health care plans should be passed on to employees for those employees who choose to participate in those higher cost plans.
7. Continue to purchase health insurance through Health Trust. The Health Trust plans offer the most coverage at the lowest cost.
8. Transition to HMO plans for those communities that have not already done so. These plans offer the best coverage at the lowest cost. The MTB20 HMO plan offers the lowest premium for a comparatively high quality health insurance plan. However some of the HMO plans that have deductibles can result in an appreciable cost savings for those employees who can absorb the risk.
9. Transition to lower cost prescription plans with higher copays. This further enhances consumerism by encouraging employees to use generic prescriptions when available.
10. The SVRTA Employee Benefits Study Committee should be a permanent committee that meets when needed to review changes in the health insurance plans, the ACA and other options that may be in the best interest of the SVRTA communities. This report should be updated prior to renewal of future plan contracts.

It is important to note that the proposed recommendations have, to one degree or another have been implemented in some of the SVRTA Towns. The level of cost reduction for any given SVRTA community will depend upon the number of recommended changes that a town implements. Some of the towns have already implemented many of the proposed changes. Those communities will not see dramatic cost reductions. Those communities implementing many of the proposed recommendations for the first time will see higher levels of cost reduction.

2014 POS Health Plan Comparison

Health Trust			Interlocal	School Care
Medical Plan Code	BC2T10+	BC2T20	POS$10 High Harvard Pilgrim	POS Open Access
Prescription Plan Code	R$3/15M$1	R$3/15M$1	$0/$15/$15	
single	$779.46	N/A	$820	
2-person	$1,558.93	N/A	$1,641	
family	$2,104.55	N/A	$2,216	
Prescription Plan Code				RX5/15/35
single				$776.00
2-person				$1,552.50
family				$2,095.50
Prescription Plan Code	RX10/20/45	RX10/20/45		
single	$740.47	$724.42		
2-person	$1,480.94	$1,448.84		
family	$1,999.27	$1,955.93		
Prescription Plan Code	R10/25/40 M10/40/70	R10/25/40 M10/40/70		
single	$716.29	$700.86		
2-person	$1,432.58	$1,401.72		
family	$1,933.99	$1,892.32		
Office Visit Copay	$10	$20	10/ 80% out of network	$10
ER Copay	$50	$100	$50	$50
Urgent Care Copay	$50	$50		$25
Allergy Shots			$5/ 80% out of network	
Mental Health			$10 co pay/ $10 group/80% out of network	$10/ (80% after deductible out of network)
PCP Referred Deductible[1]	N/A	N/A		$10
Self Referred Deductible[2]	$500/$1,500	$250/$500		$10
Chiro Visit Max	25 visits	35 visits	$10 co pay/ $10 group/80% out of network	$10/20 Visits/ (80% after deductible out of network
PT, OT, ST Max	60 visits	60 visits	100%	$10/60 Visits/ (80% after deductible out of network)
Durable Medical Equipment (includes Hearing Aids)	Covered at 80% after $100 deductible	Covered at 80% after $100 deductible	100%/ 80% out of network	Covered at 80%/ (80% after deductible out of network)
$40 eyewear reimbursement	N/A	N/A		
Slice of Life	Included	Included		

1 - Deductible on certain services when provided by or referred by PCP (per person/per family) 2 - Deductible on services accessed outside of the network without a PCP referral (per person/per family)

OV - PCP visit copayment SV - Specialty visit copayment

Prescription Plan Code	R$3/15M$1	RX5/15/35	RX10/20/45	R10/25/40 M10/40/70
Retail Pharmacy Copay (up to 34- day supply)	$3 generic $15 brand	$5 generic $15 preferred brand $35 non-preferred brand	$10 generic $20 preferred brand $45 non-preferred brand	$10 generic $25 preferred brand $40 non-preferred brand
Mail Service Copay (up to 90-day supply)	$1 generic or brand	$5 generic $15 preferred brand $35 non-preferred brand	$10 generic $20 preferred brand $45 non-preferred brand	$10 generic $40 preferred brand $70 non-preferred brand

2014 HMO Health Plan Comparison

Health Trust					Interlocal				School Care
Medical Plan Code	MTB20	MTB15IPDED	MTBSOS20/40 1KDED	HMO High $5 (K8F) Harvard Pilgrim	Super HMO $15 Harvard Pilgrim	HMO High $10 $500 Harvard Pilgrim	HMO LOW $15 $1000 Harvard Pilgrim	HMO $25 LP $1000 Harvard Pilgrim	**HMO Open Access**
Prescription Plan Code	R$3/15M$1	R$3/15M$1	R$3/15M$1		0/15/15 (retail) 0/1/1 (mail)	0/25/40 (retail and mail)	0/25/40 (retail and mail)	0/25/40 (retail and mail)	
single	N/A	N/A	N/A		$ 676.21	$ 622.99	$ 597.66	$ 556.31	
2-person	N/A	N/A	N/A		$ 1,351.92	$ 1,247.03	$ 1,196.30	$ 1,123.46	
family	N/A	N/A	N/A		$ 1,824.01	$ 1,681.11	$ 1,613.25	$ 1,499.12	
Prescription Plan Code									RX5/15/35
single									$693.00
2-person									$1,386.00
family									$1,871.00
Prescription Plan Code	RX10/20/45	RX10/20/45	RX10/20/45						
single	$653.63	$638.61	$530.48						
2-person	$1,307.27	$1,277.23	$1,060.96						
family	$1,764.81	$1,724.26	$1,432.30						
Prescription Plan Code	R10/25/40 M10/40/70	R10/25/40 M10/40/70	R10/25/40 M10/40/70						
single	$632.23	$617.83	$513.09						
2-person	$1,264.47	$1,235.66	$1,026.18						
family	$1,707.03	$1,668.14	$1,385.35						
Office Visit Copay	$20	$15	OV$20/SV$40	$5	$15	$10	$15	$25	$10
ER Copay	$100	$100	$100	$50	$50	$50	$150	$150	$50
MRI Scans				100%	100%	100% after deductible	100% after deductible	100% after deductible	
Maternity Care				100%	100%	100% after deductible	100% after deductible	100% after deductible	
Urgent Care Copay	$50	$50	$50		$25	$25	$75	$75	$25
PCP Referred Deductible[1]	N/A	$500/$1,500	$1,000/$3,000			$500/$1000	$1000/$3000	$1000/$3000	$1,000/$2,000
Inpatient Mental Health and Substance Abuse				100%	100%	100%	100%	100%	
Outpatient Mental Health and Substance Abuse				$5copay/$5 group	$15copay/$10 group	$10copay/$10 group	$15copay/$5 group	$25 copay/$10 group	
Self Referred Deductible[2]	N/A	N/A	N/A						
Chiro Visit Max	12 visits	12 visits	12 visits	$5/12 Visits	$15/unlimited	$10/12 visits	$15/12 Visits	$25/12 Visits	$10/20 Visits
PT, OT, ST Max	60 visits	60 visits	20 visits per therapy	$5/ 40 Visits	$15/unlimited	$10/ 40 Visits	$15/ 25 Visits PT/OT separate 25 visits ST	$25/60 Visits	$10/60 Visits
Skilled Nursing Facility/ Inpatient Rehab				100%/100 visits	100%/100 visits	100%/100 visits	100% after deductible/100 visits	100% after deductible/100 visits	
Home Care				100%	100%	100%	100%	100%	
Allergy Shots				$5	$5	$5	$5	$5	
Durable Medical Equipment (includes Hearing Aids)	Covered at 80%	Covered at 80% after $100 deductible	Covered at 80% after $100 deductible	Covered at 80% respiratory equip 100%	Covered at 80% respiratory equip 100%	Covered at 80% respiratory equip 100%	Covered at 80% after $100 deductible respiratory equip 100%	Covered at 80% after $100 deductible respiratory equip 100%	Covered at 80%
$40 eyewear reimbursement	Benefit available once per year	Benefit available once per year	N/A						
Maximum Out of Pocket				Copays & DME Coinsurance	Copays & DME Coinsurance	$1,00/$3,000 + Rx copay	$2,000/$5,000 + Rx copay	$2,500/$5,000	
Save ON				$10-$75 Rewards	$10-$75 Rewards	10-$75 Reward	$10-$75 Rewards	$10-$75 Rewards	
Slice of Life	Included	Included	Included		customizable wellness reimbursement and incentive programs tailored to fit the needs of the collective				

2014 High Deductible Health Plan Comparison

Health Trust			School Care		Interlocal
Medical Plan Code	Lumenos 2500	Lumenos 5000	Open Access	CDHP	PPO HAS $1500
single	$529.97	$430.48	$641	$606.50	
2-person	$1,059.93	$860.95	$1,282	$1,231	
family	$1,430.91	$1,162.28	$1,731	$1,637.50	
Net Cost after Choice Fund (if eligible) *Subscriber must take the online Health Assessment to be eligible.				250/$500 Deductible $1,000/$2,000 Out of pocket	
Calendar Year Deductible	$2,500/$5,000 (Single Plan / 2-Person or Family Plan)	$5,000/$10,000 (Single Plan / 2-Person or Family Plan)	$250/$500 (Single Plan/ 2-Person or Family Plan)	$1,250/$2,500 (Single Plan/ 2-Person or Family Plan)	
In-Network Coinsurance	Covered at 100% after deductible	Covered at 100% after deductible	Covered at 80% after deductible	Covered at 80% after deductible	Covered at 100% after deductible
Out-of-Network Coinsurance	Covered at 70% after deductible	Covered at 70% after deductible	Covered at 80% after deductible	Covered at 80% after deductible	Covered at 80% after deductible
In-Network Out-of-Pocket Maximum	$2,500/$5,000	$5,000/$10,000	$1,000/$2,000		$1,500/$3,000
Out-of-Network Out-of-Pocket Maximum	$5,000/$10,000	$10,000/$20,000		$2,000/$4,000	$3,000/$6,000
Anthem's Lumenos High Deductible Health Plans cover routine preventive care at 100% when received from a participating provider.					

DISCLAIMER: Monthly rates are based on a minimum of 75% participation of all eligible employees. HealthTrust's medical underwriting guidelines do not allow an employee to have the choice between medical plans that only differ by the accompanying RX plan. An employer is allowed to offer two plans to the same group of employees, one without a deductible and one with a deductible. Active employees and retirees must be offered the same prescription drug coverage. HealthTrust reserves the right to revisit these rates if there is a +/- 10% in enrollment. All deductibles and benefit limits shown are per calendar year. These charts are intended for summary purposes only. Details of coverage are set forth in separate documents, which govern these plans.

Prepared: 12/13/2013

2014 Allenstown's
Health Insurance Cost Analysis

Current Monthly Cost @ 80/20 Cost Share					Current Annual Cost 80/20 Cost Share		
Plan Type	Medical Plan Code	Total Monthly Cost	Town Cost	Employee Cost	Total Annual Cost	Town Share	Employee Share
Prescription Plan Code		R$3/15M$1				80%	20%
single	BC2T10+	$779.46	$ 624	$ 156	$ 9,354	$ 7,483	$ 1,871
2-person		$1,558.93	$ 1,247	$ 312	$ 18,707	$ 14,966	$ 3,741
family		$2,104.55	$ 1,684	$ 421	$ 25,255	$ 20,204	$ 5,051
Prescription Plan Code		R10/25/40 M10/40/70				80%	20%
single	BC2T10+	$716	$ 573	$ 143	$ 8,595	$ 6,876	$ 1,719
2-person		$1433	$ 1,146	$ 287	$ 17,191	$ 13,753	$ 3,438
family		$1934	$ 1,547	$ 387	$ 23,208	$ 18,566	$ 4,642
Prescription Plan Code		R10/25/40 M10/40/70				80%	20%
single	MTB20	$632	$ 506	$ 126	$ 7,587	$ 6,069	$ 1,517
2-person		$1264	$ 1,012	$ 253	$ 15,174	$ 12,139	$ 3,035
family		$1707	$ 1,366	$ 341	$ 20,484	$ 16,387	$ 4,097

Monthly Cost with Diversified Cost Share*					Proposed Annual Cost Share*		
Plan Type	Medical Plan Code	Total Monthly Cost	Town Cost	Employee Cost	Total Annual Cost	Town Share	Employee Share
Prescription Plan Code		R$3/15M$1	Town Cost	Employee Cost		65%	35%
single	BC2T10+	$779.46	$ 506	$ 274	$ 9,354	$ 6,069	$ 3,284
2-person		$1,558.93	$ 1,012	$ 547	$ 18,707	$ 12,139	$ 6,568
family		$2,104.55	$ 1,366	$ 739	$ 25,255	$ 16,387	$ 8,867
Prescription Plan Code		R10/25/40 M10/40/70				71%	29%
single	BC2T10+	$716	$ 506	$ 211	$ 8,595	$ 6,069	$ 2,526
2-person		$1433	$ 1,012	$ 421	$ 17,191	$ 12,139	$ 5,052
family		$1934	$ 1,366	$ 568	$ 23,208	$ 16,387	$ 6,820
Prescription Plan Code		R10/25/40 M10/40/70				80%	20%
single	MTB20	$632	$ 506	$ 126.45	$ 7,587	$ 6,069	$ 1,517
2-person		$1264	$ 1,012	$ 252.89	$ 15,174	$ 12,139	$ 3,035
family		$1707	$ 1,366	$ 341.41	$ 20,484	$ 16,387	$ 4,097

***Proposed Annual Cost Share allows an equivalent dollar amount for 80% of the MTB20 Plan to be used toward BC@T10+ option.**

HealthTrust

February 2014

Excise Tax on High-Cost Employer Health Plans (Cadillac Tax) - Effective 2018 Tax Year

The Excise Tax on High Cost Employer-Sponsored Health Coverage, also known as the "Cadillac Tax", becomes effective in 2018. In addition to being an important revenue raising provision of the Patient Protection and Affordable Care Act (PPACA), the Cadillac Tax is intended to encourage employers, health insurance providers and consumers to control health costs. Please note that this discussion is based solely on the provisions in the PPACA law and much uncertainty remains as we are awaiting further guidance and regulations.

Beginning in 2018, a 40 percent excise tax will be imposed on the excess cost of employer group health plan coverage over certain threshold amounts. The estimated starting thresholds are $10,200 for individual coverage and $27,500 for 2-person or family coverage. Higher thresholds will apply for early retirees (age 55-65) and plans with a majority of employees in high-risk occupations (police and fire). The 2018 thresholds also may be increased depending on actual medical inflation between 2010 and 2018 using a measure that looks to the Federal Employees Health Benefits (FEHB) program and pursuant to an age and gender adjustment. Starting in 2019, the thresholds will be indexed for inflation.

The Cadillac Tax is calculated by comparing the total cost of employer sponsored group health plan coverage for employees and former employees (retirees) to the thresholds discussed above. If the total cost (*which includes total premium paid by both the employer and employee as well as certain contributions to a Health Savings Account (HSA), a Health Reimbursement Account, or a Health Flexible Spending Account*) *exceeds* the annual threshold limits, the "coverage provider" will be responsible to pay a 40% excise tax on *only* the amount exceeding the threshold for each affected employee.

The "coverage provider" for purposes of liability to pay the tax means (i) the insurer for fully insured group health plans, (ii) the employer for HSA plan contributions, and (iii) the plan administrator for self-insured or other employer sponsored group health plan coverage. While it is not clear whether the employer or HealthTrust will be treated as the plan administrator responsible for paying the tax with respect to HealthTrust medical plans, the ultimate liability for the excise tax will rest with the employer either directly or on a pass-through basis. In each case, employers will be responsible for calculating the excess benefit that is subject to the tax with respect to each covered employee or retiree.

We have been providing member groups with the attached Excise Tax Calculator planning tool to assist in determining if you may become subject to the Excise Tax on certain high-cost plans ("Cadillac Tax") under PPACA in 2018. Please note that instructions are included on the first tab of the spreadsheet, however, please call if you have any other questions.

Please specifically note the **Estimated Annual Percentage Increase** factor utilized in the calculator. This factor is intended to estimate how much medical premiums will increase annually from now until 2018. You may want to utilize a different percentage increase factor based on your own past rate adjustments and renewals. There are many variables that will impact future rates and actual percentage increases over time. Using the percentage increase factor, the calculator will project the excise tax amount, if any, per employee per month as well as the estimated total annual excise tax based on the number of employees by membership type.

Over the coming months, HealthTrust will continue to analyze our current medical and prescription drug plan options and evaluate potential lower cost options that may be offered in the future. Should you have any other questions or need additional information, please do not hesitate to your HealthTrust Benefits Advisor.

This healthcare reform material is provided for general informational purposes. It is not intended as and does not constitute legal or tax advice. Questions regarding your specific circumstances should be addressed to your legal, tax or other professional advisers.

Instructions for Excise Tax Calculator

The attached Excise Tax calculator planning tool will assist you in determining if you may become subject to the Excise Tax ("Cadillac Tax") on certain high-cost plans under PPACA in 2018. Instructions are included on the first tab of the spreadsheet. ***This calculator is for illustrative purposes only and is not intended as and does not constitute legal or tax advice; questions regarding your specific circumstances should be addressed to your legal, tax or other professional advisers.***

Select Annual Tab or Monthly Tab
There are two options for calculating the potential tax – Annual or Monthly. The calculator will project the excise tax amount, if any, per employee per month or year by plan type and then provide a **Total Estimated Annual Excise Tax.**

Follow these steps:

1. Estimated Annual Percentage Increase Factor. This factor is intended to estimate how much medical premiums will increase annually from now until 2018. You may want to change this percentage factor based on your own past rate adjustments and renewals. It is important to note that there are many variables that will impact future rates and actual percentage increases over time. Consider that your group's claim experience, current medical trend, and modifications to your benefit plans may have an impact on future increases.

2. Premium amounts. Enter the annual or monthly premium amounts for each of your benefit options by membership type. Premium is the amount that both the employer and employee pay for coverage, *including* any EMPLOYER contributions to Health Savings Accounts (HSAs), Health Reimbursement Arrangements (HRAs) and Healthcare Flexible Spending Accounts (Health FSAs).

3. Enrollment numbers. Enter the number of enrolled employees by membership type – Single, 2-Person, Family; to calculate the overall projected tax amount by membership type.

4. The **Total Estimated Annual Excise Tax** will display automatically**.** Keep in mind that this tool provides only an estimate of the projected tax. Several factors could affect this projection including future changes to the excise tax requirement and final regulations, modifications to benefit plans, and changes to your group's makeup of single, 2 person and family plans.

The purpose of the calculator is to assist in determining if you might become subject to the Excise Tax on High-Cost Employer Health Plans under PPACA. This Workbook is not intended as and does not constitute legal or tax advice. Questions regarding your specific circumstances should be addressed to your legal, tax or other professional advisers.

P:\HealthTrust Operations\Federal\Healthcare Reform\Cadillac Tax\DS Excise Tax Calculator Tool on High Cost Health Plans.xls

Planning for the 40% Excise Tax on High Cost Health Plans in 2018

If the 2018 premium is greater than the numbers below the employer will pay a 40% excise tax* for each affected employee		
Contract Type	Annual PremiumThreshold	Monthly Premium Threshold
1-Person Contrac	$10,200.00	$850.00
2-P or Family Cor	$27,500.00	$2,291.67

* 40% excise tax calculated only on the amount exceeding the threshold. (e.g.,Dollar Difference x .40)

Notes: Police and firefighters, as well as retirees over 55, have higher 2018 annual thresholds of $11,850.00 and $30,950.00.

STEP #1

Enter the ESTIMATED ANNUAL PERCENTAGE INCREASE for these benefits: 6.80%

STEP #2

Enter the current premiums for these benefits in the yellow boxes below:

**Premium is the amount that both the employer and employee pay for coverage, including any EMPLOYER contributions to Health Savings Accounts (HSAs), Health Reimbursement Arrangements (HRAs) and Healthcare Flexible Spending Accounts (Health FSAs).

STEP #3

Enter the Avg # Employees by Membership Type

Projecting 2013 monthly rates that might invoke the excise tax in 2018									
	Projected Monthly Rates								
Renewal Year	Enter Current Monthly Premium** 2014	2015	2016	2017	2018**	Monthy Tax Owed per Employee**	Enter Avg # Employees	Estimated Monthly Excise Tax	Estimated Annual Excise Tax
1-Person		$0.00	$0.00	$0.00	$0.00	No Tax		No Tax	No Tax
2-Person		$0.00	$0.00	$0.00	$0.00	No Tax		No Tax	No Tax
Family		$0.00	$0.00	$0.00	$0.00	No Tax		No Tax	No Tax
							Estimated Annual Total Excise Tax:		$0.00

*Note: If the boxes and the numerals turn to **RED** you will have exceeded the 2018 threshold and the estimated excise tax is shown.*

The purpose of the calculator is to assist in determining if you might become subject to the High Cost Health Plan Excise Tax under PPACA. This Workbook is not intended as and does not constitute legal or tax advice. Questions regarding your specific circumstances should be addressed to your legal, tax or other professional advisers.

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	Projected Monthly Rates								
Renewal Year	Enter Current Monthly Premium** 2014	2015	2016	2017	2018**	Monthy Tax Owed per Employee**	Enter Avg # Employees	Estimated Monthly Excise Tax	Estimated Annual Excise Tax
1-Person	$716.00	$764.69	$816.69	$872.22	$931.53	$32.61	9	$293.52	$3,522.21
2-Person	$1,433.00	$1,530.44	$1,634.51	$1,745.66	$1,864.37	No Tax	9	No Tax	No Tax
Family	$1,934.00	$2,065.51	$2,205.97	$2,355.97	$2,516.18	$89.80	5	$449.02	$5,388.29
							Estimated Annual Total Excise Tax:		$8,910.49

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	Projected Monthly Rates								
Renewal Year	Enter Current Monthly Premium** 2014	2015	2016	2017	2018**	Monthy Tax Owed per Employee**	Enter Avg # Employees	Estimated Monthly Excise Tax	Estimated Annual Excise Tax
1-Person	$779.46	$832.46	$889.07	$949.53	$1,014.10	$65.64	9	$590.74	$7,088.92
2-Person	$1,558.93	$1,664.94	$1,778.15	$1,899.07	$2,028.20	No Tax	9	No Tax	No Tax
Family	$2,104.55	$2,247.66	$2,400.50	$2,563.73	$2,738.07	$178.56	5	$892.80	$10,713.64
							Estimated Annual Total Excise Tax:		$17,802.56

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Projecting 2013 monthly rates that might invoke the excise tax in 2018

	Projected Monthly Rates								
Renewal Yea	Enter Current Monthly Premium** 2014	2015	2016	2017	2018**	Monthy Tax Owed per Employee**	Enter Avg # Employees	Estimated Monthly Excise Tax	Estimated Annual Excise Tax
1-Person	$632.00	$674.98	$720.87	$769.89	$822.25	No Tax	9	No Tax	No Tax
2-Person	$1,264.00	$1,349.95	$1,441.75	$1,539.79	$1,644.49	No Tax	9	No Tax	No Tax
Family	$1,707.00	$1,823.08	$1,947.05	$2,079.44	$2,220.85	No Tax	5	No Tax	No Tax
							Estimated Annual Total Excise T		$0.00

*Note: If the boxes and the numerals turn to **RED** you will have exceeded the 2018 threshold and the estimated excise tax is*

The purpose of the calculator is to assist in determining if you might become subject to the High Cost Health Plan Excise Tax under PPACA. This Workbook is not intended as and does not constitute legal or tax advice. Questions regarding your specific circumstances should be addressed to your legal, tax or other professional advisers.

HEALTHTRUST

BENEFITS OVERVIEW

CARE • QUALITY • COMMITMENT • VALUE

WELCOME TO HEALTHTRUST!

HealthTrust is a nonprofit risk pool that provides high quality, cost-effective employee benefits and health education programs to the public sector exclusively. We serve more than 75,000 New Hampshire employees, retirees and their family members while reducing costs through pooling strategies and a focus on preventive healthcare. Our more than 400 Member groups include municipalities, counties, school districts, and quasi-governmental entities. We provide plans, programs and services to school teachers and principals, firefighters, police officers, public works employees, office workers and many other puhlic sector professionals in New Hampshire.

HealthTrust is governed by a dedicated, active Board of Directors including locally elected or appointed officials and employees. As members of the public sector themselves, these volunteer board members bring a wealth of experience working in local governments and school districts and they have a unique understanding of Members' and enrollees' needs. Every decision made by the Board is rooted in service to the public sector.

In 2014, HealthTrust celebrates our 30th year serving the benefit needs of the New Hampshire public sector through innovative plans and services that allow our Members to keep their employees, their families, and retirees healthy and productive. Over those three decades, our plans, programs and services have continually evolved to meet our Members' and enrollees' changing needs. In this overview, we are excited to update you on the comprehensive array of employee benefits that HealthTrust offers, including:

- High quality medical and dental coverage
- Prescription drug coverage
- Effective health management/wellness programs
- Life, long-term and short-term disability coverage
- Flexible Spending Accounts
- A comprehensive employee assistance program
- Transition and survivor care programs

We welcome your questions and feedback. Our Enrollee Services department delivers expertise with a human touch. Calls are handled by people who work right in our office in Concord, New Hampshire, who understand the details of your plan and can answer your questions knowledgably. Together we can make the next 30 years – and beyond – healthy, productive years for New Hampshire's public employees.

This overview provides general information about medical plan options currently available through HealthTrust. You will receive a plan certificate and cost-sharing schedule, specific to your medical plan, upon enrollment.

The information included herein may change upon the sole discretion of HealthTrust and without prior notice.

OUR MISSION

To provide high quality, cost-effective employee benefit products and services for public employers and employees in New Hampshire in order to reduce costs through pooling strategies with a commitment to education, health promotion and disease prevention.

PLAN OVERVIEW

Understanding Medical Plan Basics

Upon enrollment into any HealthTrust medical plan, enrollees will receive a plan certificate of coverage and cost-sharing schedule. Always refer to these first for your plan's specific details. The following is general information about the medical plan options available through HealthTrust.

All HealthTrust plans provide the following benefits.

Comprehensive Features. These include:

- An extensive provider network.
- Physician office visits that are covered after a reasonable copayment—without any claim forms.
- Medical and surgical care.
- Inpatient hospital care.
- Preventive services coverage, such as routine physical examinations and immunizations (covered in full).
- Worldwide coverage for emergency and urgently needed care.

Comprehensive Prescription Drug Coverage. All medical plans include prescription drug benefits that support your overall health, treat illness or chronic disease and manage pain.

- **Short-Term Prescriptions:** Enrollees in a *Matthew Thornton Blue*℠ Health Maintenance Organization (HMO) or *BlueChoice*® Point-of-Service (POS) plan receive a prescription drug card through CVS Caremark for purchasing short-term prescriptions at a retail pharmacy.

A copy of the *Your Personal Prescription Benefit Program* summary of specific prescription drug benefits, will be provided upon

You may purchase up to a 34-day supply of short-term medication at a retail pharmacy for one copayment.

Indemnity plan enrollees have access to Anthem Blue Cross and Blue Shield's (BCBS) prescription drug benefit, and use their medical plan ID card for filling short-term prescriptions at the pharmacy.

- **Long-Term Prescriptions:** All enrollees have access to the *CVS Caremark Mail Service Program*. Convenient and easy to use, the mail service program offers up to a 90-day supply of long-term or maintenance medication for one copayment.

Coverage While Traveling. When you need care while traveling, you can be assured that you'll receive the same level of benefits that you would at home when you obtain care from any Anthem BCBS network provider.

Managed Care

All of the medical plan options available to you include managed care features. Managed care ensures that you receive the appropriate care at the time you need it; managed care also works to improve the quality of that care. An indemnity plan with managed care requirements requires you to take a more active role in participating in your healthcare. It is your responsibility to ensure that you abide by the required managed care guidelines when you receive certain services from providers who do not participate in the Anthem BCBS network or practice outside of New Hampshire.

Matthew Thornton Blue HMO

By managing enrollees' total healthcare within a network and emphasizing preventive care, an HMO is easy-to-use and generally offers the least in out-of-pocket costs. A primary care provider (PCP) selected from the network coordinates the majority of your care, ensuring consistency and continuity of care.

Selecting a PCP. A PCP is considered the main source for all healthcare, including referrals and claims processing. They are, generally speaking, the person seen first for all your medical care. At the time of your plan enrollment one PCP can be chosen for your entire family (such as a family or general practitioner), or different PCPs can be selected for each person (such as a pediatrician for children).

To find a PCP, log onto ***www.healthtrustnh.org*** and click on the **Resources** tab. Go to Provider Directories>Medical Plan.

To view a listing of all Anthem PCPs (as of the date shown), click on the **Anthem BlueChoice (POS) and Matthew Thornton Blue (HMO) Participating Primary Care Provider (PCP) List.**

To look up a PCP on Anthem's website, click on the **Anthem Blue Cross and Blue Shield Provider Directory** link. Be sure to select "Family/General Practice, Internal Med" or "Pediatrician" in the Specialty field in Step 2. Click on the **More options: sub-specialty, patient acceptance, PCP** bar and click the "Able to serve as a Primary Care Physician (PCP)" box.

Coordinated Care. While your PCP coordinates most care, there are times when another specialist, healthcare professional or hospital may be required. In these cases, your PCP will develop a treatment plan, refer care to an appropriate medical professional and make sure care is appropriate and medically necessary. Remember that *your PCP must provide, authorize or arrange for medical care—otherwise, care received without a referral is not covered.* There are exceptions. While routine OB/GYN services, maternity care, routine vision care and chiropractic services do not require PCP approval, a network provider must be utilized to receive benefits.

Emergency/Urgent Care. An *emergency* is a sudden condition that could jeopardize life or well-being if medical treatment is delayed. Examples include possible heart attacks, broken bones and convulsions. In an emergency, go *to your nearest emergency room and notify your PCP within 24 hours of receiving treatment.*

Urgent care refers to medical conditions that are not life- or limb-threatening bur require prompt medical attention. Examples include high fevers, cuts and sprains. To receive the highest level of benefits in an urgent care situation, do the following:

- Call your PCP, regardless of the time of night or day.
- Explain the problem to the doctor or nurse.
- Get instructions on how to proceed.

Site of Service

Built on an HMO platform, the Matthew Thornton Blue℠ Site of Service plans follow the same guidelines for accessing care, utilizing a specific network of providers and obtainiug PCP referral for specialty care. The Access Blue New England℠ Site of Service plans utilize a specific network of providers but allow individuals to access care directly from any provider in the network. The Site of Service plans are designed to help reduce or moderate the cost of healthcare while also rewarding enrollees for accessing care in the most cost-effective locations.

Site of Service plans offer comprehensive coverage with competitive rates. And, although the Site of Service plans include a deductible for the most costly care – inpatient services, outpatient surgical treatment, high cost diagnostics and laboratory tests – enrollees are provided with an alternative that reduces their out-of-pocket costs when they choose a lower-cost independent laboratory or ambulatory surgery center to receive services.

- By choosing an independent laboratory for care, an individual can eliminate the deductible for laboratory services; therefore, the plan pays 100 percent of covered laboratory expenses. Independent labs provide the same level of quality and offer the same types of services as other outpatient labs, but at much reduced rates.
- An ambulatory surgery center provides a wide range of same-day surgical services, such as tonsillectomy or knee arthroscopy. The cost for a routine outpatient procedure is limited to a copayment with a Site of Service plan when an ambulatory surgical center is used for outpatient surgical treatment.

While the plans allow enrollees to receive care anywhere within the network, enrollees are encouraged to utilize more cost-effective facilities. When they do, they lower their contribution to the cost of their care, as well as reducing the overall cost of that care.

BlueChoice POS Plans

BlueChoice POS Plans let you take advantage of many attractive features that combine the freedom of a traditional plan with the cost savings of an HMO. Each time you need care, you may choose to see your PCP or visit another provider, which may increase the cost of your care.

Selecting a PCP. A PCP is considered the main source for all medical care, including referrals and claims processing. They are, generally speaking, the person seen first for all your medical care. One PCP can be chosen for your entire family (such as a family or general practitioner), or different PCPs can be selected for each person (such as a pediatrician for children).

How *BlueChoice* Works. Each time you need care, you decide whether to see your PCP or visit another provider—inside or outside of the *BlueChoice* network. Your choice determines how your care is covered:

1. *PCP-referred benefits.* When your PCP provides or coordinates your care, you pay the least in out-of-pocket expenses. For some services (such as preventive physical exams and vision exams), you receive 100 percent coverage. For other services (such as hospitalizations and CT scans), your care is covered at the highest level for in-network care.

2. *Self-referred benefits.* If you choose to see a doctor without first seeing your PCP, or without a referral, you're still covered. Generally, if you choose to self-refer care directly from a *BlueChoice* participating provider, you have the least amount of out-of-pocket expenses associated with self-referred care. For care that is accessed directly from a provider who does not participate in the *BlueChoice* network, the cost of care is generally shared between you and the plan. You typically are responsible for a calendar-year deductible, as well as for a percentage of the cost of care up to a maximum out-of-pocket expense. Once you reach the maximum out-of-pocket expense, care is covered at 100 percent of the maximum allowable benefit* for the remainder of the calendar year. This option offers you the most freedom and control, and you still

* A "maximum allowable benefit" is the amount that a medical plan allows for a particular service in your geographical area.

receive substantial benefits. However, you share in more of the cost for your healthcare services.

Emergency/Urgent Care. For emergency and urgent care situations, follow the same procedures previously outlined under the ***Matthew Thornton Blue*** **HMO** section of this booklet on page 5.

Indemnity Plans

Indemnity, or traditional fee-for-service plans, provide freedom of choice when accessing care. Enrollees may choose their own doctors, arrange for covered medically necessary specialty care and select a hospital that meets their individual needs.

Indemnity plans are traditional medical plans that pay for covered medical services regardless of your choice of physician or hospital. You are covered for preventive care, routine doctor visits, hospitalization, prescriptions, surgery and more. Indemnity plans cover most care at 80 percent after you meet a calendar-year deductible. When you reach a calendar-year out-of-pocket maximum, the plan pays 100 percent of eligible expenses for the remainder of the calendar year up to the maximum allowable benefit.*

Provided that you use a network provider, preventive care—such as routine exams, PSA screenings, annual gynecological exams, including mammograms and Pap tests and immunizations—is covered at 100 percent, through network providers

Accessing Care. When you or a covered family member needs care, simply go to the doctor or hospital of your choice. While indemnity plans do not require you to stay in a network, there are certain advantages to using an Anthem BCBS network provider:

- *No excess charges.* All indemnity plans pay healthcare claims based on your area's prevailing rates. Some doctors charge more than the prevailing rate. Anthem BCBS network providers agree to accept the plan's maximum allowable benefit.* This means there aren't any excess charges that you are responsible for.
- *No claim forms or bills to submit.* Many providers ask you to pay up-front, then submit a claim for reimbursement. Anthem BCBS network providers agree to bill their services directly, which means you won't have to submit claim forms. Instead, you're billed only for your share of any covered expenses.

Preferred Provider Organization (PPO) Plan

The PPO medical plan allows the flexibility of accessing care from any network physician at any time, as well as the ability to directly access care from non-network providers.

Accessing Care. Selecting a PCP is not required for access to any care; however, lower out-of-pocket expenses are realized when using a network physician.

A PPO plan also allows specialty care to be obtained without a referral, but using a network specialist means less out-of-pocket costs. Preventive or routine care—typically provided during an office visit—is covered at 100 percent through network providers. For more complex and expensive care like CT scans, MRIs or care received in an outpatient setting, you'd pay more for the cost of the care but still be protected from substantial out-of-pocket expense when you see a network provider.

When receiving out-of-network care, you share more in the cost of your care. You'd be responsible for more deductible and coinsurance expenses than you would from a network provider. However, you'd still have the security of an annual out-of-pocket maximum. Remember, though, that where you elect to receive your care—and who you choose to provide it—is your choice.

Lumenos® Preferred Blue

Lumenos is HealthTrust's consumer driven healthcare plan. It is a traditional high deductible health plan that is available to be used alone or in combination with a tax-favored Health Savings Account (HSA).

As a traditional plan, the Lumenos plan is a high deductible health plan that offers enrollees more choice and control over how and where their healthcare dollars are spent. Individuals can access care from any provider, although utilizing a Lumenos

What's Important?

The cost of your medical plan is generally shared by you and your employer. Employee and employer contributions are not subject to federal income or Social Security taxes and generally are deducted from an employee's paycheck. Your contributions, as well as those of your employer, can be considerable. After reviewing your available medical plan options, consider the following to decide what is most important to you:

- Is my doctor in the network? What about my gynecologist or my child's pediatrician?
- How do we normally access care? Does our PCP provide and arrange for our care, or do we want to directly access care from providers outside of the network?
- How important is my contribution towards care? Can I absorb a higher office visit or emergency room copayment if my monthly contributions are reduced?
- What type of medications do we take? Can we use generic medication?
- Do any of the plans provide programs for asthma, diabetes or other chronic conditions?
- Will I be impacted by any plan limitations?

While you can't predict all your future healthcare needs, it makes sense to consider the services you expect to need in the coming year and then evaluate your options. Once you've identified your needs, reviewing the overview of plans your employer has selected will be much more meaningful.

participating provider reduces out-of-pocket costs. No matter the type of care — prescription drugs, inpatient care, lab expenses — all care is applied toward the plan's deductible. Once rhe deductible has been met, no additional out-of-pocket costs are required for the remainder of the year when using a Lumenos participating provider; covered services are paid in full. Care is still covered when using a non-participating provider but enrollees pay a percentage—30 percent—toward the cost of care.

In addition, the Lumenos plan encourages individuals to obtain regular preventive care. Preventive care under the plan is not subject to the deductible and is paid at 100 percent.

The Lumenos plan has been designed as a high deductible health plan qualified to be combined with an HSA. HSAs are tax-favored accounts that are funded with tax-free contributions made by an employer, employee or a combination of both. Funds can be drawn from the account to pay for medical care that is subject to the plan's deductible. Balances remaining at the end of a plan year are allowed to roll over from one year to the next to pay for future healthcare needs, including healthcare coverage in retirement.

Using Your Benefits

Know your benefits: Does your plan require a copayment or deductible/coinsurance? Be prepared to pay these amounts when accessing care.

Use your ID card: Be sure to provide a copy of your most recent ID card to your provider. Your ID card contains important identifying information that will be used to submit your claim.

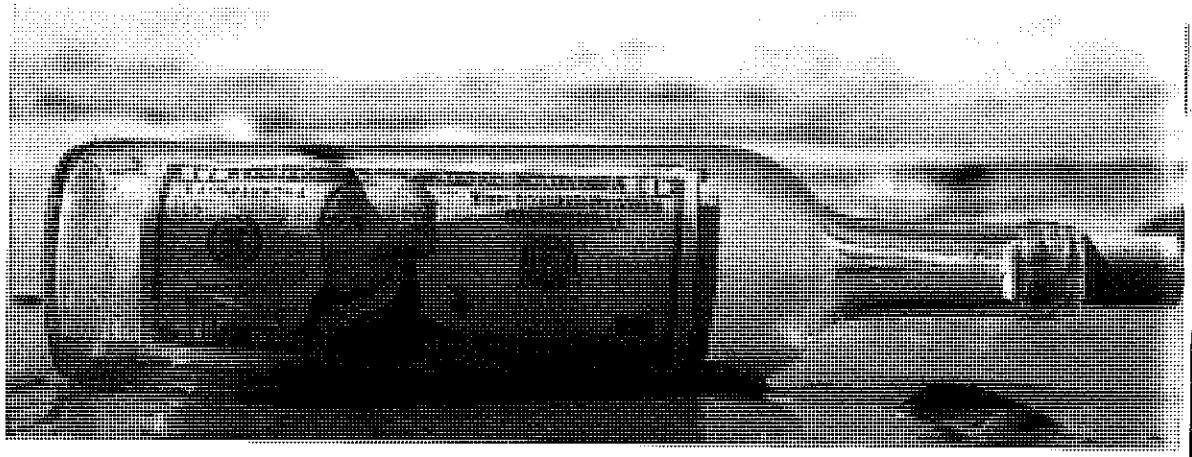
Use network providers in order to limit your out-of-pocket expenses.

Use the emergency room only in an emergency when an illness is limb- or life-threatening. Emergency care is expensive and unnecessary for routine care/non-emergency care.

Keep everyone up-to-date by notifying both your employer and your plan of any changes to the following: address, coverage status, dependent eligibility or important life events like marriage or birth.

Vision Care Discount Program

You and your family can access quality, discounted eye care services through EyeMed Vision Care. Its network of more than 35,000 providers nationwide includes private practicing optometrists, ophthalmologists, opticians and leading optical retailers like Target Optical, LensCrafters and Pearl Vision. Enrollment in the vision care discount program is automatic once you are enrolled in a HealthTrust–sponsored medical plan or dental plan. Simply tell your provider that you participate in the EyeMed discount plan and show your Anthem ID card and/or Delta Dental ID card. For more information regarding the specific discounts, visit *www.anthem.com*, *www.nedelta.com*, or *www.eyemedvisioncare.com*.



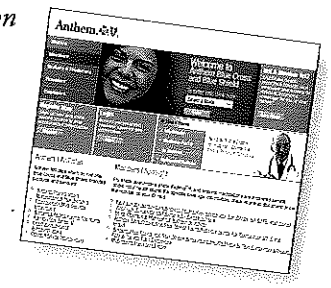
INCENTIVE PROGRAM

Because healthcare represents one of the most significant costs faced today, we all have a responsibility to help keep these costs under control. One way to assist is to monitor your provider bills and processed claims statements to ensure billing accuracy. You can do this by requesting and reviewing an *Explanation of Benefits** from Anthem BCBS, or by accessing your claims information online through the MyAnthem™ section of ***www.anthem.com.***

With HealthTrust's Incentive Program, you may be eligible to receive 50 percent of the savings for each claim error that is identified and corrected—up to $1,000.

Here are steps to take for ensuring proper billing and claims processing:

1. Each time you receive medical care, obtain and study your itemized hospital/doctor bill or statement of services. Check for duplicate services or services not received.
2. Visit ***www.anthem.com.*** Login the Member Login box to access your claims information on Anthem's secure site. Click on the "Claims" tab to view and print claims Anthem has processed. Review and compare the online claims information—or the Anthem BCBS *Explanation of Benefits*—to the bill or statement of services from the provider. The following questions are just a few examples of what to consider:



   a. Did you receive all the medical services you were billed for?
   b. Did Anthem BCBS pay for any services you did not actually receive?
   c. Did you have an outpatient procedure that was billed as an inpatient stay?
3. If you do find an error or discrepancy, report it to Anthem BCBS by calling the "Member Services" toll-free phone number listed on the back of your medical plan ID card. You can also write to: Anthem Blue Cross and Blue Shield, Claims Department, PO Box 533, North Haven, CT 06473-0533. Anthem BCBS will investigate the discrepancy and, when appropriate, reprocess the claim.
4. Once the claim is reprocessed, submit a copy of both the original and corrected *Explanation of Benefits,* or the printed claims payment from MyAnthem, plus a completed *HealthTrust Incentive Program Reimbursement Request Form*** to: HealthTrust Incentive Program, PO Box 617, Concord, NH, 03302.

NOTE: *You may be mailed Internal Revenue Service Form 1099 for any paid incentive received that is not considered tax-exempt.*

*Anthem BCBS only provides *Explanation of Benefits* forms for services that require an employee cost share beyond a copayment. However, you can log into MyAnthem anytime to review all of your claims history or request an *Explanation of Benefits.*

Downloadable from the "Resources/Printable Forms" section of ***www.healthtrustnh.org* or call **800.527.5001** to request a form.

EMPLOYEE ASSISTANCE PROGRAM

Staying healthy means more than just following doctors' orders. Sometimes you need help with the day-to-day issues that can cause stress, worry and simply wear you out mentally and physically. That's why HealthTrust offers you and your covered family members our *Life Resources - Employee Assistance Program* (EAP), provided in partnership with Health Resources, an AllOne company. The EAP offers HealthTrust enrollees, retirees, and covered family members wide-ranging services including...

Counseling. Regardless of the issue you're facing – anxiety, depression, substance abuse, parent/child conflict, caregiver srress or other emotional concern – the EAP provides up to six free telephone counseling sessions per issue. If you prefer to talk to a behavioral health provider in person, we can locate a licensed counselor who has experience helping people with problems similar to those you are facing.

Legal Advice. Whether you need help with divorce or custody issues, preparing a will, real estate or landlord/tenant problems, or other legal issue (excluding job-related and criminal-related concerns), the EAP can help. For each legal issue, the EAP offers you one free 30-minute office or telephone consultation with an experienced attorney. If you want to continue to work with that attorney, you receive 25 percent off the attorney's hourly fee.

Financial Consultations. Need help preparing your taxes? Want expert advice on the best way to resolve your debt? Are you weighing your options for saving for college or retirement? For these and other financial issues you can receive a free 30-to-60-minute telephone consultation with a financial planner or a certified public accountant.

Additional Resources: The EAP can refer you to the people who can help your life run more smoothly, whether you need to find a caregiver for your child or aging parent, a pet sitter for your Labrador retriever, a plumber, an electrician, or any other vital assistance.

Information and Training: You and your covered family members can use the AllOne website to explore college options with your teenager, research a disease, calculate your mortgage payments, assess your relationship commitment readiness or any number of other issues. The website provides over 5,000 regularly updated articles, over 90 online training programs and a broad range of self-assessment tools to guide you in making healthy lifestyle choices and decision making. Visit ***www.allonehealtheap.com,*** and type in the username: **healthtrust** and the password: **member.**

These and other services are available free of charge to HealthTrust enrollees, retirees and covered family members. For more information or to take advantage of these services, contact Health Resources directly at 800.759.8122 (TTY users please use Relay) or HealthTrust Enrollee Services at 800.527.5001.

SLICE OF LIFE PROGRAM

A comprehensive medical plan goes beyond providing coverage when health issues occur; it also aims to prevent health problems through education and by encouraging smart lifestyle choices. HealthTrust's *Slice of Life* health management program is designed to help you and your covered family members assess your current health, set goals to improve your health, and then take steps to achieve those goals.

Health Assessment: HealthTrust partners with Onlife Health to offer you and your eligible family members a chance to fill out a Health Assessment (HA) online (***www.onlifehealth.com***) and receive a personal wellness report that identifies your health risks and helps you set goals to reduce those risks. The HA is completely confidential and takes only about 10 to 15 minutes to fill out. Completing your HA earns you a reward and makes you eligible to participate in all *Slice of Life* programs to earn more rewards and to get and stay healthy.

Biometric Health Screenings: Studies show that "knowing your numbers" – certain important measures of your health – is vital to improving your health. That's why HealthTrust partners with Occupational Health and Wellness Management (OHWM) to offer biometric health screenings free of charge to you and your covered family members. OHWM medical professionals will determine your weight, body mass index (BMI), waist circumference, blood pressure, blood sugar, and total cholesterol, HDL and ratio, discuss your results with you and help you plan a strategy to improve them, if necessary. You can also opt to complete your biometric health screening with your own primary care provider. If you have filled out your HA, having a biometric health screening earns you a reward. For details, visit ***www.healthtrustnh.org***.

Health Awareness Program: Once you have completed your HA, you and your covered family members can receive money back for taking health and safety classes through our *Health Awareness Program*. Classes covered include exercise classes, CPR training, stress-reduction, nutritional counseling, parenting and childbirth instruction, diabetes education, and more.

Life Points Incentive Program: Receive Life Points for making smart choices such as having screening exams and annual check-ups, consulting a health coach, attending a HealthTrust health and safety workshop, or logging on to ***www.onlifehealth.com*** to use health trackers to record your physical activity, tobacco use, food intake, and more. Life Points can be used to earn cash rewards and raffle entries.

Health Coaching and Self-Directed Programs: Staying motivated after you decide to make a lifestyle change can be the trickiest part of improving your health for the long-term. The health coaches affiliated with our partner, Onlife Health, can help. Whether you want to stop smoking, lose weight, reduce stress, or boost your health in other ways, connecting with a health coach can help you make smart choices and stick with them. Prefer to go it alone? Try one of Onlife Health's **Onmytime** self-directed programs. They provide activities and strategies for success and trackers so you can monitor your progress, but you set the pace. For more information about both services, visit ***www.onlifehealth.com***.

This is a brief overview of the *Slice of Life* program. For a more detailed description of the *Slice of Life* program offerings, visit our website at ***www.healthtrustnh.org*** and/or refer to your Activation Kit.

HealthTrust

Anthem BlueCross BlueShield

BlueChoice®
Cost Sharing Schedule

This Cost Sharing Schedule is an important part of Your Subscriber Certificate and is an outline of Your coverage. Do not rely on this outline alone. Keep this schedule with Your Certificate because it contains important information about coverage and limitations. Please read Your Subscriber Certificate carefully as important terms and limitations apply.

Cost Sharing Summary	PCP-Referred Benefits	Self-Referred Benefits*
	YOUR COST	
Visit Copayment Applies each time You visit Your Primary Care Provider (PCP) or Network obstetrical/gynecological specialist.	$10 per visit	not applicable
Specialty Visit Copayment Applies each time You visit a specialist. This Copayment also applies each time You visit a Network Physician at a Network Walk-In Center for diagnosis, care and treatment of an illness or injury.	$10 per visit	
Emergency Room Copayment	$50 per visit	
Urgent Care Facility Copayment Applies each time You visit a licensed hospital's Network urgent care facility for diagnosis, care and treatment of an illness or injury.	$50 per visit	not applicable
Standard Deductible	not applicable	$500 per Member, per year $1,500 per family, per year
Standard Coinsurance	not applicable	30%
Coinsurance Maximum	not applicable	$1,000 per Member, per year $3,000 per family, per year
Durable Medical Equipment, Medical Supplies and Prosthetics **Deductible** **Coinsurance**	 $100 per Member, per year 20%	 $100 per Member, per year 50%
Out-of-Pocket Limit** Includes all Deductibles, Coinsurance, and Copayments You pay during a year. It does not include Your premium, penalties, out-of-network expenses, amounts over the Maximum Allowable Benefit or charges for noncovered services.	$6,350 per Member, per year $12,700 per family, per year	not applicable
Inpatient Precertification Penalty	N/A	$500

*Benefits are limited to the Maximum Allowable Benefit (MAB). Under Out-of-Network Benefits, You may be responsible for paying the difference between the MAB and charge. Please see Section 2 of Your Subscriber Certificate for details. Self-referred care may require preauthorization/precertification from Anthem. Please refer to Your Subscriber Certificate for details.

**Once the Out-of-Pocket Limit is satisfied, You will not have to pay additional Deductibles, Coinsurance, or Copayments for the rest of the year.

Please note that throughout this schedule any reference to year means calendar year.

Coverage Outline	PCP-Referred Benefits	Self-Referred Benefits*
	YOUR COST	
Medical/Surgical Care		
I. Inpatient Services		
In a Short Term General Hospital (Facility charges for medical, surgical and maternity admissions)	You pay $0	Standard Deductible and Coinsurance, plus any balances
In a Skilled Nursing Facility (Facility charges) Up to 100 Inpatient days per Member, per year†		
In a Physical Rehabilitation Facility (Facility charges) Up to 100 Inpatient days per Member, per year†		
Inpatient physician and professional services (Such as physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests)† For Skilled Nursing or Physical Rehabilitation Facility admissions: limited to the number of Inpatient days stated above.		
II. Outpatient Services		
Preventive Care		
Preventive Care and screenings as required by law including, but not limited to: -Immunizations for babies, children and adults (including travel and rabies immunizations) -Cancer screenings such as; Mammograms, pap smears, prostatic specific antigen (PSA) screening, routine colonoscopy and sigmoidoscopy -Routine physical exams for babies, children and adults (including one annual gynecological exam) -Lead screening -Outpatient/office contraceptive services -Nutrition counseling -Routine vision exams - One exam each year for Members 18 years old and younger; one exam every two years for Members 19 years old and older.† -Routine hearing exams - One exam each year for Members 18 years old and younger.†	You pay $0	Standard Deductible and Coinsurance, plus any balances
Medical/Surgical Care in a Physician's Office or Walk-In Center or furnished by an Independent Ambulatory Surgical Center, Independent Infusion Therapy Provider, Independent Laboratory Provider, or Independent Radiology Provider		
Medical exams, consultations, anesthesia, medical treatments, and Network Provider services at a Network Walk-In Center	Visit Copayment or Specialty Visit Copayment	Standard Deductible and Coinsurance, plus any balances
Injections (including allergy injections)	You Pay $0	
Office surgery		
Laboratory tests (including allergy testing)		
X-ray tests (including ultrasound)		
MRA, MRI, PET, SPECT, CT Scan, CTA, chemotherapy, medical supplies and drugs		
Maternity care (prenatal and postpartum visits) Please see Your Subscriber Certificate for information about total maternity care.	You pay no Visit Copayment for prenatal or postpartum office visits. Your share of the cost for delivery of a baby is indicated above under "Inpatient Services" or below under "Outpatient Facility Care."	

* Benefits are limited to the Maximum Allowable Benefit (MAB). Under Self-Referred Benefits, You may be responsible for paying the difference between the MAB and charge. Please see Section 2 of Your Subscriber Certificate for details. Self-referred care may require preauthorization/precertification from Anthem. Please refer to Your Subscriber Certificate for details.

† Any combination of Network or PCP-Referred Benefits and Out-of-Network or Self-Referred Benefits counts toward this limit.

	PCP-Referred Benefits	Self-Referred Benefits*
	YOUR COST	
Outpatient Facility Care in the Outpatient Department of a Hospital, a Short Term General Hospital's Ambulatory Surgical Center, a Hemodialysis Center or Birthing Center		
Medical exams and consultations by a physician	Visit Copayment or Specialty Visit Copayment	Standard Deductible and Coinsurance, plus any balances
Services of a surgeon, operating room for surgery and anesthesia	You Pay $0	
Physician and professional services for the delivery of a baby or management of therapy Hemodialysis, chemotherapy, radiation therapy, infusion therapy, MRA, MRI, PET, SPECT, CT Scan, CTA Fees for use of a facility, medical supplies, drugs, other ancillaries, observation		
Laboratory and x-ray tests (including ultrasounds)		
Emergency Room Visits and Urgent Care Facility Visits		
Use of the emergency room (The Copayment is waived if You are admitted)	Emergency Room Copayment	
Use of a licensed hospital's urgent care facility	Urgent Care Facility Copayment	Standard Deductible and Coinsurance, plus any balances
Physician's fee, surgery, MRA, MRI, PET, SPECT, CT Scan, CTA, medical supplies and drugs	You Pay $0	
Laboratory and x-ray tests		
Ambulance Services Transport by ambulance must be Medically Necessary	You Pay $0	
III. Outpatient Physical Rehabilitation Services		
Physical Therapy and Occupational Therapy and Speech Therapy Up to a combined maximum of 60 visits per Member, per year†	You Pay $0	Standard Deductible and Coinsurance, plus any balances
Cardiac Rehabilitation Visits	Visit Copayment or Specialty Visit Copayment	
Chiropractic Care • **Office visit** - up to 25 visits per Member, per year	You Pay $0	
• **Laboratory and x-ray tests** furnished by a chiropractor		
Early Intervention Services	Visit Copayment or Specialty Visit Copayment	
IV. Home Care		
Physician services Medical exams, injections, medical treatments, surgery and anesthesia	Visit Copayment or Specialty Visit Copayment	Standard Deductible and Coinsurance, plus any balances
Home Health Agency services	You Pay $0	
Hospice		
Infusion Therapy		
Durable Medical Equipment, Medical Supplies and Prosthetics	Subject to the DME Deductible and Coinsurance	Subject to the DME Deductible and Coinsurance plus any balances

* Benefits are limited to the Maximum Allowable Benefit (MAB). Under Self-Referred Benefits, You may be responsible for paying the difference between the MAB and charge. Please see Section 2 of Your Subscriber Certificate for details. Self-referred care may require preauthorization/precertification from Anthem. Please refer to Your Subscriber Certificate for details.

† Any combination of Network or PCP-Referred Benefits and Out-of-Network or Self-Referred Benefits counts toward this limit.

	PCP-Referred Benefits	Self-Referred Benefits*
	YOUR COST	
V. Behavioral Health Care (Mental Health and Substance Abuse Care)		
Outpatient/Office Visits		
Mental Health Visits: Unlimited Medically Necessary visits **Substance Abuse Visits:** Unlimited Medically Necessary visits (including detoxification and substance abuse rehabilitation services)	Visit Copayment or Specialty Visit Copayment	Standard Deductible and Coinsurance, plus any balances
Partial Hospitalization and Intensive Outpatient Treatment Programs		
Mental Disorders: Unlimited Medically Necessary care **Substance Abuse Conditions**: Unlimited Medically Necessary care for rehabilitation and detoxification	You pay $0	Standard Deductible and Coinsurance, plus any balances
Inpatient Care		
Mental Disorders: Unlimited Medically Necessary Inpatient days	You pay $0	Standard Deductible and Coinsurance, plus any balances
Substance Abuse Conditions: • Medical detoxification days - Unlimited Medically Necessary Inpatient days • Substance abuse rehabilitation – Unlimited Medically Necessary Inpatient days		
Scheduled Ambulance Transport Limited to Medically Necessary transport from one facility to another	You pay $0	
VI. Prescription Eyewear		
not applicable		

* Benefits are limited to the Maximum Allowable Benefit (MAB). Under Self-Referred Benefits, You may be responsible for paying the difference between the MAB and charge. Please see Section 2 of Your Subscriber Certificate for details. Self-referred care may require preauthorization/precertification from Anthem. Please refer to Your Subscriber Certificate for details.

HealthTrust

Anthem BlueCross BlueShield

BlueChoice®
Cost Sharing Schedule

This Cost Sharing Schedule is an important part of Your Subscriber Certificate and is an outline of Your coverage. Do not rely on this outline alone. Keep this schedule with Your Certificate because it contains important information about coverage and limitations. Please read Your Subscriber Certificate carefully as important terms and limitations apply.

Cost Sharing Summary	**Option 1** *When Your PCP provides or refers Your care*	**Option 2** *When You seek care directly from a BlueChoice provider*	**Option 3*** *When You seek care from any out-of-network provider*
	YOUR COST		
Visit Copayment Applies each time You visit Your Primary Care Provider (PCP) or Network obstetrical/gynecological specialist.	$10 per visit	$30 per visit	not applicable
Specialty Visit Copayment Applies each time You visit a specialist. This Copayment also applies each time You visit a Network Physician at a Network Walk-In Center for diagnosis, care and treatment of an illness or injury.	$10 per visit	$30 per visit	not applicable
Emergency Room Copayment	$50 per visit		
Urgent Care Facility Copayment Applies each time You visit a licensed hospital's Network urgent care facility for diagnosis, care and treatment of an illness or injury.	$50 per visit	$50 per visit	not applicable
Standard Deductible	not applicable	not applicable	$150 per Member, per year $450 per family, per year
Standard Coinsurance	not applicable	20%	20%
Coinsurance Maximum	not applicable	$600 per Member, per year $1,800 per family, per year	$900 per Member, per year $2,700 per family, per year
Durable Medical Equipment, Medical Supplies and Prosthetics **Deductible** **Coinsurance**	 not applicable not applicable	 not applicable 20%	 not applicable 20%
Out-of-Pocket Limit** Includes all Deductibles, Coinsurance, and Copayments You pay during a year. It does not include Your premium, penalties, out-of-network expenses, amounts over the Maximum Allowable Benefit or charges for noncovered services.	$6,350 per Member, per year $12,700 per family, per year		not applicable
Inpatient Precertification Penalty	not applicable	not applicable	$500

Please note that throughout this schedule any reference to year means calendar year.

* Benefits are limited to the Maximum Allowable Benefit (MAB). Under Option 3 Benefits, You may be responsible for paying the difference between the MAB and charge. Please see Section 2 of Your Subscriber Certificate for details. Self-referred care may require preauthorization/precertification from Anthem. Please refer to Your Subscriber Certificate for details.

**Once the Out-of-Pocket Limit is satisfied, You will not have to pay additional Deductibles, Coinsurance, or Copayments for the rest of the year.

Coverage Outline	Option 1 *When Your PCP provides or refers Your care*	Option 2 *When You seek care directly from a BlueChoice provider*	Option 3* *When You seek care from any out-of-network provider*
	YOUR COST		
Medical/Surgical Care			
I. Inpatient Services			
In a Short Term General Hospital (Facility charges for medical, surgical and maternity admissions) **In a Skilled Nursing Facility** (Facility charges) **In a Physical Rehabilitation Facility** (Facility charges) **Inpatient physician and professional services** (Such as physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests)	You pay $0	Standard Coinsurance	Standard Deductible and Coinsurance, plus any balances
II. Outpatient Services			
Preventive Care			
Preventive Care and screenings as required by law including, but not limited to: -Immunizations for babies, children and adults (including travel and rabies immunizations) -Cancer screenings such as; Mammograms, pap smears, prostatic specific antigen (PSA) screening, routine colonoscopy and sigmoidoscopy -Routine physical exams for babies, children and adults (including one annual gynecological exam) -Lead screening -Outpatient/office contraceptive services -Nutrition counseling -Routine vision exams - One exam each year for Members 18 years old and younger; one exam every two years for Members 19 years old and older.† -Routine hearing exams - One exam each year for Members 18 years old and younger.†	You pay $0	You pay $0	Standard Deductible and Coinsurance, plus any balances
Medical/Surgical Care in a Physician's Office or Walk-In Center or furnished by an Independent Ambulatory Surgical Center, Independent Infusion Therapy Provider, Independent Laboratory Provider, or Independent Radiology Provider			
Medical exams, consultations, anesthesia, medical treatments, and Network Provider services at a Network Walk-In Center	Visit Copayment or Specialty Visit Copayment	Visit Copayment or Specialty Visit Copayment	Standard Deductible and Coinsurance, plus any balances
Injections (including allergy injections) Office surgery Laboratory tests (including allergy testing) X-ray tests (including ultrasound)	You Pay $0	You Pay $0	
MRA, MRI, PET, SPECT, CT Scan, CTA, chemotherapy, medical supplies and drugs		Standard Coinsurance	
Maternity care (prenatal and postpartum visits) Please see your Subscriber Certificate for information about total maternity care.	You pay no Visit Copayment for prenatal or postpartum office visits. Your share of the cost for delivery of a baby is indicated above under "Inpatient Services" or below under "Outpatient Facility Care."		

* Benefits are limited to the Maximum Allowable Benefit (MAB). Under Option 3 Benefits, You may be responsible for paying the difference between the MAB and charge. Please see Section 2 of Your Subscriber Certificate for details. Self-referred care may require preauthorization/precertification from Anthem. Please refer to Your Subscriber Certificate for details.

† Any combination of Option 1, 2 or 3 Benefits counts toward this limit.

<table>
<tr><th></th><th>Option 1
When Your PCP provides or refers Your care</th><th>Option 2
When You seek care directly from a BlueChoice provider</th><th>Option 3*
When You seek care from any out-of-network provider</th></tr>
<tr><th></th><th colspan="3">YOUR COST</th></tr>
<tr><td colspan="4">Outpatient Facility Care in the Outpatient Department of a Hospital, a Short Term General Hospital's Ambulatory Surgical Center, a Hemodialysis Center or Birthing Center</td></tr>
<tr><td>Medical exams and consultations by a physician</td><td>Visit Copayment or Specialty Visit Copayment</td><td>Visit Copayment or Specialty Visit Copayment</td><td rowspan="4">Standard Deductible and Coinsurance, plus any balances</td></tr>
<tr><td>Services of a surgeon, operating room for surgery and anesthesia</td><td rowspan="3">You Pay $0</td><td rowspan="3">Standard Coinsurance</td></tr>
<tr><td>Physician and professional services for the delivery of a baby or management of therapy

Hemodialysis, chemotherapy, radiation therapy, infusion therapy, MRA, MRI, PET, SPECT, CT Scan, CTA

Fees for use of a facility, medical supplies, drugs, other ancillaries, observation</td></tr>
<tr><td>Laboratory and x-ray tests (including ultrasounds)</td><td>You Pay $0</td></tr>
<tr><td colspan="4">Emergency Room Visits and Urgent Care Facility Visits</td></tr>
<tr><td>Use of the emergency room
(The Copayment is waived if You are admitted)</td><td colspan="3">Emergency Room Copayment</td></tr>
<tr><td>Use of a licensed hospital's urgent care facility</td><td>Urgent Care Facility Copayment</td><td>Urgent Care Facility Copayment</td><td rowspan="3">Standard Deductible and Coinsurance, plus any balances</td></tr>
<tr><td>Physician's fee, surgery, MRA, MRI, PET, SPECT, CT Scan, CTA, medical supplies and drugs</td><td rowspan="2">You Pay $0</td><td rowspan="2">You Pay $0</td></tr>
<tr><td>Laboratory and x-ray tests</td></tr>
<tr><td>Ambulance Services
Transport by ambulance must be Medically Necessary</td><td colspan="3">You pay $0</td></tr>
<tr><td colspan="4">III. Outpatient Physical Rehabilitation Services</td></tr>
<tr><td>Physical Therapy and Occupational Therapy and Speech Therapy</td><td>You pay $0</td><td>Standard Coinsurance</td><td rowspan="4">Standard Deductible and Coinsurance, plus any balances</td></tr>
<tr><td>Cardiac Rehabilitation Visits</td><td rowspan="2">Visit Copayment or Specialty Visit Copayment</td><td>Visit Copayment or Specialty Visit Copayment</td></tr>
<tr><td>Chiropractic Care
• Office visit - unlimited</td><td rowspan="2">not applicable</td></tr>
<tr><td>• Laboratory and x-ray tests furnished by a chiropractor</td><td>You Pay $0</td></tr>
<tr><td>Early Intervention Services</td><td>Visit Copayment or Specialty Visit Copayment</td><td>Visit Copayment or Specialty Visit Copayment</td></tr>
<tr><td colspan="4">IV. Home Care</td></tr>
<tr><td>Physician services
Medical exams, injections, medical treatments, surgery and anesthesia</td><td>Visit Copayment or Specialty Visit Copayment</td><td>Visit Copayment or Specialty Visit Copayment</td><td rowspan="3">Standard Deductible and Coinsurance, plus any balances</td></tr>
<tr><td>Home Health Agency services
Hospice
Infusion Therapy</td><td rowspan="2">You Pay $0</td><td rowspan="2">Standard Coinsurance</td></tr>
<tr><td>Durable Medical Equipment, Medical Supplies and Prosthetics</td><td>Standard Coinsurance, plus any balances</td></tr>
</table>

*Benefits are limited to the Maximum Allowable Benefit (MAB). Under Option 3 Benefits, You may be responsible for paying the difference between the MAB and charge. Please see Section 2 of Your Subscriber Certificate for details. Self-referred care may require preauthorization/precertification by Anthem. Please refer to Your Subscriber Certificate for details.

† Any combination of Option 1, 2 or 3 Benefits counts toward this limit.

	Option 1 *When You obtain care from a Network Provider*	Option 3* *When You obtain care from any Eligible Mental Health or Substance Abuse Provider*
Option 2 Benefits are not available for Behavioral Health care.	**YOUR COST**	
V. Behavioral Health Care (Mental Health and Substance Abuse Care)		
Outpatient/Office Visits		
Mental Health Visits: Unlimited Medically Necessary visits **Substance Abuse Visits:** Unlimited Medically Necessary visits (including detoxification and substance abuse rehabilitation services)	Visit Copayment or Specialty Visit Copayment	Standard Deductible and Coinsurance, plus any balances
Partial Hospitalization and Intensive Outpatient Treatment Programs		
Mental Disorders: Unlimited Medically Necessary care **Substance Abuse Conditions**: Unlimited Medically Necessary care for rehabilitation and detoxification	You Pay $0	Standard Deductible and Coinsurance, plus any balances
Inpatient Care		
Mental Disorders: Unlimited Medically Necessary Inpatient days **Substance Abuse Conditions:** • Medical detoxification days - Unlimited Medically Necessary Inpatient days • Substance abuse rehabilitation – Unlimited Medically Necessary Inpatient days	You Pay $0	Standard Deductible and Coinsurance, plus any balances
Scheduled Ambulance Transport Limited to Medically Necessary transport from one facility to another	You Pay $0	
VI. Prescription Eyewear		
Benefits are limited to a maximum of **$40** per Member, every two calendar years. Please refer to Your Prescription Eyewear Rider for more information.		

* Benefits are limited to the Maximum Allowable Benefit (MAB). Under Option 3 Benefits, You may be responsible for paying the difference between the MAB and charge. Please see Section 2 of Your Subscriber Certificate for details. Self-referred care may require preauthorization/precertification from Anthem. Please refer to Your Subscriber Certificate for details.

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Matthew Thornton Blue [SM]
Cost Sharing Schedule

This Cost Sharing Schedule is an important part of Your Subscriber Certificate and is an outline of Your coverage. Do not rely on this outline alone. Keep this schedule with Your Certificate because it contains important information about coverage and limitations. Please read Your Subscriber Certificate carefully as important terms and limitations apply.

Cost Sharing Summary	YOUR COST
Visit Copayment Applies each time You visit Your Primary Care Provider (PCP) or Network obstetrical/gynecological specialist.	$5 per visit
Specialty Visit Copayment Applies each time You visit a specialist. This Copayment also applies each time You visit a Network Provider at a Network Walk-In Center for diagnosis, care and treatment of an illness or injury.	$5 per visit
Emergency Room Copayment	$25 per visit
Urgent Care Facility Copayment Applies each time You visit a licensed hospital's Network urgent care facility for diagnosis, care and treatment of illness or injury.	$25 per visit
Standard Deductible	not applicable
Standard Coinsurance	
Coinsurance Maximum	
Durable Medical Equipment, Medical Supplies and Prosthetics **Deductible** **Coinsurance**	 not applicable 20%
Out-of-Pocket Limit* Includes all Deductibles, Coinsurance, and Copayments You pay during a year. It does not include Your premium or charges for noncovered services.	$6,350 per Member, per year $12,700 per family, per year

*Once the Out-of-Pocket Limit is satisfied, You will not have to pay additional Deductibles, Coinsurance, or Copayments for the rest of the year.

Please note that throughout this schedule any reference to year means calendar year.

Coverage Outline	YOUR COST
Medical/Surgical Care	
I. Inpatient Services	
In a Short Term General Hospital (Facility charges for medical, surgical and maternity admissions)	You pay $0
In a Skilled Nursing Facility (Facility charges) Up to 100 Inpatient days per Member, per year	
In a Physical Rehabilitation Facility (Facility charges) Up to 100 Inpatient days per Member, per year	
Inpatient physician and professional services (Such as physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests) For Skilled Nursing or Physical Rehabilitation Facility admissions: limited to the number of Inpatient days stated above.	
II. Outpatient Services	
Preventive Care	
Preventive Care and screenings as required by law including, but not limited to: -Immunizations for babies, children and adults (including travel and rabies immunizations) -Cancer screenings such as; Mammograms, pap smears, prostatic specific antigen (PSA) screening, routine colonoscopy and sigmoidoscopy -Routine physical exams for babies, children and adults (including one annual gynecological exam) -Lead screening -Outpatient/office contraceptive services -Nutrition counseling -Routine vision exams - One exam each year for Members 18 years old and younger; one exam every two years for Members 19 years old and older. -Routine hearing exams - One exam each year for Members 18 years old and younger.	You pay $0
Medical/Surgical Care in a Physician's Office or Walk-In Center or furnished by an Independent Ambulatory Surgical Center, Independent Infusion Therapy Provider, Independent Laboratory Provider, or Independent Radiology Provider	
Medical exams, consultations, anesthesia, medical treatments, and Network Provider services at a Network Walk-In Center	Visit Copayment or Specialty Visit Copayment
Injections (including allergy injections)	You pay $0
Office surgery	
Laboratory tests (including allergy testing)	
X-ray tests (including ultrasound)	
MRA, MRI, PET, SPECT, CT Scan, CTA, Chemotherapy, medical supplies and drugs	
Maternity care (prenatal and postpartum visits) Please see Your Subscriber Certificate for information about total maternity care.	You pay no Visit Copayment for prenatal or postpartum office visits. Your share of the cost for delivery of a baby is the same as shown for "Inpatient Services" (above) and "Outpatient Facility Care" (below).

	YOUR COST
Outpatient Facility Care in the Outpatient Department of a Hospital, a Short Term General Hospital's Ambulatory Surgical Center, a Hemodialysis Center or Birthing Center	
Medical exams and consultations by a physician	Visit Copayment or Specialty Visit Copayment
Services of a surgeon, operating room for surgery and anesthesia	You pay $0
Physician and professional services for the delivery of a baby or management of therapy. Hemodialysis, chemotherapy, radiation therapy, infusion therapy, MRA, MRI, PET, SPECT, CT Scan, CTA Fees for use of a facility, medical supplies, drugs, other ancillaries, observation	
Laboratory and x-ray tests (including ultrasounds)	
Emergency Room Visits and Urgent Care Facility Visits	
Use of the emergency room (The Copayment is waived if you are admitted)	Emergency Room Copayment
Use of a licensed hospital's urgent care facility in the Network	Urgent Care Facility Copayment
Physician's fee, surgery, MRA, MRI, PET, SPECT, CT Scan, CTA, medical supplies and drugs	You pay $0
Laboratory and x-ray tests	
Ambulance Services Transport by ambulance must be Medically Necessary	
III. Outpatient Physical Rehabilitation Services	
Physical Therapy and Occupational Therapy and Speech Therapy Up to a combined maximum of 60 visits per Member, per year	Visit Copayment or Specialty Visit Copayment
Cardiac Rehabilitation Visits	
Chiropractic Care • **Office visits -** up to 12 visits per Member, per year	
• **Laboratory and x-ray tests** furnished by a chiropractor	You pay $0
Early Intervention Services	Visit Copayment or Specialty Visit Copayment
IV. Home Care	
Physician services Medical exams, injections, medical treatments, surgery and anesthesia	Visit Copayment or Specialty Visit Copayment
Home Health Agency services	You pay $0
Hospice	
Infusion Therapy	
Durable Medical Equipment, Medical Supplies and Prosthetics	Subject to the DME Coinsurance

	YOUR COST
V. Behavioral Health Care (Mental Health and Substance Abuse Care)	
Outpatient/Office Visits	
Mental Health Visits: Unlimited Medically Necessary visits **Substance Abuse Visits:** Unlimited Medically Necessary visits (including detoxification and substance abuse rehabilitation services)	Visit Copayment or Specialty Visit Copayment
Partial Hospitalization and Intensive Outpatient Treatment Programs	
Mental Disorders: Unlimited Medically Necessary care **Substance Abuse Conditions**: Unlimited Medically Necessary care for rehabilitation and detoxification	You pay $0
Inpatient Care	
Mental Disorders: Unlimited Medically Necessary Inpatient days **Substance Abuse Conditions**: • Medical detoxification days – Unlimited Medically Necessary Inpatient days • Substance abuse rehabilitation – Unlimited Medically Necessary Inpatient days	You pay $0
Scheduled Ambulance Transport Limited to Medically Necessary transport from one facility to another	
VI. Prescription Eyewear	
Benefits are limited to a maximum of **$40** per Member, per year. Please refer to your Prescription Eyewear Rider for more information.	

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Matthew Thornton Blue[SM]
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Cost Sharing Summary	YOUR COST
Visit Copayment Applies each time You visit Your Primary Care Provider (PCP) or Network obstetrical/gynecological specialist.	$20 per visit
Specialty Visit Copayment Applies each time You visit a specialist. This Copayment also applies each time You visit a Network Provider at a Network Walk-In Center for diagnosis, care and treatment of an illness or injury.	$20 per visit
Emergency Room Copayment	$100 per visit
Urgent Care Facility Copayment Applies each time You visit a licensed hospital's Network urgent care facility for diagnosis, care and treatment of illness or injury.	$50 per visit
Standard Deductible	not applicable
Standard Coinsurance	
Coinsurance Maximum	
Durable Medical Equipment, Medical Supplies and Prosthetics **Deductible** **Coinsurance**	 not applicable 20%
Out-of-Pocket Limit* Includes all Deductibles, Coinsurance, and Copayments You pay during a year. It does not include Your premium or charges for noncovered services.	$6,350 per Member, per year $12,700 per family, per year

*Once the Out-of-Pocket Limit is satisfied, You will not have to pay additional Deductibles, Coinsurance, or Copayments for the rest of the year.

Please note that throughout this schedule any reference to year means calendar year.

Coverage Outline	YOUR COST
Medical/Surgical Care	
I. Inpatient Services	
In a Short Term General Hospital (Facility charges for medical, surgical and maternity admissions)	You pay $0
In a Skilled Nursing Facility (Facility charges) Up to 100 Inpatient days per Member, per year	
In a Physical Rehabilitation Facility (Facility charges) Up to 100 Inpatient days per Member, per year	
Inpatient physician and professional services (Such as physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests) For Skilled Nursing or Physical Rehabilitation Facility admissions: limited to the number of Inpatient days stated above.	
II. Outpatient Services	
Preventive Care	
Preventive Care and screenings as required by law including, but not limited to: -Immunizations for babies, children and adults (including travel and rabies immunizations) -Cancer screenings such as; Mammograms, pap smears, prostatic specific antigen (PSA) screening, routine colonoscopy and sigmoidoscopy -Routine physical exams for babies, children and adults (including one annual gynecological exam) -Lead screening -Outpatient/office contraceptive services -Nutrition counseling -Routine vision exams - One exam each year for Members 18 years old and younger; one exam every two years for Members 19 years old and older. -Routine hearing exams - One exam each year for Members 18 years old and younger.	You pay $0
Medical/Surgical Care in a Physician's Office or Walk-In Center or furnished by an Independent Ambulatory Surgical Center, Independent Infusion Therapy Provider, Independent Laboratory Provider, or Independent Radiology Provider	
Medical exams, consultations, anesthesia, medical treatments, and Network Provider services at a Network Walk-In Center	Visit Copayment or Specialty Visit Copayment
Injections (including allergy injections)	You pay $0
Office surgery	
Laboratory tests (including allergy testing)	
X-ray tests (including ultrasound)	
MRA, MRI, PET, SPECT, CT Scan, CTA, Chemotherapy, medical supplies and drugs	
Maternity care (prenatal and postpartum visits) Please see Your Subscriber Certificate for information about total maternity care.	You pay no Visit Copayment for prenatal or postpartum office visits. Your share of the cost for delivery of a baby is the same as shown for "Inpatient Services" (above) and "Outpatient Facility Care" (below).

	YOUR COST
Outpatient Facility Care in the Outpatient Department of a Hospital, a Short Term General Hospital's Ambulatory Surgical Center, a Hemodialysis Center or Birthing Center	
Medical exams and consultations by a physician	Visit Copayment or Specialty Visit Copayment
Services of a surgeon, operating room for surgery and anesthesia	You pay $0
Physician and professional services for the delivery of a baby or management of therapy Hemodialysis, chemotherapy, radiation therapy, infusion therapy, MRA, MRI, PET, SPECT, CT Scan, CTA Fees for use of a facility, medical supplies, drugs, other ancillaries, observation	
Laboratory and x-ray tests (including ultrasounds)	
Emergency Room Visits and Urgent Care Facility Visits	
Use of the emergency room (The Copayment is waived if you are admitted)	Emergency Room Copayment
Use of a licensed hospital's urgent care facility in the Network	Urgent Care Facility Copayment
Physician's fee, surgery, MRA, MRI, PET, SPECT, CT Scan, CTA, medical supplies and drugs	You pay $0
Laboratory and x-ray tests	
Ambulance Services Transport by ambulance must be Medically Necessary	
III. Outpatient Physical Rehabilitation Services	
Physical Therapy and Occupational Therapy and Speech Therapy Up to a combined maximum of 60 visits per Member, per year	Visit Copayment or Specialty Visit Copayment
Cardiac Rehabilitation Visits	
Chiropractic Care • **Office visits -** up to 12 visits per Member, per year	
• **Laboratory and x-ray tests** furnished by a chiropractor	You pay $0
Early Intervention Services	Visit Copayment or Specialty Visit Copayment
IV. Home Care	
Physician services Medical exams, injections, medical treatments, surgery and anesthesia	Visit Copayment or Specialty Visit Copayment
Home Health Agency services	You pay $0
Hospice	
Infusion Therapy	
Durable Medical Equipment, Medical Supplies and Prosthetics	Subject to the DME Coinsurance

	YOUR COST
V. Behavioral Health Care (Mental Health and Substance Abuse Care)	
Outpatient/Office Visits	
Mental Health Visits: Unlimited Medically Necessary visits **Substance Abuse Visits:** Unlimited Medically Necessary visits (including detoxification and substance abuse rehabilitation services)	Visit Copayment or Specialty Visit Copayment
Partial Hospitalization and Intensive Outpatient Treatment Programs	
Mental Disorders: Unlimited Medically Necessary care **Substance Abuse Conditions**: Unlimited Medically Necessary care for rehabilitation and detoxification	You pay $0
Inpatient Care	
Mental Disorders: Unlimited Medically Necessary Inpatient days **Substance Abuse Conditions**: • Medical detoxification days – Unlimited Medically Necessary Inpatient days • Substance abuse rehabilitation – Unlimited Medically Necessary Inpatient days	You pay $0
Scheduled Ambulance Transport Limited to Medically Necessary transport from one facility to another	
VI. Prescription Eyewear	
Benefits are limited to a maximum of **$40** per Member, per year. Please refer to your Prescription Eyewear Rider for more information.	

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Cost Sharing Schedule

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Cost Sharing Summary	YOUR COST
Visit Copayment Applies each time You visit Your Primary Care Provider (PCP) or Network obstetrical/gynecological specialist.	$20 per visit
Specialty Visit Copayment Applies each time You visit a specialist. This Copayment also applies each time You visit a Network Provider at a Network Walk-In Center for diagnosis, care and treatment of an illness or injury.	$20 per visit
Emergency Room Copayment	$150 per visit
Urgent Care Facility Copayment Applies each time You visit a licensed hospital's Network urgent care facility for diagnosis, care and treatment of illness or injury.	$75 per visit
Standard Deductible	$250 per Member, per year $750 per family, per year
Standard Coinsurance	not applicable
Coinsurance Maximum	
Durable Medical Equipment, Medical Supplies and Prosthetics **Deductible** **Coinsurance**	 $100 per Member, per year 20%
Out-of-Pocket Limit* Includes all Deductibles, Coinsurance, and Copayments You pay during a year. It does not include Your premium or charges for noncovered services.	$6,350 per Member, per year $12,700 per family, per year

*Once the Out-of-Pocket Limit is satisfied, You will not have to pay additional Deductibles, Coinsurance, or Copayments for the rest of the year.

Please note that throughout this schedule any reference to year means calendar year.

Coverage Outline	YOUR COST
Medical/Surgical Care	
I. Inpatient Services	
In a Short Term General Hospital (Facility charges for medical, surgical and maternity admissions)	Standard Deductible
In a Skilled Nursing Facility (Facility charges) Up to 100 Inpatient days per Member, per year	
In a Physical Rehabilitation Facility (Facility charges) Up to 100 Inpatient days per Member, per year	
Inpatient physician and professional services (Such as physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests) For Skilled Nursing or Physical Rehabilitation Facility admissions: limited to the number of Inpatient days stated above.	
II. Outpatient Services	
Preventive Care	
Preventive Care and screenings as required by law including, but not limited to: -Immunizations for babies, children and adults (including travel and rabies immunizations) -Cancer screenings such as; Mammograms, pap smears, prostatic specific antigen (PSA) screening, routine colonoscopy and sigmoidoscopy -Routine physical exams for babies, children and adults (including one annual gynecological exam) -Lead screening -Outpatient/office contraceptive services -Nutrition counseling -Routine vision exams - One exam each year for Members 18 years old and younger; one exam every two years for Members 19 years old and older. -Routine hearing exams - One exam each year for Members 18 years old and younger.	You pay $0
Medical/Surgical Care in a Physician's Office or Walk-In Center or furnished by an Independent Ambulatory Surgical Center, Independent Infusion Therapy Provider, Independent Laboratory Provider, or Independent Radiology Provider	
Medical exams, consultations, anesthesia, medical treatments, and Network Provider services at a Network Walk-In Center	Visit Copayment or Specialty Visit Copayment
Injections (including allergy injections)	You pay $0
Office surgery	
Laboratory tests (including allergy testing)	
X-ray tests (including ultrasound)	
MRA, MRI, PET, SPECT, CT Scan, CTA, Chemotherapy, medical supplies and drugs	Standard Deductible
Maternity care (prenatal and postpartum visits) Please see Your Subscriber Certificate for information about total maternity care.	You pay no Visit Copayment for prenatal or postpartum office visits. Your share of the cost for delivery of a baby is the same as shown for "Inpatient Services" (above) and "Outpatient Facility Care" (below).

	YOUR COST
Outpatient Facility Care in the Outpatient Department of a Hospital, a Short Term General Hospital's Ambulatory Surgical Center, a Hemodialysis Center or Birthing Center	
Medical exams and consultations by a physician	Visit Copayment or Specialty Visit Copayment
Services of a surgeon, operating room for surgery and anesthesia	You pay $0
Physician and professional services for the delivery of a baby or management of therapy Hemodialysis, chemotherapy, radiation therapy, infusion therapy, MRA, MRI, PET, SPECT, CT Scan, CTA Fees for use of a facility, medical supplies, drugs, other ancillaries, observation	Standard Deductible
Laboratory and x-ray tests (including ultrasounds)	You pay $0
Emergency Room Visits and Urgent Care Facility Visits	
Use of the emergency room (The Copayment is waived if you are admitted)	Emergency Room Copayment
Use of a licensed hospital's urgent care facility in the Network	Urgent Care Facility Copayment
Physician's fee, surgery, MRA, MRI, PET, SPECT, CT Scan, CTA, medical supplies and drugs	Standard Deductible
Laboratory and x-ray tests	You pay $0
Ambulance Services Transport by ambulance must be Medically Necessary	Standard Deductible
III. Outpatient Physical Rehabilitation Services	
Physical Therapy and Occupational Therapy and Speech Therapy Up to a combined maximum of 60 visits per Member, per year	Visit Copayment or Specialty Visit Copayment
Cardiac Rehabilitation Visits	
Chiropractic Care • **Office visits -** up to 12 visits per Member, per year	
• **Laboratory and x-ray tests** furnished by a chiropractor	You pay $0
Early Intervention Services	Visit Copayment or Specialty Visit Copayment
IV. Home Care	
Physician services Medical exams, injections, medical treatments, surgery and anesthesia	Visit Copayment or Specialty Copayment
Home Health Agency services	Standard Deductible
Hospice	
Infusion Therapy	
Durable Medical Equipment, Medical Supplies and Prosthetics	Subject to the DME Deductible and Coinsurance

	YOUR COST
V. Behavioral Health Care (Mental Health and Substance Abuse Care)	
Outpatient/Office Visits	
Mental Health Visits: Unlimited Medically Necessary visits **Substance Abuse Visits:** Unlimited Medically Necessary visits (including detoxification and substance abuse rehabilitation services)	Visit Copayment or Specialty Visit Copayment
Partial Hospitalization and Intensive Outpatient Treatment Programs	
Mental Disorders: Unlimited Medically Necessary care **Substance Abuse Conditions**: Unlimited Medically Necessary care for rehabilitation and detoxification	Standard Deductible
Inpatient Care	
Mental Disorders: Unlimited Medically Necessary Inpatient days **Substance Abuse Conditions**: • Medical detoxification days – Unlimited Medically Necessary Inpatient days • Substance abuse rehabilitation – Unlimited Medically Necessary Inpatient days	Standard Deductible
Scheduled Ambulance Transport Limited to Medically Necessary transport from one facility to another	
VI. Prescription Eyewear	
Benefits are limited to a maximum of **$40** per Member, per year. Please refer to your Prescription Eyewear Rider for more information.	

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Cost Sharing Summary	YOUR COST
Visit Copayment Applies each time You visit Your Primary Care Provider (PCP) or Network obstetrical/gynecological specialist.	$15 per visit
Specialty Visit Copayment Applies each time You visit a specialist. This Copayment also applies each time You visit a Network Provider at a Network Walk-In Center for diagnosis, care and treatment of an illness or injury.	$15 per visit
Emergency Room Copayment	$100 per visit
Urgent Care Facility Copayment Applies each time You visit a licensed hospital's Network urgent care facility for diagnosis, care and treatment of illness or injury.	$50 per visit
Standard Deductible	$500 per Member, per year $1,500 per family, per year
Standard Coinsurance	not applicable
Coinsurance Maximum	
Durable Medical Equipment, Medical Supplies and Prosthetics **Deductible** **Coinsurance**	 $100 per Member, per year 20%
Out-of-Pocket Limit* Includes all Deductibles, Coinsurance, and Copayments You pay during a year. It does not include Your premium or charges for noncovered services.	$6,350 per Member, per year $12,700 per family, per year

*Once the Out-of-Pocket Limit is satisfied, You will not have to pay additional Deductibles, Coinsurance, or Copayments for the rest of the year.

Please note that throughout this schedule any reference to year means calendar year.

Coverage Outline	YOUR COST
Medical/Surgical Care	
I. Inpatient Services	
In a Short Term General Hospital (Facility charges for medical, surgical and maternity admissions)	Standard Deductible
In a Skilled Nursing Facility (Facility charges) Up to 100 Inpatient days per Member, per year	
In a Physical Rehabilitation Facility (Facility charges) Up to 100 Inpatient days per Member, per year	
Inpatient physician and professional services (Such as physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests) For Skilled Nursing or Physical Rehabilitation Facility admissions: limited to the number of Inpatient days stated above.	
II. Outpatient Services	
Preventive Care	
Preventive Care and screenings as required by law including, but not limited to: -Immunizations for babies, children and adults (including travel and rabies immunizations) -Cancer screenings such as; Mammograms, pap smears, prostatic specific antigen (PSA) screening, routine colonoscopy and sigmoidoscopy -Routine physical exams for babies, children and adults (including one annual gynecological exam) -Lead screening -Outpatient/office contraceptive services -Nutrition counseling -Routine vision exams - One exam each year for Members 18 years old and younger; one exam every two years for Members 19 years old and older. -Routine hearing exams - One exam each year for Members 18 years old and younger.	You pay $0
Medical/Surgical Care in a Physician's Office or Walk-In Center or furnished by an Independent Ambulatory Surgical Center, Independent Infusion Therapy Provider, Independent Laboratory Provider, or Independent Radiology Provider	
Medical exams, consultations, anesthesia, medical treatments, and Network Provider services at a Network Walk-In Center	Visit Copayment or Specialty Visit Copayment
Injections (including allergy injections)	You pay $0
Office surgery	
Laboratory tests (including allergy testing)	
X-ray tests (including ultrasound)	
MRA, MRI, PET, SPECT, CT Scan, CTA, Chemotherapy, medical supplies and drugs	Standard Deductible
Maternity care (prenatal and postpartum visits) Please see Your Subscriber Certificate for information about total maternity care.	You pay no Visit Copayment for prenatal or postpartum office visits. Your share of the cost for delivery of a baby is the same as shown for "Inpatient Services" (above) and "Outpatient Facility Care" (below).

	YOUR COST
Outpatient Facility Care in the Outpatient Department of a Hospital, a Short Term General Hospital's Ambulatory Surgical Center, a Hemodialysis Center or Birthing Center	
Medical exams and consultations by a physician	Visit Copayment or Specialty Visit Copayment
Services of a surgeon, operating room for surgery and anesthesia	You pay $0
Physician and professional services for delivery of a baby or management of therapy Hemodialysis, chemotherapy, radiation therapy, infusion therapy, MRA, MRI, PET, SPECT, CT Scan, CTA Fees for use of a facility, medical supplies, drugs, other ancillaries, observation	Standard Deductible
Laboratory and x-ray tests (including ultrasounds)	You pay $0
Emergency Room Visits and Urgent Care Facility Visits	
Use of the emergency room (The Copayment is waived if you are admitted)	Emergency Room Copayment
Use of a licensed hospital's urgent care facility in the Network	Urgent Care Facility Copayment
Physician's fee, surgery, MRA, MRI, PET, SPECT, CT Scan, CTA, medical supplies and drugs	Standard Deductible
Laboratory and x-ray tests	You pay $0
Ambulance Services Transport by ambulance must be Medically Necessary	Standard Deductible
III. Outpatient Physical Rehabilitation Services	
Physical Therapy and Occupational Therapy and Speech Therapy Up to a combined maximum of 60 visits per Member, per year	Visit Copayment or Specialty Visit Copayment
Cardiac Rehabilitation Visits	
Chiropractic Care • **Office visits -** up to 12 visits per Member, per year	
• **Laboratory and x-ray tests** furnished by a chiropractor	You pay $0
Early Intervention Services	Visit Copayment or Specialty Visit Copayment
IV. Home Care	
Physician services Medical exams, injections, medical treatments, surgery and anesthesia	Visit Copayment or Specialty Visit Copayment
Home Health Agency services	Standard Deductible
Hospice	
Infusion Therapy	
Durable Medical Equipment, Medical Supplies and Prosthetics	Subject to the DME Deductible and Coinsurance

	YOUR COST
V. Behavioral Health Care (Mental Health and Substance Abuse Care)	
Outpatient/Office Visits	
Mental Health Visits: Unlimited Medically Necessary visits **Substance Abuse Visits:** Unlimited Medically Necessary visits (including detoxification and substance abuse rehabilitation services)	Visit Copayment or Specialty Visit Copayment
Partial Hospitalization and Intensive Outpatient Treatment Programs	
Mental Disorders: Unlimited Medically Necessary care **Substance Abuse Conditions**: Unlimited Medically Necessary care for rehabilitation and detoxification	Standard Deductible
Inpatient Care	
Mental Disorders: Unlimited Medically Necessary Inpatient days **Substance Abuse Conditions**: • Medical detoxification days – Unlimited Medically Necessary Inpatient days • Substance abuse rehabilitation – Unlimited Medically Necessary Inpatient days	Standard Deductible
Scheduled Ambulance Transport Limited to Medically Necessary transport from one facility to another	
VI. Prescription Eyewear	
Benefits are limited to a maximum of **$40** per Member, per year. Please refer to your Prescription Eyewear Rider for more information.	

HealthTrust

Anthem BlueCross BlueShield

Matthew Thornton Blue [SM]
Site of Service Plan
Cost Sharing Schedule

This Cost Sharing Schedule is an important part of Your Subscriber Certificate and is an outline of Your coverage. Do not rely on this outline alone. Keep this schedule with Your Certificate because it contains important information about coverage and limitations. Please read Your Subscriber Certificate carefully as important terms and limitations apply.

Cost Sharing Summary	YOUR COST
Visit Copayment Applies each time You visit Your Primary Care Provider (PCP) or Network obstetrical/gynecological specialist.	$20 per visit
Specialty Visit Copayment Applies each time You visit a specialist. This Copayment also applies each time You visit a Network Provider at a Network Walk-In Center for diagnosis, care and treatment of an illness or injury.	$40 per visit
Emergency Room Copayment	$100 per visit
Urgent Care Facility Copayment Applies each time You visit a licensed hospital's Network urgent care facility for diagnosis, care and treatment of illness or injury.	$50 per visit
Standard Deductible	$1,000 per Member, per year $3000 per family, per year
Standard Coinsurance	not applicable
Coinsurance Maximum	
Durable Medical Equipment, Medical Supplies and Prosthetics **Deductible** **Coinsurance**	 $100 per Member, per year 20%
Out-of-Pocket Limit* Includes all Deductibles, Coinsurance, and Copayments You pay during a year. It does not include Your premium or charges for noncovered services.	$6,350 per Member, per year $12,700 per family, per year

*Once the Out-of-Pocket Limit is satisfied, You will not have to pay additional Deductibles, Coinsurance, or Copayments for the rest of the year.

Please note that throughout this schedule any reference to year means calendar year.

Coverage Outline	YOUR COST
Medical/Surgical Care	
I. Inpatient Services	
In a Short Term General Hospital (Facility charges for medical, surgical and maternity admissions)	Standard Deductible
In a Skilled Nursing Facility (Facility charges) Up to 100 Inpatient days per Member, per year	
In a Physical Rehabilitation Facility (Facility charges) Up to 100 Inpatient days per Member, per year	
Inpatient physician and professional services (Such as physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests) For Skilled Nursing or Physical Rehabilitation Facility admissions: limited to the number of Inpatient days stated above.	
II. Outpatient Services	
Preventive Care	
Preventive Care and screenings as required by law including, but not limited to: -Immunizations for babies, children and adults (including travel and rabies immunizations) -Cancer screenings such as; Mammograms, pap smears, prostatic specific antigen (PSA) screening, routine colonoscopy and sigmoidoscopy -Routine physical exams for babies, children and adults (including one annual gynecological exam) -Lead screening -Outpatient/office contraceptive services -Nutrition counseling -Routine vision exams - One exam each year for Members 18 years old and younger; one exam every two years for Members 19 years old and older. -Routine hearing exams - One exam each year for Members 18 years old and younger.	You Pay $0
Medical/Surgical Care in a Physician's Office or Walk-In Center or furnished by an Independent Ambulatory Surgical Center, Independent Infusion Therapy Provider, Independent Laboratory Provider, or Independent Radiology Provider	
Medical exams, consultations, anesthesia, medical treatments, and Network Provider services at a Network Walk-In Center	Visit Copayment or Specialty Visit Copayment
Injections (including allergy injections)	
Office surgery	
Surgery and anesthesia in an independent ambulatory surgical center in the Network	$75 per admission
Laboratory tests (including allergy testing) provided by an Independent Laboratory Provider in the Network	You Pay $0
X-ray tests (including ultrasound)	Standard Deductible
MRA, MRI, PET, SPECT, CT Scan, CTA, Chemotherapy, medical supplies and drugs	
Maternity care (prenatal and postpartum visits) Please see Your Subscriber Certificate for information about total maternity care.	You pay no Visit Copayment for prenatal or postpartum office visits. Your share of the cost for delivery of a baby is the same as shown for "Inpatient Services" (above) and "Outpatient Facility Care" (below).

	YOUR COST
Outpatient Facility Care in the Outpatient Department of a Hospital, a Short Term General Hospital's Ambulatory Surgical Center, a Hemodialysis Center or Birthing Center	
Medical exams and consultations by a physician	Visit Copayment or Specialty Visit Copayment
Services of a surgeon, operating room for surgery and anesthesia	Standard Deductible
Physician and professional services for the delivery of a baby or management of therapy Hemodialysis, chemotherapy, radiation therapy, infusion therapy, MRA, MRI, PET, SPECT, CT Scan, CTA Fees for use of a facility, medical supplies, drugs, other ancillaries, observation	
Laboratory and x-ray tests (including ultrasounds)	
Emergency Room Visits and Urgent Care Facility Visits	
Use of the emergency room (The Copayment is waived if you are admitted)	Emergency Room Copayment
Use of a licensed hospital's urgent care facility in the Network	Urgent Care Facility Copayment
Physician's fee, surgery, MRA, MRI, PET, SPECT, CT Scan, CTA, medical supplies and drugs	Standard Deductible
Laboratory and x-ray tests	
Ambulance Services Transport by ambulance must be Medically Necessary	
III. Outpatient Physical Rehabilitation Services	
Physical Therapy and Occupational Therapy and Speech Therapy Up 20 visits per therapy per Member, per year	Specialty Visit Copayment
Cardiac Rehabilitation Visits	
Chiropractic Care • **Office visits -** up to 12 visits per Member, per year	
• **Laboratory and x-ray tests** furnished by a chiropractor	Standard Deductible
Early Intervention Services	Specialty Visit Copayment
IV. Home Care	
Physician services Medical exams, injections, medical treatments, surgery and anesthesia	Visit Copayment or Specialty Copayment
Home Health Agency services	Standard Deductible
Hospice	
Infusion Therapy	
Durable Medical Equipment, Medical Supplies and Prosthetics	Subject to the DME Deductible and Coinsurance

	YOUR COST
V. Behavioral Health Care (Mental Health and Substance Abuse Care)	
Outpatient/Office Visits	
Mental Health Visits: Unlimited Medically Necessary visits **Substance Abuse Visits:** Unlimited Medically Necessary visits (including detoxification and substance abuse rehabilitation services)	Visit Copayment or Specialty Visit Copayment
Partial Hospitalization and Intensive Outpatient Treatment Programs	
Mental Disorders: Unlimited Medically Necessary care **Substance Abuse Conditions**: Unlimited Medically Necessary care for rehabilitation and detoxification	Standard Deductible
Inpatient Care	
Mental Disorders: Unlimited Medically Necessary Inpatient days **Substance Abuse Conditions**: • Medical detoxification days – Unlimited Medically Necessary Inpatient days • Substance abuse rehabilitation – Unlimited Medically Necessary Inpatient days	Standard Deductible
Scheduled Ambulance Transport Limited to Medically Necessary transport from one facility to another	
VI. Prescription Eyewear	
n/a	

HealthTrust

Anthem BlueCross BlueShield

Lumenos Preferred Blue®
Cost Sharing Schedule

This Cost Sharing Schedule is an important part of Your Subscriber Certificate and is an outline of Your coverage. Do not rely on this outline alone. Keep this schedule with Your Certificate because it contains important information about coverage and limitations. Please read Your Subscriber Certificate carefully as important terms and limitations apply.

Cost Sharing Summary	Network Benefits	Out-of-Network Benefits*
	YOUR COST	
Visit Copayment Applies each time You visit a Preferred Provider or Preferred obstetrical/gynecological specialist.	N/A	N/A
Specialty Visit Copayment Applies each time You visit a specialist. This Copayment also applies each time You visit a Preferred Physician at a Preferred Walk-In Center for diagnosis, care and treatment of an illness or injury.	N/A	
Emergency Room Copayment	N/A	
Urgent Care Facility Copayment Applies each time You visit a Preferred licensed hospital's urgent care facility for diagnosis, care and treatment of an illness or injury.	N/A	N/A
Standard Deductible+	$2,500 per Member, per year $5,000 per 2-person or family, per year	
Standard Coinsurance+	N/A	30%
Coinsurance Maximum	N/A	$2,500 per Member, per year $5,000 per 2-person or family, per year
Durable Medical Equipment, Medical Supplies and Prosthetics **Deductible** **Coinsurance**	 Standard Deductible N/A	 Standard Deductible Standard Coinsurance
Out-of-Pocket Limit** Includes all Deductibles, Coinsurance, and Copayments You pay during a year. It does not include Your premium, amounts over the Maximum Allowable Benefit or charges for noncovered services.	$2,500 per Member, per year $5,000 per family, per year	$5000 per Member, per year $10,000 per family, per year
Inpatient Precertification Penalty	N/A	N/A

* Benefits are limited to the Maximum Allowable Benefit (MAB). Under Out-of-Network Benefits, You may be responsible for paying the difference between the MAB and charge. Please see Section 2 of Your Subscriber Certificate for details. Self-referred care may require preauthorization/precertification from Anthem. Please refer to Your Subscriber Certificate for details.

**Once the Out-of-Pocket Limit is satisfied, You will not have to pay additional Deductibles, Coinsurance, or Copayments for the rest of the year.

+If You are enrolled at the 2-person or family level, eligible expenses incurred by You or any of Your enrolled family members count toward satisfying the entire 2-person/family deductible and/or coinsurance.

Please note that throughout this schedule any reference to year means calendar year.

Coverage Outline	Network Benefits	Out-of-Network Benefits*
	YOUR COST	
Medical/Surgical Care		
I. Inpatient Services		
In a Short Term General Hospital (Facility charges for medical, surgical and maternity admissions)	Standard Deductible	Standard Deductible and Coinsurance plus any balances
In a Skilled Nursing Facility (Facility charges) Up to 100 Inpatient days per Member, per year†		
In a Physical Rehabilitation Facility (Facility charges) Up to 100 Inpatient days per Member, per year†		
Inpatient physician and professional services (Such as physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests) For Skilled Nursing or Physical Rehabilitation Facility admissions: limited to the number of Inpatient days stated above.		
II. Outpatient Services		
Preventive Care		
Preventive Care and screenings as required by law including, but not limited to: -Immunizations for babies, children and adults (including travel and rabies immunizations) -Cancer screenings such as; Mammograms, pap smears, prostatic specific antigen (PSA) screening, routine colonoscopy and sigmoidoscopy -Routine physical exams for babies, children and adults (including one annual gynecological exam) -Lead screening -Outpatient/office contraceptive services -Nutrition counseling -Routine vision exams -Routine hearing exams	You Pay $0	Standard Deductible and Coinsurance, plus any balances
Medical/Surgical Care in a Physician's Office or Walk-In Center or furnished by an Independent Ambulatory Surgical Center, Independent Infusion Therapy Provider, Independent Laboratory Provider, or Independent Radiology Provider		
Medical exams, consultations, anesthesia, medical treatments, and Preferred Provider services at a Network Walk-In Center	Standard Deductible	Standard Deductible and Coinsurance plus any balances
Injections (including allergy injections)		
Office surgery		
Laboratory tests (including allergy testing)		
X-ray tests (including ultrasound)		
MRA,MRI, PET, SPECT, CT Scan, CTA, chemotherapy, medical supplies and drugs		
Maternity care (prenatal and postpartum visits) Please see Your Subscriber Certificate for information about total maternity care.	Your share of the cost for delivery of a baby is indicated above under "Inpatient Services" or below under "Outpatient Facility Care."	

* Benefits are limited to the Maximum Allowable Benefit (MAB). Under Out-of-Network Benefits, You may be responsible for paying the difference between the MAB and charge. Please see Section 2 of Your Subscriber Certificate for details. Self-referred care may require preauthorization/precertification from Anthem. Please refer to Your Subscriber Certificate for details.

† Any combination of Network Benefits and Out-of-Network Benefits counts toward this limit.

	Network Benefits	Out-of-Network Benefits*
	YOUR COST	
Outpatient Facility Care in the Outpatient Department of a Hospital, a Short Term General Hospital's Ambulatory Surgical Center, a Hemodialysis Center or Birthing Center		
Medical exams and consultations by a physician	Standard Deductible	Standard Deductible and Coinsurance plus any balances
Services of a surgeon, operating room for surgery and anesthesia		
Physician and professional services for the delivery of a baby or management of therapy Hemodialysis, chemotherapy, radiation therapy, infusion therapy, MRA, MRI, PET, SPECT, CT Scan, CTA Fees for use of a facility, medical supplies, drugs, other ancillaries, observation		
Laboratory and x-ray tests (including ultrasounds)		
Emergency Room Visits and Urgent Care Facility Visits		
Use of the emergency room	Standard Deductible	Standard Deductible and Coinsurance plus any balances
Use of a licensed hospital's urgent care facility		
Physician's fee, surgery, MRA, MRI, PET, SPECT, CT Scan, CTA, medical supplies and drugs		
Laboratory and x-ray tests		
Ambulance Services Transport by ambulance must be Medically Necessary	Standard Deductible	
III. Outpatient Physical Rehabilitation Services		
Physical Therapy and Occupational Therapy and Speech Therapy Up to a combined maximum of 60 visits per Member, per year†	Standard Deductible	Standard Deductible and Coinsurance plus any balances
Cardiac Rehabilitation Visits		
Chiropractic Care • **Office visit**		
• **Laboratory and x-ray tests** furnished by a chiropractor		
Early Intervention Services		
IV. Home Care		
Physician services Medical exams, injections, medical treatments, surgery and anesthesia	Standard Deductible	Standard Deductible and Coinsurance plus any balances
Home Health Agency services – Up to 100 visits per Member, per year†		
Hospice		
Infusion Therapy		
Durable Medical Equipment, Medical Supplies and Prosthetics		

* Benefits are limited to the Maximum Allowable Benefit (MAB). Under Out-of-Network Benefits, You may be responsible for paying the difference between the MAB and charge. Please see Section 2 of Your Subscriber Certificate for details. Self-referred care may require preauthorization/precertification from Anthem. Please refer to Your Subscriber Certificate for details.

† Any combination of Network Benefits and Out-of-Network Benefits counts toward this limit.

	Network Benefits	Out-of-Network Benefits*
	YOUR COST	
V. Behavioral Health Care (Mental Health and Substance Abuse Care)		
Network Benefits are available when You obtain Covered Services from a Preferred Provider, as approved in advance. **Out-of-Network Benefits** are available when You obtain Covered Services from any Eligible Mental Health or Substance Abuse Provider, as approved in advance.		
Outpatient/Office Visits		
Mental Health Visits: Unlimited Medically Necessary visits **Substance Abuse Visits:** Unlimited Medically Necessary visits (including detoxification and substance abuse rehabilitation services)	Standard Deductible	Standard Deductible and Coinsurance plus any balances
Partial Hospitalization and Intensive Outpatient Treatment Programs		
Mental Disorders: Unlimited Medically Necessary care **Substance Abuse Conditions**: Medically Necessary care for rehabilitation and detoxification	Standard Deductible	Standard Deductible and Coinsurance plus any balances
Inpatient Care		
Mental Disorders: Unlimited Medically Necessary Inpatient days **Substance Abuse Conditions:** • Medical detoxification days - Unlimited Medically Necessary Inpatient days • Substance abuse rehabilitation – Unlimited Medically Necessary Inpatient days	Standard Deductible	Standard Deductible and Coinsurance plus any balances
Scheduled Ambulance Transport Limited to Medically Necessary transport from one facility to another	Standard Deductible	
VI. Prescription Eyewear		
not applicable		
VII. Prescription Drugs		
Subject to any Standard Deductible and/or Standard Coinsurance shown on Page 1 of this Cost Sharing Schedule. Benefits and limitations are stated in Your Pharmacy Rider.		

* Benefits are limited to the Maximum Allowable Benefit (MAB). Under Out-of-Network Benefits, You may be responsible for paying the difference between the MAB and charge. Please see Section 2 of Your Subscriber Certificate for details. Self-referred care may require preauthorization/precertification from Anthem. Please refer to Your Subscriber Certificate for details.

Lumenos® Preferred Blue Subscriber Certificate

What You Need to Know about Your Local Government Center HealthTrust High-Deductible Managed Health Care Plan

8324NH NH (1/11)

Welcome To The Family!

LGC HealthTrust and Anthem welcome You and thank You for allowing us the privilege to serve Your health care plan needs.

If there are ever any concerns, questions or suggestions that You may have, there are several options for communicating with us. You may contact us by telephone as follows:

- LGC HealthTrust Representatives may be reached during business hours at 1-800-527-5001
- Anthem Customer Service Center Representatives may be reached during business hours at 1-888-224-4896

You may write to us at the following addresses:

LGC HealthTrust
P.O. Box 617
Concord, NH 03302-0617

Anthem Blue Cross and Blue Shield
P.O. Box 660
North Haven, CT 06473-0660

You may visit us at the following addresses:

LGC HealthTrust
25 Triangle Park Drive
Concord, NH

Anthem Blue Cross and Blue Shield
3000 Goffs Falls Road
Manchester, NH

You may also contact us through our websites. Our websites contain valuable information and can provide answers to many frequently asked questions. To contact us through our websites, please enter:

LGC HealthTrust
www.nhlgc.org

Anthem Blue Cross and Blue Shield
www.anthem.com

We look forward to a long-lasting and positive relationship.

Maura Carroll
Executive Director
Local Government Center HealthTrust, LLC

Lisa M. Guertin
President and General Manager
Anthem Blue Cross and Blue Shield, New Hampshire

Introduction

Please see Section 14 for definitions of specifically capitalized words

This Lumenos Preferred Blue Subscriber Certificate describes the terms and conditions of Benefits coverage under LGC HealthTrust's Lumenos Preferred Blue managed health care plan (the "Plan"). The Plan is a high deductible health care plan that is compatible for use with a separate tax-qualified Health Savings Account. Your Group is making the Plan available to You and other eligible Employees as an important employee benefit. This Certificate describes the Benefits available under the Plan as well as Your rights and responsibilities, including procedures You must follow. Benefits are provided and funded by Local Government Center HealthTrust, LLC ("LGC HealthTrust"), while Anthem Health Plans of New Hampshire, Inc., operating as Anthem Blue Cross and Blue Shield ("Anthem"), provides certain administrative services, including claims processing and utilization management.

LGC HealthTrust has sole and exclusive discretion in interpreting coverage and Benefits available under the Plan including the terms, conditions, limitations and exclusions set forth in this Certificate, and in making factual determinations related to Benefits. LGC HealthTrust may, from time to time, delegate discretionary authority to other persons or entities providing services in regard to the Plan (for example, Anthem). Examples of such delegation of discretionary authority appear in this Certificate where LGC HealthTrust provides Anthem the right to make the final determination of Benefits for Covered Services. Any change or amendment to the Plan or this Certificate must be made in writing and must be duly adopted by LGC HealthTrust. No person or entity has any authority to make any oral changes or oral amendments to the Plan or this Certificate. LGC HealthTrust further reserves the right to terminate the Plan by giving advance notice of at least 30 days to You and Your Group.

LGC HealthTrust may, in its sole discretion, arrange for various persons or entities (for example, Anthem) to provide administrative services in regard to the Plan, including claims processing and utilization management services. The identity of the service provider and the nature of the service provider may be changed from time to time, at the sole discretion of LGC HealthTrust, and without prior notice to or approval by Groups or Members.

Section 1: Overview – How Your Plan Works – General Information

Please see Section 14 for definitions of specially capitalized words.

I. About This Certificate

This is Your Lumenos Preferred Blue Subscriber Certificate. It describes the relationship among You, Your health care provider, Your Group and the Plan. You and Your eligible Dependents are entitled to the Benefits described in this Certificate provided that all conditions for membership described in Section 13 have been met. Certain rights and responsibilities are also described in this Certificate.

Your Cost Sharing Schedule (enclosed with this Certificate) is an Important Part of this Certificate. It lists Your cost sharing amounts (Copayments, Deductibles and Coinsurance). Certain Benefit limitations are also shown on Your Cost Sharing Schedule. LGC HealthTrust may issue riders or endorsements that amend this Subscriber Certificate by describing additional Covered Services or limitations. Please read Your Certificate carefully, because it explains the terms of Your coverage.

II. Your Benefit Options

There are two levels of Benefits under this managed health care Plan:

- **Network Benefits.** You have lesser out-of-pocket expense under Network Benefits. With few exceptions (explained in Section 3), You must receive Covered Services from a Preferred Provider to be eligible for Network Benefits.

- **Out-of-Network Benefits.** You may receive Covered Services from an Out-of-Network Provider. Significant Benefits are available under this option, but Your out-of-pocket costs are greater.

Please see Sections 3 and 4 for more information about Network Benefits and Out-of-Network Benefits.

III. Precertification

Lumenos Preferred Blue is a managed health care Plan. This means that Anthem (or a designated administrator) works with You and Your health care providers to assure that You receive the Covered Services You need in the most appropriate health care setting. In most cases, Anthem works with You and Your provider to discuss proposed services before You receive the care. To begin the process, You must request approval from Anthem before You receive certain Covered Services. This written approval is called "Precertification." Precertification is not a guarantee of Benefits. Benefits are subject to all of the terms and conditions of this Certificate, including but not limited to, Copayments, Deductibles, Coinsurance, limitations and exclusions.

When You contact Anthem for Precertification, Anthem will obtain information from You and from Your physician in order to review the Medical Necessity of the service. If Anthem determines that Your care is Medically Necessary, Anthem will notify You, Your physician and the hospital or facility that the service is approved. If Anthem determines that the care is not Medically Necessary, Anthem will notify You and Your physician.

Whether You choose Network Benefits or Out-of-Network Benefits, please call Anthem at the telephone number on Your identification card to obtain Precertification for the following services. Benefits may be reduced if You do not obtain Precertification from Anthem as required:

- **Inpatient Admissions.** You must contact Anthem for Precertification of Inpatient Admissions. If You do not obtain Precertification from Anthem as required, a Precertification Penalty may be applied to the cost of Medically Necessary Covered Services. The Penalty (if any) is shown on page 1 of Your Cost Sharing Schedule. You are responsible for paying any Penalty. If You do not obtain Precertification as required and Anthem later determines that Your care was not Medically Necessary, then no Benefits will be available and You will be responsible for the full cost of Your care.

- **Non-emergency Inpatient Admissions.** You must obtain Precertification from Anthem at least seven days *before* the day You are admitted to a hospital, Skilled Nursing Facility or Physical Rehabilitation Facility for non-emergency care. This Precertification requirement also applies if Your medical physician admits You to a Short-term General Hospital for medical detoxification. A non-emergency admission is any Inpatient admission that is not for Emergency Care, as defined in Section 6. Non-emergency admissions include but are not limited to elective, scheduled or planned Inpatient admissions.

- **Notice of Maternity Admissions.** At the end of Your pregnancy, You, or someone acting for You, must call Anthem at 1-800-531-4450 within 48 hours after You are admitted to the hospital (or on the next business day, whichever is later). This rule applies to admissions for vaginal deliveries and for *unscheduled* caesarian section deliveries.

  Note: For caesarian section deliveries scheduled in advance, follow the Precertification rules stated in 1 (above) for "Non-emergency Inpatient Admissions." You must contact Anthem at 1-800-531-4450 to obtain Precertification at least seven days before the date of Your Inpatient admission.

- **Emergency Admissions.** Please see Section 6 for complete information about Precertification for emergency admissions.

- **Inpatient Admissions for Behavioral Health Care**. You must obtain preauthorization from Anthem before any Inpatient admission for Behavioral Health Care. Please see Section 7, V, "Behavioral Health Care for complete information.

- **"Schedule A" Services.** LGC HealthTrust reserves the right to publish a listing of Outpatient services that require Precertification *before* You receive them. Any Outpatient service that requires Precertification will be listed on a Schedule A endorsement to Your Certificate. When applicable, the Schedule A endorsement will be enclosed with Your Subscriber Certificate. You must call Anthem for Precertification at least seven days *before* receiving any service listed on Schedule A. The services listed on the Schedule A may be changed from time to time. You will receive advance notice of any additions to Schedule A.

  Please see Section 7, V for more information about any Outpatient Behavioral Health Care service for which You must obtain preauthorization from Anthem before You receive the care.

IV. The Network

The network consists of Preferred Providers. Preferred Providers are independent contractors who furnish Covered Services to Members. Anthem does not, nor does it intend to, engage in the performance or delivery of medical or hospital services or other types of health care. Preferred Providers are:

- **In the Service Area:** Physicians, including primary care providers (internists, family practitioners, general practitioners, Advanced Practice Registered Nurse (APRN), and pediatricians) and specialists, hospitals and other health care providers and facilities *in the Service Area* that have a network payment agreement directly with Anthem to provide Covered Services to Members. Preferred Providers located in the Service Area are listed in the Provider Directory. Since the printed directory is updated periodically, Your directory book may not always be current at the time You need to arrange for Covered Services. To locate the most up-to-date information about Preferred Providers in the Service Area, please go to Anthem's website, www.anthem.com. Or, You may contact Anthem's Customer Service Center for assistance. The toll-free telephone number is on Your identification card.

- **Outside the Service Area:** Physicians including primary care providers (internists, family practitioners, general practitioners, Advanced Practice Registered Nurse (APRN), and pediatricians), hospitals and other health care providers and facilities *outside the Service Area* that have a Preferred payment agreement with the local Blue Cross and Blue Shield plan (the Local Plan). To locate Preferred Providers outside the Service Area, please call the BlueCard Access Call Center at 1-800-810-BLUE (2583).

Payment agreements may include financial incentives or risk sharing relationships related to provision of services or referrals to other Preferred Providers, Out-of-Network Providers and disease management programs. Financial incentives for cost-effective care are consistent with generally recognized professional standards. If You have questions regarding such incentives or risk sharing relationships, please contact Your provider or Anthem.

Anthem may subcontract particular services to organizations or entities that have specialized expertise in certain areas. Subcontractors may include but are not limited to prescription drugs and Behavioral Health Care. Such subcontracted organizations or entities may make Benefit determinations and/or perform administrative, claims paying, network management or customer service duties on Anthem's behalf.

The selection of a Preferred Provider or any other provider and the decision to receive or decline to receive health care services is the sole responsibility of the Member. Contracting arrangements between Preferred Providers and Anthem (or between Preferred Providers and another Blue Cross and Blue Shield plan) should not, in any case, be understood as a guarantee or warranty of the professional services of any provider or the availability of a particular provider.

Physicians, hospitals, facilities and other providers who are not Preferred Providers are Out-of -Network Providers.

V. Group Coverage

You are covered under this Certificate as part of a Group. Eligibility rules are determined by Your Group and LGC HealthTrust. By submitting Your signed Medical Enrollment Application and by authorizing Your Group to make premium payments to LGC HealthTrust on Your behalf, You agree to the terms of this Certificate. Provided that the required premium is paid on time, Your coverage becomes effective on a date determined by Your Group and by LGC HealthTrust as described in Section 13, II.

VI. Services Must be Medically Necessary

Each service that You receive must be Medically Necessary, as determined by Your provider, Anthem and the Local Plan. Otherwise, no Benefits are available. This requirement applies to each Section of this Certificate. Please see Section 14 for the definition of "Medically Necessary."

Anthem has the right to review services after they have been furnished in order to confirm that they were Medically Necessary. If the services are received in the Service Area from a Preferred Provider, and are later determined to be not Medically Necessary, the Preferred Provider is prohibited from billing You for the portion of services that would have been covered if they had been Medically Necessary unless You have otherwise agreed in writing *before* You receive the services. For services received outside the Service Area, You may be responsible for the full cost of services that are not Medically Necessary, even if the provider is a Preferred Provider or a BlueCard Provider. You are responsible for the full cost of services provided by an Out-of-Network Provider that Anthem determines to be not Medically Necessary.

VII. No Preexisting Condition Exclusion

LGC HealthTrust does not apply or enforce any preexisting condition exclusions with respect to Your coverage under the Plan.

VIII. Contact Information for LGC HealthTrust and Anthem

If You have any questions about Your health plan coverage or Benefits available under this Certificate, please call or write to LGC HealthTrust or Anthem at the locations listed in this article. All correspondence with LGC HealthTrust or Anthem should include Your Group name and number, Your identification number and Your telephone number.

Name, business address and telephone number of LGC HealthTrust:

LGC HealthTrust
P.O. Box 617
Concord, NH 03302-0617
Telephone Number: 603-226-2861
1-800-527-5001

Name, business address and telephone number of Anthem:

Anthem Blue Cross and Blue Shield
P.O. Box 660
North Haven, CT 06473-0660
Telephone Number: 1-888-224-4896

Section 2: Cost Sharing Terms

Please see Section 14 for definitions of other specially capitalized words.

Under this managed health care Plan, You share the cost of certain Covered Services. Please see Your Cost Sharing Schedule for specific cost sharing amounts.

If a Copayment, Coinsurance and/or Deductible amount is collected from a Member at the time of service and the amount exceeds the Member's Copayment, Coinsurance and/or Deductible liability as determined by Anthem, Preferred Providers who have a written payment agreement directly with Anthem are required to promptly refund to the Member the amount overpaid and will not apply the overpayment to outstanding balances due on unprocessed claims.

Depending upon the cost sharing plan chosen by Your Group, You will find some or all of the following terms on Your Cost Sharing Schedule:

I. Copayments

Copayments are fixed dollar amounts that You pay each time You receive certain Covered Services. Your Plan may or may not include Copayments. The following is not a complete list of Copayment requirements that may apply. Other Copayment requirements may be explained on Your Cost Sharing Schedule or in riders or endorsements that amend this Certificate.

A **Visit Copayment** applies to Outpatient visits for medical/surgical care and Behavioral Health Care. Copayment amounts may vary according to the type of provider You visit. For example, the Copayment for a visit to Your primary care provider may be less than the Copayment for a visit to a specialist.

The **Emergency Room Copayment** applies each time You use the emergency room at a hospital. This Copayment is waived if You are admitted to the hospital for Inpatient care directly from the emergency room.

Please note: In addition to the Emergency Room Copayment, a Deductible and/or Coinsurance may apply. For example, Your cost sharing plan may include a Deductible and Coinsurance for the physician and ancillary services furnished during Your visit. Please refer to Your Cost Sharing Schedule for more information about Your share of the cost for use of the emergency room. Please see Section 6, "Emergency Care" for more information about emergency room visits.

Prescription Drug Copayment. Prescription Drug Copayments apply as shown on Your Cost Sharing Schedule and as described in Your Pharmacy Rider.

II. Deductible

A Deductible is a fixed dollar amount that You pay for each Member's Covered Services each calendar year *before* Benefits are available for payment under this Plan.

The **Standard Deductible** applies to most Covered Services. Any exceptions are stated on Your Cost Sharing Schedule.

Deductible met under one option (Network Benefits or Out-of-Network Benefits) applies toward meeting any Deductible required under the other option.

III. Coinsurance

After any applicable Deductible is met, Your Plan pays a percentage of the cost of certain Covered Services. You also pay a percentage. The percentage that You pay is called "Coinsurance." Coinsurance only applies to Covered Services if shown on Your Cost Sharing Schedule.

Standard Coinsurance applies only if stated on Your Cost Sharing Schedule. Coinsurance met under Network Benefits applies only towards meeting the Network Benefits Coinsurance Maximum. Coinsurance met under Out-of-Network Benefits applies only toward meeting the Out-of-Network Coinsurance Maximum.

Note: Your Plan includes a Pharmacy Rider. A separate Coinsurance may apply to pharmacy purchases. Any Coinsurance amounts are shown on Your Cost Sharing Schedule and do not count toward meeting any other Coinsurance limit.

IV. Deductible and Coinsurance Maximums and the Out-of-Pocket Limit

Depending on the cost sharing plan chosen by Your Group, the following cost sharing limits may apply. Please refer to Your Cost Sharing Schedule:

A. If You are covered under a single membership and You meet Your Deductible requirement, no further Deductible is required for the remainder of the calendar year. If You meet Your Coinsurance Maximum, no further Coinsurance is required for the remainder of the calendar year.

B. If You are covered under a family membership and the family Deductible is met during the calendar year, no further Deductible is required for the family for the remainder of the calendar year. One Member or all Members collectively can satisfy the family Deductible. If Your family Coinsurance Maximum is met, no further Coinsurance is required for the remainder of the calendar year. One Member or all Members collectively can satisfy the family Coinsurance Maximum.

C. For all membership types, the Out-of-Pocket Limit is equal to the Deductibles plus the Coinsurance requirements combined. Deductibles met under either Network or Out-of-Network Benefits are combined toward meeting the Out-of-Pocket Limit. However, Coinsurance met under Network Benefits counts only toward the Network Benefits Out-of-Pocket Limit and Coinsurance met under Out-of-Network Benefits counts only toward the Out-of-Network Out-of-Pocket Limit.

D. Your Plan includes a Pharmacy Rider. A separate Deductible and Coinsurance may apply to pharmacy purchases. These amounts are shown on Your Cost Sharing Schedule and do not count toward meeting any other Deductible or Coinsurance Maximums.

Deductible amounts are limited to the Maximum Allowable Benefit. Coinsurance is a percentage of the Maximum Allowable Benefit. Amounts that exceed the Maximum Allowable Benefit do not count toward Your Deductible or Coinsurance requirements or maximums. Copayments and the cost of noncovered services do not count toward any Deductible or Coinsurance requirements or maximums.

V. Other Out-of-Pocket Costs

In addition to the cost sharing amounts shown on Your Cost Sharing Schedule, You are responsible for paying other costs, as follows:

A. Certain **annual limits** may apply under this Plan. Annual limits may apply to certain Covered Services, as stated on Your Cost Sharing Schedule and in this Certificate. For example, coverage for Outpatient physical, occupational and speech therapy visits, or coverage for medical equipment may be limited to a calendar year visit or dollar maximum. You are responsible for the cost of services that exceed an annual limit.

B. A **Lifetime Maximum** may apply to Your coverage, as shown on Your Cost Sharing Schedule. Benefits paid for all Covered Services count toward this maximum. If You had coverage under an Anthem coverage or a LGC HealthTrust sponsored health plan administered by Anthem immediately prior to the date You became covered under this Certificate and both plans were made available to You through the same Group, Benefits paid under the previous Certificate will be applied toward this Lifetime Benefit Maximum unless Your Group arranges for Anthem coverage under a different Anthem product.

C. Amounts That Exceed the Maximum Allowable Benefit. Benefits under this Plan are limited to the Maximum Allowable Benefit. "Maximum Allowable Benefit" means the dollar amount available for a specific Covered Service. This is determined as stated in Section 14.

Amounts that exceed the Maximum Allowable Benefit do not count toward meeting any cost sharing requirements or other out-of-pocket costs.

Preferred Providers and BlueCard Providers agree to accept the Maximum Allowable Benefit as payment in full. You are responsible for paying the difference between the Maximum Allowable Benefit and the provider's charge if You receive Covered Services from an Out-of-Network New Hampshire Provider or a NonBlueCard Provider outside New Hampshire.

E. Noncovered or Excluded Services. You are responsible for paying the full cost of any service that is not described as a Covered Service in this Certificate. You are responsible for paying the full cost of any service that is excluded from coverage in this Certificate. This applies even if Your physician or other Designated Provider prescribes, orders or furnishes the service.

Section 3: Network Benefits

Please see Section 14 for definitions of specially capitalized words.

I. The Preferred Level of Benefits

With few exceptions, You must receive Covered Services from a Preferred Provider to be eligible for Network Benefits. Exceptions are stated in article III of this Section. Network Benefits are the highest level of Benefits available under this managed health care plan.

Please remember that You must obtain Precertification *before* You receive certain Covered Services. Benefits are not available for care which is not Medically Necessary. You are responsible for the cost of any service which is not Medically Necessary as determined by Anthem. Please see Section 1 for more information about Precertification.

Under Network Benefits, You enjoy the following advantages:

- You have lesser out-of-pocket expense, as shown on Your Cost Sharing Schedule.
- You do not have to pay the difference between the Maximum Allowable Benefit and the Preferred Provider's charge. Throughout the United States of America, Preferred Providers agree to accept the Maximum Allowable Benefit as payment in full.
- You do not have to file claim forms or manage the payment of Benefits to Your provider. Preferred Providers will submit claim forms for You. Anthem pays Benefits directly to Preferred Providers.

Preferred Providers located in the Service Area are listed in the Provider Directory. The printed directory is updated periodically and may not always be current at the time You need to arrange for Covered Services. To locate the most up-to-date information about Preferred Providers in the Service Area, please go to Anthem's website, www.anthem.com. Or, You may contact Anthem's Customer Service Center for assistance. The toll-free telephone number is on Your identification card.

To locate Preferred Providers outside the Service Area, please call the BlueCard Access Call Center at 1-800-810-BLUE (2583).

II. Referrals to Specialist

At times, Your Preferred Provider will find it necessary to refer You to another physician or hospital for specialized care. In most cases, You will be referred to another Preferred Provider. To help ensure that Network Benefits are available for Covered Services, it is Your responsibility (not the provider's) to:

- Be sure that the specialist or hospital is a Preferred Provider
- Obtain Precertification from Anthem *before* You receive certain Covered Services, as explained in Section 1.

III. Exceptions Outside the Service Area

In the following circumstances *outside the Service Area*, Network Copayments, Deductible and Coinsurance will apply even if Your care is furnished by an Out-of-Network Provider:

- You receive care from a BlueCard Provider and there is no Preferred Provider Network available in Your location, as determined by the Local Plan, **or**

- You receive care from a BlueCard specialist (such as a cardiologist or physical therapist) in a location where the Preferred Provider Network is available, but the network does not include Preferred Providers of the same or similar specialty, as determined by the Local Plan.

Note: Covered emergency ambulance Services are eligible for Network Benefits, regardless of the location of the service. Out-of-Network Benefits are not applicable.

Except as stated above, only Out-of-Network Copayments, Deductible, Coinsurance and Plan rules apply when services are furnished by an Out-of-Network Provider. Please see Section 4 for complete information.

Section 4: Out-of-Network Benefits

Please see Section 14 for definitions of specially capitalized words.

I. Out-of-Network Benefits

You have the freedom to seek Medically Necessary Covered Services from an Out-of-Network Provider. Significant Benefits are available under this option, but Your share of the cost is higher, as shown on Your Cost Sharing Schedule.

Please remember that You must obtain Precertification *before* You receive certain services. Benefits may be reduced if You do not obtain Precertification for Medically Necessary Inpatient care as required. Benefits may be denied if non-approved services are not Medically Necessary. Anthem determine Medical Necessity according to the definition found in Section 14. **Please see Section 1, III for more information about Precertification.**

II. Benefits

You pay the Out-of-Network Benefits Copayments and Deductible and Coinsurance amounts for Covered Services. These amounts are higher than Your out-of-pocket costs under Network Benefits. Please see Your Cost Sharing Schedule for details.

Benefits are limited to the Maximum Allowable Benefit. Under Out-of-Network Benefits, a provider may bill You for amounts that exceed Anthem's Maximum Allowable Benefit. Please Section 2 for more information about this cost sharing requirement.

No Benefits are available for services that are not Medically Necessary. The definition of Medical Necessity is found in Section 14.

III. Out-of-Network Benefits are Not Available for All Covered Services

Out-of-Network Benefits are not available for the following services:

- **Covered organ and tissue transplant services** are eligible for Network Benefits *only*. Out-of-Network Benefits are not available. Please see Section 7, VI for complete details about "Organ and Tissue Transplants."

- **Covered emergency ambulance services** are eligible for Network Benefits, regardless of the location of the service. Out-of-Network Benefits are not applicable.

Section 5: About Managed Care

Please see Section 14 for definitions of specially capitalized words.

Lumenos Preferred Blue Is a Managed Health Care Plan. This means that when You receive certain Covered Services, Anthem (or another designated administrator) works with You and Your health care providers to determine if You are receiving Medically Necessary services.

A Member's right to Benefits under the Plan is subject to certain clinical policies and administrative procedures. Clinical policies are used by Anthem to determine Benefits and include such things as Anthem's Medical Policies and utilization review criteria. You may obtain information about these policies by contacting Anthem. Administrative procedures include such things as Precertification, Concurrent Review and Care Management. A description of these procedures is provided in this Section and elsewhere in this Certificate. Your failure to follow required administrative procedures will result in a reduction or denial of Benefits.

None of Anthem's employees or the providers that Anthem contracts with to make medical management decisions, are paid or provided incentives to deny or withhold Benefits for services that are Medically Necessary and are otherwise covered. In addition, Anthem requires members of its clinical staff to sign an annual statement. This statement verifies that they are not receiving payments that would either encourage or reward them for denying Benefits for services that are Medically Necessary and are otherwise covered.

I. Your Role

You play an important role in this managed health care Plan. As a Member, You should become familiar with and follow Plan rules and procedures. These are described in Sections 1 through 6 of this Certificate. Knowing and following Plan rules and procedures is the best way for You to enjoy all of the advantages of this coverage. For example, You must contact Anthem for Precertification before You receive certain services, as explained in Section 1. Otherwise, Your Benefits may be reduced.

Your suggestions about improving the plan are important to Anthem. Please contact Anthem's Customer Service to let Anthem know about Your suggestions. The toll-free telephone number is on Your identification card. You can appeal any decision made by Anthem about Your coverage. Please see Section 11 for information about how to inform Anthem about Your suggestions or to use the appeal procedure.

II. The Role of Preferred Providers

Preferred Providers will work together to make sure that You have access to the health care services that You need. Your Preferred Physician can best oversee and coordinate Your care if You choose to contact him or her before You receive health care services. You access the higher level of Benefits under this managed health care Plan by seeking care from a Preferred Provider.

Most often, Your Preferred Physician will provide Your routine or urgent care directly. If Your physician determines that You require specialized care that falls outside his or her clinical expertise or services offered, Your physician will refer You to another provider. With few exceptions, You will be referred to a Preferred Provider.

III. Anthem's Role

As the administrator of Benefits under this Plan, Anthem's Medical Director and Medical Services Division play an important role in the management of Your Benefits. Some examples are:

A. Precertification. You must obtain Precertification from Anthem's Medical Services Division before You receive Inpatient care and before You receive certain Outpatient care. Emergency admissions must be reported to Anthem within 48 hours so that Anthem can conduct a Precertification review. If You have any questions regarding managed care guidelines, or to determine which services require Precertification, please call the number on the back of Your identification card. "Precertification" refers to the process used by Anthem to review Your health care services to determine if the service is Medically Necessary. Precertification does not guarantee coverage for or the payment of the service or procedure reviewed.

Whenever Anthem reviews a Precertification request, Anthem's Medical Director may discuss the services with Your provider and may ask for medical information about You and the proposed services. Anthem's Medical Director may determine that Benefits are available only if You receive services from a Preferred Provider, a Contracting Provider or from a Designated Provider that is, in the opinion of Anthem's Medical Director, most appropriate for Your care. The decision to receive or decline to receive health care services is Your sole responsibility, regardless of the coverage decision made.

B. Prior Approval. At Your provider's request, Anthem will review proposed services to determine if the service is a Covered Service. For example, if Your provider proposes a surgery that may be considered cosmetic or dental (and therefore not covered), he or she must submit clinical information for review *before* You receive the service.

C. Determinations about Medical Necessity. Anthem is given the right to make determinations about whether or not a service is Medically Necessary. Please see Section 14 for a definition of "Medically Necessary."

Please note: Anthem's Medical Policy reflects the standards of practice and medical interventions identified as reflecting appropriate medical practice. The purpose of Medical Policy is to assist in Anthem's determination of Medical Necessity. However, the Benefits, exclusions and limitations under this Plan take precedence over Medical Policy. Medical technology is constantly changing and Anthem reserves the right to review and update Medical Policy periodically.

D. Determinations about Experimental or Investigational Services. Anthem is given the right to make determinations about whether or not a service is Experimental or Investigational. Please see Section 8, II for more information about "Experimental/Investigational Services."

E. Review of New Technologies. Anthem is given the right to make determinations about coverage for new technologies. Anthem evaluates new medical technologies to define medical efficacy and to determine appropriate coverage. Anthem's evaluations are focused on the following factors:

- The technology must have final approval from the appropriate governmental regulatory bodies.
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
- The technology must improve net health outcomes.
- The technology must be as beneficial as any established alternatives.
- The improvement must be attainable outside the Investigational setting.

F. Case Management. Anthem maintains case management programs that tailor services to the individual needs of Members and seek to improve the health of Members. Case management is Anthem's process of evaluating and arranging for Medically Necessary treatment for Members identified as being eligible for individual case management. Participation in case management programs is voluntary.

Anthem's case managers are registered nurses and other qualified health professionals who work collaboratively with the Member, the Member's family and providers to coordinate the Member's healthcare Benefits. In certain extraordinary circumstances involving intensive case management, Anthem is given the right to provide Benefits for care that is Medically Necessary but not listed as a Covered Service in this Certificate. Anthem also is given the right to extend Benefits for Covered Services beyond the Benefit maximums stated in this Certificate. Decisions regarding case management are made on a case-by-case basis. By providing services through case management, the Plan makes exception only for a specific case and is not committed to providing similar coverage and Benefits again for You, nor for other Members. All other terms and conditions of this Certificate shall be strictly administered.

Anthem is given the right to alter or discontinue case management when it is no longer Medically Necessary. The Member or the Member's representative shall be notified in writing of alterations or a discontinuation of case management. Members who disagree with Anthem's determination may utilize the appeal procedure described in Section 11.

IV. Important Notes About this Section

Benefits are not guaranteed by Your provider's referral, Anthem's Precertification or Prior Approval. Benefits are subject to all of the terms and conditions of the Certificate in effect on the date You receive services.

Anthem's decisions about Precertification, Prior Approval requests, Medical Necessity, Experimental/Investigational services and new technologies are not arbitrary. Anthem's Medical Director or Medical Services Division takes into consideration the recommendations of the Member's provider and clinical information when making a decision about a Member's Benefit eligibility. When appropriate to review a proposed service, Anthem's Medical Director or Medical Services Division considers published peer-review medical literature about the service, including the opinion of experts in the relevant specialty. At times, Anthem may consult with experts in the specialty. Anthem may also review determinations or recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

Section 6: Urgent and Emergency Care

Please see Section 14 for definitions of specially capitalized words.

This Section is a guide to help You determine when You will be eligible for Network Benefits for Urgent and Emergency Care without contacting a Preferred Provider or Anthem in advance.

I. Urgent Care

Whenever possible, contact a Preferred Provider or Anthem (for Behavioral Health Care) for direction when You need urgent medical care. Examples of conditions that may require urgent care are: sprain, sore throat, rash, earache, minor wound, moderate fever or abdominal or muscle pain.

II. Emergency Care

It may not always be possible or safe to delay treatment long enough to consult with Your provider *before* You seek care. In a severe emergency, go to the nearest emergency facility immediately for Emergency Care. Call 911 for assistance if necessary.

Emergency Care means Covered Services You receive due to the sudden onset of a serious condition. A serious condition is a medical, psychological or substance abuse condition that manifests itself by symptoms of such severity that You need immediate medical attention to prevent any of the following:

- Serious jeopardy to Your health
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Examples of conditions or symptoms that may require Emergency Care are: suspected heart attack or stroke; a broken bone; uncontrolled bleeding; unconsciousness (including as a result of drug overdose or alcohol poisoning); or if You are at serious risk of harming Yourself or another person.

III. Emergency Room Visits for Emergency Care

Benefits are available for Emergency Care in any licensed hospital emergency room provided that Your condition meets the definition of Emergency Care as stated in article II of this Section. Your share of the cost for use of the emergency room is shown on Your Cost Sharing Schedule. Please be sure to call Your Preferred Provider or Anthem (for Behavioral Health Care) for direction *before* You receive follow-up care after an emergency room visit.

IV. Inpatient Admissions to a Hospital for Emergency Care

Your share of the cost for Inpatient Services is shown on Your Cost Sharing Schedule.

Medical/Surgical and Behavioral Health Admissions for Emergency Care. Benefits are available for an Inpatient admission for medical/surgical Emergency Care provided that Your condition meets the definition of Emergency Care as stated in article II of this Section.

You (or someone acting for You) must notify Anthem for Precertification within 48 hours after You are admitted (or on the next business day after You are admitted, whichever is later). If You are unable to call within 48 hours, Anthem's Medical Director will determine if Your circumstances prevented timely notification. Anthem determines whether or not Emergency Care conditions are met by reviewing Your admission records. Call Anthem at the number on Your identification card to notify Anthem of Your emergency admission.

If You do not notify Anthem about Your emergency admission as required, only Out-of-Network Benefits may be available for Medically Necessary Inpatient care. A Precertification Penalty may apply if Anthem determines that Your admission was a planned admission.

No Benefits will be available if Your admission was not Medically Necessary. Under Out-of-Network Benefits, You are responsible for the full cost of care that is not Medically Necessary.

V. Limitations

In addition to the limitations and exclusions listed in Section 7, VI and in Section 8, the following limitations apply to Emergency Care:

A. "Follow-up" care is any related Covered Service that You receive after Your initial emergency room visit. To be eligible for Network Benefits for medical/surgical conditions, Your follow-up care must be provided by a Preferred Provider. Otherwise, only Out-of-Network Benefits are available.

For Mental Disorders or Substance Abuse Conditions, the Plan rules stated in Section 7, V apply to follow-up care.

B. When determining whether or not Your services meet the definition of Emergency Care, Anthem will consider not only the outcome of Your emergency room visit or hospital admission, but also the symptoms that caused You to seek the care. To make this determination, Anthem reserves the right to review medical records after You have received Your services.

C. Emergency Care and Urgent Care do not include routine or elective care. Routine care includes, but is not limited to, routine medical examinations, routine gynecological examinations, diagnostic tests related to routine care, medication checks, immunizations or other preventive care. Elective care is care that can be delayed until You can contact Your physician or Anthem (for Behavioral Health Care) for direction. Examples of elective care include, but are not limited to: scheduled Inpatient admissions or scheduled Outpatient care. Emergency Care does not include any service related to or resulting from routine or elective care.

D. No Benefits are available for care related to, resulting from, arising from or provided in connection with noncovered services or for complications arising from noncovered services, even if the care meets Anthem's definitions of Emergency Care and/or Medical Necessity.

Section 7: Covered Services

Please see Section 14 for definitions of specially capitalized words.

This Section describes Covered Services for which LGC HealthTrust provides Benefits under the Plan. All Covered Services must be furnished by a Designated Provider. Preventive Care services are listed in article II, A of this Section. All other Covered Services must be Medically Necessary for the diagnosis and treatment of disease, illness, injury, or for maternity care. Otherwise, no Benefits are available.

Please remember the Plan guidelines explained in Sections 1 through 6. Some important reminders are:

- Members are entitled to the Covered Services described in this Section. All Benefits are subject to the exclusions, described in Section 8, and elsewhere in this Certificate and any amendments to this Certificate.

- To receive maximum Benefits, You must follow the terms of the Certificate, including, if applicable, receipt of care from a Preferred Provider, BlueCard Provider or Designated Provider, and obtaining any required Precertification.

- Benefits for Covered Services are based on the Maximum Allowable Benefit for such service. Deductible amounts are limited to the Maximum Allowable Benefit. Coinsurance is a percentage of the Maximum Allowable Benefit. No Benefits are available for amounts that exceed the Maximum Allowable Benefit.

- Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Certificate.

- The Plan's payment for Covered Services will be limited by any applicable Copayment, Coinsurance, Deductible, or annual or lifetime payment limit indicated in this Certificate and on Your Cost Sharing Schedule.

- The fact that a provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and does not guarantee payment.

- Anthem's determinations about Referrals, Precertification, Medical Necessity, Experimental/Investigational Services and new technology are based on the terms of this Certificate, including, but not limited to the definition of Medical Necessity. The definition of Medical Necessity is stated in Section 14. Anthem's medical policy assists in Anthem's determinations. Anthem's medical policy reflects the standards of practice and medical interventions identified as reflecting appropriate medical practice. However, the Benefits, exclusions and limitations stated in this Certificate take precedence over medical policy. You have the right to appeal Benefit determinations made by Anthem, including Adverse Determinations regarding Medical Necessity. Please see Section 11 for complete information.

Please note:

- This Section often refers to Your Cost Sharing Schedule. Your cost sharing amounts and important limitations are shown on the Cost Sharing Schedule.

- The higher level of Benefits (Network Benefits) is available when You receive Covered Services from a Preferred Provider. Under Out-of-Network Benefits, Your out-of-pocket costs are greater. Please see Sections 3 and 4 for more information about Your Benefit options.

- Please remember that You must call Anthem to obtain Precertification before You receive certain Covered Services. Benefits will be reduced if You do not follow Precertification rules. Benefits may be denied if non-approved services are not Medically Necessary. Please see Section 1, III, and article V, in this Section for more information. Precertification rules for Emergency Care are stated in Section 6.

I. Inpatient Services

Benefits are available for Medically Necessary facility and professional fees related to Inpatient medical/surgical admissions. This includes maternity admissions. Coverage includes the following:

A. Care in a Short Term General Hospital. Semi-private room and board, nursing care, pharmacy services and supplies, laboratory and x-ray tests, operating room charges, delivery room and nursery charges, physical, occupational and speech therapy typically provided in a Short Term General Hospital while You are a bed patient are covered. Custodial Care is not covered. Please see Section 8, II, L for a definition of Custodial Care.

Statement of Rights Under The Newborns' and Mothers' Health Protection Act. Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., Your physician, nurse midwife, or physician assistant), after consulting with the mother, discharges the mother or her newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization from the Plan or any insurance issuer for prescribing a length of stay up to 48 hours (or 96 hours).

B. Care in a Skilled Nursing Facility or Physical Rehabilitation Facility. Semi-private room and board, nursing and ancillary services typically provided in a Skilled Nursing or Physical Rehabilitation Facility while You are a bed patient are covered. *Benefits may be limited as shown on Your Cost Sharing Schedule*. Custodial Care is not covered. Please see Section 8, II, L for a definition of Custodial Care.

C. Inpatient Physician and Professional Services. Physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests are covered. Benefits for Inpatient medical care are limited to daily care furnished by the attending physician, unless another physician's services are Medically Necessary. For Skilled Nursing or Physical Rehabilitation Facility admissions, *Benefits may be limited as shown on Your Cost Sharing Schedule*. Custodial Care is not covered. Please see Section 8, II, L for a definition of Custodial Care.

Please see article V, "Behavioral Health Care" and article VI, "Important Information about Other Covered Services" for related information about Inpatient services. Also, see Section 8 for important limitations and exclusions that may apply to Inpatient services.

II. Outpatient Services

Benefits are available for Medically Necessary facility and professional fees related to Outpatient medical/surgical care. Coverage includes the following:

A. Preventive Care. In general, the term "Preventive Care" under this Certificate refers to medical care for adults and children with no current symptoms or prior history of a medical condition associated with the care. For Members who have current symptoms or have been diagnosed with a medical condition, services associated with the symptoms or diagnoses are not Preventive Care. Some exceptions to this definition are listed in this article but otherwise, services for the diagnosis or treatment of an illness, injury or medical condition are covered under other applicable sections of this Certificate. Whether or not a service is Preventive Care, Benefits are subject to the cost sharing requirements specified on Your Cost Sharing Schedule.

For the purposes of this article, the following Preventive Care services are covered:

1. Immunizations and vaccines for babies, children and adults (including rabies immunizations but not including travel immunizations)

2. Mammograms, pap smears, lead screening, prostatic specific antigen (PSA) screening

3. Routine physical exams for babies, children and adults (including one annual gynecological exam)

4. Routine vision exams to determine the need for vision correction. The exam must be furnished by an Optometrist or Ophthalmologist who is a Preferred Provider. Otherwise, only Out-of-Network Benefits are available. Benefits may be limited as shown on Your Cost Sharing Schedule. Please see article VI, H "Vision Services" for information about services for eye disease or injury.

5. Routine hearing exams to determine the need for hearing correction. Benefits may be limited as shown on Your Cost Sharing Schedule. Please see article VI, B, "Hearing Services" for information about Benefits available for diagnosis and treatment of ear disease or injury.

B. Medical/Surgical Care in a Physician's Office. In addition to Preventive Care commonly provided in a physician's office (see article A, above), the following services are covered:

1. Medical exams, consultations, office surgery and anesthesia, injections (including allergy injections), medical treatments (including allergy treatments), including services furnished at a Walk-In Center.

2. Laboratory and x-ray tests (including allergy testing and ultrasound)

3. CT Scan, MRI, chemotherapy

4. Medical supplies and drugs administered in a physician's office. Benefits are available for covered prescription medications, injectable drugs, radioactive materials, dressings and casts for the prevention of disease, illness or injury or for therapeutic purposes. No Benefits are available for fertility hormones or fertility drugs under this Certificate.

   Hormones, insulin and prescription drugs purchased at a physician's office for use outside the office are not covered under this Certificate. Durable Medical Equipment, Medical Supplies and Prosthetics, purchased for use outside a physician's office, are covered under article IV, E of this Section.

5. Maternity care. Total maternity care includes the provder's fees for prenatal visits, delivery, Inpatient medical care and postpartum visits. Most often, Your provider bills all of these fees together in one charge for delivery of a

baby and the Benefit includes all of the services combined. The Benefit is available according to the coverage in effect on the date of delivery. Note: If a provider furnishes *only* prenatal care or the delivery, or postpartum care, Benefits are available according to the coverage in effect on the date You receive the care.

Benefits are available for routine maternity care furnished by a New Hampshire Certified Midwife (NHCM), provided that the NHCM is certified under New Hampshire law and acting within an NHCM's scope of practice as defined in New Hampshire law. Coverage includes, but is not limited to home deliveries. Out-of-Network NHCM services are covered only if the midwife is certified under New Hampshire law.

Benefits are available for urgent and emergency care as described in Section 6 and all of the Medically Necessary Covered Services described in this Section with respect to pregnancy, tests and surgery related to pregnancy, complications of pregnancy, termination of pregnancy or miscarriage. Ultrasounds in pregnancy are covered only when Medically Necessary. Please see subsection VI, C, "Infertility Services" for important restrictions regarding infertility treatment.

6. Family planning visits, such as medical exams related to family planning and genetic counseling. Outpatient/office contraceptive services are covered, provided that the services are related to the use of FDA approved contraceptives. Examples of covered contraceptive services are: office visits, consultations, examinations and services related to the use of federal legend oral contraception or contraceptive patches, IUD insertion, diaphragm fitting, or contraceptive injections.

   Prescription and nonprescription contraceptive drugs and devices (such as oral contraceptives, IUDs, diaphragms, and contraceptive injections) are not covered under this Certificate. No Benefits are available for services related to the use of nonprescription contraceptives. Examples of noncovered services are: contraceptive creams and foams, condoms, spermicidal jelly or contraceptive sponges.

   Fertility hormones and fertility drugs are not covered under this Certificate. Benefits for infertility services are limited as explained in article VI, C, of this Section.

7. Nutrition counseling by a registered dietitian practicing independently or as part of a physician practice or Outpatient hospital clinic. Benefits may be limited as shown on Your Cost Sharing Schedule.

   Benefits are available for weight management counseling provided during covered nutrition counseling visits or as part of a covered diabetes management program (see 8 below). No other non-surgical service, treatment, procedure or program for weight or appetite control, weight loss, weight management or control of obesity is covered under this Certificate. However, Benefits are available for Medically Necessary Covered Services furnished to treat diseases and ailments caused by or resulting from obesity or morbid obesity.

   For information about surgical services to treat diseases and ailments caused by or resulting from obesity or morbid obesity, please see article VI, G, 4, "Surgery conditions caused by obesity."

C. **Outpatient Facility Care in the Outpatient Department of a Hospital, Ambulatory Surgical Center, Hemodialysis Center or Birthing Center**. In addition to Preventive Care commonly provided in an Outpatient facility (see article A of this Section), Benefits are available for Medically Necessary facility and professional services in the Outpatient department of a Short Term General Hospital, Ambulatory Surgical Center, Hemodialysis Center or Birthing Center. Coverage includes the following:

1. Medical exams and consultations by a provider

2. Operating room for surgery or delivery of a baby

3. Provider and professional services including surgery, anesthesia, delivery of a baby or management of therapy

4. Hemodialysis, chemotherapy, radiation therapy, infusion therapy,

5. CT Scan, MRI,

6. Medical supplies, drugs, other ancillaries, facility charges, including but not limited to facility charges for observation (a period of up to 24 hours during which Your condition is monitored to determine if Inpatient care is Medically Necessary)

7. Laboratory and x-ray tests, including ultrasounds

Please note: Ambulatory Surgical Centers and Birthing Centers must have a written payment agreement with Anthem or with their local Blue Cross and Blue Shield plan. Otherwise, the center is not a Designated Provider and no Benefits will be available for services provided to You in the facility. This exclusion applies even if the care is prescribed by a Designated Provider and meets Antehem's definition of Medical Necessity.

Also, see article III of this Section.

D. **Emergency Room Visits for Emergency Care.** Benefits are shown on Your Cost Sharing Schedule. Please see Section 6 for important guidelines about Emergency Care.

E. **Ambulance Services**. Benefits are available for Medically Necessary ambulance transport to a medical facility for Emergency Care. For example, coverage includes ambulance transport to a hospital from the scene of an accident or to a hospital from Your home due to symptoms of a heart attack.

Covered ambulance transport is subject to the Network Benefits Copayments, Deductible and Coinsurance. However, if You receive Out-of-Network Services, You may be responsible for the difference between the Maximum Allowable Benefit and the provider's charge.

In addition to the limitations and exclusions listed in Section 8, the following limitations apply to Ambulance Services:

- Non-emergency ambulance transport is not covered. If transport in a non-emergency vehicle (such as by car) is medically appropriate, ambulance transport is not covered. No Benefits are available for the cost of transport in vehicles such as chair ambulance, car or taxi, except as stated in article VI, D "Organ and Tissue Transplants"

- No Benefits are provided for transportation to or from medical appointments.

- Benefits are provided for air ambulance transport furnished by an air ambulance service to take You to a hospital only when it is Medically Necessary for You to be transported by air rather than ground ambulance. If Anthem determines that air ambulance transportation was not Medically Necessary, and that ground ambulance would have been Medically Necessary, the Plan will provide the Maximum Allowable Benefit for a ground ambulance. In this case, You pay the difference between the Maximum Allowable Benefit and the air ambulance charge.

F. Diabetes Management Programs. To be eligible for Benefits, Covered diabetes management programs must be ordered by Your physician and furnished by a certfied, registered or licensed health care expert in diabetes management. Covered Services include:

- Individual counseling visits,
- Group education programs and fees required to enroll in an approved group education program, and
- External insulin pump education is covered for Members whose external insulin pump has been approved by Anthem. The Diabetes Education Provider must be pump-certified. Please see subsection IV, E, "Durable Medical Equipment, Medical Supplies and Prosthetics" for information about coverage for external insulin pumps.

For information about diabetes education programs or Preferred Diabetes Education Providers, visit Anthem's website at www.anthem.com or call Customer Service. The toll-free phone number is on Your identification card.

In addition to the Limitations and Exclusions listed in Section 8, the following limitations apply to diabetes management services:

- In the Service Area, Benefits are limited to Covered Services furnished by a Preferred Diabetes Education Provider. Outside the Service Area, Covered Services must be furnished by a certified, registered or licensed health care expert in diabetes management.

- Benefits are available for fees required to enroll in an approved group education program. No Benefits are available for costs related to materials, activities or supplies in addition to the enrollment fee.

- Insulin, diabetic medications, blood glucose monitors external insulin pumps and diabetic supplies are not covered under this subsection. Please see subsection IV, E, "Durable Medical Equipment, Medical Supplies and Prosthetics" for information about diabetic supplies.

  Benefits are available for weight management counseling provided as part of a covered diabetes management program or during covered nutrition counseling visits (see B, 7 above). No other non-surgical service, treatment, procedure or program for weight or appetite control, weight loss, weight management or control of obesity is covered under this Certificate. However, Benefits are available for Medically Necessary Covered Services furnished to treat diseases and ailments caused by or resulting from obesity or morbid obesity.

For information about surgical services to treat diseases and ailments caused by or resulting from obesity or morbid obesity, please see subsection VI, G, 4, "Surgery for conditions caused by obesity."

III. Outpatient Physical Rehabilitation Services

Benefits are available for Medically Necessary Outpatient Physical Rehabilitation Services. Coverage includes the following:

A. Physical Therapy, Occupational Therapy and Speech Therapy in an office or in the Outpatient department of a Short Term General Hospital or Skilled Nursing Facility. Benefits may be limited, as shown on Your Cost Sharing Schedule. Any combination of physical, occupational or speech therapy visits counts toward this limit.

Physical therapy must be furnished by a licensed physical therapist. Occupational therapy must be furnished by a licensed occupational therapist. Speech therapy must be furnished by a licensed speech therapist. Otherwise, no Benefits are available.

Speech therapy services must be Medically Necessary to treat speech and language deficits or swallowing dysfunctions during the acute-care stage of an illness or injury. Otherwise, no Benefits are available.

Covered Services for speech therapy are limited to:

1. An evaluation by a licensed speech therapist to determine if speech therapy is Medically Necessary, and

2. Individual speech therapy sessions (including services related to swallowing dysfunctions) by a licensed speech therapist.

Physical, occupational and speech therapy services must be furnished during the acute care stage of an illness or injury. Therapy is covered for long-term conditions only when an acute medical condition occurs during the illness, such as following surgery. No Benefits are available for therapy furnished beyond the acute care stage of an illness or injury. Therapy services must be restorative, with the expectation of concise, measurable gains and goals as judged by Your physician and by Anthem. Services must provide significant improvement within a reasonable and generally predictable period of time. Services must require the direct intervention, skilled knowledge and attendance of a licensed physical, occupational or speech therapist. Noncovered services include, but are not limited to: on-going or life-long exercise and education programs intended to maintain fitness, including voice fitness, or to reinforce lifestyle changes. Including but not limited to lifestyle changes effecting the voice. Such on-going services are not covered, even if ordered by Your physician or supervised by skilled program personnel. In addition to the limitations and exclusions listed in Section 8 of this Certificate, no Benefits are available for voice therapy, vocal retraining, preventive therapy or therapy provided in a group setting. No Benefits are available for educational reasons or for Developmental Disabilities, except as stated in D, "Early Intervention Services." No Benefits are available for sport, recreational or occupational reasons.

Please see article VI, A "Dental Services" for Benefit information about physical therapy for treatment of TMJ disorders.

B. Cardiac Rehabilitation. Benefits are available for Outpatient cardiac rehabilitation programs. The program must meet Anthem's standards for cardiac rehabilitation. Please call Anthem at 1-800-531-4450 to determine program eligibility. Otherwise, no Benefits are available.

Covered Services are exercise and education under the direct supervision of skilled program personnel in the intensive rehabilitation phase of the program. The program must start within three months after a cardiac condition is diagnosed or a cardiac procedure is completed. The program must be completed within six months of the diagnosis or procedure.

No Benefits are available for portions of a cardiac rehabilitation program extending beyond the intensive rehabilitation phase. Noncovered services include but are not limited to ongoing or life-long exercise and education maintenance programs intended to maintain fitness or to reinforce permanent lifestyle changes. Such on-going services are not covered, even if ordered by Your physician or supervised by skilled program personnel.

C. Chiropractic Care.

The following are **Covered Services** when furnished by a licensed chiropractor:

- **Office visits** for assessment, evaluation, spinal adjustment, manipulation and physiological therapy before (or in conjunction with) spinal adjustment. Benefits may be limited as shown on Your Cost Sharing Schedule, and
- Medically Necessary **diagnostic laboratory and x-ray tests**

In addition to the limitations and exclusions stated in Section 8, the following limitations apply specifically to chiropractic care:

- Wellness care is not covered.
- The services must be Medically Necessary for the treatment of an illness or injury that is diagnosed or suspected by a licensed chiropractor or another provider, and
- Chiropractic care must be provided in accordance with New Hampshire law.

You may choose to receive noncovered services. However, You are responsible for the full cost of any chiropractic care that is not covered, as stated above.

D. Early Intervention Services. Early intervention services are covered for eligible Members from birth to the Member's third birthday. Eligible Members are those with significant functional physical or mental deficits due to a Developmental Disability or delay. Covered Services include Medically Necessary physical, speech/language and occupational therapy, nursing care, and psychological counseling provided by Eligible Behavioral Health Providers such as Clinical Social Workers. Physical, speech and occupational therapy visits do not count toward any annual limits that may apply to A of this article. However, Benefits may be limited, as shown on Your Cost Sharing Schedule.

IV. Home Care

Benefits are available for Medically Necessary Home Care. Covered Services are limited to the following:

A. Physician Services. Benefits are available for physician visits to Your home or place of residence to furnish medical/surgical care that is the same as or similar to services ordinarily provided in an office setting.

B. Home Health Agency Services. Benefits are available for Medically Necessary services furnished by a Preferred or BlueCard Home Health Agency in Your home or other place of residence. Benefits are available only when, due to the severity of a medical condition, it is not reasonably possible for You to travel from Your home to another treatment site.

Covered Services are limited to the following:

- Part-time or intermittent skilled nursing care by (or under the supervision of) a Registered Nurse
- Part-time or intermittent home health aide services that consist primarily of caring for You under the supervision of a Registered Nurse
- Prenatal and postpartum homemaker visits. Homemaker visits must be Medically Necessary otherwise no Benefits are available. . For example, if You are confined to bed rest, or Your activities of daily living are otherwise restricted by order of Your physician, prenatal and/or postpartum homemaker visits may be considered Medically Necessary. When determining the Medical Necessity of such services, Anthem's case manager will consult with Your physician.
- Physical, occupational, or speech therapy. Therapy provided by a Home Health Agency does not count toward any annual limits that may apply to article III, A (above).
- Nonprescription medical supplies and drugs. Nonprescription medical supplies and drugs may include surgical dressings and saline solutions. Prescription drugs, certain intravenous solutions and insulin are not included.

C. Hospice. Hospice care is home management of a terminal illness. Benefits are available for Covered Services, provided that the following conditions are met:

- Care must be approved in advance by the patient's physician and by Anthem's Precertification,
- Care must be furnished by a Preferred or BlueCard Hospice Provider. No Benefits are available for the services of an Out-of-Network New Hampshire Provider or a non BlueCard Provider outside New Hampshire,
- The patient must have a terminal illness with a life expectancy of six months or less, as certified by a physician,
- The patient or his/her legal guardian must make an informed decision to focus treatment on comfort measures when treatment to cure the condition is no longer possible or desired,

- The patient or his/her legal guardian, the patient's physician and medical team must support hospice care because it is in the patient's best interest, and

- A primary care giver must be available on an around-the-clock basis. A primary care giver is a family member, friend or hired help who accepts 24-hour responsibility for the patient's care. The primary care giver does not need to live in the patient's home.

The hospice provider and Anthem will establish an individual hospice plan that meets Your individual needs. Each portion of a hospice plan must be Medically Necessary and specifically Precertified by Anthem. Otherwise, no Benefits are available. Covered Services that may be part of the individual hospice plan are:

- Skilled nursing visits

- Home health aide and homemaker services

- Physical therapy for comfort measures. These therapy services do not count toward any annual limits that may apply to article III, A of this Section

- Social service visits

- Durable medical equipment and medical supplies. These items do not count toward any Maximum Benefit that is stated on Your Cost Sharing Schedule for Durable Medical Equipment, Medical Supplies and Prosthetics.

- Respite care (in the home) to temporarily relieve the primary care giver from care-giving functions

- Continuous care, which is additional respite care to support the family during the patient's final days of life

- Bereavement services provided to the family or primary care giver following the death of the hospice patient.

D. Infusion Therapy. Benefits are available for Medically Necessary home infusion therapy furnished by a licensed infusion therapy provider. Covered Services are:

- Home nursing services for intravenous antibiotic therapy, chemotherapy or parenteral nutrition therapy

- Antibiotics, chemotherapy agents, medications and solutions used for parenteral nutrients

- Associated supplies and portable, stationary or implantable infusion pumps

E. Durable Medical Equipment, Medical Supplies and Prosthetics. Benefits are available for durable medical equipment (DME), medical supplies and prosthetics. To be eligible for Network Benefits, Covered Services must be ordered in advance by Your physician and furnished by a Preferred Provider. To be eligible for Out-of-Network Benefits, Covered Services must be ordered by Your physician and furnished by a licensed medical equipment supplier. Under Out-of-Network Benefits, You are responsible for paying the difference between the Maximum Allowable Benefit and the charge, as explained in Section 2.

1. **Durable Medical Equipment (DME).** Benefits are available for covered DME. In order to be covered, the DME must meet all of the following criteria, otherwise no Benefits are available. The DME must be:

    - Primarily and customarily used for a medical purpose
    - Useful only for the specific illness or injury that Your provider has diagnosed or suspects

- Non-disposable and specifically designed and intended to withstand repeated use
- Appropriate for use in the home.

Examples of covered DME include, but are not limited to, crutches, apnea monitors, oxygen and oxygen equipment, wheelchairs, special hospital type beds and home dialysis equipment. Enteral pumps and related equipment are covered for Members who are not capable of ingesting enteral formula orally. Oxygen humidifiers are covered if prescribed for use in conjunction with other covered oxygen equipment.

Benefits are available for external insulin infusion pumps for insulin dependent diabetics. External insulin pumps must be approved in advance by Anthem. To determine eligibility, please ask Your physician to contact Anthem for prior approval *before* You purchase the pump.

Anthem will require treatment and clinical information in writing from Your physician. Anthem will review the information and determine in writing whether the services are covered under this Certificate, based on the criteria stated in this Certificate and in Anthem's guidelines for external infusion pumps. You may contact Anthem to request a copy of Anthem's internal guidelines or go to Anthem's website, www.anthem.com. Anthem's review determination is not a guarantee of Benefits. Benefits are subject to all of the terms and conditions of this Certificate and Your Cost Sharing Schedule. Please see article II, A of this Section for information about external insulin pump education. Implantable insulin infusion pumps are not covered.

Benefits are also available for orthopedic braces for support of a weak portion of the body or to restrict movement in a diseased or injured part of the body.

Hearing Aids.

Benefits are available for one initial hearing aid per ear and one hearing aid per ear each time a hearing aid prescription changes for Members who are **18** years old or Younger. No Benefits are available for hearing aids for Members who are **19** years old or older.

Effective January 1, 2011 for January Plan Years and July 1, 2011 for July Plan Years, the preceding paragraph is removed and replaced by the following paragraph for Hearing Aids coverage:

Hearing aids are covered as stated in article VI, B "Hearing Services" (below). Benefits are limited to one hearing aid per ear each time a hearing aid prescription changes. Please see article VI, B "Hearing Services" for more information.

2. **Medical Supplies.** Benefits are available for medical supplies. In order to be covered, medical supplies must be small, disposable items designed and intended specifically for medical purposes and appropriate for treatment of the specific illness or injury that Your provider has diagnosed. Otherwise, no Benefits are available.

   Examples of covered medical supplies include: needles and syringes, ostomy bags and skin bond necessary for colostomy care. Eyewear (frames and/or lenses or contact lenses) is covered only if the lens of Your eye has been surgically removed or is congenitally absent.

   Please note: if Your Group has purchased a Prescription Eyewear Rider, please see Your rider for information about eyewear for routine vision correction.

   Other covered medical supplies are:

   - **Diabetic supplies.** Diabetic supplies are covered for Members who have diabetes. Examples of covered diabetic supplies include, but are not limited to: diabetic needles and syringes, blood glucose monitors, test strips and lancets. Coverage is provided under this article when supplies are purchased from a licensed DME provider.

Please note: Coverage and cost sharing is provided as described in Your Pharmacy Rider for diabetic supplies purchased at a pharmacy.

- **Enteral formula and modified low protein food products.** Benefits are available for **enteral formulas** required for the treatment of impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length or motility of the gastrointestinal tract. Benefits are available for **food products modified to be low protein** for persons with inherited diseases of amino acids and organic acids. For modified low protein food products, Benefits are limited to a total of $1,800 per Member, per calendar year. To be eligible for Benefits, Your physician must issue a written order stating that the enteral formula and/or food product is:

  - Needed to sustain life;
  - Medically Necessary; and
  - The least restrictive and most cost-effective means for meeting Your medical needs.

  Otherwise, no Benefits are available.

  If You purchase enteral formula or food products modified to be low protein in an Outpatient setting, Benefits are subject to the cost sharing amounts shown under part II of Your Cost Sharing Schedule for "medical supplies."

3. **Prosthetics**. Benefits are available for prosthetics that replace an absent body part or the function of a permanently impaired body part. Prosthetic limbs are covered prosthetics. Prosthetic limbs are artificial devices that replace, in part or in whole, an arm or leg. Post-mastectomy breast prostheses and scalp hair prosthesis are other examples of covered prosthetics.

   Coverage for external breast prostheses is limited to 2 prostheses per breast, per calendar year. The Maximum Allowable Benefit for breast prosthesis includes the cost of fitting for the prosthesis.

   Clothing necessary to wear a covered prosthetic device is also covered. This includes stump socks worn with prosthetic limbs and post-mastectomy bras worn with breast prosthesis. Coverage for post-mastectomy bras is limited to 3 bras per Member, per calendar year.

   A **scalp hair** prosthesis is an artificial substitute for scalp hair that is made specifically for You. Benefits are available for scalp hair prostheses for Members who have hair loss as a result of alopecia areata, alopecia totalis, or alopecia medicamentosa resulting from treatment of any form of cancer or leukemia and/or who have permanent hair loss as a result of injury. For Members who have hair loss as a result of alopecia medicamentosa resulting from the treatment of any form of cancer or leukemia, Benefits are limited to a total of $500 per Member per calendar year. Scalp hair prostheses are subject to the Deductible and Coinsurance stated on page 1 of Your Cost Sharing Schedule

   To be eligible for Benefits for scalp hair prostheses, Your physician must state in writing that the prosthesis is Medically Necessary. You must submit Your physician's statement with Your claim.

   Except as described above, no Benefits are available for scalp hair prostheses or wigs. For example, except as stated above, no Benefits are available for temporary hair loss. No Benefits are available for male pattern baldness.

4. Limitations. In addition to the limitations and exclusions listed in Section 8, the following limitations apply specifically to this article E:

- Whether an item is purchased or rented, Benefits are limited to the Maximum Allowable Benefit. Benefits will not exceed the Maximum Allowable Benefit for the least expensive service that meets Your medical needs. If Your service is more costly than is Medically Necessary, You will be responsible for paying the difference between the Maximum Allowable Benefit for the least expensive service and the charge for the more expensive service.

- If You rent or purchase equipment and Benefits are paid equal to the Maximum Allowable Benefit, no further Benefits will be provided for rental or purchase of the equipment.

- Anthem is given the right to determine if equipment should be rented instead of purchased. For example, if Your physician prescribes a hospital bed for short-term home use, the bed must be rented instead of purchased if short-term rental is less expensive than the purchase price. In such instances, Benefits are limited to what would be paid for rental, even if You purchase the equipment. You will be responsible for paying the difference between the Maximum Allowable Benefit for rental and the charge for purchase.

- Burn garments (or burn anti-pressure garments) are covered only when prescribed by Your physician for treatment of third degree burns, deep second degree burns or for areas of the skin that have received a skin graft. Covered burn garments include gloves, face hoods, chin straps, jackets, pants, leotards, hose or entire body suits which provide pressure to burned areas to help with healing.

- Support stockings are covered for a diagnosis of phlebitis or other circulatory disease. Gradient pressure aids (stockings) are covered only when prescribed by Your physician for treatment of lymphedema or venous stasis. Also, the degree of pressure required for Your condition must be at least 25 mm Hg. Otherwise, gradient pressure aids are not covered. Anti-embolism stockings are not covered. Inelastic compression devices are not covered. The Maximum Allowable Benefit for covered gradient pressure aids includes the Benefit for fitting of the garment. No additional Benefits are available for fitting.

- Neither rental nor purchase of manual breast pumps is covered.

- Electric breast pumps are not covered. Exception: Rental of an electric breast pump may be covered for up to two months, provided that pump is Medically Necessary, as stated in Section 14. Purchase of an electric breast pump is not covered.

- Benefits are available for custom-fitted helmets or headbands (dynamic orthotic cranioplasty) to change the shape of an infant's head only when the service is provided for moderate to severe asymmetry (nonsynostotic plagiocephaly and brachycephaly) and the condition meets the definition of a **reconstructive service** found in article VI, G, "Surgery" below in this Section. To be eligible for Benefits, an infant Member must be at least three months old, but no older than 18 months. Also, the infant must have completed at least two months of cranial repositioning therapy or physical therapy with no substantial improvement. Otherwise, no Benefits are available for cranial helmets or any other device intended to change the shape of a child's head.

- Benefits are available for broad or narrow band ultraviolet light (UVB) home therapy equipment only if the therapy is conducted under a physician's supervision with regularly scheduled exams. The therapy is covered only for treatment of the following skin disorders: severe atopic dermatitis and psoriasis, mild to moderate atopic dermatitis or psoriasis (when standard treatment has failed, as documented by medical records), lichen planus, mycosis fungoides, pityriasis lichenoides, pruritus of hepatic disease and pruritus of renal failure. UVB home therapy is not covered for any other skin disorder. Ultraviolet light A home therapy (UVA) is not covered.

  Please see Section 8, I, C, "Ultraviolet Light Therapy and Laser Therapy for Skin Disorders," for information about out-of-home ultraviolet light therapy.

5. **Exclusions.** In addition to the other limitations and exclusions stated in Section 8, the following services and supplies are not covered. These exclusions apply even if the services or supplies are provided, ordered or prescribed by a Designated Provider and even if the services or supplies meet the definition of Medical Necessity found in Section 14 of this Certificate.

   No Benefits are available for:

   - Arch supports, corrective shoes, foot orthotics (and fittings, castings or any services related to footwear or orthopedic devices) or any shoe modification
   - Special furniture, such as seat lift chairs, elevators (including stairway elevators or lifts), back chairs, special tables and posture chairs, adjustable chairs, bed boards, bed tables, and bed support devices of any type including adjustable beds
   - Glasses, sports bras, nursing bras and maternity girdles or any other special clothing, except as stated in this article
   - Nonprescription supplies, first aid supplies, ace bandages, cervical pillows, alcohol, peroxide, betadine, iodine, phisohex solution, alcohol wipes, betadine, iodine swabs, or items for personal hygiene
   - Bath seats or benches (including transfer seats or benches), whirlpools or any other bath tub, rails or grab bars for the bath, toilet rails or grab bars, commodes, raised toilet seats, bed pans
   - Heat lamps, heating pads, hydrocoliator heating units, hot water bottles, batteries and cryo cuffs (water circulating delivery systems)
   - Biomechanical limbs, computers, physical therapy equipment, physical or sports conditioning equipment, exercise equipment, or any other item used for leisure, sports, recreational or vocational purposes, any equipment or supplies intended for educational or vocational rehabilitation, vehicles, scooters or any similar mobility device
   - Safety equipment, including, but not limited to, hats, belts, harnesses, safety glasses or restraints
   - Costs related to residential or vocational remodeling or indoor climate/air quality control, air conditioners, air purifiers, humidifiers, dehumidifiers, vaporizers and any other room heating or cooling device or system
   - Self-monitoring devices (except blood glucose monitors), TENS units for incontinence, biofeedback devices, self-teaching aids, books, pamphlets, video tapes, video disks, fees for Internet sites or software, or any other media instruction or for any other educational or instructional material, technology or equipment
   - Dentures, orthodontics, dental prosthesis and appliances
   - Convenience services and supplies are not covered under any portion of this Certificate. Please see Section 8, II, J for a definition of "Convenience Services."

   Except as specified in this article and in any amendment to this Certificate, no Benefits are available for the cost of Durable Medical Equipment, Medical Supplies, or Prosthetic Devices.

V. Behavioral Health Care

Behavioral Health Care (Mental Health and Substance Abuse Care). Benefits are available for Medically Necessary Behavioral Health Care. Behavioral Health Care means Covered Services provided to treat Mental Disorders and Substance Abuse Conditions, which are defined in B, below.

A. **Contact Anthem to Preauthorize Inpatient Behavioral Health Care.** You must contact Anthem for preauthorization *before* You are admitted to a hospital or other Inpatient facility, as noted in B (below). After You call, Anthem will send You an authorization letter. The approved Covered Services and Eligible Providers will be specified in the letter.

If You fail to contact Anthem for preauthorization as required, and Anthem later determines that Your care did not meet the coverage criteria stated in this Certificate, including Anthem's definition of Medical Necessity stated in Section 14, no Benefits will be available and You will be responsible for the full cost of the care.

Please call Anthem at the toll-free number listed on Your identification card.

The terms "preauthorize" and "preauthorization" refer to Anthem's written confirmation that a service is Medically Necessary. Preauthorization is not a guarantee of Benefits. Benefits are subject to all of the terms and conditions of the Certificate in effect on the date You receive Covered Services.

B. **Covered Services**. Benefits are available for the diagnosis, crisis intervention and treatment of Behavioral Health Illnesses. Behavioral Health Illnesses include Mental Disorders and Substance Abuse Conditions. '

- **Mental Disorder** is a nervous or mental condition identified in the most current version of the Diagnostic and Statistical Manual (DSM), published by the American Psychiatric Association, excluding those disorders designated by a "V Code" and those disorders designated as criteria sets and axes provided for further study in the DSM. This term does not include chemical dependency such as alcoholism. A mental disorder is one that manifests symptoms that are primarily mental or nervous, regardless of any underlying physical or biological cause(s) or disorder(s).

- **Substance Abuse Condition** is a condition, including alcoholism or other chemical dependency, brought about when an individual uses alcohol and/or other drugs in such a manner that his or her health is impaired and/or ability to control actions is lost. Nicotine addiction is not a Substance Abuse Condition under the terms of this Certificate.

In determining whether or not a particular condition is a Mental Disorder or Substance Abuse Condition, Anthem will refer to the most current edition of the Diagnostic and Statistical Manual (DSM), published by the American Psychiatric Association and may also refer to the International Classification of Diseases (ICD) Manual.

Network Benefits are available when You receive Covered Services from a Preferred Provider. A Preferred Provider is an Eligible Mental Health or Substance Abuse Provider who has a Preferred written agreement with Anthem or the Local Plan to make Covered Mental Health and Substance Abuse Care available to Members.

Out-of-Network Benefits are available when You obtain Covered Services from any Eligible Mental Health or Substance Abuse Provider (who is not a Preferred Provider). Under Out-of-Network Benefits, You are responsible for paying the difference between the Maximum Allowable Benefit and the charge if You receive Covered Services from any provider who is not a Preferred Provider.

Benefits are available for the following Covered Services:

1. **Outpatient/office visits.** Covered Services are: diagnosis and evaluation, therapy and counseling, medication checks and psychological testing, including but not limited to Medically Necessary psychological testing for bariatric surgery candidates. Visits for psychological testing and medication checks are covered. Emergency room visits are not covered under this article. Emergency room visits are covered under the terms of Section 6, "Urgent and Emergency Care."

   Outpatient/office visits for Substance Abuse Conditions may be furnished during the detoxification stage of treatment or during stages of rehabilitation.

Covered Services must be furnished by an Eligible Behavioral Health Provider, as defined in C (below) and are subject to all the terms of this article. Otherwise, no Benefits are available.

2. **Partial Hospitalization and Intensive Outpatient Treatment Programs**. Benefits are available for Partial Hospitalization and Intensive Outpatient Treatment Programs (sometimes called "day/evening" programs) for treatment of Mental Disorders and for substance abuse rehabilitation. Covered Services include facility fees and counseling and therapy services typically provided by a Partial Hospitalization or Intensive Outpatient Treatment Program.

   Covered Services must be furnished by a Partial Hospitalization Program or Intensive Outpatient Treatment Program as defined in C, below and are subject to all of the terms of this article. Otherwise, no Benefits are available.

3. **Inpatient care.** You must contact Anthem for preauthorization *before* You are admitted to a hospital or other facility for Inpatient care. *Exception for emergency admissions:* You must notify Anthem of an emergency Inpatient admission within 48 hours after You are admitted or on the next business day after You are admitted, whichever is later. Otherwise, Benefits may be reduced as described in A, above.

   - **For Mental Disorders**, Covered Services include Medically Necessary semi-private room and board, nursing care and other facility fees and Inpatient counseling and therapy services typically provided as part of an Inpatient admission for treatment of Mental Disorders.

     Covered Services must be furnished by an Eligible Mental Health Provider, as defined in C (below) and are subject to all of the terms of this article. Otherwise, no Benefits are available.

   - **For Substance Abuse Conditions**, Covered Services include Medically Necessary semi-private room and board, nursing care and other facility fees, Inpatient counseling and therapy services typically provided as part of an Inpatient admission for treatment of Substance Abuse Conditions during the detoxification stage of treatment or during stages of rehabilitation.

     Covered Services must be furnished by an Eligible Behavioral Health Provider, as defined in C (below) and are subject to all of the terms of this article. Otherwise, no Benefits are available.

     Please note: Inpatient admissions ordered by a medical/surgical physician (not an Eligible Behavioral Health Provider) for medical detoxification are not subject to the terms of this article. Precertification and notification rules are stated in Section 1, III and Section 6, "Urgent and Emergency Care." Benefits are available as stated in article I, "Inpatient Services."

4. **Scheduled Ambulance Transport.** Benefits are available for Medically Necessary *scheduled* ambulance transport from one facility to another. If transport in a non-emergency vehicle (such as by car) is medically appropriate, ambulance transport is not covered. No Benefits are available for the cost of transport in vehicles such as chair ambulance, car or taxi. **Please note:** Emergency ambulance transportation is not covered under this article. Please see article II, E, "Ambulance Services" above for more information.

C. Eligible Behavioral Health Providers. As approved by Anthem, Eligible Behavioral Health Providers include the following:

Licensed Clinical Social Worker - an individual who is licensed as a clinical social worker under New Hampshire law. A Clinical Social Worker whose practice is conducted outside New Hampshire must be licensed or certified to practice independently as a Clinical Social Worker according to the law in the state where the individual's practice is conducted. Otherwise, the individual is not an Eligible Provider.

Licensed Clinical Mental Health Counselor - an individual who is licensed as a clinical mental health counselor under New Hampshire law. A Clinical Mental Health Counselor can also be an individual who is licensed or certified to practice independently as a Clinical Mental Health Counselor according to the provisions of law in another state where his or her practice is conducted.

Community Mental Health Center - a licensed center approved by the Director of the Division of Mental Health and Developmental Services, Department of Health and Human Services of the State of New Hampshire as a Community Mental Health Center as defined in the Community Mental Health Centers Act of 1963 or licensed in accordance with the provisions of the laws of the state in which they practice which meet or exceed the certification standards of the State of New Hampshire.

Intensive Outpatient Treatment Program - an intensive, nonresidential behavioral health program designed to reduce or eliminate the need for an Inpatient admission. The program must provide multidisciplinary structured, therapeutic group treatment under the direction of a qualified Eligible Behavioral Health Provider. A qualified provider is an Eligible Behavioral Health Provider, as defined in this article, who has achieved at least a master's degree in his or her field of practice and is practicing within the scope of his or her license. In most instances, the program will operate at least three hours per day, three days per week.

Licensed Alcohol and Drug Abuse Counselor - an individual who is licensed as an Alcohol and Drug Abuse Counselor under New Hampshire law. An Alcohol and Drug Abuse Counselor may also be an individual whose practice is conducted outside New Hampshire must be licensed or certified to practice independently as an Alcohol and Drug Abuse Counselor according to the law in the state where the individual's practice is conducted. Otherwise, the individual is not a Designated Provider.

Licensed Marriage and Family Therapist - an individual who is licensed as a marriage and family therapist under New Hampshire law. A Marriage and Family Therapist can also be an individual who is licensed or certified to practice independently as a Marriage and Family Therapist according to the provisions of law in another state where his or her practice is conducted. To be eligible for Benefits, Marriage and Family Therapists must furnish Covered Services as stated in Section 7, V. Marriage or couple's counseling is not covered under this Certificate.

Partial Hospitalization Program - means an intensive nonresidential behavioral health program designed to reduce or eliminate the need for an Inpatient admission. The program must provide multidisciplinary structured, therapeutic group treatment under the direction of a qualified Eligible Behavioral Health Provider. A qualified provider is an Eligible Behavioral Health Provider, as defined in this article, who has achieved at least a master's degree in his or her field of practice and is practicing within the scope of his or her license. In most instances, the program will operate at least 6 hours per day, five days per week.

Licensed Pastoral Psychotherapist - a professional who is licensed under New Hampshire law and who is a fellow or diplomat in the American Association of Pastoral Counselors.

Private or Public Hospital - a licensed Private Psychiatric Hospital or Public Mental Health Hospital that provides diagnostic services, treatment and care of acute Mental Disorders under the care of a staff of physicians. A Private or Public Hospital must provide 24-hour nursing service by or under the supervision of a Registered Nurse (R.N.) and must keep permanent medical history records.

Psychiatrist - a professional who is a licensed physician and is Board Certified or Board Eligible according to the regulations of the American Board of Psychiatry and Neurology.

Psychiatric Advanced Practice Registered Nurse - a professional who is licensed as a registered nurse in advanced practice by the State of New Hampshire or licensed in accordance with the provisions of the laws of the state in which they practice and who is certified as a clinical specialist in psychiatric and mental health nursing.

Licensed Psychologist - a professional who is licensed under New Hampshire law, or under a similar statute in another state, which meets or exceeds the standards under New Hampshire law or is certified or licensed in another state and listed in the National Register of Health Service Providers in Psychology.

Residential Psychiatric Treatment Facility - a licensed facility approved by the Director of the Division of Mental Health and Developmental Services, Department of Health and Human Services of the State of New Hampshire.

Short Term General Hospital - a health care institution having an organized professional and medical staff and Inpatient facilities which care primarily for patients with acute diseases and injuries with an average patient length of stay of 30 days or less.

Substance Abuse Treatment Provider - a facility that is approved by Anthem and which meets the following criteria: is licensed, certified or approved by the state where located to provide substance abuse rehabilitation, and is affiliated with a hospital under a contractual agreement with an established patient referral system, or is accredited by the Joint Commission on Accreditation of a Hospital as a Substance Abuse Treatment Provider.

Please note: Benefits are provided for Covered Services furnished by Eligible Behavioral Health Providers located outside New Hampshire only when the services are Preauthorized by Anthem *in advance* or as otherwise required under this Certificate, and the provider is licensed according to state requirements that are substantially similar to those required by Anthem. Also, the provider must meet the educational and clinical standards that Anthem requires for health care provider eligibility. Otherwise, no Benefits are available.

D. Criteria for Coverage. To be eligible for Benefits, Covered Services must be Medically Necessary and must meet the following criteria:

Benefits are available only for Mental Disorders and Substance Abuse Conditions that are subject to favorable modification through therapy. The Mental Disorder or Substance Abuse Condition must be shown to affect the ability of a Member to perform daily activities at work, at home, or at school. Benefits are available for approved periodic care for a chronic Mental Disorder to prevent deterioration of function. Benefits are available for approved expenses arising from the diagnosis, evaluation and treatment of Mental Disorders and Substance Abuse Conditions. Additionally, Benefits are available for approved periodic care for a chronic Mental Disorder or Substance Abuse Condition to prevent deterioration of function.

Services must be problem-focused and goal-oriented and demonstrate ongoing improvement in a Member's condition or level of functioning.

Services must be in keeping with national standards of mental health or substance abuse professional practice as reflected by scientific and peer specialty literature.

E. Exclusions. In addition to the limitations and exclusions stated in Section 8, no Benefits are available for the following:

- Except as required by law, services extending beyond the period necessary for diagnosing and evaluating any Mental Disorder or Substance Abuse Condition which, according to generally accepted professional standards, is not subject to favorable modification through therapy. Such disorders include, but are not limited to: mental retardation, Developmental Disabilities, behavioral disabilities and characterological disorders,

- Duplication of services (the same services provided by more than one therapist during the same period of time),

- Therapy, counseling or any non-surgical Inpatient or Outpatient service, care or program to treat obesity or for weight control. Benefits are available for Covered Services to treat Mental Disorders and Substance Abuse Conditions caused by or resulting from obesity or morbid obesity.

- Custodial Care, Convenience Services, convalescent care, milieu therapy, marriage or couples counseling, therapy for sexual dysfunctions, recreational or play therapy, education evaluation or career counseling,
- Services for nicotine withdrawal or nicotine dependence,
- Psychoanalysis,
- Confinement or supervision of confinement that is primarily due to adverse socioeconomic conditions, placement services and conservatorship proceedings,
- Missed appointments,
- Telephone therapy or any other therapy or consultation that is not "face-to-face" interaction between the patient and the provider,
- Inpatient care for detoxification extending beyond the Medically Necessary detoxification phase of a Substance Abuse Condition,
- Care extending beyond Medically Necessary therapy for detoxification and/or rehabilitation for a Substance Abuse Condition in an Outpatient/office setting.
- No Benefits are available for methodone or suboxone maintenance therapy or programs or any similar maintenance therapy or program or for any related testing, supplies, visits or treatment.
- Experimental/Investigational services or nontraditional therapies such as crystal or aroma therapies,
- With the exception of Emergency Care, no Benefits are available for services that You receive on the same day that You participate in a partial hospitalization or intensive treatment program.

VI. Important information About Other Covered Services

This article includes other services that are covered and often involve Covered Services defined elsewhere in this Section. For example, the Organ and Tissue Transplants described in D (below) involve Inpatient and Outpatient services described through article I, "Inpatient Services" and II, "Outpatient Services" (above in this Section).

The limitations and exclusions stated in this article are in addition to those stated in Section 8. Limitations and exclusions apply even if You receive services from Your physician or according to Your physician's order or according to the recommendation of another Designated Provider and even if the service meets the definition of Medical Necessity. No Benefits are available for any services performed in conjunction with, arising from, or as a result of complications of a non-covered service. All of the Plan rules, terms and conditions stated elsewhere in this Certificate apply to the services in this article.

A. Dental Services

Dental Services. Dental Services are defined as any care relating to the teeth and supporting structures, such as the gums, tooth sockets in the jaw and soft or bony portions of upper and lower jaws that contain the teeth. Dental Services may be furnished by a dentist, Oral surgeon or other Designated Provider. For the purposes of this article, Dental Services also include care of the temporomandibular joint (TMJ) to the extent stated below.

Under this Certificate, Benefits are limited to the following Covered Dental Services. No other Dental Service is a Covered Service. Except as specifically stated in this article, Covered Services must be furnished by a Network Provider. Otherwise,

no Benefits are available. The following Dental Services are Covered Services:

1. Treatment of Accidental Injury to Sound Natural Teeth. Benefits are available for Medically Necessary Dental Services resulting from an accidental injury to sound natural teeth and gums when the course of treatment for the accidental injury is received or authorized within 3 months of the date of the injury. Treatment made necessary due to injury to the jaw and oral structures other than teeth shall be covered consistent with terms and conditions of this Certificate.

No Benefits are available for diagnosis or treatment if You damage Your teeth, supporting structures or appliances as a result of biting or chewing. No Benefits are available to repair, restore or replace items such as fillings, crowns caps or appliances.

Cost sharing amounts for covered Inpatient and Outpatient Dental Services are shown under parts I and II of Your Cost Sharing Schedule.

2. a. Surgical removal of erupted teeth before radiation therapy for malignant disease. Benefits are limited to:

- The surgeon's fee for the surgical procedure,
- Intravenous sedation furnished by the surgeon,
- General anesthesia furnished by a licensed anesthesiologist or anesthetist who is not the surgeon.

No Benefits are available for related preoperative or postoperative care, including medical, laboratory and x-ray services. No Benefits are available for related facility fees unless the provisions of 4 (below) apply.

b. Surgical correction of a facial bone fracture (not to include the portion of upper and lower jaws that contain the teeth, except as otherwise stated in this article) and surgical removal of a lesion or tumor by a dentist or oral surgeon are covered to the same extent as any other surgical procedure covered under this Certificate.

Cost sharing amounts for covered oral surgery, anesthesia, office and facility care are shown in parts I and II of Your Cost Sharing Schedule.

3. Surgical correction or repair of the temporomandibular joint (TMJ) is covered, provided that the Member has completed at least five months of unsuccessful non-surgical treatment, as medically documented. Coverage is limited to surgical procedures that are Medically Necessary to correct or repair a disorder of the temporomandibular joint, caused by (or resulting in) a specific medical condition such as degenerative arthritis, jaw fractures or jaw dislocations. Administration of general anesthesia by a licensed anesthesiologist or anesthetist is covered in conjunction with a covered surgery. Medically Necessary Inpatient and Outpatient hospital care is covered in conjunction with a covered surgery, subject to all of the terms of this Certificate.

Cost sharing amounts for surgery are shown in parts I and II of Your Cost Sharing Schedule.

4. Medically Necessary hospital charges (Inpatient or Outpatient), surgical day care facility charges and administration of general anesthesia by a licensed anesthesiologist or anesthetist for:

- Children under the age of 6. The child's dental condition must be so complex that the dental procedure must be done under general anesthesia and must be done in a hospital or surgical day care facility setting. A licensed dentist and the child's physician must determine *in advance* that anesthesia and hospitalization are Medically Necessary due to the complexity of the child's condition. Anthem must approve the care in advance.

- Members who have exceptional medical circumstances or a Developmental Disability. The exceptional medical circumstance or the Developmental Disability must be one that places the Member at serious risk unless the dental procedure is done under general anesthesia and must be done in a hospital or surgical day care facility setting. The Member's physician and Anthem must approve the services in advance.

Cost sharing amounts for Inpatient and Outpatient facility charges and for professional anesthesia charges are shown in parts I and II of Your Cost Sharing Schedule.

5. Oral Surgery and Treatment of Temporomandibular Joint (TMJ) Disorders. With the exception of physical therapy, Your physician does not have to direct You for services described in this article. However, all Covered Services must be furnished by a Preferred Provider. Otherwise, only Out-of-Network Benefits are available.

Covered Services include:

a. Oral Surgery. Benefits are available for the surgical removal of bone impacted teeth and gingivectomy. Coverage is limited to:

- The surgeon's fee for the surgical procedure (no Benefits are available for related preoperative or postoperative care, including medical, laboratory and x-ray services)
- Intravenous sedation furnished by the operating dentist or oral surgeon
- Anesthesia furnished by an anesthesiologist who is not the operating dentist or oral surgeon
- For gingivectomy, excision of the soft tissue wall of the "pocket," up to four quadrants per lifetime.

Benefits for oral surgery and anesthesia are subject to the cost sharing amounts as shown on Your Cost Sharing Schedule for surgery and anesthesia.

No Benefits are available for anesthesia services by the surgeon, surgical exposure of impacted teeth to aid eruption, osseous and flap procedures in conjunction with gingivectomy or any other services for periodontal disease (such as scaling and root planing, prophylaxis and periodontal evaluations).

b. Orthognathic Surgery. Benefits are available for Medically Necessary orthognathic surgery to correct jaw and craniofacial deformities causing significant functional impairment.

Cost sharing amounts for covered oral surgery, anesthesia, office and facility care shown under section I and II of Your Cost Sharing Schedule.

c. Treatment of Temporomandibular Joint (TMJ) disorders. The following are Covered Services for treatment of TMJ disorders:

- Medical exams and medical treatment. The initial evaluation, follow-up treatment for adjustment of an orthopedic repositioning splint and trigger point injection treatment are covered.

Benefits are subject to the cost sharing amounts as shown for medical exams and medical treatments in part II of Your Cost Sharing Schedule.

- Diagnostic x-rays of the TMJ joint and other facial bones

Benefits are subject to the cost sharing amounts as shown for x-ray tests in part II of Your Cost Sharing Schedule.

- Physical therapy. To be eligible for physical therapy Benefits, physical therapy must be ordered by Your physician and furnished by a Preferred or BlueCard Physical Therapist. Otherwise, only Out-of-Network Benefits are available. The therapist must bill services separately from the dentist or oral surgeon who directs Your TMJ treatment.

Benefits are subject to the cost sharing amounts and any annual limit for physical therapy as shown in part III of Your Cost Sharing Schedule.

- Orthopedic repositioning splints. Benefits for orthopedic repositioning splints are subject to the cost sharing amounts as shown on page 1 of Your Cost Sharing Schedule for Durable Medical Equipment, Medical Supplies and Prosthetics.

Diagnostic arthroscopy for TMJ disorders is not covered.

Except as stated above, no Benefits are available for treatment of cavities, tooth extractions, care of the gums, teeth, or bones supporting the teeth, treatment of a periodontal disorder, disease or abscess, services, supplies or procedures to change the height or position of teeth or otherwise restore occlusion (such as bridges, crowns or orthodontia, including braces), false teeth, or any other dental service.

No Benefits are available for x-rays of the teeth, biofeedback training, occlusal adjustments and dental procedures such as tooth build-up or occlusal appliances (such as night guards, trismus appliances, bruxism splints or occlusal guards). Orthodontic care and orthodontic appliances are not covered under any portion of Your Certificate.

No Benefits are available for noncovered dental procedures, even when Your provider and Anthem authorize hospitalization and anesthesia for the procedure. No Benefits are available if You damage Your teeth or appliances as a result of biting or chewing.

B. Hearing Services

Benefits are available for *diagnosis and treatment of ear disease or injury*. Your provider must find or suspect injury to the ear or a diseased condition of the ear. Otherwise, no Benefits are available. For example, Benefits are available for laboratory hearing tests furnished by an audiologist, provided that Your provider finds or suspects injury to the ear or a diseased condition of the ear. No Benefits are available for hearing aids except as stated above in article IV, E "Durable Medical Equipment, Medical Supplies and Prosthetics."

Covered Services (Inpatient and Outpatient care) are described throughout this Section 7. Cost sharing amounts are shown under parts I and II of Your Cost Sharing Schedule.

To be eligible for Network Benefits, Covered Services must be furnished by a Preferred Provider. Otherwise, only Out-of-Network Benefits are available.

Except as stated in article II, A, 7 "routine hearing exams," no Benefits are available for *routine* hearing services to determine the need for hearing correction.

Effective January 1, 2011 for January Plan Years and July 1, 2011 for July Plan Years, the preceding paragraphs of this article B are removed and replaced by the following provisions for Hearing Services coverage:

1. **Diagnosis and Treatment of Ear Disease or Injury.** In addition to Benefits for Medically Necessary routine hearing exams as described in article II, A, 5, Benefits are available for Inpatient and Outpatient services to diagnose and treat ear disease or injury. Benefits are also available for the professional services of a hearing care professional or hearing instrument dispenser for the fitting, dispensing, servicing, or sale of hearing aids as stated in 2 "Hearing Aids" (below).

   To be eligible for Benefits, Your physician must find or suspect injury to the ear, a diseased condition of the ear, or that hearing aids are Medically Necessary. Otherwise, no Benefits are available.

Covered Services (Inpatient and Outpatient care) for diagnosis and treatment of ear disease or injury and professional services related to hearing aids are described throughout Section 7. Cost sharing amounts are shown under parts I and II of Your Cost Sharing Schedule "Inpatient Services" and "Outpatient Services."

2. **Hearing Aids.** Benefits are available for one hearing aid per ear each time a hearing aid prescription changes. "Hearing aid" means any instrument or device designed, intended, or offered for the purpose of improving a person's hearing and any parts, attachments, or accessories, including ear molds. A hearing aid must be prescribed, fitted, serviced and dispensed by an Audiologist or other Designated Provider who is a hearing instrument dispenser or other hearing care professional. Otherwise, no Benefits are available.

   A hearing care professional is a person who is a licensed audiologist, a licensed hearing aid dispenser, or a licensed physician.

   A hearing instrument dispenser is a person who is a licensed hearing care professional that engages in the selling, practice of fitting, selecting, recommending, dispensing, or servicing of hearing aids or the testing for means of hearing aid selection or who advertises or displays a sign or represents himself or herself as a person who practices the testing, fitting, selecting, servicing, dispensing, or selling of hearing aids. The "practice of fitting, dispensing, servicing, or sale of hearing aids" means the measurement of human hearing with an audiometer, calibrated to the current American National Standard Institute standards for the purpose of making selections, recommendations, adoptions, services, or sales of hearing aids including the making of ear molds as a part of the hearing aid.

   Hearing aids furnished by a licensed durable medical equipment provider are subject to any cost sharing amounts shown on Your Cost Sharing Schedule for durable medical equipment and are subject to the terms and conditions of Section 7 "Covered Services," IV "Home Care," E "Durable Medical Equipment, Medical Supplies and Prosthetics."

   When hearing aids are furnished by a Designated Provider who is not a licensed durable medical equipment provider, Covered Services are subject to the same cost sharing amounts as shown on part II of Your Cost Sharing Schedule for "medical supplies."

   Charges for batteries, cords, and individual or group auditory training devices and any instrument or device used by a public utility in providing telephone or other communication services are not covered.

   Benefits for hearing aids are limited to the Maximum Allowable Benefit. Benefits will not exceed the Maximum Allowable Benefit for the least expensive service that meets Your medical needs. If Your service is more costly than is Medically Necessary, You will be responsible for paying the difference between the Maximum Allowable Benefit for the least expensive service and the charge for the more expensive service.

C. Infertility Services

Benefits are available for the infertility services listed in this article. For the purposes of determining Benefit availability, "Infertility" is defined as the diminished or absent capacity to create a pregnancy. Infertility may occur in either a female or a male.

Infertility may be suspected when a presumably healthy woman who is trying to conceive does not become pregnant after her uterus has had contact with sperm during 12 ovulation cycles in a period of up to 24 consecutive months, as medically documented. For women over age 35, infertility may be suspected after a woman's uterus has had contact with sperm during six ovulation cycles in a period of up to 12 consecutive months, as medically documented. Anthem, on behalf of the Plan, may waive the applicable time limits when the cause of infertility is known and medically documented.

Please note: Menopause in a woman is considered a natural condition and is not considered "infertility" for the purposes of determining Benefit availability under this Plan.

After the time limits stated above are met, Benefits are available for Covered Services to determine the cause of medically documented infertility only. Covered Services are limited to the following diagnostic services:

1. **Infertility Diagnostic Services.**

   - Medical exams
   - Laboratory tests, including sperm counts and motility studies, sperm antibody tests, cervical mucus penetration tests
   - Surgical procedures to determine the cause of infertility
   - Ultrasound and other imaging exams, such as hysterosalpingography, to determine the cause of infertility or to establish tubal patency

   Covered Services to determine the cause of medically documented infertility may be provided to male or female Members. Coverage is not available to partners who are not Members.

   Benefits are subject to the cost sharing amounts shown under parts I and II of Your Cost Sharing Schedule.

2. **Infertility Exclusion**. No Benefits are available for treatment of infertility. No Benefits are available for the following services or any care related to these services:

   - Surgical procedures to correct medical conditions contributing to infertility
   - Any infertility procedure performed during an operation not related to an infertility diagnosis
   - Male or female fertility drugs and hormones administered in an Outpatient setting, and any service to prescribe or monitor the use of fertility drugs or hormones
   - Sonograms (ultrasounds), laboratory services, radiological services or any other service related to a noncovered procedure
   - Egg or sperm procurement, harvesting or processing (including donor services), egg or sperm banking, storage or cryopreservation, microfertilization (egg drilling or tweaking)
   - Sperm penetration assays, electroejaculation procedures
   - Intracervical or intrauterine (IUI) artificial insemination (AI), using the partner's sperm (AIH) or donor sperm (AID)
   - Assisted reproduction technology (ART), such as intravaginal culture, microvolume straw technique, in-vitro fertilization and embryo transfer (IVF-ET), natural oocyte retrieval (NORIF or NORIVF), gamete intrafallopian transfer (GIFT), peritoneal ovum and sperm transfer (POST), zygote intrafallopian transfer (ZIFT), cryopreservation of embryos or cryopreserved embryo transfer (CET), direct intraperitoneal insemination (DIPI), intracytoplasmic sperm injection (ICSI), preimplantation genetic diagnosis (PGD)
   - Culture and fertilization of oocytes, co-culture of embryos and assisted embryo hatching

- Microsurgical epididymal sperm aspiration (MESA)
- Genetic engineering, any selective fetal reduction
- Any service related to achieving pregnancy through surrogacy or gestational carriers
- Diagnosis and treatment following elective or voluntary sterilization
- Reversal of elective or voluntary sterilization, and treatment needed as a result of successful or unsuccessful sterilization reversal
- Supplies (such as thermometers and kits to predict ovulation)
- Menopause in a woman is considered a natural condition and is not considered to be infertility, as defined above. No Benefits are available for infertility diagnosis, procedures or treatment for a woman who is menopausal or perimenopausal (or for their male partners), unless the woman is experiencing menopause at a premature age.

The above exclusions apply whether or not a Member has a medically documented diagnosis of infertility. Please see Section 8, II for other exclusions that may apply.

D. Organ and Tissue Transplants

Organ and tissue transplants are covered according to the terms of this article. Network Benefits are available for covered transplants. Out-of-Network Benefits are not applicable or available.

To be eligible for Network Benefits, transplants must be approved in advance according to Your physician's order and Anthem's Precertification. You and the organ donor must receive services from a Preferred Provider, Contracting Provider or other Designated Provider, as determined by Anthem. Otherwise, no Benefits are available. The organ recipient must be a Member. When the organ donor is a Member, and the recipient is a not a Member, no Benefits are available for services received by the donor or by the recipient. Exception: Human leukocyte antigen laboratory tests (histocompatibility locus antigen testing) to screen for the purposes of identifying a Member as a potential bone marrow transplant donor is covered, even if there is no specified recipient at the time of screening and/or an identified recipient is not a Member. Benefits are limited to the Maximum Allowable Benefit as allowed by law. New Hampshire law prohibits providers from billing Members for the difference between the Maximum Allowable Benefit and the provider's charge.

- The Member must meet the criteria for testing as established by the Match Registry (the National Marrow Donor Program), and
- The screening is furnished by a Network Provider acting within the scope of the provider's license.

Benefits are available only if You meet all of the criteria for transplant eligibility as determined by Anthem and by the provider. The transplant must be generally considered the treatment of choice by Anthem and by the provider. Otherwise, no Benefits are available. Transplants are not covered for patients with certain systemic diseases, contraindications to immunosuppressive drugs, positive test results for HIV (with or without AIDS), active infection, active drug, alcohol or tobacco use or behavioral or psychiatric disorders likely to compromise adherence to strict medical regimens and post-transplant follow-up.

Covered Services. The following transplants are covered if all of the conditions stated in this article are met:

- Cornea, heart, heart-lung, kidney, kidney-pancreas, liver, and pancreas

- Allogeneic (HLA identical match) bone marrow transplants for acute leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma (for children who are at least one year old), aplastic anemia, chronic myelogenous leukemia, infantile malignant osteopetrosis, severe combined immunodeficiency, Thalassemia major and Wiskott-Aldrich syndrome

- Autologous bone marrow (autologous stem cell support) transplants and autologous peripheral stem cell support transplants for acute lymphocytic or nonlymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors.

- Single or double lung transplants for the following end-stage pulmonary diseases: primary fibrosis, primary pulmonary hypertension and emphysema. Double lung transplants are covered for cystic fibrosis.

- Small bowel transplants for Members with short bowel syndrome when there is irreversible intestinal failure, an established TPN (total parenteral nutrition) dependence for a minimum of two calendar years, or there is evidence of severe complications from TPN. Simultaneous small bowel/liver transplants are covered for children and adults with short bowel syndrome when there is irreversible intestinal failure, an established TPN dependence for a minimum of two calendar years, evidence of severe complications from TPN or evidence of impending end-stage liver failure.

Due to advances in transplant procedures and constantly changing medical technology, Anthem is given the right to periodically review and update the list of transplant procedures that are Covered Services. For the most up to date list of covered transplant procedures, please contact Anthem's Customer Service Center at the number on Your identification card.

Benefits are available for the tissue typing, surgical procedure, storage expense and transportation costs directly related to the donation of a human organ or other human tissue used in a covered transplant procedure. Benefits are available only to the extent that the costs are not covered by other insurance.

Transportation costs for travel to and from the site for the transplant surgery for the patient and one other individual and lodging and meal costs for the individual other than the patient are covered expenses. If the transplant recipient is a minor, transportation, lodging and meal costs are extended to two other individuals. Total transportation, and reasonable and necessary lodging and meal costs, not to exceed $150 per day, are not to exceed a maximum of $10,000 for the patient and all accompanying individuals for each completed covered transplant.

Benefits are subject to the cost sharing amounts as shown in parts I and II of Your Cost Sharing Schedule.

No Benefits are available for any transplant procedure that is not a Covered Service as described in this article IV, D. Experimental or Investigational transplant procedures and any related care (including care for complications of a noncovered procedure) are not covered except as stated below in E, "Qualified Clinical Trials" and Section 8, II, O, "Experimental and Investigational Services." No Benefits are available for procedures that are not Medically Necessary. No Benefits are available for any service or supply related to surgical procedures for artificial or nonhuman organs or tissues. No Benefits are available for transplants using artificial parts or nonhuman donors. Benefits are not provided for services and supplies related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This exclusion includes but is not limited to: services for implantation, removal, and complications. This exclusion does not apply to Left Ventricular Assist Devices when used as a bridge to a heart transplant.

E. Qualified Clinical Trials: Routine Patient Care

Benefits are available for Medically Necessary routine patient care *related to* drugs and devices that are the subject of clinical trials, provided that all of the following terms and conditions are met:

1. The drug or device under study must be approved for sale by the FDA (regardless of indication).

2. The drug or device under study must be for cancer or any other life-threatening condition.

3. The drug or device must be the subject of a clinical trial approved by one of the following:

    - One of the National Institutes of Health (NIH),
    - An NIH cooperative group or an NIH center,
    - The FDA (in the form of an Investigational new drug application or exemption),
    - The federal department of Veterans Affairs or Defense, or
    - An institutional review board of an institution in New Hampshire that has a multiple assurance contract approved by the Office of Protection from Research Risks of the NIH.

4. Standard treatment has been or would be ineffective, does not exist or there is no superior non-Investigational treatment alternative.

5. The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training and volume of patients treated to maintain expertise.

6. The available clinical or preclinical data provides a reasonable expectation that the treatment will be at least as effective as the non-Investigational alternative.

7. For phase III or IV clinical trials (clinical trials involving leading therapeutic or diagnostic alternatives), Benefits are available for routine patient care, provided that all of the conditions stated in this article are met, and subject to all of the other terms and conditions of this Certificate.

8. For phase I or II clinical trials (clinical trials involving emerging technologies), Benefits are available for routine patient care only if:

    - All of the conditions stated in this article are met and subject to all of the other terms and conditions of this Certificate, and
    - Anthem reviews all of the information available regarding Your individual participation in a Phase I or II clinical trial and determines that Benefits will be provided for Your routine patient care. Otherwise, no Benefits are available for routine patient care related to phase I or II clinical trials.

Routine patient care means the Medically Necessary Covered Services described in this Certificate for which Benefits are regularly available, no applicable exclusion is stated in this Certificate and for which reimbursement is regularly made to a Preferred Provider according to the terms of the provider's agreement with Anthem. For example, if surgery is Medically Necessary to implant a device that is being tested in a phase III or IV clinical trial, the surgery and any Medically Necessary hospital care are covered according to the terms and conditions of this Certificate. Plan rules and cost sharing rules apply to routine patient care as for any other similar service. Cost sharing amounts for routine patient care costs are shown in the applicable parts of Your Cost Sharing Schedule. For example: Your share of the cost for Inpatient services is found in part I of the Cost Sharing Schedule and Your share of the cost for Infusion Therapy is found in part IV. For Phase I and II clinical trials, Anthem is given the right to determine Benefit eligibility for routine patient care on a case-by-case basis.

Routine patient care does not include:

- The drug or device that the trial is testing,
- Experimental/Investigational drugs or devices not approved for market for any indication by the FDA,
- Non-health care services that a Member may be required to receive in connection with the clinical trial or services that are provided to You for no charge,
- Services that are clearly inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis,
- The cost of managing the research associated with the clinical trial. This includes, but is not limited to items or services provided primarily to collect data, and not used in the direct provision of Medically Necessary health care services. For example, monthly CT scans for a condition that usually requires fewer scans are not routine patient care,
- Services that are not Medically Necessary or that are not specifically stated as a Covered Service in this Certificate. Services subject to an exclusion or limitation stated in this Certificate are not routine patient care.

F. Required Exams or Services

Court ordered examinations or services are covered, provided that:

- The services are Covered Services furnished by a Designated Provider, and
- All of the terms and conditions of this Certificate are met.

No Benefits are available for examinations for participation in athletic or recreational activities or for attending a school, camp, or other program, unless furnished during a covered medical exam, as described in this Section 7.

Benefits are subject to the cost sharing amounts as shown in parts I, II and V of Your Cost Sharing Schedule.

Except as stated above, no Benefits are available for examinations or services that are ordered by a third party and are not Medically Necessary to treat an illness or injury that Your provider finds or reasonably suspects. No Benefits are available for examinations or services that are required to obtain or maintain employment, insurance or professional or other licenses.

G. Surgery

Benefits are available for covered surgical procedures, including the services of a surgeon, specialist, anesthetist or anesthesiologist and for preoperative and postoperative care.

A Surgical Assistant is a Designated Provider acting within the scope of his or her license who actively assists the operating surgeon in performing a covered surgical service. Benefits are available for the Medically Necessary services of a Surgical Assistant provided that:

- The surgery is a Covered Service, **and**
- The surgery is not on Anthem's list of surgical procedures that do not require a Surgical Assistant. Anthem's list is changeable. Please contact Your physician or Customer Service before Your surgery to obtain the most current information. Anthem's toll-free telephone number is on Your identification card.

Administration of general anesthesia is covered, provided that:

- The surgery is a Covered Service, **and**

- The anesthesia is administered by a licensed anesthesiologist or anesthetist who is not the surgeon.

Surgery includes correction of fractures and dislocations, delivery of a baby, endoscopies and any incision or puncture of the skin or tissue that requires the use of surgical instruments to provide a Covered Service. Benefits are subject to the cost sharing amounts shown under parts I and II of Your Cost Sharing Schedule.

Under the terms of this article, surgery does not include: inoculation, vaccination, collection of blood or administration or injection of drugs or trigger point injections for treatment of TMJ disorders. Surgery does not include any service excluded from coverage under the terms of this Certificate.

Limitations. In addition to the limitations and exclusions stated elsewhere in this Certificate, the following limitations apply to surgery:

1. **Reconstructive Surgery. <u>Benefits are available for breast reconstruction following mastectomy for patients who elect reconstruction.</u>** Breast reconstruction can include reconstruction to both affected breasts or one affected breast. Reconstruction can also include reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast (to produce a symmetrical appearance) in the manner chosen by the patient and the physician.

   Otherwise, Benefits are available for Medically Necessary reconstructive surgery only if at least one of the following criteria is met. **Reconstructive surgery or services must be:**

   - Made necessary by accidental injury; or

   - Necessary for reconstruction or restoration of a functional part of the body following a covered surgical procedure for disease or injury; or

   - Medically Necessary to restore or improve a bodily function, or

   - Necessary to correct birth defects for covered dependent children who have functional physical deficits due to the birth defect. Corrective surgery for children who do not have functional physical deficits due to the birth defect is not covered under any portion of this Certificate.

   Reconstructive surgery or procedures or services that do not meet at least one of the above criteria is not covered under any portion of this Certificate.

   Provided that the above definition of reconstructive surgery is met, the following reconstructive surgeries are eligible for Benefits:

   - Mastectomy for Gynecomastia

   - Mandibular/Maxillary orthognathic surgery

   - Port wine stain removal

   Benefits are available based on the criteria stated in this Certificate. Please see article IV, E, 4 “Durable Medical Equipment, Medical Supplies and Prosthetics,” for information about coverage for helmets or adjustable bands used to change the shape of an infant’s head.

2. **Cosmetic Services**. Cosmetic Services are not covered under any portion of this Certificate. Please see Section 8, II for a definition of Cosmetic Services.

3. **Dental Services.** Dental Services are covered only as stated above in article VI, A, "Dental Services." Except as stated above in A, no Benefits are available for Dental Services, including dental surgery, under any portion of this Certificate.

4. **Surgery for conditions caused by obesity.** Benefits are available for bariatric surgery that is Medically Necessary for the treatment of diseases and ailments caused by or resulting from obesity or morbid obesity. The definition of Medical Necessity is found in Section 14. When applying the definition of Medical Necessity to bariatric surgery services, Anthem uses standards that are consistent with qualification and treatment criteria set forth by the American Society for Metabolic and Bariatric Surgery or the American College of Surgeons.

   Surgery to treat the condition of obesity itself is not covered under any portion of this Certificate, even if the surgery, service or program is ordered by Your physician or performed or ordered by another Designated Provider. This exclusion applies even if the surgery, service or program meets the definition of Medical Necessity. Except as stated in this article, no Benefits are available for bariatric surgery or any other surgery intended to manage or control appetite or body weight.

   Please see "Diabetes Management Programs" in Section II, F and "nutrition counseling" in Section II, B, 7 for information about Benefits for non-surgical services for weight management, management of obesity and treatment of the diseases and ailments caused by or resulting from obesity.

5. **Postoperative medical care.** Postoperative medical care is the medical care related to and provided after the surgery. The Maximum Allowable Benefit for surgery includes the Benefit payment for postoperative medical care. No Benefits beyond the surgical Maximum Allowable Benefit are available for surgery-related postoperative medical care.

6. **Organ/tissue transplant surgery.** Please see D, "Organ and Tissue Transplants" (above in this article) for important information about coverage and limitations for organ/tissue transplant surgery.

7. **Intravenous (IV) Sedation and local anesthesia.** The Maximum Allowable Benefit for surgery includes the Benefit payment for IV sedation and/or local anesthesia. No Benefits beyond the surgical Maximum Allowable Benefit are available for IV sedation and/or local anesthesia.

8. **Surgery related to noncovered services**. No Benefits are available for surgery or any other care related to, resulting from, arising from or provided in connection with noncovered services or for complications arising from noncovered services. This exclusion applies even if the service is furnished or ordered by Your physician or other Designated Provider and meets Anthem's definition of Medical Necessity.

If Your proposed surgical services may be considered noncovered reconstructive, cosmetic, dental, weight loss/weight management surgery or if Your surgical services may be considered noncovered under other portions of this Certificate, You should contact Anthem *before* You receive the services. Please ask Your physician to submit a written description of the service to:

Anthem Blue Cross and Blue Shield
P.O. Box 660
North Haven, CT 06473-0660.

Anthem will review the information and determine in writing whether the requested services are covered or excluded under this Certificate. Anthem's review determination is not a guarantee of Benefits. Benefits are subject to all of the terms and conditions of this Certificate.

H. Vision Services

Benefits are available for the diagnosis and treatment of eye disease or injury. Covered Services (Inpatient and Outpatient care) are described throughout this Section 7.

Benefits are subject to the cost sharing amounts as shown in parts I and II of Your Cost Sharing Schedule.

Except as stated in article II, A, 3, "routine vision," no Benefits are available for routine vision care to determine the need for vision correction or for the prescription and fitting of corrective lenses, including contact lenses. No Benefits are available for services, supplies or charges for eye surgery to correct errors of refraction, such as near-sightedness, including, without limitation, radial keratotomy and PRK Laser (photo refractive keratectomy) or excimer laser refractive keratectomy.

Unless Your Group has purchased a Prescription Eyewear Rider, eyewear (frames, lenses and contact lenses) is covered for medical conditions only as stated above in article IV, E, 2.

No Benefits are available for vision therapy including, without limitation, treatment such as vision training, orthoptics, eye training, or eye exercises.

Section 8: Limitations and Exclusions

Please see Section 14 for definitions of specially capitalized words.

I. Limitations

The following are important limitations that apply to the Covered Services stated in Section 7. In addition to other limitations, conditions or exclusions set forth elsewhere in this Certificate, Benefits for expenses related to the services, supplies, conditions or situations described in this article are limited as indicated below. Limitations apply to these items and services even if You receive them from Your physician or according to Your physician's order or according to the recommendation of another Designated Provider. All of the Plan rules, terms and conditions stated elsewhere in this Certificate apply to services described in this article.

Please remember, this Plan does not cover any service or supply not specifically listed as a Covered Service in this Certificate. The following list of limitations is not a complete list of all services, supplies, conditions or situations for which Benefits are limited. Limitations are stated throughout this Certificate. If a service is not covered, then all services performed in conjunction with, arising from, or as a result of complications with respect to that service are not covered.

Anthem's determinations about Precertification, Medical Necessity, Experimental/Investigational Services and new technology are based on the terms of this Certificate, including, but not limited to the definition of Medical Necessity found in Section 14. Anthem's medical policy assists in Anthem's determinations. Anthem's medical policy reflects the standards of practice and medical interventions identified as reflecting appropriate medical practice. However, the Benefits, exclusions and limitations stated in this Certificate take precedence over medical policy. You have the right to appeal Benefit determinations made by Anthem, including Adverse Determinations regarding Medical Necessity. Please see Section 11 for more information about the appeal process.

A. Human Growth Hormones. No Benefits are available for human growth hormones, except:

- To treat children with short stature as defined by Anthem, and who have an absolute deficiency in natural growth hormones, or
- To treat children with short stature as defined by Anthem, and who have chronic renal insufficiency and who do not have a functioning renal transplant.

Depending on the Designated Provider of Your services, Your share of the cost for human growth hormones is shown on Your Cost Sharing Schedule under section II, "Medical Supplies," or section IV, "Infusion Therapy" of Your Cost Sharing Schedule for medical supplies. Cost sharing amounts for Benefits under Your Pharmacy Rider are shown on page 1 of Your Cost Sharing Schedule.

B. Private Room. If You occupy a private room, You will have to pay the difference between the hospital's charges for a private room and the hospital's most common charge for a semi-private room, unless it is Medically Necessary for You to occupy a private room. Your physician must provide Anthem with a written statement in advance regarding the Medical Necessity of Your use of a private room, and Anthem must agree in advance that private room accommodations are Medically Necessary.

Benefits are subject to the cost sharing amounts as shown in section I of Your Cost Sharing Schedule.

C. Ultraviolet Light Therapy and Ultraviolet Laser Therapy for Skin Disorders. Benefits are available for out-of-home ultraviolet light and laser therapy as follows:

- Ultraviolet light therapy is covered for treatment of atopic dermatitis, chronic urticaria, eczema, lichen planus, mycosis fungoides (cutaneous T-cell lymphoma), pityriasis lichenoides, pityriasis rosea, pruritus of renal failure, psoriasis or vitiligo.

- Psoralen with Ultraviolet A light therapy is covered for treatment of acute or chronic pityriasis lichenoides, atopic dermatitis, eczema, lichen planus, mycosis fungoides (cutaneous T-cell lymphoma), psoriasis and vitiligo.

- Ultraviolet laser therapy for the treatment of inflammatory skin disorders such as psoriasis, provided that:

    - The inflammation is limited to less than or equal to 10% of the member's body surface area, and

    - The member has undergone conservative therapy with topical agents, with or without standard non-laser ultraviolet light therapy, and the conservative therapy was not successful as documented in medical records.

Except as stated in this article, no Benefits are available for ultraviolet light or laser therapy for skin disorders.

Please see Section 7, IV, E "Durable Medical Equipment, Medical Supplies and Prosthetics" for information about coverage for Medically Necessary equipment and supplies for home ultraviolet light therapy for skin disorders. Except as stated in Section 7 and in this article, no Benefits are available for ultraviolet light therapy or ultraviolet laser therapy for skin disorders.

This limitation applies even if the therapy is furnished, prescribed, or supervised by a Designated Provider and even if the therapy meets the definition of Medical Necessity.

II. Exclusions

No Benefits are available for the following items or services. This subsection is not a complete list of all noncovered services. Other limitations, conditions and exclusions are set forth elsewhere in this Certificate. Please remember, this Plan does not cover any service or supply not specifically listed as a Covered Service in this Certificate.

Anthem is given the right to make determinations about Precertification, Medical Necessity, Experimental/Investigational services and new technology based on the terms of this Certificate, including, but not limited to the definition of Medical Necessity found in Section 14. Anthem's medical policy assists in Anthem's determinations. Anthem's medical policy reflects the standards of practice and medical interventions identified as reflecting appropriate medical practice. However, the Benefits, exclusions and limitations stated in this Certificate take precedence over medical policy. You have the right to appeal Benefit determinations made by Anthem, including Adverse Benefit Determinations regarding Medical Necessity. The appeal procedure is stated in Section 11 in this Certificate.

No Benefits are available for the cost of any noncovered services or for the cost of any care related to, resulting from, arising from or provided in connection with noncovered services or for complications arising from noncovered services. The limitations and exclusions found in this article of this Certificate and in any other portion of this Certificate apply even if the service is furnished or ordered by Your physician or other Designated Provider and/or the service meets the definition of Medical Necessity.

A. Alternative Medicine or Complementary Medicine. No Benefits are available for alternative or complementary medicine, even if the service is recommended by Your physician and even if the services are beneficial to You. Alternative or complementary medicine is any protocol or therapy for which the clinical effectiveness has not been proven, established or medically documented or otherwise fails to meet the definition of Medical Necessity as stated in Section 14. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris.

B. Amounts That Exceed the Maximum Allowable Benefit. Benefits for Covered Services are limited to the Maximum Allowable Benefit. As stated in this Certificate, You may be responsible for any amount that exceeds the Maximum Allowable Benefit. See Section 14 for a definition of "Maximum Allowable Benefit."

C. Artificial Insemination. In general terms, "artificial insemination" refers to insemination by any means other than natural sexual intercourse. No Benefits are available for artificial insemination, any assistive reproduction technology or any related service. Please see Section 7, VI, C, for detailed information.

D. Biofeedback Services. Biofeedback services are not covered.

E. Blood and Blood Products. No Benefits are available for costs related to the donation, drawing or storage of designated blood. Designated blood is blood that is donated and then designated for a specific person's use at a later date. No Benefits are available for blood, blood donors, blood products or packed red blood cells when participation in a volunteer blood program is available.

F. Care Furnished by a Family Member. No Benefits are available for care furnished by an individual who normally resides in Your household or is a member of Your immediate family. Your immediate family is defined to include parents, siblings, spouses, children and grandparents.

G. Care Received When You Are Not Covered Under This Certificate. No Benefits are available for any service that You receive *before* the effective date of Your coverage under this Certificate.

If an Inpatient admission began *before* the effective date of Your coverage under this Certificate and this coverage replaces that of another carrier. Benefits will be provided under this Certificate for Inpatient days occurring on or after the effective date of Your coverage under this Certificate, unless this coverage replaces that of another carrier and the terms of the prior carrier's policy provides coverage for the entire admission (admission date to discharge date), and subject to all the terms and conditions of this Certificate for Medically Necessary Inpatient services.

Except as stated in Section 13, IV, Benefits are not available for Inpatient days or any other services that occur after the termination date of coverage under this Certificate.

H. Care or Complications Related To Noncovered Services. No Benefits are available for the cost of any noncovered services or for the cost of any care related to, resulting from, arising from or provided in connection with noncovered services or for complications arising from noncovered services, except as stated in Section 7, VI, A, "Dental Services."

The limitations and exclusions found in this Section and in any other portions of this Certificate apply, even if the service is furnished or ordered by Your physician or other Designated Provider and/or the service meets the definition of Medical necessity. Benefits for any complications resulting from noncovered or unauthorized services are excluded from coverage.

I. Chelating Agents. No Benefits are available for any service, supply or treatment for which a chelating agent is used, except for providing treatment for heavy metal poisoning.

J. Convenience Services. No Benefits are available for the cost of any service that is primarily for the convenience of a Member, a Member's family, or a Designated Provider. This exclusion applies even if the service is provided while You are ill or injured, under the care of a Designated Provider, and even if the services are furnished, ordered or prescribed by a Designated Provider. Noncovered Convenience Services include, but are not limited to: telephone and television rental charges in a hospital, non-patient hospital fees, charges for holding a room while You are temporarily away from a facility, personal comfort and personal hygiene services, linen or laundry services, the cost of 'extra' equipment or supplies that are rented or purchased primarily for convenience, late discharge charges and admission kit charges.

K. Cosmetic Services. No Benefits are available for Cosmetic Services. The cost of care related to, resulting from, arising from or medical conditions caused by or provided in connection with Cosmetic Services is not covered. No Benefits are available for care furnished for complications arising from Cosmetic Services. Cosmetic Services include but are not limited to any care, procedure, service, equipment, supplies or medications primarily intended to change Your appearance, to improve You appearance or furnished for psychiatric or psychological reasons. For example: surgery or treatments to change the texture or appearance of Your skin are not covered. No Benefits are available for surgery or treatments to change the size, shape or appearance of facial or body features (such as Your nose, eyes, ears, cheeks, chin, chest or breasts), except for the covered surgery described in Section 7, VI, "Surgery."

L. Custodial Care and Domiciliary Care. No Benefits are available for services, supplies or charges for Custodial Care. Custodial Care is not covered, even if the services are furnished or prescribed by a Designated Provider. Custodial Care is primarily for the purpose of assisting You in the activities of daily living and is not specific treatment for an illness or injury. It is care that has minimal therapeutic value and cannot in itself be expected to substantially improve a medical condition. Custodial Care is excluded, even if You receive the care during the course of an illness or injury while under the supervision of a Designated Provider, and even if the care is prescribed or furnished by a Designated Provider and is beneficial to You. Custodial Care is not covered, whether or not it is furnished in a facility (such as a Short-term General Hospital, Skilled Nursing Facility or Physical Rehabilitation Facility), at home or in another residential setting. Noncovered Custodial Care includes, but is not limited to:

- Assistance with walking, bathing, or dressing;
- Oral hygiene, ordinary skin and nail care, maintaining personal hygiene or safety;
- Transfer or positioning in bed;
- Normally self-administered medicine;
- Meal preparation;
- Feeding by utensil, tube, or gastrostomy;
- Routine maintenance of ostomies;
- Catheter care;
- Suctioning;
- Using the toilet;
- Enemas;
- Preparation of special diets;
- Supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel;
- Domiciliary care. Domiciliary care is care provided in a residential institution or setting, treatment center, halfway house, or school because a member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included. Domiciliary care is Custodial Care and is not covered under any portion of this Certificate; and

- Convalescent care. Convalescent care is Custodial Care that You receive during a period of recovery from an acute illness or injury.

M. Disease or Injury Sustained as a Result of War or Participation in Riot or Civil Disobedience. No Benefits are available for care required to diagnose or treat any illness or injury that is a result of war, participation in a riot or other act of civil disobedience. Benefits are not available for illness or injury when the cause of the illness or injury was a Member's commission of any illegal activity, unless otherwise required by law or regulation.

N. Educational, Instructional, Vocational Services and Developmental Disability Services. Except as stated in Section 7, II, A "Diabetes Management Programs", no Benefits are available for educational or instruction programs or services. Noncovered services include, but are not limited to, education evaluation, testing, classes, therapy, tutoring, counseling, programs, equipment or supplies. No Benefits are available for vocational/occupational evaluations, testing, classes, therapy, counseling, programs, equipment or supplies. Except as stated in Section 7, III, D "Early Intervention" and V "Behavioral Healthcare", no Benefits are available for services, counseling, therapy, supplies, equipment or programs for behavioral reasons or for Developmental Disabilities.

O. Experimental/Investigational Services. Anthem is given the right to determine if services or supplies are Experimental/Investigational. Except as stated in Section 7, VI, E "Qualified Clinical Trials," the Plan will not pay for Experimental/Investigational services. No Benefits are available for the cost of care related to, resulting from, arising from or provided in connection with Experimental/Investigational services." No Benefits are available for care furnished for complications arising from Experimental/Investigational services.

1. **Experimental or Investigational service** means any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply that is Experimental or Investigational and is used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition.

   a. Anthem will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental or Investigational if one or more of the following criteria apply when the service is rendered with respect to the use for which Benefits are sought. The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply:

   - Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration ("FDA") or any other state or federal regulatory agency and such final approval has not been granted; or
   - Has been determined by the FDA to be contraindicated for the specific use; or
   - Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
   - Is subject to review and approval of an Institutional Review Board ("IRB") or other body serving a similar function; or
   - Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental or Investigational or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product equipment, procedure, treatment, service, or supply is under evaluation.

   b. Any Service not deemed Experimental or Investigational, based on the above criteria, may still be deemed to be Experimental or Investigational by Anthem if:

- The scientific evidence is not conclusory concerning the effect of the service on health outcomes;

- The evidence does not demonstrate that the service improves the net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;

- The evidence does not demonstrate that the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; or

- The evidence does not demonstrate that the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

c. When applying the provisions of (a) and (b) above to the administration of Benefits under the Plan, Anthem may include one or more items from the following list which is not all inclusive:

- Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or

- Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or

- Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or

- Documents of an IRB or other similar body performing substantially the same function; or

- Consent document(s) used by the treating physicians, other medical professionals, or facilities, or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or

- The written protocol(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or

- Medical records; or

- The opinions of consulting providers and other experts in the field.

Anthem uses the terms of this article in reviewing services that may be Experimental/Investigational. Anthem's medical policy assists in Anthem's review. Anthem's medical policy reflects the standards of practice and medical interventions identified as reflecting appropriate medical practice. However, the Benefits, exclusions and limitations stated in this Certificate take precedence over medical policy.

You have the right to appeal Benefit determinations made by Anthem, including Adverse Benefits Determinations regarding Experimental/Investigational Services. Please see Section 11 for more information about appeals.

P. Food and Food Supplements. No Benefits are available for foods, food supplements or for vitamins except as provided in Section 7, IV, E "Durable Medical Equipment, Medical Supplies and Prosthetics." Please refer to that Section for information about Benefits. See Your Pharmacy Rider for coverage information.

Q. Foot Care (that is routine), Foot Orthotics and Corrective Shoes. No Benefits are available for routine foot care. Services or supplies in connection with corns, calluses, flat feet, fallen arches, weak feet or chronic foot strain are not covered. No Benefits are available for foot orthotics, inserts or support devices for the feet. Corrective shoes are not covered.

R. Free Care. No Benefits are provided for any care if the care is furnished to You without charge or would normally be furnished to You without charge. This exclusion will also apply if the care would have been furnished to You without charge if You were not covered under this Certificate or under any other health plan or other insurance.

S. Government Programs. No Benefits are available for Covered Services to the extent that benefits for such services are paid or payable (or could reasonably be expected to be payable if a claim were made) under any of the following:

- Medicare or any other federal, state or local government program for which the government is the primary payer, including CHAMPUS/TRICARE. Exception: Benefits are available under this Certificate even though You may be eligible for Medicaid; or
- Any federal, state, county, municipal, or other government agency, including Medicare and the Veteran's Administration, for service-connected disabilities.

Please see Section 10 for more information regarding Medicare.

T. Home Test Kits. No Benefits are available for laboratory test kits for home use. These include, but are not limited to, home pregnancy tests and home HIV tests.

U. Hospitalization for Noncovered Services. No Benefits are available for hospital services or any other health care service related to, arising from, the result of, caused by or provided in connection with noncovered services or for complications arising from noncovered services, except as stated in Section 7, VI, A, "Dental Services." No Benefits are available for expenses incurred when You choose to remain in a hospital or another health care facility beyond the discharge time recommended by Your physician or by Anthem.

V. Missed Appointments. Physicians and other providers may charge You for failing to keep scheduled appointments without giving reasonable notice to the office. No Benefits are provided for these charges. You are solely responsible for the charges.

W. Non-Hospital Institutions. No Benefits are available for care or supplies in:

- Any facility that is not specifically stated as a covered facility in this Certificate;
- Convalescent homes or similar institutions and facilities that provide primarily custodial, maintenance or rest care; or
- Health resorts, spas, sanitariums, sanatoriums or tuberculosis hospitals.

X. Nonmember Biological Parents. No Benefits are available for services received by the biological parent of an adopted child, unless the biological parent is a Member.

Y. Premarital Laboratory Work. No Benefits are available for premarital laboratory work required by any state or local law.

Z. Private Duty Nurses. No Benefits are available for private duty nurses.

AA. Processing Fees. No Benefits are available for the cost of obtaining medical records or other documents that Anthem considers necessary to administer Benefits under this Certificate.

AB. Rehabilitation Services. No Benefits are available for rehabilitation services primarily intended to improve the level of physical functioning for enhancement of job, athletic, or recreational performance. No Benefits are available for programs such as, but not limited to, work hardening programs and programs for general physical conditioning.

AC. Reversal of Voluntary Sterilization. No Benefits are provided for the reversal of sterilization, including infertility treatment that is needed as a result of a prior elective or voluntary sterilization (or elective sterilization reversal) procedure.

AD. Sclerotherapy for Varicose Veins and Treatment of Spider Veins. Except when treatment is Medically Necessary as defined in Section 14 of this Certificate, no Benefits are available for sclerotherapy for the treatment of varicose veins of the lower extremities including, but not limited to: ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy. Treatment of telangiectatic dermal veins (spider veins) by sclerotherapy or any other method is not covered under any portion of this Certificate because such treatment is considered to be cosmetic and not Medically Necessary.

AE. Services Not Covered and Care Related to Noncovered Services. No Benefits are available for services that are not specifically described as Covered Services in this Certificate. No Benefits are available for services that are not covered due to a limitation or exclusion stated in this Certificate. This exclusion applies even if the service meets the definition of Medical Necessity and it applies even if a Designated Provider furnishes or orders the service. No Benefits are available for care related to, resulting from, arising from, caused by or provided in connection with noncovered services or for complications arising from noncovered services. Examples of noncovered services include but are not limited to:

- Services furnished by any individual or entity that is not a Designated Provider, except at the sole discretion of Anthem;
- Services received by someone other than the patient, except as stated in Section 7, VI, D "Organ and Tissue Transplants;"
- A separate fee for the services of interns, nurses, residents, fellows, physicians or other providers such as hospital-based ambulance services that are salaried or otherwise compensated by a hospital or other facility;
- The travel time and related expenses of a provider;
- A provider's charge to file a claim or to transcribe or duplicate Your medical records;
- Fees, postage, taxes or other charges for the shipping or handling of covered equipment or services;
- Prescription drugs purchased at a retail pharmacy, doctor's office or through a mail service pharmacy for "take-home" use. Please see Your Pharmacy Rider for information on prescription drugs purchased at a retail pharmacy.
- Nonlegend or "over-the-counter" drugs, medications, vitamins, minerals, supplements, supplies or devices. Please see Your Pharmacy Rider for information on prescription drugs purchased at a retail pharmacy.

AF. Sex Change Treatment. No Benefits are available for surgical procedures or any other service, drug, product or therapy related to altering Your sex from one gender to the other.

AG. Smoking Cessation Drugs, Programs or Services. Except as stated in Your Pharmacy Rider or any other rider, amendment, or endorsement providing such coverage, no Benefits are available under this Plan for smoking cessation programs, products, drugs or medications, hypnosis, supplies or devices of any kind intended to help You quit smoking or to wean You off nicotine. Such services are not covered, even if administered in a physician's office, ordered by a physician or if a physician's written prescription order is required for purchase of the service.

AH. Surrogate Parenting. No Benefits are available for costs associated with surrogate parenting or gestational carriers. Please see Section 7, VI, C, 2 "Infertility Exclusions" for detailed information.

AI. Transportation. No Benefits are available for transportation costs, except as described in Sections 7, II, E, "Ambulance Services."

AJ. Workers' Compensation. No Benefits are available for any care, condition, disease, or injury that arises out of or in the course of employment when You are covered by Workers' Compensation, unless You or Your employer waived coverage in accordance with New Hampshire law.

AK. X-Rays. No Benefits are available for diagnostic x-rays in connection with research or study, except as explained for routine patient care costs in Section 7, VI, E "Qualified Clinical Trials." No Benefits are available for orthopantagrams.

Section 9: Claim Procedure

Please see Section 14 for definitions of specially capitalized words.

This Section explains the Plan's procedure regarding the submission and processing of claims. For purposes of this Section, Adverse Benefit Determination means any of the following: the Plan's denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a Benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a Member's eligibility for coverage under this Certificate. Adverse Benefit Determinations also include the Plan's denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for, a Benefit resulting from the application of the utilization review procedures, as well as the Plan's determination not to cover an item or service for which Benefits are otherwise provided based on a determination that the item or service is Experimental, Investigational or not Medically Necessary or appropriate, as well as a rescission of coverage.

You may appeal any Adverse Benefit Determination or other decision that Anthem makes about Your coverage, Your Benefits or any failure to provide coverage or Benefits. Please see Section 11 for information about the appeals procedure.

I. Post-Service Claims

Post-Service Claims are claims for services that You have received. Post-Service Claims do not include requests for reimbursement made by providers according to the terms of their agreement with Anthem or with a Subcontractor, unless:

- Benefits are reduced or denied, and
- Under the terms of an agreement with Anthem or with a Subcontractor, the provider can bill You for amounts exceeding Your Copayment, Deductible and/or Coinsurance.

A. Time Limit for Submitting Post-Service Claims. In order for Anthem to make payments for Post-Service Claims, Anthem must receive Your claim for Benefits within 12 months after You receive the service. Otherwise, Benefits will be available only if:

- It was not reasonably possible to submit the claim within the 12-month period, and
- The claim is submitted as soon as reasonably possible after the 12-month period.

If services are furnished by a Preferred Provider or by a BlueCard Provider, You do not have to fill out any claim forms.

If services are furnished by an Out-of-Network Provider, You may need to submit Your own claim form. Please contact Your Group Benefits Administrator or Anthem to obtain the correct claim form as prescribed by Anthem for submission. Anthem's toll-free telephone number is shown on Your identification card. Please complete the claim form, include Your itemized bill and any information about other insurance payment and submit the claim to the address indicated on the claim form.

For more information about Preferred and Out-of-Network Providers, please see article V, below.

B. Timeframe for Post-Service Claim Determinations. Anthem will make a Post-Service Claim determination within 30 days after receipt of the claim, except as follows:

- Anthem may extend the 30-day period one time per claim for up to 15 additional days. This extension will occur if Anthem determines that it is necessary due to matters beyond their control. Anthem will notify You about such an extension before the initial 30-day period ends.

- If the extension is required because You or Your authorized representative failed to provide the information needed to make a determination, the extension notice will specify the requirements. You will be afforded at least 45 days from receipt of the notice within which to provide the information. The period of time between the date of the request for information and the date Anthem receives the information is "carved out" of (does not count against) the timeframes described above for Post-Service Claim determinations.

Anthem will notify You of a Post-Service Adverse Benefit Determination as stated in article III of this Section.

II. Pre-Service Claims

Certain services are covered in part or in whole only if You obtain Precertification from Anthem. Requests for Precertification and preauthorization, submitted under the terms of this Certificate, are Pre-Service Claims. Pre-service Claim means any claim for a Benefit with respect to which the terms of the Plan condition receipt of the Benefit, in whole or in part, on approval of the Benefit in advance of obtaining medical care. Pre-Service Claims do not include requests for reimbursement made by providers according to the terms of their agreement with Anthem or a Subcontractor.

A. Pre-Service Claims (non-urgent). For non-urgent Pre-Service Claims, You must obtain Precertification from Anthem in advance of the service. Please see Section 1, III and Section 4, I for a description of Benefit reductions that may occur if You do not obtain Precertification as required. Other Precertification requirements may be stated in other sections and riders or endorsements that amend this Certificate.

No fees for submitting a Pre-Service Claim will be assessed against You or Your authorized representative. You may authorize a representative to submit or pursue a Pre-Service Claim or Benefit determination by submitting Your written statement in a form prescribed by Anthem, acknowledging the representation. To find out about required authorization forms, please contact the Customer Service Center phone number shown on Your identification card.

1. **Time Limit for Submitting Pre-Service Claims.** Unless it is not reasonably possible for You to do so, Pre-Service Claims must be submitted within the applicable timeframes stated in this Certificate. For example, as stated in Section 6, IV, You must request Precertification within 48 hours after an Emergency Inpatient admission.

2. **Timeframes for Pre-Service Claim Determinations.** Anthem will make a determination about Your Pre-Service Claim within the following timeframes. Timeframes begin when Anthem receives Your claim and end when Anthem makes a claim determination. Anthem will make a determination within a reasonable time period, but in no event more than 15 days after receipt of the claim, except as follows:

    - The timeframe may be extended one time per claim for up to 15 additional days. This extension will occur if it is necessary due to matters beyond the control of Anthem. You will be notified about any extension before the initial 15-day period ends.

    - If the extension is required because You or Your authorized representative failed to provide the information needed to make a determination, the extension notice will specify the requirements. You will be afforded at least 45 days from receipt of the notice within which to provide the information. The period of time between the date of the request and the date Anthem receives the information is "carved out" of (does not count against) the timeframes described above for non-urgent Pre-Service Claim determinations.

    Anthem will notify You of a Pre-Service Adverse Benefit Determination as stated in article III of this Section.

B. Urgent Care Claim means a request for Precertification or preauthorization submitted as *required* under this Certificate, for medical care or treatment with respect to which the application of time periods for making non-urgent Pre-Service Claim determinations:

- Could seriously jeopardize Your life or health or Your ability to regain maximum function, or

- In the opinion of a provider with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

You may authorize a representative to submit or pursue an Urgent Care Claim or Benefit determination by submitting Your written statement in a form prescribed by Anthem acknowledging the representation. To find out about required authorization forms, please contact the Customer Service Center phone number shown on Your identification card. Exception: For Urgent Care Claims, Anthem will consider a health care professional with knowledge of Your condition (such as Your treating provider) to be Your authorized representative without requiring Your written acknowledgment of the representation.

1. **Time Limit for Submitting Urgent Care Claims.** Unless it is not reasonably possible for You to do so, Urgent Care Claims must be submitted within the applicable timeframes stated in this Certificate.

2. **Timeframes for Urgent Care Claim Determinations.** Anthem will make a determination as soon as possible, taking into account the medical exigencies, but in no event later than 72 hours after receipt of the claim, unless You or Your authorized representative fail to provide Anthem with the information Anthem needs to make a determination. In the case of such failure, Anthem will notify You within 24 hours after receipt of the claim. The notice will specify the information necessary to make a determination. You will be given no less than 48 hours to provide the specified information. The period of time between the date of the request and the date Anthem receives the information is "carved out" of (does not count against) the timeframes described above for Urgent Care Claim determinations.

Anthem will notify You of an Urgent Care Adverse Benefit Determination as stated in article III of this Section.

C. Concurrent Care Claims. After Anthem has precertified a course of treatment, if a reduction in the precertified number of treatments due to a continuing lack of Medical Necessity is determined by Anthem, or the course of treatment is about to end and Your provider requests additional treatment beyond that which has been precertified, You will be notified of any reduction or termination of the precertified period or number of treatments (except when due to Plan amendment or termination) sufficiently in advance to allow You to appeal and obtain a determination on review before Benefits are reduced or terminated.

You may authorize a representative to submit or pursue a Concurrent Care Claim or Benefit determination by submitting Your written statement in a form prescribed by Anthem acknowledging the representation. To find out about required authorization forms, please contact the Customer Service Center phone number shown on Your identification card.

1. **Time Limit for Submitting Concurrent Care Claims.** Unless it is not reasonably possible for You to do so, Concurrent Care Claims must be submitted within the applicable timeframes stated in this Certificate.

2. **Timeframes for Concurrent Care Claim Determinations.** For requests to extend a precertified course of treatment, a determination will be made as soon as possible, taking into account the medical exigencies. You will be notified of the determination within 24 hours of receipt of the claim, provided that You make the claim at least 24 hours *before* the precertified treatment period expires.

Anthem will notify You of a Concurrent Care Adverse Benefit Determination as stated in article III of this Section.

III. Notice of an Adverse Benefit Determination

The notice of an Adverse Benefit Determination will be in writing or by electronic means and will include the following:

- The date of service, the health care provider, and the claim amount (if applicable)
- The specific reason(s) for the determination, including the specific provision of Your Plan on which the determination is based and the denial code and its meaning if available
- A description of the standard, if any, that was used in denying a claim
- If applicable, a description of any additional information which is necessary and an explanation of why the information is necessary
- A description of the appeal procedure, including time limits and a description of the expedited appeal procedure for Urgent Care Claims
- If an internal guideline (such as a rule, protocol, or other similar provision) was relied upon in making the Adverse Benefit Determination, Anthem will reference the guideline in the notice. Anthem will either include a copy of the guideline or Anthem will inform You that a copy is available to You free of charge upon request
- If an Adverse Benefit Determination is based on a Medical Necessity or Experimental/Investigational treatment or other similar exclusion or limit, Anthem will include an explanation of the scientific or clinical judgment for the determination, applying the terms of this Certificate to Your medical circumstances, or Anthem will state that such explanation will be provided free of charge at Your request

Please note that for Urgent Care Claims, the information described above may be provided to You orally within the timeframe described in article II of this Section. However, a written or electronic notification will be furnished to You not more than three days after the oral notification.

Anthem will not release proprietary information protected by third party contracts.

IV. Appeals

Please see Section 11 for complete information about the Appeal Procedure. By accepting this Certificate, You agree that You will not take legal action about a Adverse Benefit Determination until You have exhausted the internal appeal procedure as stated in Section 11.

V. General Claims Processing Information

In most instances, claims are processed as follows:

Preferred Provider or BlueCard Provider Services. When You receive Covered Services from a Preferred Provider or from a BlueCard Provider, You will not have to fill out any claim forms. Simply identify Yourself as a Member and show Your Anthem identification card before You receive the care. Preferred Providers and BlueCard Providers will file claims for You. You pay only the applicable Copayment, Deductible or Coinsurance amount to the provider when You receive Your Covered Services. Eligible Benefits will be paid directly to Preferred Providers or BlueCard Providers.

BlueCard Program. When You obtain health care services through BlueCard outside the geographic area Anthem serves, the amount You pay for Covered Services is calculated on the lower of:

- The billed charges for Your Covered Services, or
- The negotiated price that the onsite Blue Cross and/or Blue Shield Plan ("Host Plan") passes onto Anthem

Often this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Plan. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with Your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an **average** expected savings with Your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over or underestimation of past prices. However, the amount You pay is considered a final price.

Statutes in a small number of states may require the Host Plan to use a basis for calculating Member liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate Member liability calculation methods that differ from the usual BlueCard method noted above or require a surcharge, Anthem would then calculate Your liability for any Covered Services in accordance with the applicable state statute in effect at the time You received Your care.

Whether using a BlueCard Provider or a Preferred Provider, You will always receive the benefit of the lesser of provider charges or the rate the on-site Blue Cross or Blue Shield Plan has negotiated with its providers.

Out-of-Network Services. When You receive a Covered Service from an Out-of-Network Provider in New Hampshire, or a NonBlueCard Provider, You may have to fill out a claim form. You can get claim forms from Anthem's Customer Service Center. The toll-free number is 1-888-224-4896. Mail Your completed claim form to Anthem, along with the original itemized bill.

When traveling outside of the country, You should obtain itemized bills translated to English. Charges for Covered Services should be stated in terms of United States currency. To determine the United States currency amount, please use the exchange rate as it was on the date You received the care.

Out-of-Network New Hampshire Providers and NonBlueCard Providers may ask You to pay the entire charge at the time of Your visit. It is up to You to pay the provider. Generally, Anthem will pay eligible Benefits directly to You. Benefits equal the Maximum Allowable Benefit, minus any applicable Copayment, Deductible or Coinsurance amount. You may be responsible for amounts that exceed the Maximum Allowable Benefit and for the applicable Copayment, Deductible or Coinsurance amounts.

Anthem reserves the right to pay either You or the hospital or any other provider. You cannot assign any Benefits or monies due under this Certificate to any person, provider, corporation, organization or other entity. Any assignment by You will be void and have no effect. Assignment means the transfer to another person, provider, corporation, organization or other entity of Your right to the Benefits available under this Certificate.

Section 10: Other Party Liability

Please see Section 14 for definitions of specially capitalized words.

The following Coordination of Benefits (COB) guidelines and related other party liability rules apply to all claims that are submitted for payment under the Plan.

I. Coordination of Benefits (COB)

Please note: You may not hold or obtain Benefits under both this Plan and a nongroup (individual) health insurance policy issued by Anthem or any other insurer.

Coordination of Benefits sets the payment responsibilities when You are covered by more than one health care plan or policy. COB is intended to prevent duplication of payment and overpayments for Covered Services furnished to Members. If any Member is covered under another health care plan or policy, Benefits will be coordinated as stated in this Section.

For purposes of this Section only, "**health care plan or policy**" means any of the following, which provide benefits or services for, or by reason of, medical care or treatment:

- Group or individual hospital, surgical, medical or major medical coverage provided by Anthem Blue Cross and Blue Shield (Anthem), a private insurer or an insurance company, an HMO, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured), a prepayment group or individual practice plan, or a prepayment plan of any other organization. COB applies to any coverage including self-insured, self-funded or unfunded benefit plans or plans administered by a government, such as "socialized medicine" plans. COB also applies to union welfare plans, employee or employer benefit organizations, or any other insurance that provides medical benefits,

- Except as stated in this Section, any insurance policy, contract or other arrangement or other insurance coverage where a health benefit is provided, arranged or paid, on an insured or uninsured basis,

- Any coverage for students sponsored by, provided through or insured by a school, sports program or other educational institution above the high school level except for school accident type coverage.

- The medical benefits coverage in automobile "no fault" or "personal injury protection" (PIP) type contracts, not including medical payments coverage, also known as part B in the personal automobile policy or med pay.

For the purposes of this Section, the terms "health care plan" or "policy" do not refer to: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; medical payments coverage in a personal automobile policy, also known as Part B or med pay coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

The term "health care plan or policy" will be interpreted separately with respect to:

- Each policy, contract or other arrangement for benefits or services; or

- That portion of any such policy, contract or other arrangement which reserves the right to take the benefits of the other health care plan or policy into consideration in determining its benefits and that portion which does not take such benefits into consideration.

COB also applies when You are covered by more than two policies.

Please remember that Your payments under this Certificate (such as Deductible and Coinsurance amounts or any annual limits) are Your responsibility whether this Plan is Primary or Secondary. Also, the rules as stated in Sections 1 through 4 apply whether LGC HealthTrust is Primary or Secondary.

A. Definitions. The following definitions apply to the terms of this Section:
Primary means the health care plan or policy that is responsible for processing Your claims for eligible benefits first. When this Plan is Primary, this Plan will provide the full extent of Benefits covered under this Certificate, up to the Maximum Allowable Benefit without regard to the possibility that another health care plan or policy may cover some expenses.

Secondary means the plan responsible for processing claims for Allowable Expenses after the Primary plan has issued a benefit determination. When this Plan is Secondary, Benefits under this Plan may be reduced so that payments from all health care plans or policies combined do not exceed 100% of the total Allowable Expense.

Allowable Expense means a health care service expense that is eligible for Secondary Benefits under this health care Plan. Allowable Expenses include, but are not limited to, any deductible, coinsurance and copayment cost shares required under a Primary plan. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered to be the benefit available under that plan.

The following limitations apply to Allowable Expenses:

- An expense must be for a Medically Necessary Covered Service, as defined in this Certificate. Otherwise, no portion of the expense is an Allowable Expense.

- When the Primary plan has provided full benefits and there is no Member liability for claim payment, no portion of the expense is an Allowable Expense.

- When the Primary plan has provided benefits and there is Member liability for claim payment, the following rules apply to Secondary coverage under this Plan:

    a. If all plans covering the claim compute benefits or services based on a usual and customary fee, relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for the specific claim is not an Allowable Expense.

    b. If all plans covering the claim compute benefits or services based on a negotiated fee, any amount in excess of the highest negotiated fee for the specific claim is not an Allowable Expense.

    c. If one plan computes benefits or services for a claim based on a usual and customary fee, relative value schedule reimbursement methodology or other similar reimbursement methodology, and another plan computes benefits or services based on a negotiated fee, the Primary plan's payment arrangement shall be the Allowable Expense for all plans. Exception: If a Preferred Provider contracts with Anthem to accept a negotiated amount as payment in full when this Plan is the Secondary payer and such negotiated amount differs from the Primary payer’s arrangement, Anthem’s negotiated amount will be the Allowable Expense used to determine Secondary Benefits. The total amount in payments and/or services provided by all payers combined will not exceed the Maximum Allowable Benefit.

- If the Primary plan bases payment for a claim on the provider’s full charge and does not utilize usual and customary fees, relative value schedule reimbursement methodologies or other similar reimbursement methodologies and does not negotiate fees with providers, the combination of benefits paid by the Primary plan and this Plan will not exceed the Maximum Allowable Benefit. The difference between the Maximum Allowable Benefit and the provider’s charge is not an Allowable Expense.

- When benefits are reduced under a Primary plan due to an individual's failure to comply with the Primary plan's provisions, the amount of the reduction is not an Allowable Expense. Examples of these types of plan provisions include, but are not limited to: managed care requirements for second surgical opinions, Inpatient and Outpatient Precertification requirements and rules about access to care (such as network restrictions and referral rules).

- Any expense that a health care provider by law or in accordance with a contractual agreement is prohibited from charging a Member is not an Allowable Expense.

B. The Order of Payment is Determined by COB. COB uses the following rules to determine the Primary and Secondary payers when You are covered by more than one health care plan or policy.

1. **Important General Rules:**

   - **Services Outside the United States of America (U.S.A.).** If You have coverage under this Plan and any plan outside the U.S.A. (including plans administered by a government, such as "socialized medicine" plans), the out-of-country plan is Primary when You receive care outside the U.S.A. This Plan is Primary when You receive services in the U.S.A. This rule applies *before* any of the following rules (including the rules for children of separated or divorced parents).

   - **Liability Laws.** To the extent permitted by applicable law, when any benefits are available as Primary benefits to a Member under Medicare (see article C "Medicare Program" below) or any Workers' Compensation Laws, Occupational Disease Laws or other employer liability laws, those benefits will be Primary.

   - **No or Inconsistent COB Rule.** Except for group coverage that supplements a basic part of a benefit package and provides supplementary coverage (such as major medical coverage superimposed over base hospital/surgical coverage), any health care plan or policy that does not contain a coordination of benefits provision consistent with the terms of this Section is always Primary.

2. **Order of Payment Rules.** If You are covered by more than one health care plan or policy and none of the rules listed in 1 (above) apply, the order of benefits will be determined by using the first of the following rules that apply:

   - **Employee/Dependent Rule.** If You are the employee or Subscriber under one policy and You are a dependent under the other, the policy under which You are an employee or Subscriber is Primary. Exception: If You are a Medicare beneficiary and, as a result of federal law, Medicare is Secondary under the plan covering You as a dependent and Primary to the Plan covering You as an employee or Subscriber, then the order of benefits is reversed so that the plan covering You as an employee or Subscriber is the Secondary plan and the other plan is Primary.

   - **Dependent Child Covered Under More Than One Plan**. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one plan, the order of benefits is determined as follows:

     - For a Dependent child whose parents are married or are living together, whether or not they have ever been married, the following "birthday rule" applies:

       a. The plan of the parent whose birthday falls earlier in the calendar year is Primary, or

       b. If both parents have the same birthday, the plan that has covered the parent the longest is Primary.

     - For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

a. If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of the court decree terms, that plan is Primary. This rule applies to plan years commencing after the plan is given notice of the court decree.

b. If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of (1 above) the "birthday rule" shall determine the order of benefits.

c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of (1 above) the "birthday rule" shall determine the order of benefits.

d. If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The plan covering the custodial parent;
- The plan covering the spouse of the custodial parent;
- The plan covering the non-custodial parent; and then
- The plan covering the spouse of the non-custodial parent.

A "custodial parent" is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

For a Dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of 1 or 2 above shall determine the order of benefits as if those individuals were the parents of the child.

- **Active Employee or Retired or Laid-off Employee.** The plan that covers a Member as an active employee (that is an employee who is neither laid off nor retired) is Primary. The plan covering that same Member as a retired or laid-off employee is Secondary. The same rule applies if a Member is a dependent of an active employee and that same Member is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the "Employee/Dependent" rule (above) can determine the order of benefits.

- **COBRA or Other Continuation Coverage.** If a Member is covered under COBRA or a similar "right of continuation" law under either federal law or other continuation coverage, and the Member is also covered under another policy that is not a continuation policy, the continuation coverage is Secondary and the other plan is Primary. If the other plan does not have this rule and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the "Employee/Dependent" rule (above) can determine the order of benefits.

- **Longer/Shorter Length of Coverage**. The plan that covered the person as an employee, Member, policyholder, Subscriber or retiree longer is Primary and the plan that covered the Member the shorter period of time is Secondary.

- **If the preceding rules do not determine the order of benefits**, Allowable Expenses shall be shared equally between the health care plans or policies. In addition, this Plan will not pay more than it would have paid had it been the Primary plan.

C. Medicare Program. Medicare Secondary Payer (MSP) laws determine whether Medicare benefits will be Primary or Secondary to the Benefits available under this Plan. Factors that determine which plan is Primary include, but are not limited to, Your status as an active employee, Your age, and the reason that You are eligible for Medicare.

If Medicare is the Secondary plan according to MSP laws, coverage under this Plan is Primary. If Medicare is the Primary plan according to MSP laws, coverage under this Plan is Secondary. When Medicare is the Primary plan, You need to be enrolled in Parts A and B of Medicare because Benefits under this Plan will only be paid Secondary to Benefits available under Parts A and B of Medicare. The Secondary Benefits payable under this Plan will assume that You are eligible to receive both Medicare Part A and Part B benefits.

If You are entitled to Medicare benefits when You enroll in this Plan, You must inform Your Group Benefits Administrator and state this information on Your Medical Enrollment Application. If You become entitled to Medicare benefits after You enroll, You must inform Your Group Benefits Administrator and LGC HealthTrust immediately.

When You become entitled to Medicare benefits, You should contact Your local Social Security Office right away to discuss Medicare rules regarding enrollment in Parts A, B and D of Medicare.

II. Workers' Compensation

No Benefits are available for any care, condition, disease or injury that arises out of or in the course of employment when You are covered by Workers' Compensation, unless You or Your employer waived coverage in accordance with New Hampshire law.

III. Subrogation and Reimbursement

These provisions apply when this Plan pays Benefits as a result of an injury, illness, impairment or medical condition You sustain and You have a right to a Recovery or have received a Recovery. For purposes of this Certificate, "Recovery" shall mean money You receive or are entitled to receive from another person, entity or any other source as a result of injury, illness, impairment or medical condition caused by another. Such payments shall include but are not limited to, any money from another, the other's insurer or from any "Home Owner's," "Uninsured Motorist," "Underinsured Motorist," "Medical-Payments," "No-Fault," "Personal Injury Protection" or other insurance coverage or similar provision. Regardless of how You or Your representative or any agreements characterize the Recovery You receive, it shall be subject to the Subrogation and Reimbursement provisions of this Section.

Benefits will be provided for medical care paid, payable or required to be provided under this Certificate, and the Benefits paid, payable or required to be provided. LGC HealthTrust and/or Anthem must be reimbursed by the Member for such payments from medical payments coverage and other property and casualty insurance including homeowners insurance coverage.

Anthem may reduce any Benefit paid, payable or required to be paid under this Certificate by the amount that the Member has received in payment from medical payments coverage and other property and casualty insurance including homeowners insurance coverage.

If benefits are exhausted under a medical payments coverage or other similar property and casualty insurance, Benefits are available under this Plan, subject to all of the terms and conditions of this Certificate. Unexhausted medical payments coverage means coverage amounts available in excess of payments made to You or Your representative to reimburse Your out-of-pocket expenses paid for medical care under this Certificate.

A. Subrogation. If You suffer an injury, illness, impairment or medical condition that is the result of another party's actions, and this Plan pays Benefits to treat such injury, illness, impairment or medical condition, LGC HealthTrust will be subrogated to Your Recovery rights. LGC HealthTrust, and/or Anthem acting on LGC HealthTrust's behalf, may proceed in Your name against the responsible party. Additionally, LGC HealthTrust and/or Anthem acting on LGC HealthTrust's behalf shall have the right to recover payments this Plan makes on Your behalf from any party responsible for compensating You for Your injury, illness, impairment or medical condition. All of the following shall apply, except to the extent limited by applicable law:

- LGC HealthTrust and/or Anthem acting on LGC HealthTrust's behalf may pursue LGC HealthTrust's subrogation rights and shall have first priority for the full amount of Benefits this Plan has paid from any Recovery regardless of whether You are fully compensated, and regardless of whether the payments You receive make You whole for Your losses and injuries.

- You and Your legal representative may not waive or otherwise prejudice in any way LGC HealthTrust's subrogation rights set forth in this Section. You and Your legal representative must do whatever is necessary to enable LGC HealthTrust and/or Anthem to exercise such rights.

- LGC HealthTrust and/or Anthem have the right to take whatever legal action they see fit against any party or entity to recover Benefits paid under this Plan.

- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full LGC HealthTrust's and/or Anthem's subrogation claim and any claim still held by You, LGC HealthTrust's and/or Anthem's subrogation claim shall be first satisfied before any part of a Recovery is applied to Your claim, Your attorney fees, other expenses or costs.

- This Plan, LGC HealthTrust and Anthem are not responsible for any attorney fees, other expenses or costs You incur without the prior written consent of LGC HealthTrust. Further, the "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay Benefits paid by this Plan.

Nothing in this Section shall be construed to limit the Plan's, LGC HealthTrust's and/or Anthem's right to utilize any remedy provided by law to enforce LGC HealthTrust's rights to subrogation under this Section. LGC HealthTrust's and/or Anthem, acting on its behalf, is entitled to reimbursement from the responsible party or any other party You receive payment from to the extent of Benefits provided. LGC HealthTrust and/or Anthem reserves the right to compromise on the amount of the claim if LGC HealthTrust and/or Anthem, acting on its behalf, determines that it is appropriate to do so. Any action that interferes with LGC HealthTrust's subrogation rights may result in the termination of coverage for the Subscriber and covered Dependents.

B. Reimbursement. If You obtain a Recovery and LGC HealthTrust and/or Anthem have not been repaid for the Benefits this Plan paid on Your behalf, LGC HealthTrust and/or Anthem shall have a right to be repaid from the Recovery up to the amount of the Benefits paid on Your behalf. All of the following shall apply, except to the extent limited by applicable law:

- LGC HealthTrust and/or Anthem are entitled to reimbursement from any Recovery, in first priority, notwithstanding any allocation made in a settlement agreement or court order, and even if the Recovery does not fully satisfy a judgment, settlement or underlying claim for damages or fully compensate or make You whole.

- You and Your legal representative must hold in trust for LGC HealthTrust and/or Anthem the proceeds of the gross Recovery (i.e., the total amount of Your Recovery before attorney fees, other expenses or costs) to be paid to LGC HealthTrust and/or Anthem immediately upon Your receipt of the Recovery. You must fully reimburse LGC HealthTrust and/or Anthem, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay Benefits paid by this Plan.

- This Plan shall be entitled to deduct any of the unsatisfied portion of the amount of Benefits paid by the Plan or the amount of Your Recovery, whichever is less, from any future Benefits under the Plan if:

    1. You fail to disclose to LGC HealthTrust and/or Anthem the amount of Your Recovery;

    2. The amount this Plan paid on Your behalf is not repaid or otherwise recovered by LGC HealthTrust and/or Anthem; or

    3. You fail to cooperate with LGC HealthTrust and/or Anthem

- LGC HealthTrust and/or Anthem shall also be entitled to recover any of the unsatisfied portion of the amount paid by the Plan or the amount of Your Recovery, whichever is less, directly from the providers to whom payments have been made. In such a circumstance, it may then be Your obligation to pay the provider the full amount billed by the provider, and the Plan would have no obligation to pay the provider.

IV. LGC HealthTrust's and Anthem's Rights Under this Certificate

LGC HealthTrust, and/or Anthem acting on LGC HealthTrust's behalf, reserves the right to:

- Take any action needed to carry out the terms of this Section and the Certificate,

- Exchange information with other insurance companies and/or other parties,

- Recover any excess payment made under this Plan from another party or reimburse another party for its excess payment, and

- Take the actions set forth in this Section when necessary without notifying the Member.

This provision is not intended to permit dissemination of information to persons who do not have a legitimate interest in such information. Neither does this provision permit the dissemination of information prohibited by law.

Whenever another plan or entity pays benefits that should have been paid by this Plan, Anthem, on behalf of the Plan, has the right to pay the other plan or entity any amount that Anthem determines in its discretion to be warranted to satisfy the intent of this Section. Amounts so paid are Benefits under this Certificate and, to the extent of such payments, the Plan, LGC HealthTrust and Anthem are fully discharged from liability under this Certificate.

If the Plan has provided Benefits subject to reimbursement or subrogation and You recover payments from another source which You do not pay to LGC HealthTrust and/or Anthem, LGC HealthTrust and/or Anthem has the right to offset these amounts against any other amount that would otherwise be payable under this Certificate.

Mistaken Payments. On occasion, a payment may be made by the Plan to You, or on Your behalf, when You are not covered, for a service which is not covered, or which is more than is appropriate for the service (for example, the Plan pays the healthcare provider amounts that are Your responsibility, such as Deductibles, Copayments or Coinsurance). When an incorrect payment or overpayment is made, LGC HealthTrust and/or Anthem acting on the LGC HealthTrust's behalf, has the right to recover such payment from You or any Member, person or entity (including any Member, provider, insurance company or health care plan) to whom or for whom such payment was made. In the event recovery of a payment made in error to a Member is sought, Anthem, acting on LGC HealthTrust's behalf, will notify the Member who is subject to the recovery. The Member must either remit the required amount to Anthem or provide Anthem with written notice of the reason(s) the Member disputes the recovery notice. The recovery amount or the written notice must be received by Anthem within 60 days of the recovery notice. If the recovery amount or written notice is not received within 60 days of the recovery notice, or Anthem disagrees with the Member's dispute of the recovery notice, Anthem is given the right to deduct or offset any amounts paid in error or overpaid by the Plan from any pending or future claim payable to or on behalf of any Member enrolled under this Certificate. If Anthem deducts or offsets such amount payable to a provider, it will then be Your obligation to pay the provider the full amount billed by the provider, and the Plan would have no obligation to pay the provider.

V. Your Agreement and Responsibility Under This Section

You have the responsibility to provide prompt, accurate and complete information to LGC HealthTrust and Anthem about other health care plans and/or insurance policies or benefits You may have in addition to Your LGC HealthTrust coverage. Other health care plans, insurance policies or benefits include, but are not limited to, benefits from other health coverage, Workers' Compensation, and/or claims against liability or casualty insurance companies arising from any injury, illness, impairment or medical condition You receive. By accepting this Certificate, You agree to cooperate with LGC HealthTrust and Anthem, and You agree to provide information about any other health coverage on an annual basis or when necessary to carry out the terms of this Section.

By accepting this Certificate You agree to:

- Promptly notify LGC HealthTrust and/or Anthem of how, when and where an accident or incident resulting in personal injury, illness, impairment or medical condition to You occurred and all information regarding the parties involved,
- Cooperate with LGC HealthTrust and/or Anthem in the investigation, settlement and protection of rights,
- Not do anything to prejudice the rights LGC HealthTrust and Anthem,
- Send to LGC HealthTrust and/or Anthem copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury, illness, impairment or medical condition to You, and
- Promptly notify LGC HealthTrust and/or Anthem if You retain an attorney or if a lawsuit is filed on Your behalf.

Any action which interferes with LGC HealthTrust's rights under this Section or the Certificate may result in the termination of coverage for the Subscriber and covered Dependents.

Please call Anthem's Customer Service at **1-888-224-4896** if You have questions about any portion of this Section.

Section 11: Member Satisfaction Services and Appeal Procedure

Please see Section 14 for definitions of specially capitalized words.

This Section explains how to contact LGC HealthTrust or Anthem when You have questions, suggestions, concerns or complaints.

Please note that oral statements by agents or representatives of LGC HealthTrust or Anthem do not change the Benefits described in this Certificate.

I. Member Satisfaction Services

LGC HealthTrust and Anthem provide quality member satisfaction services through their respective Customer Service Centers. All LGC HealthTrust and Anthem personnel are responsible for addressing Your concerns in a manner that is accurate, courteous, respectful and prompt. Customer Service Representatives are available to:

- Answer questions You have about Your membership, Your Benefits, Covered Services, Participating Providers, payment of claims, and about Anthem policies and procedures,
- Provide information or Plan materials that You want or need (such as health promotion brochures, copies of Your Participating Provider Directory for Members with Indemnity Coverage, or replacement of identification cards),
- Make sure Your suggestions are brought to the attention of the appropriate persons at LGC HealthTrust or Anthem, and
- Provide assistance to You (or Your authorized representative) when You want to file an internal appeal.

LGC HealthTrust and Anthem use Your identification number to locate Your important records with the least amount of inconvenience to You. Your identification number is on Your identification card. Please be sure to include Your entire identification number (with the three-letter prefix) when You call or write.

LGC HealthTrust or Anthem will respond to most of Your questions or requests at the time of Your call or within a few days. Please see articles II and III for information about internal appeals.

If You have a concern about the quality of care offered to You by a Participating Provider (such as waiting times, provider behavior or demeanor, adequacy of facilities or other similar concerns), You are encouraged to discuss Your concerns directly with the provider before You contact an Anthem Customer Service Representative.

Please contact **LGC HealthTrust** about Your membership, wellness programs, or Plan materials. Call LGC HealthTrust at: **1-800-527-5001**	Or, You may write to: LGC HealthTrust PO Box 617 Concord, NH 03302-0617
Please contact **Anthem's Customer Service Center** about Your Benefits, Covered Services, Plan materials, or a Participating Provider. Call Anthem at: **1-800-225-2666**	Or, You may write to: Customer Service Center Anthem Blue Cross and Blue Shield PO Box 660 North Haven, CT 06473-0660

For more information about Member Services, please visit Anthem's website at www.anthem.com.

II. Internal Appeal Procedure

Introduction. You have the right to receive Benefits as described in this Certificate. You may appeal any Adverse Benefit Determination made by Anthem. **You or Your authorized representative must file Your appeal within 180 calendar days after You are notified of the Adverse Benefit Determination.** This section explains the internal appeal procedure.

By accepting this Certificate, You agree that You will take no court action related to Your coverage or Benefits under the Plan before completing the steps described below. Your obligations under this Certificate are fulfilled when the first level internal appeal procedure is completed as stated in this article. A voluntary second level of internal appeal, which may be a panel review, independent review, or other process consistent with the entity reviewing the appeal, is also available as stated in this article. The time frame allowed for Anthem to complete its review is dependent upon the type of review involved (e.g. pre-service, concurrent, post-service, urgent, etc.).

Please see Section 14 for definitions of "Adverse Benefit Determination," "Urgent Care Claim," Pre-Service Claim" and "Post-Service Claim."

Internal appeals are conducted and overseen by Anthem. No fees for submitting an appeal will be assessed against You or Your authorized representative.

Who may submit an internal appeal? You or Your authorized representative may submit an internal appeal. A person is an authorized representative if:

- You submit a written statement in a form prescribed by Anthem acknowledging the representation. To find out about required authorization forms, please contact Anthem's Customer Service Center at the toll-free telephone number on Your identification card. Exception: For Urgent Care Claim appeals, Anthem will consider a health care professional with knowledge of Your condition (such as Your treating provider) to be Your authorized representative without requiring Your written acknowledgment of the representation, or

- A court order is in effect authorizing the person to act on Your behalf, and a copy of the order is on file with Anthem.

What should be included with an internal appeal? You will have the opportunity to submit written comments, documents, rewards, and other information supporting Your claim. Anthem's review of Your claim will take into account all information You submit, regardless of whether it was submitted or considered in the initial benefit determination. Please include Your identification number (including the three-letter prefix) and describe the services that You are submitting for review. If possible, refer to the date You received the service and state the name of the doctor, hospital or other provider that furnished the care. You may also want to include:

- Bills that You have received from the provider,

- Any information that You believe is important for review, such as statements from Your physician or letters You received from Anthem, and

- A reference to the portion of this Certificate that You believe pertains to Your appeal. You should state the outcome You are expecting as a result of Your appeal.

Anthem may ask You to sign an authorization so that medical records can be obtained to conduct the appeal.

Internal Appeal Process. To exercise Your right to an internal appeal, please take the following steps:

A. First Level Appeal.

For pre-service claims involving urgent/concurrent care, You may obtain an expedited appeal. You or Your authorized representative may request it orally or in writing. All necessary information, including Anthem's decision, can be sent between Anthem and You by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, You or Your authorized representative must contact Anthem at the number shown on Your identification card and provide at least the following information:

- the identity of the claimant;
- the date (s) of the medical service;
- the specific medical condition or symptom;
- the provider's name
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for appeals should be submitted in writing by You or Your authorized representative, except where the acceptance of oral appeals is otherwise required by the nature of the appeal (e.g. urgent care). You or Your authorized representative must submit a request for review to:

Anthem Blue Cross and Blue Shield, ATTN: Appeals
P.O. Box 518
North Haven, CT 06473-0518

Upon request, Anthem will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to Your claim. "Relevant" means that the document, record, or other information:

- was relied on in making the benefit determination; or
- was submitted, considered, or produced in the course of making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the Plan, applied consistently for similarly-situated claimants; or
- is a statement of the Plan's policy or guidance about the treatment or benefit relative to Your diagnosis.

Anthem will also provide You, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with Your claim. In addition, before You receive an Adverse Benefit Determination on review based on a new or additional rationale, Anthem will provide You, free of charge, with the rationale.

How Your Appeal will be Decided. When Anthem considers Your appeal, Anthem will not rely upon the initial benefit determination or, for voluntary second-level appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A voluntary second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not medically necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Notification of the Outcome of the Appeal.

- **If You appeal a claim involving urgent/concurrent care**, Anthem will notify You of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of Your request for appeal.

- **If You appeal any other pre-service claim**. Anthem will notify You of the outcome of the appeal within 30 days after receipt of Your request for appeal.

- **If You appeal a post-service claim**, Anthem will notify You of the outcome of the appeal within 60 days after receipt of Your request for appeal.

Content of Notice of an Appeal Determination. You will be notified in writing of the appeal determination. If the denial of Benefits is upheld, in whole or in part, the written notice will include the following:

- The specific reason(s) for the determination, including reference to the specific provision of this Certificate on which the determination is based,

- If an internal rule, guideline, protocol or other similar provision was relied upon in making the Adverse Benefit Determination, a statement that such a rule, guideline, protocol or other similar provision was relied upon,

- If the determination is based upon a finding that the service under appeal is Experimental, Investigational or not Medically Necessary or appropriate, the notice will include:

    - The name and credentials of the person reviewing the appeal, including board status and the state or states where the person is currently licensed.

    - An explanation of the clinical rationale for the determination. This explanation will recite the terms of this Certificate or of any clinical review criteria or any internal rule, guideline, protocol, or other similar provision that was relied upon in making the denial and how these provisions apply to Your specific medical circumstance.

    - A statement that You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information (such as copies of rules, guidelines, protocols or other similar criterion upon which the Adverse Benefit Determinations based) relevant to Your claim for Benefits. The records on file with Anthem may be limited in scope. Please contact Your physician if You have questions or concerns about the content of Your medical records, and

    - A statement describing all other dispute resolutions options available to You, including but not limited to Your options for internal review, external review or for bringing a legal action.

Appeal Denial. If Your appeal is denied, that denial will be considered an Adverse Benefit Determination. The notification from Anthem will include all of the information set forth in the above section entitled "Content of Notice of an Appeal Determination."

B. Voluntary Second Level Internal Appeal

If You are not satisfied with the Plan's mandatory first level appeal decision, a voluntary second level appeal may be available You are not required to complete a voluntary second level appeal prior to submitting a request for an independent External Review.. If You would like to initiate a second level appeal, please submit Your request to Anthem at:

Anthem Blue Cross and Blue Shield, Attn: Appeals
PO box 518
North Haven, CT 06473-0518

Your appeal must be in writing unless Anthem determines that it is not reasonable to require a written statement. For example, expedited appeals may be submitted orally or in writing. **Your appeal must be submitted within at least 180 days of Anthem's notice stating the results of Your first level internal appeal.** You do not have to re-send the information that You submitted for Your first level internal appeal. However, You are encouraged to submit any additional information that You think is important for review. If Anthem finds that more information is required in order to conduct Your appeal, You will be notified in writing as soon as possible.

Time Frames for Voluntary Second Level Appeal Determinations. Anthem will complete a voluntary second level appeal within 45 business days after receiving all the information necessary to complete the review.

III. External Review

If the outcome of the mandatory first level appeal and/or voluntary second level of appeal is based on medical judgment and adverse to You, You may be eligible for an independent External Review pursuant to federal law. There is no charge for You to initiate an independent External Review. This is not an additional step that You must take in order to fulfill Your appeal procedure obligations described above. Your decision to seek External Review will not affect Your rights to any other benefits under this Plan. The External Review decision is final and binding on all parties except that it does not prevent You from pursuing any other remedy You may have under this Plan or at law.

You must submit Your request for External Review to Anthem **within four (4) months** of the notice of Your final internal Adverse Benefit Determination.

A request for an External Review must be in writing unless Anthem determines that it is not reasonable to require a written statement. You do not have to re-send the information that You submitted for internal appeal(s). However, You are encouraged to submit any additional information that You think is important for review.

For Pre-Service Claims involving urgent/concurrent care, You may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through Anthem's internal appeal process. You or Your authorized representative may request it orally or in writing. All necessary information, including Anthem's decision, can be sent between Anthem and You by telephone, facsimile or other similar method.

To proceed with an Expedited External Review, You or Your authorized representative must contact Anthem at the number shown on Your identification card and provide at least the following information:

- the identity of the claimant;
- t he date (s) of the medical service;
- the specific medical condition or symptom;
- the provider's name
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for External Review should be submitted in writing unless Anthem determines that it is not reasonable to require a written statement. Such requests should be submitted by You or Your authorized representative to:

Anthem Blue Cross and Blue Shield, ATTN: Appeals
P.O. Box 518
North Haven, CT 06473-0518

LGC HealthTrust and Anthem reserve the right to modify the policies, procedures and timeframes in this Section upon further clarification from the Department of Health and Human Services or the Department of Labor.

IV. Requirements Before Filing a Lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by You in a court of law or in any other forum, unless it is commenced within three years of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's first level internal Appeals Procedure (but not any voluntary second level of appeal) before filing a lawsuit or taking other legal action related to Your coverage or Benefits under the Plan.

V. Disagreement With Recommended Treatment

Your provider is responsible for determining the health care services that are appropriate for You. You may disagree with Your provider's decisions and You may decide not to comply with the treatment that is recommended by Your provider. You may also request services that Your provider feels are incompatible with proper medical care. In the event of a disagreement or failure to comply with recommended treatment, You have the right to refuse the recommendations of Your provider. In all cases, Anthem, on behalf of LGC HealthTrust, has the right to deny Benefits for care that is not a Covered Service or is not Medically Necessary as defined in this Certificate or is otherwise not covered under the terms of this Certificate.

Section 12: General Provisions

Please see Section 14 for definitions of specially capitalized words.

I. Amendment and Termination

LGC HealthTrust may amend or modify the Plan or this Certificate through a written amendment signed by a duly authorized representative of LGC HealthTrust. Upon the approval of any such amendment, it will become effective in accordance with its terms as to You and all other Members. No person or entity has any authority to make any oral changes or oral amendments to the Plan or this Certificate. LGC HealthTrust reserves the right to terminate the Plan by giving advance notice of at least 30 days to You and Your Group.

II. Applicable Law

The Plan and this Certificate shall be construed and enforced according to the applicable laws of the State of New Hampshire, except as the same may be superseded by applicable federal law.

III. Waiver of Rights

On occasion, LGC HealthTrust may, at its option, choose not to enforce all the terms and conditions of this Certificate; however, LGC HealthTrust does not thereby waive or give up any rights to enforce any term or condition in the future. No agent of LGC HealthTrust or Anthem has the right to change or waive any of the provisions of this Certificate without the approval of an authorized representative of LGC HealthTrust.

IV. LGC HealthTrust and Anthem are not Responsible for Acts of Providers

LGC HealthTrust and Anthem are not liable for the acts or omissions of any individuals or institutions furnishing care or services to You.

V. Rights to Administer Plan

LGC HealthTrust reserves the right to determine eligibility for participation in this Plan. Anthem, as delegated by LGC HealthTrust, or anyone acting on Anthem's behalf, shall determine the administration of Benefits in such a manner that has a rational relationship to the terms set forth herein. Anthem's determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Experimental/Investigational, whether surgery is cosmetic, and whether charges are consistent with the Maximum Allowable Benefit. However, a Member may utilize all applicable appeals procedures.

LGC HealthTrust and Anthem, or anyone acting on their behalf, shall have all the powers necessary or appropriate to enable them to carry out their respective duties in connection with the operation and administration of the Plan and this Certificate. This includes, without limitation, the power to construe the Certificate, to determine all questions arising under the Certificate and to make, establish and amend the rules, regulations and procedures with regard to the interpretation and administration of the provisions of this Certificate. However, these powers shall be exercised in such a manner that has reasonable relationship to the provisions of the Certificate, provider agreements, and applicable state or federal laws. A specific limitation or exclusion will override more general Benefit language.

VI. Limitation on Enforcement of This Certificate

No person or entity other than LGC HealthTrust, Anthem or a Member is, or will be, entitled to bring any action to enforce any provision of this Certificate against LGC HealthTrust, Anthem or a Member. The covenants, undertakings and agreements set forth in this Certificate will be solely for the benefit of, and will be enforceable only by, LGC HealthTrust, Anthem and the Members covered under this Certificate.

VII. Confidentiality and Privacy

LGC HealthTrust and Anthem respect and carefully preserve the privacy and confidentiality of Members and their personal health information. As part of that protection, compliance with state and federal laws regarding privacy of personal and health information is maintained. For a copy of LGC HealthTrust's Notice of Privacy Practices, which describes in detail LGC HealthTrust's privacy practices, or if You have any questions about the privacy of Your personal and health information, please contact LGC HealthTrust as follows:

Privacy Officer
LGC HealthTrust
P.O. Box 617
Concord, NH 03302-0617

VIII. Acknowledgment of Understanding

It is expressly acknowledged and understood that the administrative services provided by Anthem for You, Your Group and LGC HealthTrust are subject to an agreement between Anthem and LGC HealthTrust, and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the State of New Hampshire. The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association with the U.S. Patent and Trademark Office in Washington, D.C., and in other countries. Further, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. This provision shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under the provisions of this Certificate and the agreement between Anthem and LGC HealthTrust.

IX. Right of Offset

LGC HealthTrust reserves the right to empower Anthem to offset any amounts owed to the Plan by a Member against any amounts due from the Plan to such Member or any other Member receiving Benefits through the same Subscriber.

X. Separability Clause

If any provision of this Certificate is invalid or unenforceable under any applicable statute or rule of law, then the affected provision shall be curtailed and limited only to the extent necessary to bring the provision within the applicable legal requirements and this Certificate as so modified shall continue in full force and effect.

XI. Spendthrift Provision

The right to receive Benefits under the Plan shall not be assignable or subject to attachment or receivership, nor shall it pass to any trustee in bankruptcy or be reached or applied by any legal process for the payment of any applications of the Member.

XII. Non-ERISA Governmental Plan

The Plan is a governmental plan established and maintained by Your Group and LGC HealthTrust, and as such is exempt from the provisions of the Employee Retirement and Income Security Act of 1974 (ERISA).

XIII. Headings, Pronouns and Cross References

Section and subsection headings contained in this Certificate are inserted for convenience of reference only, will not be deemed to be a part of this Certificate for any purpose, and will not in any way define or affect the meaning, construction or scope of any of the provisions hereof.

All pronouns and any variations thereof will be deemed to refer to the masculine, feminine, neuter, singular or plural, as the identity of the person or entity may require.

In this Certificate, You find "cross references." For example, when You review Section 7, please also refer to Section 8 for Limitations and Exclusions. These cross references are for Your convenience only. Cross references are not intended to represent all of the terms, conditions and limitations set forth in this Certificate.

Section 13: Eligibility, Enrollment, Termination of Coverage and Continuation of Coverage

Please see Section 14 for definitions of specially capitalized words.

I. Eligibility

Effective January 1, 2011 for January Plan Years and July 1, 2011 for July Plan Years, the following Eligibility provisions apply:

You must meet Your Group's eligibility rules and the terms set forth by LGC HealthTrust in this Certificate to be eligible for membership.

Membership will not be denied solely due to medical risk factors such as health status, current or past medical conditions (physical or mental), claims experience or receipt of health care services, genetic information, disability or evidence of insurability (including conditions arising out of domestic violence).

Subscriber. If You meet the definition of Employee as defined in Section 14, You are eligible to enroll as a Subscriber on the first day of the calendar month following the date determined mutually by Your Group and LGC HealthTrust in accordance with applicable rules and procedures of LGC HealthTrust, provided that You:

1. Have satisfied any applicable Probationary Period established by Your Group; and
2. Are certified as being an eligible Employee or Retiree by Your Group.

Dependents. Depending upon the type of coverage You select ("family" or "two person"), in addition to You, the Subscriber, the following members of Your family are also eligible for enrollment under the Plan as Dependents:

- **Your Spouse.** Your spouse is eligible to enroll unless You are legally separated. Throughout this Certificate, any reference to "spouse" means:

  - The individual to whom You are lawfully married, as recognized under the laws of the state where You live, or

  - The individual with whom You have entered into a lawful civil union as recognized under laws that provide same gender couples in lawful civil unions with the same rights, responsibilities and obligations as afforded to lawfully married couples.

  Throughout this Certificate any reference to "marriage" means a lawful marriage or lawful civil union. References to legal separation apply to marriage and civil union legal separations. References to divorce apply to the termination of a marriage or civil union.

  Coverage is available for same-sex or opposite-sex Domestic Partners (including "common law" type relationships and other unmarried couples) **only if** Your Group has purchased a Domestic Partner Rider and **only if** all of the criteria for membership are met, as stated in the Domestic Partner Rider.

Your or Your spouse's Dependent children under 26 years of age. "Children" include: natural children, legally adopted children, children for whom You are the proposed adoptive parent and who have been lawfully placed in Your custody pursuant to an adoption proceeding under the provisions of New Hampshire law before the adoption becomes final, children for whom You are the legal guardian, stepchildren who are dependent upon the Subscriber for support, and children for whom there is a Medical Child Support Order in effect, pursuant to state domestic relations laws. Foster children and grandchildren are not eligible for coverage unless they meet the definition of "children" above.. Please see "Special Enrollment," "Newborn Children" and "Adopted Children" in this Section for more information.

- **An Unmarried Incapacitated Dependent.** A child 26 years of age or older and physically or mentally incapable of self-support (as certified by a physician), when coverage would otherwise end because the child no longer meets any of the eligibility criteria outlined above. The physical or mental incapacity must have occurred *before* the child reached age 26 and must have occurred while the Dependent was a covered Dependent child. Incapacitated Dependents may remain covered as long as their disability continues and as long as they are financially dependent on the Subscriber and are incapable of self-support. LGC HealthTrust must receive an application for the incapacitated Dependent child status and medical certification of the incapacity by a physician within 31 days of the date coverage would otherwise end for the child. Anthem's Medical Director must certify Your Dependent child's incapacitated status and LGC HealthTrust may periodically request that the incapacitated status of Your child be recertified.

Please note: By accepting this Certificate, You represent that all statements made in Your Medical Enrollment Application, or any other documentation You provide with respect to eligibility and enrollment of You or Your Dependents, are true to the best of Your knowledge and belief. You agree to give LGC HealthTrust information upon request that LGC HealthTrust needs to verify coverage eligibility. Examples of documentation that LGC HealthTrust may need to decide membership eligibility are information regarding: Dependent child status, incapacitated child status, marital status, divorce, legal separation, birth, adoption or court orders regarding health care coverage for Your Dependent children.

LGC HealthTrust reserves the right to retroactively cancel Your and/or Your Dependents coverage under the Plan if You fail to provide verification upon request or misrepresent the eligibility status of You or any of Your Dependents.

II. Enrollment and Effective Date of Coverage

Initial Enrollment. If You have satisfied the eligibility requirements described in article I of this Section, You may enroll Yourself and any then eligible Dependents by submitting a Medical Enrollment Application to Your Group Benefits Administrator within 31 days from the date You first satisfy Your Probationary Period. Provided LGC HealthTrust receives the Application within 31 days of Your satisfying the eligibility requirements, coverage will become effective as of the first day of the month following Your eligibility date. An applicant is considered enrolled only upon acceptance of the Medical Enrollment Application by LGC HealthTrust. If a Medical Enrollment Application is received by LGC HealthTrust after 31 days, but within 60 days, from the date You first satisfy Your Probationary Period, Your coverage and the coverage of any eligible Dependents then being enrolled will become effective on the first day of the month following receipt of the Application. If Your Medical Enrollment Application is not submitted within the required timeframes when You first become eligible, You (and Your Dependents) may not enroll at a later date, except during an open enrollment period or special enrollment period or in the case of certain qualified family status change events as described on the following pages.

If You return from full-time active service following a call to active military duty, no Probationary Period applies (a Probationary Period is a period of time, if any, that a Group ordinarily requires to pass before the Group's health care plan becomes effective. See Section 14 for the definition). You and eligible family members can reenroll in Your Group's health care plan, provided You apply for reemployment within the time period permitted by the Uniformed Services Employment and Reemployment Act (USERRA). The time period allowed for reemployment depends on the length of Your active military duty. To reenroll in Your Group's health care plan, Your application must be received within 31 days of Your reemployment date. Coverage will be effective on the effective date of Your reemployment.

Open Enrollment. There will be an annual open enrollment period for Your Group during the 60 days prior to, and during the month which includes, Your Group's Anniversary Date (either January 1 or July 1) each year. If a Medical Enrollment Application is received by LGC HealthTrust on or before the last day of the annual open enrollment period, coverage will be effective as of the Anniversary Date. If, however, the Medical Enrollment Application is not received by LGC HealthTrust by the end of the annual open enrollment period, the requested enrollment may not be made until the next open enrollment period. Special open enrollment periods may be allowed for a Group at the sole discretion of LGC HealthTrust.

Special Enrollment. A special enrollment period will be available to You and/or Your eligible Dependents in the following circumstances in accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA) and the Children's Health Insurance Program Reauthorization Act of 2009.

- **Involuntary Loss of Other Insurance Coverage.** If You decline enrollment for Yourself or Your Dependents because of other health insurance coverage, You may in the future be able to enroll those individuals in this Plan other than at Your Group's open enrollment period, provided that You request enrollment and apply within 31 days after an involuntary loss of such other insurance coverage. For this purpose, an involuntary loss of other insurance coverage means (i) if the other coverage is COBRA continuation coverage, such COBRA coverage has been exhausted, or (ii) if the other coverage is not COBRA coverage, the coverage is ended due to a loss of eligibility for that coverage (other than for nonpayment of employee premiums or termination of coverage for cause), or employer contributions towards the other coverage have been terminated.

- **New Dependents.** If You have previously declined enrollment, and You have a new Dependent as a result of marriage, birth, adoption, placement for adoption, You may be able to enroll Yourself and Your Dependents, provided that LGC HealthTrust receives a Medical Enrollment Application within 31 days after the marriage, birth, adoption or placement for adoption. These special enrollment rights are in addition to Your right to add Dependents to Your existing coverage as described elsewhere in this Section.

- **Loss of coverage, or becoming eligible for premium assistance, under Medicaid or a State's Children's Health Insurance Program.** If You or Your Dependent are eligible but not enrolled under the Plan, You (or Your Dependent) may enroll during the plan year in either of the following situations:

  - You or Your Dependent lose coverage under a Medicaid plan (under title XIX of the Social Security Act) or under a State Children's Health Insurance Plan (under title XXI of the Social Security Act) due to loss of eligibility for such coverage; or

  - You or Your Dependent becomes eligible for state funded group health plan premium assistance with respect to this Plan through a state Medicaid or Children's Health Insurance Program.

  You must request enrollment under the Plan by submitting a completed Medical Enrollment Application to LGC HealthTrust within 60 days of the date the other coverage is lost or the date You or Your Dependent is determined to be eligible for premium assistance (whichever is applicable).

  Coverage for Your or Your Dependent(s) will become effective as of the first of the month following the date coverage is lost or the date of Your Dependent(s) eligibility for premium assistance.

Enrolling New Dependents. If You are already enrolled, You may enroll any newly eligible Dependent by submitting a Medical Enrollment Application to Your Group Benefits Administrator within 31 days after the Dependent first becomes eligible. Provided LGC HealthTrust receives the Application within 31 days of eligibility, coverage for a newly eligible Dependent (other than a newborn or adopted child) will become effective as of the first day of the month following his/her eligibility date as a Dependent. A newly eligible Dependent is considered enrolled only upon acceptance of the Medical Enrollment Application by LGC HealthTrust. Please see "Newborn Children" and "Adopted Children" below for special effective date rules for newborn and adopted children. If a Medical Enrollment Application is received by LGC HealthTrust after 31 days, but within 60 days, from the date Your Dependents first become eligible, the coverage will become effective the first day of the month following receipt of the Application. If an Application is not received within 60 days, the newly eligible Dependent may not be enrolled until the next open enrollment or a special enrollment period.

Newborn Children. Your newborn child is eligible for Benefits described in this Certificate for up to 31 days from the child's date of birth, as long as Your coverage is in effect during that time. However, You must complete a Medical Enrollment Application to add the child to Your membership as a covered Dependent child. The Application must show Your child's name and date of birth. If You do not have a "family" membership when Your child is added, You must also indicate on the Application that You want to change Your type of membership (for example, from "two person" to "family" or "single" to "two person" or "family"). You can obtain a Medical Enrollment Application from Your Group Benefits Administrator. To maintain continuous coverage for Your newborn child, You must submit the Application to Your Group Benefits Administrator, and LGC HealthTrust must receive Your Application within 31 days of the child's birth.

- If LGC HealthTrust receives Your Medical Enrollment Application within 31 days of the child's birth, Your change in membership type will become effective on the first day of the month following the child's date of birth. If LGC HealthTrust does not receive Your Medical Enrollment Application within 31 days after birth, Your newborn child's eligibility for Benefits will end at midnight on the 31st day after the date of birth.

- If the Application requesting to add the newborn child, or change membership type, is not received by LGC HealthTrust within 31 days, but is received within 60 days of the date of birth, the addition of Your child and/or change in membership type will become effective on the first day of the month following LGC HealthTrust's receipt of the Application. In this situation, no Benefits are available for services that Your newborn child receives between the end of the initial 31 days of coverage and the effective date of Your child's membership as a covered Dependent child. If an Application is not received within 60 days, the newly eligible Dependent may not be enrolled until the next open enrollment or a special enrollment period.

If Your covered Dependent child gives birth, Your newborn grandchild is eligible for Benefits for up to 31 days following the newborn child's date of birth. You cannot add the grandchild to Your membership unless You adopt or become the legal guardian of the grandchild.

Adopted Children. Your adopted child is eligible for Benefits described in this Certificate as of the date of adoption or placement for adoption. For Your adopted child to receive coverage from the date of adoption or placement for adoption, You must complete a Medical Enrollment Application and submit the Application to Your Group Benefits Administrator within 31 days of the date of adoption or placement for adoption. The Application must show Your child's name, date of birth, and date of adoption or placement for adoption. For purposes of this Section, "placement for adoption" means that the children for whom You are the proposed adoptive parent have been lawfully placed in Your custody pursuant to an adoption proceeding under the provisions of New Hampshire law before the adoption becomes final. If You do not have a "family" membership when Your adopted child is added, You must also indicate on the Application that You want to change Your type of membership (for example, from "two person" to "family" or "single" to "two person" or "family").

- You can obtain a Medical Enrollment Application from Your Group Benefits Administrator. If LGC HealthTrust receives Your Medical Enrollment Application within 31 days of the child's adoption, or placement for adoption, coverage of the child and any change in membership type will become effective on the first day of the month following the child's date of adoption or placement for adoption.

- If the Application requesting to add the adopted child and/or change membership type is not received by LGC HealthTrust within 31 days, but is received within 60 days of the date of adoption or placement for adoption, coverage of Your adopted child and any change in membership type will become effective on the first day of the month following LGC HealthTrust's receipt of the Application. If an Application is not received within 60 days, the newly eligible Dependent may not be enrolled until the next open enrollment or a special enrollment period.

Qualified Family Status Changes. You may enroll or remove Dependents and/or change Your type of membership ("single," "two person," or "family") during a Plan Year provided that such change is due to and consistent with a qualified family status change. A qualified family status change will include:

- Marriage
- Birth
- Adoption or placement for adoption
- New legal guardianship
- Divorce or legal separation
- A change in a Dependent's eligibility
- A change in Your employment status or that of Your spouse that affects Your health plan coverage
- A significant change in Your health plan cost or coverage, or that of Your spouse's, relating to that individual's employment status or coverage
- Your spouse's employer holds open enrollment at a time other than Your employer — and, as a result of its benefit offerings, You would like to make a change (if Your Group recognizes this as a qualified change in status)
- Death

Your Group and LGC HealthTrust will not automatically change Your type of membership. You must request any desired change in membership and promptly notify Your Group of any Dependents to be added or removed from Your membership under the Plan. A request to change membership type and/or to enroll or remove Dependents should be made by submitting a Medical Enrollment Application to Your Group within 31 days of the qualified family status change.

If a Medical Group Application requesting to enroll Dependents and/or to change membership type is received by LGC HealthTrust within 31 days of a qualified family status change, the requested change(s) will take effect on the first of the month following the date of the event. If the Medical Group Application is not received by LGC HealthTrust within 31 days but is received within 60 days from the date of the qualified family status change event, the requested change will become effective the first of the month following receipt of the Medical Group Application. If a request is not made within 60 days, coverage for Your Dependents and membership type may not be changed until the next open enrollment or special enrollment.

Medicare Eligibility. If You or any of Your Dependents become eligible for Medicare, contact Your Group Benefits Administrator. Please see Section 10, I, C for more information.

Effective Date for Benefits. The effective date of Your coverage under this Certificate is determined by Your Group and LGC HealthTrust pursuant to the rules described above in this Section. After Your coverage under this Certificate begins, Benefits are available according to the coverage in effect on the "date of service." For purposes of this Certificate "date of service" means:

- For Inpatient hospital *facility* charges, the date of admission;

- For Inpatient *professional* services (such as Inpatient medical care or surgery furnished by a physician), the date You receive the care;

- For professional maternity care (prenatal care, delivery of the baby and post partum care), the date of delivery, provided that the total maternity care was furnished by one provider; and

- For Outpatient services (such as emergency room visits, Outpatient hospital care, office visits, physical therapy or Outpatient surgery, etc), the date You receive the care.

Your Responsibility to Provide Notice of Changes. It is Your responsibility to inform Your Group and LGC HealthTrust of changes in Your or any of Your Dependent's name or address. It is also Your responsibility to inform Your Group and LGC HealthTrust if You need to add a Member to Your coverage or when a Member is no longer eligible for coverage under Your Certificate. Notice requirements regarding continuation coverage election are stated in article IV below.

Name changes and membership changes must be made through Your Group Benefits Administrator. You will be required to sign a Medical Enrollment Application in order to effect the change. Failure to timely notify Your Group Benefits Administrator of changes in the eligibility status of You or any of Your Dependents may result in a cancellation of coverage or delay in enrollment for You or Your Dependents.

You can contact LGC HealthTrust about a change of address at:

LGC HealthTrust
PO Box 617
Concord, NH 03302-0617
1-800-527-5001

Please include Your identification number (shown on Your identification card) whenever You correspond with Your Group, LGC HealthTrust or Anthem.

Disclosing Other Coverage. As another condition of membership, You agree to provide information to Your Group and LGC HealthTrust regarding any other health coverage under which You and/or Your Dependents are entitled to benefits. Your receipt of benefits through another health care plan may affect Your Benefits under this Certificate. Please see Section 10 for more information about how Benefits are determined when You and/or Your Dependents are covered under more than one health care plan, including Medicare.

III. Termination of Coverage

This article describes circumstances under which Your coverage under the Plan will terminate. Whether or not You or Your Group contacts LGC HealthTrust to effect any of the terminations in this article, LGC HealthTrust will administer the terminations if LGC HealthTrust has knowledge of the termination event. Subject to any right to continuation of coverage as described in article IV of this Section, Benefits under this Certificate, including Benefits for services rendered after the date of termination for medical conditions arising prior to the date of termination, shall automatically terminate at midnight on the earliest of the dates specified below. In no event are Benefits available for Covered Services rendered or delivered after the date coverage under the Plan terminates.

Membership will not be terminated solely due to medical risk factors such as health status, current or past medical conditions (physical or mental), claims experience or receipt of health care services, genetic information, disability or evidence of insurability (including conditions arising out of domestic violence).

Under certain circumstances, You and Your covered Dependents who are no longer eligible for coverage are entitled to continue coverage under the Plan (or convert to an individual policy). Please see article IV for more information.

When coverage under Your Certificate ends, a Certificate of Creditable Coverage (as required by HIPAA) will be issued to You. You should present the document to any succeeding carrier whose plan includes a preexisting condition exclusion period. Please call Customer Service if You have questions about Certificates of Creditable Coverage or to request a copy of Your Certificate of Creditable Coverage.

Coverage will automatically terminate for You and/or Your Dependents at midnight on the earliest of the following dates:

- The date LGC HealthTrust ceases to offer any health benefit plans to Groups. LGC HealthTrust may, at its discretion at any time, discontinue this Plan as long as You and Your Group are given 30 days advance notice;

- The date as of which Your Group terminates Your Group's participation in the Plan;

- The end of the month in which You or Your enrolled Dependents no longer meet the eligibility requirements for coverage under the Plan, or such other date as of which Your Group Benefits Administrator notifies LGC HealthTrust to terminate Your coverage;

- The date specified by LGC HealthTrust that Your (and Your enrolled Dependents') coverage will end because Your Group failed to pay any required premium or other contribution for Your coverage under the Plan;

- The date of Your or Your eligible Dependent's enrollment (or such other date as specified by LGC HealthTrust) if LGC HealthTrust or Anthem determines that You have made a misrepresentation, or otherwise have furnished misleading, deceptive, incomplete, fraudulent or untrue statements or other information which is material to Your eligibility or enrollment, on, or with respect to, the Medical Enrollment Application or other required documentation in obtaining or maintaining coverage under the Plan;

- The date LGC HealthTrust determines that You or Your enrolled Dependent(s) have failed to comply with the procedures and requirements set forth under the provisions of Section 10 "Other Party Liability" of this Certificate;

- The date specified by LGC HealthTrust in a notice of cancellation or nonrenewal of Your Group's participation in the Plan or in LGC HealthTrust, sent to Your Group by LGC HealthTrust, due to Your Group's failure to meet LGC HealthTrust's minimum employee participation requirements or other requirements under the Group's participation agreement with LGC HealthTrust; or

- The date established by LGC HealthTrust for other causes as permitted by law. Cause may include failure to disclose other health plan coverage, fraud committed by a Member in connection with any claim filed under this Certificate, or if an unauthorized person is allowed to use any Member's identification card or if a Member otherwise cooperates in the unauthorized use of such Member's identification card.

Your Death. Your coverage will terminate on the date of Your death. Please see article IV of this Section for information about how covered surviving spouses and other covered Dependents can elect to continue coverage following Your death.

Termination of Your Marriage. If You become divorced or legally separated, the coverage of Your spouse will terminate at the end of the month which includes the date of divorce or legal separation. You must submit a Medical Enrollment Application indicating a change in marital status within 31 days of such change. However, Your failure to submit the enrollment form does not prohibit Your Group or LGC HealthTrust from terminating the membership of an individual who no longer meets the definition of a covered spouse. Please see article IV of this Section for information about how Your former spouse and other covered Dependents can elect to continue coverage.

Termination of a Dependent Child's Coverage. A Dependent child's coverage under this Certificate will terminate at the end of the month which includes the date on which the child no longer satisfies the eligibility requirements of a Dependent child as set forth in article I, Eligibility above. You must submit a Medical Enrollment Application within 31 days of such change.

IV. Continuation of Group Coverage

This article explains some of the ways You and Your covered family members can choose to continue group coverage when coverage would otherwise end. A separate document which describes these continuation rights in further detail is provided to You and Your covered spouse (if You are married) upon initial enrollment in the Plan.

Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). COBRA is a federal law which requires Your Group to offer You and Your enrolled Dependents ("qualified beneficiaries") the opportunity to continue group coverage under the Plan for a temporary period, at Your expense, when Benefits would otherwise end because of certain "qualifying events." COBRA continuation rights under the Plan are available only through Your Group. LGC HealthTrust assists Your Group with certain COBRA notice and other administrative requirements.

Qualifying Events – You and Your enrolled Dependents will become qualified beneficiaries if Your coverage under the Plan would otherwise end due to one of the following qualifying events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than gross misconduct.

Additionally, Your enrolled Dependents will become qualified beneficiaries if their coverage would otherwise end due to one of the following qualifying events:

- You, the employee, die;
- You divorce or legally separate;
- You become entitled to Medicare benefits (under Part A, Part B, or both); or
- In the case of a child, he or she is no longer an eligible Dependent under the Plan.

Notices and Election Rights – COBRA coverage is available under the Plan to qualified beneficiaries only after Your Group and LGC HealthTrust have been notified that a qualifying event has occurred. **You or an eligible family member who is a qualified beneficiary must notify Your Group Benefits Administrator within 60 days of the date coverage under the Plan would otherwise end due to Your divorce, legal separation or a child losing Dependent status.** If You or Your eligible family member fails to provide notice within this 60-day notice period, any eligible family member who loses coverage will not be offered the right to elect continuation coverage.

Once You notify Your Group of the qualifying event, Your Group will then notify LGC HealthTrust. Your Group also must notify LGC HealthTrust of other qualifying events including Your death, termination of employment, reduction in hours of employment, or Medicare entitlement.

After LGC HealthTrust receives notice that a qualifying event has occurred, LGC HealthTrust will provide notice to eligible qualified beneficiaries of their right to elect COBRA continuation coverage. Each qualified beneficiary will have an independent right to elect COBRA coverage and will have until the **later of** the following dates to make their election:

- 60 days after the date their coverage would otherwise end due to the qualifying event; or
- 60 days after the date the qualified beneficiary receives notice of the right to elect COBRA coverage.

If COBRA coverage is not elected by the election deadline, all COBRA rights will be forfeited and no continuation coverage will be available to the qualified beneficiary.

Nature and Duration of COBRA Coverage – If You or Your covered family members elect COBRA, You generally will receive the same coverage and enrollment rights as are provided to similarly situated active employees of Your Group and their family members.

COBRA coverage is a temporary continuation of coverage under the Plan. The maximum period of COBRA coverage will depend on the nature of the qualifying event as follows:

- ***18 months*** if the qualifying event is Your termination of employment or reduction in hours of employment (the 18-month period may be extended to 29 months if a qualified beneficiary is determined to be disabled by the Social Security Administration at any time during the first 60 days of COBRA coverage); or

- ***36 months*** if the qualifying event is Your death, divorce or legal separation, Medicare entitlement, or a child losing Dependent status.

Additional non-COBRA continuation period for former or surviving spouses – In addition to the maximum COBRA coverage period, the following continuation periods are available under the Plan:

- If the qualifying event is divorce or legal separation and the former spouse is a qualified beneficiary age 55 or older at the time of the relevant court decree, the maximum continuation period will extend until the former spouse becomes eligible for coverage under another group health plan or Medicare; or

- If the qualifying event is Your death and Your surviving spouse is a qualified beneficiary age 55 or older at the time of Your death, the maximum continuation period will extend until Your surviving spouse becomes eligible for coverage under another group health plan or Medicare.

Please note: The Plan does not provide additional continuation coverage rights to former spouses under NH RSA 415:18,VII-b.

COBRA coverage will terminate prior to the maximum coverage period upon certain termination events which apply under COBRA law. Eligibility for COBRA coverage under the Plan will end if Your Group terminates participation in the Plan for its active employees.

Cost of Continuation Coverage – You and other eligible qualified beneficiaries will be obligated to pay the full premium cost for COBRA or other continuation coverage unless Your Group has other premium payment arrangements. An administrative fee as allowed by law may also apply. Specific information regarding the premium costs and payment terms for continuation coverage will be included in the COBRA election notice provided upon a qualifying event.

Continuation of Coverage Due to Military Service (USERRA). In the event You are no longer actively at work because You are called to military service in the Armed Forces of the United States, You may elect to continue health coverage for You and Your enrolled Dependents (if any) under the Plan in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA). "Military service" means performance of duty on a voluntary or involuntary basis, and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

You may elect to continue to cover You and Your enrolled Dependents (if any) under the Plan. You may be obligated to pay the full premium cost (and any applicable administrative fee) for continuation coverage under the Plan. This may include the amount Your Group normally pays on Your behalf. If Your military service is for a period of less than 31 days, You may not be required to pay more than the active employee contribution, if any, for the continuation coverage. If continuation is elected under this provision, the maximum period of continuation coverage under the Plan shall be the lesser of:

- 24 months; or

- Your period of military service (measured from the date the military service begins and ending on the day after the date on which You fail to apply for re-employment or return to employment with Your Group).

Whether or not You elect continuation coverage, if You return to Your position of employment, Your and Your eligible Dependents' coverage under the Plan will be reinstated. No Probationary Period or exclusions may be imposed on You or Your eligible Dependents in connection with this reinstatement unless a sickness or injury is determined by the Secretary of Veteran Affairs to have been incurred in, or aggravated during, the performance of military service.

For more information regarding COBRA and other continuation coverage rights and obligations, please contact Your Group Benefits Administrator or LGC HealthTrust, or refer to the COBRA information document provided to You upon initial enrollment. If You would like a current version of the COBRA initial notice, please contact LGC HealthTrust.

Conversion Rights. If Your coverage under this Plan ends for any reason, You may convert to an Anthem nongroup coverage, provided that:

- You have been covered under this Plan for at least 60 days;
- You are not covered (or eligible for coverage) under another group policy; and
- You apply for nongroup coverage within 31 days after the termination of Your coverage under this Plan.

You will be responsible to pay the full premium for the converted nongroup coverage. For information about nongroup coverage, please contact Anthem.

Section 14: Definitions

This Section defines some of the capitalized words and phrases found throughout this Certificate:

Adverse Benefit Determination means denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a Benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a Member's eligibility for coverage under this Certificate, The Plan's denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit resulting from the application of the utilization review, as well as the Plan's determination not to cover an item or service for which Benefits are otherwise provided based on a determination that the item or service is experimental or investigational or not medically necessary or appropriate, as well as a rescission of coverage.

Anniversary Date means the first day of the Group's Plan Year. The Anniversary Date is January 1 for Groups with a January Plan Year and July 1 for Groups with a July Plan Year.

Anthem means Anthem Health Plans of New Hampshire, Inc., doing business as Anthem Blue Cross and Blue Shield, which is licensed in the State of New Hampshire as a third party administrator. LGC HealthTrust has contracted with Anthem to provide certain services, including claims processing, administration and utilization management services, for this managed health care Plan described in this Certificate.

Behavioral Health Care means Covered Services means Covered Services provided to treat Mental Disorders and Substance Abuse Conditions. Please see Section 7, V, B for additional information.

Benefits means reimbursement or payments available for Covered Services, as described in this Certificate.

Birthing Center means an Outpatient facility operating in compliance with all applicable state licensing and regulatory requirements for Birthing Centers. The primary function of a Birthing Center is to provide Outpatient facility services for prenatal care, delivery of a baby and postpartum care for a mother and her newborn. To be eligible for Benefits under this Certificate, a Birthing Center must have a written agreement directly with Anthem or with another Blue Cross and Blue Shield plan to provide Covered Services to Members. Otherwise, no Benefits are available for services furnished by a Birthing Center.

BlueCard Provider means a Designated Provider located outside New Hampshire that has a standard written payment agreement with the Local Plan. BlueCard Providers do not have Preferred written payment agreements with the Local Plan. Therefore, they are not Preferred Providers.

Certificate means this Plan document between a Subscriber and LGC HealthTrust regarding the terms and limitations of coverage under this managed health care Plan. The Certificate includes the Subscriber Certificate (this document), Your Medical Enrollment Application, Your identification card, Your Cost Sharing Schedule and any endorsements and/or riders that amend the Subscriber Certificate.

Contracting Provider means a Designated Provider that has a written agreement with Anthem to provide certain Covered Services to Members. A Contracting Provider is not a Preferred Provider.

Cost Sharing Schedule means the document that lists the cost sharing amounts that apply under Your Plan. Your Cost Sharing Schedule is a part of Your Certificate.

Covered Service means the services, products, supplies or treatment specifically described as being eligible for Benefits in this Certificate. To be a Covered Service the service, product, supply or treatment must be:

- Medically Necessary or otherwise specifically described as a Covered Service under this certificate;

- Within the scope of the license of the Designated Provider performing the service;
- Rendered while coverage under this Certificate is in force; and
- Not Experimental or Investigational or otherwise excluded or limited under the terms of this Certificate, or by any endorsement, rider or amendment to this Certificate.

The Plan rules stated in this Certificate and in any amendment to this Certificate must be met. Otherwise, a service may not be a Covered Service. Plan rules include, but are not limited to, rules such as those pertaining to services furnished by Preferred Providers and requirements about Precertification or preauthorization from Anthem.

Dependent means a person who is eligible to be enrolled for Benefits under the Plan as a dependent of the Subscriber under the provisions of Section 13.

Designated Provider means the following health care providers, each being duly licensed or certified as required by law in the state which regulates their licensure and practice and each acting within the scope of the applicable license or certification: Short Term General Hospitals, Skilled Nursing and Physical Rehabilitation Facilities, facilities for laboratory and x-ray tests and screenings, individuals licensed and certified to interpret laboratory and x-ray tests and screenings, licensed hospital emergency room facilities, Network Urgent Care Facilities, Network Walk-In Centers, ambulatory surgical centers that have a written payment agreement with Anthem or the Blue Cross and Blue Shield plan where the center is located, hemodialysis centers, home dialysis providers and Birthing Centers that have a written payment agreement with Anthem or the Blue Cross and Blue Shield plan where the Birthing Center is located, and cardiac rehabilitation programs. Physicians include Doctors of Medicine (MDs) and Advanced Practice Registered Nurses (APRNs) acting within the scope of their licenses. Designated Providers also include physician assistants, nurses and nurse-anesthetists. Home health, hospice and visiting nurse association providers and their certified staff members are also Designated Providers. Infusion therapy providers, licensed durable medical equipment, medical supply or prosthetic providers, licensed retail pharmacies, designated licensed mail-order pharmacies, licensed ambulance transportation providers, physical, occupational and speech therapists, doctors of osteopathy and doctors of podiatry are Designated Providers. Chiropractors, audiologists, optometrists, nutrition counselors, Network Diabetes Education Providers, Eligible Behavioral Health Providers, Network New Hampshire Certified Midwives (Network NHCMs), dentists and oral surgeons are Designated Providers only to the extent of coverage stated in Section 7 in this Certificate. Except at the sole discretion of Anthem, no other provider is a Designated Provider. For example, Doctors of Chiropractic are Designated Providers only to the extent stated in Section 7. Practitioners such as acupuncturists, electrologists, doctors of naturopathic medicine and any provider of alternative or complimentary medicine are not Designated Providers. School infirmaries are not Designated Providers. Except as specified in Section 7 of this Certificate, as required by law or by exception at Anthem's discretion, Benefits are available only when Covered Services are:

- Furnished by a provider, or
- Ordered by a provider and furnished by a Designated Provider

Developmental Disabilities means chronic mental or physical impairments that occur at an early age, are likely to continue indefinitely, result in substantial functional limitations and require special care and services of lifelong or extended duration. Such disabilities include, but are not limited to, abnormalities of the neurological and musculoskeletal systems due to congenital chromosomal anomalies or perinatal disorders, any of which may cause mental retardation or delays in mental development as well as abnormalities or delays in motor functioning and development.

Employee means any person who is described as an employee in the governing documents applicable to LGC HealthTrust other than a person who is so described solely by reason of being a spouse or dependent. Generally, "Employee" will include, in whole or in part as each Group may determine, any person who is (1) actively engaged in employment with a Group on a Full-Time or a Part-Time basis, (2) a retiree or on leave of absence, or (3) a qualifying publicly elected or appointed official of a Group. For purposes of (1) above, a person is employed (a) on a "Full-Time" basis if he or she is an active full-time employee working 30 or more hours a week at the group's designated place of employment, and (b) on a "Part-Time" basis if he or she is actively at work and is scheduled to work a minimum of half the weekly hours of a Full-Time employee, but at least 15 hours per week.

Group means any New Hampshire political subdivision or instrumentality thereof which is a participant in LGC HealthTrust and has elected to provide health care coverage under the Plan to its eligible Employees and their Dependents. Your Group is Your employer.

Group Benefits Administrator means the person at Your place of employment who handles health benefits for Your Group.

Home Health Agency means a state authorized and licensed agency or organization that provides nursing and therapeutic care in the home of the Member. It must maintain permanent records of services provided to its patients, employ a full-time administrator and have at least one Registered Nurse (R.N.) either on the staff or available to it.

Inpatient means care received while You are a bed patient in a hospital, Skilled Nursing Facility or Physical Rehabilitation Facility.

LGC HealthTrust means Local Government Center LGC HealthTrust, LLC, doing business as LGC HealthTrust, a New Hampshire limited liability company.

Local Plan (or Host Plan) means the Blue Cross and Blue Shield Plan in the geographic area where You receive Covered Services (outside the Service Area). The Local Plan has Preferred Provider payment agreements with local Preferred Providers. The Local Plan has standard payment agreements with BlueCard Providers.

Maximum Allowable Benefit means the dollar amount available for a specific Covered Service. Anthem determines the Maximum Allowable Benefit for approved Covered Services that You receive in New Hampshire. Anthem also determines the Maximum Allowable Benefit for approved Covered Services that You receive from a NonBlueCard Provider outside New Hampshire. The Local Plan determines the Maximum Allowable Benefit for Covered Services furnished by a BlueCard Provider. Preferred Providers and BlueCard Providers accept the Maximum Allowable Benefit as payment in full.

Medical Child Support Order shall mean, in accordance with New Hampshire RSA 161-H:1, any valid judgment or order to provide health coverage for a dependent child of the Subscriber issued by any court or administrative body of the State of New Hampshire or any other state including an order in a final decree of divorce.

Medical Director means a physician licensed under RSA 329 and employed by Anthem who is responsible for Anthem's utilization review techniques and methods and their administration and implementation.

Medical Enrollment Application (or Application) means the application form that must be completed, signed and submitted to Your Group Benefits Administrator. An applicant is enrolled for Benefits under the Plan and this Certificate only upon acceptance of the Medical Enrollment Application by LGC HealthTrust. This form is also used to notify LGC HealthTrust of changes in membership and enrollment information.

Medically Necessary (or Medical Necessity) means health care services or products provided to an enrollee for the purposes of preventing, stabilizing, diagnosing, or treating an illness, injury, or disease or the symptoms of an illness, injury, or disease in a manner that is:

- Consistent with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration;
- Demonstrated through scientific evidence to be effective in improving health outcomes;
- Representative of "best practices" in the medical profession; and
- Not primarily for the convenience of the enrollee or the Provider.

Please note: The fact that a Designated Provider or other health practitioner orders, prescribes, recommends or furnishes health care services or products will not cause the intervention to be automatically considered Medically Necessary. Anthem may consult the Medical Director and/or independent medical specialists, peer review committees, or other health care professionals qualified to make a recommendation regarding the Medical Necessity of any service or product prescribed for a Member.

You have the right to appeal Benefit determinations made by Anthem or its delegated entities, including Adverse Benefit Determinations regarding medical necessity. Please refer to the appeal process in Section 11 of this Certificate for complete information.

Member means a Subscriber and any Dependent covered under the Plan.

Network Service means a Covered Service that You receive from a Preferred Provider.

NonBlueCard Provider means a Designated Provider outside New Hampshire that does not have a written payment agreement with the Local Blue Cross and Blue Shield Plan.

Out-of-Network Provider means any Designated Provider that is not a Preferred Provider. Providers who have not contracted or affiliated with Anthem's designated Subcontractor(s) for the services that are Covered Services under this Certificate are also considered Out-of-Network Providers.

Providers who have not contracted or affiliated with Anthem's designated subcontractor(s) for the services they perform under this Certificate are also considered Out-of-Network Providers.

Out-of-Network Services means a Covered Service that You receive from an Out-of-Network Provider.

Outpatient means any care received in a health care setting other than an Inpatient setting ("Inpatient" is defined above).

Physical Rehabilitation Facility means a state authorized and licensed facility for physical rehabilitation services where short-term active professional care is provided.

Plan means LGC HealthTrust's Lumenos Preferred Blue managed health care plan, as described in this Certificate, which LGC HealthTrust makes available to Groups.

Plan Year means the twelve month period selected by Your Group for its participation in the Plan. Each Group will select either a January (January 1 through December 31) or July (July 1 through June 30) Plan Year. The initial Plan Year for each Group will be the period beginning with the first of the month in which participation in the Plan begins and ending with the next December 31 or June 30, depending on whether the Group selects a January or July Plan Year. Thereafter, the Plan Year will be each successive twelve-month period.

Post-Service Claims are claims for services that You have received. Post-Service Claims do not include requests for reimbursement made by providers according to the terms of their agreement with Anthem or with a Subcontractor unless:

- Benefits are reduced or denied, and
- The provider can bill You for amounts exceeding Your Copayment, Deductible and/or Coinsurance under the terms of an agreement with Anthem.

Precertification or Precertify means Anthem's written confirmation that a service is Medically Necessary. Precertification is not a guarantee of Benefits. Benefits are subject to all of the terms and conditions of the Certificate that is in effect on the date that You receive Covered Services.

Precertification Penalty means the penalty that may apply if You do not obtain Precertification as required. Please see Sections 1 and 5 for more information about Precertification and the Precertification Penalty. The Precertification Penalty (if any) is shown on Your Cost Sharing Schedule.

Preferred Birthing Center means a Birthing Center that has a Preferred written agreement directly with Anthem or with the Local Plan to provide Covered Services to Members.

Preferred Diabetes Education Provider means a certified, registered or licensed health care expert in diabetes management who has a Preferred written agreement directly with Anthem to furnish diabetes counseling and diabetes education to Members.

Preferred New Hampshire Certified Midwife (NHCM) means an individual who is certified under New Hampshire law and who has a Preferred written agreement directly with Anthem to provide Covered Services to Members.

Preferred Nutrition Counselor means a registered or licensed dietitian practicing independently or as part of a physician practice or hospital clinic and who has a Preferred written agreement directly with Anthem or with the Local Plan to provide nutrition counseling to Members.

Preferred Provider means any Designated Provider that has a preferred written payment agreement with Anthem or with the Local Plan to provide Covered Services to Members.

Preferred Walk-In Center means a free-standing center that has a written payment agreement directly with Anthem or with the Local Plan to provide health services without appointments for diagnosis, care and treatment of urgent illness or injury.

Pre-Service Claim means any claim for a Benefit with respect to which the terms of the Plan condition receipt of the Benefit, in whole or in part, on approval of the Benefit in advance of obtaining medical care.

Prior Approval means the process by which You or Your provider may request that Anthem review proposed services to determine if services are Covered Services.

Probationary Period means the period of time established by Your Group which You must work before You are eligible to enroll for coverage under this Certificate.

Retiree means a person who is retired from active employment with a Group and who the Group determines is eligible to continue coverage under this Certificate pursuant to NH RSA 100-A:50 and/or the applicable LGC HealthTrust and Group rules governing eligibility for retiree coverage.

Service Area means the State of New Hampshire including the cities and towns of Maine, Massachusetts and Vermont whose borders directly adjoin the New Hampshire border whose Designated Providers have *Preferred* written payment agreements directly with Anthem.

Short Term General Hospital means a health care institution having an organized professional and medical staff and Inpatient facilities which care primarily for patients with acute diseases and injuries with an average patient length of stay of 30 days or less.

Skilled Nursing Facility means an institution which is in compliance with all state licensing and regulatory requirements and which provides room and board accommodations and 24-hour-a-day nursing care under the supervision of a Provider and/or Registered Nurse (R.N.) while maintaining permanent medical history records.

Subcontractor means an organization or entities with specialized expertise in certain areas to which Anthem may subcontract particular services under the Plan. Subcontracted services may include but are not limited to services related to mental health and/or substance abuse care. Such Subcontractors or subcontracted organizations or entities may make Benefit determinations and/or perform administrative, claims paying, or customer service duties on behalf of Anthem.

Subscriber means You, the Employee or Retiree, who is properly enrolled and accepted for coverage under the Plan and to whom this Certificate is issued.

Urgent Care Claims means a request for Precertification submitted as required under this Certificate, for medical care or treatment with respect to which the application of time periods for making non-urgent Pre-Service Claims determination:

- Could seriously jeopardize Your life or health or Your ability to regain maximum function, or
- In the opinion of a physician with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent Care Facility means a licensed free-standing facility that provides urgent health services for diagnosis, care and treatment of illness or injury. Please see Section 6, "Urgent and Emergency Care" for more information about urgent care.

Walk-In Center means a free-standing center that provides episodic health services without appointments for diagnosis, care and treatment of urgent illness or injury.

Year means a calendar year, unless specifically stated otherwise. A calendar year starts on January 1 and ends on December 31 in any given year.

You or Your means You, the person to whom this Certificate is issued (the Subscriber), Your covered spouse and other covered Dependents-collectively the Members, unless specifically stated (or where the context provides) otherwise.

HealthTrust

MEDICOMP THREE

Medicare Supplemental Plan

MEDICOMP THREE FEATURES

Comprehensive Coverage

An important part of HealthTrust's Medicomp Three plan is its supplemental medical coverage. This portion of the plan pays the deductible and coinsurance required by Medicare Parts A and B—lowering your out-of-pocket costs for some types of care. Medicomp Three also provides Major Medical Benefits that may help pay for additional services that Medicare does not customarily pay.

Coverage No Matter Where You Are

With HealthTrust's Medicomp Three plan, there is no need to worry about traveling in the United States. You can choose to use a provider who accepts Medicare assignment and receive the maximum benefits, but you're covered even if you see a provider who doesn't.

Administered by Anthem Blue Cross and Blue Shield

Your Medicomp Three medical coverage is administered by Anthem Blue Cross and Blue Shield (Anthem), one of the most respected names in the business.

This brochure helps to explain how Medicomp Three coverage works by providing an overview of covered services. While this brochure is intended to describe your benefits as accurately as possible, the specific terms and conditions of eligibility and benefits are set forth in and governed by your Medicomp Three Subscriber Certificate, Prescription Benefit Program *summary (if you have elected prescription drug coverage) and any other separate documents relating to features of the plan.*

In the event of any discrepancy between this brochure and those documents, the terms of the Subscriber Certificate *or* Prescription Benefit Program *summary will govern. This brochure does not constitute a contract, or any offer to form a contract, and is not binding on any party. The benefits describe in this brochure may be changed at any time without prior notice.*

STRENGTHENING YOUR HEALTHCARE PLAN

Affordable, comprehensive healthcare is important to everyone—and it becomes even more important at retirement. That's why HealthTrust offers the Medicomp Three supplemental medical plan.

Medicare Parts A and B provide valuable healthcare coverage to retirees. But this coverage is not complete. To help protect you from additional out-of-pocket costs, Medicomp Three pays the deductible and coinsurance required by Medicare Parts A and B—lowering your out-of-pocket costs for some types of care.

Medicomp Three consists of two parts:

- ***Medicare Complementary Benefits***, which picks up where Medicare leaves off, paying required deductibles and coinsurance for Medicare-approved services, and
- ***Major Medical Benefits***, which may cover services that Medicare does not. Major Medical Benefits are provided in addition to Medicare Complementary Benefits. Major Medical coverage is determined by HealthTrust and Anthem as set forth in the *Medicomp Three Subscriber Certificate*.

This brochure highlights how Medicare Complementary and Major Medical Benefits work with Medicare to provide you with a comprehensive healthcare plan.

Questions about Medicare Coverage? If you have questions about Medicare, call 800.MEDICARE (800.633.4227); TTY, call 877.486.2048. Representatives are available 24 hours a day, seven days a week. Be sure to have your Medicare ID card on hand when you call. You can also learn more by reviewing the current *Medicare & You* booklet, available at your local Medicare office or by visiting the Medicare website at *www.medicare.gov*.

UNDERSTANDING MEDICARE

Before we look at how Medicomp Three works, it's important that you understand the basics of Medicare. Medicare is a national health insurance program for people age 65 and older, as well as for those with qualifying disabilities. It consists of multiple parts:

- ***Part A—Hospital Insurance***. Part A provides limited coverage for inpatient care in hospitals, critical access hospitals and skilled nursing facilities. Part A also covers hospice care and some home healthcare. You do incur out-of-pocket costs, including deductibles and coinsurance.
- ***Part B—Medical Insurance***. Part B provides coverage for doctor visits, laboratory tests, emergency room and urgent care, durable medical equipment, outpatient hospital care, vaccinations (including flu, pneumonia and hepatitis B shots), mammograms, prostate cancer screenings and pap tests. It also covers other services that Part A does not, such as some occupational and physical therapy costs. As with Part A, you are subject to out-of-pocket costs, including deductibles and coinsurance.

To be eligible for Medicomp Three, you must be enrolled in both Medicare Parts A and B. While there is no premium for Medicare Part A, you do need to pay Medicare a monthly premium for Part B coverage. Check your Medicare identification card to see if you have Part A and/or Part B coverage.

Important Note – Medicare's required deductibles and coinsurance amounts may change each calendar year. For the most up-to-date deductible and coinsurance figures, review the current *Medicare & You* booklet available at your local Medicare office or by visiting the Medicare website at *www.medicare.gov,* or call 800.MEDICARE (800.633.4227).

Medicare Part D

Medicare offers prescription drug coverage known as Medicare Part D. This coverage is available to everyone with Medicare by enrolling in a Medicare Part D plan and paying a monthly premium. All Medicare Part D plans provide at least a standard level of prescription drug coverage set by Medicare.

If you are enrolled in a HealthTrust Medicomp Three with Prescription Drug Coverage Plan (MCRX), you do not need to also enroll in a Medicare Part D Plan. This is because the MCRX plan is considered "creditable" coverage which means that the prescription drug coverage is as good as or better than coverage available through a standard Medicare Part D plan. Please see the last page of this brochure for additional information regarding your prescription drug coverage.

HOW MEDICOMP THREE WORKS

Medicomp Three provides certain protections to help you get the highest level of benefits available. For example, your coverage cannot be denied or delayed due to any pre-existing condition. Also if your care is not covered by Medicare in whole or in part, you may submit a Major Medical claim. If your Major Medical claim is denied, you are responsible for paying 100 percent of the cost. For more information, see the *Major Medical Benefits* section on page 6.

Medicomp Three consists of two parts—Medicare Complementary Benefits and Major Medical Benefits. Now, let's look at each part.

Medicare Complementary Benefits

Medicare Parts A and B pay benefits after you have met certain deductibles and/or coinsurance. This means, if your only coverage is through Medicare, you will likely have to pay for some of your care.

However, the Medicomp Three Medicare Complementary Benefits cover 100 percent of Medicare Parts A and B required deductibles and coinsurance amounts. This means your out-of-pocket cost for care is lowered or eliminated.

The following pages look at how Medicare Complementary Benefits supplement your Medicare benefits.

Inpatient Hospital Stays

Medicare Part A provides limited coverage for inpatient care in hospitals, critical access hospitals, and skilled nursing facilities. Part A also covers hospice care and some home healthcare.

Inpatient hospital coverage includes:

- A semiprivate room,
- Meals,
- General nursing care,
- Other hospital services and supplies,
- Care you receive at a critical access hospital, and
- Inpatient behavioral healthcare.

Coverage *does not* include:

- Private duty nursing,
- A television or telephone in your room, or
- A private room, unless medically necessary.

Medicare Part A requires payment of an annual deductible as well as coinsurance for some Part A services. But, Medicomp Three Complementary Benefits cover 100 percent of these costs.

This chart shows how Medicare Part A and Medicomp Three Complementary Benefits cover inpatient hospital care.

	Medicare Part A Pays	Medicomp Three Complementary Benefits Pay	You Pay*
Inpatient Hospital Benefits			
First 60 days	100% after calendar year Medicare Part A deductible	Medicare Part A deductible per calendar year	**$0**
Days 61 through 90	100% after Medicare Part A coinsurance per day	Medicare Part A coinsurance per day	**$0**
Days 91 through 150**	100% after Medicare Part A coinsurance per day	Medicare Part A coinsurance per day	**$0**
After 150 days of continuous confinement	$0	90% of covered services, up to a lifetime maximum of 365 days	10% of covered services, up to a lifetime maximum of 365 days Then 100% of charges. You may submit these charges for consideration for payment under Major Medical
Blood	100% after 3 pints	100% of first 3 pints	**$0**

** Any remaining balance for covered services may be eligible for coverage under Major Medical. For specific information about Major Medical Benefits, refer to Sections 3–5 of the* Medicomp Three Subscriber Certificate.
*** Note that Days 91 through 150 are one-time lifetime reserve days.*

Skilled Nursing Home Benefits

Skilled nursing home coverage includes:

- A semiprivate room,
- Meals,
- Skilled nursing and rehabilitative services, and
- Other services and supplies, generally after a related three-day inpatient hospital stay. Limited to up to 100 days per benefit period.

Please note that custodial care is *not* covered.

Medicare Part A covers 100 percent of Medicare-eligible expenses received in a semiprivate room in a skilled nursing facility during the first 20 days.

But, Part A requires payment of coinsurance from Days 21 through 100. Medicomp Three Complementary Benefits cover 100 percent of this cost.

This chart shows how Medicare Part A and Medicomp Three Complementary Benefits cover skilled nursing home care.

	Medicare Part A Pays	Medicomp Three Complementary Benefits Pay	You Pay*
Skilled Nursing Home Benefits**			
First 20 days	100%	$0	**$0**
Days 21 through 100	100% after calendar year Medicare Part A coinsurance per day	Medicare Part A coinsurance per day	**$0**
After 100 days of continuous confinement	$0	$0	100% of charges. You may submit these charges for consideration for payment under Major Medical

** Any remaining balance for covered services may be eligible for coverage under Major Medical. For specific information about Major Medical Benefits, refer to Sections 3–5 of the* Medicomp Three Subscriber Certificate.
*** Before you receive skilled nursing home care, you are strongly advised to confirm that the facility qualifies for Medicare benefits.* Skilled nursing home confinement must follow a hospitalization and be medically necessary. Custodial care is not covered.

Medical Service Benefits

Medicare Part B covers Medicare-eligible expenses for services rendered by physicians and other Medicare-approved providers, including independent laboratories, ambulance services and independent physical therapists.

Some outpatient hospital services are also covered under Medicare Part B.

Medicare Part B requires payment of an annual deductible as well as coinsurance for certain services. Medicomp Three Complementary Benefits cover 100 percent of these costs.

This chart shows how Medicare Part B and Medicomp Three Complementary Benefits cover medical service care.

	Medicare Part B Pays	Medicomp Three Complementary Benefits Pay	You Pay*
Medical Service Benefits			
Physician services, hospital outpatient services, prosthetic devices, durable medical equipment, immunosuppressive drugs	80% of Medicare-approved charges after annual Medicare Part B deductible per calendar year	Remaining 20% of Medicare-approved charges and annual Medicare Part B deductible per calendar year	$0 for Medicare-eligible expenses 100% of non- Medicare-eligible expenses. You may submit these charges for consideration for payment under Major Medical
Blood	100% after 3 pints	100% of first 3 pints	**$0**
Non-inpatient psychiatric services (psychiatric maximums and exceptions may apply)**	80% of Medicare eligible expenses after psychiatric reduction, if applicable	Psychiatric reduction and 20% of Medicare-eligible expenses	$0 for Medicare-eligible expenses 100% of non-Medicare-eligible expenses. You may submit these charges for consideration for payment under Major Medical

** Any remaining balance for covered services may be eligible for coverage under Major Medical. For specific information about Major Medical Benefits, refer to Sections 3 through 5 of the* Medicomp Three Subscriber Certificate.
*** For psychiatric maximums and exceptions, refer to the Medicare & You handbook available from your local Medicare office by calling 800.633.4227 or at* www.medicare.gov.

MAJOR MEDICAL BENEFITS

Major Medical Benefits are an important component of your Medicomp Three plan.

Please Note: Major Medical Benefits are in addition to your Medicare Complementary Benefits. Major Medical Benefits do not duplicate coverage that is available under Medicare Part A, Medicare Part B or Medicare Complementary Benefits.

If you receive care or services that Medicare does not cover, or if Medicare covers some but not all of your care, you may submit these charges not covered by Medicare to be considered for coverage under Major Medical.

How Major Medical Benefits Are Paid

HealthTrust's Medicomp Three plan pays 100 percent of the cost of eligible Major Medical covered services; *you pay nothing out-of-pocket*.

Please note that Major Medical covers approved care at 100 percent of the *maximum allowable benefit*. The *maximum allowable benefit* is the amount the plan allows for a particular service in your geographical area. Amounts that exceed the *maximum allowable benefit* are not eligible for payment and are considered out-of-pocket expenses to you.

With Major Medical, covered medical services are reimbursable regardless of your choice of physician or hospital.

Maximum Lifetime Benefit

Major Medical carries a lifetime benefit maximum of $1 million. You are responsible for 100 percent of any costs in excess of this maximum.

Any Major Medical Benefits count toward this maximum, as do any benefits previously paid by Anthem while you were covered by any Anthem and/or HealthTrust-sponsored Anthem plan.

Eligible Services

While there is no guarantee that the services listed below will always be accepted for Major Medical payment, we encourage you to submit claims for:

- Ambulance services,
- Chiropractic care received from a participating provider,
- Diabetes management programs,
- Emergency care, which is defined as care required to prevent serious jeopardy to your health, impairment of bodily functions or dysfunction of a bodily organ or part. This includes heart attacks, broken bones, stroke, uncontrolled bleeding and unconsciousness,
- Hospice care received from a participating provider,
- Immunizations,
- Laboratory and x-ray tests.

For a list of services eligible for submission under Major Medical—as well as a list of limitations and exclusions—see your *Medicomp Three Subscriber Certificate*, available from Anthem by calling 800.225.2666.

Determining Claims

When determining whether your claim qualifies for Major Medical Benefits, Anthem considers the following:

1. Were the services and supplies medically necessary?
2. Were the services and supplies ordered, performed, prescribed, or supervised by a qualifying physician?
3. Are the charges consistent with the maximum allowable benefit determination?
4. If the claim is in connection with a hospital stay, are the charges within the hospital's semiprivate room rate?

Anthem will notify you if your Major Medical claim is approved or denied. *If coverage is denied, you are responsible for paying 100 percent of any remaining balance*.

In addition, benefits are subject to any applicable deductible, coinsurance, benefit period restrictions, and lifetime maximums that may apply.

PRESCRIPTION DRUG BENEFITS

With Medicomp Three with Prescription Drug Coverage Plan, you receive comprehensive prescription drug benefits administered by CVS Caremark – as soon as your coverage becomes effective with HealthTrust. Please refer to your CVS Caremark "Your Personal Prescription Drug Benefit Program" summary for information regarding your prescription drug coverage.

HealthTrust's MCRX coverage is considered "creditable" coverage which means that the prescription drug coverage is as good as or better than coverage available through a standard Medicare Part D plan. Being enrolled in a creditable coverage plan also allows you to avoid late-enrollment fees if you later switch to a Medicare Part D plan. However, you will not be able to enroll in a Medicare Part D plan until your prescription drug coverage with MCRX ends.

If your group offers a HealthTrust Medicomp Three without Prescription Drug Coverage Plan (MCNRX) and you elect the MCNRX coverage, you will need to enroll in a Medicare Part D plan for your prescription drug coverage.

CONTACT INFORMATION

Organization	Services
HealthTrust **800.527.5001** ***www.healthtrustnh.org***	Provides answers to questions about your enrollment plan materials and the *Slice of Life* health management programs
Medicare **800.MEDICARE (800.633.4227)** ***www.medicare.gov***	Provides answers to questions about Part A, Part B, and Part D coverage, and other Medicare programs
Anthem Blue Cross and Blue Shield **800.225.2666** ***www.anthem.com***	Provides answers about your benefits, covered services, plan materials, *Subscriber Certificate* and participating providers
LifeResources—Employee Assistance Program* **800.759.8122** ***Link to their organization is available at www.healthtrustnh.org.***	Provides counseling and resources for a variety of member needs
CVS Caremark **888.726.1631** ***www.caremark.com***	Provides answers about your prescription drug program benefits and services

HealthTrust

PO Box 617 • Concord, NH 03302-0617
Tel: 603.226.2861 • 800.527.5001 (NH Toll Free) • Fax: 603.415.3099
Website: *www.healthtrustnh.org*

HealthTrust

CVS CAREMARK

Your Personal Prescription Benefit Program

	RETAIL PHARMACY	MAIL SERVICE PHARMACY
	For immediate or short-term medication needs*	For maintenance or long-term medication needs*
YOU WILL PAY	• **$3** for each generic medication • **$15** for each preferred/non-preferred brand-name medication**	• **$1** for each generic medication • **$1** for each preferred/non-preferred brand-name medication**
	• **$0** for contraceptives, devices and emergency contraception (brand-name medications with direct generic equivalents will require an applicable copayment)	
DAY SUPPLY LIMIT	Up to a **34**-day supply	Up to a **90**-day supply
REFILL LIMIT	One initial fill plus two refills for maintenance or long-term medications. For each additional fill you will pay 100% of the prescription cost.	None
PRIOR AUTHORIZATION REQUIRED	Botox and Myobloc for non-cosmetic purposes only; Wellbutrin and its generics. **All forms of Wellbutrin and its generics are not covered for use as a smoking deterrent.**	

*Your plan may have coverage limits, be subject to dispensing limitations and may not cover certain medications. Please contact CVS Caremark at 1-888-726-1631 or log on to www.caremark.com for the most up-to-date plan information.

**When a generic equivalent is available but the pharmacy dispenses the brand-name medication for any reason other than a doctor's "dispense as written" or equivalent instructions, you will pay the generic copayment plus the difference in cost between the brand-name and the generic.

Where to Fill Your Prescriptions

Choosing where to fill your prescription depends on whether you are ordering a short-term or long-term medication:

Short-term medications are generally taken for a limited amount of time and have a limited amount of refills, such as an antibiotic. You can fill prescriptions for these medications at any pharmacy in the CVS Caremark retail network.

- Choose from more than 64,000 network pharmacies nationwide, including over 20,000 independent community pharmacies
- Find a participating pharmacy at www.caremark.com

Tip: To avoid filling out claims paperwork, bring your Prescription Card with you when you pick up your prescription and use a pharmacy in the CVS Caremark retail network. Additional Prescription Cards may be obtained by calling Customer Care toll-free at 1-888-726-1631.

Long-term medications are taken regularly for chronic conditions such as high blood pressure, asthma, diabetes or high cholesterol. You will generally save money by using mail service for these prescriptions. Choose **one** of four easy ways to start using the CVS Caremark Mail Service Pharmacy:

1. Fill out and send in a mail service order from - use the one included with your welcome kit or print one at www.caremark.com
2. Use the FastStart® tool found on www.caremark.com
3. Call FastStart® toll-free at 1-800-875-0867
4. Ask your doctor to call in the prescription through the toll-free FastStart® physician number at 1-800-378-5697

Customer Care

If you have questions about your prescriptions or benefits, you can contact Customer Care 24 hours a day, seven days a week, toll-free at **1-888-726-1631** or by e-mail at **customerservice@caremark.com**. For Telecommunication Device assistance, please call toll-free **1-800-863-5488**. **Caremark.com** is also available to help you manage your prescription drug benefits. By registering online, you can order mail service refills, check order status, price medications, and much more.

Your feedback is important as it helps us improve our service. Please contact us with any questions or concerns at 1-888-726-1631.
Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

To contact HealthTrust, please call toll-free at **1-800-527-5001** between the hours of 8:30 a.m. and 4:30 p.m. (EST) Monday through Friday or visit **www.healthtrustnh.org**. HealthTrust Enrollee Services Representatives are available for issues or concerns with enrollment or eligibility, and any other prescription benefit-related inquiry.
For further information or questions, you may also e-mail Enrollee Services at **enrolleeservices@healthtrustnh.org**.

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Getting Your Prescription Filled at a Retail Pharmacy

CVS Caremark Participating Retail Pharmacies
Participating retail pharmacies can easily access information about your prescription benefit plan and the appropriate payment. You will not need to file any additional paperwork when you use a pharmacy in the CVS Caremark retail network. If you use a pharmacy outside the CVS Caremark retail network, you will pay more for your prescription(s) in most cases. Non-participating retail pharmacies will ask you to pay 100 percent of the prescription price. Then, you will need to submit a paper claim form along with the original prescription receipt(s) for reimbursement of covered expenses.

Day Supply Limit
You can get up to a 34-day supply of medication each time you have a prescription filled at a participating retail pharmacy. Ask your doctor to write a prescription for up to a 34-day supply, when clinically appropriate.

Refill Limit
You may obtain one initial fill plus two refills for maintenance or long-term medications at a retail pharmacy. It will then be necessary for you to utilize CVS Caremark Mail Service Pharmacy for additional supplies. Otherwise, you will be responsible for 100 percent of the cost of the medication when filled at a retail pharmacy. To determine if your prescription medication is classified as maintenance or long-term, please call Customer Care toll-free at 1-888-726-1631.

Getting Your Prescription Filled Through the CVS Caremark Mail Service Pharmacy

CVS Caremark operates two mail service pharmacies across the United States to provide quick service to plan participants wherever they live. To ensure your safety, our mail service pharmacies are staffed by registered pharmacists. Just like your neighborhood pharmacist, our pharmacists check each prescription to make sure it is filled correctly. In addition, your prescription history is reviewed to identify any possible problems with new medications you may be prescribed.

Day Supply Limit
You can get up to a 90-day supply of medication when you get a prescription filled through the CVS Caremark Mail Service Pharmacy. Ask your doctor to write a prescription for up to a 90-day supply plus three refills for up to one year when clinically appropriate. **Please Note:** *By law, CVS Caremark must fill your prescription for the exact quantity of medication prescribed by your doctor, up to the 90-day supply limit.*

Payment Options
While checks and money orders are accepted, the preferred method of payment is by credit card. For credit card payments, simply include your VISA®, Discover®, MasterCard® or American Express® number and expiration date in the space provided on the mail service order form.

Convenient Home Delivery
Please allow 10-14 days for delivery from the time your order is placed. Refills are delivered within seven days following CVS Caremark's receipt of your refill request by phone or online. Your package will include a new mail service order form and an invoice, if applicable. You will also receive the same type of information about your prescribed medication that you would receive from a retail pharmacy.

Other Important Plan Information

Drug List
Your plan is subject to a list of prescription drugs that are preferred by the plan because of their safety, clinical effectiveness and ability to help control prescription drug costs. The drug list is updated on a regular basis. Log on to www.caremark.com or call Customer Care toll-free at 1-888-726-1631 to access the most current drug list for your plan.

Prior Authorization
Some medications may require approval before the prescription can be filled. Your retail pharmacist will give you or your doctor a toll-free number to call in order to obtain approval. The CVS Caremark Mail Service Pharmacy will contact your doctor directly for approval.

Specialty Medications
Specialty medications are used for the treatment of chronic and/or genetic conditions, such as multiple sclerosis, rheumatoid arthritis or hepatitis C, and are often injected or infused. All specialty medications will be provided by CVS Caremark's Specialty Pharmacy. CVS Caremark's Specialty Pharmacy is a mail order facility dedicated to dispensing specialty medications. Questions? Call CVS Caremark Specialty Pharmacy toll-free at 1-800-237-2767.

HealthTrust

CVS CAREMARK

Your Personal Prescription Benefit Program

	RETAIL PHARMACY	MAIL SERVICE PHARMACY
	For immediate or short-term medication needs*	For maintenance or long-term medication needs*
YOU WILL PAY	• **$10** for each generic medication • **$25** for each preferred brand-name medication** • **$40** for each non-preferred brand-name medication**	• **$10** for each generic medication • **$40** for each preferred brand-name medication** • **$70** for each non-preferred brand-name medication**
	• **$0** for contraceptives, devices and emergency contraception (brand-name medications with direct generic equivalents will require an applicable copayment)	
DAY SUPPLY LIMIT	Up to a **34**-day supply	Up to a **90**-day supply
REFILL LIMIT	One initial fill plus two refills for maintenance or long-term medications. For each additional fill you will pay 100% of the prescription cost.	None
PRIOR AUTHORIZATION REQUIRED	Botox and Myobloc for non-cosmetic purposes only; Wellbutrin and its generics. **All forms of Wellbutrin and its generics are not covered for use as a smoking deterrent.**	

*Your plan may have coverage limits, be subject to dispensing limitations and may not cover certain medications. Please contact CVS Caremark at 1-888-726-1631 or log on to www.caremark.com for the most up-to-date plan information.

**When a generic equivalent is available but the pharmacy dispenses the brand-name medication for any reason other than a doctor's "dispense as written" or equivalent instructions, you will pay the generic copayment plus the difference in cost between the brand-name and the generic.

Where to Fill Your Prescriptions

Choosing where to fill your prescription depends on whether you are ordering a short-term or long-term medication:

Short-term medications are generally taken for a limited amount of time and have a limited amount of refills, such as an antibiotic. You can fill prescriptions for these medications at any pharmacy in the CVS Caremark retail network.

- Choose from more than 64,000 network pharmacies nationwide, including over 20,000 independent community pharmacies
- Find a participating pharmacy at www.caremark.com

Tip: To avoid filling out claims paperwork, bring your Prescription Card with you when you pick up your prescription and use a pharmacy in the CVS Caremark retail network. Additional Prescription Cards may be obtained by calling Customer Care toll-free at 1-888-726-1631.

Long-term medications are taken regularly for chronic conditions such as high blood pressure, asthma, diabetes or high cholesterol. You will generally save money by using mail service for these prescriptions. Choose **one** of four easy ways to start using the CVS Caremark Mail Service Pharmacy:

1. Fill out and send in a mail service order from - use the one included with your welcome kit or print one at www.caremark.com
2. Use the FastStart® tool found on www.caremark.com
3. Call FastStart® toll-free at 1-800-875-0867
4. Ask your doctor to call in the prescription through the toll-free FastStart® physician number at 1-800-378-5697

Customer Care

If you have questions about your prescriptions or benefits, you can contact Customer Care 24 hours a day, seven days a week, toll-free at **1-888-726-1631** or by e-mail at **customerservice@caremark.com**. For Telecommunication Device assistance, please call toll-free **1-800-863-5488**. **Caremark.com** is also available to help you manage your prescription drug benefits. By registering online, you can order mail service refills, check order status, price medications, and much more.

Your feedback is important as it helps us improve our service. Please contact us with any questions or concerns at 1-888-726-1631.
Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

To contact HealthTrust, please call toll-free at **1-800-527-5001** between the hours of 8:30 a.m. and 4:30 p.m. (EST) Monday through Friday or visit **www.healthtrustnh.org**. HealthTrust Enrollee Services Representatives are available for issues or concerns with enrollment or eligibility, and any other prescription benefit-related inquiry.
For further information or questions, you may also e-mail Enrollee Services at **enrolleeservices@healthtrustnh.org**.

Getting Your Prescription Filled at a Retail Pharmacy

CVS Caremark Participating Retail Pharmacies
Participating retail pharmacies can easily access information about your prescription benefit plan and the appropriate payment. You will not need to file any additional paperwork when you use a pharmacy in the CVS Caremark retail network. If you use a pharmacy outside the CVS Caremark retail network, you will pay more for your prescription(s) in most cases. Non-participating retail pharmacies will ask you to pay 100 percent of the prescription price. Then, you will need to submit a paper claim form along with the original prescription receipt(s) for reimbursement of covered expenses.

Day Supply Limit
You can get up to a 34-day supply of medication each time you have a prescription filled at a participating retail pharmacy. Ask your doctor to write a prescription for up to a 34-day supply, when clinically appropriate.

Refill Limit
You may obtain one initial fill plus two refills for maintenance or long-term medications at a retail pharmacy. It will then be necessary for you to utilize CVS Caremark Mail Service Pharmacy for additional supplies. Otherwise, you will be responsible for 100 percent of the cost of the medication when filled at a retail pharmacy. To determine if your prescription medication is classified as maintenance or long-term, please call Customer Care toll-free at 1-888-726-1631.

Getting Your Prescription Filled Through the CVS Caremark Mail Service Pharmacy

CVS Caremark operates two mail service pharmacies across the United States to provide quick service to plan participants wherever they live. To ensure your safety, our mail service pharmacies are staffed by registered pharmacists. Just like your neighborhood pharmacist, our pharmacists check each prescription to make sure it is filled correctly. In addition, your prescription history is reviewed to identify any possible problems with new medications you may be prescribed.

Day Supply Limit
You can get up to a 90-day supply of medication when you get a prescription filled through the CVS Caremark Mail Service Pharmacy. Ask your doctor to write a prescription for up to a 90-day supply plus three refills for up to one year when clinically appropriate. **Please Note:** *By law, CVS Caremark must fill your prescription for the exact quantity of medication prescribed by your doctor, up to the 90-day supply limit.*

Payment Options
While checks and money orders are accepted, the preferred method of payment is by credit card. For credit card payments, simply include your VISA®, Discover®, MasterCard® or American Express® number and expiration date in the space provided on the mail service order form.

Convenient Home Delivery
Please allow 10-14 days for delivery from the time your order is placed. Refills are delivered within seven days following CVS Caremark's receipt of your refill request by phone or online. Your package will include a new mail service order form and an invoice, if applicable. You will also receive the same type of information about your prescribed medication that you would receive from a retail pharmacy.

Other Important Plan Information

Drug List
Your plan is subject to a list of prescription drugs that are preferred by the plan because of their safety, clinical effectiveness and ability to help control prescription drug costs. The drug list is updated on a regular basis. Log on to www.caremark.com or call Customer Care toll-free at 1-888-726-1631 to access the most current drug list for your plan.

Prior Authorization
Some medications may require approval before the prescription can be filled. Your retail pharmacist will give you or your doctor a toll-free number to call in order to obtain approval. The CVS Caremark Mail Service Pharmacy will contact your doctor directly for approval.

Specialty Medications
Specialty medications are used for the treatment of chronic and/or genetic conditions, such as multiple sclerosis, rheumatoid arthritis or hepatitis C, and are often injected or infused. All specialty medications will be provided by CVS Caremark's Specialty Pharmacy. CVS Caremark's Specialty Pharmacy is a mail order facility dedicated to dispensing specialty medications. Questions? Call CVS Caremark Specialty Pharmacy toll-free at 1-800-237-2767.

HealthTrust

CVS CAREMARK

Your Personal Prescription Benefit Program

	RETAIL PHARMACY	MAIL SERVICE PHARMACY
	For immediate or short-term medication needs*	For maintenance or long-term medication needs*
YOU WILL PAY	• **$10** for each generic medication • **$20** for each preferred brand-name medication** • **$45** for each non-preferred brand-name medication**	• **$10** for each generic medication • **$20** for each preferred brand-name medication** • **$45** for each non-preferred brand-name medication**
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3. Call FastStart® toll-free at 1-800-875-0867
4. Ask your doctor to call in the prescription through the toll-free FastStart® physician number at 1-800-378-5697

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Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

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For further information or questions, you may also e-mail Enrollee Services at **enrolleeservices@healthtrustnh.org**.

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Payment Options
While checks and money orders are accepted, the preferred method of payment is by credit card. For credit card payments, simply include your VISA®, Discover®, MasterCard® or American Express® number and expiration date in the space provided on the mail service order form.

Convenient Home Delivery
Please allow 10-14 days for delivery from the time your order is placed. Refills are delivered within seven days following CVS Caremark's receipt of your refill request by phone or online. Your package will include a new mail service order form and an invoice, if applicable. You will also receive the same type of information about your prescribed medication that you would receive from a retail pharmacy.

Other Important Plan Information

Drug List
Your plan is subject to a list of prescription drugs that are preferred by the plan because of their safety, clinical effectiveness and ability to help control prescription drug costs. The drug list is updated on a regular basis. Log on to www.caremark.com or call Customer Care toll-free at 1-888-726-1631 to access the most current drug list for your plan.

Prior Authorization
Some medications may require approval before the prescription can be filled. Your retail pharmacist will give you or your doctor a toll-free number to call in order to obtain approval. The CVS Caremark Mail Service Pharmacy will contact your doctor directly for approval.

Specialty Medications
Specialty medications are used for the treatment of chronic and/or genetic conditions, such as multiple sclerosis, rheumatoid arthritis or hepatitis C, and are often injected or infused. All specialty medications will be provided by CVS Caremark's Specialty Pharmacy. CVS Caremark's Specialty Pharmacy is a mail order facility dedicated to dispensing specialty medications. Questions? Call CVS Caremark Specialty Pharmacy toll-free at 1-800-237-2767.

Pharmacy Rider

This Pharmacy Rider("Rider") amends Your Subscriber Certificate. It is part of Your Certificate. Except as stated in this Rider, all of the terms of Your Certificate apply.

I. Covered Services

Benefits are available for prescription drugs purchased at a licensed Pharmacy. Covered Services must be ordered in writing, by telephone or electronically by a physician who is duly licensed to authorize a prescription order or refill in the ordinary course of his or her professional practice.

Covered Services include:

- Prescription legend drugs which are dispensed pursuant to a prescription order, under federal law or state law.
- Prescribed insulin and oral diabetes medications. Prescribed diabetic supplies such as blood glucose test strips, lancets and diabetic needles and syringes for diabetic Members. Basic blood glucose monitors are also covered for diabetic Members. Any cost exceeding the Maximum Allowed Amount for a basic blood glucose monitor is not covered. For example, costs for convenience features (such as features that download information to a computer or special portability features) are not covered.
- Prescription legend contraceptive drugs (oral, implantable and injectable).
- Contraceptive devices, such as IUDs and diaphragms. If an IUD is provided in an Outpatient setting, You are eligible for Benefits as described in this rider, provided that You submit a claim form and receipt to Anthem for the IUD.
- Vitamins that require a prescription by law.
- Human growth hormones. Benefits are available to treat children with short stature who have an absolute deficiency in natural growth hormone. Benefits are also available to treat children with short stature who have chronic renal insufficiency and who do not have a functioning renal transplant. Human growth hormones must be authorized *in advance* by Your child's physician and must be precertified by Anthem. Please call Anthem at 1-800-531-4450 for Precertification.
- Fertility drugs and hormones

II. About Special Programs

From time to time Anthem may initiate various programs to encourage the use of more cost-effective or clinically-effective Prescription Drugs including, but not limited to, Generic Drugs, mail order Drugs, over the counter or *preferred* products. Such programs may involve reducing or waiving Copayments or Coinsurance for certain drugs or *preferred* products for a limited period of time.

Therapeutic Drug Substitution Program - Your pharmacy Benefits include a therapeutic drug substitution program approved by the Plan and managed by Anthem's Pharmacy Benefits Management. This is a voluntary program designed to inform You and Your physician about possible alternatives to certain prescribed drugs. Anthem's Pharmacy Benefits Management may contact You and Your prescribing physician to make You aware of

substitution options. Therapeutic substitution may also be initiated at the time the prescription is dispensed. Only You and Your physician can determine whether the therapeutic substitute is appropriate for You.

III. Pharmacy Options

Benefits are available for covered prescriptions when purchased at any licensed Pharmacy. Prescriptions must meet all of the criteria stated in this Rider. Otherwise, no Benefits are available.

Prescriptions must be purchased a licensed pharmacy. In general, Your out-of-pocket costs are less if You purchase prescriptions at a Network Pharmacy. A Network Pharmacy is a pharmacy that has a written agreement with Anthem's Pharmacy Benefits Management to provide Covered Services to Members. Network Pharmacies accept the Maximum Allowed Amount as payment in full for Covered Services. For a list of pharmacies in the network, visit Anthem's website www.anthem.com.

Benefits are also available when You purchase prescriptions at an *Out-of-Network Pharmacy*. An Out-of-Network Pharmacy is a pharmacy that does not have a written agreement with Anthem's Pharmacy Benefits Management to provide Covered Services to Members.

If You purchase Your prescriptions at an Out-of-Network Pharmacy or if You do not show Your Identification Card at a Network Pharmacy, You will be required to pay the full cost of the prescription. To obtain reimbursement, a completed claim form must be submitted as directed on the form. Reimbursement is limited to the Maximum Allowed Amount, minus Your cost sharing (Deductible and/or Coinsurance). The Maximum Allowed Amount (contracted discount rate with pharmacy) is the dollar amount available for a specific prescription item.

Please see Cost Sharing" (below) for more information about Your share of the cost.

IV. Cost Sharing

The following types of cost sharing may apply to Covered Services under this Rider. These cost sharing amounts are subject to the Standard Deductible and Coinsurance shown on Your Cost Sharing Schedule.

Your Deductible and Coinsurance will not be reduced by any discounts, rebates or other funds received by Anthem's Pharmacy Benefits Management from drug manufacturers, wholesalers, distributors, similar vendors or funds received by Anthem from the Pharmacy Benefits Management.

No payment will be made by the Plan for any Covered Service unless Anthem's negotiated rate exceeds any applicable Copayment for which You are responsible.

Deductible - the dollar amount each Member must pay each Calendar Year before the Plan pays Benefits. Deductible amounts are limited to the Maximum Allowed Amount.

Coinsurance - the percentage of the Maximum Allowed Amount that You pay after Your Deductible is met.

V. Limitations

In addition to the limitations and exclusions stated in Your Subscriber Certificate, the following limiations apply to Benefits under this Rider.

You may purchase up to a 90-day supply of a covered prescription drug at one time, provided that the drug is a Covered Service, the quantity is ordered by Your physician and the drug does not require Prior Authorization from Anthem.

- Law regulates supplies of controlled substances. To be eligible for Benefits, they must be purchased at a retail pharmacy. They cannot be purchased from the mail service pharmacy.

- Benefits are available for Medically Necessary routine patient care costs incurred during Your treatment in accordance with phases I, II, III and/or IV of a qualified clinical trial for cancer or any other life-threatening condition. For the purposes of this Rider, routine patient care costs are services that would be Covered Services if You were receiving non-investigational treatment instead of treatment during a qualified clinical trial.

  Coverage for routine patient care costs during phase I or II of a clinical trial will be decided by Anthem on a case by case basis. The appeal procedure outlined in Your Certificate is available if You disagree with Anthem's decisions about coverage. Please see Your Subscriber Certificate for more information.

- Benefits are available for drugs prescribed for off-label use if recognized for treatment of the indication in one of the standard reference compendia; or in the medical literature, as recommended by current American Medical Association policies. However, No Benefits are available for a drug prescribed for off-label use if the FDA has determined its use to be contraindicated for the prescribed use.

- **Certain prescription drugs (or the prescribed quantity of a particular drug) require Prior Authorization.**

  Network Pharmacies are notified about drugs that require Prior Authorization at the time You fill Your prescription. Network pharmacist may contact Anthem's Pharmacy Benefits Management at 1-800-338-6180.

  If Your physician has not obtained Prior Authorization and he/she is not available at the time of dispensing, the network pharmacists will contact Anthem's Pharmacy Benefits Management. If clinical information is <u>not</u> required to fill Your prescription, the authorization will be approved.

  If Your physician has not obtained Prior Authorization and he/she is not available at the time of dispensing, the network pharmacists will contact Anthem's Pharmacy Benefits Management. If clinical information is required, Your prescription may not be immediately filled. Anthem's Pharmacy Benefits Management will contact the prescribing physician and respond to Your physician within 48 hours of receipt of the supporting clinical rationale.

  Out-of-Network Pharmacies are not notified about drugs that require Prior Authorization. If Anthem's Pharmacy Benefits Management determines that clinical information is required, Your prescribing physician will be required to submit supporting clinical information before Your claim can be processed. Anthem will respond to Your physician within 48 hours of receipt of the clinical information.

  Important Note: The authorization of a prescription drug does not modify the prescription drug tier list. Inclusion of a drug or related item on the prescription drug tier list is not a guarantee of coverage. Coverage is subject to all of the terms of Your Subscriber Certificate and this Rider. The appeal procedure outlined in Your Subscriber Certificate is available if You disagree with Anthem's Prior Authorization decision.

  A *Prescription Drug Program* flyer was issued with Your Certificate. For the most current information about drugs requiring Prior Authorization, please call Anthem's Customer Service for assistance. The toll free telephone number is listed on Your identification card. Or, call Anthem at 1-800-874-7122, or visit Anthem's website www.anthem.com.

VI. Exclusions

In addition to the limitations and exclusions stated in Your Subscriber Certificate, no Benefits are available under this Rider for:

- Prescriptions taken by or administered to a Member in any Outpatient setting (except as stated in this rider); Prescriptions taken by or administered to a Member who is a patient in a licensed hospital, nursing home, sanitarium or similar institution, or charges for such administration.

- Appetite suppressants, anorectics, or any drug used for the purpose of weight management

- Vaccines, toxoids (substance used to produce immunity such as tetanus toxoids)

- Biologicals, blood or blood plasma, plasma expanders or proteins
- Cosmetic agents or medications used for cosmetic purposes
- Prescriptions that are not approved by the FDA for clinical use
- Nonlegend (over-the-counter) prescriptions, including:
    - prescriptions for which there is an over-the-counter (OTC) therapeutic equivalent,
    - vitamins or other dietary substances that do not require a prescription by law,
    - supplies that can be used for non-medical purposes, such as alcohol or alcohol wipes, and
    - homeopathic products or herbal remedies.
- Replacement prescriptions resulting from loss, theft, or damage
- Compounded Prescription Legend Drugs without ingredients requiring a prescription order
- Therapeutic devices or appliances, support garments and non-medical substances regardless of intended use, including non diabetic needles and syringes. Please see Your Subscriber Certificate for more information about Benefits for some of these items.
- Prescription refills that exceed the physician's order or refills dispensed after one year from the physician's original order.
- Prescription legend and nonlegend drugs, medications, supplies, devices or any other services to eliminate or reduce dependency on, or addiction to tobacco and tobacco products.
- Any prescription that is not Medically Necessary, as defined in Your Subscriber Certificate.
- Fertility hormones and fertility drugs.

VII. Definitions

Brand Drug means a prescription that is marketed under its trade name.

Generic Drug means a prescription that is chemically and therapeutically equivalent to a Brand name product.

Maximum Allowed Amount. For prescription drugs, the Maximum Allowed Amount is the amount determined by Anthem using prescription drug cost information provided by Anthem's Pharmacy Benefits Management (PBM).

Network Pharmacy means a pharmacy that has a written agreement with Anthem's Pharmacy Benefits Management to provide Covered Services to Members. Network Pharmacies accept Anthem's Maximum Allowed Amount as payment in full for Covered Services.

Out-of-Network Pharmacy means a pharmacy that does not have a written agreement with Anthem's Pharmacy Benefits Management to provide Covered Services to Members.

Prescription Legend Drug, Prescription Drug, or Drug means a medicinal substance that is produced to treat illness or injury and is dispensed to Outpatients. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that states, "Caution: Federal law prohibits dispensing without a prescription." Compounded (combination) medications, which contain at least one such medicinal substance, are considered to be Prescription Legend Drugs. Insulin is considered a Prescription Legend Drug under this Rider.

Over the counter drugs that are recommended by the U.S. Preventive Services Task Force (USPSTF) as Preventive Services are considered Prescription Legend Drugs.

Prior Authorization means the process of obtaining authorization for services or certain covered drugs that have been approved by the Food and Drug Administration (FDA) for specific medical conditions by reviewing related documentation, verifying benefits and medical necessity to assure the service is a Covered Service and is Medically Necessary. These services are reviewed to make You are getting the appropriate treatment regimens based on medical guidelines to assure the highest quality outcome for You and decreasing costs without compromising the quality of care. The approval criteria was developed and endorsed by the Anthem Pharmacy and Therapeutics Committee and is based on information from the FDA and manufacturers, medical literature, actively practicing consultant physicians and appropriate external organizations.

VIII. About the Pharmacy Benefits Management

Anthem contracts with a Pharmacy Benefits Management to manage the pharmacy Benefits available under this Rider. The Pharmacy Benefits Management has a nationwide network of retail pharmacies and mail order pharmacies.

The Pharmacy Benefits Management has established a National Pharmacy &Therapeutics Committee which consists of health care professionals, including nurses, pharmacists, and physicians. The purpose of this committee is to assist in determining clinical appropriateness of drugs; determining whether a drug should be included in Anthem's Formulary; determining the tier assignments of drugs; and advising on programs to help improve care. Such programs may include, but are not limited to, drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and drug profiling initiatives.

Pharmacy services - Pharmacy services include, but are not limited to: providing clinical pharmacy management services, making recommendations to and updating the prescription drug tier list, formulary, managing a network of retail pharmacies and operating the mail order pharmacy services. In consultation with Anthem, the Pharmacy Benefits Management provides services to promote and enforce the appropriate use of pharmacy Benefits, such as review for possible excessive use; recognized and recommended dosage regiments; optimization of medication therapy; drug interactions or drug/pregnancy concerns.

You may review a copy of the most current prescription drug tier list on Anthem's website www.anthem.com. You may also request copies of these materials by calling Anthem's Customer Service. The toll free telephone number is listed on Your identification card. Or, You may call Anthem at 1-800-874-7122. The prescription drug tier list is subject to periodic review and amendment. Inclusion of a drug or related item is not a guarantee of coverage.

Maura Carroll
Executive Director
Local Government Center HealthTrust

Lisa M. Guertin
President and General Manager
Anthem New Hampshire

HealthTrust

DELTA DENTAL

Outline of Benefits

This Outline of Benefits describes the level of coverage under your employer's HealthTrust Dental Plan for services performed by dentists who participate in the Delta Dental PPO and Delta Dental Premier networks. Employees and their eligible dependents are free to visit *any* dentist, participating or nonparticipating. Visit Northeast Delta Dental's Web site at *www.nedelta.com* for an updated list of participating dentists. Your employer's HealthTrust Dental Plan includes all of the following coverage categories. This information is provided for summary purposes only; certain benefit limitations may apply. Please refer to your Dental Plan Description available at *www.healthtrustnh.org* – log on to the secure coverage section, then click on the "HealthTrust Dental Coverage" link in the purple "Learn More" box located in the lower right-hand corner of the screen. In the event of a conflict or discrepancy between this Outline of Benefits and either the Plan Document or the Dental Plan Description, the Plan Document or the Dental Plan Description will prevail.

Dental Plan Option 1

Coverage A Diagnostic/Preventive	Coverage B Basic	Coverage C Major	Coverage D Orthodontics
Deductible: None	**Deductible**: $25 Per Person, Per Year ($75 Per Family)		**Deductible: None**
Covered at * 100%	**Covered at * 80%**	**Covered at * 50%**	**Covered at * 50%**
Diagnostic: Evaluations - twice in a calendar year X-rays - complete series or panoramic film once in a 3-year period; bitewing x-rays - once in a calendar year; x-rays of individual teeth as necessary Oral cancer screening/brush biopsy - once in a calendar year, no age limit **Preventive:** Cleanings (routine and/or periodontal) - four per calendar year Fluoride - twice in a calendar year through age 18 Space maintainers - through age 15 Sealant application to permanent molars - once in a 3-year period per tooth, for children through age 18	**Restorative:** Amalgam (silver) fillings and/or Composite (white) fillings (anterior and posterior teeth) **Oral Surgery:** Surgical and routine extractions **Endodontics:** Root canal therapy **Periodontics:** Periodontal cleaning (maintenance procedures - routine and/or periodontal) - four per calendar year Treatment of gum disease Clinical crown lengthening **Denture Repair:** Repair of a removable denture to its original condition **Emergency Palliative Treatment**	**Prosthodontics:** Removable and fixed partial dentures (bridge); complete dentures Rebase and reline (dentures) Crowns Onlays Implants	**Orthodontics:** Correction of crooked teeth for dependent children through the end of the month in which the child turns 19
Calendar Year Maximum: $1,000 per person (Coverages A, B and C combined) beginning each January 1st			**Orthodontic Lifetime Maximum:** $1,000 Per Person

***Benefit percentages shown are based upon the actual charge submitted to a maximum of the participating dentist's approved fees, or Delta Dental's allowance for non-participating dentists.**

Rev. 10/13

Delta Dental PPO and Delta Dental Premier Dentist Networks

You'll get the best value from your Plan when you receive your dental care from a Delta Dental PPO participating dentist who generally accepts lower fees for services. You may also choose to visit a dentist who participates in the larger Delta Dental Premier network and still enjoy savings. Nearly 3 out of 4 dentists in the country participate in the Delta Dental Premier network. Participants enjoy:

▲ **No balance billing:** Because participating dentists accept Delta Dental's approved amount for service, you will normally pay less when you visit a participating dentist.
▲ **No claim forms:** Participating dentists will prepare and submit claim forms for you.
▲ **Direct payment:** Northeast Delta Dental pays the dentist directly, so you don't have to pay the covered amount up-front and wait for a reimbursement check.

To find out if your dentist is part of the Delta Dental PPO or Delta Dental Premier network, call your dentist or visit Northeast Delta Dental's Web site at ***www.nedelta.com***. Click on Find a Dentist, then Local or National Dentist Directory. You can also call Northeast Delta Dental's Customer Service Department at 800.832.5700 or 603.223.1234.

Claim Submission Process

Participating Dentists
▲ Present your ID card to the dentist at the time of your visit.
▲The dentist will submit your claim to Northeast Delta Dental.
▲ Northeast Delta Dental will send you a Explanation of Benefits detailing what has been processed under your Plan's coverage. You are responsible to pay any remaining balance directly to the dentist.

Nonparticipating Dentists
Your Plan provides coverage regardless of the patients' choice of dentists, participating or not. When visiting a nonparticipating dentist within the Northeast Delta Dental operating area of Maine, New Hampshire and Vermont, payment for services rendered will be based on the lesser of the dentist's actual submitted charge or Delta Dental's allowance for nonparticipating dentists. The patient may be required to submit the claim directly and pay for the services at the time they are provided. The Explanation of Benefits and the claim payment will go to the subscriber; the patient will be responsible for any remaining balance. (In Maine, the claim payment will go to the subscriber unless a valid assignment of benefits has been received).

When visiting a nonparticipating dentist outside the Northeast Delta Dental operating area, payment for services rendered will be based on the lesser of the dentist's actual submitted charge or an amount equal to a selected percentile of a nationally-recognized database for the area in which the services were provided. The patient may be required to submit the claim directly and pay for the services at the time they are provided; the patient will be responsible for any remaining balance. The Explanation of Benefits will go to the subscriber. The claim payment will go to the dentist unless the claim is marked "paid," otherwise it will be sent to the subscriber. (In Maine, the claim payment will go to the subscriber unless a valid assignment of benefits has been received).

Predetermination of Benefits

Northeast Delta Dental strongly encourages predetermination of cases involving costly or extensive treatment plans. Although it's not required, predetermination helps avoid any potential confusion regarding your Plan's payment and your financial obligation to the dentist.

Coordination of Benefits

When a covered individual under this Plan has additional group dental coverage, the Coordination of Benefits provision described in your Dental Plan Description will determine the sequence and extent of payment. If you have any questions, please contact Delta Dental's Customer Service department at 800.832.5700 or 603.223.1234.

Identification Card

Upon your initial enrollment in a HealthTrust Dental Plan, two identification cards from Delta Dental will be produced and distributed. Both cards are issued in the subscriber's name, but can be used by everyone covered under the Plan.

Dental Plan Description

The Dental Plan Description describes the benefits of your Plan and tells you how to use your Plan. You can access your Dental Plan Description by going to ***www.healthtrustnh.org*** – log on to the secure coverage section, then click on the "HealthTrust Dental Coverage" link in the purple "Learn More" box located in the lower right-hand corner of the screen. Please review this document in order to understand the benefits and provisions of your employer's HealthTrust Dental Plan.

Who is Eligible

All eligible employees and their eligible dependents, generally defined as:

- Spouse;
- Dependent children from age 2 to age 26;
- Unmarried incapacitated dependent children, age 26 or older.

Please refer to the Dental Plan Description for additional information regarding dependent eligibility.

Eligibility or Benefits Questions

If you have questions regarding eligibility or benefits, please contact your employer or HealthTrust Enrollee Services at 800.527.5001.

Claims Questions

If you have further questions, please contact Northeast Delta Dental's Customer Service department at 800.832.5700 or 603.223.1234.

This Outline of Benefits should be used only as a guideline for your dental plan coverage. For detailed information on your Plan's terms, conditions, limitations, exclusions and guarantees, please refer to your Dental Plan Description or consult your employer.

Dental

Plan Description

for Benefits Provided by HealthTrust

HealthTrust

DELTA DENTAL®

Northeast Delta Dental

INTRODUCTION AND GENERAL INFORMATION

HealthTrust would like to welcome you to the growing number of people receiving dental benefits through our Dental Care programs. As an additional employee benefit, your employer is providing you with a Dental Care program. Coverage under the program is provided by HealthTrust, Inc. ("HealthTrust"), while Delta Dental Plan of New Hampshire ("Delta Dental") administers the program and pays the claims.

This booklet describes the terms and conditions of coverage and Benefits under your employer's HealthTrust Dental Plan ("the Plan"). Please read the booklet carefully so that you will understand how to obtain Benefits under the Plan. But, before you turn the page, we would like you to know some of the reasons we selected Delta Dental as our Claims Administrator.

- Delta Dental is a not-for-profit organization established and supported by Dentists to make more Dental Care available to the general public.
- Northeast Delta Dental is affiliated with a national association known as Delta Dental Plans Association which provides Dental Care programs in all states and U.S. territories.

Delta Dental PPO and Delta Dental Premier Dentist national networks

Delta Dental is affilliated with a national association known as Delta Dental Plans Association which provides dental care programs in all states and U.S. territories.

A substantial majority of Dentists nationwide participate with Delta Dental through Participating Dentist Agreements. The Participating Dentist networks under the Plan include both the Delta Dental PPO and Delta Dental Premier networks. These networks are available to you.

You will receive the best value under the Plan when you visit a Delta Dental PPO Dentist. Delta Dental PPO dentists are part of a more limited network of Participating Dentists who offer lower fees to their Delta Dental PPO patients. You also receive benefits under the Plan when you choose to visit Delta Dental Premier dentists who are part of a more broad-based network of Participating Dentists and whose fees may be higher than those of the Delta Dental PPO dentists. Delta Dental PPO and Delta Dental Premier dentists agree not to charge patients for dental fees which exceed those filed and accepted by Northeast Delta Dental.

The Outline of Benefits (provided to you upon initial enrollment) provides details about the Plan offered by your employer, including the types of dental Benefits for which you are eligible. You can also obtain a copy of the Outline of Benefits by contacting HealthTrust or Delta Dental at the numbers listed below.

HealthTrust has sole and exclusive discretion in interpreting the Benefits provided under the Plan and the other terms, conditions, limitations, and exclusions set out in the Plan Document and this Dental Plan Description, and in making factual determinations related to the Plan and its Benefits. HealthTrust may, from time to time, delegate discretionary authority to Delta Dental or other persons or entities providing services in regard to the Plan. HealthTrust reserves the right to change, interpret, modify, withdraw, or add Benefits to this Plan without prior notice to or approval by you or your employer. HealthTrust further reserves the right, at its discretion at any time, to terminate this Plan by giving advance notice of at least 30 days to your employer.

The legal documents governing the Plan consist of the Plan Document and this Dental Plan Description. Any change or amendment to the Plan, its Benefits or its terms and conditions, must be made solely in a written amendment to the Plan, signed by an authorized representative of HealthTrust. No person or entity has any authority to make any oral changes or amendments to the Plan.

This Dental Plan Description is intended to be an easy-to-read summary of the Benefits of the Plan. It is subject to, and superseded by the Plan Document. For a complete description of Benefits and the terms and conditions of coverage under the Plan, you may obtain a copy of the Plan Document from your employer.

If you have any questions about your Plan, please check with your employer or call or write to HealthTrust or Delta Dental at the locations listed below. All correspondence with HealthTrust or Delta Dental should include your employer's name and number, your identification number and your telephone number.

HealthTrust:
HealthTrust
25 Triangle Park Drive
P.O. Box 617
Concord, NH 03302-0617
603.224.7447
800.527.5001

Delta Dental:
Delta Dental Plan of New Hampshire
One Delta Drive
P.O. Box 2002
Concord, NH 03302-2002
603.223.1234
800.832.5700

I. DEFINITIONS

1. **Anniversary Date** means the first day of your Participating Group's Plan Year (either January 1 or July 1).
2. **Benefits** means the classifications of covered Dental Care referred to in this Dental Plan Description (including the Outline of Benefits) and the Plan Document which are to be rendered to Eligible Persons enrolled in the Plan.
3. **Claims Administrator** means Delta Dental Plan of New Hampshire to whom claims administration of the Plan has been assigned.
4. **Co-payment** means the amount of the Dental Care cost that the Eligible Person is required to pay as specified in the Outline of Benefits.
5. **Deductible** means the portion of the charge for covered Dental Care which you (the Subscriber) or an Eligible Dependent must pay before the Plan's liability begins as specified in the Outline of Benefits.
6. **Delta Dental** means the Delta Dental Plan of New Hampshire.
7. **Dental Care** means dental services ordinarily provided by Dentists for diagnosis or treatment of dental disease, injury, or abnormality based on valid dental need in accordance with accepted standards of dental practice at the time the service is rendered.
8. **Dental Group Application (or Application)** means the form that must be completed, signed, and submitted by you and your employer to HealthTrust. An applicant is enrolled for Benefits under the Plan only upon acceptance of the Dental Group Application by HealthTrust. This form is also used to notify HealthTrust of changes in enrollment information.
9. **Dental Plan Description (or DPD)** means this document. The Dental Plan Description together with the Plan Document form the terms and conditions under which Delta Dental will administer your dental Benefits program.
10. **Dentist** means a person duly licensed to practice dentistry in the state in which the Dental Care is provided.
11. **Dependent** means a person who may be enrolled for Benefits under the Plan as described in Section II, ELIGIBILITY/ENROLLMENT/TERMINATION/CONTINUATION OF BENEFITS, of this Dental Plan Description.
12. **Eligible Dependents** means those Dependents who meet the eligibility criteria and who are properly enrolled for coverage under the Plan as described in Section II of this Dental Plan Description.
13. **Eligible Persons** means you, the Subscriber, and your Eligible Dependent(s) who are enrolled for coverage under the Plan as described in Section II of this Dental Plan Description and the Outline of Benefits.
14. **Full-Time Student** means a Dependent child who is enrolled and attending a public or private institute of higher learning on a full-time basis (as defined by the school). The Dependent student is considered to be a Full-Time Student during periods of vacation established by the school, unless the student terminates Full-Time Student status immediately following the period of vacation.
15. **HealthTrust** means HealthTrust, Inc., a New Hampshire voluntary corporation.
16. **Maximum** means the maximum dollar amount the Plan will pay in any Plan Year (or lifetime for orthodontic Benefits) for covered Benefits as specified in the Outline of Benefits.
17. **Non-Participating Dentist** means a Dentist who has not signed a participating agreement with Northeast Delta Dental or another Delta Dental company.
18. **Northeast Delta Dental** means the association of Delta Dental Plans of Maine, New Hampshire and Vermont, collectively known as Northeast Delta Dental.
19. **Outline of Benefits** means the document provided to you upon initial enrollment which describes the specific dental Benefit coverage options, and terms and conditions of coverage available under the Plan selected by your employer.

20. **Participating Dentist** means a Dentist whose current fees are filed with and/or accepted by Northeast Delta Dental, and who has signed a participating agreement with Northeast Delta Dental. A Participating Dentist will abide by such uniform rules and regulations as are from time to time prescribed by Northeast Delta Dental. A Dentist who has signed a participating agreement with a Delta Dental company in another state is also a Participating Dentist.

21. **Participating Group (or your employer)** means your employer that is a participating member of HealthTrust and has elected to provide dental coverage under the Plan.

22. **Plan** means the Participating Group's HealthTrust Dental Plan as described in the Plan Document and this Dental Plan Description.

23. **Plan Document** means the comprehensive description of dental Benefits available under the Plan.

24. **Plan Yea**r means the twelve (12) month period selected by your employer during which Eligible Persons may receive Benefits under the Plan as specified in the Outline of Benefits.

25. **Predetermination** means an administrative procedure where the Dentist submits the treatment plan to Delta Dental in advance of performing Dental Care. Delta Dental recommends that you ask your Dentist to request Predetermination of proposed services, which are considered to be other than brief or routine. Predetermination provides an estimate of what your Plan will pay for the services, which helps avoid confusion and misunderstanding between you and your Dentist.

26. **Probationary Period** means the period of time as determined by your employer before you become eligible for Benefits under the Plan.

27. **Processing Policies** means the policies approved by Delta Dental, as may be amended from time to time, to be used in processing treatment plans for Predetermination of Benefits and for payment.

28. **Selected Benefits** means the specific coverage options selected by your employer as specified in the Outline of Benefits.

29. **Selected Percentage** means the percentage amount of charges for Selected Benefits which the Plan will pay as specified in the Outline of Benefits.

30. **Subscriber (or you)** means you, an employee or retiree who satisfies the eligibility criteria established by your employer and HealthTrust, and who is properly enrolled for coverage under the Plan as described in Section II of this Dental Plan Description.

II. ELIGIBILITY/ENROLLMENT/TERMINATION OF COVERAGE/CONTINUATION OF COVERAGE

(A) ELIGIBILITY

Your employer may choose to have either Employee Only (no Dependent coverage), or Employee and Dependents coverage. If Dependent coverage is offered and you elect to cover your eligible Dependents, you must enroll all of your eligible Dependents who are under 19 years of age (who do not otherwise have dental coverage) and keep them enrolled for the term of each Plan Year unless there is a qualified family status change (as described later in this Section II).

You and your Dependents are eligible to enroll in the Plan only if you meet all applicable eligibility requirements, including any Probationary Period established by your employer. For details regarding your employer's eligibility requirements, see the Outline of Benefits or ask your employer.

NOTE: By accepting coverage under the Plan, you represent that all statements made in your Dental Group Application, or any other documentation that you provide with respect to your and your Dependent's eligibility and enrollment, are true to the best of your knowledge and belief. You must give your employer or HealthTrust information upon request that HealthTrust deems necessary to verify coverage eligibility. Examples of documentation that HealthTrust may need to decide membership eligibility are information regarding: Dependent child status, incapacitated child status, marital status, divorce, legal separation, adoption or court orders regarding health care coverage for Eligible Dependent children.

HealthTrust reserves the right to retroactively cancel an Eligible Person's coverage under the Plan if you fail to provide verification upon request or misrepresent the eligibility status of you or any of your Dependents.

1. **Eligible Employee**

   You are eligible to enroll as a Subscriber on the first day of the calendar month following the date determined by your employer and HealthTrust provided that you:

   (a) have satisfied any applicable Probationary Period; and

   (b) are certified as being an eligible employee or retiree.

2. **Eligible Dependents (if Dependent Coverage is Offered by Your Employer)**

   You may enroll the following persons as Dependents provided that Dependent coverage is offered by your employer:

   (a) **Your Spouse.** Your spouse is eligible to enroll unless you are legally separated. Throughout this DPD, any reference to your "spouse" means:

      i. the individual to whom you are lawfully married, as recognized under the laws of the state where you live, or

      ii. the individual with whom you have entered into a lawful civil union as recognized under laws that provide same gender couples in lawful civil unions with the same rights, responsibilities and obligations as afforded to lawfully married couples.

   Throughout this DPD any reference to "marriage" means a lawful marriage or lawful civil union. References to legal separation apply to marriage and civil union legal separations. References to divorce apply to the termination of a marriage or civil union.

   Coverage is available for same-sex or opposite-sex domestic partners (including "common law" type relationships and other unmarried couples) **only if** your employer has purchased a Domestic Partner Rider and **only if** all of the criteria for domestic partner status and eligibility are met, as stated in the Rider.

   (b) **You (or your spouse's) child who is:**

      i. at least 2 and under 26 years of age whether married or unmarried; or

      ii. An unmarried incapacitated dependent who is 26 years of age or older and physically or mentally incapable of self-support (as certified by a physician), when coverage would otherwise end because the child no longer meets any of the eligibility criteria outlined above.

The physical or mental incapacity must have occurred before the child reached age 26 and must have occurred while the Dependent was a covered Dependent child. Incapacitated Dependents may remain covered as long as their disability continues and as long as they are financially dependent on you and are incapable of self-support. HealthTrust must receive an Application for the incapacitated Dependent child status and medical certification of the incapacity by a physician within 31 days of the date coverage would otherwise end for the child. HealthTrust must approve a Dependent child's incapacitated status and may periodically request that the incapacitated status of the child be recertified.

In addition, a newborn child will be covered for the initial 31-day period following birth at no additional premium. Coverage may resume on the first day of the month following the child's second birthday if the child is properly enrolled at that time.

Definition of a Child

As used above, the term "child" means:

i. a natural child or a stepchild who is dependent upon you for support;

ii. a legally adopted child, or a child who has been placed for adoption with you or your spouse. (For this purpose, "placed for adoption" means that the child has been placed in the custody of you or your spouse pursuant to an adoption proceeding under the provisions of NH Revised Statutes Annotated 170-B before the adoption becomes final);

iii. a child for whom you or your spouse has been appointed the permanent legal guardian by court order; or

iv. a child otherwise required to be enrolled under the Plan by federal or state law or by court order.

A foster child or grandchild is not eligible for coverage as a Dependent unless the child meets the definition of "child" above.

(B) ENROLLMENT

If you have satisfied the eligibility requirements described in the preceding section, you may enroll yourself and all eligible Dependents by submitting a Dental Group Application to your employer within 31 days from the date you first satisfy your Probationary Period. An applicant is considered enrolled only upon acceptance of the Dental Group Application by HealthTrust. Provided that HealthTrust receives your Dental Group Application within 31 days of the date you first satisfy any applicable Probationary Period, coverage will be effective as of the first day of the calendar month following your eligibility date. If the Dental Group Application is received by HealthTrust after 31 days but within 60 days from the date you first satisfy any applicable Probationary Period, your coverage will become effective the first of the month following receipt of the application.

If you do not enroll yourself or your Dependents within 60 days after you first become eligible under the Plan, you may not enroll at a later date, except during an open enrollment period, a special enrollment period or in the event of a "qualified family status change" (as described later in this section).

NOTE: You and all your enrolled Dependents must remain enrolled throughout the Plan Year and may be removed only during an open enrollment period, except in the event of a qualified family status change.

1. **Open Enrollment Period.** There will be an "annual open enrollment period" during the 60 days prior to, and during the month which includes, your employer's Anniversary Date each year. If the Dental Group Application is received by HealthTrust on or before the last day of the annual open enrollment period, coverage will become effective on the Anniversary Date. If, however, the Dental Group Application is not received by the end of the annual open enrollment period, the requested enrollment may not be made until the next open enrollment period. Special open enrollment periods maybe allowed at the sole discretion of HealthTrust.

2. **Special Enrollment Period.** A special enrollment period will be offered to you and/or your eligible Dependents in the following circumstances:

   (a) **Involuntary Loss of Other Insurance Coverage**

   If you decline enrollment for yourself and/or your eligible Dependents when initially eligible or during an annual open enrollment because of coverage under another group dental plan or dental insurance, you will be permitted to enroll yourself and/or your Dependents in the Plan within 31 days after an involuntary loss of such other insurance coverage. For this purpose, an "involuntary loss" of other insurance coverage means (i) if the other coverage is COBRA continuation coverage, such COBRA coverage has been

exhausted, or (ii) if the other coverage is not COBRA continuation coverage, the coverage has been terminated as a result of loss of eligibility (other than loss due to failure to pay premiums on a timely basis or termination of coverage for cause), or employer contributions towards the other coverage have been terminated.

(b) **New Dependents**

If you previously declined enrollment upon initial eligibility or during an annual open enrollment period and you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you will be permitted to enroll yourself and your Dependents in the Plan within 31 days after the marriage, birth, adoption, or placement for adoption.

You and any Dependents who become eligible for enrollment pursuant to these Special Enrollment provisions may enroll in the Plan by submitting a completed Dental Group Application in accordance with the above timeframes and the terms and conditions for enrollment set forth in the following section. Coverage of such individual(s) will become effective in accordance with that section and the applicable event allowing for special enrollment.

(c) **Loss of Coverage, or Becoming Eligible for Premium Assistance, under Medicaid or a State's Children's Health Insurance Program.**

If you and/or your Dependent(s) are eligible but not enrolled under the Plan, you may enroll during the Plan Year in either of the following situations:

i. You or your Dependent loses coverage under a Medicaid plan (under title XIX of the Social Security Act) or under a State Children's Health Insurance Plan (under title XXI of the Social Security Act) due to loss of eligibility for such coverage; or

ii. You or your Dependent becomes eligible for state funded group health plan premium assistance with respect to this Plan through a state Medicaid or Children's Health Insurance Program.

You must request enrollment under the Plan by submitting a completed Dental Group Application within 60 days of the date the other coverage is lost or the date you or your Dependent is determined to be eligible for premium assistance (whichever is applicable). Coverage for you and/or your Dependent(s) will become effective as of the first of the month following the date coverage is lost or the date of your Dependent(s) eligibility for premium assistance.

3. **Changes in Enrollment upon Qualified Family Status Changes**

You may enroll or remove Dependents and/or change coverage type during a Plan Year provided that such change is due to and consistent with a qualified family status change. A "qualified family status change" includes:

(a) your marriage, divorce, or legal separation;

(b) adoption, placement for adoption or a change in legal custody of a child who is at least two years of age, or a change in a child's eligibility under SECTION II (A) 2 (b);

(c) death of your spouse or a Dependent child;

(d) a change in employment status of you or your spouse that affects dental benefits coverage (e.g., termination or commencement of employment, a change from part-time to full-time status or vice versa, an unpaid leave of absence, a strike or lockout); or

(e) a significant change in your dental plan cost or coverage, or that of your spouse's, relating to you or your spouse's employment status or coverage;

(f) your spouse's employer holds open enrollment at a time other than your employer – and, as a result of its benefit offerings you would like to make a change and your employer recognizes this as a qualified change in status); or

(g) your or your Dependents involuntary loss of, or becoming newly eligible for, other dental insurance coverage.

You may enroll or remove Dependents and/or change coverage type by submitting a Dental Group Application to your employer within 31 days of the qualified family status change. The Application must include any requested change in coverage type. If a Dental Group Application

requesting to enroll Dependent(s) and/or to change coverage type is received by HealthTrust within 31 days of a qualified family status change, the requested change(s) will take effect on the first of the month following the date of the event. If the Dental Group Application is not received by HealthTrust within the 31 days but is received within 60 days from the date of the qualified family status change event, the requested change will become effective the first of the month following receipt of the Dental Group Application. If a request is not made within 60 days, coverage of Eligible Dependents and coverage type may not be changed until the next open enrollment or special enrollment period.

4. **Retroactivity Limit on Additions or Removal of Enrolled Dependents**

You must request any desired change in coverage type and must promptly notify your employer and HealthTrust of any Dependent(s) to be added to or removed from coverage under the Plan. HealthTrust is not responsible for automatically changing your coverage type or adding or removing Dependents upon a qualified family status change event. Except as otherwise provided for in this DPD and the Plan Document, additions or terminations of enrolled Dependents or changes of coverage type may not be made more than 31 days retroactively.

(C) TERMINATION OF COVERAGE

This section describes circumstances under which your coverage under the Plan will terminate. Whether or not you or your employer contacts HealthTrust to effect any of the terminations in this section, HealthTrust will administer the termination if HealthTrust has knowledge of the termination event. In no event are Benefits available for Dental Care rendered or delivered after the date coverage under the Plan terminates:

Subject to any right to continue coverage as described below under CONTINUATION OF COVERAGE, your (or your Eligible Dependents') coverage will automatically terminate on the earliest of the following dates:

1. The date HealthTrust ceases to offer any dental benefit plans to Participating Groups;
2. The date as of which your employer terminates its participation in the Plan;
3. The end of the month during which you or your Eligible Dependent(s) no longer meet the eligibility requirements for coverage under the Plan, or such other date as of which your employer notifies HealthTrust to terminate your coverage;
4. The date specified by HealthTrust that the your coverage will end because your employer failed to pay any required contribution for coverage under the Plan;
5. The date of your or your Eligible Dependent(s) enrollment if HealthTrust or the Claims Administrator determines that you have made a misrepresentation on the Dental Group Application or used fraud in obtaining or maintaining coverage under the Plan;
6. The date specified by HealthTrust that your employer failed to meet the Plan's or HealthTrust's requirements or other requirements for continued participation in the Plan or in HealthTrust; or
7. The date established by HealthTrust for other causes as permitted by law. Cause may include failure to disclose other dental plan coverage, fraud committed by an Eligible Person in connection with any claim filed under the Plan, or if an unauthorized person is allowed to use any Eligible Person's identification card or if an Eligible Person otherwise cooperates in the unauthorized use of such Eligible Person's identification card.

(D) CONTINUATION OF COVERAGE

1. **Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA** – COBRA is a federal law which requires the Participating Group to offer Eligible Persons ("qualified beneficiaries") the opportunity to continue group coverage under the Plan for a temporary period, at the Eligible Person's expense, when coverage would otherwise end because of certain "qualifying events." COBRA continuation rights under the Plan are available only through the Participating Group. HealthTrust assists the Participating Group with certain COBRA notice and other administrative requirements. Subscribers and covered spouses will receive a separate document, which describes the continuation rights in further detail, upon initial enrollment in the Plan.

2. **Qualifying Events** – Eligible Persons will become qualified beneficiaries if their coverage under the Plan would otherwise end due to one of the following qualifying events:

- Subscriber's hours of employment are reduced; or
- The Subscriber's employment ends for any reason other than gross misconduct.

Additionally, Eligible Dependents will become qualified beneficiaries if their coverage would otherwise end due to one of the following qualifying events:

- The Subscriber dies;
- The Subscriber divorces or legally separates;
- The Subscriber becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- In the case of an Eligible Dependent, he or she no longer meets the eligibility requirements for coverage under the Plan.

3. **Notices and Election Rights** – COBRA coverage is available under the Plan to qualified beneficiaries only after the Participating Group and HealthTrust have been notified that a qualifying event has occurred. The Subscriber or an Eligible Dependent who is a qualified beneficiary must notify the Participating Group within 60 days of the date coverage under the Plan would otherwise end due to divorce, legal separation or a child losing Dependent status. If the Subscriber or an Eligible Dependent fails to provide notice within this 60-day notice period, any Eligible Person who loses coverage will not be offered the right to elect continuation coverage.

   Once the Participating Group is notified of a qualifying event, the Participating Group must then notify HealthTrust. The Participating Group also must notify HealthTrust of other qualifying events including the Subscriber's death, termination of employment, reduction in hours of employment, or Medicare entitlement.

   After HealthTrust receives notice that a qualifying event has occurred, HealthTrust will provide notice to eligible qualified beneficiaries of their right to elect COBRA continuation coverage. Each qualified beneficiary will have an independent right to elect COBRA coverage and will have until the later of the following dates to make their election:

   - 60 days after the date their coverage would otherwise end due to the qualifying event; or
   - 60 days after the date the qualified beneficiary receives notice of the right to elect COBRA coverage.

   If COBRA coverage is not elected by the election deadline, all COBRA rights will be forfeited and no continuation coverage will be available to the qualified beneficiary.

4. **Nature and Duration of COBRA Coverage** – If a qualified beneficiary elects COBRA, the qualified beneficiary generally will receive the same coverage and enrollment rights as are provided to similarly situated active employees of the Participating Group and their family members.

   COBRA coverage is a temporary continuation of coverage under the Plan. The maximum period of COBRA coverage will depend on the nature of the qualifying event as follows:

   - ***18 months*** if the qualifying event is the Subscriber's termination of employment or reduction in hours of employment (the 18-month period may be extended to 29 months if a qualified beneficiary is determined to be disabled by the Social Security Administration at any time during the first 60 days of COBRA coverage); or
   - ***36 months*** if the qualifying event is the Subscriber's death, divorce or legal separation, Medicare entitlement, or a child losing Dependent status.

   Additional non-COBRA continuation period for former or surviving spouses – In addition to the maximum COBRA coverage period, the following continuation periods are available under the Plan:

   - If the qualifying event is divorce or legal separation and the former spouse is a qualified beneficiary age 55 or older at the time of the relevant court decree, the maximum continuation period will extend until the former spouse becomes eligible for coverage under another group dental plan or Medicare; or

- If the qualifying event is the Subscriber's death and the Subscriber's surviving spouse is a qualified beneficiary age 55 or older at the time of the death, the maximum continuation period will extend until the surviving spouse becomes eligible for coverage under another group dental plan or Medicare.

NOTE: The Plan does not provide additional continuation coverage rights to former spouses under NHRSA 415:18,VII-b.

COBRA coverage will terminate prior to the maximum coverage period upon certain termination events which apply under COBRA law. Eligibility for COBRA coverage under the Plan will end if your employer terminates participation in the Plan for its active employees.

5. **Cost of Continuation Coverage** – You and other qualified beneficiaries will be obligated to pay the full cost for COBRA or other continuation coverage unless your employer has other premium payment arrangements. An administrative fee as allowed by law may also apply. Specific information regarding the premium cost and payment terms for continuation coverage will be included in the COBRA election notice provided upon a qualifying event.

6. **Continuation of Coverage Due to Military Service (USERRA)** – In the event you are no longer actively at work because you are called to military service in the Armed Forces of the United States, you may elect to continue coverage for you and any Eligible Dependents under the Plan in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA). "Military service" means performance of duty on a voluntary or involuntary basis, and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

   You may elect to continue to cover yourself and any Eligible Dependents under the Plan. You may be obligated to pay the full premium cost (and any applicable administrative fee) for continuation coverage under the Plan. This may include the amount your employer normally pays on your behalf. If your military service is for a period of less than 31 days, you may not be required to pay more than the active employee contribution, if any, for the continuation coverage. If continuation is elected under this provision, the maximum period of continuation coverage under the Plan shall be the lesser of:

   - 24 months; or
   - Your period of military service (measured from the date the military service begins and ending on the day after the date on which you fail to apply for re-employment or return to employment with your employer).

   Whether or not you elect continuation coverage, if you return to employment with your employer, you and your Eligible Dependents' coverage under the Plan will be reinstated. No Probationary Period or exclusions may be imposed on you or your Eligible Dependents in connection with this reinstatement unless a sickness or injury is determined by the Secretary of Veteran Affairs to have been incurred in, or aggravated during, the performance of military service.

   For more information regarding COBRA and other continuation coverage rights and obligations, please contact your Group Benefits Administrator or HealthTrust, or refer to the COBRA information document provided to you upon initial enrollment. If you would like a current version of the COBRA initial notice, please contact HealthTrust.

7. **Availability of Individual Coverage** – When your group coverage under the Plan ends for any reason, including at the end of any continuation of coverage period, you may apply for an individual plan with Northeast Delta Dental. Individual policies will be subject to terms, conditions, and limitations set forth in the individual policy. Applications will be subject to Northeast Delta Dental's normal underwriting requirements. Application forms and information are available by calling Northeast Delta Dental at 800.537.1715, or accessing the information at www.nedelta.com.

III. HOW TO FILE A CLAIM

To Use Your Plan Follow These Steps:

1. Please read this Dental Plan Description carefully to familiarize yourself with the Benefits and provisions of your dental Plan.
2. You are assured of receiving full Benefits under the Plan if you visit a Participating Dentist. Ask your Dentist if he/she participates with Delta Dental; visit Northeast Delta Dental's website at **www.nedelta.com**; refer to your Delta Dental Participating Dentist Directory; or call Northeast Delta Dental for information.
3. When you visit your dental office, inform them that you are covered under a Delta Dental program and show your identification card. Your Dentist will perform an evaluation and plan the course of treatment. When the treatment has been completed, the claim form will be sent to Northeast Delta Dental for payment of covered services.
4. **For Participating Dentists:** Participating Dentists will have claim forms in their offices which they will submit directly to Northeast Delta Dental. A Participating Dentist will not charge you at the time of treatment for covered services, but may request payment for non-covered services, Deductibles or Co-payments. Northeast Delta Dental will pay Participating Dentists directly, based on the Dentist's submitted charges and filed fees. An Explanation of Benefits form will be sent to you which will indicate the amount you should pay, if any, to your Dentist.
5. **For Non-Participating Dentists within the Northeast Delta Dental operating area of Maine, New Hampshire and Vermont,** you may be asked to bring a claim form with you which is available by calling Northeast Delta Dental or may be downloaded from **www.nedelta.com**. Your dental office will either submit directly to Northeast Delta Dental, or they may ask you to submit the claim. Payment will be limited to the applicable Selected Percentage of the lesser of the Dentist's actual submitted charge or Delta Dental's allowance for Non-Participating Dentists located in the tri-state region. Payment will be made to you unless the state in which the services are rendered requires that assignments of Benefits be honored and Northeast Delta Dental receives written notice of an assignment on the claim form before payment for Benefits is made. Unless assignment of Benefits applies, you will be responsible for paying the Dentist both the payment you receive from Delta Dental and any remaining balance due.
6. **For Non-Participating Dentists Outside Maine, New Hampshire and Vermont,** you may be asked to bring a claim form which is available by calling Northeast Delta Dental or may be downloaded from **www.nedelta.com**. Your dental office will either submit directly to Northeast Delta Dental, or they may ask you to submit the claim. Payment will be limited to the applicable Selected Percentage of the lesser of the actually submitted charge or an amount equal to a selected percentile of a nationally recognized database of dental charges for the geographic area in which the services were provided. When there is not sufficient fee information available for a specific dental procedure, Northeast Delta Dental will determine an appropriate payment amount. Payment will be made to you unless the state in which the services are rendered requires that assignments of Benefits be honored and Northeast Delta Dental receives written notice of an assignment on the claim form before payment for Benefits is made. Unless assignment of Benefits applies, you will be responsible for paying the Dentist both the payment you receive from Delta Dental and any remaining balance due.
7. You or someone in the dental office must fill in the patient information portion of the claim form. Please be sure information is complete and accurate to ensure the prompt and correct payment of your claim.

Predetermination of Benefits

HealthTrust and Delta Dental strongly encourage Predetermination of cases involving costly or extensive treatment plans. Although it is not required, Predetermination helps to avoid any potential confusion regarding the Plan's payment and your financial obligation to the Dentist.

The Predetermination voucher reflects your Benefits based on the procedures and costs submitted by your dental office. Questions concerning Predetermination should be directed to Northeast Delta Dental's Customer Service Department at 800.832.5700 or 603.223.1234.

NOTE: Predetermination does NOT guarantee payment. Rather, Predetermination is an estimate of Benefits payable based on your current Plan Benefits. A new Plan Year and/or change in Benefits under the Plan may alter the final payment payable, because payment is based on information on file at the time treatment is provided (the date of service), which may be different than information available at the time the Predetermination estimate was given. Any changes in a Dentist's fee schedule or participating status may also affect the Plan's final payment.

IV. BENEFITS

Eligible Persons will be entitled to only those Benefits selected by your employer as listed in the Outline of Benefits. This Section IV outlines the various coverage categories of dental Benefits that can be selected under the Plan.

Coverage A - Diagnostic and Preventive Benefits

- Please refer to the Outline of Benefits for specific Benefit information.
- Only those coverage classifications selected by your employer will apply.
- Time limitations will be measured from the date the service was last performed.

Diagnostic:	Evaluation and radiographs (x-rays) to determine required dental treatment.
	Limited oral evaluations – problem focused.
	Oral evaluations – twice in a calendar year. This can be a comprehensive or periodic evaluation provided by a specialist or a general Dentist.
	Radiographs – a complete series or panoramic film (x-ray) once in any period of three (3) consecutive years; bitewing films (x-rays) once in a calendar year; and films (x-rays) of individual teeth as necessary.
	Oral cancer screening such as a brush biopsy once in a calendar year, no age limit.
Preventive:	Specific procedures employed to prevent the occurrence of dental disease.
	Prophylaxis (cleaning) up to four (4) times in a calendar year (child prophylaxis through age twelve (12), adult prophylaxis thereafter), as recommended by the Dentist. A prophylaxis can be routine (Coverage A) or periodontal maintenance under Coverage B - Basic Benefits.
	A full mouth debridement is covered once in a lifetime and, when performed, is counted towards your prophylaxis benefit.
	Fluoride treatment twice in a calendar year through age eighteen (18).
	Space Maintainers through age fifteen (15).
	Sealants through age eighteen (18).

Coverage A Exclusions and Limitations:

1. A panoramic film, with or without accompanying bitewings, is considered the same as a complete series and is paid as such.
2. Cone beam imaging is not a covered Benefit.
3. Sealant Benefit limitation:
   (a) Sealant Benefit is provided only to Eligible Dependents through age eighteen (18).
   (b) Sealant Benefit includes the application of sealants to caries-free (no decay) and restoration-free permanent molars only.
   (c) Sealant Benefit is provided no more than once per tooth in any period of three (3) consecutive years.
4. A limited oral evaluation, when done in conjunction with a procedure (other than radiographs) on the same visit, is considered a part of, and included in the fee for, the procedure. A limited oral evaluation-problem focused, when done with a procedure (other than radiographs) on the same visit, is not a covered Benefit. The patient is responsible for any separate fee.
5. One oral cancer screening procedure such as a brush biopsy is covered in a twelve (12) month period. Associated pathological laboratory fees for these services are not a covered Benefit. The patient is responsible for any separate fee.

6. Payment for additional periapical radiographs within a thirty-day (30-day) period of a complete series or panoramic film, unless there is evidence of trauma, is subject to a consulting Dentist's review. A Participating Dentist agrees not to charge a separate fee.

7. The replacement or repair of space maintainers is not a covered Benefit unless performed by a Dentist who did not perform the original placement.

8. Space maintainers are a covered Benefit for Eligible Dependents through age fifteen (15) when a space is being maintained for an erupting permanent tooth.

9. A prophylaxis, a full mouth debridement, or periodontal maintenance is essentially a duplication of services when provided on the same day of treatment as periodontal scaling and root planing. Payment is made for a periodontal scaling and root planing and a Participating Dentist agrees not to charge a separate fee.

Coverage B - Basic Benefits

- Please refer to the Outline of Benefits for specific Benefit information.
- Only those coverage classifications selected by your employer will apply.
- Time limitations will be measured from the date the service was last performed.

Restorative:

- Amalgam (silver) and/or resin (white) restorations (fillings).
- If Coverage C – Major Benefits is not offered, and unless otherwise specified in the Outline of Benefits, payment for restorative crowns and onlays will be at the selected Co-payment percentage specified in the Outline of Benefits for a four (4) surface amalgam restoration.

Oral Surgery: Extractions and covered surgical procedures.

Periodontics: Treatment of diseased tissue supporting the teeth and periodontal maintenance.

Prophylaxis (cleaning) up to four (4) times in a calendar year (child prophylaxis through age twelve (12), adult prophylaxis thereafter), as recommended by the Dentist. A prophylaxis can be routine under Coverage A - Diagnostic and Preventive Benefits or periodontal maintenance (Coverage B).

A full mouth debridement under Coverage A - Diagnostic and Preventive Benefits is covered once in a lifetime and, when performed, is counted towards your prophylaxis Benefit.

Endodontics: Pulpal therapy apicoectomies, retrograde fillings, and root canal therapy.

Denture Repair: Repair of a removable complete or partial denture to its original condition.

Clinical Crown Lengthening

Palliative Treatment: Minor emergency treatment for the relief of pain.

Anesthesia: General anesthesia or intravenous sedation, when administered in a dental office and in conjunction with: an extraction; tooth reimplantation; surgical exposure of a tooth; surgical placement of implant body (only when Coverage C - Major Benefits is specified in the Outline of Benefits); biopsy; transseptal fiberotomy; alveoloplasty; vestibuloplasty; incision and drainage of an abscess; frenulectomy and/or frenuloplasty.

General anesthesia will also be covered when administered in conjunction with procedures performed in the dental office for the following covered patients:

(a) A child under the age of six (6) who is determined by a licensed Dentist in conjunction with a licensed primary care physician to have a dental condition of significant complexity which requires the child to receive general anesthesia for the treatment of such condition; or

(b) A person who has exceptional medical circumstances or a developmental disability, as determined by a licensed physician, which place the person at serious risk.

Coverage B Exclusions and Limitations:

1. A prophylaxis, a full mouth debridement, or periodontal maintenance is essentially a duplication of services when provided on the same day of treatment as periodontal scaling and root planing. Payment is made for the periodontal scaling and root planing. A Participating Dentist agrees not to charge a separate fee.
2. Tooth preparation, bases, copings, sedative fillings, impressions, local anesthesia, or other services that are part of a complete dental procedure are considered components of, and included in the fee for, the complete procedure. A Participating Dentist agrees not to charge a separate fee.

3. Payment is made for one (1) restoration in each tooth surface irrespective of the number of combinations of restorations placed. A Participating Dentist agrees not to charge a separate fee.
4. Benefits are not paid for the replacement of an amalgam restoration within twelve (12) months of its placement or for a resin restoration within twenty-four (24) months of its placement.
5. Routine post-operative visits are considered part of, and included in the fee for, the total procedure. A Participating Dentist agrees not to charge a separate fee.
6. Periodontal scaling and root planing is a covered Benefit per quadrant once in any period of twelve (12) consecutive months. Benefits are paid for a maximum of two (2) quadrants per office visit.
7. Exploratory surgical services are not a covered Benefit. The patient is financially responsible.
8. An adjustment will be made for two (2) or more restoration surfaces which are normally joined together. A Participating Dentist agrees not to charge a separate fee.
9. Root canal therapy on a tooth is a Benefit once in any period of three (3) consecutive years.
10. An indirect pulp cap, when rendered at the same time as the final restoration, is considered a base and is not a Benefit when billed as a separate procedure. A Participating Dentist agrees not to charge a separate fee.
11. Clinical crown lengthening is a covered Benefit once per tooth per lifetime and only when performed in a healthy periodontal environment in which bone must be removed for placement of the restoration or crown.
12. Clinical crown lengthening is not a covered Benefit when performed on the same day as a crown preparation, restoration or osseous surgery. A Participating Dentist agrees not to charge a separate fee.
13. Clinical crown lengthening, when performed in conjunction with other periodontal procedures, will be subject to a consulting Dentist's review. Payment will be based on the most comprehensive procedure.
14. Recementation of a crown, inlay, onlay and/or partial restoration is a Benefit once in any period of twelve (12) consecutive months.
15. Recementation of a cast or prefabricated post and core is a Benefit once in any period of twelve (12) consecutive months.
16. Anterior deciduous root canal therapy is not a covered Benefit.
17. A partial pulpotomy is a covered Benefit on permanent teeth only.
18. A root canal or apexification procedure that is performed within thirty (30) days of a partial pulpotomy, and is performed by the same Dentist, will have the payment for the procedure reduced by the payment for the partial pulpotomy. A Participating Dentist agrees not to charge a separate fee.
19. Gingivectomy, gingival flap procedure, osseous surgery, bone replacement graft, distal wedge, or soft tissue graft procedure is a Benefit once in any period of three (3) consecutive years. A gingivectomy for the removal of hypoplastic tissue is not a covered Benefit unless diseased tissue is present.

NOTE: HealthTrust and Delta Dental strongly encourage Predetermination of cases involving costly or extensive treatment plans. Although it is not required, Predetermination helps to avoid any potential confusion regarding the Plan's payment and your financial obligation to the Dentist.

Coverage C - Major Benefits

- Please refer to the Outline of Benefits for specific Benefit information.
- Only those coverage classifications selected by your employer will apply.
- Time limitations will be measured from the date the service was last performed.

Restorative Crowns and Onlays:	Crowns and onlays when a tooth cannot be adequately restored with amalgam (silver) or resin (white) restorations.
Prosthodontics:	Fixed partial dentures (abutment crowns and pontics); removable complete and partial dentures, including rebase and reline of such prosthetic appliances; core buildups; cast and prefabricated post and cores; and fixed partial denture and crown repairs.
Implant Services:	Surgical placement of an endosteal implant body, including healing cap.
Implant Supported Prosthetics:	Crowns, fixed or removable partial dentures, and full dentures anchored in place by an implanted device.

Coverage C Exclusions and Limitations:

1. Onlays or crowns made of resin-based composite, porcelain, porcelain fused to metal, full cast metal, or resin fused to metal (where the metal is high noble metal, titanium, noble metal or predominantly base metal) are not Benefits for Eligible Dependents under the age of twelve (12).
2. Tissue conditioning is not a covered Benefit.
3. Coverage C - Major Benefits time limitations:
   (a) One (1) complete maxillary (upper) and one (1) complete mandibular (lower) denture in any period of seven (7) consecutive years.
   (b) One (1) complete maxillary (upper) denture rebase and one (1) complete mandibular (lower) denture rebase in any period of seven (7) consecutive years.
   (c) A removable or fixed partial denture in any period of seven (7) consecutive years unless the loss of additional teeth requires the construction of a new appliance.
   (d) Crowns, onlays, core buildups, and post and cores are a Benefit once per tooth in any period of seven (7) consecutive years.
   (e) The period of seven (7) consecutive years referred to in (a), (b), (c) and (d) above is to be measured from the date the service was last performed.
   (f) Implant body and implant abutment are Benefits once in a lifetime per site.
4. Inlays are not a covered Benefit.
5. A core buildup or post and core performed on the same day as an inlay or onlay is not a covered Benefit. A Participating Dentist agrees not to charge a separate fee.
6. Removable or fixed partial dentures are not Benefits for patients under the age of twelve (12).
7. If abutment teeth have moved to partially close an edentulous area, only the number of pontics necessary to fill that area are covered Benefits. The patient will be responsible for any additional fee.
8. Recementation of a fixed partial denture is a Benefit once in any period of twelve (12) consecutive months.
9. The relining of a denture is a Benefit once in any period of three (3) consecutive years.
10. Implant services are not a Benefit for patients under the age of sixteen (16).
11. Eposteal and transosteal implants are optional. An allowance will be paid equal to an endosteal implant. The patient will be responsible for any additional fee.
12. Sectioning of a fixed partial denture in order to remove the denture prior to placing a new denture is not a covered Benefit. Sectioning of a fixed partial denture to preserve a portion of the denture for continued use may be covered but is subject to review by a consulting Dentist.

NOTE: HealthTrust and Delta Dental strongly encourage Predetermination of cases involving costly or extensive treatment plans. Although it is not required, Predetermination helps to avoid any potential confusion regarding the Plan's payment and your financial obligation to the Dentist.

Coverage D - Orthodontic Benefits

- Please refer to the Outline of Benefits for specific Benefit information.
- Only those coverage classifications selected by your employer will apply.
- Time limitations will be measured from the date the service was last performed.

Orthodontics: Necessary treatment and procedures required for the correction of malposed (crooked) teeth for Eligible Dependent children until the end of the month of their nineteenth (19) birthday or as specified in the Outline of Benefits.

Placement of device to facilitate eruption of an impacted tooth.

Coverage D Exclusions and Limitations:

1. Orthodontic Benefit limitations:
   (a) Orthodontic Benefits are provided until the end of the month of the Eligible Dependent's nineteenth (19) birthday. You, your spouse, and your Eligible Dependents age nineteen (19) and over will not be eligible for orthodontic Benefits unless adult coverage is specified in the Outline of Benefits.
   (b) For treatment commenced while a patient is eligible for orthodontic Benefits, the Claims Administrator will initiate payment of its liability up to the orthodontic Maximum specified in the Outline of Benefits once bands or orthodontic devices are placed.
   (c) For patients who become eligible after orthodontic treatment has commenced, the Claims Administrator will pro-rate the Plan's liability based on the number of remaining months of active treatment compared to the total number of months of active treatment.
   (d) Active treatment includes procedures undertaken and appliances used with those procedures for the purpose of bringing teeth into proper position and alignment. Active treatment does not include space maintainers, palate expanders or other devices used to prepare the patient for services to position and align teeth.
2. Clear orthodontic appliances are included in orthodontic Benefits provided that upon the consulting Dentist's review of pretreatment radiographs it is indicated that the patient has full adult dentition.

   Clear appliances are subject to all orthodontic limitations and conditions and are subject to review by a consulting Dentist. The patient is responsible for any difference between the cost of the clear orthodontic treatment and the cost of conventional orthodontic procedures.
3. The Plan's payment for orthodontic Benefits shall be limited to the lifetime Maximum per patient specified in the Outline of Benefits. The Claims Administrator will make one (1) payment at the start of treatment for the Plan's total liability.
4. For Participating Groups with orthodontic Benefits, placement of an appliance must take place for the Claims Administrator to make payment on diagnostic records. Diagnostic casts, photographs and other diagnostic records are included in the total case fee. If banding does not take place, the Plan has no liability beyond its share of the allowable fee for a comprehensive oral evaluation.
5. The replacement or repair of an orthodontic appliance is not a covered Benefit if done by the same orthodontist who placed the appliance. If performed by an orthodontist who did not originally place the appliance, payment will be made for one repair per lifetime.

NOTE: HealthTrust and Delta Dental strongly encourage Predetermination of cases involving costly or extensive treatment plans. Although it is not required, Predetermination helps to avoid any potential confusion regarding the Plan's payment and your financial obligation to the Dentist.

V. GENERAL EXCLUSIONS AND LIMITATIONS

1. Unless otherwise specified in the Outline of Benefits, the dental Benefits provided by the Plan will not include the following:

   (a) Services for injuries or conditions compensable under workers' compensation or employer's liability laws.

   (b) Services that are determined by the Claims Administrator to be rendered for cosmetic reasons, such as bleaching or whitening of teeth, placement of veneers, correction of congenital malformations, or cosmetic surgery. (This exclusion is not intended to exclude services provided to newborn children for congenital defects or birth abnormalities.)

   (c) Services, including but not limited to endodontics and prosthodontics (including restorative crowns and onlays), started prior to the date you or your Eligible Dependent became enrolled in the Plan.

   (d) Services not provided by a Dentist, or under the supervision of a Dentist, or that are not within the scope of the license of the Dentist or of the license of the person supervised by the Dentist.

   (e) Prescription drugs, premedications, the application of anti-microbial agents and/or relative analgesia.

   (f) Charges for: (a) hospitalization; (b) general anesthesia or intravenous sedation for restorative dentistry (except as noted in Section IV, Coverage B - Basic Benefits); (c) preventive control programs; (d) periodontal splinting; (e) myofunctional therapy; (f) treatment of temporomandibular joint (TMJ) dysfunction and related diagnostic procedures; (g) equilibration; and (h) gnathological reporting.

   (g) Charges for failure to keep a scheduled visit with the Dentist.

   (h) Charges for completion of forms. Such charges will not be made to you or your Eligible Dependent by Participating Dentists.

   (i) Dental Care which is not necessary and customary, as determined by generally accepted dental practice standards.

   (j) Dental Care or supplies which are not within the classification of Benefits defined in this DPD and selected by your employer as specified in the Outline of Benefits.

   (k) Appliances, procedures, or restorations for: (i) implant services (unless your employer offers Coverage C - Major Benefits); (ii) increasing vertical dimension; (iii) analyzing, altering, restoring, or maintaining occlusion; (iv) replacing tooth structure lost by attrition or abrasion; (v) correcting congenital or developmental malformations; or (vi) esthetic purposes.

   (l) Payments of Benefits incurred by you and/or your Eligible Dependent after the date you become ineligible for Benefits under the Plan.

   (m) Charges for Dental Care or supplies for which no charge would have been made in the absence of dental Benefits.

   (n) Charges for Dental Care or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared.

   (o) All services, including evaluations and radiographs, performed for orthodontic purposes where the employer does not offer Coverage D - Orthodontic Benefits. If services are rendered they should be done so with the agreement of the patient to assume additional cost.

   (p) Temporary services.

   (q) A consultation unless performed by a practitioner who is not performing further services.

   (r) Case presentation and treatment planning. The patient will be responsible for any additional fee.

   (s) Athletic mouthguards and occlusal guards (nightguards).

   (t) Pulp vitality tests.

   (u) Incomplete treatment.

2. Unless otherwise specified in the Outline of Benefits, the Dental Care Benefits provided by the Plan will be limited as follows:

(a) Dental Care rendered by other than a Dentist will not be a Benefit, except that scaling or cleaning of teeth and topical application of fluoride and such other treatment performed by a licensed dental hygienist will be a Benefit, if the treatment is rendered under the supervision and guidance of a Dentist, in accordance with generally accepted dental practice standards.

(b) Optional Dental Care: In all cases in which you or your Eligible Dependent selects more expensive Dental Care than is customarily provided, the Plan will pay the Selected Percentage for the Dental Care which is customarily provided to restore the tooth to contour and function. You or your Eligible Dependent will be responsible for the remainder of the Dentist's fee.

(c) Predetermination does not guarantee payment. Payment is based upon eligibility, Benefits selected by your employer and allowable charges at the time the Dental Care is rendered. If Coordination of Benefits is involved, the amount of payment is subject to change dramatically pending payment by the primary carrier.

(d) Services completed or in progress at you or your Eligible Dependent's date of death will be paid in full to the limit of the Plan's liability.

(e) When services for Dental Care in progress are interrupted and completed thereafter by another Dentist, the Claims Administrator will review the claim to determine the payment, if any, due each Dentist.

(f) Maximum Payment:

(i) The Maximum amount payable in any Plan Year, or portion thereof, will be limited to the amount specified in the Outline of Benefits.

(ii) The Plan's payment will be reduced by any Deductible as specified in the Outline of Benefits.

(g) Specialized techniques including, but not limited to, precision attachments, implant services (unless your employer offers Coverage C - Major Benefits), overdentures (and associated procedures), personalizations or characterization, are limited. The patient will be responsible for part of or the entire fee for these services.

(h) Diagnostic casts (study models) and/or photographs are not a covered Benefit under the Plan unless done for orthodontic purposes and your employer offers Coverage D - Orthodontic Benefits. The charge for such services should be included in the total case fee.

(i) Benefits are paid for amalgam (silver) or resin (white) restorations for treatment of caries. If a tooth can be restored with amalgam or resin, use of gold, an inlay, an onlay, or a crown is at the option of the patient and the patient will be responsible for any additional fee.

(j) A claim (or satisfactory written proof acceptable to the Claims Administrator) must be furnished to the Claims Administrator at its principal office within twenty-four (24) months from the date the Dentist provided Dental Care. No payment will be made on a claim with dates of service in excess of the twenty-four (24) month limitation.

(k) The date of incurred liability refers to the date a service is subject to the applicable Deductible, Co-payment, Maximum Benefit, and limitations. The total cost of the service is applied to the Plan Year during which the service is incurred, irrespective of the Plan Year in which the service is completed.

The Plan's date of incurred liability for multiple visit procedures is as follows:

(i) Restorative Crowns and Onlays – Total cost for crowns and onlays will be incurred on the date that the tooth is prepared.

(ii) Fixed Partial Dentures (abutment crowns and pontics) – The total cost for fixed partial dentures will be incurred on the date that the teeth are prepared to receive said appliance.

(iii) Removable Complete and Partial Dentures – Total cost for removable complete and partial dentures will be incurred on the date that the final impressions are taken for said appliance.

(iv) Endodontics – Total cost for endodontic treatment will be incurred when the pulp chamber of the tooth is opened.

(v) Implant Body – Total cost for the implant body, including healing cap, will be incurred on the date of surgical placement.

(vi) Implant Prosthetics – Total cost for the prosthetic portion of an implant will be incurred on the date the final impression is taken for said appliance.

(vii) Orthodontics – Total cost for orthodontic treatment will be incurred on the date the initial bands, or a segment thereof, or a device, is placed in the patient's mouth.

VI. COORDINATION OF BENEFITS (DUAL COVERAGE)

The Coordination of Benefits provision is designed to provide maximum Benefits coverage, but not to exceed 100% of the total fee for a given service. In the event that any Eligible Person is entitled to benefits under any other dental benefit program, the following Coordination of Benefits provisions will determine the sequence and the extent of payment of Benefits under this Plan. Such other benefit programs may include any other group sponsored dental plan in which the Eligible Person is enrolled.

When an Eligible Person is covered under another dental benefit program the following rules will establish the order of determining liability:

1. When only one plan has a Coordination of Benefits provision, the plan without such provision will determine its benefits first.

2. The plan covering the Eligible Person solely as an employee will determine its benefits before the plan that covers the Eligible Person solely as a dependent.

3. The plan covering the Eligible Person solely as a dependent of the parent whose birthday occurs earlier in a calendar year will determine its benefits before the plan covering the Eligible Person solely as a dependent of the parent whose birthday occurs later in a calendar year ("Birthday Rule"). A parent's year of birth is not relevant. If both parents have the same birthday (month and day), the benefits of the plan which covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time. If the other dental benefit program does not use the "Birthday Rule" then that plan's provisions will determine the order of liability.

4. Notwithstanding paragraph (3) above, the order of payment for the claims of a Dependent child of divorced or legally separated parents will be as follows:

   (a) the plan of the parent with custody;

   (b) the plan of the spouse of the parent with custody (step-parent);

   (c) the plan of the parent without custody; or

   (d) if the parents have joint custody, paragraph (3) above will apply.

   However, when the parents are divorced or legally separated and there is a court decree which establishes financial responsibility with respect to the child, the benefits of the plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefits of any other plan which covers the child as a dependent.

5. If paragraphs (1) through (4) above do not establish an order of benefit determination, the benefits of the plan which has covered the Eligible Person for the longer period of time will be determined first.

6. When this Plan is the first to determine its Benefits under paragraph 1 through 5 above, Benefits under this Plan will be paid without regard to coverage under any other plan. When this Plan is not the first to determine its Benefits and there are remaining expenses of the type allowable, Delta Dental will pay only the amount by which the Benefits under this Plan exceed the amount of benefits payable under the other plan or the amount of such remaining expenses, whichever is less. In other words, the combined payment of both plans will not exceed the total cost of the service.

The Claims Administrator may use such reasonable efforts as it deems suitable to determine the existence of other benefit programs but will be under no obligation to do so.

The payment of Benefits under this Plan will be affected by the benefits that would be payable under any and all other plans only to the extent that the Claims Administrator is furnished with information relative to such other plans by your employer or an employee of any other insurance company, or other organization or person.

7. For the purposes of determining the applicability and implementing the terms of this SECTION VI or any provisions of similar purpose of any other plan, the Claims Administrator may, without the consent of or notice to any person, release to or obtain from any insurance company or such other organization or person with a legitimate interest in such information, any information with respect to any person which it deems to be necessary for such purposes. In so acting, the Claims Administrator will comply with all federal and state law requirements governing disclosures. Any person claiming Benefits under this Plan will furnish to the Claims Administrator such information as may be necessary to implement this provision.

8. Multiple Coverage. In coordinating benefits with any other dental plan, time limitations and frequency of service limitations will not change. Coverage for services, when a specified number are provided per a specified time period, will not be added together to provide more than the number of services specified per time period under this Plan. For example, if each plan covers two cleanings in a calendar year, the combined plans will still only cover two cleanings in any calendar year. If a cleaning is covered under this Plan, but has been paid for, whether in full or part, by another plan, the cleaning will count toward the maximum number of cleanings allowed under this Plan.

VII. GENERAL CLAIMS INQUIRY

After a claim is submitted to and processed by the Claims Administrator (as described in Section III, HOW TO FILE A CLAIM), you will be sent an Explanation of Benefits form. This notice will explain the Benefits that were paid on your behalf, let you know if any services are denied, and give you the reason(s) for the denial.

If you have any questions regarding your Benefits, you may call Northeast Delta Dental for an explanation at 603.223.1234 or 800.832.5700. You will be connected directly to their Customer Service Department.

The Customer Service Representative will need to know the claim number which is located at the top of your Explanation of Benefits form or, if that information is not available, the Subscriber's identification number. This will enable a quick response to your inquiry.

VIII. DISPUTED CLAIMS PROCEDURE

If after you have followed the General Claims Inquiry procedure you disagree with the Benefit determination, you may use the Claims Administrator's Disputed Claims Procedure. You may request a review of your claim within six (6) months of the issuing of the Claims Administrator's original Explanation of Benefits. Your written request for a review should be personally delivered or mailed certified mail, return receipt requested, to the Vice President, Professional Relations, Northeast Delta Dental, One Delta Drive, PO Box 2002, Concord, New Hampshire, 03302-2002.

Your request for a review of your claim should reference the claim(s) in question, your name and address, and the reasons you think the denial should be evaluated, and any additional materials you wish to present.

The Vice President, Professional Relations, or his designee, may request additional documents as necessary to make such a review and will promptly review your claim. If the claim is wholly or partially denied, you will be furnished with a notice of the decision within thirty (30) days after receipt of the disputed claim. The written notice will include:

1. the specific reason(s) for denial, and
2. specific reference to the Plan provision(s) upon which the denial is based.

If your request for review results in an additional payment, it will be made within fifteen (15) working days of the Claims Administrator's response.

If you do not receive notice within the thirty-day (30-day) period, the claim is considered denied in order that you may proceed to the Disputed Claims Review Procedure.

If you have any problem securing a review of your claim, contact your employer for assistance.

IX. DISPUTED CLAIMS REVIEW PROCEDURE

The Disputed Claims Review Procedure allows you to request a review from the Claims Administrator's Disputed Claims Review Committee after receipt of written notification of the Vice President, Professional Relations' denial of your claim. The Review Committee is composed of Participating Dentists, non-Dentist members of the Board of Directors, and representatives of group purchasers/groups.

You or your duly authorized representative may appeal to the Review Committee by filing a request for review before the final appeal date set forth in the Vice President, Professional Relations' notice denying the claim, or, if no date is given, within six (6) months of the notice. It is recommended that your written request be sent certified mail, return receipt requested, to the Review Committee at the Northeast Delta Dental address noted previously but you may also submit your request by standard mail. It must state specifically the reasons for requesting a review. It should contain issues, comments, and supporting materials stating why you believe the Claims Administrator's response was incorrect. Not later than thirty (30) days after receipt of your request, the Review Committee will render its written decision, including specific reasons for the decision.

In addition or as an alternative to the written request procedure, you may request a hearing from the Review Committee to consider matters raised in your appeal. At the hearing, you are entitled to representation by legal counsel or other duly authorized representatives, to request the presence of a stenographer to transcribe the hearing, to present evidence, to request the testimony of witnesses and to cross-examine witnesses. You or your representative may review the Plan Document and related pertinent documents. The hearing will be scheduled with prompt written notice to you not later than thirty (30) days after your request. A decision will be rendered not later than thirty (30) days after the hearing. The decision of the Review Committee will be in writing and will include specific reasons for the decision.

X. GENERAL PROVISIONS

Notice Of Change of Status

You must notify HealthTrust, through your employer, of any event causing a change in the status of an Eligible Person. Events that can affect status include, but are not limited to, marriage, birth, death, divorce, a change in a child's age or student status, involuntary loss of other dental coverage, etc. For further details refer to ENROLLMENT in Section II of this Dental Plan Description.

Assignment

Benefits of Eligible Persons are personal and cannot be transferred or assigned.

Right of Recovery

In the event Benefits are paid under the Plan, the Plan and the Claims Administrator will be subrogated to all of the Eligible Person's rights of recovery against any third person or organization that may be liable. The Eligible Person will execute and deliver such documents and do whatever else is necessary to secure such rights.

Doctor-Patient Relationship

The Eligible Person has the freedom to choose any Dentist. Dentists rendering service under the Plan are independent contractors and will maintain the traditional doctor-patient relationship. The Dentist will be solely responsible to the patient for dental advice and treatment and any resulting liability.

Loss of Eligibility During Treatment

If an Eligible Dependent loses eligibility while receiving dental treatment, only covered services received while eligible will be considered for payment.

Maintaining Your Privacy

HealthTrust and Northeast Delta Dental respect and carefully preserve the privacy and confidentiality of Subscribers and their Dependents. As part of that protection, compliance with all state and federal laws regarding privacy of personal and health information is maintained. For a copy of either HealthTrust's or Northeast Delta Dental's Notice of Privacy Practices, that describe in detail their respective privacy practices or, if you have any questions about the privacy of your health information, please contact:

Privacy Officer
HealthTrust
25 Triangle Park Drive
PO Box 617
Concord, NH 03302-0617
800.527.5001

Privacy Officer
Northeast Delta Dental
One Delta Drive
PO Box 2002
Concord, NH 03302-2002
800.537.1715

Non-ERISA Governmental Plan

The Plan is a governmental plan established and maintained by your employer and HealthTrust, and as such is exempt from the provisions of the Employee Retirement and Income Security Act of 1974 (ERISA).

Waiver of Rights

On occasion, HealthTrust may, at its option, choose not to enforce all the terms and conditions of the Plan; however, HealthTrust does not thereby waive or give up any rights to enforce any term or condition in the future. No agent of HealthTrust or Northeast Delta Dental has the right to change or waive any of the provisions of the Plan without the approval of an authorized representative of HealthTrust.

Applicable Law

The Plan, the Plan Document and this Dental Plan Description shall be construed and enforced according to the applicable laws of the State of New Hampshire, except as the same may be superseded by applicable federal law.

Amendment and Termination

HealthTrust may, at its sole discretion at any time, amend or modify the Plan through a written amendment signed by a duly authorized representative of HealthTrust. Upon the signing of any such amendment, it will become effective in accordance with its terms as to you and all other Eligible Persons. No person or entity has any authority to make any oral changes or oral amendments to the Plan. HealthTrust reserves the right to terminate the Plan at any time by giving advance notice of at least thirty (30) days to your employer.

XI. Frequently Asked Questions

1. **May I choose any Dentist?**

   Yes. You are free to choose any Dentist as defined in Section I, Definitions.

2. **Will Delta Dental make payment directly to the Dentist or will I receive payment?**

   If the Dentist is participating, Delta Dental will make payment directly to the Dentist. If the Dentist does not participate, payment for services rendered will be made directly to you unless the state in which the services are rendered requires that payment be sent to the Dentist.

3. **What difference does it make if I go to a Participating Dentist or a Non-Participating Dentist?**

   The Plan does not restrict you from visiting any Dentist. However, if you go to a Participating Dentist reimbursement may result in lower out-of-pocket expense for you. Delta Dental will pay the Participating Dentist the applicable Selected Percentage of the allowable fee (as such fees are filed with and/or accepted by Northeast Delta Dental or another Delta Dental company), or the actual submitted charge, whichever is less. Such payment, together with your Co-payment, will satisfy in full the claim of the Participating Dentist for the Dental Care provided.

   If you are treated by a Non-Participating Dentist, Delta Dental will make payment directly to you on the basis of the Dentist's fee up to the maximum amount allowed for Non-Participating Dentists unless the state in which the services are rendered requires that payment be sent to the Dentist. You will be responsible for paying the Dentist both any payment you receive from Delta Dental and any remaining balance due.

4. **When does my Dental coverage begin?**

   Refer to the Probationary Period in the Outline of Benefits. Only dental services received after you become eligible will be covered.

5. **How much of the dental bill do I pay?**

   You are responsible for the amount shown on your Explanation of Benefits form that will include any charges for optional treatment or specific exclusions of your program. Your Dentist may request your Copayment, Deductible, and payment for non-covered services at the time services are rendered.

6. **Am I covered for all dental services?**

   Not necessarily. Your coverage is described in this document and in the Outline of Benefits. Covered benefits are governed by the Exclusions, Limitations, and Delta Dental's current Processing Policies.

7. **What if my spouse is covered by another dental plan?**

   You may be entitled to as much as (but not more than) 100% of your Dentist's charges for covered benefits. It is important that you inform your Dentist of any dual coverage so that the proper claim filing procedures may be followed and that you get the maximum benefit from your dental program.

8. **Is it necessary for me to have my Dentist get a Predetermination for my dental services?**

   HealthTrust and Delta Dental strongly encourage Predetermination of cases involving costly or extensive treatment plans. Although it is not required, Predetermination helps avoid any potential confusion regarding the Plan's payment and your financial obligation to your Dentist.

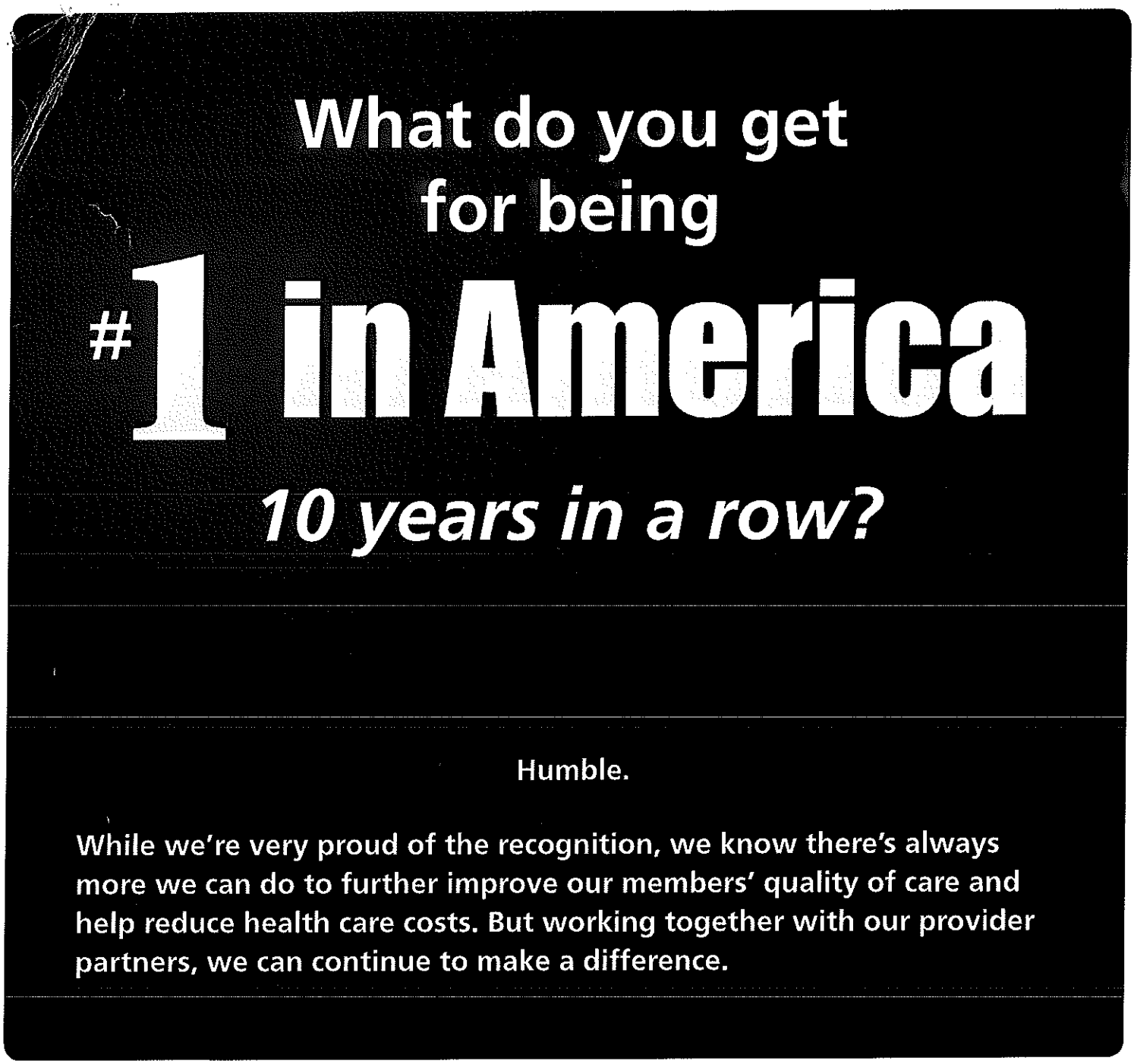
HealthTrust

HealthTrust
PO Box 617 • 25 Triangle Park Drive • Concord, NH 03302-0617
Toll-Free: 800.527.5001 • Phone: 603.226.2861 • Fax: 603.226.2988
www.healthtrustnh.org

DELTA DENTAL®

Northeast Delta Dental

Northeast Delta Dental
One Delta Dental • P.O. Box 2002 • Concord, NH 03302-2002
Customer Service: 800.832.5700 • 603.223.1234
TTY/Hearing Impaired Access Number: 800.332.5905
www.nedelta.com



COUNT US IN Harvard Pilgrim Health Care

Harvard Pilgrim is the #1 private health plan in America again according to an annual ranking of the nation's best health plans by the National Committee for Quality Assurance (NCQA). **Harvard Pilgrim is the only private health plan in the nation to be named #1 for member satisfaction and quality of care for ten consecutive years.***

* NCQA's Private Health Insurance Plan Rankings, 2011-14, HMO/POS. NCQA's Health Insurance Plan Rankings 2010-11 – Private. *U.S.News*/NCQA America's Best Health Insurance Plans 2005-2009 (annual). America's Best Health Insurance Plans is a trademark of *U.S.News & World Report.* NCQA The State of Health Care Quality 2004. Harvard Pilgrim Health Care of New England, Harvard Pilgrim's New Hampshire affiliate, is the top-ranked HMO/POS health plan in New Hampshire and the 9th highest-ranked private health plan in America.

cc4136 9_13

NEW HAMPSHIRE INTERLOCAL TRUST

POS High $10 (4MF)
Harvard Pilgrim

	In Network	Out of Network
Hospital Inpatient/Day Surgery	100%	80% after deductible
Hospital Outpatient	100%	80% after deductible
MRI/CT Scans	100%	80% after deductible
Emergency Room (waived if admitted)	$50 copay	$50 copay
Ambulance Services	100%	80% after deductible
Preventative Care	100%	80% after deductible
Physician Services/Office Visit	$10 copay	80% after deductible
Allergy Injections	$5 copay	80% after deductible
Maternity Care	100%	80% after deductible
Routine Annual Eye Exam	$10 copay Discounts for Frames/lenses	80% after deductible
Home Health Care	100%	80% after deductible
Skilled Nursing Facility/Inpatient Rehabilitation	100%	80% after deductible
Physical/Occupational Therapy	100%	80% after deductible
Speech Therapy	100%	80% after deductible
Chiropractic Care	$10 copay	80% after deductible
Durable Medical Equipment (DME)	100%	80% after deductible
Oxygen & Respiratory Equipment	100%	80% after deductible
Inpatient Mental Health & Substance Abuse	100%	80%
Outpatient Mental Health & Substance Abuse	$10 copay; $10 group	80%
Best Buy Deductible: Individual (Family)	None	$250 ($500)
Maximum Out of Pocket: Individual (Family)	Copays	$1,000 ($2,000) + Rx copays
Maximum Lifetime Benefit	Unlimited	Unlimited

This is only a summary of benefits, please consult appropriate schedule of benefits. Exceptions & exclusions apply.
Benefit limits, deductibles and out of pocket maximums are based on a calendar year.

Mar-14

NEW HAMPSHIRE INTERLOCAL TRUST

HMO High $5 (K8F)
Harvard Pilgrim

	In-Network
Hospital Inpatient/Day Surgery	100%
Hospital Outpatient	100%
MRI/CT Scans	100%
Emergency Room (waived if admitted)	$50 copay
Ambulance Services	100%
Preventative Care	100%
Physician Services/Office Visit	$5 copay
Allergy Injections	$5 copay
Maternity Care	100%
Routine Annual Eye Exam	$5 copay; Discounts for Frames/lenses
Home Health Care	100%
Skilled Nursing Facility/Inpatient Rehabilitation	100%; combined 100 day limit
Physical/Speech/Occupational Therapy	$5 copay; combined 40 visit limit
Chiropractic Care	$5 copay; 12 visit limit
Durable Medical Equipment (DME)	80%
Oxygen & Respiratory Equipment	100%
Inpatient Mental Health & Substance Abuse	100%
Outpatient Mental Health & Substance Abuse	$5 copay, $5 group
Best Buy Deductible: Individual (Family)	None
Maximum Out of Pocket: Individual (Family)	Copays & DME Coinsurance
Maximum Lifetime Benefit	Unlimited

This is only a summary of benefits, please consult appropriate schedule of benefits. Exceptions & exclusions apply.
Benefit limits, deductibles and out of pocket maximums are based on a calendar year.

saveON℠

FROM Harvard Pilgrim Health Care

Help employees save on out-of-pocket costs while *lowering your overall medical expenses*

As you know, the costs of medical tests and procedures often vary widely with no significant difference in quality. Harvard Pilgrim's voluntary SaveOn program engages members to make smarter health care choices, and rewards them for doing so.

SaveOn makes it easy for Harvard Pilgrim members to find care for covered outpatient medical procedures and diagnostic tests from participating providers at a lower cost. Members can call every time they require eligible tests or procedures.*

SaveOn helps reduce medical costs

By empowering and rewarding sound health-care decision making, you can reduce medical costs without changing benefits or cost shifting.

SaveOn uses Harvard Pilgrim's paid claims data to identify lower priced, Harvard Pilgrim-participating providers conveniently located to a member's home or work.

Examples of potential savings per service

Colonoscopy screening	**Range: $855 - $2,572** **Potential Savings: $1,717**
MRI spine, lumbar (without contrast)	**Range: $492 - $2,083** **Potential Savings: $1,591**
Common routine labs	**Range: $125 - $410** **Potential Savings: $285**

Ranges based on Harvard Pilgrim's data in the Massachusetts/ New Hampshire region. Actual service prices vary by provider.

How SaveOn works

1. Harvard Pilgrim members voluntarily call **(855) 7SAVEON** (855-772-8366) whenever their doctor recommends an outpatient test or procedure such as:
   - Bone density study
   - Colonoscopy
   - Lab work
   - Mammogram
   - Radiology (e.g., MRI and CT scan)
   - Ultrasound
   - Other non-emergency outpatient tests and procedures
2. SaveOn nurses inform members if there are any lower-cost, Harvard Pilgrim-participating providers available in their area. They can even reschedule the appointment and help with any necessary paperwork.**
3. Members can choose one of the lower-cost providers, have the test or procedure at the low-cost provider and earn between $25 and $75. If members are already seeing a lower-cost provider, they can receive a $10 reward for calling.**

Reward dollars depend on the service and the associated cost savings (see other side for rewards and eligibility details). Members receive the reward in the mail after Harvard Pilgrim processes the claim, about 45 days after members receive their Harvard Pilgrim Activity Summary.***

*For Massachusetts-based employers, members may receive a maximum of five rewards per calendar year.

** $150 minimum savings for reward. Some plan designs may require a referral and/or prior authorization before receiving services from the lower-cost provider. To ensure the services will be covered, members should refer to their plan documents or contact Harvard Pilgrim's Member Services department.

*** Reward payments are considered taxable income. You should consult a tax advisor for more information.

Turn over to learn more ➲

Communications to promote SaveOn year-round

Once you purchase SaveOn, we send your Harvard Pilgrim enrollees a letter to their homes introducing them to the program. We include a Tyvek card sleeve featuring the SaveOn phone number so they can keep it handy with their Harvard Pilgrim member ID card.

SaveOn's success depends upon promoting the program within your company. You have access to a variety of templates available online to use as fliers or emails to your employees throughout the year. The more you spread the word about SaveOn, the more your employees will use it, and you'll see savings on medical costs.

Preferred pricing for Harvard Pilgrim customers

Tandem Care, our SaveOn program administrator, offers Harvard Pilgrim customers discounted, per employee, per month rates. As the employer, you fund earned rewards.

Employer reporting to demonstrate savings

Each month, you'll receive a detailed monthly SaveOn report that includes the number of calls received, projected and confirmed savings, and rewards distributed.

Program eligibility

SaveOn is available for purchase in Massachusetts and New Hampshire to fully and self-insured employers with 51-plus eligible employees.

SaveOn's reward structure

Here's what your Harvard Pilgrim members and their dependents will receive when using SaveOn:

- **$10 minimum reward*** for Harvard Pilgrim members who call and are already scheduled at a low-cost provider
- **$25 reward*** for Harvard Pilgrim members switching to a low-cost provider for:
  - Bone density study
  - Lab work
  - Mammogram
  - Ultrasound
- **$50 reward**** for Harvard Pilgrim members switching to a low-cost provider for:
  - MRI
  - CT scan
  - PET scan
- **$75 reward***** for Harvard Pilgrim members switching to a low-cost provider for:
  - Colonoscopy
  - Other outpatient surgeries

* Minimum savings to qualify for $10 and $25 reward is $150

** Minimum savings to qualify for $50 reward is $250

*** Minimum savings to quality for $75 reward is $350

Learn more

Visit **www.harvardpilgrim.org/saveon**, call your broker or contact your Harvard Pilgrim account executive at **(800) 848-9995.**

Examples of cost differences

saveON℠

Mammogram Concord, NH Area	
Location	**Price**
Nashua, NH	$191
Derry, NH	$248
Bedford, NH	$296
Manchester, NH	$330
Derry, NH	$342
Manchester, NH	$362
Franklin, NH	$412
Laconia, NH	$412
New London, NH	$453
Concord, NH	$455
Manchester, NH	$465
Concord, NH	$481
Plymouth, NH	$541

MRI: Lumbar Spine w/o dye Concord, NH Area	
Location	**Price**
Bedford, NH	$808
Manchester, NH	$820
Nashua, NH	$920
Derry, NH	$951
Manchester, NH	$1,036
Manchester, NH	$1,252
Laconia, NH	$1,395
Franklin, NH	$1,395
Concord, NH	$1,838
Rochester, NH	$2,018
New London, NH	$2,182
Manchester, NH	$2,322
Concord, NH	$2,384

Colonoscopy, screening Concord, NH Area	
Location	**Price**
Concord, NH	$1,350
Derry, NH	$1,700
Concord, NH	$1,700
Manchester, NH	$1,800
Bedford, NH	$1,800
Plymouth, NH	$1,800
Nashua, NH	$1,900
Rochester, NH	$2,200
Laconia, NH	$2,450
Franklin, NH	$2,450
Nashua, NH	$2,500
Manchester, NH	$2,800
Manchester, NH	$3,200
New London, NH	$3,200

Common Lab Tests: Concord, NH Area	Price Range
Comprehensive Metabolic Panel	$13 - $153
CBC, Complete	$10 - $61
Lipid Panel	$17 - $150
Thyroid Stimulating Hormone (TSH)	$21 - $142
Vitamin D	$38 - $472
TOTAL	**$100 - $978**

Harvard Pilgrim Health Care

NEW HAMPSHIRE
INTERLOCAL TRUST

Super HMO High $15 (CC-S0F)
Harvard Pilgrim
In-Network

Hospital Inpatient/Day Surgery	100%
Hospital Outpatient	100%
MRI/CT Scans	100%
Emergency Room (waived if admitted)	$50 copay
Ambulance Services	100%
Preventative Care	100%
Physician Services/Office Visit	$15 copay
Allergy Injections	$5 copay
Maternity Care	100%
Routine Annual Eye Exam	$15 copay; Discounts for Frames/lenses
Home Health Care	100%
Skilled Nursing Facility/Inpatient Rehabilitation	100%; combined 100 day limit
Physical/Speech/Occupational Therapy	$15 copay; unlimited visit limit
Chiropractic Care	$15 copay; unlimited visit limit
Durable Medical Equipment (DME)	80%
Oxygen & Respiratory Equipment	100%
Inpatient Mental Health & Substance Abuse	100%
Outpatient Mental Health & Substance Abuse	$15 copay, $10 group
Best Buy Deductible: Individual (Family)	None
Maximum Out of Pocket: Individual (Family)	Copays & DME Coinsurance
Maximum Lifetime Benefit	Unlimited

This is only a summary of benefits, please consult appropriate schedule of benefits. Exceptions & exclusions apply.
Benefit limits, deductibles and out of pocket maximums are based on a calendar year.

NEW HAMPSHIRE INTERLOCAL TRUST

HMO High $10 $500 (LWF)
Harvard Pilgrim Best Buy
In-Network

Hospital Inpatient/Day Surgery	100% after deductible
Hospital Outpatient	100%
MRI/CT Scans	100% after deductible
Emergency Room (waived if admitted)	$50 copay
Ambulance Services	100% after deductible
Preventative Care	100%
Physician Services/Office Visit	$10 copay
Allergy Injections	$5 copay
Maternity Care	Prenatal and Postpartum Care 100%; Delivery 100% after deductible
Routine Annual Eye Exam	$10 copay; Discounts for Frames/lenses
Home Health Care	100%
Skilled Nursing Facility/Inpatient Rehabilitation	100% after deductible; combined 100 day limit
Physical/Speech/Occupational Therapy	$10 copay; combined 40 visit limit
Chiropractic Care	$10 copay; 12 visit limit
Durable Medical Equipment (DME)	80%
Oxygen & Respiratory Equipment	100%
Inpatient Mental Health & Substance Abuse	100%
Outpatient Mental Health & Substance Abuse	$10 copay, $10 group
Best Buy Deductible: Individual (Family)	$500 ($1,000)
Maximum Out of Pocket: Individual (Family)	$1,500 ($3,000) + RX copays
Maximum Lifetime Benefit	Unlimited

This is only a summary of benefits, please consult appropriate schedule of benefits. Exceptions & exclusions apply.
Benefit limits, deductibles and out of pocket maximums are based on a calendar year.

NEW HAMPSHIRE INTERLOCAL TRUST

HMO Low $15 $1000 (2RWF)
Harvard Pilgrim Best Buy

	In-Network
Hospital Inpatient/Day Surgery	100% after deductible
Hospital Outpatient	100%
MRI/CT Scans	100% after deductible
Emergency Room (waived if admitted)	$150 copay
Ambulance Services	100% after deductible
Preventative Care	100%
Physician Services/Office Visit	$15 copay
Allergy Injections	$5 copay
Maternity Care	Prenatal and Postpartum Care: 100% Delivery: 100% after deductible
Routine Annual Eye Exam	$15 copay; Discounts for Frames/lenses
Home Health Care	100%
Skilled Nursing Facility/Inpatient Rehabilitation	100% after deductible; combined 100 day limit
Physical/Occupational Therapy	$15 copay; combined 25 visit limit
Speech Therapy	$15 copay; 25 visit limit
Chiropractic Care	$15 copay; 12 visit limit
Durable Medical Equipment (DME)	separate $100 deductible; then 80%
Oxygen & Respiratory Equipment	100%
Inpatient Mental Health & Substance Abuse	100%
Outpatient Mental Health & Substance Abuse	$15 copay, $5 group
Best Buy Deductible: Individual (Family)	$1,000 ($3,000)
Maximum Out of Pocket: Individual (Family)	$2,000 ($5,000) + Rx copays
Maximum Lifetime Benefit	Unlimited

This is only a summary of benefits, please consult appropriate schedule of benefits. Exceptions & exclusions apply.
Benefit limits, deductibles and out of pocket maximums are based on a calendar year.

NEW HAMPSHIRE INTERLOCAL TRUST

HMO $25 LP $1000
Harvard Pilgrim Best Buy
In-Network

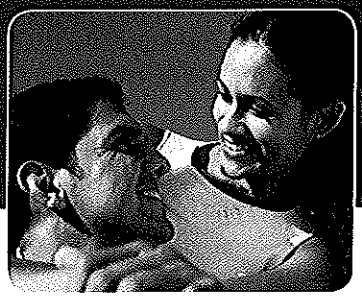
Hospital Inpatient/Day Surgery	100% after deductible
Outpatient Surgery*	100% at select LP Providers; 100% after deductible at other network providers
Diagnostic Laboratory Services*	100% at select LP Providers; 100% after deductible at other network providers
X-Rays	100% after deductible
MRI/CT Scans	100% after deductible
Emergency Room (waived if admitted)	$150 copay
Ambulance Services	100% after deductible
Preventative Care	100%
Physician Services/Office Visit	$25 copay
Scopic Procedures*	100% at select LP Providers; 100% after deductible at other network providers
Allergy Injections	$5 copay
Maternity Care	100% prenatal and postpartum care; delivery 100% after deductible
Routine Annual Eye Exam	$25 copay
Home Health Care	100%
Skilled Nursing Facility/Inpatient Rehabilitation	100% after deductible; combined 100 day limit
Physical/Occupational Therapy	$25 copay; combined 60 visit limit
Speech Therapy	
Chiropractic Care	$25 copay; 12 visit limit
Durable Medical Equipment (DME)	separate $100 deductible, then 80%
Respiratory Equipment (Including Oxygen)	100%
Inpatient Mental Health & Substance Abuse	100%
Outpatient Mental Health & Substance Abuse	$25 copay ($10 group)
Best Buy Deductible: Individual (Family)	$1,000 ($3,000)
Maximum Out of Pocket: Individual (Family)	$2,500 ($5,000)
Maximum Lifetime Benefit	Unlimited

* Select LP Providers are pre-determined by Harvard Pilgrim.

Dec-13

This is only a summary of benefits, please consult appropriate schedule of benefits. Exceptions & exclusions apply.
Benefit limits, deductibles and out of pocket maximums are based on a plan year.

HOW IT WORKS:



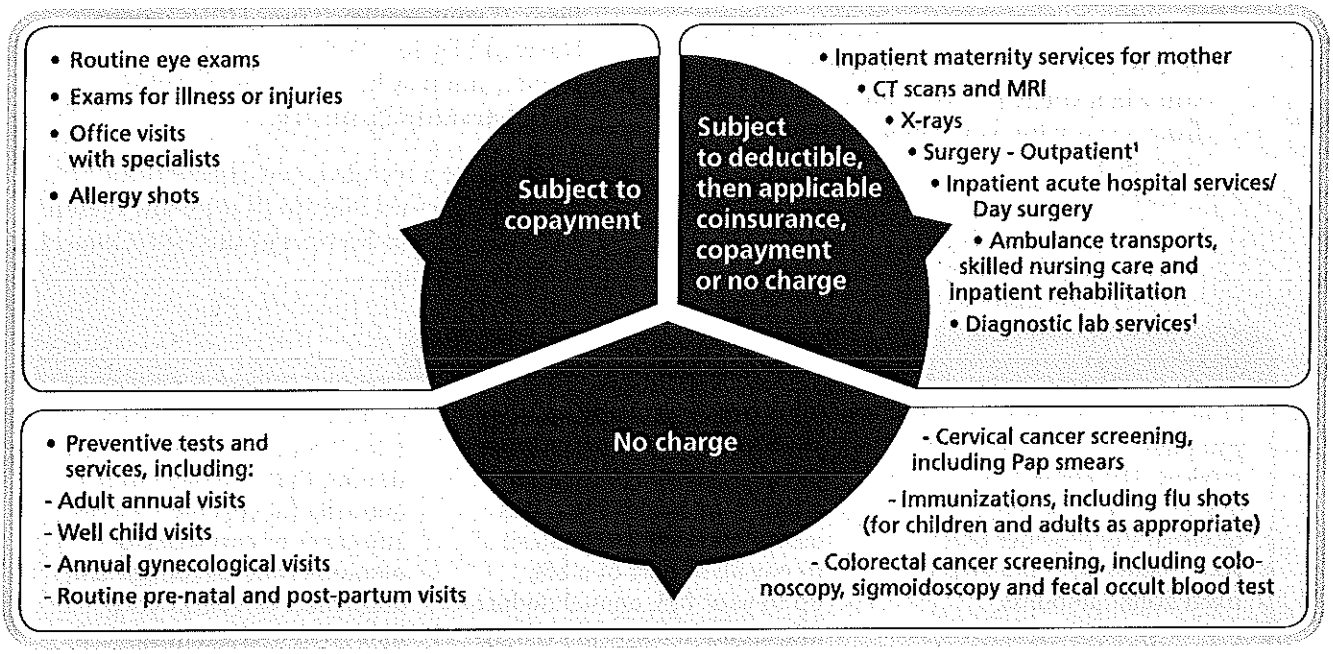
The Harvard Pilgrim Best Buy HMO-LP *New Hampshire*

The Harvard Pilgrim Best Buy HMO-LP offers Harvard Pilgrim's high-quality coverage at a more affordable premium than a traditional HMO.

- **You'll choose a primary care provider (PCP) to deliver or arrange for your medical care.**
- **For some services you will pay a copayment.**
- **For other services you must first satisfy a deductible, and depending on your plan, pay coinsurance or copayments.**
- **Certain tests and screenings are covered at no charge.**

How services are covered

These are partial lists of covered services under a typical Best Buy HMO-LP plan. An example of how your cost sharing applies follows on the next page. Refer to the *Schedule of Benefits* for a complete list of benefits. The *Schedule of Benefits* governs in any case where the information in this document is different.



[1] With Best Buy HMO - LP plans, the deductible for these services will be waived when you receive them from our LP (low-cost provider) network. Instead, services will require a copayment or will be covered at no charge. Refer to the *Schedule of Benefits* for a full list of benefits.

Continued on next page ▸

Harvard Pilgrim HealthCare *of New England* | NEW HAMPSHIRE INTERLOCAL TRUST

EXAMPLE: You visit your PCP's office because you are injured, and your PCP sends you for an MRI.

- Exams for injuries are subject to an office visit copayment. Your copayment does not apply toward your deductible amount.
- MRIs are subject to the deductible. If you have not yet paid the full, annual deductible, you pay all charges for the MRI up to the deductible amount, plus any applicable co-insurance or copayment. If you have already paid the full, annual deductible amount, you would pay either coinsurance, a copayment or nothing for the MRI (depending on the cost-sharing requirements of your particular plan).

In summary, you would be responsible for the copayment for the exam, plus charges for the MRI if you had not yet met your total deductible or out-of-pocket maximum (if applicable).

Your PCP's role

Your PCP is the doctor or nurse practitioner who will see you for routine check-ups and treat you when you're sick or injured. If you need care from a specialist, you will need a referral from your PCP.

It's very important for you to choose a PCP when you enroll. If you do not choose a PCP, we will assign one to you. You must have your PCP provide your care (except in emergencies) and give you a referral for most kinds of specialty care in order for Harvard Pilgrim to provide coverage for the service.

Finding a PCP is easy

To find a PCP:

- use our online directory (updated weekly) at **www.harvardpilgrim.org/providerdirectory**
- call one of our representatives (see "Questions?" at the end of this document for phone numbers).
- use our printed *Provider Directory* (your employer may have a copy, or you can call Harvard Pilgrim to request one).

If you will have dependents on your plan, each can have a different PCP. Please write the PCPs' names and **provider ID codes** in the designated spaces on your enrollment form. If your employer uses *HPHConnect*, Harvard Pilgrim's Web-based transaction service, you may be able to enroll online at **www.harvardpilgrim.org.**

Once you're a member, you can choose a different Harvard Pilgrim PCP for any reason. Just call Member Services or use *HPHConnect* to make a change.

GLOSSARY

COPAYMENT: A dollar amount you pay for certain covered services. The copayment is due at the time of your visit or when the provider bills you. Copayments are always fixed dollar amounts.

Some plans have two levels of copayments for outpatient visits. For these plans the amount you pay depends on the type of provider you visit or service you receive.

DEDUCTIBLE: A dollar amount you must pay annually before certain services are covered under your health plan. This means you may be required to pay all or part of a bill, up to your full, annual deductible amount. Some plans may require you to pay coinsurance or copayments after you pay your annual deductible.

COINSURANCE: A percentage of the cost of covered services that you must pay after you have paid your full, annual deductible amount.

OUT-OF-POCKET MAXIMUM: A limit on the amount of cost sharing that you have to pay annually for covered services. The types of cost sharing amounts (such as copayment, deductible or coinsurance amounts) that count toward the out-of-pocket maximum may vary by plan.

See the *Schedule of Benefits* for more detailed information on copayments, deductibles and coinsurance, and the services to which they apply.

Facts about referrals

If you need specialty care, your PCP will refer you to another physician or appropriate medical professional. Referrals are not necessary for some services, such as routine eye exams (if covered under your plan) or most gynecological care.

You're covered when you're traveling . . .

When you're away, you're covered for care you may need if you become sick or injured. Harvard Pilgrim covers unexpected or unforeseen care (e.g., for earaches, flu, etc.) when you're traveling outside the state in which you live.

And in an emergency

Harvard Pilgrim covers all medical emergencies (e.g., heart attack, stroke, choking, loss of consciousness or seizures). Just go to the nearest emergency facility or call 911 or another local emergency number.

With the Best Buy HMO, emergency room care services may be subject to the deductible and/or a copayment, depending on your particular plan. Please see the *Schedule of Benefits* for details.

If you are hospitalized, you must call Harvard Pilgrim within 48 hours, or as soon as you can (or ask someone to do this for you). If your attending physician notifies your PCP, this requirement will be met. Your PCP will arrange for any follow-up care you may need.

Be well, save money and more

Learn about different health topics and ways to be well. Keep more money in your wallet with discounts on eyewear and fitness and nutrition programs.[2] Look up your plan details and find out about typical costs for tests and procedures. Visit **www.harvardpilgrim.org** to learn more.

Questions?

If you're already a member, call Member Services with questions at **(888) 333-4742.** For TTY service, call **(800) 637-8257.**

If you're not yet a member, call **(800) 848-9995.**

To learn more about us in general, visit **www.harvardpilgrim.org.**

[2] These savings programs are not insurance products. Rather, they are discounts for programs and services designed to keep members healthy and active.

Save money

with low-cost providers

Harvard Pilgrim's Best Buy – LP plans give you an easy way to lower your out-of-pocket costs and save money.

How?

Just ask your doctor to send you to one of our select low-cost providers (LP) when you need services such as lab tests or outpatient surgery.

We'll waive your deductible for these services and instead cover lab tests at no charge or require a copayment for outpatient surgery. See your plan's *Schedule of Benefits* for details and more information.

Why?

Costs for medical tests and procedures often vary widely with no significant difference in quality. So why pay more if you don't have to?

Receiving services from our low-cost providers helps you save money with lower out-of-pocket costs.

HAVE QUESTIONS OR NEED HELP?

Call Member Services at **(888) 333-4742.** For TTY service, call (800) 637-8257.

This list may change at any time without prior notice. Refer to the online provider directory at www.harvardpilgrim.org/providerdirectory for the latest information.

Lab locations change frequently. Before you visit, please check the ConVerge Diagnostics (www.convergedx.com), LabCorp (www.labcorp.com) and Quest Diagnostics (www.questdiagnostics.com) Web sites to confirm the locations of their patient service centers on this list.

Harvard Pilgrim Health Care *of New England*

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care and its affiliates, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

LAB LOCATIONS

Your plan will cover lab services at no charge when you have them done at the following locations. HMO plans require your primary care provider's or specialist's referral. See the *Schedule of Benefits* for details.

Lab locations change frequently. Before you visit, please check the ConVerge Diagnostics (www.convergedx.com), LabCorp (www.labcorp.com) and Quest Diagnostics (www.questdiagnostics.com) Web sites to confirm the locations of their patient service centers on this list.

New Hampshire

NAME	ADDRESS	CITY/TOWN	PHONE NUMBER
ConVerge Diagnostic Services	282 Route 101, Suite 9 & 10	Amherst	(603) 249-5746
LabCorp	101 Riverway Place	Bedford	(603) 622-2357
Androscoggin Valley Hospital Lab	59 Page Hill Road	Berlin	(603) 752-2200
Newfound Family Practice	5 School Street	Bristol	(603) 524-3211
Quest Diagnostics	280 Pleasant Street	Concord	(603) 229-0684
ConVerge Diagnostic Services	10 Ferry Street, Suite 201	Concord	(603) 715-5910
CH Lab at DH - Concord	253 Pleasant Street	Concord	(603) 226-2200
CH Medical Offices at Horseshoe Pond	One Corporate Center, 60 Commercial Street	Concord	(603) 230-1200
Concord Orthopaedic Professional Association	264 Pleasant Street	Concord	(603) 724-2383
Memorial Medical Office Building on the Concord Hospital Campus	246 Pleasant Street	Concord	(603) 227-7180
Quest Diagnostics	6 Tsienneto Road	Derry	(603) 437-3870
Quest Diagnostics	14 Tsienneto Road	Derry	(603) 425-7614
LabCorp	Central Commons, 750 Central Avenue	Dover	(603) 749-4444
CH Medical Offices East	1990 Dover Road	Epsom	(603) 736-6235
CH Medical Offices East	1990 Dover Road	Epsom	(603) 736-6235
LabCorp	Exeter Executive Park, 19 Hampton Road, #13	Exeter	(603) 772-9603
Franklin Regional Hospital Independent Lab	15 Aiken Avenue	Franklin	(603) 524-3211
Westside Healthcare	125 South Main Street	Franklin	(603) 524-3211
Quest Diagnostics	14 Country Club Road	Gilford	(866) 697-8378
ConVerge Diagnostic Services	391 West Street	Keene	(603) 352-6631
Quest Diagnostics	668 Main Street	Keene	(603) 352-9031
Lakes Region General Hospital Independent Lab	80 Highland Street	Laconia	(603) 524-3211
Quest Diagnostics	6 Buttrick Road, Suite 200	Londonderry	(603) 537-9882
Quest Diagnostics	195 McGregor Street, Center Entrance	Manchester	(603) 625-2864
Interlakes Medical Center	238 Daniel Webster Highway	Meredith	(603) 524-3211
Quest Diagnostics	300 Main Street	Nashua	(603) 578-0321
Penacook Family Physicians	4 Crescent Street	Penacook	(603) 753-4302
Quest Diagnostics	200 Griffin Road, Unit 12	Portsmouth	(603) 431-1025
LabCorp	Lafayette Professional Building, 230 Lafayette Road, Building D	Portsmouth	(603) 436-5311
LabCorp	875 Greenland Road, Unit B-2	Portsmouth	(603) 436-1760
LabCorp	40 Winter Street	Rochester	(603) 332-6181
Quest Diagnostics	45 Stiles Road, Suite 102	Salem	(603) 890-2462
LabCorp	25 Pelham Road, Suite 103A	Salem	(603) 890-3708
LabCorp	289 Main Street	Salem	(603) 890-5446
Quest Diagnostics	4 D West Road, Unit #2, Suite B-3b	Stratham	(603) 772-3028
Cottage Hospital Lab	90 Swiftwater Road	Woodsville	(603) 747-9000

Massachusetts

NAME	ADDRESS	CITY/TOWN	PHONE NUMBER
Quest Diagnostics	138 Haverhill Street	Andover	(978) 475-7520
Quest Diagnostics	22 Mill Street, Suite 107	Arlington	(781) 641-1941
Quest Diagnostics	22 Mill Street, 2nd Floor	Arlington	(617) 894-3041
Quest Diagnostics	221 Boston Road, Suite 1	Billerica	(978) 667-5212
Quest Diagnostics	319 Longwood Avenue	Boston	(617) 731-2240
Quest Diagnostics	340 Wood Road, Suite 302	Braintree	(781) 849-7993
Quest Diagnostics	11 Nevins Street, Suite 204	Brighton	(617) 787-1040
Quest Diagnostics	280 Washington Street, Suite 101	Brighton	(617) 562-1533
Quest Diagnostics	736 Cambridge Street, Suite Sm5	Brighton	(617) 779-6417
Quest Diagnostics	77 Warren Street, 1st Floor, Room 158	Brighton	(617) 562-5349
Quest Diagnostics	225 Quincy Avenue	Brockton	(508) 586-5955
Quest Diagnostics	1 Pearl Street	Brockton	(508) 584-2010
Quest Diagnostics	830 Oak Street	Brockton	(508) 588-0308
LabCorp	1073 Pleasant Street	Brockton	(508) 427-1734
Quest Diagnostics	1101 Beacon Street	Brookline	(617) 566-2810
Quest Diagnostics	1180 Beacon Street, Suite D	Brookline	(617) 232-5733
Quest Diagnostics	1 Brookline Place, Suite 120	Brookline	(617) 735-8870
Quest Diagnostics	575 Mount Auburn Street	Cambridge	(617) 547-4502
Quest Diagnostics	39 Village Square	Chelmsford	(978) 256-1268
Quest Diagnostics	223 Chief Justice Cushing Highway	Cohasset	(781) 383-0180
Quest Diagnostics	140 Commonwealth Avenue	Danvers	(978) 777-6060
Quest Diagnostics	501 Main Street	Dennis	(508) 385-5251
Quest Diagnostics	101 President Avenue, 1st Floor	Fall River	(508) 324-4105
Quest Diagnostics	350 Gifford Street, Suite 15-17	Falmouth	(508) 540-2642
Quest Diagnostics	190 Nonotuck Street, #104	Florence	(413) 584-3864
Quest Diagnostics	10 Commercial Street	Foxboro	(508) 698-1721
Quest Diagnostics	70 Walnut Street, First Floor	Foxboro	(508) 543-0954
Quest Diagnostics	61 Lincoln Street	Framingham	(508) 370-7341
Quest Diagnostics	655 Concord Street	Framingham	(508) 879-0852
Quest Diagnostics	135 Webster Street	Hanover	(781) 871-2005
Quest Diagnostics	1421 Orleans Road, Route 39, Suite S102	Harwich	(508) 432-7764
Quest Diagnostics	253 Pleasant Lake Avenue	Harwich	(508) 430-1592
Quest Diagnostics	209 Summer Street	Haverhill	(978) 374-3712
LabCorp	215 Summer Street, Suite 14	Haverhill	(978) 372-2722
Quest Diagnostics	51 Main Street, First Floor	Hyannis	(508) 778-4100
LabCorp	69 Camp Street, Suite 3	Hyannis	(508) 790-0151
Quest Diagnostics	695 Truman Parkway	Hyde Park	(617) 364-0917
Quest Diagnostics	101 Amesbury Street, Suite 204	Lawrence	(978) 975-4098
Quest Diagnostics	817 Merrimack Street	Lowell	(978) 458-7980
Quest Diagnostics	50 Tremont Street	Melrose	(781) 979-0806
ConVerge Diagnostic Services	One City Hall Plaza	Melrose	(781) 665-0788
Quest Diagnostics	421 Merrimack Street	Methuen	(978) 685-2316
Quest Diagnostics	1 Branch Street	Methuen	(978) 688-4745
LabCorp	411 Merrimack Street, Suite 205	Methuen	(978) 686-9657
LabCorp	380 Merrimack Street, Suite B2	Methuen	(978) 794-4350
Quest Diagnostics	500 E. Washington Street Suite 22	N. Attleboro	(508) 643-4880

Massachusetts (continued)

NAME	ADDRESS	CITY/TOWN	PHONE NUMBER
LabCorp	1400 Centre Street, Suite 208	Newton Center	(617) 244-0923
Quest Diagnostics	170 Pleasant Street	North Andover	(978) 989-0870
LabCorp	200 Sutton Street, Suite 135	North Andover	(978) 685-0063
Quest Diagnostics	49 State Road	North Dartmouth	(508) 993-2601
Quest Diagnostics	825 Washington Street	Norwood	(781) 255-0231
Quest Diagnostics	886 Washington Street	Norwood	(781) 762-4238
Quest Diagnostics	335 Morse Street, 1st Floor	Norwood	(781) 769-5128
Quest Diagnostics	229 Cranberry Highway	Orleans	(508) 255-2010
Quest Diagnostics	23 W. Bay Road	Osterville	(508) 428-0973
ConVerge Diagnostic Services	200 Corporate Place	Peabody	(800) 618-9992
Quest Diagnostics	42 Summer Street	Pittsfield	(413) 499-8718
Quest Diagnostics	57 Long Pond Road	Plymouth	(508) 747-1570
Quest Diagnostics	49 Harry Kemp Way	Provincetown	(508) 487-2062
Quest Diagnostics	21 School Street	Quincy	(617) 786-9990
Quest Diagnostics	500 Congress Street, Suite 1E	Quincy	(617) 773-0080
Quest Diagnostics	230 Washington Street	S. Attleboro	(508) 399-8140
Quest Diagnostics	73 Pleasant Street	S. Weymouth	(781) 335-4208
Quest Diagnostics	780 Chestnut Street	Springfield	(413) 788-7714
LabCorp	966 Park Street, Suite B-7	Stoughton	(781) 297-5208
Quest Diagnostics	8 Burnham Street, 1st Floor	Turners Falls	(413) 772-0318
Quest Diagnostics	1426 Main Street, Suite 3	Walpole	(508) 660-2975
Quest Diagnostics	20 Hope Avenue, Suite 311	Waltham	(781) 647-0347
Quest Diagnostics	106 Main Street	Wareham	(508) 295-0477
LabCorp	72 Cudworth Road	Webster	(508) 461-0019
Quest Diagnostics	3130 State Highway, Route 6	Wellfleet	(508) 349-6404
LabCorp	2081 Centre Street	West Roxbury	(617) 325-2167
Quest Diagnostics	100 MLK, Jr. Boulevard	Worcester	(508) 754-0178
Quest Diagnostics	255 Park Avenue	Worcester	(508) 755-7450
LabCorp	352 Belmont Street	Worcester	(508) 757-8005
LabCorp	140 West Boylston Drive	Worcester	(508) 856-0327
LabCorp	123 Summer Street	Worcester	(508) 363-6263
Quest Diagnostics	24 Common Street	Wrentham	(508) 384-2630
Quest Diagnostics	667 South Street	Wrentham	(508) 384-8532

Maine

NAME	ADDRESS	CITY/TOWN	PHONE NUMBER
Concentra	219 Capitol Street	Augusta	(207) 629-5005
Concentra	34 Gilman Road	Bangor	(207) 941-8300
Mednow Clinic Ellsworth	5 Long Lane	Ellsworth	(207) 667-4655
Concentra	59 East Street	Lewiston	(207) 784-1680
Concentra	29 Winter Street	Norway	(207) 743-7399
Concentra	1600 Congress Street	Portland	(207) 774-7751
Intermed-Marginal Way	84 Marginal Way	Portland	(207) 774-5816
Intermed-Foden Road	100 Foden Road	S. Portland	(207) 874-1489
Intermed-Yarmouth	259 Main Street	Yarmouth	(207) 846-9013

Rhode Island			
NAME	ADDRESS	CITY/TOWN	PHONE NUMBER
Quest Diagnostics	1145 Reservoir Avenue	Cranston	(401) 946-8244
Quest Diagnostics	1524 Atwood Avenue, 1st Floor	Johnston	(401) 521-0232
LabCorp	6 Blackstone Valley Place, Bldg. 7, Suite 707	Lincoln	(401) 333-7925
LabCorp	692 Aquidneck Avenue	Middletown	(401) 846-3104
Quest Diagnostics	407 East Avenue	Pawtucket	(401) 727-1031
Quest Diagnostics	333 School Street	Pawtucket	(401) 724-2970
Quest Diagnostics	1352 Smith Street	Providence	(401) 353-8370
Quest Diagnostics	1 Randall Square	Providence	(401) 456-0545
LabCorp	100 Highland Avenue, Suite 302	Providence	(401) 272-0561
LabCorp	756 Eddy Street, Suite 101	Providence	(401) 272-1929
Quest Diagnostics	730 Kingstown Road	Wakefield	(401) 782-6180
Quest Diagnostics	897 Warwick Avenue	Warwick	(401) 781-7540
Quest Diagnostics	215 Toll Gate Road, Suite 102	Warwick	(401) 737-9032
Quest Diagnostics	300 Toll Gate Road, Suite LI5	Warwick	(401) 738-5450

Vermont			
NAME	ADDRESS	CITY/TOWN	PHONE NUMBER
LabCorp	789 Pine Steet	Burlington	(802) 657-3542

OUTPATIENT SURGICAL CENTERS

Your plan will cover outpatient surgery with a copayment when you have it performed at one of the following locations. HMO plans require your primary care provider's or specialist's referral. See the *Schedule of Benefits* for details.

New Hampshire			
NAME	ADDRESS	CITY/TOWN	PHONE NUMBER
Barrington Surgical Care, LLC	944 Calef Highway	Barrington	(603) 664-0100
Bedford Ambulatory Surgical Center, LLC	11 Washington Place	Bedford	(603) 622-3670
NovaMed Surgery Center of Bedford, LLC dba, NH Eye Surgicenter	105 Riverway Place	Bedford	(603) 627-9540
Androscoggin Valley Hospital ASC	59 Page Hill Road	Berlin	(603) 752-2200
Capital Orthopaedic Surgery Center	264 Pleasant Street	Concord	(603) 224-3368
Concord Ambulatory Surgery Center	60 Commercial Street, Suite 301	Concord	(603) 415-9460
Concord Endoscopy Center, LLC	1 Corporate Place, 60 Commercial Street, Suite 201	Concord	(603) 415-9450
Concord Eye Surgery, LLC	246 Pleasant Street, Suite 105B	Concord	(603) 224-6503
Capital Orthopaedic Surgery Center	14 Tsienneto Road, Suite 100	Derry	(603) 224-3368
Franklin Regional Hospital Outpatient Surgery	15 Aiken Avenue	Franklin	(603) 524-3211
Hillside ASC, LLC d/b/a LRGHealthcare Ambulatory Surgical Center at Hillside Medical Park	14 Maple Street	Gilford	(603) 527-7514
Laconia Clinic Ambulatory Surgical Center	724 North Main Street	Laconia	(603) 527-2760
Lakes Region General Hospital Outpatient Surgery	80 Highland Avenue	Laconia	(603) 524-3211
Dartmouth Hitchcock Clinic Manchester Surgery Center	100 Hitchcock Way	Manchester	(603) 629-1171

New Hampshire (continued)

NAME	ADDRESS	CITY/TOWN	PHONE NUMBER
Elliot One Day Surgery Center	185 Queen City Avenue	Manchester	(603) 663-5900
Centers For Pain Solutions, LLC	280 Main Street, Suite 420	Nashua	(603) 577-3003
Nashua Ambulatory Surgical Center, LLC	15 Riverside Street	Nashua	(603) 622-3670
NovaMed Surgery Center of Nashua, LLC dba, Nashua Eye Surgery Center	5 Coliseum Avenue	Nashua	(603) 882-9800
The Surgery Center of Greater Nashua	10 Prospect Street	Nashua	(603) 578-9909
Northeast Surgical Care	2299 Woodbury Avenue	Newington	(603) 431-5563
Atlantic Plastic Surgery Center	100 Griffin Road, Suite B	Portsmouth	(800) 633-6860
Portsmouth Regional Ambulatory Surgery Center	333 Borthwick Avenue, Suite 200	Portsmouth	(603) 433-0941
Salem Surgery Center, LP	32 Stiles Road, Unit 101	Salem	(603) 898-3610
Dr. O'Connell's Pain Care Centers, Inc., dba, Pain Care Centers, Inc.	255 Route 108	Somersworth	(603) 692-3166
Stratham Ambulatory Surgery Center	4B West Road	Stratham	(603) 772-2076
Cottage Hospital Ambulatory Services	90 Swiftwater Road	Woodsville	(603) 747-9000

Massachusetts

NAME	ADDRESS	CITY/TOWN	PHONE NUMBER
Middlesex Endoscopy Center, LLC dba Middlesex Digestive Health and Endoscopy Center	45A Discovery Way	Acton	(978) 429-2000
Cataract & Laser Center Associates, PC	1 Berkshire Square	Adams	(413) 943-9934
Valley Medical Group, PC, dba Valley Medical Group Ambulatory Surgery and Procedure Center	31 Hall Drive	Amherst	(413) 772-3329
Cataract & Laser Center of the North Shore, LLC	349 North Main Street	Andover	(978) 475-0959
New England Surgery Center, LLC	900 Cummings Center, Suite 122U	Beverly	(978) 922-4670
Boston Eye Surgery & Laser Center	50 Staniford Street	Boston	(617) 723-2015
South Shore Endoscopy Center	659 Washington Street	Braintree	(781) 849-9577
Endoscopy Center of SouthEast MA	One Pearl Street, Suite 1800	Brockton	(508) 586-9327
Richard A. Bartlett, MD, PC	77 Pond Avenue, Suite 104-C	Brookline	(617) 735-1800
Longwood Plastic Surgery, P.C.	235 Cypress Street, Suite 210	Brookline	(617) 383-6250
Northeast Plastic Surgery, P.C.	15 Village Square	Chelmsford	(978) 256-8048
Cataract & Laser Center, Inc.	333 Elm Street	Dedham	(781) 326-3800
Same Day SurgiCenter, Inc.	272 Stanley Street	Fall River	(508) 672-2290
Cape Cod Surgery Center, Inc.	160 Falmouth Road, Suite B	Falmouth	(774) 238-4410
Charles River Endoscopy, LLC	571 Union Avenue, 2nd Floor	Framingham	(508) 665-4111
Cataract & Laser Center Central, LLC	95 Mechanic Street	Gardner	(978) 632-6674
Cape And Islands Endoscopy Center, LLC	700 Attuck's Lane, Suite 1B	Hyannis	(508) 775-7751
Hyde Park Pain Management, LLC	188 Providence Street	Hyde Park	(617) 833-6100
Central MA Ambulatory Endoscopy Center	105 Erdman Way	Leominster	(978) 840-6767
Northeast Endoscopy Center, LLC	59 Composite Way	Lowell	(978) 349-2146
Cataract Surgery Center of Milford, Inc.	145 West Street	Milford	(508) 381-6040
Advanced Eye Surgery Center, LLC	500 Faunce Corner Road, Suite 180	North Dartmouth	(508) 717-0270
Candescent Eye Health Surgicenter, LLC d/b/a Greater New Bedford Surgicenter	51 State Street	North Dartmouth	(508) 997-1274
Eastern Massachusetts Surgery Center, LLC	100 Morse Street	Norwood	(781) 255-0362

Massachusetts (continued)

NAME	ADDRESS	CITY/TOWN	PHONE NUMBER
Peabody Surgery Center, LLC	7 First Avenue	Peabody	(978) 531-6966
Orthopaedic Surgical Center of The North Shore, LLC	One Orthopedic Drive, Main Level	Peabody	(978) 818-6514
Berskshire Cosmetic & Reconstructive Surgery Center	426 South Street	Pittsfield	(413) 496-9272
Berkshire Endoscopy Center, LLC	53 Eagle Street, 3rd Floor	Pittsfield	(413) 236-5959
East Pond Enterprises, Inc.	40 Industrial Park Road	Plymouth	(508) 747-7246
Plymouth Laser Center, PC, dba Plymouth Laser & Surgical Center, PC	40 Industrial Park Road	Plymouth	(508) 746-6178
Boston Plastic Surgery	2300 Crown Colony Drive, Suite 101	Quincy	(617) 786-7600
Boston University Eye Associates	90 New State Highway	Raynham	(508) 947-5433
Cape Cod ASC, LLC, d/b/a Ambulatory Surgery and Laser Center of Cape Cod	280 Heritage Park, Suite F	Sandwich	(508) 833-6050
Cape Cod Eye Surgery & Laser Center	282 Rt. 130 & Cotuit Road	Sandwich	(508) 833-8222
MD Sine, LLC d/b/a Surgery Center of New England	55 St. George Road	Springfield	(413) 736-7463
Pioneer Valley Surgicenter, LLC	3550 Main Street, Suite 103	Springfield	(413) 788-9700
Northeast Ambulatory Center	3 Woodland Road, Suite 321	Stoneham	(781) 665-5233
North Shore Cataract & Laser Center	91 Montvale Avenue	Stoneham	(781) 438-5995
DHA Endoscopy, LLC	91 Montvale Avenue, Suite 103	Stoneham	(781) 835-2111
East Bay Surgery Center, LLC	440 Swansea Mall Drive	Swansea	(508) 324-1171
Boston IVF, dba Surgery Center of Waltham	130 Second Avenue	Waltham	(781) 434-6400
West Suburban Eye Surgery Center, LLC, dba Surgisite Boston	1440 Main Street	Waltham	(781) 891-9300
Boston Eye Surgery & Laser Center (Waltham)	52 Second Avenue, Suite 2500	Waltham	(781) 768-5590
Boston Out-Patient Surgical Suites, LLC	840 Winter Street	Waltham	(781) 895-4901
Boston Surgery Center, LLC	85 First Avenue	Waltham	(781) 647-7246
Boston Endoscopy Center	175 Worcester Street	Wellesley	(617) 754-0800
West Bridgewater MA Endoscopy ASC, LLC dba Commonwealth Endoscopy Center	120 West Center Street	West Bridgewater	(508) 588-6700
Cataract & Laser Center West, LLC	171 Interstate Drive	West Springfield	(413) 737-5500
Weymouth Endoscopy, LLC	1085 Main Street	Weymouth	(781) 331-2911
New England Eye Surgical Center, Inc.	696 Main Street	Weymouth	(781) 331-3820
ARC Worcester Surgical Center, LP dba Worcester Surgical Center	300 Grove Street	Worcester	(508) 754-0700
Surgical Eye Experts of New England, LLC, dba SEE New England	385 Grove Street	Worcester	(508) 453-8820
New England Surgical Center for Out Patient Endoscopy, LLC	630A Plantation Street	Worcester	(508) 853-2058

NEW HAMPSHIRE INTERLOCAL TRUST

Prescription Drug Options As of July 1, 2013

Prescription Drug Plan Options with $0 Tier 1 Copayment							
Retail (30 Day Supply)	$0/$15/$15	$0/$15/$15	$0/$15/$15	$0/$20/$30	$0/$20/$30	$0/$25/$40	$0/$30/$50
Mail Order (90 Day Supply)	$0/$1/$1	$0/$7/$7	$0/$15/$15	$0/$1/$1	$0/$20/$30	$0/$25/$40	$0/$30/$50

Prescription Drug Plan Options with Low Tier 1 Copayment					
Retail (30 Day Supply)	$5/$20/$30	$5/$20/$30	$10/$30/$50	$10/$30/$50	$15/$45/$70
Mail Order (90 Day Supply)	$5/$20/$30	$10/$30/$50	$10/$30/$50	$15/$45/$70	$15/$45/$70

NEW 4-Tier Prescription Drug Plan Options				
Retail (30 Day Supply)	$0/$10/$20/$30	$0/$10/$20/$30	$0/$10/$30/$50	$5/$15/$30/$50
Mail Order (90 Day Supply)	$0/$10/$20/$30	$0/$10/$40/$60	$0/$10/$30/$50	$5/$15/$30/$50

Jul-13

Harvard Pilgrim's 4-Tier Prescription Drug Program for New Hampshire Interlocal Trust

FEATURING TIER 1 DRUGS AT NO COST TO YOU – A $0 COPAYMENT!

Harvard Pilgrim is doing more to help control premium increases and out-of-pocket costs – like ensuring your employees always pay a low copayment on our lowest-cost generic drugs. With our 4-Tier Prescription Drug Program for New Hampshire Interlocal Trust, members pay $0 for Tier 1.

How the 4-Tier Prescription Drug Program works
Our four-tier benefit places all covered medications into one of four levels or tiers.

TIER 1 $0 **TIER 1, OUR LOWEST COST TIER, CONSISTS OF MANY LOW-COST GENERIC DRUGS.** Your employees will pay nothing, a $0 copayment, for any prescription drug in Tier 1. Tier 1 drugs contain the same active ingredients as their brand-name counterparts.

TIER 2 $$ **TIER 2 CONSISTS PRIMARILY OF HIGHER-COST GENERIC DRUGS.** These drugs contain the same active ingredients as their brand-name counterparts. Tier 2 may also include brand-name drugs that Harvard Pilgrim has determined to be more effective, less costly or to have fewer side effects than similar medications.

Did you know? Generic drugs contain the same active ingredients as their brand-name counterparts.

TIER 3 $$$ **TIER 3 CONSISTS MOSTLY OF BRAND-NAME DRUGS WITHOUT GENERIC EQUIVALENTS.** These drugs have been selected by the plan based on review of the relative safety, effectiveness and cost of the many brand-name drugs on the market. In some cases, Tier 3 may include generic drugs determined to be more costly than their brand-name alternatives.

TIER 4 $$$$ **TIER 4 CONSISTS OF DRUGS** that the plan has not included in Tier 1, Tier 2 or Tier 3.

$0—$$$$: The number of dollar signs indicates the cost level of prescriptions in that tier, $0 being the lowest and $$$$ being the highest.

More ways for your employees to save
With some Harvard Pilgrim plans, members can save a full, one month's copayment when using our mail order program for Tier 2, 3 or 4 maintenance medications (up to a 90-day supply)*. Members can access this information via **www.harvardpilgrim.org** under "Pharmacy Program."

Questions?
If you have questions or would like to learn more, please call New Hampshire Interlocal Trust at **1-888-960-6448.**

*Savings vary based on specific plan design.

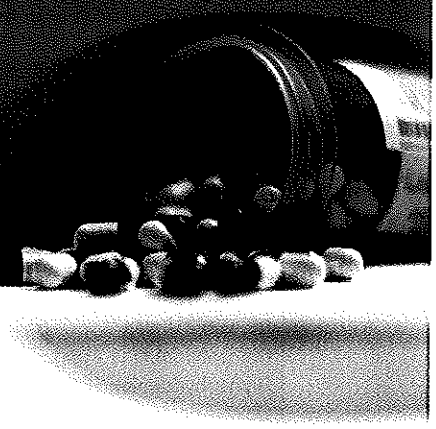
Harvard Pilgrim Health Care

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care and its affiliates, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

NEW HAMPSHIRE INTERLOCAL TRUST

TIER 1 PRESCRIPTIONS AT NO COST TO YOU—A **$0** COPAYMENT WITH

Harvard Pilgrim's 4-Tier Drug Program



You'll pay a low, $0 copayment (for up to a 30-day supply) on many generic prescriptions to treat a variety of diseases and conditions.[1] All generic drugs contain the same active ingredients as their brand-name counterparts.

If you take any of our Tier 1 drugs regularly, your prescriptions cost you nothing through the mail service prescription drug program when you order a 90-day supply.[2]

Check out the wide range of Tier 1 medications available with our 4-Tier Prescription Drug Program

Tier 1 drug name	Drug form	Tier 1 drug name	Drug form
Acetaminophen-Codeine 120-12mg/5mL	Elixir	Atenolol 100mg	Tablet
Acetaminophen-Codeine 300mg-15mg	Tablet	Atenolol-Chlorthalidone 50mg-25mg	Tablet
Acetaminophen-Codeine 300mg-30mg	Tablet	Atenolol-Chlorthalidone 100mg-25mg	Tablet
Ak-Pentolate 1%	Drops	Atropine Sulfate 1%	Drops
Albuterol Sulfate 2mg	Tablet	Atropine Sulfate 1%	Ointment
Albuterol Sulfate 2mg/5mL	Syrup	Betamethasone Valerate 0.1%	Cream
Albuterol Sulfate 4mg	Tablet	Betamethasone Valerate 0.1%	Ointment
Allopurinol 100mg	Tablet	Bleph-10	Drops
Allopurinol 300mg	Tablet	Captopril 12.5mg	Tablet
Alprazolam 0.25mg	Tablet	Captopril 25mg	Tablet
Alprazolam 0.5mg	Tablet	Captopril 50mg	Tablet
Alprazolam 1mg	Tablet	Cheratussin AC 100-10mg/5mL	Liquid
Alprazolam 2mg	Tablet	Chloral Hydrate 500mg/5mL	Syrup
Amiloride-Hydrochlorothiazide 5mg-50mg	Tablet	Chlordiazepoxide 5mg	Capsule
Amitriptyline 10mg	Tablet	Chlordiazepoxide 10mg	Capsule
Amitriptyline 25mg	Tablet	Chlordiazepoxide 25mg	Capsule
Amitriptyline 50mg	Tablet	Chlorothiazide 250mg	Tablet
Amitriptyline 75mg	Tablet	Chlorothiazide 500mg	Tablet
Amitriptyline 100mg	Tablet	Chlorthalidone 25mg	Tablet
Amitriptyline 150mg	Tablet	Chlorthalidone 50mg	Tablet
Amoxicillin 125mg	Chewable Tablet	Chlorzoxazone 500mg	Tablet
Amoxicillin 125mg/5mL	Oral Suspension	Ciprofloxacin 250mg	Tablet
Amoxicillin 250mg	Capsule	Ciprofloxacin 500mg	Tablet
Amoxicillin 250mg	Chewable Tablet	Ciprofloxacin 750mg	Tablet
Amoxicillin 250mg/5mL	Oral Suspension	Clonazepam 0.5mg	Tablet
Amoxicillin 400mg/5mL	Oral Suspension	Clonazepam 1mg	Tablet
Amoxicillin 500mg	Capsule	Clonazepam 2mg	Tablet
Amoxicillin 875mg	Tablet	Clonidine 0.1mg	Tablet
Atenolol 25mg	Tablet	Clonidine 0.2mg	Tablet
Atenolol 50mg	Tablet	Clonidine 0.3mg	Tablet

[1] If you're enrolled in our Best Buy HSA PPO coverage, all covered drugs (including those purchased through the mail service prescription drug program) apply toward your in-network medical deductible.

[2] Savings vary based on specific benefit design.

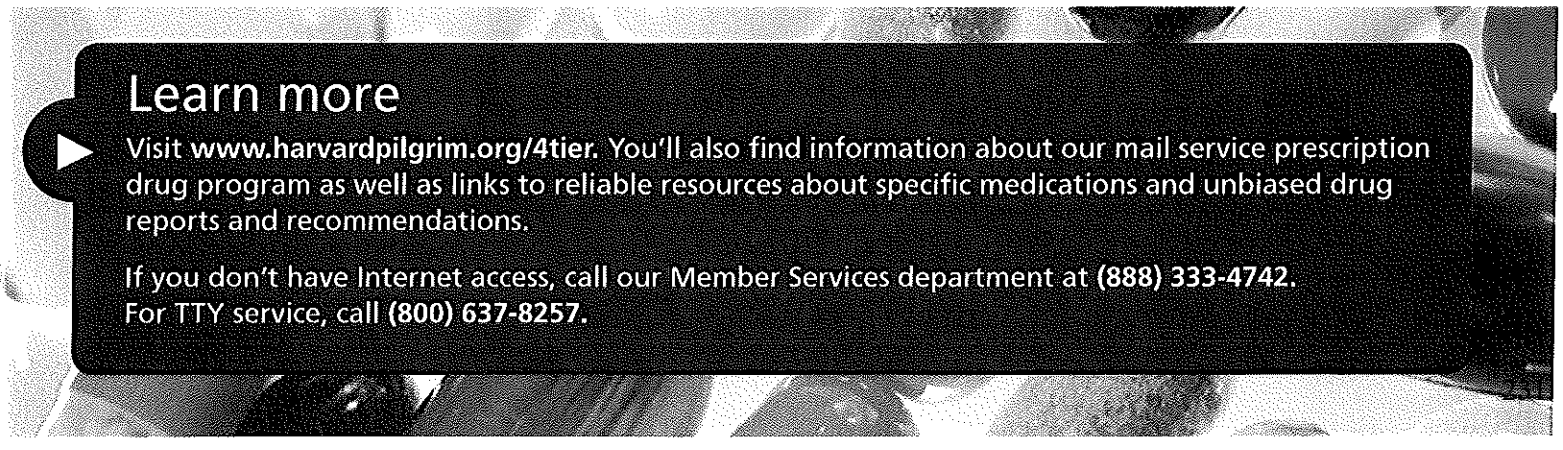
Continued ▸

Harvard Pilgrim HealthCare | NEW HAMPSHIRE INTERLOCAL TRUST

Tier 1 drug name	Drug form
Cyanocobalamin 1000 mcg/mL	Vial
Cyclopentolate 1%	Drops
Dexamethasone 0.5mg	Tablet
Dexamethasone 0.75mg	Tablet
Dexamethasone 1mg	Tablet
Dexamethasone 1.5mg	Tablet
Dexamethasone 4mg	Tablet
Diazepam 2mg	Tablet
Diazepam 5mg	Tablet
Diazepam 10mg	Tablet
Digoxin 125mcg	Tablet
Digoxin 250mcg	Tablet
Diphenhydramine 25mg	Capsule
Diphenhydramine 50mg	Capsule
Doxazosin 4mg	Tablet
Doxazosin 8mg	Tablet
Doxepin 10mg	Capsule
Doxepin 25mg	Capsule
Doxepin 50mg	Capsule
Doxepin 75mg	Capsule
Doxepin 100mg	Capsule
Doxycycline Hyclate 50mg	Capsule
Doxycycline Hyclate 100mg	Tablet
Doxycycline Hyclate 100mg	Capsule
Enalapril 2.5mg	Tablet
Enalapril 5mg	Tablet
Enalapril 10mg	Tablet
Enalapril 20mg	Tablet
Endocet 5mg-325mg	Tablet
Ethedent 0.25 (0.55mg)	Chewable Tablet
Ethedent 0.5 (1.1mg)	Chewable Tablet
Ethedent 1 (2.2mg)	Chewable Tablet
Famotidine 20mg	Tablet
Fluconazole 150mg	Tablet
Fluoxetine 10mg	Capsule
Fluoxetine 10mg	Tablet
Fluoxetine 20mg	Capsule
Flurazepam 15mg	Capsule
Flurazepam 30mg	Capsule
Folic Acid 1mg	Tablet
Furosemide 20mg	Tablet
Furosemide 40mg	Tablet
Furosemide 80mg	Tablet
Gani-Tuss NR 100-10mg/5mL	Liquid
Gentak 0.3%	Drops
Gentamicin Sulfate 0.1%	Cream
Gentamicin Sulfate 0.1%	Ointment
Gentamicin Sulfate 0.3%	Drops
Glimepiride 1mg	Tablet
Glimepiride 2mg	Tablet
Glimepiride 4mg	Tablet
Glipizide 5mg	Tablet
Glipizide 10mg	Tablet
Glyburide 1.25mg	Tablet
Glyburide, Micronized 1.5mg	Tablet
Glyburide, Micronized 3mg	Tablet
Glyburide, Micronized 6mg	Tablet
Guaifenesin-Codeine 100-10mg/5mL	Liquid
Hydrochlorothiazide 12.5mg	Capsule
Hydrochlorothiazide 25mg	Tablet
Hydrochlorothiazide 50mg	Tablet
Hydrocodone-Acetaminophen 5mg-500mg	Tablet
Hydrocodone-Acetaminophen 7.5-650mg	Tablet
Hydrocodone-Acetaminophen 7.5-750mg	Tablet
Hydrocortisone 1%	Cream
Hydrocortisone 1%	Ointment
Hydrocortisone 2.5%	Cream
Hydrocortisone 2.5%	Ointment
Ibuprofen 400mg	Tablet
Ibuprofen 600mg	Tablet
Ibuprofen 800mg	Tablet
Indapamide 1.25mg	Tablet
Indapamide 2.5mg	Tablet
Iophen-C NR 100-10mg/5mL	Liquid
Isoniazid 100mg	Tablet
Isoniazid 300mg	Tablet
Isosorbide Dinitrate 5mg	Tablet
Isosorbide Dinitrate 10mg	Sublingual Tablet
Isosorbide Dinitrate 10mg	Tablet
Lisinopril 2.5mg	Tablet
Lisinopril 5mg	Tablet
Lisinopril 10mg	Tablet
Lisinopril 20mg	Tablet
Lisinopril 30mg	Tablet
Lisinopril 40mg	Tablet
Medroxyprogesterone Acetate 2.5mg	Tablet
Medroxyprogesterone Acetate 5mg	Tablet
Medroxyprogesterone Acetate 10mg	Tablet
Metoprolol Tartrate 25mg	Tablet
Metoprolol Tartrate 50mg	Tablet
Metoprolol Tartrate 100mg	Tablet
Metronidazole 250mg	Tablet
Metronidazole 500mg	Tablet
Mytussin AC 100-10mg/5mL	Liquid
Natalcare Pic	Tablet
Natalcare Plus	Tablet
Natalcare Rx	Tablet
Natalcare Three	Tablet
Natatab FA	Tablet
Neomycin-Bacitracin-Polymyxin 3.5mg-400	Ointment
Neomycin-Polymyxin-Dexameth 0.1%	Drops
Neomycin-Polymyxin-Dexameth 3.5-10K-1	Ointment
Nystatin 100,000units/gm	Cream
Nystatin 100,000units/gm	Ointment
Nystatin-Triamcinolone 100,000-0.1	Cream
Nystatin-Triamcinolone 100,000-0.1	Ointment
Oxycodone-Acetaminophen 5mg-325mg	Tablet
Penicillin V Potassium 125mg/5mL	Oral Suspension
Penicillin V Potassium 250mg	Tablet
Penicillin V Potassium 250mg/5mL	Oral Suspension
Penicillin V Potassium 500mg	Tablet
Phenazopyridine 100mg	Tablet
Phenazopyridine 200mg	Tablet
Phenobarbital 15mg	Tablet
Phenobarbital 16.2mg	Tablet

Tier 1 drug name	Drug form
Phenobarbital 30mg	Tablet
Phenobarbital 32.4mg	Tablet
Phenobarbital 60mg	Tablet
Phenobarbital 64.8mg	Tablet
Phenobarbital 97.2mg	Tablet
Phenobarbital 100mg	Tablet
Phenylephrine 2.5%	Drops
Pilocarpine 0.5%	Drops
Pilocarpine 1%	Drops
Pilocarpine 2%	Drops
Pilocarpine 4%	Drops
Piroxicam 10mg	Capsule
Piroxicam 20mg	Capsule
Polyvitamin with Iron-Fluoride 0.25mg/mL	Drops
Polyvitamin with Iron-Fluoride 0.5mg/mL	Drops
Prednisolone 5mg	Tablet
Prednisone 1mg	Tablet
Prednisone 2.5mg	Tablet
Prednisone 5mg	Dose Pack
Prednisone 5mg	Tablet
Prednisone 10mg	Dose Pack
Prednisone 10mg	Tablet
Prednisone 20mg	Tablet
Prednisone 50mg	Tablet
Prenafirst	Tablet
Prenaplus	Tablet
Prenatabs FA	Tablet
Prenatal 1 Plus 1	Tablet
Prenatal 19	Chewable Tablet
Prenatal Low Iron	Tablet
Prenatal MTR	Tablet
Prenatal Plus 27mg-1mg	Tablet
Prenatal Rx 1 60mg-1mg	Tablet
Prenatal Z 65mg-1mg	Tablet
Prochlorperazine Maleate 5mg	Tablet
Prochlorperazine Maleate 10mg	Tablet
Procto-Pak 1%	Cream
Promethazine-DM 15-6.25/5mL	Syrup
Propranolol 10mg	Tablet
Propranolol 20mg	Tablet
Propranolol 40mg	Tablet
Propranolol 80mg	Tablet
Renaf 0.5 (1.1mg)	Chewable Tablet
Renaf 1 (2.2mg)	Chewable Tablet
Renal Caps 1mg	Capsule
Reno Caps 1mg	Capsule
Roxicet 5mg-325mg	Tablet
simvastatin 5mg	Tablet
simvastatin 10mg	Tablet
simvastatin 20mg	Tablet
simvastatin 40mg	Tablet
simvastatin 80mg	Tablet
Sodium Fluoride 0.25 (0.55)	Chewable Tablet
Sodium Fluoride 0.5 (1.1mg)	Tablet
Sodium Fluoride 0.5 (1.1mg)	Chewable Tablet
Sodium Fluoride 0.5mg/mL	Drops
Sodium Fluoride 1mg (2.2mg)	Chewable Tablet
Sulfacetamide Sodium 10%	Drops
Sulfamide 10%	Drops
Temazepam 15mg	Capsule
Temazepam 30mg	Capsule
Tetracycline 250mg	Capsule
Tetracycline 500mg	Capsule
Thyroid 32.5mg	Tablet
Thyroid 60mg	Tablet
Thyroid 65mg	Tablet
Thyroid 120mg	Tablet
Tobramycin Sulfate 0.3%	Drops
Trazodone 50mg	Tablet
Trazodone 100mg	Tablet
Triamcinolone Acetonide 0.025%	Cream
Triamcinolone Acetonide 0.025%	Ointment
Triamcinolone Acetonide 0.1%	Cream
Triamcinolone Acetonide 0.1%	Ointment
Triamcinolone Acetonide 0.5%	Cream
Triamcinolone Acetonide 0.5%	Ointment
Triamterene-Hydrochlorothiazide 37.5-25mg	Capsule
Triamterene-Hydrochlorothiazide 37.5-25mg	Tablet
Triamterene-Hydrochlorothiazide 75-50mg	Tablet
Trimox 250mg	Capsule
Trimox 250mg/5mL	Oral Suspension
Trinate 28mg-1mg	Tablet
Tri-Vitamin with Iron-Fluoride 0.25mg/mL	Drops
Tri-Vitamin-Fluoride 0.25mg/mL	Drops
Tri-Vitamins with Fluoride 0.5mg/mL	Drops
Vinate One 60mg-1mg	Tablet
Vinate-M 27mg-1mg	Tablet
Vi-Q-Tuss 100-5mg/5	Syrup
Vitamin D 50,000 units	Capsule

This list is subject to change at any time.



Learn more

Visit **www.harvardpilgrim.org/4tier.** You'll also find information about our mail service prescription drug program as well as links to reliable resources about specific medications and unbiased drug reports and recommendations.

If you don't have Internet access, call our Member Services department at **(888) 333-4742.**
For TTY service, call **(800) 637-8257.**

Phase 1

Earning Period: April 1, 2014 – June 30, 2014
Applied/Available: July 1, 2014 – December 31, 2014
Amount Earned: $250 per subscriber

When	April-June $250
Quarterly Activities	- Open Enrollment Meeting
NOTE: Participants **MUST** complete the activity in its entirety to receive the $250 into the HRA.	
	Total Wellness Dollars per Subscriber $250

Phase 2

Earning Period: July 1, 2014 – December 31, 2014
Applied/Available: January 1, 2015 – December 30, 2015
Amount Earned: up to $500 per subscriber ($250 per quarter)

Health Questionnaire (Requirement)

When	July-September $250	October-December $250
Quarterly Activities	- SaveOn Education - 4-Week Challenge	- Education Session - Health Coaching Enrollment
NOTE: Participants **MUST** complete the quarter in its entirety to receive any HRA dollars, but may opt out of any quarter.		
When	Ongoing	
	Participants may substitute any Quarterly Activity with one of the options below.	
Alternative Activities	- PCP Annual Physical - Biometric Screenings - Wellness Committee Member and Meeting Attendance - Pool-Wide NHIT Challenge (Seasonal, will take place in quarter 1 and quarter 3)	
	Total Wellness Dollars per Subscriber up to $500	

Phase 3

Earning Period: January 1, 2015 – December 31, 2015
Applied/Available: January 1, 2016 – December 30, 2016
Amount Earned: up to $500 per subscriber ($125 per quarter)

Health Questionnaire (Requirement)

When	January-March $125	April-June $125	July-September $125	October-December $125
Quarterly Activities	- Vendor Fair	- Open Enrollment Meeting *(Requirement)* - 4-Week Challenge	- Consumerism Session -Health Coaching Graduation	- Educational Session - 4-Week Challenge
NOTE: Participants **MUST** complete the quarter in its entirety to receive any HRA dollars, but may opt out of any quarter.				
When	Ongoing			
	Participants may substitute any Quarterly Activity with one of the options below.			
Alternative Options	- PCP Annual Physical - Biometric Screenings - Wellness Committee Member and Meeting Attendance - Pool-Wide NHIT Challenge (Seasonal, will take place in quarter 1 and quarter 3)			
	Total Wellness Dollars per Subscriber up to $500			

Incentive HRA

The New Hampshire Interlocal Trust (NHIT) suggests the following plan for implementing an incentive Health Reimbursement Account (HRA). This is a three-part program to help introduce, build, and maintain employee acceptance and engagement in the incentive HRA program.

At the **<Member's>** request, the NHIT has designed the following annual plan that gives each subscriber the opportunity to earn quarterly incentives to be deposited into an HRA account. The HRA program will coincide with the plan's deductible, from January to December. The maximum incentive earned will be $500 per calendar year.

Phase 1 will kick off the program in the spring of 2014 for the plan year beginning July 2014. Because the <Member's> plan renewal runs from July to June, Phase 2 will be a six-month introductory phase for the HRA and its wellness incentives, which will run from July 2014 to December 2014. Beginning January 2015, the HRA year will restart and a new wellness incentive phase will begin.

Wellness incentive dollars for the HRA will always be earned in the phase prior to the period that the funds would be available.

Program Overview:

- The incentive HRA program will correspond with the calendar year deductible, running from **January 1st through December 31st**
  - The program will be broken out into phases (see second page for timeline and details)
- To be eligible for the program a subscriber must complete the Health Questionnaire (HQ) in phases two, three and any future years that the incentive HRA program is offered
- Participants will have the opportunity to complete quarterly activities in each phase to earn HRA incentive dollars
  - Quarterly activities must be completed within the designated quarter
- Participants are required to track and submit any applicable quarterly activity documents to NHIT
  - All tracking documents will be provided by NHIT
  - All documents must be submitted quarterly by the dates indicated by NHIT
- Alternative activities are available to complete in place of missed quarterly activities
  - Each alternative activity can only be utilized once per phase
  - Open enrolment meetings are required and cannot be replaced with an alternative activity

NEW HAMPSHIRE INTERLOCAL TRUST

	2014 Medicare Part A & B Coverage	ME $5 (30) Harvard Pilgrim
In-Patient Hospital (Including Day Surgery) **	Covered Under Part A	100%
Day 1-60	100% after Medicare Part A Deductible* ($1,216 per benefit period)	
Day 61-90	100% after Medicare Part A Coinsurance ($304 per day)	
Skilled Nursing (SNF)	Covered Under Part A; 100 day max/benefit period	100%
Days 1-20	100% after a minimum 3-day inpatient hospital stay	
Days 21-100	100% after SNF Coinsurance ($152 per day)	
Outpatient Hospital	80% after MedicarePart B Deductible ($147/cy); varies by service	100%
Emergency Room	80% after Medicare Part B Deductible ($147/cy); varies by service	$30 copay
Ambulance Services	80% after Medicare Part B Deductible and Coinsurance	100%
MRI/CT Scans	80% after Medicare Part B Deductible ($147/cy); varies by service	100%
Preventive Care	100%	100%
Physician Services/Office Visit***	80% after Medicare Part B Deductible	$5 Copay
Physical/Speech/Occupational Therapy	80% after Medicare Part B Deductible ($147/cy) and Coinsurance varies by service	$5 copay
Chiropractic Care	80% after Medicare Part B Deductible ($147/cy) and Coinsurance varies by service	$5 copay
Allergy Injections	80% after Medicare Part B Deductible ($147/cy) and Coinsurance varies by service	$5 copay
Routine Annual Eye Exam	80% after Medicare Part B Deductible ($147/cy) and Coinsurance varies by service	$5 copay; Discounts for Frames/lenses
Home Health Care	Covered Under Part A 100%	100%
Durable Medical Equipment (DME)****	80% after Medicare Part B Deductible ($147/cy) and Coinsurance; varies by service	100%
Inpatient Mental Health	100% after Part A Deductible	100%; 60 days max
Outpatient Mental Health	80% after Medicare Part B Deductible ($147/cy) and Coinsurance varies by service	$5 copay; 24 visits max
Inpatient Substance Abuse	100% after Part A Deductible	100% 30 day max
Outpatient Substance Abuse	80% after Medicare Part B Deductible ($147/cy) and Coinsurance varies by service	$5 copay; $500 max/cy
Prescription Drugs	Not Covered	$0/$25/$40
Mail Order Drugs	Not Covered	$0/$25/$40
Deductible: Individual*	Part A and Part B Deductibles Apply	None
Maximum Out of Pocket: Individual	Part A and Part B Deductibles/Coinsurance + Rx Cost	Copays
Maximum Lifetime Benefit	Unlimited	Unlimited

cy = calendar year max=maximum

This is only a summary of benefits, please consult appropriate Schedule of Benefits for more information.

*This deductible doe not include carryover provision.

** An additional 60 "Lifetime Reserve" days are available to each enrolled member who exceeds the 90 day maximum per benefit period.
2014 Medicare coinsurance for this benefit is $608 per day.

***Medicare covers a yearly "Wellness" visit and a one-time "Welcome to Medicare" preventive visit.

****Durable Medical Equipment includes: certain medical equipment like a walker, wheelchair or hospital bed ordered by your doctor.

A benefit Period begins the first day of hospitalization and ends after you haven't received any inpatient hospital care for 60 consecutive days.

NOTE: Medicare Parts A & B is a calendar year plan. Rates and benefits are subject to change on the first of each year.

The plan year for Medicare Enhance coincides with your employer group's renewal.

NEW HAMPSHIRE
INTERLOCAL TRUST

Member Groups as of April 2014

1. Alexandria, Town of
2. Amherst, Town of
3. Berlin School District
4. Bethlehem, Town of
5. Berlin, City of
6. Boscawen, Town of
7. Carroll County
8. Colebrook, Town of
9. Coos County
10. Grantham, Town of
11. Hillsborough County
12. Jefferson, Town of
13. Keene, City of
14. Laconia, City of
15. Lancaster, Town of
16. Monroe, Town of
17. North Country Education Services
18. New Ipswich, Town of
19. Rindge, Town of
20. SAU 70– Hanover
21. SAU 9– Conway
22. Sullivan County
23. Tilton-Northfield Fire and EMS
24. Tuftonboro, Town of
25. Wakefield, Town of
26. Warner, Town of
27. Whitefield, Town of

May 23, 2014

Shaun Mulholland, Town Administrator
Town of Allenstown, NH
16 School St
Allenstown, NH 03275

Re: SVRTA **Illustrative** Medical Insurance Quote

Dear Shaun:

Thank you for allowing SCHOOLCARE an opportunity to provide the Suncook Valley Regional Town Association with a medical insurance quote.

We have reviewed the census and claims data provided. Please note that these monthly rates are **illustrative** for the period **July 1, 2014 – June 30, 2015.**

Medical Option #1: ***Office Visit Copay $10 and Rx $5/$15/$35***

Benefit Plan	Single	Two Person	Family
Open Access+	$641.00	$1,282.00	$1,731.00
HMO (Open Access)	$693.00	$1,386.00	$1,871.00
POS (Open Access)	$776.00	$1,552.50	$2,095.50

Medical Option 2: Consumer Driven Health Plan (CDHP)
$1,250/$2,500 Deductible, $2,000/$4,000 OOP Max

Benefit Plan	Single	Two Person	Family
CDHP with Choice Fund	$606.50	$1,213.00	$1,637.50

Retiree Medicare Supplement Plans:

Benefit Plan	Single	Two Person	Family
65+ with Rx (retirees only)	*$380.48	n/a	n/a
65+ without Rx (retirees only)	*$207.00	n/a	n/a

*Retiree Medicare Supplement Plans are subject to change annually on January 1st.

SCHOOLCARE offers several advantages including:

- All plans offer a **nationwide provider network** whereby referrals within the Cigna network are not required. Members can access Cigna medical providers and facilities in 50 U.S. states at the in-network level of benefits. This network also includes the major specialty and teaching hospitals in the Boston area.

- ***Good For You!*** health and wellness incentives: up to $800 annually for a single plan or $1,200 annual for two-person/family plans. Incentive dollars are rewarded for participating in the Keeping Fit program by exercising regularly, attending health education classes such as Weight Watchers, yoga, zumba, first aid, and much more.

- The Coalition provides a 24/7 Employee Assistance Program (EAP), and full services for COBRA and retiree administration all at no additional cost to the employer.

- The Coalition provides Identity Fraud Reimbursement Coverage up to $10,000 for all enrolled members, spouses, domestic partners, children under the age of 25 and parents residing in the members' household.

- The Coalition also contracts with Benefit Strategies to provide Section 125 Administration (Flexible Spending Accounts). The only cost to the employers is a fee of $2.50 per participant per month for claims administration. There are no fees for set-up or renewal and document preparation.

If you have any questions or would like to further discuss our programs in more detail please call either Joanne Trainor (ext. 308) or myself (ext. 305) at 800-562-5254.

Sincerely,

Lisa J. Duquette

Lisa J. Duquette
Executive Director

Enclosures

SchoolCare
Summary of Benefits

Benefits outlined below are intended only as a general summary. All benefits are subject to the terms and conditions of your Health Benefits Booklet. In the event of any inconsistency between this summary and the actual provisions of the plan, the provisions as defined in the Health Benefits Booklet and Endorsements will govern. Covered benefits are subject to review for medical necessity. Out of network payments to providers are based on reasonable and customary charges. Subscriber is responsible for charges above reasonable and customary. Plan year is defined from July 1 through June 30.

BENEFITS	Open Access Point of Service (In Network)	Open Access Point of Service (Out of Network)
DEDUCTIBLES, MAXIMUMS (All copays and coinsurance contribute to the Out-of-Pocket Maximums.)	A POS MEMBER PAYS	A POS MEMBER PAYS
Plan Year Deductible	$0	Individual: $300; Family: $600
Coinsurance	20% (DME and EPA only)	20%
Out-of-Pocket Maximum/Plan Year (Medical)	Individual: $1,000; Family: $2,000	Individual: $900; Family: $1,800
Out-of-Pocket Maximum/Plan Year (Prescription Drugs)	Individual: $2,000; Family: $4,000	Not Covered
Maximum Lifetime benefit	Unlimited	Unlimited
PREVENTIVE CARE*		
Routine Physical Examination	$0	Not Covered
Routine Immunizations	$0	Not Covered
Well Child Preventive Care	$0	Not Covered
Well Woman Preventive Care	$0	Not Covered
Adult Preventive Care	$0	Not Covered
Additional services such as urinalysis and EKG	$0	Not Covered
* Includes Naturopathic Services (In-Network only), Routine Laboratory and Diagnostic Testing		
ROUTINE VISION CARE		
Routine Exam (one every 12 months for all ages)	$10 per visit	Not Covered
Discounts Available for Eyewear		
HEARING TESTS	$10 per visit	Not Covered
OTHER PHYSICIAN SERVICES*		
Office Visits and/or Office Surgery	$10 per visit	Deductible, then 20% to the Out of Pocket Maximum
Maternity Care	$10 per visit (initial visit only)	Deductible, then 20% to the Out of Pocket Maximum
* Includes Naturopathic Services (In-Network only)		
OUTPATIENT DIAGNOSTIC TESTING	$0	Deductible, then 20% to the Out of Pocket Maximum
Radiology and Laboratory Services		
(prior authorization required for some tests)		
HOSPITAL CARE	$0 (Inpatient admissions and some outpatient procedures require prior authorization)	Deductible, then 20% to the Out of Pocket Maximum (Inpatient admissions and some outpatient procedures require prior authorization)
Inpatient Services		
Same Day or Outpatient Surgery		
Radiation and Chemotherapy		
Physician Visits and Services		
Anesthesiologist Services		
Operating Room		
X-ray and Laboratory Services		
Medications and Supplies		
Newborn Care		

OVER

Point of Service (Open Access)

BENEFITS	Open Access Point of Service (In Network)	Open Access Point of Service (Out of Network)
EMERGENCY & URGENT CARE Hospital Emergency Room Urgent Care Facility *(Medically Necessary and Worldwide)*	A POS MEMBER PAYS $50 per visit (waived if admitted) $25 per visit (waived if admitted)	A POS MEMBER PAYS $50 per visit (waived if admitted) $25 per visit (waived if admitted)
MENTAL HEALTH/SUBSTANCE ABUSE		
OUTPATIENT (Physician's office)	$10 copay per visit	Deductible, then 20% to the Out of Pocket Maximum
INPATIENT HOSPITALIZATION AND OUTPATIENT FACILITY (prior authorization required)	$0	Deductible, then 20% to the Out of Pocket Maximum
PRESCRIPTION DRUGS Through participating pharmacies Oral contraceptives (generic) covered at $0 copay (prior authorization required for some drugs)	Retail: (30 day supply) $5 generic/$15 preferred brand name/$35 non-preferred brand name drugs. Maintenance: (90 day supply) $5 generic/$15 preferred brand name/$35 non-preferred brand name drugs available only through Cigna Home Delivery mail order.	Through participating pharmacies. See previous column.
PHYSICAL, OCCUPATIONAL AND SPEECH THERAPIES		
OUTPATIENT: short-term rehab, up to 60 days per person/per plan year; includes PT, OT, ST and cardiac rehab (combined maximum in and out of network)	$10 per day	Deductible, then 20% to the Out of Pocket Maximum
INPATIENT (prior authorization required)	$0	Deductible, then 20% to the Out of Pocket Maximum
CHIROPRACTIC CARE 20 days per person/per plan year (combined maximum in and out of network)	$10 per day	Deductible, then 20% to the Out of Pocket Maximum
ACUPUNCTURE* 12 days per person/per plan year (combined maximum in and out of network) **Coverage based on Cigna's medical guidelines.*	$10 per day	$10 per day
DURABLE MEDICAL EQUIPMENT (DME)	20%	Deductible, then 20% to the Out of Pocket Maximum
EXTERNAL PROSTHETIC APPLIANCES (EPA)	20%	Deductible, then 20% to the Out of Pocket Maximum
OTHER BENEFITS ORAL SURGERY *(accidents only)* REMOVAL OF BONEY IMPACTED WISDOM TEETH SKILLED NURSING CARE *(100 days maximum per person/per plan year)* AMBULANCE *(if not a true emergency, services are not covered)* BLOOD TRANSFUSIONS HOME HEALTH SERVICES HOSPICE	$0 ($10, Physician's office) $0 ($10, Physician's office) $0 $0 $0 $0 $0	All other covered services subject to plan year deductible and 20% coinsurance to the out-of-pocket maximum for the plan year. (Exception: Ambulance service treated at in-network level)
GOOD FOR YOU ! BY SCHOOLCARE Health and Wellness Incentives, Employee Assistance Program	Covered	Covered

OVER

HMO (Open Access)

SCHOOLCARE
SUMMARY OF BENEFITS

Benefits outlined below are intended as a general summary and are covered only when using a Cigna participating provider. All benefits are subject to the terms and conditions of your Health Benefits Booklet. In the event of any inconsistency between this Summary and the Health Benefits Booklet, the provisions as defined in the Health Benefits Booklet and Endorsements will govern. Covered benefits are subject to review for medical necessity. Plan year is defined from July 1 through June 30.

BENEFITS	OPEN ACCESS HMO
DEDUCTIBLES, MAXIMUMS	AN HMO MEMBER PAYS
Plan Year Deductible	$0
Coinsurance	20% (DME and EPA only)
Out-of-Pocket Maximum/Plan Year (Medical)	Individual: $1,000; Family: $2,000
Out-of-Pocket Maximum/Plan Year (Prescription Drugs)	Individual: $2,000; Family: $4,000
Maximum Lifetime benefit	Unlimited
	All copays and coinsurance contribute to the Out-of-Pocket Maximums.
PREVENTIVE CARE*	
Routine Physical Examination	$0
Routine Immunizations	$0
Well Child Preventive Care	$0
Well Woman Preventive Care	$0
Adult Preventive Care	$0
Additional services such as urinalysis and EKG	$0
* Includes Naturopathic Services, Routine Laboratory and Diagnostic Testing	
ROUTINE VISION CARE	
Routine Exam (one every 12 months for all ages)	$10 per visit
Discounts Available for Eyewear	
HEARING TESTS	$10 per visit
OTHER PHYSICIAN SERVICES*	
Office Visits and/or Office Surgery	$10 per visit
Maternity Care	$10 per visit (initial visit only)
* Includes Naturopathic Services	
OUTPATIENT DIAGNOSTIC TESTING	$0
Radiology and Laboratory Services	
(prior authorization required for some tests)	
HOSPITAL CARE	$0 (Inpatient admissions and some outpatient procedures require prior authorization.)
Inpatient Services	
Same Day or Outpatient Surgery	
Radiation and Chemotherapy	
Physician Visits and Services	
Anesthesiologist Services	
Operating Room	
X-ray and Laboratory Services	
Medications and Supplies	
Newborn Care	
EMERGENCY & URGENT CARE	
Hospital Emergency Room	$50 per visit (waived if admitted)
Urgent Care Facility	$25 per visit (waived if admitted)
(Medically Necessary and Worldwide, In or Out of Network)	

OVER

HMO (Open Access)

BENEFITS	OPEN ACCESS HMO
MENTAL HEALTH/SUBSTANCE ABUSE	AN HMO MEMBER PAYS
OUTPATIENT (Physician's office)	$10 copay per visit
INPATIENT HOSPITALIZATION AND OUTPATIENT FACILITY (prior authorization required)	$0
PRESCRIPTION DRUGS Through participating pharmacies Oral contraceptives (generic) covered at $0 copay (prior authorization required for some drugs)	Retail: (30 day supply) $5 generic/$15 preferred brand name/$35 non-preferred brand name drugs Maintenance: (90 day supply) $5 generic/$15 preferred brand name/$35 non-preferred brand name drugs available only through Cigna Home Delivery mail order.
PHYSICAL, OCCUPATIONAL AND SPEECH THERAPIES	
OUTPATIENT: short-term rehab, up to 60 days per person/per plan year; includes PT, OT, ST and cardiac rehab (combined maximum)	$10 per day
INPATIENT (prior authorization required)	$0
CHIROPRACTIC CARE 20 days per person/per plan year	$10 per day
ACUPUNCTURE* *(In or Out of Network)* 12 days per person/per plan year **Coverage based on Cigna's medical guidelines.*	$10 per day
DURABLE MEDICAL EQUIPMENT (DME)	20%
EXTERNAL PROSTHETIC APPLIANCES (EPA)	20%
OTHER BENEFITS ORAL SURGERY *(accidents only)* REMOVAL OF BONEY IMPACTED WISDOM TEETH SKILLED NURSING CARE *(100 days maximum per person/per plan year)* AMBULANCE *(if not a true emergency, services are not covered)* BLOOD TRANSFUSIONS HOME HEALTH SERVICES HOSPICE	$0 ($10, Physician's office) $0 ($10, Physician's office) $0 $0 $0 $0 $0
GOOD FOR YOU ! BY SCHOOLCARE Health and Wellness Incentives, Employee Assistance Program	Covered

OVER

SCHOOLCARE
SUMMARY OF BENEFITS

Benefits outlined below are intended as a general summary and are covered only when using a Cigna participating provider. All benefits are subject to the terms and conditions of your Health Benefits Booklet. In the event of any inconsistency between this Summary and the Health Benefits Booklet, the provisions as defined in the Health Benefits Booklet and Endorsements will govern. Covered benefits are subject to review for medical necessity. Plan year is defined from July 1 through June 30.

BENEFITS	OPEN ACCESS + (In-Network Benefits Only)
DEDUCTIBLES, MAXIMUMS*	**YOU PAY**
Plan Year Deductible (Medical) Coinsurance (Medical) Out-of-Pocket Maximum/Plan Year (Medical) Out-of-Pocket Maximum/Plan Year (Prescription Drugs) Maximum Lifetime Benefit *No one person will incur more than the individual deductible/out-of-pocket maximum	Individual: $250; Family: $500 20% Individual: $1,000; Family: $2,000 Individual: $2,000; Family: $4,000 Unlimited All copays and coinsurance contribute to the Out-of-Pocket Maximums.
PREVENTIVE CARE* Routine Physical Examination Routine Immunizations Hearing Tests Well Child Preventive Care Well Woman Preventive Care Adult Preventive Care Additional services such as urinalysis and EKG Routine Eye Exam (one every 12 months for all ages) Discounts Available for Eyewear * Includes Naturopathic Services, Routine Laboratory and Diagnostic Testing	 $0 $0 $0 $0 $0 $0 $0 $0
OTHER PHYSICIAN SERVICES* Office Visits and/or Office Surgery Maternity Care * Includes Naturopathic Services	 Deductible, then 20% to the Out of Pocket Maximum Deductible, then 20% to the Out of Pocket Maximum
OUTPATIENT DIAGNOSTIC TESTING Radiology and Laboratory Services (prior authorization required for some tests)	Deductible, then 20% to the Out of Pocket Maximum
HOSPITAL CARE Inpatient Services Same Day or Outpatient Surgery Radiation and Chemotherapy Physician Visits and Services Anesthesiologist Services Operating Room X-ray and Laboratory Services Medications and Supplies Newborn Care	Deductible, then 20% to the Out of Pocket Maximum (Inpatient admissions and some outpatient procedures require prior authorization)

OVER

OPEN ACCESS +

BENEFITS	OPEN ACCESS + (In-Network Benefits Only)
EMERGENCY & URGENT CARE	YOU PAY
Hospital Emergency Room Urgent Care Facility *(Medically Necessary and Worldwide, In or Out of Network)*	$50 per visit (waived if admitted) $25 per visit (waived if admitted)
MENTAL HEALTH/SUBSTANCE ABUSE	
OUTPATIENT (Physician's office)	$0
INPATIENT HOSPITALIZATION AND OUTPATIENT FACILITY (prior authorization required)	$0
PRESCRIPTION DRUGS Through participating pharmacies	Retail: (30 day supply) $5 generic/$15 preferred brand name/$35 non-preferred brand name drugs.
Oral contraceptives (generic) covered at $0 copay (prior authorization required for some drugs)	Maintenance drugs: (90 day supply) $0 generic/$15 preferred brand name/$35 non-preferred brand name drugs available only through Cigna Home Delivery mail order.
PHYSICAL, OCCUPATIONAL AND SPEECH THERAPIES	
OUTPATIENT: short-term rehab, up to 60 days per person/per plan year, includes PT, OT, ST and cardiac rehab (combined maximum).	Deductible, then 20% to the Out of Pocket Maximum
INPATIENT (prior authorization required)	Deductible, then 20% to the Out of Pocket Maximum
CHIROPRACTIC CARE 20 days per person/per plan year	Deductible, then 20% to the Out of Pocket Maximum
ACUPUNCTURE* *(In or Out of Network)* 12 days per person/per plan year *Coverage based on Cigna medical guidelines.	Deductible, then 20% to the Out of Pocket Maximum
DURABLE MEDICAL EQUIPMENT	Deductible, then 20% to the Out of Pocket Maximum
EXTERNAL PROSTHETIC APPLIANCES	Deductible, then 20% to the Out of Pocket Maximum
OTHER BENEFITS ORAL SURGERY *(accidents only)* REMOVAL OF BONEY IMPACTED WISDOM TEETH SKILLED NURSING CARE *(100 days per person/per plan year maximum)* AMBULANCE *(if not a true emergency, services are not covered)* BLOOD TRANSFUSIONS HOME HEALTH SERVICES HOSPICE	All other covered services subject to plan year deductible and 20% coinsurance to the out-of-pocket maximum for the plan year.
GOOD FOR YOU! BY SCHOOLCARE Health and Wellness Incentives, Employee Assistance Program	Covered

OVER

CDHP Choice Fund

SchoolCare
Summary of Benefits

Benefits outlined below are intended as a general summary and are covered only when using a CIGNA participating provider. All benefits are subject to the terms and conditions of your Health Benefits Booklet. In the event of any inconsistency between this Summary and the Health Benefits Booklet, the provisions as defined in the Health Benefits Booklet and Endorsements will govern. Covered benefits are subject to review for medical necessity. Plan year is defined from July 1 through June 30.

BENEFITS	CDHP (In-Network Benefits Only)
DEDUCTIBLES, MAXIMUMS*	**TOTAL COST**
Plan Year Deductible	Individual: $1,250; Family: $2,500
Coinsurance	20%
Out-of-Pocket Maximum/Plan Year	Individual: $2,000; Family: $4,000
Maximum Lifetime Benefit	Unlimited
* All family members contribute towards family deductible/out-of-pocket max.	
CHOICE FUND*	**SCHOOLCARE PAYS***
SchoolCare embedded Choice Fund (health reimbursement account) to be used to pay for eligible out-of-pocket expenses during the plan year.	Individual: $1,000; Family: $2,000
* Subscriber must take the online Health Assessment to be eligible.	
NET COST AFTER CHOICE FUND *(if eligible)**	**YOU PAY**
Deductible	Individual: $ 250; Family: $ 500
Out-of-Pocket Costs	Individual: $1,000; Family: $2,000
* Subscriber must take the online Health Assessment to be eligible.	
PREVENTIVE CARE*	
Routine Physical Examination	$0
Routine Immunizations	$0
Well Child Preventive Care	$0
Well Woman Preventive Care	$0
Adult Preventive Care	$0
Additional services such as urinalysis and EKG	$0
Routine Eye Exam (one every 12 months for all ages)	$0
Discounts Available for Eyewear	$0
* Includes Naturopathic Services, Routine Laboratory and Diagnostic Testing	
OTHER PHYSICIAN SERVICES*	
Office Visits and/or Office Surgery	Deductible, then 20% to the Out of Pocket Maximum
Maternity Care	Deductible, then 20% to the Out of Pocket Maximum
* Includes Naturopathic Services	
OUTPATIENT DIAGNOSTIC TESTING	
Radiology and Laboratory Services	Deductible, then 20% to the Out of Pocket Maximum
(prior authorization required for some tests)	
HOSPITAL CARE	Deductible, then 20% to the Out of Pocket Maximum
Inpatient Services	(Inpatient admissions and some outpatient procedures require prior authorization)
Same Day or Outpatient Surgery	
Radiation and Chemotherapy	
Physician Visits and Services	
Anesthesiologist Services	
Operating Room	
X-ray and Laboratory Services	
Medications and Supplies	
Newborn Care	

OVER

CDHP Choice Fund

BENEFITS	CDHP (In-Network Benefits Only)
HEARING TESTS	Deductible, then 20% to the Out of Pocket Maximum
EMERGENCY & URGENT CARE Hospital Emergency Room Urgent Care Facility (Medically Necessary and Worldwide)	 Deductible, then 20% to the Out of Pocket Maximum Deductible, then 20% to the Out of Pocket Maximum
MENTAL HEALTH/SUBSTANCE ABUSE OUTPATIENT INPATIENT (prior authorization required) DRUG/ALCOHOL ABUSE (prior authorization required) (diagnosis, detox, rehab, and medical treatment)	 Deductible, then 20% to the Out of Pocket Maximum Deductible, then 20% to the Out of Pocket Maximum Deductible, then 20% to the Out of Pocket Maximum
PRESCRIPTION DRUGS Retail: (30 day supply) through participating pharmacies Maintenance drugs: (90 day supply) available only through Cigna Home Delivery mail order. Oral contraceptives (generic) covered at $0 copay (prior authorization required for some drugs)	(Generic*, Preferred Brand Name, Non-Preferred Brand Name) Deductible, then 10% to the Out of Pocket Maximum** Deductible, then 10% to the Out of Pocket Maximum** *Certain Preventive Generic Drugs, Retail or Mail Order: $0 **$75 maximum after deductible
PHYSICAL, OCCUPATIONAL AND SPEECH THERAPIES OUTPATIENT: short-term rehab, up to 60 days per person/per plan year, includes PT, OT, ST and cardiac rehab (combined maximum). INPATIENT (prior authorization required)	 Deductible, then 20% to the Out of Pocket Maximum Deductible, then 20% to the Out of Pocket Maximum
CHIROPRACTIC CARE 20 days per person/per plan year	Deductible, then 20% to the Out of Pocket Maximum
ACUPUNCTURE* 12 days per person/per plan year *Coverage based on CIGNA medical guidelines.	Deductible, then 20% to the Out of Pocket Maximum
DURABLE MEDICAL EQUIPMENT	Deductible, then 20% to the Out of Pocket Maximum
EXTERNAL PROSTHETIC APPLIANCES	Deductible, then 20% to the Out of Pocket Maximum
OTHER BENEFITS ORAL SURGERY *(accidents only)* REMOVAL OF BONEY IMPACTED WISDOM TEETH SKILLED NURSING CARE *(100 days per person/per plan year maximum)* AMBULANCE *(if not a true emergency, services are not covered)* BLOOD TRANSFUSIONS HOME HEALTH SERVICES HOSPICE	All other covered services subject to plan year deductible and 20% coinsurance to the out-of-pocket maximum for the plan year.
GOOD FOR YOU! BY SCHOOLCARE Health and Wellness Incentives, Employee Assistance Program	Covered

OVER

NH School Health Care Coalition
SCHOOLCARE 65+

January 1, 2014

Summary of Benefits

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD*

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	SCHOOLCARE 65+ Pays	You Pay
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but $1,216	$1,216(Part A Ded.)	$0
61st thru 90th day	All but $304 a day	$304 a day	$0
91st day and after :			
While using 60 lifetime reserve days	All but $608 a day	$608 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $152 a day	Up to $152 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	Balance

(Note: Benefits will be paid for only those expenses which are determined to be Medicare Eligible by the Federal Medicare Program or its administrators, except as otherwise specified. For complete details, please see the Master Policy.)

(over)

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR*

*Once you have been billed $147 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	SCHOOLCARE 65+ Pays	You Pay
MEDICAL EXPENSES - In or Out of the Hospital and Outpatient Hospital Treatment, such as physician services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First $147 of Medicare Approved Amounts*	$0	$147 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $147 of Medicare Approved Amounts*	$0	$147 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Blood tests for Diagnostic Services	100%	$0	$0

MEDICARE PARTS A & B

HOME HEALTH CARE			
Medicare Approved Services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment:			
First $147 of Medicare Approved Amounts*	$0	$147 (Part B Deductible)	$0
Remainder of charges	80%	20%	$0

OTHER BENEFITS

FOREIGN TRAVEL			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA:			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum of $50,000	20% and amounts over the $50,000 lifetime maximum

Benefit Overview

Express Scripts Medicare™ (PDP) for SCHOOLCARE

YOUR 2014 PRESCRIPTION DRUG PLAN BENEFIT

The benefit described in this document is your final benefit after combining the standard Medicare Part D benefit with additional coverage being provided by SCHOOLCARE. The following table provides a summary of your benefit, including final cost-sharing information. This plan provides coverage across all stages of your benefit.

Initial Coverage stage

You will pay the following until your total yearly drug costs (what you and the plan pay) reach $2,850:

Tier	Retail One-Month (31-day) Supply	Retail Three-Month (90-day) Supply	Home Delivery Three-Month (90-day) Supply
Tier 1: **Generic Drugs**	$7 copayment	$21 copayment	$10 copayment
Tier 2: **Preferred Brand Drugs**	$25 copayment	$75 copayment	$35 copayment
Tier 3: **Non-Preferred Brand Drugs**	$25 copayment	$75 copayment	$35 copayment
Tier 4: **Specialty Tier Drugs**	5% coinsurance	5% coinsurance	5% coinsurance

If your doctor prescribes less than a full month's supply of certain drugs, you will pay a daily cost-sharing rate based on the actual number of days of the drug that you receive.

You may receive up to a 90-day supply of certain maintenance drugs (medications taken on a long-term basis) by mail through our home delivery service. There is no charge for standard shipping.

Not all drugs are available at a 90-day supply, and not all retail pharmacies offer a 90-day supply. Please contact Express Scripts Medicare Customer Service at the numbers on the back of this document for more information.

Coverage Gap stage	After your total yearly drug costs reach $2,850, you will continue to pay the same cost-sharing amount as in the Initial Coverage stage until your yearly out-of-pocket drug costs reach $4,550.
Catastrophic Coverage stage	After your yearly out-of-pocket drug costs (what you and others pay on your behalf, including manufacturer discounts but excluding payments made by your Medicare prescription drug plan) reach $4,550, you will pay **the greater of 5% coinsurance or:** • a $2.55 copayment for covered generic drugs (including brand drugs treated as generics) • a $6.35 copayment for all other covered drugs.

Long-Term Care (LTC) Pharmacy
Long-term care pharmacies must dispense brand-name drugs in amounts less than a 14-day supply at a time. They may also dispense less than a one month's supply of generic drugs at a time. Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed.

Out-of-Network Coverage
For prescriptions filled at out-of-network pharmacies, you will pay the same cost-sharing amounts as for prescriptions filled at in-network retail pharmacies.

If you go to an out-of-network pharmacy and try to use your member ID card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription and the plan will reimburse you for your share of the cost. You will need to send us your request for payment, along with your receipt documenting the payment you have made. It's a good idea to make a copy of all of your receipts for your records. For information on how to submit a claim, please review the information provided in the *Quick Reference Guide* included with your Welcome Kit, contact Express Scripts Medicare Customer Service at the numbers at the end of this document or visit our website to download a copy of the "Direct Claim Form."

IMPORTANT PLAN INFORMATION

- The service area for this plan is all 50 states, the District of Columbia, and Puerto Rico. You must live in one of these areas to participate in this plan. We may reduce our service area and no longer offer services in the area in which you reside.
- Your plan uses a formulary—a list of covered drugs. Express Scripts may periodically add or remove drugs, make changes to coverage limitations on certain drugs, or change how much you pay for a drug. If any formulary change limits your ability to fill a prescription, you will be notified before the change is made.
- The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.
- Your healthcare provider must get prior authorization from Express Scripts Medicare for certain drugs.
- If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.

- If you request an exception for a drug and Express Scripts Medicare approves the exception, you will pay the Non-Preferred Brand Drug cost-share for that drug.
- You must continue to pay your Medicare Part B premium, if not otherwise paid for under Medicaid or by another third party.

ANSWERS TO FREQUENTLY ASKED QUESTIONS

Who is eligible for this plan?
You are eligible for this plan if you are entitled to Medicare Part A and are enrolled in Medicare Part B, live in the plan's service area, and are eligible for benefits from SCHOOLCARE.

You can be in only one Medicare prescription drug plan at a time. If you are currently enrolled in a Medicare Advantage (MA) Plan that **includes Medicare prescription drug coverage,** your enrollment in this plan may end that enrollment. In addition, you may not be enrolled in an individual MA Plan—even one without prescription drug coverage—at the same time as this plan. You may, however, be enrolled in this plan and an MA-only plan if it has been coordinated through your employer. Please contact SCHOOLCARE if you have questions about other plan types and the impact your enrollment in this plan may have.

> **Important:** If you choose a prescription drug plan outside your former employer/retiree group's offering, this decision may impact other benefits, such as medical coverage. Please contact SCHOOLCARE for more information before making a decision to leave this plan, or for information about other options that may be available to you.

Do I qualify for Extra Help to pay for my prescription drug premiums and costs?
To see if you qualify for Extra Help, call Medicare at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week (TTY users should call 1.877.486.2048); the Social Security Office at 1.800.772.1213 between 7 a.m. and 7 p.m., Monday through Friday (TTY users should call 1.800.325.0778); or your State Medicaid Office. If you qualify, Medicare will tell the plan how much assistance you will receive, and Express Scripts will send you information on the amount you will pay once you are enrolled in this plan.

Will my income affect my Medicare Part D premium?
Most people will pay their plan's standard Medicare Part D premium. However, some people may have to pay an extra amount because of their yearly income. If your modified adjusted gross income as reported on your IRS tax return from two years ago (the most recent tax return information provided to Social Security by the IRS) is more than $85,000 for individuals and married individuals filing separately or $170,000 for married individuals filing jointly, you'll have to pay extra for your Medicare prescription drug coverage. This extra amount is called the income-related monthly adjustment amount. If you have to pay an extra amount, Social Security—not your Medicare plan—will send a letter telling you what the extra amount will be and how to pay it. No matter how you usually pay your plan premium, the extra amount will be withheld from your Social Security or Office of Personnel Management benefit check. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. *The extra amount must be paid separately and cannot be paid with your monthly plan premium.* If you have any questions about this extra amount, contact Social Security

at 1.800.772.1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call 1.800.325.0778.

Does my plan cover Medicare Part B or non–Part D drugs?
In addition to providing coverage of Medicare Part D drugs, this plan provides coverage for Medicare Part B medications, as well as for some other non–Part D medications that are not normally covered by a Medicare prescription drug plan. The amounts paid for these medications will not count toward your total drug costs or total out-of-pocket expenses. Please call Express Scripts Medicare Customer Service for additional information about specific drug coverage and your cost-sharing amount.

What is a Medication Therapy Management (MTM) Program?
A Medication Therapy Management (MTM) Program is a free service we offer to help you manage your medications. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate, but it is recommended that you take full advantage of this covered service if you are selected. Contact Express Scripts Medicare Customer Service for more details.

The benefit information provided is a brief summary, not a complete description of benefits. For more information, contact Express Scripts Medicare. Limitations, copayments and restrictions may apply. Benefits, formulary, pharmacy network, premium and/or copayments/coinsurance may change on January 1 of each year.

Express Scripts Medicare Customer Service

1.866.838.3932

24 hours a day, 7 days a week

We have free language interpreter services available for non-English speakers.

TTY: **1.800.716.3231**

You can also visit us on the Web at **www.Express-Scripts.com**.

This document may be available in braille. Please call Customer Service at the phone numbers listed above for assistance.

For questions about premiums, enrollment and eligibility, please contact SCHOOLCARE at **1.800.562.5254.** Hours of operation are Monday through Friday, 8:30 a.m. to 4:30 p.m., Eastern Time.

Express Scripts Medicare (PDP) is a prescription drug plan with a Medicare contract.
Enrollment in Express Scripts Medicare depends on contract renewal.

EXPRESS SCRIPTS®

Good For You!

Wellness programs by SCHOOLCARE

Summary of Reward Programs

Good For You! is SCHOOLCARE's commitment to your health and wellness. It is a collection of evidence-based, achievable and fun wellness programs. Programs offer participants incentives for exercising and taking care of their health. SCHOOLCARE'S philosophy behind the wellness programs is to focus on the subscriber and spouse. We designed the program to help educate adults on their health and wellness in hopes that the habits would then be passed on to their dependents.

Annual Reward Points

One (1) reward point equals $1

Individuals can earn up to $800, Couples/Families can earn up to $1,200 in a combination of reward points and reimbursements per plan year.

(Plan year runs July 1st through June 30th)

Keeping Fit Earn 125 in reward points every six months for working out on your own or at a fitness facility.

- Both the SCHOOLCARE subscriber and covered spouse/partner are eligible to participate
- Eligible participants must take a confidential health assessment at www.MyCigna.com
- A minimum of 12 workouts per month for six consecutive months are required
- 20 minutes of vigorous or 30 minutes of moderate activity are required
- **Weekly** progress must be recorded on the *Good For You!* (*GFY!*) web portal at www.SchoolCareGoodForYou.org

Health Education Reimbursement Up to $300 maximum per family in reimbursement with reward points for pre-approved health related classes.

- Requires pre-approval request before or upon registering for classes. Submit request through the *GFY!* web portal at www.SchoolCareGoodForYou.org
- Available to any SCHOOLCARE covered family member
- Must be a health-related, group instructional program (some restrictions apply)

Health Assessment (HA) Earn 150 reward points annually by taking the confidential health assessment online at www.MyCigna.com.

- Available to the SCHOOLCARE subscriber and covered spouse/partner
- Eligible participants must complete the entire health assessment **including biometric measures. Numbers must be entered for Height, Weight, Waist circumference, Systolic & Diastolic Blood Pressure, Total Cholesterol and HDL to receive reward points**
- HA reward points are paid out on a monthly basis

Personal Health Team Subscriber and covered spouse/partner can earn 25 reward points for participating in phone consultations with Cigna's confidential health coaching program.

- Available to the SCHOOLCARE subscriber, covered spouse/partner and dependents with certain chronic conditions
- Individuals may choose to participate or opt out
- Earn 25 points for participating in 2 calls during the plan year with a Cigna medical professional for a chronic other conditions

Workplace Wellness Seminar Subscribers can earn 25 *GFY!* reward points when they participate in a workplace wellness seminar sponsored by SCHOOLCARE and Cigna.

- Available to the SCHOOLCARE subscriber only
- Eligible participants will receive a maximum of 25 points per year for attending a wellness seminar
- Professional development credit is also available for most seminars
- Seminar reward points are paid out at the end of the plan year

Preventive Incentive Rewards participants with 10 *GFY!* reward points each preventive medical screening.

- Available to SCHOOLCARE subscriber and covered spouse/partner
- Points are rewarded for having any of the following preventive screenings: annual physical, colorectal cancer, prostate cancer, mammogram, OB GYN exam
- Eligible participants will receive 10 reward points per exam per year for preventive screenings
- Preventive reward points are paid out at the end of the plan year

***GFY!* Adventure** Annual 10 week self-paced exercise adventure.

- Available to SCHOOLCARE subscriber only
- Eligible participants can earn 75 *GFY!* reward points for completing the adventure
- The program is based on real life adventures which participants follow at their own pace with their own exercise
- Program registration begins in January and the Adventure begins in March

Vision Network Savings Program powered by Cigna Vision

CIGNA HEALTHY REWARDS®

Plan #: 9234030

Routine Vision Care Services	Customer Cost*
Routine Vision Examination: Including but not limited to eye health examination, dilation, refraction and prescription for glasses	$5 off routine exam
Standard Clear Plastic or Glass Lenses:	
Single Vision	Up to $50
Bifocal	Up to $75
Trifocal	Up to $105
Lens Options:	
Standard UV Coating	Up to $15
Standard Scratch-Resistance	Up to $15
Standard Polycarbonate	Up to $40
Standard Anti-Reflective Coating	Up to $45
Progressives	20% savings
Other Add-Ons and Services	20% savings
Frames:	
Most locations:	25% off retail prices on frames
Retailers such as: Empire Vision, EyeMasters, Hour Eyes, JC Penney Optical, Sears Optical, Target Optical, Pearle Vision and Visionworks	40% off retail price on most frames**
Contact Lenses and Professional Services:	
Contact Lens Professional Services (Fitting and Evaluation)	$10 off contact lens exam
Contact Lenses	Check with your Cigna Vision network eye care professional for any available offers on contact lenses.
Non-Prescription Sunglasses**	20% savings
Frequency:	
Exam and Materials	Unlimited

* Regional variance – national schedule shown above. Check with your Cigna Vision network eye care professional for details. ** Select frames may not be available for savings.

The Cigna Vision network offers over 20,000 locations nationwide, including these national retail opticals:

Empire Vision Centers · EyeMasters · HOUR EYES · OPTICAL · PEARLE VISION · Sears Optical · Visionworks

This is a discount program – this is NOT insurance.

GO YOU

Cigna.

These discounts are only available through a Cigna Vision network eye care professional. Customers are responsible to pay the discounted amounts directly to the Cigna Vision network eye care professional at the time of service. *Stated discounts cannot be used in conjunction with other discounts, promotions or prior orders. Network eye care professionals are independent contractors solely responsible for your routine vision examination and products.*

Healthy Rewards® is a discount program. Some Healthy Rewards programs are not available in all states. If your Cigna HealthCare plan includes coverage for any of these services, this program is in addition to, not instead of, your plan coverage. Healthy Rewards programs are separate from your Medical plan. A discount program is NOT insurance, and you must pay the entire discounted charge.

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Know what's important to YOU

Programs and services that help you make the most of your Cigna health plan.

Good information for better health

Nothing is more important than your good health. That's why there's **myCigna.com** – your online home for assessment tools, plan management, medical updates and much more.

On **myCigna.com** you can:

- **Choose** doctors and create a list of nearby hospitals and pharmacies.
- **Verify** plan details such as coverage, copays and deductibles.
- **Find** information and estimate costs for medical procedures and treatments.
- **Find** personalized health and wellness recommendations.
- **Learn** about health conditions, treatments and medications.
- **Keep track** of medical conditions, medications, surgeries, immunizations and emergency contacts.
- **Organize** and track all medical expense information.

Get To Know Your Health

Understanding your health can be the first step toward improvement, and a health assessment is a great way to get started. This easy-to-complete questionnaire about your health and well-being:

- **Asks** questions about habits, stress levels, family history and your overall health, and also records basic information such as weight, blood pressure and cholesterol level.
- **Creates** a personalized report with details about your most important health issues.
- **Offers** suggestions for health screenings, and information about wellness and health programs.
- **Gives** you information to share with your doctor at your next wellness visit.

GO YOU℠

Cigna.

Caring for you in sickness and in health

At Cigna, we focus on helping to keep you well. That's why preventive care services are covered when you receive them from a doctor who participates in the Cigna network. Covered preventive care services include, but are not limited to:

- Wellness visits
- Screenings for high blood pressure and cholesterol
- Testing for diabetes and colon cancer
- Clinical breast exams and mammograms
- Pap tests

A phone call away

Any time you need us, feel free to call the toll-free number printed on the back of your Cigna ID card. We are available 24 hours a day, 7 days a week.

- We'll answer questions, resolve problems and make sure you're satisfied with your Cigna health plan.
- You can order an ID card, update insurance information and check claim status.
- Health coaches can work with you on improving specific health issues.
- Nurses can offer detailed answers to your health questions, and help you decide where and when to seek medical attention.
- If you want to speak with someone in Spanish, we have bilingual representatives. We also have services that can translate 150 other languages.

Managing prescription medications

Choosing the medication that's right for you should be up to you and your doctor. We offer an extensive list of brand and generic medications so you can decide what's best for you, based on how well it works and how much it costs. With more than 57,000 pharmacies in our network, you'll also have convenient access to your medications.

To help you stay healthy and manage the prescription medications you or your family may need, we offer:

- A home delivery program to order prescription medications you take on a regular basis and have them delivered right to your home.
- A website to review your pharmacy coverage, track your expenses, research available medications and ask a pharmacist questions.
- An online price quote tool to learn what you'll pay for a specific medication and provides a report you can use to speak with your doctor about low-cost options.

Health and wellness discounts

Save money when you purchase health and wellness products and services through the Cigna Healthy Rewards® program.* Programs include:

- Weight and nutrition management
- Fitness
- Tobacco cessation
- Vision and hearing care
- Vitamins, health and wellness products
- Alternative medicine
- Anticavity dental products
- Healthy lifestyle products

Cigna®

* Some Healthy Rewards programs are not available in all states. If your Cigna plan includes coverage for any of these services, this program is in addition to, not instead of, your plan coverage. **A discount program is NOT insurance, and you must pay the entire discounted charge.**

SCHOOLCARE
HEALTH BENEFIT PLANS

SERVICE PARTNERSHIP

benefit strategies LLC

FLEXIBLE BENEFIT PLAN ADMINISTRATION

The New Hampshire School Health Care Coalition ("SCHOOLCARE") is pleased to partner with Benefit Strategies, LLC, the leading Flex Plan Administrator in New Hampshire, to design, communicate and administer your new or existing Section 125 Flex Benefit Plan and Flexible Spending Accounts.

Services:

- ✓ Flexible Benefit Plan Design
- ✓ Employee Communication Meetings & Printed Materials
- ✓ Customized Enrollment Forms
- ✓ Suggested Plan Document & Summary Plan Description
- ✓ On-line Account Access
- ✓ Weekly Claims Reimbursement Via Check or Direct Deposit
- ✓ FlexExpress Debit Card for Immediate Claims Reimbursement

$2.50 per participant per month

(Employees may elect to participate in both the health care and dependent care FSAs at no additional fee.)

No set-up or annual renewal fees!

» Employee saves Federal and FICA taxes (22.65% or more) on the amount of funds deducted from their pay

» Employer saves on the matching FICA (7.65%)

FOR MORE INFORMATION CONTACT:

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SCHOOLCARE
HEALTH BENEFIT PLANS

Service and Satisfaction

SCHOOLCARE Mission: To provide education and training for employees and employers to become informed health consumers with healthier life styles, and enable the purchase of quality health care in a cost effective manner.

- SCHOOLCARE regularly surveys its members for their level of satisfaction with the health plan. The results for 2011:
  - ✓ 99% were satisfied with the quality of their health care;
  - ✓ 96% were satisfied with the provider network of doctors and hospitals;
  - ✓ 97% were satisfied with the level of benefits offered in the program;
  - ✓ 98% agreed with the statement that their claims were being paid both accurately and in a timely manner; and
  - ✓ 98% would recommend SchoolCare to a fellow educator in another school district.

- Most importantly, employers and employees know they can call the Executive Director, Lisa Duquette, in Manchester, NH or the Coordinator of Benefit Programs, Jeff Kantorowski, in Concord, NH to answer any questions and assist in the resolution of any problems they are experiencing with the health plan.

Cigna HealthCare administers benefits for SCHOOLCARE. Cigna insures over 125,000 lives in New Hampshire and is one of the five largest insurers in the country. CIGNA is committed to providing the highest quality health benefits and has a solid reputation for knowledge, expertise and service.

- Cigna HealthCare of New Hampshire has earned the highest level of accreditation (EXCELLENT) from the National Committee for Quality Assurance, NCQA, an independent review organization.

- In December 2011, Cigna's behavioral health care centers nationwide earned Full Accreditation from the National Committee for Quality Assurance Managed Behavioral Healthcare Organization (MBHO). MBHO evaluates how well a health plan manages its entire delivery system, including physicians, hospitals and other facilities, and administrative services.

- In 2011 and 2010, DALBAR, a leading third-party evaluator, gave Cigna's Explanation of Benefits a top-rated "excellent" designation for clarity, content and design. Cigna's Explanation of Benefits also won the ClearMark 2011 Center for Plain Language award.

Cigna reserves the right to make changes to this drug list without notice. Your plan may cover additional medications; please refer to your enrollment materials for details. Cigna does not take responsibility for any medication decisions made by the doctor or pharmacist. Cigna may receive payments from manufacturers of certain preferred brand medications, and in limited instances, certain non-preferred brand medications, that may or may not be shared with your plan depending on its arrangement with Cigna. Depending upon plan design, market conditions, the extent to which manufacturer payments are shared with your plan and other factors as of the date of service, the preferred brand medication may or may not represent the lowest-cost brand medication within its class for you and/or your plan.

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Three-Tier Plan

2014 Cigna

prescription drug list

Choosing the medication that is right for you is between you and your doctor. This prescription drug list offers you an extensive list of brand name and generic medications that are covered under your pharmacy plan.

Choosing where to fill your medication should be easy, too. With access to a complete network of retail pharmacies (including all major chains and most local and regional pharmacies) and Cigna Home Delivery Pharmacy, you have convenient access to your medications – whether you pick them up or have them delivered to your home.

Within this document you will find a list of medications covered under your plan, in an easy-to-read format. You will see:

1. Medications split into three categories (generic, preferred brand and non-preferred brand)
2. Health conditions and medications listed in alphabetical order
3. Symbols to let you know if there are any important details related to coverage

GO YOU.

Offered by: Connecticut General Life Insurance Company or Cigna Health and Life Insurance Company.

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Your three-tier prescription drug list

A three-tier prescription drug list splits medications into three categories (or tiers):

1st Tier – Generic Medications: Generic medications have the same active ingredients, safety, dosage, quality and strength as their brand name counterparts. You will usually pay less for generic medications under a three-tier plan.

2nd Tier – Preferred Brand Medications: Preferred brand medications will usually cost more than a generic, but may cost less than a non-preferred brand on a three-tier plan.

3rd Tier – Non-Preferred Brand Medications: Non-preferred brand medications generally have generic alternatives and/or one or more preferred brand options within the same drug class. You will usually pay more for non-preferred medications on a three-tier plan.

Preventive prescription drug option

Preventive medications are described as medications that are used to prevent a disease or condition in people with risk factors such as: high blood pressure, high cholesterol, diabetes, asthma, osteoporosis, heart attack and stroke, or to prevent the recurrence of the disease or condition in people who have recovered.

Preventive medications do not include drugs used to treat an existing illness, injury or condition. Some pharmacy plans require you to pay a certain amount (deductible) before the plan coverage begins, but preventive medications may be covered before you reach that amount. To be sure, you can read your enrollment materials to see how preventive medications are covered specific to your plan. Also, a list of all covered preventive medications is available on **myCigna.com.** Preventive medications are identified by a "PM" symbol within the drug list search.

Exclusions and limitations

Plans typically do not provide coverage for the following, except as required by law or by the terms of your specific plan:

1. Any medications available over-the-counter (OTC) that do not require a prescription by federal or state law, and any medication that is a pharmaceutical alternative to an OTC medication other than insulin [examples include OTC Benadryl, Maalox, Sudafed PE, etc.].
2. Medications that are therapeutically equivalent as determined by the Cigna HealthCare Pharmacy and Therapeutics Committee in which at least one of the medications within the class is available over the counter [examples include Rx equivalents to OTC Allegra, Claritin and Zyrtec (Allegra D, Clarinex, Xyzal) and Rx equivalents to OTC Prevacid, Prilosec and Zantac (Aciphex, Kapidex, Nexium, Axid, Pepcid, Zantac)].
3. Any injectable infertility medications, and any injectable medications that require health care professional supervision and are not typically considered self-administered medications. The following are examples of health care professional-supervised medications: injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents.
4. Any medications that are experimental or investigational within the meaning set forth in the summary plan description.
5. Food and Drug Administration (FDA) approved medications used for purposes other than those approved by the FDA unless the medication is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopoeia Drug Information or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal.
6. Any prescription and non-prescription supplies (such as ostomy supplies), devices and appliances.
7. Any contraceptive medications and prescription appliances for contraception.
8. Implantable contraceptive products.
9. Any fertility medication.
10. Any medications used for treatment of sexual dysfunction, including but not limited to erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido.
11. Any prescription vitamins (other than prenatal vitamins), dietary supplements and fluoride products.
12. Medications used for cosmetic purposes, such as medications used to reduce wrinkles, medications to promote hair growth, medications used to control perspiration and fade cream products.
13. Any diet pills or appetite suppressants (anorectics).
14. Prescription smoking cessation products.
15. Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis (the prevention of travel-related diseases).
16. Replacement of prescription medications and related supplies due to loss or theft.
17. Medications used to enhance athletic performance.
18. Medications that are to be taken by, or administered to, a customer while the customer is a patient in a licensed hospital, skilled nursing facility, rest home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
19. Prescriptions more than one year from the original date of issue.

GENERICS	PREFERRED BRANDS	NON-PREFERRED BRANDS
	VITAMINS* *(CONTINUED)*	
**All plans cover all generic prescription prenatal vitamins, even though not listed here.*	PNV Folic Acid-Iron Precare Premier PreferaOB Prenatal Vitamin Prefera-OB One Prenata Prenatal 19 Prenate AM Prenate Chewable Prenate DHA Prenate Elite Prenate Mini Provida OB Stuart Prenatal Stuartnatal Plus Stuartnatal Plus 3 TL-Select DHA Tricare Tricare Prenatal Compleat Vinate Care VIVA CT Viva DHA VP-PNV-DHA	
	MISCELLANEOUS	
** Please check your enrollment materials to determine whether this medication is covered under your plan.*		
aminocaproic acid buprenorphine cyclobenzaprine hydrocodone/ chlorpheniramine suspension leucovorin levocarnitine lindane megestrol methocarbamol naltrexone naltrexone hcl pentoxifylline pramoxine/hydrocortisone quinine sulfate riluzole sodium phenylbutarate sodium polystyrene sulfonate spinosad tizanidine tranexamic acid	Analpram Advanced Analpram HC Analpram-E Aranesp (PA)* Buphenyl Chantix* Epogen (PA)* Fosrenol Pramosone Procrit (PA)* Proctofoam-HC Renvela Rilutek SPS Suboxone TussiCaps Zavesca (PA) Zemplar	Arcalyst (PA) Cortifoam Cuvposa Epifoam Gattex (PA)* Ilaris (PA) Kuvan Lysteda Natroba Nimotop Nuedexta Nymalize Phoslo Phoslyra Promacta (PA) Proscysbi Ravicti Rectiv Renagel Revia Sklice Tussionex Ulesfia Virtuz Zanaflex Zutripro

Understanding Cigna's prescription drug list

Every medication available on Cigna's prescription drug list has been approved by the U.S. Food and Drug Administration (FDA). This list represents the most commonly prescribed medications. If you do not see a specific medication on this list, please check **myCigna.com** to see all of the medications covered under your plan.

The symbols on the list mean

If a medication on the list has one of the following symbols, your doctor may have to get an authorization (approval) for coverage of that medication.

PA: Prior Authorization may be required for different reasons. To learn the requirements needed for coverage of a specific medication, feel free to give us a call.

QL: Quantity Limit means you may have coverage for a limited amount of a specific medication.

AGE: Age Requirement means that a person must be within a specific age group for a specific medication to be covered.

ST: Step Therapy is a prior authorization program that requires you to try other medications available to treat the same condition before the medication with the "ST" is covered.

myCigna.com

Our customer website that can help you manage your prescription coverage:

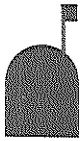
When you visit **myCigna.com**, you can:

- Look up the details of your specific pharmacy plan
- Research thousands of available medications
- Compare medication prices using the Prescription Drug Price Quote tool
- Ask a pharmacist questions
- And much, much more!

Medications delivered right to your home

Cigna Home Delivery Pharmacy is designed for people who take prescription medications on a regular basis (including specialty medications). The benefits of Cigna Home Delivery Pharmacy include:

- **QuickFill**, our automatic refill reminder service, makes it simple for you to fill prescriptions through email or phone
- Getting up to a 90-day supply of your medications in one fill
- Delivery of medications to your door at no additional charge
- Licensed pharmacists available to help 24/7
- CoachRx: a free tool that can help with reminders, coaching and information. Visit **Cigna.com/coachrx** to learn more
- It's easy to switch! Just call 1.800.835.3784



Save time and money with the convenience of Cigna Home Delivery Pharmacy

For more information, visit the Cigna Home Delivery Pharmacy page on **myCigna.com**.

GENERICS	PREFERRED BRANDS	NON-PREFERRED BRANDS
SKIN CONDITIONS *(CONTINUED)*		
		Umecta Vanos (PA, ST) Vectical Verdeso (PA, ST) Westcort (PA, ST) Xolegel Ziana Zyclara (ST)
SLEEP		
midazolam hcl quazepam zaleplon zolpidem zolpidem ER	Silenor	Ambien (PA, ST) Ambien CR (PA, ST) Doral Edluar (PA, ST) Intermezzo (PA, ST) Lunesta (PA, ST) Rozerem (PA, ST) Sonata (PA, ST) Zolpimist (PA, ST)
TRANSPLANT		
azathioprine cyclosporine mycophenolate moefetil tacrolimus	Azasan Cellcept Neoral Prograf Rapamune Sandimmune	Imuran Myfortic Zortress
VITAMINS*		
calcitriol cyanocobalamin folic acid **All plans cover all generic prescription prenatal vitamins, even though not listed here.*	Active OB Bal-Care DHA Essential Citranatal Citranatal B-Calm Citranatal Harmony Duet DHA Duet DHA Balanced Duet DHA EC Gesticare DHA Infanate Balance Nata Komplete Natachew Natafort Neevo Neevo DHA Nestabs Nestabs ABC Nestabs DHA Nexa Plus Nexa Select OB Complete OB Complete DHA OB Complete Petite	

GENERICS	PREFERRED BRANDS	NON-PREFERRED BRANDS
SKIN CONDITIONS *(CONTINUED)*		
betamethasone dipropionate	Differin (AGE)	Benzefoam
betamethasone dipropionate/propylene glycol	Enbrel (PA)	Bromday
betamethasone valerate	Exelderm	Carmol HC (PA, ST)
calcipotriene	Fluoroplex	Clindacin Pac
Claravis (QL)	Humira (PA)	Clobex (PA, ST)
clinicamycinphosphate/ benzoyl peroxide gel	Kenalog spray (PA, ST)	Condylox
clobetasol propionate	Klaron	Cutivate (PA, ST)
clobetasol propionate/emoll	Locoid (lotion)	Dermatop (PA, ST)
desonide	Loprox shampoo	Desonate (PA, ST)
desoximetasone	Lotemax	Desowen (PA, ST)
diflorasone diacetate	Metrogel 1%	Diprolene (PA, ST)
fluocinolone acetonide	Naftin	Diprolene AF (PA, ST)
fluocinonide/emollient	Noritate	Dovonex cream
fluorouracil topical	Nucort (PA, ST)	Duac
fluticasone propionate	Oracea	Elidel (PA, ST)
halobetasol prop/ ammonium lac	Retin-A Micro (AGE)	Elocon (PA, ST)
halobetasol propionate	Soriatane	Epiduo (AGE)
hydrocortisone	Tazorac	First Hydrocort (PA, ST)
hydrocortisone acetate/ aloe vera	Texacort (PA, ST)	Halog (PA, ST)
hydrocortisone acetate/urea		Ilevro
hydrocortisone butyrate		Locoid Cr/Oint/Soln (PA, ST)
hydrocortisone valerate		Luxiq (PA, ST)
imiquimod		Metrogel
isotretinoin (QL)		Metrolotion
mafenide acetate		Momexin (PA, ST)
metronidazole		Nuzon (PA, ST)
mometasone furoate		Olux (PA, ST)
Myorisan (QL)		Olux-e (PA, ST)
mupirocin calcium		Pandel (PA, ST)
podofilox		PB Wash
prednicarbate		Pediaderm HC (PA, ST)
Sotret (QL)		Prolensa
sulfacetamide		Protopic (PA, ST)
tretinoin (AGE)		Regranex (PA)
triamcinolone acetonide		Remicade (PA)
Urea		Retin-A
		Scalacort DK
		Solaraze
		Sorilux
		Stelara (PA)
		Synalar (PA,ST)
		Synalar TS (PA,ST)
		Tacionex
		Targretin gel
		Temovate (PA, ST)
		Topicort (PA, ST)
		Topicort LP (PA, ST)
		Ultravate (PA, ST)
		Ultravate PAC (PA, ST)
		Ultravate X (PA, ST)

Health care reform and you

The Patient Protection and Affordable Care Act (PPACA), commonly referred to as "health care reform," was signed into law on March 23, 2010. This important legislation will result in changes to every American's health coverage. Some of the changes took effect in 2010, and most of the law's effects will be felt by 2014. Cigna will comply with all provisions of the law including those that impact your pharmacy coverage plan. For example, depending upon the final government regulations, coverage of medications that have not traditionally been included in pharmacy plans, such as specific over-the-counter (OTC) medications, may be made available at no cost-share to you. As with all covered medications, we would require a prescription from your doctor to process the claim under your pharmacy plan (including OTC medications). To get the most current information, visit **www.informedonreform.com** or **Cigna.com** and look for the "Informed on Reform" link.

If you have questions

Please call the toll-free number on the back of your Cigna ID card. We're here to help.

GENERICS	PREFERRED BRANDS	NON-PREFERRED BRANDS
ADD/ADHD AND STIMULANTS		
amphetamine/dextroamphetamine dexmethylphenidate methamphetamine methylphenidate/ER/24 HR ER methylphenidate hcl modafanil	Adderall XR Focalin XR Intuniv Strattera Vyvanse	Adderall (PA, ST) amphetamine/dextroamphetamine XR Concerta (PA, ST) Daytrana (PA, ST) Desoxyn (PA, ST) Focalin (PA, ST) Kapvay Metadate CD (PA, ST) Methylin (PA, ST) Nuvigil Provigil Quillivant XR Ritalin (PA, ST) Ritalin ER Ritalin LA (PA, ST) Ritalin SR (PA, ST) Zenzedi (PA,ST)
AIDS/HIV		
abacavir didanosine lamivudine lamivudine/zidovudine nevirapine stavudine zidovudine	Aptivus Crixivan Emtriva Epzicom Fuzeon (PA) Invirase Isentress Kaletra Lexiva Norvir Prezista Rescriptor Reyataz Selzentry Sustiva Trizivir Truvada Viracept Viramune XR Viread	Atripla Combivir Complera Edurant Epivir Fulyzaq (PA) Intelence Retrovir Videx Viramune Zerit Ziagen
ALLERGY		
azelastine nasal clemastine fumarate cyproheptadine desloratadine flunisolide nasal fluticasone nasal hydroxyzine ipratropium nasal	Astepro Epinephrine (QL) Epipen (QL) Epipen Jr. (QL) Nasonex Veramyst	Adrenaclick (QL) Astelin Atrovent (nasal) Auvi-Q (QL) Beconase AQ (PA, ST) Clarinex Dymista (PA, ST) Flonase (PA, ST)

GENERICS	PREFERRED BRANDS	NON-PREFERRED BRANDS
SCHIZOPHRENIA		
clozapine haloperidol loxapine olanzapine olanzapine/fluoxetine hcl quetiapine risperidone thiothixene ziprasidone	Seroquel XR	Abilify Abilify Discmelt (PA, ST) Clozaril (PA, ST) Fanapt (PA, ST) Fazaclo (PA, ST) Geodon (PA, ST) Invega (PA, ST) Latuda (PA, ST) Orap Oxtellar XR Risperdal (PA, ST) Saphris (PA, ST) Seroquel (PA, ST) Symbax Zyprexa (PA, ST)
SEIZURE		
carbamazepine clonazepam diazepam divalproex felbamate gabapentin lamotrigine levetiracetam oxcarbazepine phenytoin tiagabine hcl topiramate valproate zonisamide	Celontin Diastat Diastat Acudial Dilantin (30 MG only) Felbatol Gabitril Keppra Lamictal ODT Lyrica Peganone Vimpat	Banzel Carbatrol Depakote (all forms) Dilantin Keppra XR Lamictal Lamictal XR Neurontin Onfi Potiga Saphris Stavzor Tegretol XR Topamax Trileptal Zonegran
SEXUAL DYSFUNCTION		
** Please check your enrollment materials to determine whether this medication is covered under your plan.*	Muse (PA, QL)* Viagra (PA, QL)*	Caverject (PA, QL)* Cialis (PA, QL)* Edex (PA, QL)* Levitra (PA, QL)* Staxyn (PA, QL)*
SKIN CONDITIONS		
adapalene (AGE) alclometasone dipropionate amcinonide Amnesteem (QL) Apexicon E (diflorasone diacetate) betamethasone	Benzaclin Benzamycin Pak Capex Shampoo (PA, ST) Carac Cloderm (PA, ST) Cordran (PA, ST) Cordran SP (PA, ST) Derma-Smoothe/FS (PA, ST)	Absorbica (QL) Acanya Aclovate (PA, ST) Aldara Aphthasol Atralin (AGE) Avita Bactroban

GENERICS	PREFERRED BRANDS	NON-PREFERRED BRANDS
PAIN RELIEF AND INFLAMMATORY DISEASE *(CONTINUED)*		
methotrexate morphine sulfate nabumetone naproxen opium opium/belladonna alkaloids oxaprozin oxycodone HCl oxycodone HCl/ acetaminophen oxycodone/aspirin oxymorphone oxymorphone HCl pentazocine HCl/ naloxone HCl rizatriptan benzoate (QL) sulindac tramadol HCl/ER tramadol HCl/acetaminophen tolmetin zolmitriptan		Percocet (PA, ST) Percodan (PA, ST) Ponstel (PA, ST) Remicade (PA) Roxicodone (PA, ST) Simponi (PA) Skelaxin Sprix (QL) Subsys (PA) Synalgos-DC (PA, ST) Ultracet (PA, ST) Ultram (PA, ST) Ultram ER (PA, ST) Vicodin (PA, ST) Vicodin ES (PA, ST) Vicodin HP (PA, ST) Vicoprofen (PA, ST) Voltaren (PA, ST) Voltaren XR (PA, ST) Xodol (PA, ST) Zamicet (PA, ST) Zolvit (PA, ST) Zydone (PA, ST)
PARKINSON DISEASE		
amantadine benztropine bromocriptine carbidopa/levodopa carbidopa/levodopa CR carbidopa/levodopa/ entacapone entacapone pramipexole ropinirole ropinirole XL selegiline	Azilect Apokyn (PA) Requip XL	Comtan Eldepryl Lodosyn Mirapex Mirapex ER Neupro Parcopa Requip Sinemet CR Stalevo Tasmar Zelapar
PROSTATE		
alfuzosin doxazosin finasteride leuprolide acetate (PA)* prazosin tamsulosin terazosin	Avodart Lupron Depot (PA)* Jalyn Uroxatral ** Please check your enrollment materials to determine whether this medication is covered under your plan.*	Cialis for BPH (PA, ST) Firmagon (PA) * Flomax Proscar Rapaflo Xtandi (PA) Zoladex (PA)* Zytiga (PA)

GENERICS	PREFERRED BRANDS	NON-PREFERRED BRANDS
ALLERGY *(CONTINUED)*		
levocetirizine montelukast triamcinolone nasal		Nasacort AQ (PA, ST) Omnaris (PA, ST) Patanase QNASL (PA, ST) Rhinocort AQ (PA, ST) Semprex-D Singulair Zetonna (PA, ST) Xyzal
ALZHEIMER DISEASE		
donepezil donepezil hcl galantamine hydrobomide rivastigmine (caps)	Namenda	Aricept Aricept ODT Exelon Namenda XR Razadyne Razadyne ER
ANXIETY		
alprazolam buspirone lorazepam oxazepam		Lorazepam Intensol Niravam
ASTHMA AND RESPIRATORY		
albuterol solution (nebulizer solution) albuterol sulfate (syrup, tabs) budesonide caffeine citrate cromolyn sodium (nebulizer solution) Dylix dyphylline guaifenesin/theophylline ipratropium bromide (nebulizer solution) levalbuterol (nebulizer solution) metaproterenol sulfate (syrup, tabs) montelukast sildenafil (PA) terbutaline sulfate theophylline anhydrous zafirlukast	Advair Diskus/HFA Asmanex Atrovent HFA Combivent Respimat Flovent Diskus/HFA Maxair ProAir HFA Pulmicort Pulmozyme (PA) Qvar Serevent Spiriva Symbicort Ventolin HFA Xolair (PA)	Accolate Accuneb nebulizer (PA, ST) Adcirca (PA) Alvesco Arcapta Breo Ellipta (ST) Brovana nebulizer (PA, ST) Daliresp Dulera Foradil Letairis Perforomist (PA, ST) Proventil HFA Revatio (PA) Singulair Tracleer Tudorza Pressair (ST) Ventavis Xopenex HFA Xopenex nebulizer (PA, ST)

GENERICS	PREFERRED BRANDS	NON-PREFERRED BRANDS
BIRTH CONTROL*		
** Please check your enrollment materials to determine whether these medications are covered under your specific plan.*		
Amethia	BeYaz	Angeliq
Apri	Loestrin 24 FE	Desogen
Aviane	Lo Loestrin FE	Ella
Balziva	LoSeasonique	Estrostep FE
Camila	NuvaRing	Fem FE
Camrese	Ortho Evra	Loestrin
Daysee	Ortho TriCyclen Lo	Loestrin FE
Errin	Plan B One Step	Minastrin 24 FE
Gianvi		Mircette
Jolessa		Natazia
Junel FE		Nordette
Kariva		Ortho-Cept
Kurvelo		Ortho-Cyclen
levonorgestrel		Ortho-Novum 7-7-7
Levora		Ortho-Tri-Cyclen
Loryna		Quartette
Low-Ogestrel		Safyral
Microgestin		Seasonale
Mono-Linyah		Seasonique
Necon		Tri-Norinyl
noreth-ethinyl estradiol/iron		Yaz
Nortrel		
Ocella		
Ogestrel		
Previfem		
Quasense		
Sprintec		
Tri-Linyah		
Trinessa		
Tri-Sprintec		
Vestura		
Zenchent		
Zeosa		
Zovia		
BLADDER PROBLEMS		
oxybutynin/XL	Detrol LA	Detrol (PA, ST)
tolterodine tartrate	Elmiron	Ditropan XL (PA, ST)
trospium chloride	Oxytrol	Enablex (PA, ST)
	Toviaz	Gelnique (PA, ST)
	VESIcare	Myrbetriq (PA,ST)
		Sanctura (PA, ST)
		Sanctura XR (PA, ST)
		Urocit-K

GENERICS	PREFERRED BRANDS	NON-PREFERRED BRANDS
NAUSEA AND VOMITING		
dronabinol	Emend (QL)	Anzemet (inj) (QL)
granisetron		Anzemet (tab) (QL)
ondansetron		Diclegis
prochlorperazine		Marinol
promethazine		Sancuso (QL)
trimethobenzamide		Zofran (tabs, sol)
		Zuplenz (ST)
OSTEOPOROSIS		
alendronate	Didronel	Actonel (PA, ST)
etidronate	Evista	Atelvia (PA, ST)
(Fortical) calcitonin-salmon	Forteo	Binosto (PA, ST)
ibandronate	Miacalcin	Boniva (PA, ST)
		Fosamax (PA, ST)
		Fosamax Plus D (PA, ST)
		Skelid (PA, ST)
PAIN RELIEF AND INFLAMMATORY DISEASE		
buprenorphine	Actimmune (PA)	Abstral (PA)
butorphanol nasal (QL)	Avinza	Actiq (PA)
codeine phos/carisoprodol/ asa	Celebrex	Arthrotec (PA, ST)
	Dilaudid-5	Butrans (QL)
codeine phosphate	Dipentum	Cambia (PA, ST)
codeine phosphate/aspirin	Enbrel (PA)	Cimzia (PA)
codeine sulfate	Fentora (PA)	Demerol (PA, ST)
diclofenac	Humira (PA)	Dilaudid (PA, ST)
dihy-cod tt/apap/caffeine	Indocin (suppository)	Duexis (PA, ST)
dihydroergotamine mesylate	Kadian	Durabec
etodolac	Lidoderm	Duragesic (QL)
fenoprofen	Lidorx	Exalgo (QL)
fentanyl transdermal (QL)	Lyrica	Flector (PA, ST)
fentanyl citrate (lozenge on stick) (PA)	Nucynta (ST)	Horizant (ST)
	Nucynta ER (QL)	Hycet (PA, ST)
flurbiprofen	OxyContin (QL)	Kineret (PA)
hydrocodone/ acetaminophen	Rheumatrex	Lazanda (PA)
	Roxicet (PA, ST)	Lorcet (PA, ST)
hydrocodone bitartrate/ apap	Savella	Lorcet Plus (PA, ST)
	Trexall	Lortab (PA, ST)
hydromorphone HCl	Vimovo	Magnacet (PA, ST)
ibuprofen		Maxidone (PA, ST)
ibuprofen/hydrocod bit		Mobic (PA, ST)
indomethacin		Nalfon (PA, ST)
ketoprofen		Naprelan (PA, ST)
ketorolac (PA, QL)		Naprosyn (PA,ST)
leflunamide		Norco (PA, ST)
levorphanol tartrate		Onsolis (PA)
meclofenamate		Opana
mefenamic acid		Opana ER (QL)
meloxicam		Oxecta (PA, ST)
meperidine HCl		Pennsaid (PA, ST)

GENERICS	PREFERRED BRANDS	NON-PREFERRED BRANDS
INFECTIONS *(CONTINUED)*		
nystatin		Rebetol
ofloxacin		Relenza (QL)
penicillin v potassium		Rocephin
ribavirin		Sirturo
rimantadine		Solodyn (ST)
sulfamethoxazole/ trimethoprim		Sporanox (QL)
terconazole		Suprax
terbinafine (QL)		Tobi Podhaler
tetracycline		Tyzeka
valacyclovir		Valtrex
vancomycin		Vfend (PA)
voriconazole (QL)		Victrelis (PA)
		Zithromax
		Zovirax
		Zyclara (ST)
		Zyvox (PA)
MIGRAINE		
acetaminophen/caffeine/ butalbital	Treximet (QL)	Alsuma (QL)
dihydroergotamine mesylate		Amerge (QL)
naratriptan (QL)		Axert (QL)
rizatriptan (QL)		DHE 45 (QL)
rizatriptan benzoate (QL)		Frova (QL)
sumatriptan (QL)		Imitrex (QL)
zolmitriptan		Maxalt (QL)
		Maxalt MLT (QL)
		Migranal (QL)
		Relpax (QL)
		Sumavel DosePro (QL)
		Zomig/Zomig ZMT (QL)
MULTIPLE SCLEROSIS		
	Ampyra (PA)	Aubagio (PA)
	Avonex (PA)	Betaseron (PA)
	Avonex Pen (PA)	Extavia (PA)
	Copaxone (PA)	Gilenya (PA)
	Rebif (PA)	Tecfidera (PA)
	Rebif Rebidose (PA)	

GENERICS	PREFERRED BRANDS	NON-PREFERRED BRANDS
CANCER		
anastrozole	Gleevec (PA)	Afinitor (PA)
bicalutamide	Hexalen	Afinitor Disperz (PA)
exemestane	Leukeran	Arimidex
flutamide	Lupron Depot (PA)	Aromasin
letrozole	Lysodren	Bosulif (PA)
lomustine	Matulane	Caprelsa (PA)
tamoxifen citrate	Myleran	Casodex
	Nexavar (PA)	Cometriq (PA)
	Revlimid (PA)	Droxia
	Sprycel (PA)	Erivedge (PA)
	Sutent (PA)	Fareston
	Tarceva (PA)	Femara
	Temodar (PA)	Iclusig (PA)
	Thalomid (PA)	Inlyta (PA)
	Xeloda	Jakafi (PA)
	Zolinza (PA)	Mekinist (PA)
		Panretin
		Pomalyst (PA)
		Stivarga (PA)
		Sylatron (PA)
		Tarfinlar (PA)
		Targretin (PA)
		Tasigna (PA)
		Tykerb (PA)
		Votrient (PA)
		Xalkori (PA)
		Xtandi (PA)
		Zelboraf (PA)
		Zytiga (PA)
CARDIOVASCULAR		
BLOOD THINNER/ANTI-CLOTTING		
anagrelide	Aggrenox	Agrylin (PA)
cilostazol	Arixtra (QL)	Brilinta
clopidogrel	Effient	Coumadin
dipyridamole	Fragmin (QL)	Eliquis (ST)
enoxaparin (QL)	Xarelto (QL)	Jantoven
fondaparinux (QL)		Lovenox (QL)
heparin (QL)		Plavix
ticlopidine		Pletal
warfarin		Pradaxa (ST)
HIGH BLOOD PRESSURE/HEART MEDICATIONS		
acebutolol HCl	Benicar	Accupril (PA, ST)
acetazolamide	Benicar HCT	Accuretic (PA, ST)
amiloride HCl	Bystolic	Aceon (PA, ST)
amlodipine/atorvastatin	Coreg CR	Altace (PA, ST)
amlodipine besylate	Diovan	Amturnide
atenolol	Diovan HCT	Atacand (PA, ST)
benazepril HCl	Exforge	Atacand HCT (PA,ST)

GENERICS	PREFERRED BRANDS	NON-PREFERRED BRANDS
CARDIOVASCULAR *(CONTINUED)*		
HIGH BLOOD PRESSURE/HEART MEDICATIONS		
benazepril HCl/amlodipine	Exforge HCT	Avalide (PA, ST)
benazepril HCl/HCTZ	Tarka	Avapro (PA, ST)
bendroflumethiazide/ nadolol	Tekturna	Azor
betaxolol HCl	Tekturna HCT	Betapace AF
bisoprolol fumarate		Cardura
bisoprolol/HCTZ		Cardura XL
bumetanide		Catapres, Catapres TTS
candesartan		Coreg
candesartan/HCTZ		Corgard
captopril		Cozaar (PA, ST)
captopril/HCTZ		Dutoprol
carvedilol		Edarbi (PA, ST)
chlorothiazide		Edarbychlor (PA, ST)
chlorthalidone		Hyzaar (PA, ST)
chlorthalidone/atenolol		Inderal LA
clonidine patch		Innopran XL
clonidine HCl		Levatol
Clorpres		Lotensin (PA, ST)
diltiazem		Lotensin HCT (PA, ST)
diltiazem 24 HR ER		Lotrel
doxazosin mesylate		Mavik (PA, ST)
enalapril maleate		Maxide
enalapril maleate/HCTZ		Micardis (PA, ST)
eplerenone		Micardis HCT (PA, ST)
felodipine		Monopril HCT (PA, ST)
fosinopril sodium		Nymalize
furosemide		Norpace
guanabenz acetate		Norpace CR
guanfacine		Norvasc
hydralazine HCl		Prinivil (PA, ST)
hydralazine/HCTZ		Prinzide (PA, ST)
hydralazine/reserpine/HCTZ		Sular
hydrochlorothiazide		Tekamlo
hydrochlorothiazide/ amilor HCl		Teveten (PA, ST)
indapamide		Teveten HCT (PA, ST)
irbesartan		Toprol XL
irbesartan/hct		Tribenzor (ST)
isradipine		Uniretic (PA, ST)
labetalol HCl		Univasc (PA, ST)
lisinopril		Vaseretic (PA, ST)
lisinopril/HCTZ		Vasotec (PA, ST)
losartan potassium		Verelan
losartan potassium/HCTZ		Zestoretic (PA, ST)
methazolamide		Zestril (PA, ST)
methyldopa		
methyldopa/HCTZ		

GENERICS	PREFERRED BRANDS	NON-PREFERRED BRANDS
HORMONE REPLACEMENT		
estradiol	Alora	Activella
estropipate	Anadrol-50	Axiron (ST)
ethinyl estradiol	Androderm	Cenestin
levothroid	AndroGel	Combipatch
levothyroxine	Armour Thyroid	Cytomel
Levoxyl	Divigel	Delatestryl
levothyroxine sodium	Enjuvia	Depot Testosterone
liothyronine	Estraderm	Estrace
medroxyprogesterone	Premarin	Femhrt
medroxyprogesterone acetate	Premphase	Femring
progesterone, micronized	Prempro	Fortesta (ST)
testosterone cypionate (PA)	Synthroid	Menest
testosterone enanthate (PA)	Testim	Minivielle
thyroid	Vivelle-Dot	Prefest
Unithroid		Prometrium
		Provera
		Vagifem
INFECTIONS		
acyclovir	Baraclude	Ancobon
amantadine	Cipro HC Otic	Augmentin
amoxicillin	Ciprodex	Augmentin ES 600
amoxicillin/clavulanate	Epivir HBV	Augmentin XR
azithromycin	Gris-Peg	Avelox
cefaclor ER	Hepsera	Biaxin
cefadroxil	Incivek (PA)	Biaxin XL
ceftriaxone	Intron A (PA)	Cetraxal
cefuroxime axetil	Mycostatin (tab)	Ciclodan
cephalexin	PegIntron (PA)	Cipro XR
ciclopirox	Pegasys (PA)	CNL 8
ciprofloxacin	Primsol	Coartem (QL)
clarithromycin	Qualaquin	Copegus
clindamycin	Ribapak	Dificid (PA)
doxycycline	Ribasphere	Doryx
doxycycline hyclate	Tamiflu (QL)	Ery-Tab
doxycycline monohydrate	Tobi	Famvir
erythromycin	Valcyte	Flagyl ER
famciclovir	Vancomycin hcl	Garamycin
fluconazole (QL for 150 mg only)	Vibromycin	Grifulvin V
flucytosine		Infergen (PA)
ganciclovir		Keflex
gentamicin sulfate		Ketodan
griseofulvin		Lamisil (QL)
itraconazole (QL)		Levaquin
ketoconazole		Malarone (PA)
metronidazole		Monurol
minocycline		Moxatag
minocycline hcl		Noxafil
mupirocin		Onmel (QL,ST)
nitrofurantoin		Penlac
		Priftin

GENERICS	PREFERRED BRANDS	NON-PREFERRED BRANDS
EYE CONDITIONS *(CONTINUED)*		
tobramycin/dexamethasone trifluridine	Vigamox	Tobradex (drops) Tobradex ST Tobrex Trusopt Voltaren Xalatan Zioptan (ST)
GASTROINTESTINAL (NOT HEARTBURN/ULCER)		
balsalazide budesonide cromolyn sodium (solution) dexamethasone metoclopramide hcl PEG 3350/potassium/ sodium bicarb/salt PEG 3350/potassium/ sodium bicarb/salt/ sodium sulf prednisone prednisone sodium phosphate	Apriso Asacol HD Canasa Creon Delzicol GoLytely Humira (PA) Lialda Pentasa Urso/Urso Forte Zenpep	Amitiza Cimzia (PA) Colazal Colyte Entocort EC Giazo NuLytely Pancreaze Pertzye Prepopik Rayos (ST) Relistor (PA) Remicade (PA) Simponi (PA) Suclear Sucraid Uceris Ultresa Viokace
GROWTH HORMONES		
	Humatrope (PA) Saizen (PA)	Genotropin (PA) Norditropin (PA) Nordiflex (PA) Nutropin (PA) Nutropin AQ (PA) Omnitrope (PA) Serostim (PA) Tev-Tropin (PA)
HEARTBURN/ULCER		
cimetidine famotidine lansoprazole metoclopramide misoprostol nizatidine omeprazole omeprazole/ sodium bicarbonate pantoprazole ranitidine sucralfate	Dexilant Prevpac	Aciphex (PA, ST) Helidac Nexium (PA, ST) Omeclamox-Pak Prevacid (PA, ST) Prilosec (PA, ST) Protonix (PA, ST) Zantac Syrup Zegerid (PA, ST)

GENERICS	PREFERRED BRANDS	NON-PREFERRED BRANDS
CARDIOVASCULAR *(CONTINUED)*		
HIGH BLOOD PRESSURE/HEART MEDICATIONS		
metolazone metoprolol succinate metoprolol tartrate metoprolol/HCTZ minoxidil moexipril HCl moexipril HCl/HCTZ nadolol nicardipine HCl nifedipine nimodipine perindopril erbumine pindolol prazosin HCl propranolol HCl propranolol/HCTZ quinapril quinapril HCl/HCTZ ramipril (caps only) reserpine sotalol HCl spironolactone spironolactone/HCTZ terazosin HCl timolol maleate torsemide trandolapril trandolapril/verapamil HCl valsartan HCTZ Vecamyl-mecamylamine hcl verapamil		
OTHER		
amiodarone disopyramide flecainide isosorbide dinitrate isosorbide mononitrate nitroglycerin propafenone SR	Digoxin Multaq Tikosyn	Lanoxin Nitrolingual spray Nitromist Ranexa ST) Rythmol SR Samsca (PA)

GENERICS	PREFERRED BRANDS	NON-PREFERRED BRANDS
CHOLESTEROL LOWERING		
atorvastatin	Crestor (20 & 40 MG)	Advicor
choline fenofibrate	Crestor (5 & 10 MG) (PA,ST)	Altoprev (PA, ST)
colestipol	Lovaza	Antara
fenofibrate	Simcor	Caduet
fenofibric acid	Trilipix	Colestid
fluvastatin	Welchol	Fenoglide
fluvastatin XL	Zetia	Juxtapid (PA)
gemfibrozil		Kynamro (PA)
lovastatin		Lescol
pravastatin		Lescol XL
simvastatin		Lipitor (PA, ST)
		Liptruzet
		Livalo (PA, ST)
		Lofibra
		Mevacor (PA, ST)
		Niaspan
		Pravachol (PA, ST)
		TriCor
		Vascepa (ST)
		Vytorin
		Zocor (PA, ST)
DEPRESSION		
amitriptyline		Aplenzin (PA, ST)
bupropion	Pristiq	Celexa (PA, ST)
bupropion SR	Wellbutrin XL	Cymbalta
citalopram		Desvenlafaxine ER (PA,ST)
desipramine		Effexor XR (PA, ST)
duloxetine hcl		Emsam
escitalopram		Forfivo XL (PA,ST)
fluoxetine		Lexapro (PA, ST)
fluvoxamine		Luvox CR
imipramine		Marplan
mirtazapine		Oleptro ER (ST)
nortriptyline		Paxil (PA, ST)
paroxetine		Paxil CR (PA, ST)
paroxetine CR		Prozac (PA, ST)
protriptyline		Remeron
sertraline		Sarafem (PA, ST)
trazodone		Tofranil
trimipramine		Venlafaxine HCl ER (PA, ST)
venlafaxine		Viibryd (PA, ST)
venlafaxine XR		Vivactil
		Wellbutrin (PA, ST)
		Wellbutrin SR (PA, ST)
		Zoloft (PA, ST)
DIABETES		
acarbose	ACCU-CHEK Test Strips	Actoplus Met
chlorpropamide	Apidra	Actoplus Met XR
glimepiride	Apidra SoloStar	Actos
glipizide	BD Insulin Syringes/ Pen Needles	Amaryl
glipizide/metformin		Avandamet

GENERICS	PREFERRED BRANDS	NON-PREFERRED BRANDS
DIABETES *(CONTINUED)*		
glyburide	Bydureon (QL)	Avandaryl
glyburide/metformin	Byetta	Avandia
glyburide micronized	GlucaGen HypoKit (QL)	Cycloset
metformin	Glucagon Emergency Kit (QL)	Duetact
metformin ER	Humalog	Fortamet
metformin hcl	Humulin	Glucophage XR
nateglinide	Janumet	Glyset
pioglitazone	Janumet XR	Invokana (ST)
pioglitazone hcl	Januvia	Jentadueto (ST)
pioglitazone/glimiperide	Kombiglyze XR	Juvisync (ST)
pioglitazone/metformin	Lantus	Kazano (ST)
repaglinide	Lantus SoloStar	Nesina (ST)
tolazamide	Levemir	Oseni (ST)
tolbutamide	NovoFine needles	Precose
	Novolin	Sarafem (PA, ST)
	Novolog	Starlix
	One Touch test strips	Tradjenta (ST)
	Onglyza	
	Prandimet	
	Prandin	
	SymlinPen	
	Victoza	
ENDOCRINE AND METABOLIC		
OTHER		
allopurinol	Colcrys	Egrifta (PA)
cabergoline (QL)	Increlex (PA)	Signifor (PA)
desmopressin	Lupron Depot-PED (PA)	Somatuline Depot (PA)
octreotide (PA)	Megace ES	
	Nilandron	
	Sandostatin LAR (PA)	
	Sandostatin (PA)	
	Somavert (PA)	
	Synarel	
	Uloric	
EYE CONDITIONS		
apraclonidine hcl	Alomide	Acular LS
atropine	Alphagan P 0.10%	Alocril
azelastine	AzaSite	Alrex
brimonidine	Azopt	Bepreve
bromfenac	Betimol	Besivance
ciprofloxacin	Betoptic S	Ciloxan (drops)
diclofenac	Ciloxan (ointment)	Cosopt
dorzolamide	Iopidine	Cystaran
dorzolamide/timolol	Lotemax (drops)	Durezol
epinastine	Maxidex	Elestat
flurbiprofen	Moxeza	Emadine
ketorolac	Pataday	Lastacaft
latanoprost	Patanol	Lotemax (oint)
levobunolol	Restasis	Optivar
levofloxacin	Tobradex (ointment)	Rescula
pilocarpine	Travatan Z	Simbrinza (ST)
timolol	Vexol	Timoptic

SCHOOLCARE's mission is to provide education and training for school employees and employers to become informed health consumers with healthier lifestyles, and enable the purchase of quality health care in a cost-effective manner.

Cigna

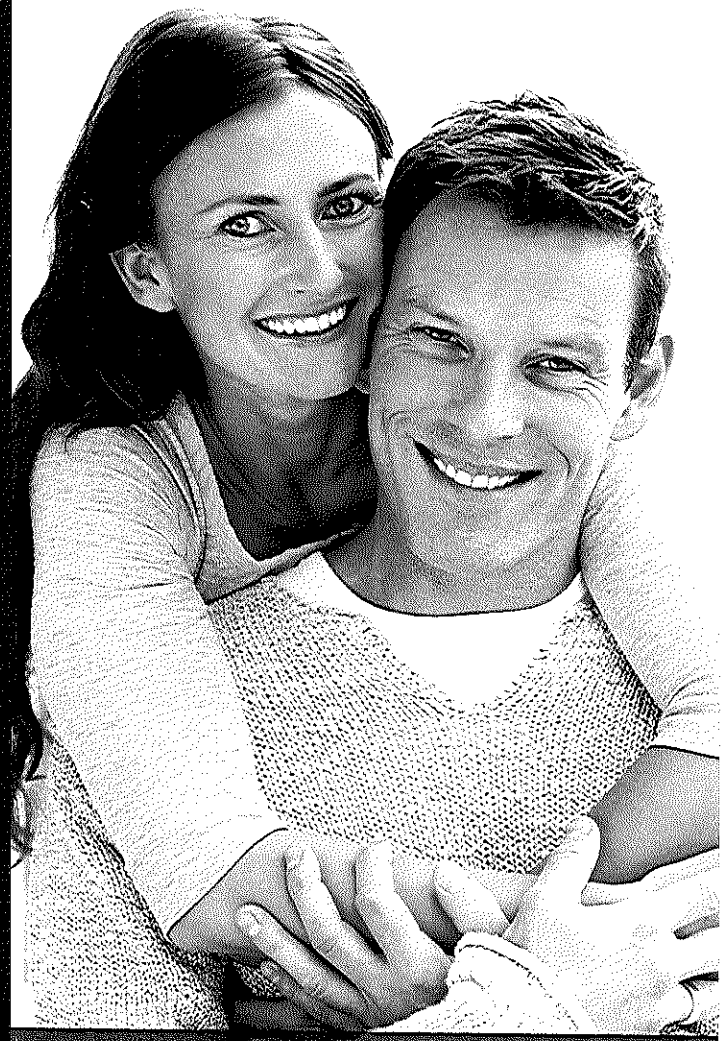
SCHOOLCARE is pleased to offer comprehensive dental plans in partnership with Cigna.

SCHOOLCARE
NH School Health Care Coalition
370 Harvey Rd, Suite 4
Manchester, NH 03103
800-562-5254 Phone
603-782-4079 Fax
www.schoolcare.org

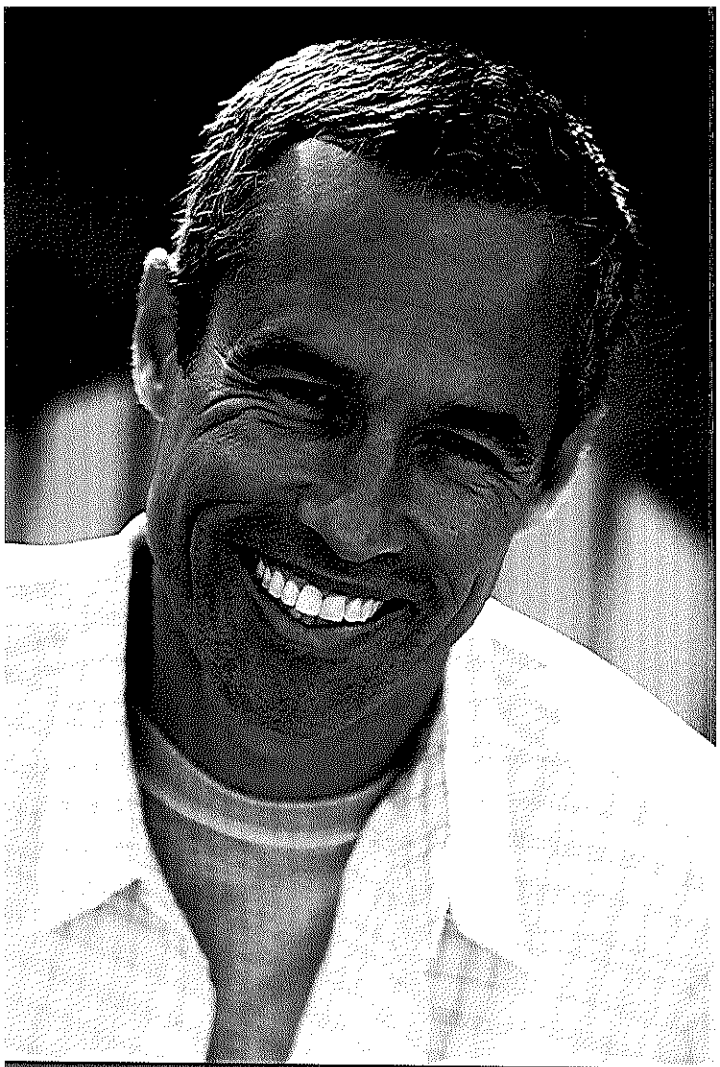
1-1-12

SCHOOLCARE
HEALTH BENEFIT PLANS

of the NEW HAMPSHIRE SCHOOL HEALTH CARE COALITION



Dental Plans



Dental Plans that will make you smile.

Quality Dental coverage you can trust from SchoolCare and Cigna.

For years, there have been limited options in New Hampshire for group dental coverage. Now, SchoolCare has partnered with Cigna to bring you quality dental plans at affordable rates. SchoolCare's dental plans match your existing plan summary of benefits, so there's no compromising on coverage in the name of price. There are 6 standard coverage plans to choose from, offering a variety of costs and coverage options.

No excess charges, no balance billing, no hassles.

SchoolCare Dental plans use Cigna's PPO so members can choose ANY dentist, in or out of Cigna's Preferred Provider network.

It just makes sense.

Beyond convenience, having both medical and dental plans administered by Cigna integrates awareness for related health factors. Research shows an association between gum disease and other health conditions such as diabetes, heart disease and stroke. By processing both medical and dental claims, risk factors can be detected and well-managed.

One stop for claims questions and resolution.

All your health benefit claims and coverage questions answered from one source. SchoolCare and Cigna representatives are there to assist you with any question you may have about your coverage or claims.

NH SCHOOL HEALTH CARE COALITION – SCHOOLCARE MEMBERS
2014-2015

SCHOOL DISTRICTS			
SAU #	Group Name	SAU #	Group Name
06	SAU 6 Office Cornish Unity	53	SAU 53 Office Allenstown Chichester Deerfield Epsom Pembroke
08	Concord	56	SAU 56 Office Rollinsford Somersworth
11	Dover	59	Winnisquam Regional
12	Londonderry	61	Farmington
13	SAU 13 Office Freedom Madison Tamworth	62	Mascoma Valley Regional
15	SAU 15 Office Auburn Candia Hooksett	63	Wilton-Lyndeborough Cooperative
16	Kensington	64	SAU 64 Office Milton Wakefield
17	Sanborn Regional	65	Kearsarge Regional
23	SAU 23 Office Bath Haverhill Cooperative Piermont Warren	68	Lincoln-Woodstock Cooperative
27	Litchfield	71	Goshen-Lempster
30	Laconia	72	Alton
31	Newmarket	74	Barrington
32	Plainfield	76	Lyme
33	Raymond	80	Shaker Regional
36	White Mountains Regional	81	Hudson
40	Milford	82	Chester
46	SAU 46 Office Andover Merrimack Valley Regional	87	Mascenic
47	Jaffrey-Rindge Cooperative	88	Lebanon
49	Governor Wentworth Regional	89	Mason

N/A	Prospect Mountain High School	N/A	NH School Administrators' Assn
MUNICIPALITIES			
Town of Albany		Town of Northfield	
Town of Andover		Town of Peterborough	
Town of Auburn		Town of Pittsburg	
Town of Bennington		Town of Plainfield	
Town of Canaan		Town of Raymond	
Town of Durham		Town of Tamworth	
Town of Gilmanton		Town of Temple	
Town of Greenfield		Town of Wolfeboro	
Town of Henniker		City of Portsmouth	
Town of Jaffrey		Newmarket Housing Authority	
Town of Lyndeborough		Portsmouth Housing Authority	
Town of Milton		Tamworth Community Nurse Association	
Town of Mont Vernon		Youth Assistance Program	
Town of New Durham			

City of Concord, NH

Beneflex Program: A Range of Options

Plan Year 2013-2014
(July 1, 2013-June 30, 2014)

General Information on the Flexible Benefits Plan

Name of Plans

City of Concord, NH Flexible Benefit Plan
City of Concord, NH Health Care Flexible Spending Account Plan
City of Concord, NH Dependent Care Flexible Spending Account Plan

Plan Sponsor and Administrator:

City of Concord
City Hall
41 Green Street
Concord, New Hampshire 03301
603-225-8535

Employer Identification Number:

02-6000177

Plan Numbers:

501 Flexible Benefit Plan
502 Health Care Flexible Spending Account Plan
503 Dependent Care Flexible Spending Account Plan

Type of Plan:

The Flexible Benefit Plan is a cafeteria plan under Section 125 of the Internal Revenue Code, allowing a choice between cash and certain qualified benefits.

Plan Effective Date:

August 1, 1989

Plan Year

The Plan year is from July 1 to June 30.

Administration:

Medical, dental, life and disability benefits are provided through insurance contracts, and administered by the insurer. Health and Dependent Care Flexible Spending Account benefits are currently administered by Benefit Strategies.

For questions or service of legal process contact:

Jennifer Johnston
Director of Human Resources and Labor Relations
Human Resources Department
City of Concord, NH
603-225-8535

Please submit Health or Dependent Care Flexible Spending Account claims to:

Benefit Strategies, LLC
PO Box 1300
Manchester, NH 03105-1300

Why Beneflex?

For many years, the City of Concord, as well as most other employers, designed benefit programs to meet the needs of the average employee. But times and lifestyles have changed. There is no "typical" City of Concord employee. Just as individuals differ in terms of capabilities, talents and skills, so are they different in terms of age, marital status, number of dependents, financial resources and personal goals. It stands to reason that their benefit needs and interests are also different. Total compensation of employees consists of two parts — direct salary and benefits. A flexible benefits plan allows employees a greater voice in how benefit dollars are spent, and permits them to spend those dollars more effectively. It also allows them the opportunity to design a benefit package that best meets their individual needs and budgets.

Advantages

Beneflex provides several key advantages over traditional benefit programs. You, the employee, make your own choices and you have a greater variety of benefit options from which to choose. The City provides benefit dollars, subject to City Council appropriation, for use in purchasing benefits. The primary purpose of the Beneflex Program is to provide employees with a full range of benefit options. Beneflex is designed to attract, retain and secure qualified employees. Cash payments to employees for opting out of coverage is considered incidental to this intent and is only permitted when employees have adequate coverage elsewhere.

Under the Beneflex Program, you may find that you wish to:

- Keep the same benefit package you have previously selected.
- Select a reduced cost health benefit and have more cash as compensation.
- Buy more benefits and reduce your cash compensation to pay for them; in most cases, additional benefits can be purchased with pre-tax dollars which means your dollars go further in buying the benefits you want.

Salary Redirection

If you purchase additional benefits, salary redirection is a way in which you can make these purchases with pre-tax dollars. Currently allowable under federal law, salary redirection means that the portion of your salary directed toward the purchase of most benefits is not included in your taxable income. Let's assume that you need to purchase a pair of eyeglasses that cost $300. If you use after-tax dollars, and you are in a 15% Federal Income Tax bracket, you would have to earn $368 to pay for your glasses (if you earn $368, $68 is taken out for Federal Income and Social Security taxes leaving you $300 to spend on your eyeglasses). With salary redirection, on a pre-tax basis using a Flexible Spending Account, you can buy the pair of eyeglasses for $300, and all you need to earn to pay for the glasses is $300, rather than $368, saving you $68.

You may want to direct a portion of your salary to purchase dental benefits or additional life insurance as well as dependent care services or health care services not covered by insurance. Salary redirection offers distinct tax advantages to you. It helps your dollars go further because it lets you use pre-tax, rather than after-tax dollars to purchase the additional benefits you desire.

Your pre-tax redirection salary contributions toward benefit purchases are made in equal amounts each week for 48 weeks each year.

Redirected Dollars: Social Security and State Retirement

With salary redirection, dollars used to pay for most benefit costs are not subject to Social Security tax either. You do not pay Social Security tax on dollars you redirect to these benefit costs. However, this means that over time your earnings used to calculate your Social Security benefit will be less, and some day your Social Security benefit will probably be slightly reduced. There's no effect on your eligibility to receive Social Security benefits, but the Social Security benefit will be based on somewhat lower lifetime earnings. All employee contributions to Beneflex are treated as earnable compensation for NH Retirement System purposes.

Annual Leave Exchange

Employees may exercise the option of trading their future annual leave accruals in exchange for additional dollars. The maximum amount of annual leave time which may be exchanged shall be limited to 80 hours of future annual leave accruals unless otherwise noted in your collective bargaining agreement. Your annual leave balance immediately preceding the exchange must be at least 40 hours. The number of dollars earned by selecting this option will vary based upon your wage rate and amount of leave exchanged at the time of enrollment. Annual leave exchanged during open enrollment will be divided equally over each of the next 12 months. Annual leave is not adjusted during the plan year to reflect changes to compensation rates. The exchange of future annual leave accruals is also subject to NH Retirement System contributions and reporting. Once annual leave is exchanged, it cannot be credited back to you, for any reason.

A Range of Benefits

The City of Concord is offering you benefit choices in each of the following areas:

- Health Care
- Dental Care
- Life Insurance
- Accident and Sickness Plan
- Flexible Spending Accounts

Plan Year

Along with this booklet, full time employees will receive a Point Sheet, which indicates the total dollars or "points", provided by the City of Concord and the benefit options. The points provided to employees are based on Federal eligibility guidelines. The two exceptions to the Federal eligibility guidelines fall under NH RSA 457-A and Healthcare Reform.

NH RSA 457-A defines marriage as the legally recognized union of two people regardless of gender. Healthcare Reform requires employers offering dependent coverage to cover adult children between the ages of 19-26.

You will receive a confirmation statement based on your benefit selections which must be signed and returned to the Human Resources Department by the date specified. The confirmation statement not only confirms your benefit elections but it also authorizes the City to deduct benefit premiums from your paycheck. In addition, it is also used to validate your point eligibility. If the confirmation statement is not received by the date indicated, we will assume you have approved your benefits and any costs as indicated on the election form.

The total dollars or "points" provided to you are determined by collective bargaining agreements or city council appropriation. Plan costs in excess of what the City provides will be deducted from your pay.

You will select benefit options on a Plan Year basis. The choices you make will remain in effect for the Plan Year unless you experience a qualifying change in status event during the Plan Year. Most qualifying change in status events are effective on the day of the event. However, any applicable payroll adjustments will begin the first of the month following the event. The City operates on a July 1 through June 30 fiscal year and Plan Year.

Qualifying Change in Status Events

A qualifying change in status event is defined as a:

Change in employee's legal marital status;
Change in number of dependents;
Change in employment status of employee or spouse;
Dependent satisfying or ceasing to satisfy dependent eligibility requirements;
Change in place of residence;
Adoption placement;
Loss of Medicaid Coverage Eligibility; and
Loss of Children's Health Insurance Program (CHIP) coverage

You are responsible to notify the Human Resources Department within 30 days of any such status change. The only exception to this is in the event that you lose coverage under the Children's Health Insurance Program (CHIP) or Medicaid. In the event of a loss in CHIP or Medicaid coverage, you have 60 days to notify the Human Resources Department of the status change. If you fail to notify the Human Resources Department, you will be required to pay the City the premium cost differential.

Eligibility

All full-time City of Concord employees are eligible for participation in the City's Beneflex programs commencing the first day of the month following 30 days of employment. Permanent part-time employees are eligible to participate in the City's Health and Dental program at their own expense and receive Short Term and Long Term Disability at the City's expense.

Situations that could result in no longer being eligible for participation in Beneflex or a reduction in plan benefits include: termination of employment, retirement, leave of absence, reduction in hours, or any of the qualifying change in status events described above. Each individual benefit plan has its own requirements described in its specific plan document.

If you lose coverage, you may be able to obtain coverage through COBRA. Details regarding COBRA are provided in individual plan certificates.

Retirement Health Coverage

State law stipulates that most retirees are eligible for enrollment in the City's group health plan. The plan selected at the last open enrollment will be the plan in effect upon retirement. Retirees are eligible for annual open enrollment, typically held during the month of June. Open enrollment is the time each year when retirees have the opportunity to make changes to their benefit selections. It is the retiree's and/or employee's responsibility to notify the City of any desired changes.

Please note special circumstances may exist for the City Premium Benefit Subsidy for health insurance. Contact the Human Resources Department prior to enrollment if you are considering retirement during the next plan year.

Health Care

The City of Concord offers a competitive benefits package (Beneflex) to its Full Time and Permanent Part Time employees. Currently there are 3 different health plans offered to most employees (and 4 different health plans offered to CFOA employees). These plans are insured by Harvard Pilgrim Heath Care and employees are given the option of choosing between the separate plans.

How To Select Your Health Plan

Selecting a less expensive health insurance option or a lower level of coverage is referred to as OPTING DOWN. If you, your spouse, your dependent children up to age 19, or dependent children who are full time students aged 19-25 have insurance coverage through another family member's employer-sponsored group plan, you have the option of "OPTING OUT" of health insurance. By OPTING OUT, you will be allowed to keep a portion of the premium savings as cash or for purchase of other benefits through the various plan options. You must provide proof of insurance (such as a copy of the plan ID card) which shows the name of the employer, the insurance company, and the group and certificate number of the coverage. Since health insurance is one of the most costly benefits, you will want to choose your coverage carefully. Also, please remember that it is your responsibility to keep the Human Resources Department informed of any changes in the number of your dependents.

Healthcare Reform requires employers to cover dependent children up to age 26. Points will be provided to cover adult dependent children up to age 26 as required by Healthcare Reform. However, Healthcare Reform does not require employers to provide additional dollars or points to you if your adult child does not participate in the City's insurance. Therefore, you would not qualify for opting out premium savings for that adult child.

NOTE: Please refer to the health insurance schedules of benefits, plan descriptions, and the benefit summary sheet that follows for additional details.

Harvard Pilgrim Health Care of New England

City of Concord

2013 - 2014

	HMO			POS *(CFOA Employees Only)*	
	Mid $15	**Best Buy 250 Mid $20**	**Best Buy $500 Low $25**	**High $5**	
				In Network	**Out of Network**
Office Copay	$15 copay / visit (No copay for preventive visits)	$20 copay / visit (No copay for preventive visits)	$25 copay / visit (No copay for preventive visits)	$5 copay / visit (No copay for preventive visits)	Covered at 80% after deductible (a.d.)
Individual Deductible	None	$250 per calendar year	$500 per calendar year	None	$250 per cy
Family Deductible	None	$750 per calendar year	$1500 per calendar year	None	$500 per cy
Surgery	Covered in full	Covered in full after deductible	Covered in full after deductible	Covered in full	Covered at 80% a.d.
ER Copay	$50 / visit	$75 / visit	$100 / visit	$50 / visit	$50 / visit
MRI / CT Scan	Covered in full	Covered in full after deductible	Covered in full after deductible	Covered in full	Covered at 80% a.d.
Ambulance	Covered in full	Covered in full after deductible	Covered in full after deductible	Covered in full	Covered at 80% a.d.
Outpatient Mental Health	$15 copay / visit for individual $10 copay / visit group therapy	$20 copay / visit for individual $10 copay / visit group therapy	$25 copay / visit for individual $5 copay / visit group therapy	$5 copay / visit for individual and group therapy	Covered at 80% (unlimited)
Inpatient Mental health	Covered in full	Covered in full	Covered in full	Covered in full	Covered at 80% (unlimited)
Outpatient Substance / Alcohol Rehabilitation	$15 copay / visit for individual $10 copay / visit group therapy	$20 copay / visit for individual $10 copay / visit group therapy	$25 copay / visit for individual $5 copay / visit group therapy	$5 copay / visit for individual and group therapy	Covered at 80% (unlimited)
Inpatient Substance / Alcohol Rehabilitation	Covered in full	Covered in full	Covered in full	Covered in full	Covered at 80% (unlimited)
PT / OT	40 visits combined with ST per cy $15 copay per visit	Combined up to 25 visits / cy $20 copay / visit	$25 copay per visit (unlimited)	Covered in full (unlimited)	Covered at 80% a.d. (Unlimited)
ST	40 visits combined with PT/OT per cy $15 copay per visit	Up to 25 visits / cy $20 copay / visit	$25 visit per visit (unlimited)	Covered in full (unlimited)	Covered at 80% a.d. (Unlimited)
SNF / Inpatient Rehabilitation	Covered in full: SNF = 100 days /cy Inpatient Rehab = 60 days /cy	Combined up to 100 days /cy Covered in full after deductible	Combined up to 100 days /cy Covered in full after deductible	Covered in full (unlimited)	Covered at 80% a.d. (Unlimited)
Chiropractic Care (limit combined in/out)	Up to 12 visits / cy $15 copay / visit	Up to 12 visits / cy $20 copay / visit	$25 copay per visit (unlimited)	$5 copay / visit (unlimited)	Covered at 80% a.d. (Unlimited)
Routine Eye Exams	1 visit per cy $15 copay / visit	1 visit per cy $20 copay / visit	1 visit per cy $25 copay / visit	1 visit per cy $5 copay / visit	Covered at 80% a.d.
DME	Covered at 80%	Covered at 80% after $100 dDeductible	Covered at 80% after $100 deductible	Covered in full (unlimited)	Covered at 80% a.d. (Unlimited)
Out of Pocket Maximum	Unlimited Costs (ie: Copays)	$1,000 Individual / $2,000 Family	$2,000 individual / $4,000 Family	Unlimited Costs (ie: Copays)	$1,000 Individual / $2,000 Family
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Benefit limits apply to both in and out unless specified.					
Prescription Drug Benefits					
Retail *	$0/$15/$15	$0/$20/$30	$5/$25/$40	$0/$15/$15	
Mail Order **	$0/$15/$15	$0/$20/$30	$5/$25/$40	$0/$15/$15	

* Retail up to 30 day supply

** Mail up to 90 day supply

Wellflex Program

The City of Concord recognizes that staying well involves more than just being covered by a medical plan. That's why we are pleased to partner with our insurers to offer a wellness program — known as Wellflex — to all full-time employees and City-insured spouses. Together, we're working toward healthy living.

How the Plan Works

Wellflex encourages you to participate in wellness activities by offering *wellpoints* for developing healthy habits. You can then use your wellpoints to help offset your share of health insurance premiums.

You can earn wellpoints by participating in:

- Beneflex/Wellflex education sessions
- Health Care Consumerism Education Sessions (every other year)
- Health Risk Appraisals (alternate every other year)
- Health education programs
- Physical exercise activities
- On-site health screenings

Wellpoints earned the previous Beneflex year will be awarded during the City's open enrollment period, typically held during the month of May. If you do not need the additional Wellpoints to purchase health insurance, they may be used for other aspects of the Beneflex program.

Research has clearly shown that promoting health and fitness at the workplace and at home helps employees reduce the rate of premium increases and related health insurance costs, improve overall health, reduce stress levels, and become wiser health care consumers. The potential value of wellness programs to employers is just as impressive, with results such as reduced absenteeism, lower health care costs, improved employee morale, reduced employee turnover, better customer service, and enhanced employee recruitment. It is a win-win situation for everyone!

Funding for the City's Wellflex Program as described in this document is subject to annual appropriation by City Council.

Dental Care

The dental plan being offered emphasizes reimbursement for preventive dental care. The purpose of the plan is to make it easier for you and your family to receive regular dental treatment, thereby encouraging good oral health. You are not required to take dental care coverage. If you select lower cost health coverage, you may be able to have dental coverage at little cost.

Subscribers in the dental plan insured by Cigna Dental may visit the dentist of their choice. If you select a participating dentist, the dental office will most likely bill Cigna Dental (the dental carrier) directly and may accept Cigna's maximum allowance as the fee for your dental procedure. Even if you select a non participating dentist, Cigna has agreed to pay all invoices as billed for the 2013 – 2014 plan year (subject to the benefits and guidelines).

Under the dental care option, when you visit a participating dentist:

- Coverage A services (diagnostic and preventive) are paid, up to 100% of the maximum allowance,
- Coverage B services are paid at 60%, and
- Coverage C and D services are paid at 50%.

The four categories of covered services are described below:

Coverage A Services

- *Diagnostic* (evaluations; 2 per policy year; x-rays – full-mouth/ panorex x-rays once in a three-year period; bitewing x-rays 2 per policy year, x-rays of individual teeth as necessary)
- *Preventive* (cleanings 2 per policy year; fluoride once per policy year under age19; space maintainers (no age limit) and sealants for children 1 per tooth every 3 years under 14.

Coverage B Services

- *Restorative* (amalgam and composite fillings – anterior teeth only)
- *Oral Surgery* (surgical and routine extractions)
- *Endodontics* (root canal therapy)
- *Periodontics* (treatment of gum disease; periodontal prophylaxis cleaning – see note below)
- *Denture Repair* (repair of removable denture to its original condition)
- *Emergency Palliative Treatment*

NOTE: 2 Cleanings are covered per policy year. This can be routine (Coverage A) or periodontal (Coverage B), but not both.

Coverage C Services

- *Prosthodontics* (bridges; partial and complete dentures; rebase and reline dentures; crowns; onlays; surgical implants)

Coverage D Services

- *Orthodontics* (correction of malposed (crooked) teeth for adults and dependent children)

Orthodontic benefits are provided for each eligible subscriber and dependent. These benefits are not subject to a lifetime maximum and may be submitted once per Plan Year as long as the patient is eligible and still in active treatment.

Your Dental Care Option

Services	Benefit
Coverage A Services	Covered at 100%
Coverage B Services	Covered at 60%
Coverage C Services	Covered at 50%
Coverage D Services	Covered at 50%
Coverage B & C Annual Deductible	$50 Individual/$150 Family
Maximum Annual Benefit Per Person	$1,000**

** This may be any combination of Coverage A, B, C, and D as indicated above.
NOTE: The above information is presented in summary form; please refer to the Dental Plan Description *booklet for complete benefit information.*

Life Insurance

Providing security for your survivors in the event of your death is an important responsibility. Most people hope to leave behind a positive legacy. Your benefit program provides a basic amount of life insurance protection for all employees (core coverage). Additional coverage can be selected according to your individual financial circumstances, future needs of your survivors, and last wishes.

These plans include Accidental Death and Dismemberment coverage which increases the benefits you would receive in the unfortunate event of an accidental death or dismemberment. Your life insurance benefit is based upon your regular annual base wages at the time of enrollment but claims are paid using wages at the time of death. Premiums on life benefits in excess of $50,000 are subject to Federal withholding and FICA tax. Options under the benefit plan are:

	High Option	Mid Option	Low Option
Death Benefit Equal to	3 times your annual salary	2 times your annual salary	1 times your annual salary up to a $150,000 max

Shaded block represents core coverage.

If an employee elects to increase life insurance coverage more than 31 days from date of hire, or if the supplemental amount of life insurance elected is $100,000 the life insurance company requires a completed evidence of insurability form.

The insurance company will notify the employee in writing if the increased coverage level has been approved or not. The current life insurance company is The Hartford Insurance Company.

**Benefits are reduced 35 % for employees age 65 and over and an additional 15% at age 70.*

Income Protection Plans For Accident and Sickness

The income protection plan for accident and sickness will pay you a portion of your income if you are unable to work due to injury or illness.

Full Coverage Plan

The Full Coverage Plan includes three separate and distinct elements: a Sick Leave Account, Short-Term Disability Income Insurance and Long-Term Disability Income Insurance. The Short-term Disability and Long Term Disability Insurances are insured by The Hartford Insurance Company.

Under the Sick Leave Account, non-exempt (hourly), probationary employees accrue .0577 hours of sick leave for each regularly scheduled hour of work during the first six months of employment. After six months, the accrual rate is .0308 hours of sick leave for each regularly scheduled hour of work. The maximum accrual is 200 hours for full-time employees. This account is used from the onset of sickness or injury for a fourteen (14) calendar day period. Exempt (salaried) employees accrue no sick leave, but are paid their regular salary for approved absences until disability insurance begins.
Short-Term Disability Insurance provides income continuation for employees from the 15th calendar day of an absence up to the 105th calendar day of a disability related absence that is not job-related. This insurance policy pays 66 2/3% of your regular weekly base gross wages less taxes and mandatory deductions (at the rate of pay just prior to the date your disability begins), up to a maximum of $1,200 per week. In addition, for both exempt and non-exempt employees, the City supplements Short-Term Disability Insurance payments, for fifteen (15) calendar days of each disability, to 100% of current weekly base gross wages for each full year of service to the City completed as of the onset of the disability.

An employee who is receiving Short-Term Disability Insurance and who does not have sufficient service time to be eligible for the full service based City supplement, shall be required to apply for annual leave through the usual annual leave process to cover time that is not covered by the insurance payments. The Sick Leave Account is used for authorized absences of less than 15 calendar days only. The Sick Leave Account may not be used to supplement Short-Term or Long-Term Disability Insurance. You may be able to use your annual leave account to supplement certain types of leaves of absence as defined with the City Procedures for Requesting Leave. Please check with the Human Resources Department if you have questions.

Employees receiving Worker's Compensation payments beyond the third consecutive day of disability also receive a pay supplement from the City, up to the employee's base net wage less mandatory deductions for taxes and retirement contributions, for a maximum of fifteen (15) weeks.

The Long-Term Disability Insurance Plan commences after 105 calendar days of disability. It pays you 60% of your regular weekly base wages (just prior to the date disability begins) up to a maximum payment of $4,700 per month. (If you receive benefits on a monthly basis from other group plans, such as Workers' Compensation, Social Security or pension, this plan supplements those benefits up to the 60% or $4,700 benefit limit. However, regardless of other coverage, this plan pays no less than $100 monthly.) The Benefit Duration is the maximum time for which benefits are paid. Depending on the age at which disability occurs, the maximum duration may vary.

Benefit Duration

Age Disabled	**Benefits Payable- Elimination period less than 180 days**
Prior to Age 63	To Normal Retirement Age or 48 months if greater
Age 63	To Normal Retirement Age or 42 months if greater.
Age 64	36 months
Age 65	30 months

Age 66	27 months
Age 67	24 months
Age 68	21 months
Age 69 and over	18 months

If you are entitled to a wage increase while you are out on Short-Term Disability, the increase will be reflected in the City supplement only. The Short-Term Disability insurance administrator will pay your regular weekly salary at the time of disability.
Please refer to the Personnel Rules & Regulations and/or applicable policies for additional information and specific procedures.

Flexible Spending Accounts

Flexible Spending Accounts (FSAs) offer a tax-effective way for you to pay certain health care and dependent care expenses. When contributing dollars to either or both FSAs, you pay no Federal Income or Social Security tax on those dollars. This can mean significant savings. In addition, if you have selected reduced health benefits, some of your benefit dollars from the City may be left over to use in these accounts as well.

Permanent part-time employees are eligible to participate in Flexible Spending Accounts at their own expense.

Health Care Reimbursement Account

During the plan year, you can deposit dollars through payroll deduction into your Health Care Reimbursement Account. The maximum annual amount you may contribute is $2,500. This pre-tax money can be used to pay health care expenses not covered or not paid for by your medical or dental coverage.

Below is a list of eligible expenses to consider reserving money for:

- The deductible or copayment under your health insurance plan
- The percentage of covered expenses your health plan doesn't pay
- Prescription drug costs, including retail, and mail order co-payments
- Dental expenses, including orthodontia
- Vision expenses, including examinations, eyeglasses (lenses and frames), prescription safety glasses, contact lenses, solutions and seeing-eye dogs
- LASIK eye surgery
- Fertility treatment expenses
- Insulin
- Weight-loss program (disease specific)
- Stop smoking programs
- Smoking deterrents
- Hearing expenses, including examinations and hearing aids
- Physical examinations (except job-related physicals)
- Psychoanalysis, psychiatric therapy, learning disability counseling by a licensed professional, inpatient care and treatment (including special schooling, if necessary) for a mental or physical

handicap and services provided by a qualified, licensed psychologist, if not paid by your health plan
- Chiropractic expenses
- Acupuncture
- Midwife expenses
- Christian Science practitioner expenses
- Special medical equipment, bought or rented because of a medical problem, such as wheelchairs, crutches and orthopedic shoes
- Medicine or other drugs prescribed by a doctor and not paid by your health plan such as vitamins, dietary supplements and birth control items. NOTE: vitamins and supplements require a Physician's Statement of Medical Necessity.
- Transportation essential to medical care, such as ambulance service
- Other medical expenses qualifying as legitimate deductions as outlined in IRS Publication #502, not including insurance premiums.

Dependent Care Assistance Account

You can make deposits to and use your Dependent Care Assistance Account in the same manner as your Health Care Reimbursement Account. For your Dependent Care Assistance Account, the dependent must be under age 13 (or incapable of self care) and be claimed as a dependent on your income tax return. You should determine if this is more advantageous than taking the direct IRS Child and Dependent Care Tax Credit on the 1040 tax form. Eligible dependent care expenses include:

Payments made for services provided in your home as long as services are not provided by someone you also claim as a dependent, or your other children under age 19. Payments made for dependent care services outside your home. Day camp programs (provided both parents are working).
*If a dependent care center is used, it must be in compliance with state and local law.

Your maximum contribution to a Dependent Care Reimbursement Account is the lowest of the following:

- $5,000, whether single or married
- $2,500 if married, filing separately, or

The lower of your or your spouse's earned income. If your spouse is a full time student or is disabled, special rules apply.

Important Considerations

The IRS allows your employer to offer this tax advantage through the Flexible Spending Accounts, but it has also imposed several restrictions. Each year, you must use all the money set aside in both your Dependent Care Reimbursement Account and medical FSA or forfeit the money left over. Because of this restriction, it is very important to plan carefully when you decide how much money you want to set aside in each account.

Generally, amounts should be used for predictable expenses. For example, working parents with children in day care usually can count on a certain level of dependent care expenses; or if you know

that you need a new pair of eyeglasses or braces for your child in the coming year, the FSA would be a tax-effective way to pay for those expenses.

You cannot pay for services through an FSA and also take the tax advantage available for those same services at income tax time. In other words, if you pay for medical expenses through a Health Care Account, you cannot also itemize those expenses as deductions on your tax return. If you pay for child or dependent care expenses through a Dependent Care Account, you cannot also take the Child and Dependent Care Tax Credit for those same expenses, and your maximum allowable expenses for the Tax Credit are reduced by the amount you are reimbursed through your FSA.

You cannot change the amount of your payroll deduction for your FSA after the beginning of the plan year except in the event of a qualifying change in status event. If you terminate your employment with the City during the plan year, you may be eligible to continue your participation in a Flexible Spending Account through COBRA. For more information, contact the Human Resources Department.

Finally, because you reduce your taxable income for FICA purposes by setting aside money in a Flexible Spending Account, your Social Security earnings for the year will be reduced. This may reduce your Social Security benefits at some time in the future. However, the tax savings you receive now should more than make up for it.

Example

Here is an example of how tax savings through redirected dollars work: Let's take the case of a married employee with one child whose family income totals $40,000 a year. This employee takes the standard deduction and three exemptions and pays $5,500 a year for non-covered and eligible medical or dependent care expenses. Your tax may vary.

	Without FSA*	With FSA
Gross Pay	$40,000	$40,000
Medical FSA Contribution	(0)	($1,500)
Dependent Care Reimbursement Account Contribution		(4,000)
Taxable Income	$40,000	$34,500
Taxes (Federal Income and FICA)†	($8,225)	($6,979)
Eligible Expenses (paid after tax)	($5,500)	(0)
Spendable Income	$26,275	$27,521
Tax Savings	$0	$1246

**Flexible Spending Account*
†Based on 15% Federal Tax Bracket

Receiving a Payment From Your Account

The Health Care Assistance accounts are prefunded at the beginning of their plan year with their full election available to them to use if need be. The Dependent Care Assistance account balances are set up to auto-post on the payroll deduction dates. When you have an eligible expense, you can apply for a reimbursement from your account. All Flexible Spending Account participants will also enjoy the added convenience of Benefit Strategies PINless FlexExpress debit card service at no additional charge, which looks and works like a typical debit card simply without the PIN number.

The FlexExpress debit card provides you with a convenient way to purchase eligible health and dependent care expenses. With the Health Care Reimbursement Account, your total annual election is immediately available for purchases made with the card. For the Dependent Care Assistance Account, the amount available for purchases is only equal to the account balance at the time of the transaction.

When the FlexExpress debit card is used it will automatically debit the charged amount from the available balance. Part of the IRS rules and regulations requires that you keep all documentation associated with the use of the FlexExpress debit card. Benefit Strategies may ask that you to send in documentation to substantiate a reimbursement to ensure that the service was for an eligible expense incurred during the plan year.

Documentation is not required if the expense equals the copayment amount required by one of the City's health plans for a doctor's office visit or by the City's plan for a pharmacy prescription. Also, if a retail store uses an Inventory Information Approval System to verify if a purchased item is on the IRS list of eligible expenses (through the item's SKU number), documentation of that purchase is not required.

If you do not wish to utilize the debit card provided to you, there is a reimbursement request form you will need to complete to receive payment from your Flexible Spending Account. You may obtain the form on the City's Intranet located at www.onconcord.org under City Forms. Benefit strategies also has the option to receive reimbursement via check or direct deposit. The direct deposit form is also located on the City's Intranet located at www.onconcord.org.

Claim forms and receipts may be submitted to Benefit Strategies on a daily basis. You will need to provide bills or receipts which include date of service, name of service provider, name of patient, service provided, and amount requested for reimbursement. Medical expenses must first be filed with your health plan. A provider's tax ID# is required only for dependent care claims. Benefit Strategies LLC processes reimbursements twice a week, on Monday's and Thursday's. You have 90 days after the end of each Plan Year to submit claims incurred during that plan year.

Health Care Assistance Account claims will be processed twice a week and you will receive a payment in the amount of your claim not to exceed the amount of your yearly contribution.

Your Dependent Care Reimbursement Account claims will be processed twice a week and you will receive a payment not to exceed the current balance in your account. When a claim exceeds your account balance, unpaid amounts are carried forward and paid to you weekly as future deposits go into your account to cover the expense.

Your Flexible Spending Account reimburses you for money paid for certain services. Benefit Strategies will not issue checks to doctors or drug stores, but will reimburse you directly for money you have paid. Benefit Strategies will try to help you use the FSA only for eligible expenses. However, Benefit Strategies and the City bear no responsibility for your taxes. You remain fully accountable to the IRS to prove the eligibility of any expense you submit.

The FSA offers a tax-effective means for you to save for certain benefit needs. Remember, there are important considerations to keep in mind and you must plan carefully to use this benefit wisely.

457 Deferred Compensation Plan(s)

A 457 Deferred Compensation Plan is a supplemental retirement savings program that allows you to make contributions on a pre-tax basis. Federal, and in most cases, state income taxes are deferred until your assets are withdrawn, usually during retirement when you may be in a lower tax bracket.

What are the benefits of participating in a 457 plan?

- You reduce your current income taxes while investing for retirement.
- Your earnings accumulate tax-deferred.
- You can dollar cost average through convenient payroll deductions.*
- You may be allowed to make additional "catch-up" contributions if you are 50 (or older) or within three years of your normal retirement age and already contributing the maximum to your plan.
- If you change jobs, you have the flexibility to move your account into your new Employer's retirement plan.
- If you retire or leave service early, there is no penalty for withdrawals.
- Supplemental investments are helpful in states, communities and jobs where no contribution is made to Social Security.
- You can increase, decrease, stop and restart contributions as often as you wish without fees or penalties.
- You may choose from a wide range of investment options. There are no restrictions or charges for reallocating your investment mix and all funds offered through all our 457 plan providers are no-load (no costs to participants) with the exception of two funds offered through PFPOPE.
- There are no minimum investment requirements.
- Your designated beneficiaries are entitled to receive all remaining funds in your account in the event of your death.
- You have the most flexible withdrawal payment options available. You determine the payment schedule that is right for you.
- You control your account even while you are withdrawing assets.

* Dollar cost averaging does not assure profit or protect against loss in a declining market. Since dollar cost averaging involves continuous investing, regardless of fluctuating prices, investors must consider their level of comfort in continuing to invest during a declining market.

Keep in Mind:
There are Internal Revenue Code limits on the amount you may contribute each year.
There are two "Catch-Up" provisions that allow you to contribute over-and-above the normal annual contribution amount.
If you retire or leave service early, there are no penalties for withdrawals. However, you will pay taxes on the amount that you withdraw.
You are required to begin withdrawing from the account by a certain age.

457 Roth

The 457 plan offered by Great West, allows for both pre-tax and Roth 457 contributions. Roth contributions are made with after-tax dollars which means you pay fewer taxes at distribution. Roth 457 contributions reduce your take-home pay because you pay taxes on your Roth 457 contributions up front, rather than deferring those taxes until you take a distribution. Your Roth distributions are income tax- and penalty-free if you withdraw your Roth contributions and earnings after you have reached a qualifying event, have had the account for at least five taxable years and:

* You are at least 59 1/2 or
* You become disabled; or
* You die (after which your beneficiary (s) will take the withdrawal).

Roth IRA

A payroll Roth IRA is a Roth IRA funded through contributions that are made directly from your pay. Making regular contributions through payroll deduction is a simple and efficient way of investing for your retirement.

You will not pay any taxes on your investment earnings while they remain in the Roth IRA. In addition, you will be free of any taxes or penalties on the assets you withdraw from a Roth IRA as long as 1) your Roth IRA has met certain five year aging requirements and 2) you have a qualifying event (e.g. first time home purchase, age 59 ½). This opportunity for lifetime tax-free earnings makes a Roth IRA an attractive way to build retirement assets. Contributions can be withdrawn any time, without penalty and tax-free. There is no minimum distributions from a Roth IRA when you turn age 70 ½.

Keep in Mind:
There are Internal Revenue Code limits on the amount you may contribute each year.
There is one "Catch-Up" provision with a Roth IRA that allows you to contribute over-and-above the normal annual contribution amount.

Visit http://www.icmarc.org for additional information.

Severance Payment

The City provides a severance payment which is based on City years of service and sick leave usage. As outlined in the Personnel Rules and Regulations at (34-4-9), eligibility for a severance payment shall extend to employees in wage schedules A, B, C, or S, at the time of actual retirement, and who retire from the City having completed at least ten (10) years of creditable service within the N.H. Retirement System. The amount to be paid shall be determined by the following formula:

Deduct the number of sick leave days used during an employee's last two (2) years of employment from the number "30" and apply the balance to the payment formula below. The base for calculations during 2013 shall be one hundred and sixty five dollars ($165). This base shall be indexed to the annual across-the-board wage increases.

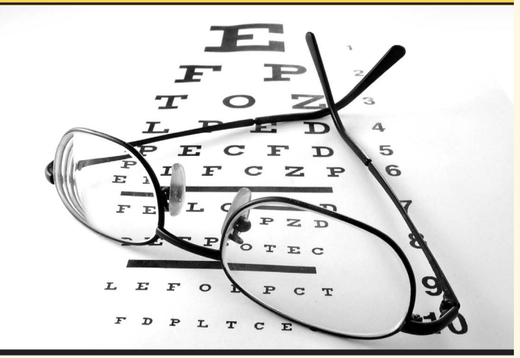
Years of Service Payment Formula
10 years thru 14 years .25 * Current Base * number of days
15 years thru 19 years .50 * Current Base * number of days
20 years thru 24 years .75 * Current Base * number of days
25 years and over Current Base * number of days

In no case shall the amount paid per day exceed the employee's standard daily rate. Consecutive sick leave days used involving more than three (3) days shall be computed as single events for purposes of calculating this benefit.

Please refer to the appropriate contract provision when administering this benefit for contractual employees who are not a part of Beneflex.

HealthTrust

HEALTHCARE FLEXIBLE SPENDING ACCOUNT



PO Box 617 • 25 Triangle Park Drive
Concord, NH 03302-0617

Telephone: 800.527.5001 • Fax: 603.415.3099
Email: fsa@healthtrustnh.org
Website: *www.healthtrustnh.org*

HealthTrust is pleased to join with your employer in offering you a **Healthcare Flexible Spending Account (Healthcare FSA)** as a potentially valuable tax-saving benefit under your employer's Flexible Benefits Plan.

This brochure summarizes how this benefit works and should help you decide whether to participate. The specific terms and conditions of the Healthcare FSA benefit are included in the Flexible Benefits Plan Document, available from your employer.

Authorized by the Internal Revenue Service (IRS), a Healthcare FSA allows you to pay for qualifying healthcare expenses with pre-tax dollars. Contributions to this account are directly deducted from your paycheck before federal income or Social Security taxes are withheld, and qualifying reimbursements are also not taxable to you.

Using pre-tax dollars to reimburse yourself for things like healthcare plan deductibles and medical expenses that your healthcare plan does not pay can mean significant savings for you!

**Healthcare Flexible Spending Account* program components are subject to change without notice.

How It Works

Once you have met the eligibility requirements established by your employer, you have the opportunity to enroll in the Healthcare FSA. You must re-enroll during the open enrollment period prior to each plan year in order to continue participating. Once you choose to enroll, you will need to:

- Estimate your expected out-of-pocket healthcare expenses for the coming plan year and review what expenses are eligible for reimbursement. A partial list of eligible expenses is included in the **Eligible Expenses** section of this brochure. A detailed list is in the Plan Document, available from your employer; the list is also downloadable from the "Resources" section of ***www.healthtrustnh.org***.

- Decide how much you want to contribute to your account up to your employer's maximum contribution limit. The amount you elect to contribute is deducted from your paycheck in equal installments throughout the plan year and deposited in your Healthcare FSA.

- Keep in mind that, once enrolled in a Healthcare FSA, you cannot change your payroll deduction amount until the next open enrollment period *except* when you experience a change in family or employment status like marriage, birth, death, divorce, taking a paid or unpaid leave of absence, termination or commencement of your or your spouse's employment, or a change in hours (such as from full-time to part-time). A more complete list of change-in-status events and other requirements for mid-year election changes are included in the Plan Document.

**Healthcare Flexible Spending Account* program components are subject to change without notice.

After you incur an eligible expense, you can seek reimbursement from your account (see the **Receiving Reimbursement** section of this brochure for more details).

Eligible Expenses

Your Healthcare FSA can only be used to reimburse qualifying healthcare expenses incurred during the plan year (or during the 2½-month grace period immediately following the plan year if elected by your employer). A healthcare expense is incurred at the time the care or service is furnished and not when you are billed, charged for or pay for the service. The Plan Document, available from your employer, provides an overview of the Healthcare FSA and a detailed listing of eligible expenses. You can also access a detailed list of eligible healthcare expenses in the "Resources" section of ***www.healthtrustnh.org***.

To qualify, the expenses must:

- Be incurred by you (the eligible employee), your spouse or your eligible dependents.
- Not otherwise be reimbursed through a group health plan, other insurance or any other source.
- Be considered medically necessary, e.g., for the purpose of treating a medical condition or illness.

Here is a partial list of expenses eligible for reimbursement through a Healthcare FSA:

- Healthcare plan deductible
- Percentage of covered expenses that the healthcare plan does not pay
- Dental expenses not reimbursed through a dental plan, including orthodontic expenses

**Healthcare Flexible Spending Account* program components are subject to change without notice.

- Hearing expenses, including examinations and hearing aids
- Vision expenses, including examinations, lenses and frames
- Contact lenses, including solutions
- Chiropractic expenses
- Acupuncture
- Equipment like wheelchairs, crutches, and orthopedic shoes required due to a special medical problem
- Costs for transportation essential to medical care, such as ambulance service
- Weight-loss programs medically prescribed for treatment of a disease (excluding "diet" foods)

Ineligible Expenses

Below is a partial list of expenses ineligible for reimbursement through a Healthcare FSA. The Plan Document, available from your employer, provides a more detailed list of ineligible expenses. Or, you can access a more detailed list from the "Resources" section of ***www.healthtrustnh.org***.

- Expenses reimbursed or entitled to reimbursement by insurance or other plan coverage
- Expenses not considered medically necessary
- Cosmetic surgery
- Health club dues
- Items or services utilized for promoting "general" health, such as vitamins and herbal medications

(continued on reverse side)

**Healthcare Flexible Spending Account* program components are subject to change without notice.

Receiving Reimbursement

When you incur an eligible healthcare expense, you can apply for a reimbursement from your account in one of two ways:

1. Submit to HealthTrust a *Flexible Spending Account Reimbursement Form* obtained from your employer or downloaded from the "Resources" section of ***www.healthtrustnh.org***.
2. Submit your claim online by going to the "Coverage" section of ***www.healthtrustnh.org***, click on the "My FSA Account" button and follow login instructions provided for entering required information plus scanning, mailing or faxing related receipts.

When seeking reimbursement from your account, you must provide copies of all related bills, receipts, explanation of benefits, or other written statements that include a description of the service, name of the provider, relationship of the person who incurred the expense, the amount of expense you have incurred, and the date the service was incurred. Please note that cancelled checks are not acceptable as proof of your expense. Mail or fax this information to:

HealthTrust
Attn: FSA Reimbursement
PO Box 617
Concord, NH 03302-0617
603.415.3099 (fax)

Incomplete forms may be delayed or returned.

**Healthcare Flexible Spending Account* program components are subject to change without notice.

Rev. 08/13

Reimbursement is provided on a weekly basis, and the minimum check amount is $20 unless it is the last claim of the plan year. Healthcare FSA expenses will be reimbursed up to the annual election amount. Reimbursement requests are limited to expenses incurred during the plan year (or during the 2½-month grace period immediately following the plan year if elected by your employer) and may be submitted for up to 90 days after the plan year (or grace period) ends.

If you leave employment during a plan year, you may have the right to elect to continue your Healthcare FSA contributions and have access to your Healthcare FSA balances for the remainder of that plan year, subject to the requirements and limitations set forth under federal COBRA law. Please see the Plan Document or contact either your employer or HealthTrust for further information.

Debit Card Option

If offered by your employer, a debit card made available by HealthTrust can be used to purchase eligible expenses. A separate brochure detailing this option will be provided by your employer as needed.

**Healthcare Flexible Spending Account* program components are subject to change without notice.

Important Tax Considerations

You should keep in mind the following tax considerations when deciding whether to participate in the Healthcare FSA program:

- ***Use-or-lose.*** IRS regulations stipulate a "use-or-lose" rule that requires employees to use all of their designated Healthcare FSA funds during the plan year (or during the 2½-month grace period immediately following the plan year if elected by your employer), or forfeit remaining balances.

- ***Cannot claim the same expenses as deductions on your income taxes.*** You cannot receive reimbursement for a qualifying expense through your Healthcare FSA and also deduct the same expense on your federal income taxes. We strongly encourage you to speak with your tax advisor before enrolling in a Healthcare FSA for tax-related questions or concerns.

- ***Reimbursement accounts affect your Social Security earnings.*** Because you reduce your taxable income by setting aside money in a Healthcare FSA, your Social Security earnings for the year may be reduced. Over time, this may also lessen your overall Social Security benefits. However, the tax savings you will receive now should compensate for those reductions.

- ***Important HSA information.*** Employees who are enrolled in a Health Savings Account (HSA) either through their employer or a spouse's employer ***cannot*** participate in a traditional Healthcare FSA per IRS regulations. A limited purpose FSA may be available; please contact your employer for further information.

**Healthcare Flexible Spending Account* program components are subject to change without notice.

Information About Your Account

Your Healthcare FSA information is available to you 24 hours a day, 7 days a week! For your convenience:

- You may access transaction information, account balances and account history by going to the "Coverage" section of ***www.healthtrustnh.org***, click on the "My FSA Account" button and follow login instructions.

- Updated account balances are provided with each reimbursement check.

- A statement of account balance and transaction history is provided 90 days prior to the end of each plan year, or request a statement anytime by calling HealthTrust at **800.527.5001**.

If you have questions about this brochure or your Healthcare FSA, please contact your employer directly, or HealthTrust at **800.527.5001**.

**Healthcare Flexible Spending Account* program components are subject to change without notice.

Healthcare Flexible Spending Account Worksheet

To estimate how much you should contribute to your Healthcare FSA, use the worksheet below. You may also want to review related expenses for the past several years for you and your covered family members.

Medical deductibles	$ _____
Dental deductibles	$ _____
Medical copayments	$ _____
Dental copayments	$ _____
Other dental (orthodontics)	$ _____
Vision / hearing care	$ _____
Prescription drug copayments	$ _____
Prescribed over-the-counter medicines	$ _____
Over-the-counter supplies and equipment	$ _____
1) **TOTAL EXPENSES**	**$** _____
2) Maximum Contribution Limit	$ _____
3) Annual Contribution (amount on line #2 or #3, whichever is less)	$ _____
4) Number of Pay Periods per Plan Year	_____
PAY PERIOD DEDUCTION (divide amount on line #3 by amount on line #4)	$ _____

**Healthcare Flexible Spending Account* program components are subject to change without notice.

The **Benny Prepaid Benefits Card**

is a debit card option that is part of the Healthcare Flexible Spending Account (FSA) or Dependent Care Reimbursement Account being administered by HealthTrust on behalf of your employer. If you have selected this option, you will receive a Benny Prepaid Benefits Card by mail from Evolution Benefits—a leading employee benefits technology company and HealthTrust's partner for providing convenient, electronic payment solutions.

Benny is prepaid to provide you with a convenient way to purchase eligible health and dependent care expenses. With the Healthcare FSA, your total annual election is immediately available for purchases made with the Card. For the Dependent Care Reimbursement Account, the amount available for purchases is only equal to the account balance at the time of the transaction.

Please read the following guidelines to ensure you benefit the most from using the Benny Prepaid Benefits Card.

NOTE: This program is subject to change without notice.

DOCUMENTING CHARGES

All charges made to the Benny Prepaid Benefits Card are only *conditionally reimbursed* until related receipts are received and approved by HealthTrust per Internal Revenue Service (IRS) regulations. Within **14 days** of using the Benny Prepaid Benefits Card to pay for an approved FSA expense, you will need to provide documentation of the expense* to HealthTrust. This can be in the form of a bill, receipt of payment (from provider or insurer), explanation of benefits or written statement from an independent, third party noting the service incurred and its expense amount.

*Documentation is not required if the expense equals the copayment amount required by 1) your employer's medical plan for a doctor's office visit, or 2) your employer's pharmacy plan for a prescription. Also, if a retail store uses an Inventory Information Approval System to verify if a purchased item is on the IRS list of eligible expenses (through the item's SKU number), documentation of that purchase is not required.

REQUIRED RECEIPTS

All receipts submitted to HealthTrust should include the following IRS-required information:

- Name & address of service provider
- Date service & expense were incurred
- Name of person receiving the service
- Detailed description of service provided
- Amount charged for service

Receipts from Benny Prepaid Benefits Card transactions cannot be submitted as substantiation because they typically do not include all of the required information previously noted. Also, if your employer allows over-the-counter items to be covered under your FSA plan, receipts must include the item's printed name; handwritten item names are not acceptable.

CORRECTIVE MEASURES

Please know that if receipts are not submitted to document your Benny Prepaid Benefits Card charges—or the Card is used incorrectly—HealthTrust and your employer are obligated by law to pursue one or more of the following corrective measures:

- Require you to reimburse HealthTrust for the amount in question
- Deny reimbursement of subsequently submitted claims incurred during the same period of coverage until the payment amount is fully recovered
- Take other action deemed reasonably necessary to recover mistaken payments and ensure that they do not recur (e.g., by denying access to the Card use until payment is recovered or revoking the Card)

If none of these methods succeed in recovering a mistaken payment, your employer may either report the amount of the mistaken payment to you and the IRS as taxable income or treat the amount owed as it would any other business debt.

SUBMITTING PAPERWORK

Please clearly mark each receipt as "Paper Substantiation for Debit Card Purchase" to ensure proper processing.

Your FSA receipts for documenting charges can be submitted to HealthTrust one of the following ways:

By fax: 603.415.3099

By mail: HealthTrust
FSA Debit Card Substantiation
PO Box 617
Concord, NH 03302-0617

By email: fsa@healthtrustnh.org

NOTE: This program is subject to change without notice.

IMPORTANT TO NOTE

We hope your Benny Prepaid Benefits Card provides you with timesaving convenience for making all of your FSA purchases. Here are a few important reminders for optimal use of your Card:

- You could be charged an annual administrative fee for use of the Card. This fee, if applicable, will be deducted from your FSA in one lump sum amount during the first month of plan participation. Please check with your employer to verify if this is part of your FSA arrangement.
- As a participant, you will receive two Cards—one for yourself and one for an eligible dependent.
- The Cards may only be used for the purchase of qualifying healthcare and/or dependent care expenses incurred during the relevant plan year, exclusive of any grace period. For FSA purposes, an expense is incurred at the time a service is furnished—*not* when you are billed, charged or pay for the service.
- Using the Card to pay for anything other than qualifying expenses will result in permanent revocation of the Card. You will be responsible for repaying any ineligible expenses charged to your Card.
- You have the option to pay using a PIN (Personal Identification Number) at the point of sale in addition to the signature process. To request a PIN for your Benny Prepaid Benefits Card:
  - Call 866.898.9795
  - The automated system will prompt you to create your own self-selected PIN for your Benny Prepaid Benefits Card. It is recommended that you create a unique PIN that cannot be easily guessed by others.
  - Keep your PIN private.
- The Card will be cancelled automatically upon your termination of employment or ineligibility for FSA benefits.
- Please notify us immediately if your Card is lost or stolen or someone has used it without your permission. A replacement Card fee may apply.

NOTE: This program is subject to change without notice.

WEBSITE MATERIALS

You can find helpful reimbursement account information from the "Resources" section of ***www.healthtrustnh.org*** or by going to the "Coverage" section, click on the "My FSA Account" button and follow login instructions for linking to downloadable forms, a *List of Eligible/Ineligible Expenses* and more.

ADDITIONAL INFORMATION

More information regarding the Benny Prepaid Benefits Card is provided on the *Flexible Spending Account Prepaid Benefits Card Frequently Asked Questions* handout, which is included in our FSA Welcome Kit. You can also download a copy of the handout by going to the "Resources" section of ***www.healthtrustnh.org***, click on the "Printable Forms" button in the left-hand sidebar and visit the "Flexible Spending Account" category. For additional assistance, contact HealthTrust by calling **800.527.5001** (toll-free) or emailing **fsa@healthtrustnh.org.**

NOTE: This program is subject to change without notice.

HealthTrust

PO Box 617 • 25 Triangle Park Drive
Concord, NH 03302-0617

www.healthtrustnh.org

Rev. 7/13

INTRODUCING

THE BENNY™
Prepaid Visa® Card

A convenient, Prepaid Benefits Card for purchasing qualified health and dependent care

A Flexible Spending Account offering from:

HealthTrust

HealthTrust

Flexible Spending Account Administration

A SERVICE OF HEALTHTRUST

- **No Set-up or Renewal Fees**
- **Plan Document Preparation**
- **Online Account Management**
- **Weekly Reimbursements**
- **Customizable Components**
  - **Prepaid Benefits Card**
  - **Over-the-Counter Reimbursement**
  - **Extended Reimbursement Deadline (Grace Period)**

RATES FOR JANUARY 1, 2014 TO DECEMBER 31, 2014:

$4.75 per employee per month
(Regardless of an employee's election to participate in Healthcare FSA, Dependent Care Reimbursement Account or both)

$6.25 per employee per month with debit card
(Additional fee for prepaid benefits card can be passed onto the employee as an employer option)

RATES FOR JULY 1, 2014 TO JUNE 30, 2015:

$4.75 per employee per month
(Regardless of an employee's election to participate in Healthcare FSA, Dependent Care Reimbursement Account or both)

$6.25 per employee per month with debit card
(Additional fee for prepaid benefits card can be passed onto the employee as an employer option)

For more information, visit the "Flexible Spending Account" section of *www.healthtrustnh.org*.

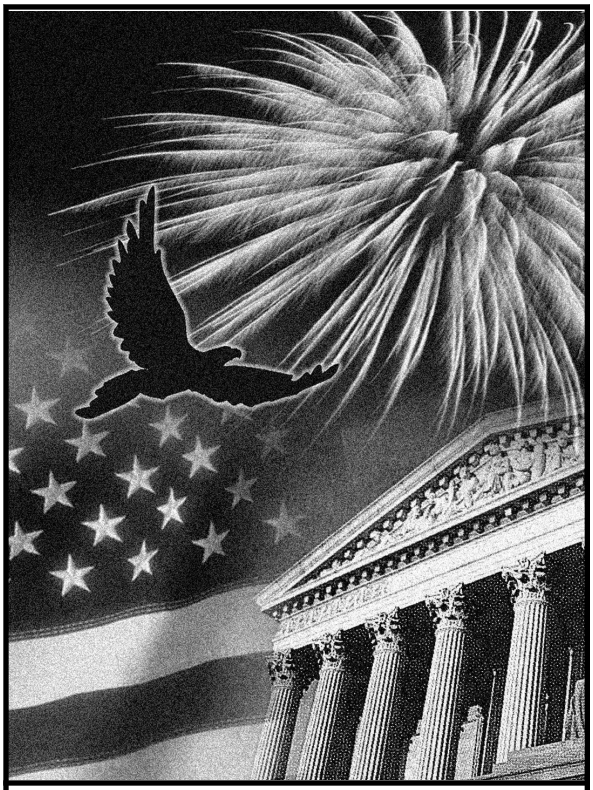
PO Box 617 • 25 Triangle Park Drive • Concord, NH 03302-0617
Toll Free: 800.527.5001 • Fax: 603.415.3099 • Email: fsa@healthtrustnh.org • *www.healthtrustnh.org*

Department of the Treasury
Internal Revenue Service

Publication 969
Cat. No. 24216S

Health Savings Accounts and Other Tax-Favored Health Plans

For use in preparing
2012 Returns



Get forms and other Information faster and easier by:

Internet IRS.gov

Jan 30, 2013

Contents

What's New

$2,500 limit on a health flexible spending arrangement (FSA). For plan years beginning after December 31, 2012, a cafeteria plan may not allow an employee to request salary reduction contributions for a health FSA in excess of $2,500.

Qualified HSA distributions. Beginning in 2012, you can no longer make a Qualified HSA distribution. See *Qualified HSA distributions* under *Flexible Spending Arrangements (FSAs)* or *Health Reimbursement Arrangements (HRAs)*.

Reminders

Future Developments. For the latest information about developments related to Publication 969, such as legislation enacted after it was published, go to *www.IRS.gov/pub969*.

Photographs of missing children. The Internal Revenue Service is a proud partner with the National Center for Missing and Exploited Children. Photographs of missing children selected by the Center may appear in this publication on pages that would otherwise be blank. You can help bring these children home by looking at the photographs and calling 1-800-THE-LOST (1-800-843-5678) if you recognize a child.

Introduction

Various programs are designed to give individuals tax advantages to offset health care costs. This publication explains the following programs.

- Health savings accounts (HSAs).
- Medical savings accounts (Archer MSAs and Medicare Advantage MSAs).

- Health flexible spending arrangements (FSAs).
- Health reimbursement arrangements (HRAs).

An HSA may receive contributions from an eligible individual or any other person, including an employer or a family member, on behalf of an eligible individual. Contributions, other than employer contributions, are deductible on the eligible individual's return whether or not the individual itemizes deductions. Employer contributions are not included in income. Distributions from an HSA that are used to pay qualified medical expenses are not taxed.

An Archer MSA may receive contributions from an eligible individual and his or her employer, but not both in the same year. Contributions by the individual are deductible whether or not the individual itemizes deductions. Employer contributions are not included in income. Distributions from an Archer MSA that are used to pay qualified medical expenses are not taxed.

A Medicare Advantage MSA is an Archer MSA designated by Medicare to be used solely to pay the qualified medical expenses of the account holder who is enrolled in Medicare. Contributions can only be made by Medicare. The contributions are not included in your income. Distributions from a Medicare Advantage MSA that are used to pay qualified medical expenses are not taxed.

A health FSA may receive contributions from an eligible individual. Employers may also contribute. Contributions are not includible in income. Reimbursements from an FSA that are used to pay qualified medical expenses are not taxed.

An HRA must receive contributions from the employer only. Employees may not contribute. Contributions are not includible in income. Reimbursements from an HRA that are used to pay qualified medical expenses are not taxed.

Comments and suggestions. We welcome your comments about this publication and your suggestions for future editions.

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Tax questions. If you have a tax question, check the information available on IRS.gov or call 1-800-829-1040. We cannot answer tax questions sent to either of the above addresses.

Health Savings Accounts (HSAs)

A health savings account (HSA) is a tax-exempt trust or custodial account that you set up with a qualified HSA trustee to pay or reimburse certain medical expenses you incur. You must be an eligible individual to qualify for an HSA.

No permission or authorization from the IRS is necessary to establish an HSA. When you set up an HSA, you will need to work with a trustee. A qualified HSA trustee can be a bank, an insurance company, or anyone already approved by the IRS to be a trustee of individual retirement arrangements (IRAs) or Archer MSAs. The HSA can be established through a trustee that is different from your health plan provider.

Your employer may already have some information on HSA trustees in your area.

If you have an Archer MSA, you can generally roll it over into an HSA tax free. See Rollovers*, later.*

What are the benefits of an HSA? You may enjoy several benefits from having an HSA.

- You can claim a tax deduction for contributions you, or someone other than your employer, make to your HSA even if you do not itemize your deductions on Form 1040.
- Contributions to your HSA made by your employer (including contributions made through a cafeteria plan) may be excluded from your gross income.
- The contributions remain in your account from year to year until you use them.
- The interest or other earnings on the assets in the account are tax free.
- Distributions may be tax free if you pay qualified medical expenses. See *Qualified medical expenses*, later.
- An HSA is "portable" so it stays with you if you change employers or leave the work force.

Qualifying for an HSA

To be an eligible individual and qualify for an HSA, you must meet the following requirements.

- You must be covered under a high deductible health plan (HDHP), described later, on the first day of the month.
- You have no other health coverage except what is permitted under *Other health coverage*, later.
- You are not enrolled in Medicare.
- You cannot be claimed as a dependent on someone else's 2012 tax return.

TIP *Under the last-month rule, you are considered to be an eligible individual for the entire year if you are an eligible individual on the first day of the last month of your tax year (December 1 for most taxpayers).*

If you meet these requirements, you are an eligible individual even if your spouse has non-HDHP family coverage, provided your spouse's coverage does not cover you.

CAUTION *If another taxpayer is entitled to claim an exemption for you, you cannot claim a deduction for an HSA contribution. This is true even if the other person does not actually claim your exemption.*

TIP *Each spouse who is an eligible individual who wants an HSA must open a separate HSA. You cannot have a joint HSA.*

High deductible health plan (HDHP). An HDHP has:

- A higher annual deductible than typical health plans, and
- A maximum limit on the sum of the annual deductible and out-of-pocket medical expenses that you must pay for covered expenses. Out-of-pocket expenses include copayments and other amounts, but do not include premiums.

An HDHP may provide preventive care benefits without a deductible or with a deductible below the minimum annual deductible. Preventive care includes, but is not limited to, the following.

1. Periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine examinations, such as annual physicals.
2. Routine prenatal and well-child care.
3. Child and adult immunizations.
4. Tobacco cessation programs.
5. Obesity weight-loss programs.
6. Screening services. This includes screening services for the following:
   a. Cancer.
   b. Heart and vascular diseases.
   c. Infectious diseases.
   d. Mental health conditions.
   e. Substance abuse.
   f. Metabolic, nutritional, and endocrine conditions.
   g. Musculoskeletal disorders.
   h. Obstetric and gynecological conditions.
   i. Pediatric conditions.
   j. Vision and hearing disorders.

   For more information on screening services, see Notice 2004-23, 2004-15 I.R.B. 725 available at *www.irs.gov/irb/2004-15_IRB/ar10.html*.

The following table shows the minimum annual deductible and maximum annual deductible and other out-of-pocket expenses for HDHPs for 2012.

	Self-only coverage	Family coverage
Minimum annual deductible	$1,200	$2,400
Maximum annual deductible and other out-of-pocket expenses*	$6,050	$12,100

* This limit does not apply to deductibles and expenses for out-of-network services if the plan uses a network of providers. Instead, only deductibles and out-of-pocket expenses for services within the network should be used to figure whether the limit applies.

TIP *The following table shows the minimum annual deductible and maximum annual deductible and other out-of-pocket expenses for HDHPs for 2013.*

	Self-only coverage	Family coverage
Minimum annual deductible	$1,250	$2,500
Maximum annual deductible and other out-of-pocket expenses*	$6,250	$12,500

* This limit does not apply to deductibles and expenses for out-of-network services if the plan uses a network of providers. Instead, only deductibles and out-of-pocket expenses for services within the network should be used to figure whether the limit applies.

Self-only HDHP coverage is an HDHP covering only an eligible individual. Family HDHP coverage is an HDHP covering an eligible individual and at least one other individual (whether or not that individual is an eligible individual).

Example. An eligible individual and his dependent child are covered under an “employee plus one” HDHP offered by the individual's employer. This is family HDHP coverage.

Family plans that do not meet the high deductible rules. There are some family plans that have deductibles

for both the family as a whole and for individual family members. Under these plans, if you meet the individual deductible for one family member, you do not have to meet the higher annual deductible amount for the family. If either the deductible for the family as a whole or the deductible for an individual family member is below the minimum annual deductible for family coverage, the plan does not qualify as an HDHP.

Example. You have family health insurance coverage in 2012. The annual deductible for the family plan is $3,500. This plan also has an individual deductible of $1,500 for each family member. The plan does not qualify as an HDHP because the deductible for an individual family member is below the minimum annual deductible ($2,400) for family coverage.

Other health coverage. You (and your spouse, if you have family coverage) generally cannot have any other health coverage that is not an HDHP. However, you can still be an eligible individual even if your spouse has non-HDHP coverage provided you are not covered by that plan.

You can have additional insurance that provides benefits only for the following items.

- Liabilities incurred under workers' compensation laws, tort liabilities, or liabilities related to ownership or use of property.
- A specific disease or illness.
- A fixed amount per day (or other period) of hospitalization.

You can also have coverage (whether provided through insurance or otherwise) for the following items.

- Accidents.
- Disability.
- Dental care.
- Vision care.
- Long-term care.

Plans in which substantially all of the coverage is through the above listed items are not HDHPs. For example, if your plan provides coverage substantially all of which is for a specific disease or illness, the plan is not an HDHP for purposes of establishing an HSA.

Prescription drug plans. You can have a prescription drug plan, either as part of your HDHP or a separate plan (or rider), and qualify as an eligible individual if the plan does not provide benefits until the minimum annual deductible of the HDHP has been met. If you can receive benefits before that deductible is met, you are not an eligible individual.

Other employee health plans. An employee covered by an HDHP and a health FSA or an HRA that pays or reimburses qualified medical expenses generally cannot make contributions to an HSA. Health FSAs and HRAs are discussed later.

However, an employee can make contributions to an HSA while covered under an HDHP and one or more of the following arrangements.

- Limited-purpose health FSA or HRA. These arrangements can pay or reimburse the items listed earlier under *Other health coverage,* except long-term care. Also, these arrangements can pay or reimburse preventive care expenses because they can be paid without having to satisfy the deductible.
- Suspended HRA. Before the beginning of an HRA coverage period, you can elect to suspend the HRA. The HRA does not pay or reimburse, at any time, the medical expenses incurred during the suspension period except preventive care and items listed under *Other health coverage.* When the suspension period ends, you are no longer eligible to make contributions to an HSA.
- Post-deductible health FSA or HRA. These arrangements do not pay or reimburse any medical expenses incurred before the minimum annual deductible amount is met. The deductible for these arrangements does not have to be the same as the deductible for the HDHP, but benefits may not be provided before the minimum annual deductible amount is met.
- Retirement HRA. This arrangement pays or reimburses only those medical expenses incurred after retirement. After retirement you are no longer eligible to make contributions to an HSA.

Health FSA – grace period. Coverage during a grace period by a general purpose health FSA is allowed if the balance in the health FSA at the end of its prior year plan is zero. See *Flexible Spending Arrangements (FSAs)*, later.

Contributions to an HSA

Any eligible individual can contribute to an HSA. For an employee's HSA, the employee, the employee's employer, or both may contribute to the employee's HSA in the same year. For an HSA established by a self-employed (or unemployed) individual, the individual can contribute. Family members or any other person may also make contributions on behalf of an eligible individual.

Contributions to an HSA must be made in cash. Contributions of stock or property are not allowed.

Limit on Contributions

The amount you or any other person can contribute to your HSA depends on the type of HDHP coverage you have, your age, the date you become an eligible individual, and the date you cease to be an eligible individual. For 2012, if you have self-only HDHP coverage, you can contribute up to $3,100. If you have family HDHP coverage, you can contribute up to $6,250.

TIP *For 2013, if you have self-only HDHP coverage, you can contribute up to $3,250. If you have family HDHP coverage you can contribute up to $6,450.*

If you were, or were considered (under the last-month rule, discussed later), an eligible individual for the entire year and did not change your type of coverage, you can contribute the full amount based on your type of coverage. However, if you were not an eligible individual for the entire year or changed your coverage during the year, your contribution limit is the greater of:

1. The limitation shown on the last line of the *Line 3 Limitation Chart and Worksheet* in the Instructions for Form 8889, Health Savings Accounts (HSAs), or
2. The maximum annual HSA contribution based on your HDHP coverage (self-only or family) on the first day of the last month of your tax year.

TIP *If you had family HDHP coverage on the first day of the last month of your tax year, your contribution limit for 2012 is $6,250 even if you changed coverage during the year.*

Last-month rule. Under the last-month rule, if you are an eligible individual on the first day of the last month of your tax year (December 1 for most taxpayers), you are considered an eligible individual for the entire year. You are treated as having the same HDHP coverage for the entire year as you had on the first day of that last month.

Testing period. If contributions were made to your HSA based on you being an eligible individual for the entire year under the last-month rule, you must remain an eligible individual during the testing period. For the last-month rule, the testing period begins with the last month of your tax year and ends on the last day of the 12th month following that month. For example, December 1, 2012, through December 31, 2013.

If you fail to remain an eligible individual during the testing period, other than because of death or becoming disabled, you will have to include in income the total contributions made to your HSA that would not have been made except for the last-month rule. You include this amount in your income in the year in which you fail to be an eligible individual. This amount is also subject to a 10% additional tax. The income and additional tax are shown on Form 8889, Part III.

Example 1. Chris, age 53, becomes an eligible individual on December 1, 2012. He has family HDHP coverage on that date. Under the last-month rule, he contributes $6,250 to his HSA.

Chris fails to be an eligible individual in June 2013. Because Chris did not remain an eligible individual during the testing period (December 1, 2012, through December 31, 2013), he must include in his 2013 income the contributions made in 2012 that would not have been made except for the last-month rule. Chris uses the worksheet for line 3 in the Form 8889 instructions to determine this amount.

January	-0-
February	-0-
March	-0-
April	-0-
May	-0-
June	-0-
July	-0-
August	-0-
September	-0-
October	-0-
November	-0-
December	$6,250.00
Total for all months	$6,250.00
Limitation. Divide the total by 12	$520.83

Chris would include $5,729.17 ($6,250.00 – $520.83) in his gross income on his 2013 tax return. Also, a 10% additional tax applies to this amount.

Example 2. Erika, age 39, has self-only HDHP coverage on January 1, 2012. Erika changes to family HDHP coverage on November 1, 2012. Because Erika has family HDHP coverage on December 1, 2012, she contributes $6,250 for 2012.

Erika fails to be an eligible individual in March 2013. Because she did not remain an eligible individual during the testing period (December 1, 2012, through December 31, 2013), she must include in income the contribution made that would not have been made except for the last-month rule. Erika uses the worksheet for line 3 in the Form 8889 instructions to determine this amount.

January	$3,100.00
February	$3,100.00
March	$3,100.00
April	$3,100.00
May	$3,100.00
June	$3,100.00
July	$3,100.00
August	$3,100.00
September	$3,100.00
October	$3,100.00
November	$6,250.00
December	$6,250.00
Total for all months	$43,500.00
Limitation. Divide the total by 12	$3,625.00

Erika would include $2,625.00 ($6,250 – $3,625.00) in her gross income on her 2013 tax return. Also, a 10% additional tax applies to this amount.

Additional contribution. If you are an eligible individual who is age 55 or older at the end of your tax year, your contribution limit is increased by $1,000. For example, if you have self-only coverage, you can contribute up to $4,100 (the contribution limit for self-only coverage ($3,100) plus the additional contribution of $1,000). However, see *Enrolled in Medicare*, later.

CAUTION *If you have more than one HSA in 2012, your total contributions to all the HSAs cannot be more than the limits discussed earlier.*

Reduction of contribution limit. You must reduce the amount that can be contributed (including any additional contribution) to your HSA by the amount of any contribution made to your Archer MSA (including employer contributions) for the year. A special rule applies to married people, discussed next, if each spouse has family coverage under an HDHP.

Rules for married people. If either spouse has family HDHP coverage, both spouses are treated as having family HDHP coverage. If each spouse has family coverage under a separate plan, the contribution limit for 2012 is $6,250. You must reduce the limit on contributions, before taking into account any additional contributions, by the amount contributed to both spouse's Archer MSAs. After that reduction, the contribution limit is split equally between the spouses unless you agree on a different division.

The rules for married people apply only if both spouses are eligible individuals.

If both spouses are 55 or older and not enrolled in Medicare, each spouse's contribution limit is increased by the additional contribution. If both spouses meet the age requirement, the total contributions under family coverage cannot be more than $8,250. Each spouse must make the additional contribution to his or her own HSA.

Example. For 2012, Mr. Auburn and his wife are both eligible individuals. They each have family coverage under separate HDHPs. Mr. Auburn is 58 years old and Mrs. Auburn is 53. Mr. and Mrs. Auburn can split the family contribution limit ($6,250) equally or they can agree on a different division. If they split it equally, Mr. Auburn can contribute $4,125 to an HSA (one-half the maximum contribution for family coverage ($3,125) + $1,000 additional contribution) and Mrs. Auburn can contribute $3,125 to an HSA.

Employer contributions. You must reduce the amount you, or any other person, can contribute to your HSA by the amount of any contributions made by your employer that are excludable from your income. This includes amounts contributed to your account by your employer through a cafeteria plan.

Enrolled in Medicare. Beginning with the first month you are enrolled in Medicare, your contribution limit is zero.

Example. You turned age 65 in July 2012 and enrolled in Medicare. You had an HDHP with self-only coverage and are eligible for an additional contribution of $1,000. Your contribution limit is $2,050 ($4,100 × 6 ÷ 12).

Qualified HSA funding distribution. A qualified HSA funding distribution may be made from your traditional IRA or Roth IRA to your HSA. This distribution cannot be made from an ongoing SEP IRA or SIMPLE IRA. For this purpose, a SEP IRA or SIMPLE IRA is ongoing if an employer contribution is made for the plan year ending with or within your tax year in which the distribution would be made.

The maximum qualified HSA funding distribution depends on the HDHP coverage (self-only or family) you have on the first day of the month in which the contribution is made and your age as of the end of the tax year. The distribution must be made directly by the trustee of the IRA to the trustee of the HSA. The distribution is not included in your income, is not deductible, and reduces the amount that can be contributed to your HSA. The qualified HSA funding distribution is shown on Form 8889, Part I, line 10 for the year in which the distribution is made.

You can make only one qualified HSA funding distribution during your lifetime. However, if you make a distribution during a month when you have self-only HDHP coverage, you can make another qualified HSA funding distribution in a later month in that tax year if you change to family HDHP coverage. The total qualified HSA funding distribution cannot be more than the contribution limit for family HDHP coverage plus any additional contribution to which you are entitled.

Example. In 2012, you are an eligible individual, age 57, with self-only HDHP coverage. You can make a qualified HSA funding distribution of $4,100 ($3,100 plus $1,000 additional contribution).

Funding distribution – testing period. You must remain an eligible individual during the testing period. For a qualified HSA funding distribution, the testing period begins with the month in which the qualified HSA funding distribution is contributed and ends on the last day of the 12th month following that month. For example, if a qualified HSA funding distribution is contributed to your HSA on August 10, 2012, your testing period begins in August 2012, and ends on August 31, 2013.

If you fail to remain an eligible individual during the testing period, other than because of death or becoming disabled, you will have to include in income the qualified HSA funding distribution. You include this amount in income in the year in which you fail to be an eligible individual. This amount is also subject to a 10% additional tax. The income and the additional tax are shown on Form 8889, Part III.

Each qualified HSA funding distribution allowed has its own testing period. For example, you are an eligible individual, age 45, with self-only HDHP coverage. On June 18, 2012, you make a qualified HSA funding distribution of $3,100. On July 27, 2012, you enroll in family HDHP coverage and on August 17, 2012, you make a qualified HSA funding distribution of $3,150. Your testing period for the first distribution begins in June 2012 and ends on June 30, 2013. Your testing period for the second distribution begins in August 2012 and ends on August 31, 2013.

The testing period rule that applies under the last-month rule (discussed earlier) does not apply to amounts contributed to an HSA through a qualified HSA funding distribution. If you remain an eligible individual during the entire funding distribution testing period, then no amount of that distribution is included in income and will not be subject to the additional tax for failing to meet the last-month rule testing period.

Rollovers

A rollover contribution is not included in your income, is not deductible, and does not reduce your contribution limit.

Archer MSAs and other HSAs. You can roll over amounts from Archer MSAs and other HSAs into an HSA. You do not have to be an eligible individual to make a rollover contribution from your existing HSA to a new HSA. Rollover contributions do not need to be in cash. Rollovers are not subject to the annual contribution limits.

You must roll over the amount within 60 days after the date of receipt. You can make only one rollover contribution to an HSA during a 1-year period.

Note. If you instruct the trustee of your HSA to transfer funds directly to the trustee of another HSA, the transfer is not considered a rollover. There is no limit on the number of these transfers. Do not include the amount transferred in income, deduct it as a contribution, or include it as a distribution on Form 8889, line 14a.

Qualified HSA distribution. This is a distribution made before January 1, 2012, from a health FSA or an HRA that is transferred to your HSA. To be a qualified HSA distribution certain conditions must be met. See *Qualified HSA distribution* under *Flexible Spending Arrangements (FSAs)* and *Health Reimbursement Arrangements (HRAs)*, later.

Testing period. You must remain an eligible individual during the testing period. For a qualified HSA distribution, the testing period begins with the month in which the qualified HSA distribution is contributed and ends on the last day of the 12th month following that month. For example, if a qualified HSA distribution is contributed to your HSA on December 31, 2011, your testing period runs from December 2011, through December 31, 2012.

If you fail to remain an eligible individual during the testing period, other than because of death or becoming disabled, you will have to include in income the qualified HSA distribution. You include this amount in income in the year in which you fail to be an eligible individual. This amount is also subject to a 10% additional tax. The income and the additional tax are shown on Form 8889, Part III.

When To Contribute

You can make contributions to your HSA for 2012 until April 15, 2013. If you fail to be an eligible individual during 2012, you can still make contributions, up until April 15, 2013, for the months you were an eligible individual.

Your employer can make contributions to your HSA between January 1, 2013, and April 15, 2013, that are allocated to 2012. Your employer must notify you and the trustee of your HSA that the contribution is for 2012. The contribution will be reported on your 2013 Form W-2.

Reporting Contributions on Your Return

Contributions made by your employer are not included in your income. Contributions to an employee's account by an employer using the amount of an employee's salary reduction through a cafeteria plan are treated as employer contributions. Generally, you can claim contributions you made and contributions made by any other person, other than your employer, on your behalf, as an adjustment to income.

Contributions by a partnership to a bona fide partner's HSA are not contributions by an employer. The contributions are treated as a distribution of money and are not included in the partner's gross income. Contributions by a partnership to a partner's HSA for services rendered are treated as guaranteed payments that are deductible by the partnership and includible in the partner's gross income. In both situations, the partner can deduct the contribution made to the partner's HSA.

Contributions by an S corporation to a 2% shareholder-employee's HSA for services rendered are treated as guaranteed payments and are deductible by the S corporation and includible in the shareholder-employee's gross income. The shareholder-employee can deduct the contribution made to the shareholder-employee's HSA.

Form 8889. Report all contributions to your HSA on Form 8889 and file it with your Form 1040 or Form 1040NR. You should include all contributions made for 2012, including those made by April 15, 2013, that are designated for 2012. Contributions made by your employer and qualified HSA funding distributions are also shown on the form.

You should receive Form 5498-SA, HSA, Archer MSA, or Medicare Advantage MSA Information, from the trustee showing the amount contributed to your HSA during the year. Your employer's contributions also will be shown in box 12 of Form W-2, Wage and Tax Statement, with code W. Follow the instructions for Form 8889. Report your HSA deduction on Form 1040 or Form 1040NR, line 25.

Excess contributions. You will have excess contributions if the contributions to your HSA for the year are greater than the limits discussed earlier. Excess contributions are not deductible. Excess contributions made by your employer are included in your gross income. If the excess contribution is not included in box 1 of Form W-2, you must report the excess as “Other income” on your tax return.

Generally, you must pay a 6% excise tax on excess contributions. See Form 5329, Additional Taxes on Qualified Plans (including IRAs) and Other Tax-Favored Accounts, to figure the excise tax. The excise tax applies to each tax year the excess contribution remains in the account.

You may withdraw some or all of the excess contributions and not pay the excise tax on the amount withdrawn if you meet the following conditions.

- You withdraw the excess contributions by the due date, including extensions, of your tax return for the year the contributions were made.
- You withdraw any income earned on the withdrawn contributions and include the earnings in "Other income" on your tax return for the year you withdraw the contributions and earnings.

If you fail to remain an eligible individual during any of the testing periods, discussed earlier, the amount you have to include in income is not an excess contribution. If you withdraw any of those amounts, the amount is treated the same as any other distribution from an HSA, discussed later.

Deducting an excess contribution in a later year. You may be able to deduct excess contributions for previous years that are still in your HSA. The excess contribution you can deduct for the current year is the lesser of the following two amounts.

- Your maximum HSA contribution limit for the year minus any amounts contributed to your HSA for the year.
- The total excess contributions in your HSA at the beginning of the year.

Amounts contributed for the year include contributions by you, your employer, and any other person. They also include any qualified HSA funding distribution made to your HSA. Any excess contribution remaining at the end of a tax year is subject to the excise tax. See Form 5329.

Distributions From an HSA

You will generally pay medical expenses during the year without being reimbursed by your HDHP until you reach the annual deductible for the plan. When you pay medical expenses during the year that are not reimbursed by your HDHP, you can ask the trustee of your HSA to send you a distribution from your HSA.

You can receive tax-free distributions from your HSA to pay or be reimbursed for qualified medical expenses you incur after you establish the HSA. If you receive distributions for other reasons, the amount you withdraw will be subject to income tax and may be subject to an additional 20% tax. You do not have to make distributions from your HSA each year.

If you are no longer an eligible individual, you can still receive tax-free distributions to pay or reimburse your qualified medical expenses.

Generally, a distribution is money you get from your health savings account. Your total distributions include amounts paid with a debit card that restricts payments to health care and amounts withdrawn from the HSA by other individuals that you have designated. The trustee will report any distribution to you and the IRS on Form 1099-SA, Distributions From an HSA, Archer MSA, or Medicare Advantage MSA.

Qualified medical expenses. Qualified medical expenses are those expenses that would generally qualify for the medical and dental expenses deduction. These are explained in Publication 502, Medical and Dental Expenses.

Also, non-prescription medicines (other than insulin) are not considered qualified medical expenses for HSA purposes. A medicine or drug will be a qualified medical expense for HSA purposes only if the medicine or drug:

1. Requires a prescription,
2. Is available without a prescription (an over-the-counter medicine or drug) and you get a prescription for it, or
3. Is insulin.

For HSA purposes, expenses incurred before you establish your HSA are not qualified medical expenses. State law determines when an HSA is established. An HSA that is funded by amounts rolled over from an Archer MSA or another HSA is established on the date the prior account was established.

If, under the last-month rule, you are considered to be an eligible individual for the entire year for determining the contribution amount, only those expenses incurred after you actually establish your HSA are qualified medical expenses.

Qualified medical expenses are those incurred by the following persons.

1. You and your spouse.
2. All dependents you claim on your tax return.
3. Any person you could have claimed as a dependent on your return except that:
   a. The person filed a joint return,
   b. The person had gross income of $3,800 or more, or
   c. You, or your spouse if filing jointly, could be claimed as a dependent on someone else's 2012 return.

For this purpose, a child of parents that are divorced, separated, or living apart for the last 6 months of the calendar year is treated as the dependent of both parents whether or not the custodial parent releases the claim to the child's exemption.

You cannot deduct qualified medical expenses as an itemized deduction on Schedule A (Form 1040) that are equal to the tax-free distribution from your HSA.

Insurance premiums. You cannot treat insurance premiums as qualified medical expenses unless the premiums are for:

1. Long-term care insurance.

2. Health care continuation coverage (such as coverage under COBRA).
3. Health care coverage while receiving unemployment compensation under federal or state law.
4. Medicare and other health care coverage if you were 65 or older (other than premiums for a Medicare supplemental policy, such as Medigap).

The premiums for long-term care insurance (item (1)) that you can treat as qualified medical expenses are subject to limits based on age and are adjusted annually. See *Limit on long-term care premiums you can deduct* in the instructions for Schedule A (Form 1040).

Items (2) and (3) can be for your spouse or a dependent meeting the requirement for that type of coverage. For item (4), if you, the account beneficiary, are not 65 or older, Medicare premiums for coverage of your spouse or a dependent (who is 65 or older) generally are not qualified medical expenses.

Health coverage tax credit. You cannot claim this credit for premiums that you pay with a tax-free distribution from your HSA. See Publication 502 for more information on this credit.

Deemed distributions from HSAs. The following situations result in deemed taxable distributions from your HSA.

- You engaged in any transaction prohibited by section 4975 with respect to any of your HSAs, at any time in 2012. Your account ceases to be an HSA as of January 1, 2012, and you must include the fair market value of all assets in the account as of January 1, 2012, on Form 8889, line 14a.
- You used any portion of any of your HSAs as security for a loan at any time in 2012. You must include the fair market value of the assets used as security for the loan as income on Form 1040 or Form 1040NR, line 21.

Examples of prohibited transactions include the direct or indirect:

- Sale, exchange, or leasing of property between you and the HSA,
- Lending of money between you and the HSA,
- Furnishing goods, services, or facilities between you and the HSA, and
- Transfer to or use by you, or for your benefit, of any assets of the HSA.

Any deemed distribution will not be treated as used to pay qualified medical expenses. These distributions are included in your income and are subject to the additional 20% tax, discussed later.

Recordkeeping. You must keep records sufficient to show that:

- The distributions were exclusively to pay or reimburse qualified medical expenses,
- The qualified medical expenses had not been previously paid or reimbursed from another source, and
- The medical expenses had not been taken as an itemized deduction in any year.

Do not send these records with your tax return. Keep them with your tax records.

Reporting Distributions on Your Return

How you report your distributions depends on whether or not you use the distribution for qualified medical expenses (defined earlier).

- If you use a distribution from your HSA for qualified medical expenses, you do not pay tax on the distribution but you have to report the distribution on Form 8889. However, the distribution of an excess contribution taken out after the due date, including extensions, of your return is subject to tax even if used for qualified medical expenses. Follow the instructions for the form and file it with your Form 1040 or Form 1040NR.
- If you do not use a distribution from your HSA for qualified medical expenses, you must pay tax on the distribution. Report the amount on Form 8889 and file it with your Form 1040 or Form 1040NR. If you have a taxable HSA distribution, include it in the total on Form 1040 or Form 1040NR, line 21, and enter "HSA" and the amount on the dotted line next to line 21. You may have to pay an additional 20% tax on your taxable distribution.

HSA administration and maintenance fees withdrawn by the trustee are not reported as distributions from the HSA.

Additional tax. There is an additional 20% tax on the part of your distributions not used for qualified medical expenses. Figure the tax on Form 8889 and file it with your Form 1040 or Form 1040NR. Report the additional tax in the total on Form 1040, line 60, or Form 1040NR, line 59, and enter "HSA" and the amount on the dotted line next to that line.

Exceptions. There is no additional tax on distributions made after the date you are disabled, reach age 65, or die.

Balance in an HSA

An HSA is generally exempt from tax. You are permitted to take a distribution from your HSA at any time; however, only those amounts used exclusively to pay for qualified medical expenses are tax free. Amounts that remain at the end of the year are generally carried over to the next year (see *Excess contributions*, earlier). Earnings on amounts in an HSA are not included in your income while held in the HSA.

Death of HSA Holder

You should choose a beneficiary when you set up your HSA. What happens to that HSA when you die depends on whom you designate as the beneficiary.

Spouse is the designated beneficiary. If your spouse is the designated beneficiary of your HSA, it will be treated as your spouse's HSA after your death.

Spouse is not the designated beneficiary. If your spouse is not the designated beneficiary of your HSA:

- The account stops being an HSA, and
- The fair market value of the HSA becomes taxable to the beneficiary in the year in which you die.

If your estate is the beneficiary, the value is included on your final income tax return.

The amount taxable to a beneficiary other than the estate is reduced by any qualified medical expenses for the decedent that are paid by the beneficiary within 1 year after the date of death.

Filing Form 8889

You must file Form 8889 with your Form 1040 or Form 1040NR if you (or your spouse, if married filing a joint return) had any activity in your HSA during the year. You must file the form even if only your employer or your spouse's employer made contributions to the HSA.

If, during the tax year, you are the beneficiary of two or more HSAs or you are a beneficiary of an HSA and you have your own HSA, you must complete a separate Form 8889 for each HSA. Enter "statement" at the top of each Form 8889 and complete the form as instructed. Next, complete a controlling Form 8889 combining the amounts shown on each of the statement Forms 8889. Attach the statements to your tax return after the controlling Form 8889.

Employer Participation

This section contains the rules that employers must follow if they decide to make HSAs available to their employees. Unlike the previous discussions, "you" refers to the employer and not to the employee.

Health plan. If you want your employees to be able to have an HSA, they must have an HDHP. You can provide no additional coverage other than those exceptions listed previously under *Other health coverage*.

Contributions. You can make contributions to your employees' HSAs. You deduct the contributions on the "Employee benefit programs" line of your business income tax return for the year in which you make the contributions. If the contribution is allocated to the prior year, you still deduct it in the year in which you made the contribution. If you are filing Form 1040, Schedule C, this is Part II, line 14.

For more information on employer contributions, see Notice 2008-59, 2008-29 I.R.B. 123, questions 23 through 27, available at www.irs.gov/irb/2008-29_IRB/ar11.html.

Comparable contributions. If you decide to make contributions, you must make comparable contributions to all comparable participating employees' HSAs. Your contributions are comparable if they are either:

- The same amount, or
- The same percentage of the annual deductible limit under the HDHP covering the employees.

The comparability rules do not apply to contributions made through a cafeteria plan.

Comparable participating employees. Comparable participating employees:

- Are covered by your HDHP and are eligible to establish an HSA,
- Have the same category of coverage (either self-only or family coverage), and
- Have the same category of employment (part-time, full-time, or former employees).

To meet the comparability requirements for eligible employees who have not established an HSA by December 31 or have not notified you that they have an HSA, you must meet a notice requirement and a contribution requirement.

You will meet the notice requirement if by January 15 of the following calendar year you provide a written notice to all such employees. The notice must state that each eligible employee who, by the last day of February, establishes an HSA and notifies you that they have established an HSA will receive a comparable contribution to the HSA for the prior year. For a sample of the notice, see Regulation 54.4980G-4 A-14(c). You will meet the contribution requirement for these employees if by April 15, 2013, you contribute comparable amounts plus reasonable interest to the employee's HSA for the prior year.

Note. For purposes of making contributions to HSAs of non-highly compensated employees, highly compensated employees shall not be treated as comparable participating employees.

Excise tax. If you made contributions to your employees' HSAs that were not comparable, you must pay an excise tax of 35% of the amount you contributed.

Employment taxes. Amounts you contribute to your employees' HSAs are generally not subject to employment taxes. You must report the contributions in box 12 of the Form W-2 you file for each employee. This includes the amounts the employee elected to contribute through a cafeteria plan. Enter code "W" in box 12.

Medical Savings Accounts (MSAs)

Archer MSAs were created to help self-employed individuals and employees of certain small employers meet the medical care costs of the account holder, the account holder's spouse, or the account holder's dependent(s).

CAUTION *After December 31, 2007, you cannot be treated as an eligible individual for Archer MSA purposes unless:*

1. *You were an active participant for any tax year ending before January 1, 2008, or*
2. *You became an active participant for a tax year ending after December 31, 2007, by reason of coverage under a high deductible health plan (HDHP) of an Archer MSA participating employer.*

A Medicare Advantage MSA is an Archer MSA designated by Medicare to be used solely to pay the qualified medical expenses of the account holder who is eligible for Medicare.

Archer MSAs

An Archer MSA is a tax-exempt trust or custodial account that you set up with a U.S. financial institution (such as a bank or an insurance company) in which you can save money exclusively for future medical expenses.

What are the benefits of an Archer MSA? You may enjoy several benefits from having an Archer MSA.

- You can claim a tax deduction for contributions you make even if you do not itemize your deductions on Form 1040 or Form 1040NR.
- The interest or other earnings on the assets in your Archer MSA are tax free.
- Distributions may be tax free if you pay qualified medical expenses. See *Qualified medical expenses*, later.
- The contributions remain in your Archer MSA from year to year until you use them.
- An Archer MSA is "portable" so it stays with you if you change employers or leave the work force.

Qualifying for an Archer MSA

To qualify for an Archer MSA, you must be either of the following.

- An employee (or the spouse of an employee) of a small employer (defined later) that maintains a self-only or family HDHP for you (or your spouse).
- A self-employed person (or the spouse of a self-employed person) who maintains a self-only or family HDHP.

You can have no other health or Medicare coverage except what is permitted under *Other health coverage*, later. You must be an eligible individual on the first day of a given month to get an Archer MSA deduction for that month.

CAUTION *If another taxpayer is entitled to claim an exemption for you, you cannot claim a deduction for an Archer MSA contribution. This is true even if the other person does not actually claim your exemption.*

Small employer. A small employer is generally an employer who had an average of 50 or fewer employees during either of the last 2 calendar years. The definition of small employer is modified for new employers and growing employers.

Growing employer. A small employer may begin HDHPs and Archer MSAs for his or her employees and then grow beyond 50 employees. The employer will continue to meet the requirement for small employers if he or she:

- Had 50 or fewer employees when the Archer MSAs began,
- Made a contribution that was excludable or deductible as an Archer MSA for the last year he or she had 50 or fewer employees, and
- Had an average of 200 or fewer employees each year after 1996.

Changing employers. If you change employers, your Archer MSA moves with you. However, you may not make additional contributions unless you are otherwise eligible.

High deductible health plan (HDHP). To be eligible for an Archer MSA, you must be covered under an HDHP. An HDHP has:

- A higher annual deductible than typical health plans, and
- A maximum limit on the annual out-of-pocket medical expenses that you must pay for covered expenses.

Limits. The following table shows the limits for annual deductibles and the maximum out-of-pocket expenses for HDHPs for 2012.

	Self-only coverage	Family coverage
Minimum annual deductible	$2,100	$4,200
Maximum annual deductible	$3,150	$6,300
Maximum annual out-of-pocket expenses	$4,200	$7,650

Family plans that do not meet the high deductible rules. There are some family plans that have deductibles for both the family as a whole and for individual family members. Under these plans, if you meet the individual deductible for one family member, you do not have to

meet the higher annual deductible amount for the family. If either the deductible for the family as a whole or the deductible for an individual family member is below the minimum annual deductible for family coverage, the plan does not qualify as an HDHP.

Example. You have family health insurance coverage in 2012. The annual deductible for the family plan is $5,500. This plan also has an individual deductible of $2,000 for each family member. The plan does not qualify as an HDHP because the deductible for an individual family member is below the minimum annual deductible ($4,200) for family coverage.

Other health coverage. You (and your spouse, if you have family coverage) generally cannot have any other health coverage that is not an HDHP. However, you can still be an eligible individual even if your spouse has non-HDHP coverage provided you are not covered by that plan. However, you can have additional insurance that provides benefits only for the following items.

- Liabilities incurred under workers' compensation laws, torts, or ownership or use of property.
- A specific disease or illness.
- A fixed amount per day (or other period) of hospitalization.

You can also have coverage (whether provided through insurance or otherwise) for the following items.

- Accidents.
- Disability.
- Dental care.
- Vision care.
- Long-term care.

Contributions to an MSA

Contributions to an Archer MSA must be made in cash. You cannot contribute stock or other property to an Archer MSA.

Who can contribute to my Archer MSA? If you are an employee, your employer may make contributions to your Archer MSA. (You do not pay tax on these contributions.) If your employer does not make contributions to your Archer MSA, or you are self-employed, you can make your own contributions to your Archer MSA. Both you and your employer cannot make contributions to your Archer MSA in the same year. You do not have to make contributions to your Archer MSA every year.

If your spouse is covered by your HDHP and an excludable amount is contributed by your spouse's employer to an Archer MSA belonging to your spouse, you cannot make contributions to your own Archer MSA that year.

Limits

There are two limits on the amount you or your employer can contribute to your Archer MSA:

- The annual deductible limit.
- An income limit.

Annual deductible limit. You (or your employer) can contribute up to 75% of the annual deductible of your HDHP (65% if you have a self-only plan) to your Archer MSA. You must have the HDHP all year to contribute the full amount. If you do not qualify to contribute the full amount for the year, determine your annual deductible limit by using the worksheet for line 3 in the Instructions for Form 8853, Archer MSAs and Long-Term Care Insurance Contracts.

Example 1. You have an HDHP for your family all year in 2012. The annual deductible is $5,000. You can contribute up to $3,750 ($5,000 × 75%) to your Archer MSA for the year.

Example 2. You have an HDHP for your family for the entire months of July through December 2012 (6 months). The annual deductible is $5,000. You can contribute up to $1,875 ($5,000 × 75% ÷ 12 × 6) to your Archer MSA for the year.

If you and your spouse each have a family plan, you are treated as having family coverage with the lower annual deductible of the two health plans. The contribution limit is split equally between you unless you agree on a different division.

Income limit. You cannot contribute more than you earned for the year from the employer through whom you have your HDHP.

If you are self-employed, you cannot contribute more than your net self-employment income. This is your income from self-employment minus expenses (including the deductible part of self-employment tax).

Example 1. Noah Paul earned $25,000 from ABC Company in 2012. Through ABC, he had an HDHP for his family for the entire year. The annual deductible was $5,000. He can contribute up to $3,750 to his Archer MSA (75% × $5,000). He can contribute the full amount because he earned more than $3,750 at ABC.

Example 2. Westley Lawrence is self-employed. He had an HDHP for his family for the entire year in 2012. The annual deductible was $5,000. Based on the annual deductible, the maximum contribution to his Archer MSA would have been $3,750 (75% × $5,000). However, after deducting his business expenses, Joe's net self-employment income is $2,500 for the year. Therefore, he is limited to a contribution of $2,500.

Individuals enrolled in Medicare. Beginning with the first month you are enrolled in Medicare, you cannot contribute to an Archer MSA. However, you may be eligible for a Medicare Advantage MSA, discussed later.

When To Contribute

You can make contributions to your Archer MSA for 2012 until April 15, 2013.

Reporting Contributions on Your Return

Report all contributions to your Archer MSA on Form 8853 and file it with your Form 1040 or Form 1040NR. You should include all contributions you, or your employer, made for 2012, including those made by April 15, 2013, that are designated for 2012.

You should receive Form 5498-SA, HSA, Archer MSA, or Medicare Advantage MSA Information, from the trustee showing the amount you (or your employer) contributed during the year. Your employer's contributions should be shown in box 12 of Form W-2, Wage and Tax Statement, with code R. Follow the instructions for Form 8853 and complete the worksheet for line 3. Report your Archer MSA deduction on Form 1040, line 36, or Form 1040NR, line 35.

Excess contributions. You will have excess contributions if the contributions to your Archer MSA for the year are greater than the limits discussed earlier. Excess contributions are not deductible. Excess contributions made by your employer are included in your gross income. If the excess contribution is not included in box 1 of Form W-2, you must report the excess as “Other income” on your tax return.

Generally, you must pay a 6% excise tax on excess contributions. See Form 5329, Additional Taxes on Qualified Plans (Including IRAs) and Other Tax-Favored Accounts, to figure the excise tax. The excise tax applies to each tax year the excess contribution remains in the account.

You may withdraw some or all of the excess contributions and not pay the excise tax on the amount withdrawn if you meet the following conditions.

- You withdraw the excess contributions by the due date, including extensions, of your tax return.
- You withdraw any income earned on the withdrawn contributions and include the earnings in “Other income” on your tax return for the year you withdraw the contributions and earnings.

Deducting an excess contribution in a later year. You may be able to deduct excess contributions for previous years that are still in your Archer MSA. The excess contribution you can deduct in the current year is the lesser of the following two amounts.

- Your maximum Archer MSA contribution limit for the year minus any amounts contributed to your Archer MSA for the year.
- The total excess contributions in your Archer MSA at the beginning of the year.

Any excess contributions remaining at the end of a tax year are subject to the excise tax. See Form 5329.

Distributions From an MSA

You will generally pay medical expenses during the year without being reimbursed by your HDHP until you reach the annual deductible for the plan. When you pay medical expenses during the year that are not reimbursed by your HDHP, you can ask the trustee of your Archer MSA to send you a distribution from your Archer MSA.

You can receive tax-free distributions from your Archer MSA to pay for qualified medical expenses (discussed later). If you receive distributions for other reasons, the amount will be subject to income tax and may be subject to an additional 20% tax as well. You do not have to make withdrawals from your Archer MSA each year.

If you no longer qualify to make contributions, you can still receive tax-free distributions to pay or reimburse your qualified medical expenses.

A distribution is money you get from your Archer MSA. The trustee will report any distribution to you and the IRS on Form 1099-SA, Distributions From an HSA, Archer MSA, or Medicare Advantage MSA.

Qualified medical expenses. Qualified medical expenses are those expenses that would generally qualify for the medical and dental expenses deduction. These are explained in Publication 502, Medical and Dental Expenses.

Also, non-prescription medicines (other than insulin) are not considered qualified medical expenses for MSA purposes. A medicine or drug will be a qualified medical expense for MSA purposes only if the medicine or drug:

1. Requires a prescription,
2. Is available without a prescription (an over-the-counter medicine or drug) and you get a prescription for it, or
3. Is insulin.

Qualified medical expenses are those incurred by the following persons.

1. You and your spouse.
2. All dependents you claim on your tax return.
3. Any person you could have claimed as a dependent on your return except that:
   a. The person filed a joint return,
   b. The person had gross income of $3,800 or more, or
   c. You, or your spouse if filing jointly, could be claimed as a dependent on someone else's 2012 return.

For this purpose, a child of parents that are divorced, separated, or living apart for the last 6 months of the calendar year is treated as the dependent of both parents whether or not the custodial parent releases the claim to the child's exemption.

You cannot deduct qualified medical expenses as an itemized deduction on Schedule A (Form 1040) that are equal to the tax-free distribution from your Archer MSA. This is the amount on line 7 of Form 8853.

Special rules for insurance premiums. Generally, you cannot treat insurance premiums as qualified medical expenses for Archer MSAs. You can, however, treat premiums for long-term care coverage, health care coverage while you receive unemployment benefits, or health care continuation coverage required under any federal law as qualified medical expenses for Archer MSAs.

Health coverage tax credit. You cannot claim this credit for premiums that you pay with a tax-free distribution from your Archer MSA. See Publication 502 for information on this credit.

Deemed distributions from Archer MSAs. The following situations result in deemed taxable distributions from your Archer MSA.

- You engaged in any transaction prohibited by section 4975 with respect to any of your Archer MSAs at any time in 2012. Your account ceases to be an Archer MSA as of January 1, 2012, and you must include the fair market value of all assets in the account as of January 1, 2012, on line 6a of Form 8853.
- You used any portion of any of your Archer MSAs as security for a loan at any time in 2012. You must include the fair market value of the assets used as security for the loan as income on Form 1040 or Form 1040NR, line 21.

Examples of prohibited transactions include the direct or indirect:

- Sale, exchange, or leasing of property between you and the Archer MSA,
- Lending of money between you and the Archer MSA,
- Furnishing goods, services, or facilities between you and the Archer MSA, and
- Transfer to or use by you, or for your benefit, of any assets of the Archer MSA.

Any deemed distribution will not be treated as used to pay qualified medical expenses. These distributions are included in your income and are subject to the additional 20% tax, discussed later.

Recordkeeping. You must keep records sufficient to show that:

- The distributions were exclusively to pay or reimburse qualified medical expenses,
- The qualified medical expenses had not been previously paid or reimbursed from another source, and
- The medical expenses had not been taken as an itemized deduction in any year.

Do not send these records with your tax return. Keep them with your tax records.

Reporting Distributions on Your Return

How you report your distributions depends on whether or not you use the distribution for qualified medical expenses (defined earlier).

- If you use a distribution from your Archer MSA for qualified medical expenses, you do not pay tax on the distribution but you have to report the distribution on Form 8853. Follow the instructions for the form and file it with your Form 1040 or Form 1040NR.
- If you do not use a distribution from your Archer MSA for qualified medical expenses, you must pay tax on the distribution. Report the amount on Form 8853 and file it with your Form 1040 or Form 1040NR. If you have a taxable Archer MSA distribution, include it in the total on Form 1040 or Form 1040NR, line 21, and enter "MSA" and the amount on the dotted line next to line 21. You may have to pay an additional 20% tax, discussed later, on your taxable distribution.

If an amount (other than a rollover) is contributed to your Archer MSA this year (by you or your employer), you also must report and pay tax on a distribution you receive from your Archer MSA this year that is used to pay medical expenses of someone who is not covered by an HDHP, or is also covered by another health plan that is not an HDHP, at the time the expenses are incurred.

Rollovers. Generally, any distribution from an Archer MSA that you roll over into another Archer MSA or an HSA is not taxable if you complete the rollover within 60 days. An Archer MSA and an HSA can only receive one rollover contribution during a 1-year period. See the Form 8853 instructions for more information.

Additional tax. There is a 20% additional tax on the part of your distributions not used for qualified medical expenses. Figure the tax on Form 8853 and file it with your Form 1040 or Form 1040NR. Report the additional tax in the total on Form 1040, line 60, or Form 1040NR, line 59, and enter "MSA" and the amount on the dotted line next to that line.

Exceptions. There is no additional tax on distributions made after the date you are disabled, reach age 65, or die.

Balance in an Archer MSA

An Archer MSA is generally exempt from tax. You are permitted to take a distribution from your Archer MSA at any time; however, only those amounts used exclusively to

pay for qualified medical expenses are tax free. Amounts that remain at the end of the year are generally carried over to the next year (see *Excess contributions*, earlier). Earnings on amounts in an Archer MSA are not included in your income while held in the Archer MSA.

Death of the Archer MSA Holder

You should choose a beneficiary when you set up your Archer MSA. What happens to that Archer MSA when you die depends on whom you designate as the beneficiary.

Spouse is the designated beneficiary. If your spouse is the designated beneficiary of your Archer MSA, it will be treated as your spouse's Archer MSA after your death.

Spouse is not the designated beneficiary. If your spouse is not the designated beneficiary of your Archer MSA:

- The account stops being an Archer MSA, and
- The fair market value of the Archer MSA becomes taxable to the beneficiary in the year in which you die.

If your estate is the beneficiary, the fair market value of the Archer MSA will be included on your final income tax return.

The amount taxable to a beneficiary other than the estate is reduced by any qualified medical expenses for the decedent that are paid by the beneficiary within 1 year after the date of death.

Filing Form 8853

You must file Form 8853 with your Form 1040 or Form 1040NR if you (or your spouse, if married filing a joint return) had any activity in your Archer MSA during the year. You must file the form even if only your employer or your spouse's employer made contributions to the Archer MSA.

If, during the tax year, you are the beneficiary of two or more Archer MSAs or you are a beneficiary of an Archer MSA and you have your own Archer MSA, you must complete a separate Form 8853 for each MSA. Enter "statement" at the top of each Form 8853 and complete the form as instructed. Next, complete a controlling Form 8853 combining the amounts shown on each of the statement Forms 8853. Attach the statements to your tax return after the controlling Form 8853.

Employer Participation

This section contains the rules that employers must follow if they decide to make Archer MSAs available to their employees. Unlike the previous discussions, "you" refers to the employer and not to the employee.

Health plan. If you want your employees to be able to have an Archer MSA, you must make an HDHP available to them. You can provide no additional coverage other than those exceptions listed previously under *Other health coverage*.

Contributions. You can make contributions to your employees' Archer MSAs. You deduct the contributions on the "Employee benefit programs" line of your business income tax return for the year in which you make the contributions. If you are filing Form 1040, Schedule C, this is Part II, line 14.

Comparable contributions. If you decide to make contributions, you must make comparable contributions to all comparable participating employees' Archer MSAs. Your contributions are comparable if they are either:

- The same amount, or
- The same percentage of the annual deductible limit under the HDHP covering the employees.

Comparable participating employees. Comparable participating employees:

- Are covered by your HDHP and are eligible to establish an Archer MSA,
- Have the same category of coverage (either self-only or family coverage), and
- Have the same category of employment (either part-time or full-time).

Excise tax. If you made contributions to your employees' Archer MSAs that were not comparable, you must pay an excise tax of 35% of the amount you contributed.

Employment taxes. Amounts you contribute to your employees' Archer MSAs are generally not subject to employment taxes. You must report the contributions in box 12 of the Form W-2 you file for each employee. Enter code "R" in box 12.

Medicare Advantage MSAs

A Medicare Advantage MSA is an Archer MSA designated by Medicare to be used solely to pay the qualified medical expenses of the account holder. To be eligible for a Medicare Advantage MSA, you must be enrolled in Medicare and have a high deductible health plan (HDHP) that meets the Medicare guidelines.

A Medicare Advantage MSA is a tax-exempt trust or custodial savings account that you set up with a financial institution (such as a bank or an insurance company) in which the Medicare program can deposit money for qualified medical expenses. The money in your account is not taxed if it is used for qualified medical expenses, and it may earn interest or dividends.

An HDHP is a special health insurance policy that has a high deductible. You choose the policy you want to use as part of your Medicare Advantage MSA plan. However, the policy must be approved by the Medicare program.

Medicare Advantage MSAs are administered through the federal Medicare program. You can get information by

calling 1-800-Medicare (1-800-633-4227) or through the Internet at www.medicare.gov.

Note. You must file Form 8853, Archer MSAs and Long-Term Care Insurance Contracts, with your tax return if you have a Medicare Advantage MSA.

Flexible Spending Arrangements (FSAs)

A health flexible spending arrangement (FSA) allows employees to be reimbursed for medical expenses. FSAs are usually funded through voluntary salary reduction agreements with your employer. No employment or federal income taxes are deducted from your contribution. The employer may also contribute.

Note. Unlike HSAs or Archer MSAs which must be reported on Form 1040 or Form 1040NR, there are no reporting requirements for FSAs on your income tax return.

For information on the interaction between a health FSA and an HSA, see *Other employee health plans* under *Qualifying for an HSA,* earlier.

What are the benefits of an FSA? You may enjoy several benefits from having an FSA.

- Contributions made by your employer can be excluded from your gross income.
- No employment or federal income taxes are deducted from the contributions.
- Withdrawals may be tax free if you pay qualified medical expenses. See *Qualified medical expenses*, later.
- You can withdraw funds from the account to pay qualified medical expenses even if you have not yet placed the funds in the account.

Qualifying for an FSA

Health FSAs are employer-established benefit plans. These may be offered in conjunction with other employer-provided benefits as part of a cafeteria plan. Employers have complete flexibility to offer various combinations of benefits in designing their plan. You do not have to be covered under any other health care plan to participate.

Self-employed persons are not eligible for an FSA.

Certain limitations may apply if you are a highly compensated participant or a key employee.

Contributions to an FSA

You contribute to your FSA by electing an amount to be voluntarily withheld from your pay by your employer. This is sometimes called a salary reduction agreement. The employer may also contribute to your FSA if specified in the plan.

You do not pay federal income tax or employment taxes on the salary you contribute or the amounts your employer contributes to the FSA. However, contributions made by your employer to provide coverage for long-term care insurance must be included in income.

When To Contribute

At the beginning of the plan year, you must designate how much you want to contribute. Then, your employer will deduct amounts periodically (generally, every payday) in accordance with your annual election. You can change or revoke your election only if there is a change in your employment or family status that is specified by the plan.

Amount of Contribution

There is no limit on the amount of money you or your employer can contribute to the accounts; however, the plan must prescribe either a maximum dollar amount or maximum percentage of compensation that can be contributed to your health FSA.

Generally, contributed amounts that are not spent by the end of the plan year are forfeited. See *Balance in an FSA*, later. For this reason, it is important to base your contribution on an estimate of the qualifying expenses you will have during the year.

Note. For plan years beginning after December 31, 2012, a cafeteria plan may not allow an employee to request salary reduction contributions for a health FSA in excess of $2,500.

A cafeteria plan offering a health FSA must be amended to specify the $2,500 limit (or any lower limit set by the employer). While cafeteria plans generally must be amended on a prospective basis, an amendment that is adopted on or before December 31, 2014, may be made effective retroactively, provided that in operation the cafeteria plan meets the limit for plan years beginning after December 31, 2012. A cafeteria plan that does not limit health FSA contributions to $2,500 is not a cafeteria plan and all benefits offered under the plan are includible in the employees' gross income. For more information, see Notice 2012-40, 2012-26 I.R.B. 1046, available at www.irs.gov/irb/2012-26_IRB/ar09.html.

Distributions From an FSA

Generally, distributions from a health FSA must be paid only to reimburse you for qualified medical expenses you incurred during the period of coverage. You must be able to receive the maximum amount of reimbursement (the amount you have elected to contribute for the year) at any time during the coverage period, regardless of the amount you have actually contributed. The maximum amount you can receive tax free is the total amount you elected to contribute to the health FSA for the year.

You must provide the health FSA with a written statement from an independent third party stating that the medical expense has been incurred and the amount of the

expense. You must also provide a written statement that the expense has not been paid or reimbursed under any other health plan coverage. The FSA cannot make advance reimbursements of future or projected expenses.

Debit cards, credit cards, and stored value cards given to you by your employer can be used to reimburse participants in a health FSA. If the use of these cards meets certain substantiation methods, you may not have to provide additional information to the health FSA. For information on these methods, see Revenue Ruling 2003-43 on page 935 of Internal Revenue Bulletin (IRB) 2003-21 at www.irs.gov/pub/irs-irbs/irb03-21.pdf, Notice 2006-69, 2006-31 I.R.B.107 available at www.irs.gov/irb/2006-31_IRB/ar10.html, and Notice 2007-2, 2007-2 I.R.B. 254 available at www.irs.gov/irb/2007-2_IRB/ar09.html.

Qualified medical expenses. Qualified medical expenses are those specified in the plan that would generally qualify for the medical and dental expenses deduction. These are explained in Publication 502, Medical and Dental Expenses.

Also, non-prescription medicines (other than insulin) are not considered qualified medical expenses for FSA purposes. A medicine or drug will be a qualified medical expense for FSA purposes only if the medicine or drug:

1. Requires a prescription,
2. Is available without a prescription (an over-the-counter medicine or drug) and you get a prescription for it, or
3. Is insulin.

Qualified medical expenses are those incurred by the following persons.

1. You and your spouse.
2. All dependents you claim on your tax return.
3. Any person you could have claimed as a dependent on your return except that:
   a. The person filed a joint return,
   b. The person had gross income of $3,800 or more, or
   c. You, or your spouse if filing jointly, could be claimed as a dependent on someone else's 2012 return.
4. Your child under age 27 at the end of your tax year.

You cannot receive distributions from your FSA for the following expenses.

- Amounts paid for health insurance premiums.
- Amounts paid for long-term care coverage or expenses.
- Amounts that are covered under another health plan.

If you are covered under both a health FSA and an HRA, see Notice 2002-45, Part V, which is on page 93 of IRB 2002-28 at www.irs.gov/pub/irs-irbs/irb02-28.pdf.

CAUTION *You cannot deduct qualified medical expenses as an itemized deduction on Schedule A (Form 1040) that are equal to the distribution you receive from the FSA.*

Qualified HSA distribution. This is a distribution made before January 1, 2012, from your health FSA that is transferred to your HSA, discussed earlier.

For more information, see Notice 2007-22, 2007-10 I.R.B. 670 available at www.irs.gov/irb/2007-10_IRB/ar10.html.

If you do not remain an eligible individual for HSA purposes during the testing period, the distribution is included in your income and is subject to a 10% additional tax. See Qualified HSA distribution under *Health Savings Accounts (HSAs)*, earlier.

Qualified reservist distribution. A special rule allows amounts in a health FSA to be distributed to reservists ordered or called to active duty. This rule applies to distributions made after June 17, 2008, if the plan has been amended to allow these distributions. Your employer must report the distribution as wages on your Form W-2 for the year in which the distribution is made. The distribution is subject to employment taxes and is included in your gross income.

A qualified reservist distribution is allowed if you were (because you were in the reserves) ordered or called to active duty for a period of more than 179 days or for an indefinite period, and the distribution is made during the period beginning on the date of the order or call and ending on the last date that reimbursements could otherwise be made for the plan year that includes the date of the order or call.

Balance in an FSA

Flexible spending accounts are "use-it-or-lose-it" plans. This means that amounts in the account at the end of the plan year cannot be carried over to the next year. However, the plan can provide for a grace period of up to 2½ months after the end of the plan year. If there is a grace period, any qualified medical expenses incurred in that period can be paid from any amounts left in the account at the end of the previous year. Your employer is not permitted to refund any part of the balance to you. See Qualified HSA distribution and Qualified reservist distribution, earlier.

Employer Participation

For the health FSA to maintain tax-qualified status, employers must comply with certain requirements that apply to cafeteria plans. For example, there are restrictions for plans that cover highly compensated employees and key employees. The plans must also comply with rules applicable to other accident and health plans. Chapters 1 and 2 of Publication 15-B, Employer's Tax Guide to Fringe Benefits, explain these requirements.

Health Reimbursement Arrangements (HRAs)

A health reimbursement arrangement (HRA) must be funded solely by an employer. The contribution cannot be paid through a voluntary salary reduction agreement on the part of an employee. Employees are reimbursed tax free for qualified medical expenses up to a maximum dollar amount for a coverage period. An HRA may be offered with other health plans, including FSAs.

Note. Unlike HSAs or Archer MSAs which must be reported on Form 1040 or Form 1040NR, there are no reporting requirements for HRAs on your income tax return.

For information on the interaction between an HRA and an HSA, see *Other employee health plans* under *Qualifying for an HSA,* earlier.

What are the benefits of an HRA? You may enjoy several benefits from having an HRA.

- Contributions made by your employer can be excluded from your gross income.
- Reimbursements may be tax free if you pay qualified medical expenses. See *Qualified medical expenses*, later.
- Any unused amounts in the HRA can be carried forward for reimbursements in later years.

Qualifying for an HRA

HRAs are employer-established benefit plans. These may be offered in conjunction with other employer-provided health benefits. Employers have complete flexibility to offer various combinations of benefits in designing their plan. You do not have to be covered under any other health care plan to participate.

Self-employed persons are not eligible for an HRA.

Certain limitations may apply if you are a highly compensated participant.

Contributions to an HRA

HRAs are funded solely through employer contributions and may not be funded through employee salary deferrals under a cafeteria plan. These contributions are not included in the employee's income. You do not pay federal income taxes or employment taxes on amounts your employer contributes to the HRA.

Amount of Contribution

There is no limit on the amount of money your employer can contribute to the accounts. Additionally, the maximum reimbursement amount credited under the HRA in the future may be increased or decreased by amounts not previously used. See *Balance in an HRA*, later.

Distributions From an HRA

Generally, distributions from an HRA must be paid to reimburse you for qualified medical expenses you have incurred. The expense must have been incurred on or after the date you are enrolled in the HRA.

Debit cards, credit cards, and stored value cards given to you by your employer can be used to reimburse participants in an HRA. If the use of these cards meets certain substantiation methods, you may not have to provide additional information to the HRA. For information on these methods, see Revenue Ruling 2003-43 on page 935 of Internal Revenue Bulletin (IRB) 2003-21 at www.irs.gov/pub/irs-irbs/irb03-21.pdf, Notice 2006-69, 2006-31 I.R.B. 107 available at www.irs.gov/irb/2006-31_IRB/ar10.html, and Notice 2007-2, 2007-2 I.R.B. 254 available at www.irs.gov/irb/2007-2_IRB/ar09.html.

If any distribution is, or can be, made for other than the reimbursement of qualified medical expenses, any distribution (including reimbursement of qualified medical expenses) made in the current tax year is included in gross income. For example, if an unused reimbursement is payable to you in cash at the end of the year, or upon termination of your employment, any distribution from the HRA is included in your income. This also applies if any unused amount upon your death is payable in cash to your beneficiary or estate, or if the HRA provides an option for you to transfer any unused reimbursement at the end of the year to a retirement plan. However, see *Qualified HSA distribution*, later.

If the plan permits amounts to be paid as medical benefits to a designated beneficiary (other than the employee's spouse or dependents), any distribution from the HRA is included in income.

Reimbursements under an HRA can be made to the following persons.

1. Current and former employees.
2. Spouses and dependents of those employees.
3. Any person you could have claimed as a dependent on your return except that:
   a. The person filed a joint return,
   b. The person had gross income of $3,800 or more, or
   c. You, or your spouse if filing jointly, could be claimed as a dependent on someone else's 2012 return.
4. Your child under age 27 at the end of your tax year.
5. Spouses and dependents of deceased employees.

For this purpose, a child of parents that are divorced, separated, or living apart for the last 6 months of the calendar year is treated as the dependent of both parents whether or not the custodial parent releases the claim to the child's exemption.

Qualified medical expenses. Qualified medical expenses are those specified in the plan that would generally qualify for the medical and dental expenses deduction. These are explained in Publication 502, Medical and Dental Expenses.

Also, non-prescription medicines (other than insulin) are not considered qualified medical expenses for HRA purposes. A medicine or drug will be a qualified medical expense for HRA purposes only if the medicine or drug:

1. Requires a prescription,
2. Is available without a prescription (an over-the-counter medicine or drug) and you get a prescription for it, or
3. Is insulin.

Qualified medical expenses from your HRA include the following.

- Amounts paid for health insurance premiums.
- Amounts paid for long-term care coverage.
- Amounts that are not covered under another health plan.

If you are covered under both an HRA and a health FSA, see Notice 2002-45, Part V, which is on page 93 of IRB 2002-28 at www.irs.gov/pub/irs-irbs/irb02-28.pdf.

CAUTION *You cannot deduct qualified medical expenses as an itemized deduction on Schedule A (Form 1040) that are equal to the distribution from the HRA.*

Qualified HSA distribution. This is a distribution made before January 1, 2012, from your HRA that is transferred to your HSA, discussed earlier.

For more information, see Notice 2007-22, 2007-10 I.R.B. 670 available at www.irs.gov/irb/2007-10_IRB/ar10.html.

If you do not remain an eligible individual for HSA purposes during the testing period, the distribution is included in your income and is subject to a 10% additional tax. See Qualified HSA distribution under *Health Savings Accounts (HSAs)*, earlier.

Balance in an HRA

Amounts that remain at the end of the year can generally be carried over to the next year. Your employer is not permitted to refund any part of the balance to you. These amounts may never be used for anything but reimbursements for qualified medical expenses. See Qualified HSA distribution, earlier.

Employer Participation

For an HRA to maintain tax-qualified status, employers must comply with certain requirements that apply to other accident and health plans. Chapters 1 and 2 of Publication 15-B, Employer's Tax Guide to Fringe Benefits, explain these requirements.

How To Get Tax Help

You can get help with unresolved tax issues, order free publications and forms, ask tax questions, and get information from the IRS in several ways. By selecting the method that is best for you, you will have quick and easy access to tax help.

Free help with your tax return. Free help in preparing your return is available nationwide from IRS-certified volunteers. The Volunteer Income Tax Assistance (VITA) program is designed to help low-moderate income, elderly, disabled, and limited English proficient taxpayers. The Tax Counseling for the Elderly (TCE) program is designed to assist taxpayers age 60 and older with their tax returns. Most VITA and TCE sites offer free electronic filing and all volunteers will let you know about credits and deductions you may be entitled to claim. Some VITA and TCE sites provide taxpayers the opportunity to prepare their return with the assistance of an IRS-certified volunteer. To find the nearest VITA or TCE site, visit IRS.gov or call 1-800-906-9887 or 1-800-829-1040.

As part of the TCE program, AARP offers the Tax-Aide counseling program. To find the nearest AARP Tax-Aide site, visit AARP's website at www.aarp.org/money/taxaide or call 1-888-227-7669.

For more information on these programs, go to IRS.gov and enter "VITA" in the search box.

Internet. You can access the IRS website at IRS.gov 24 hours a day, 7 days a week to:

- *E-file* your return. Find out about commercial tax preparation and *e-file* services available free to eligible taxpayers.
- Check the status of your 2012 refund. Go to IRS.gov and click on *Where's My Refund.* Information about your return will generally be available within 24 hours after the IRS receives your e-filed return, or 4 weeks after you mail your paper return. If you filed Form 8379 with your return, wait 14 weeks (11 weeks if you filed electronically). Have your 2012 tax return handy so you can provide your social security number, your filing status, and the exact whole dollar amount of your refund.
- *Where's My Refund?* has a new look this year! The tool will include a tracker that displays progress through three stages: (1) return received, (2) refund approved, and (3) refund sent. *Where's My Refund?* will provide an actual personalized refund date as soon as the IRS processes your tax return and approves your refund. So in a change from previous filing seasons, you won't get an estimated refund date right away. *Where's My Refund?* includes information for the most recent return filed in the current year and does not include information about amended returns.
- You can obtain a free transcript online at IRS.gov by clicking on *Order a Return or Account Transcript* under "Tools." For a transcript by phone, call

1-800-908-9946 and follow the prompts in the recorded message. You will be prompted to provide your SSN or Individual Taxpayer Identification Number (ITIN), date of birth, street address and ZIP code.

- Download forms, including talking tax forms, instructions, and publications.
- Order IRS products.
- Research your tax questions.
- Search publications by topic or keyword.
- Use the Internal Revenue Code, regulations, or other official guidance.
- View Internal Revenue Bulletins (IRBs) published in the last few years.
- Figure your withholding allowances using the IRS Withholding Calculator at www.irs.gov/individuals.
- Determine if Form 6251 (Alternative Minimum Tax—Individuals) must be filed by using our Alternative Minimum Tax (AMT) Assistant available at IRS.gov by typing *Alternative Minimum Tax Assistant* in the search box.
- Sign up to receive local and national tax news by email.
- Get information on starting and operating a small business.

Phone. Many services are available by phone.

- *Ordering forms, instructions, and publications.* Call 1-800-TAX-FORM (1-800-829-3676) to order current-year forms, instructions, and publications, and prior-year forms and instructions (limited to 5 years). You should receive your order within 10 days.
- *Asking tax questions.* Call the IRS with your tax questions at 1-800-829-1040.
- *Solving problems.* You can get face-to-face help solving tax problems most business days in IRS Taxpayer Assistance Centers (TAC). An employee can explain IRS letters, request adjustments to your account, or help you set up a payment plan. Call your local Taxpayer Assistance Center for an appointment. To find the number, go to www.irs.gov/localcontacts or look in the phone book under *United States Government, Internal Revenue Service*.
- *TTY/TDD equipment.* If you have access to TTY/TDD equipment, call 1-800-829-4059 to ask tax questions or to order forms and publications. The TTY/TDD telephone number is for individuals who are deaf, hard of hearing, or have a speech disability. These individuals can also access the IRS through relay services such as the Federal Relay Service at www.gsa.gov/fedrelay.
- *TeleTax topics.* Call 1-800-829-4477 to listen to pre-recorded messages covering various tax topics.
- *Checking the status of your 2012 refund.* To check the status of your 2012 refund, call 1-800-829-1954 or 1-800-829-4477 (automated *Where's My Refund?* information 24 hours a day, 7 days a week). Information about your return will generally be available within 24 hours after the IRS receives your e-filed return, or 4 weeks after you mail your paper return. If you filed Form 8379 with your return, wait 14 weeks (11 weeks if you filed electronically). Have your 2012 tax return handy so you can provide your social security number, your filing status, and the exact whole dollar amount of your refund. *Where's My Refund?* will provide an actual personalized refund date as soon as the IRS processes your tax return and approves your refund. *Where's My Refund?* includes information for the most recent return filed in the current year and does not include information about amended returns.

Evaluating the quality of our telephone services. To ensure IRS representatives give accurate, courteous, and professional answers, we use several methods to evaluate the quality of our telephone services. One method is for a second IRS representative to listen in on or record random telephone calls. Another is to ask some callers to complete a short survey at the end of the call.

Walk-in. Some products and services are available on a walk-in basis.

- *Products.* You can walk in to some post offices, libraries, and IRS offices to pick up certain forms, instructions, and publications. Some IRS offices, libraries, and city and county government offices have a collection of products available to photocopy from reproducible proofs. Also, some IRS offices and libraries have the Internal Revenue Code, regulations, Internal Revenue Bulletins, and Cumulative Bulletins available for research purposes.
- *Services.* You can walk in to your local TAC most business days for personal, face-to-face tax help. An employee can explain IRS letters, request adjustments to your tax account, or help you set up a payment plan. If you need to resolve a tax problem, have questions about how the tax law applies to your individual tax return, or you are more comfortable talking with someone in person, visit your local TAC where you can talk with an IRS representative face-to-face. No appointment is necessary—just walk in. Before visiting, check www.irs.gov/localcontacts for hours of operation and services provided. If you have an ongoing, complex tax account problem or a special need, such as a disability, an appointment can be requested by calling your local TAC. You can leave a message and a representative will call you back within 2 business days. All other issues will be handled without an appointment. To call your local TAC, go to www.irs.gov/localcontacts or look in the phone book under *United States Government, Internal Revenue Service*.

Mail. You can send your order for forms, instructions, and publications to the address below. You should receive a response within 10 days after your request is received.

Internal Revenue Service
1201 N. Mitsubishi Motorway
Bloomington, IL 61705-6613

Taxpayer Advocate Service. The Taxpayer Advocate Service (TAS) is your voice at the IRS. Its job is to ensure that every taxpayer is treated fairly, and that you know and understand your rights. TAS offers free help to guide you through the often-confusing process of resolving tax problems that you haven't been able to solve on your own. Remember, the worst thing you can do is nothing at all.

TAS can help if you can't resolve your problem with the IRS and:

- Your problem is causing financial difficulties for you, your family, or your business.
- You face (or your business is facing) an immediate threat of adverse action.
- You have tried repeatedly to contact the IRS but no one has responded, or the IRS has not responded to you by the date promised.

If you qualify for help, they will do everything they can to get your problem resolved. You will be assigned to one advocate who will be with you at every turn. TAS has offices in every state, the District of Columbia, and Puerto Rico. Although TAS is independent within the IRS, their advocates know how to work with the IRS to get your problems resolved. And its services are always free.

As a taxpayer, you have rights that the IRS must abide by in its dealings with you. The TAS tax toolkit at www.TaxpayerAdvocate.irs.gov can help you understand these rights.

If you think TAS might be able to help you, call your local advocate, whose number is in your phone book and on our website at www.irs.gov/advocate. You can also call the toll-free number at 1-877-777-4778. Deaf and hard of hearing individuals who have access to TTY/TDD equipment can call 1-800-829-4059. These individuals can also access the IRS through relay services such as the Federal Relay Service at www.gsa.gov/fedrelay.

TAS also handles large-scale or systemic problems that affect many taxpayers. If you know of one of these broad issues, please report it through the Systemic Advocacy Management System at www.irs.gov/advocate.

Low Income Taxpayer Clinics (LITCs). Low Income Taxpayer Clinics (LITCs) are independent from the IRS. Some clinics serve individuals whose income is below a certain level and who need to resolve a tax problem. These clinics provide professional representation before the IRS or in court on audits, appeals, tax collection disputes, and other issues for free or for a small fee. Some clinics can provide information about taxpayer rights and responsibilities in many different languages for individuals who speak English as a second language. For more information and to find a clinic near you, see the LITC page on www.irs.gov/advocate or IRS Publication 4134, *Low Income Taxpayer Clinic List*. This publication is also available by calling 1-800-TAX-FORM (1-800-829-3676) or at your local IRS office.

Free tax services. Publication 910, IRS Guide to Free Tax Services, is your guide to IRS services and resources. Learn about free tax information from the IRS, including publications, services, and education and assistance programs. The publication also has an index of over 100 TeleTax topics (recorded tax information) you can listen to on the telephone. The majority of the information and services listed in this publication are available to you free of charge. If there is a fee associated with a resource or service, it is listed in the publication.

Accessible versions of IRS published products are available on request in a variety of alternative formats for people with disabilities.

DVD for tax products. You can order Publication 1796, IRS Tax Products DVD, and obtain:

- Current-year forms, instructions, and publications.
- Prior-year forms, instructions, and publications.
- Tax Map: an electronic research tool and finding aid.
- Tax law frequently asked questions.
- Tax Topics from the IRS telephone response system.
- Internal Revenue Code—Title 26 of the U.S. Code.
- Links to other Internet-based tax research materials.
- Fill-in, print, and save features for most tax forms.
- Internal Revenue Bulletins.
- Toll-free and email technical support.
- Two releases during the year.
  – The first release will ship the beginning of January 2013.
  – The final release will ship the beginning of March 2013.

Purchase the DVD from National Technical Information Service (NTIS) at www.irs.gov/cdorders for $30 (no handling fee) or call 1-877-233-6767 toll free to buy the DVD for $30 (plus a $6 handling fee).

Index

To help us develop a more useful index, please let us know if you have ideas for index entries. See "Comments and Suggestions" in the "Introduction" for the ways you can reach us.

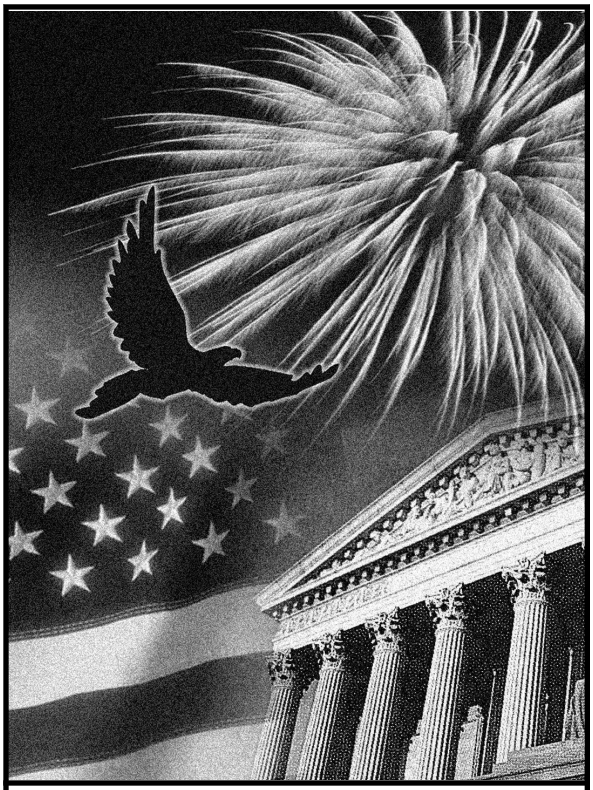
Department of the Treasury
Internal Revenue Service

Publication 502
Cat. No. 15002Q

Medical and Dental Expenses

(Including the Health Coverage Tax Credit)

For use in preparing
2012 Returns



Get forms and other Information faster and easier by:

Internet IRS.gov

Contents

What's New

Standard mileage rate. The standard mileage rate allowed for operating expenses for a car when you use it for medical reasons is 23 cents per mile. See *Transportation* under *What Medical Expenses Are Includible*.

Reminders

Future developments. For the latest information about developments related to Publication 502, such as legislation enacted after it was published, go to *www.irs.gov/pub502*.

Photographs of missing children. The Internal Revenue Service is a proud partner with the National Center for Missing and Exploited Children. Photographs of missing children selected by the Center may appear in this publication on pages that would otherwise be blank. You can help bring these children home by looking at the photographs and calling 1-800-THE-LOST (1-800-843-5678) if you recognize a child.

Introduction

This publication explains the itemized deduction for medical and dental expenses that you claim on Schedule A (Form 1040). It discusses what expenses, and whose expenses, you can and cannot include in figuring the deduction. It explains how to treat reimbursements and how to figure the deduction. It also tells you how to report the deduction on your tax return and what to do if you sell medical property or receive damages for a personal injury.

Medical expenses include dental expenses, and in this publication the term "medical expenses" is often used to refer to medical and dental expenses.

You can deduct on Schedule A (Form 1040) only the part of your medical and dental expenses that is more than 7.5% of your adjusted gross income (AGI). If your medical and dental expenses are not more than 7.5% of your AGI, you cannot claim a deduction.

This publication also explains how to treat impairment-related work expenses, health insurance premiums if you are self-employed, and the health coverage tax credit that is available to certain individuals.

Pub. 502 covers many common medical expenses but not every possible medical expense. If you cannot find the expense you are looking for, refer to the definition of medical expenses under *What Are Medical Expenses*.

See *How To Get Tax Help* near the end of this publication for information about getting publications and forms.

Comments and suggestions. We welcome your comments about this publication and your suggestions for future editions.

You can write to us at the following address:

Internal Revenue Service
Individual and Specialty Forms and Publications Branch
SE:W:CAR:MP:T:I
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224

We respond to many letters by telephone. Therefore, it would be helpful if you would include your daytime phone number, including the area code, in your correspondence.

You can email us at *taxforms@irs.gov*. Please put "Publications Comment" on the subject line. You can also send us comments from *www.irs.gov/formspubs/*. Select "Comment on Tax Forms and Publications" under "More Information."

Although we cannot respond individually to each comment received, we do appreciate your feedback and will consider your comments as we revise our tax products.

Ordering forms and publications. Visit *www.irs.gov/formspubs/* to download forms and publications, call 1-800-TAX-FORM (1-800-829-3676), or write to the address below and receive a response within 10 days after your request is received.

Internal Revenue Service
1201 N. Mitsubishi Motorway
Bloomington, IL 61705-6613

Tax questions. If you have a tax question, check the information available on IRS.gov or call 1-800-829-1040. We cannot answer tax questions sent to either of the above addresses.

Useful Items

You may want to see:

Publication

- ❑ **969** Health Savings Accounts and Other Tax-Favored Health Plans

Forms (and Instructions)

- ❑ **1040** U.S. Individual Income Tax Return
- ❑ **Schedule A (Form 1040)** Itemized Deductions
- ❑ **8885** Health Coverage Tax Credit

What Are Medical Expenses?

Medical expenses are the costs of diagnosis, cure, mitigation, treatment, or prevention of disease, and the costs for treatments affecting any part or function of the body. These expenses include payments for legal medical services rendered by physicians, surgeons, dentists, and other medical practitioners. They include the costs of equipment, supplies, and diagnostic devices needed for these purposes.

Medical care expenses must be primarily to alleviate or prevent a physical or mental defect or illness. They do not include expenses that are merely beneficial to general health, such as vitamins or a vacation.

Medical expenses include the premiums you pay for insurance that covers the expenses of medical care, and the amounts you pay for transportation to get medical care. Medical expenses also include amounts paid for qualified long-term care services and limited amounts paid for any qualified long-term care insurance contract.

What Expenses Can You Include This Year?

You can include only the medical and dental expenses you paid this year, regardless of when the services were provided. (But see *Decedent* under *Whose Medical Expenses Can You Include*, for an exception.) If you pay medical expenses by check, the day you mail or deliver the check generally is the date of payment. If you use a "pay-by-phone" or "online" account to pay your medical expenses, the date reported on the statement of the financial institution showing when payment was made is the date of payment. If you use a credit card, include medical

expenses you charge to your credit card in the year the charge is made, not when you actually pay the amount charged.

If you did not claim a medical or dental expense that would have been deductible in an earlier year, you can file Form 1040X, Amended U.S. Individual Income Tax Return, for the year in which you overlooked the expense. Do not claim the expense on this year's return. Generally, an amended return must be filed within 3 years from the date the original return was filed or within 2 years from the time the tax was paid, whichever is later.

You cannot include medical expenses that were paid by insurance companies or other sources. This is true whether the payments were made directly to you, to the patient, or to the provider of the medical services.

Separate returns. If you and your spouse live in a non-community property state and file separate returns, each of you can include only the medical expenses each actually paid. Any medical expenses paid out of a joint checking account in which you and your spouse have the same interest are considered to have been paid equally by each of you, unless you can show otherwise.

Community property states. If you and your spouse live in a community property state and file separate returns or are registered domestic partners in Nevada, Washington, or California (or a person in California who is married to a person of the same sex), any medical expenses paid out of community funds are divided equally. Generally, each of you should include half the expenses. If medical expenses are paid out of the separate funds of one individual, only the individual who paid the medical expenses can include them. If you live in a community property state and are not filing a joint return, see Publication 555, Community Property.

How Much of the Expenses Can You Deduct?

You can deduct on Schedule A (Form 1040) only the amount of your medical and dental expenses that is more than 7.5% of your AGI (Form 1040, line 38).

In this publication, the term “7.5% limit” is used to refer to 7.5% of your AGI. The phrase “subject to the 7.5% limit” is also used. This phrase means that you must subtract 7.5% (.075) of your AGI from your medical expenses to figure your medical expense deduction.

Example. Your AGI is $40,000, 7.5% of which is $3,000. You paid medical expenses of $2,500. You cannot deduct any of your medical expenses because they are not more than 7.5% of your AGI.

Whose Medical Expenses Can You Include?

You can generally include medical expenses you pay for yourself, as well as those you pay for someone who was your spouse or your dependent either when the services were provided or when you paid for them. There are different rules for decedents and for individuals who are the subject of multiple support agreements. See *Support claimed under a multiple support agreement*, later under *Qualifying Person*.

Yourself

You can include medical expenses that you paid for yourself.

Spouse

You can include medical expenses you paid for your spouse. To include these expenses, you must have been married either at the time your spouse received the medical services or at the time you paid the medical expenses.

Example 1. Mary received medical treatment before she married Bill. Bill paid for the treatment after they married. Bill can include these expenses in figuring his medical expense deduction even if Bill and Mary file separate returns.

If Mary had paid the expenses, Bill could not include Mary's expenses in his separate return. Mary would include the amounts she paid during the year in her separate return. If they filed a joint return, the medical expenses both paid during the year would be used to figure their medical expense deduction.

Example 2. This year, John paid medical expenses for his wife Louise, who died last year. John married Belle this year and they file a joint return. Because John was married to Louise when she received the medical services, he can include those expenses in figuring his medical expense deduction for this year.

Dependent

You can include medical expenses you paid for your dependent. For you to include these expenses, the person must have been your dependent either at the time the medical services were provided or at the time you paid the expenses. A person generally qualifies as your dependent for purposes of the medical expense deduction if both of the following requirements are met.

1. The person was a Qualifying Child (defined later) or a Qualifying Relative (defined later), and
2. The person was a U.S. citizen or national or a resident of the United States, Canada, or Mexico. If your qualifying child was adopted, see *Exception for adopted child*, later.

You can include medical expenses you paid for an individual that would have been your dependent except that:

1. He or she received gross income of $3,800 or more in 2012,
2. He or she filed a joint return for 2012, or
3. You, or your spouse if filing jointly, could be claimed as a dependent on someone else's 2012 return.

Exception for adopted child. If you are a U.S. citizen or national and your adopted child lived with you as a member of your household for 2012, that child does not have to be a U.S. citizen or national, or a resident of the United States, Canada, or Mexico.

Qualifying Child

A qualifying child is a child who:

1. Is your son, daughter, stepchild, foster child, brother, sister, stepbrother, stepsister, half brother, half sister, or a descendant of any of them (for example, your grandchild, niece, or nephew),
2. Was:
   a. Under age 19 at the end of 2012 and younger than you (or your spouse, if filing jointly),
   b. Under age 24 at the end of 2012, a full-time student, and younger than you (or your spouse, if filing jointly), or
   c. Any age and permanently and totally disabled,
3. Lived with you for more than half of 2012,
4. Did not provide over half of his or her own support for 2012, and
5. Did not file a joint return, other than to claim a refund.

Adopted child. A legally adopted child is treated as your own child. This child includes a child lawfully placed with you for legal adoption.

You can include medical expenses that you paid for a child before adoption if the child qualified as your dependent when the medical services were provided or when the expenses were paid.

If you pay back an adoption agency or other persons for medical expenses they paid under an agreement with you, you are treated as having paid those expenses provided you clearly substantiate that the payment is directly attributable to the medical care of the child.

But if you pay the agency or other person for medical care that was provided and paid for before adoption negotiations began, you cannot include them as medical expenses.

TIP *You may be able to take a credit for other expenses related to an adoption. See the Instructions for Form 8839, Qualified Adoption Expenses, for more information.*

Child of divorced or separated parents. For purposes of the medical and dental expenses deduction, a child of divorced or separated parents can be treated as a dependent of both parents. Each parent can include the medical expenses he or she pays for the child, even if the other parent claims the child's dependency exemption, if:

1. The child is in the custody of one or both parents for more than half the year,
2. The child receives over half of his or her support during the year from his or her parents, and
3. The child's parents:
   a. Are divorced or legally separated under a decree of divorce or separate maintenance,
   b. Are separated under a written separation agreement, or
   c. Live apart at all times during the last 6 months of the year.

This does not apply if the child's exemption is being claimed under a multiple support agreement (discussed later).

Qualifying Relative

A qualifying relative is a person:

1. Who is your:
   a. Son, daughter, stepchild, or foster child, or a descendant of any of them (for example, your grandchild),
   b. Brother, sister, half brother, half sister, or a son or daughter of any of them,
   c. Father, mother, or an ancestor or sibling of either of them (for example, your grandmother, grandfather, aunt, or uncle),
   d. Stepbrother, stepsister, stepfather, stepmother, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law, or
   e. Any other person (other than your spouse) who lived with you all year as a member of your household if your relationship did not violate local law,
2. Who was not a qualifying child (see *Qualifying Child*, earlier) of any taxpayer for 2012, and
3. For whom you provided over half of the support in 2012. But see *Child of divorced or separated parents*, earlier, *Support claimed under a multiple support agreement*, next, and *Kidnapped child* under *Qualifying Relative* in Publication 501, Exemptions, Standard Deduction, and Filing Information.

Support claimed under a multiple support agreement. If you are considered to have provided more than half of a qualifying relative's support under a multiple support agreement, you can include medical expenses you pay for that person. A multiple support agreement is used when two or more people provide more than half of a person's support, but no one alone provides more than half.

Any medical expenses paid by others who joined you in the agreement cannot be included as medical expenses by anyone. However, you can include the entire unreimbursed amount you paid for medical expenses.

Example. You and your three brothers each provide one-fourth of your mother's total support. Under a multiple support agreement, you treat your mother as your dependent. You paid all of her medical expenses. Your brothers repaid you for three-fourths of these expenses. In figuring your medical expense deduction, you can include only one-fourth of your mother's medical expenses. Your brothers cannot include any part of the expenses. However, if you and your brothers share the nonmedical support items and you separately pay all of your mother's medical expenses, you can include the unreimbursed amount you paid for her medical expenses in your medical expenses.

Decedent

Medical expenses paid before death by the decedent are included in figuring any deduction for medical and dental expenses on the decedent's final income tax return. This includes expenses for the decedent's spouse and dependents as well as for the decedent.

The survivor or personal representative of a decedent can choose to treat certain expenses paid by the decedent's estate for the decedent's medical care as paid by the decedent at the time the medical services were provided. The expenses must be paid within the 1-year period beginning with the day after the date of death. If you are the survivor or personal representative making this choice, you must attach a statement to the decedent's Form 1040 (or the decedent's amended return, Form 1040X) saying that the expenses have not been and will not be claimed on the estate tax return.

Qualified medical expenses paid before death by the decedent are not deductible if paid with a tax-free distribution from any Archer MSA, Medicare Advantage MSA, or health savings account.

What if the decedent's return had been filed and the medical expenses were not included? Form 1040X can be filed for the year or years the expenses are treated as paid, unless the period for filing an amended return for that year has passed. Generally, an amended return must be filed within 3 years of the date the original return was filed, or within 2 years from the time the tax was paid, whichever date is later.

Example. John properly filed his 2011 income tax return. He died in 2012 with unpaid medical expenses of $1,500 from 2011 and $1,800 in 2012. If the expenses are paid within the 1-year period, his survivor or personal representative can file an amended return for 2011 claiming a deduction based on the $1,500 medical expenses. The $1,800 of medical expenses from 2012 can be included on the decedent's final return for 2012.

What if you pay medical expenses of a deceased spouse or dependent? If you paid medical expenses for your deceased spouse or dependent, include them as medical expenses on your Form 1040 in the year paid, whether they are paid before or after the decedent's death. The expenses can be included if the person was your spouse or dependent either at the time the medical services were provided or at the time you paid the expenses.

What Medical Expenses Are Includible?

Following is a list of items that you can include in figuring your medical expense deduction. The items are listed in alphabetical order.

This list does not include all possible medical expenses. To determine if an expense not listed can be included in figuring your medical expense deduction, see *What Are Medical Expenses*, earlier.

Abortion

You can include in medical expenses the amount you pay for a legal abortion.

Acupuncture

You can include in medical expenses the amount you pay for acupuncture.

Alcoholism

You can include in medical expenses amounts you pay for an inpatient's treatment at a therapeutic center for alcohol addiction. This includes meals and lodging provided by the center during treatment.

You can also include in medical expenses amounts you pay for transportation to and from Alcoholics Anonymous meetings in your community if the attendance is pursuant to medical advice that membership in Alcoholics Anonymous is necessary for the treatment of a disease involving the excessive use of alcoholic liquors.

Ambulance

You can include in medical expenses amounts you pay for ambulance service.

Annual Physical Examination

See *Physical Examination*, later.

Artificial Limb

You can include in medical expenses the amount you pay for an artificial limb.

Artificial Teeth

You can include in medical expenses the amount you pay for artificial teeth.

Autoette

See *Wheelchair*, later.

Bandages

You can include in medical expenses the cost of medical supplies such as bandages.

Birth Control Pills

You can include in medical expenses the amount you pay for birth control pills prescribed by a doctor.

Body Scan

You can include in medical expenses the cost of an electronic body scan.

Braille Books and Magazines

You can include in medical expenses the part of the cost of Braille books and magazines for use by a visually impaired person that is more than the cost of regular printed editions.

Breast Pumps and Supplies

You can include in medical expenses the cost of breast pumps and supplies that assist lactation.

Breast Reconstruction Surgery

You can include in medical expenses the amounts you pay for breast reconstruction surgery, as well as breast prosthesis, following a mastectomy for cancer. See *Cosmetic Surgery*, later.

Capital Expenses

You can include in medical expenses amounts you pay for special equipment installed in a home, or for improvements, if their main purpose is medical care for you, your spouse, or your dependent. The cost of permanent improvements that increase the value of your property may be partly included as a medical expense. The cost of the improvement is reduced by the increase in the value of your property. The difference is a medical expense. If the value of your property is not increased by the improvement, the entire cost is included as a medical expense.

Certain improvements made to accommodate a home to your disabled condition, or that of your spouse or your dependents who live with you, do not usually increase the value of the home and the cost can be included in full as medical expenses. These improvements include, but are not limited to, the following items.

- Constructing entrance or exit ramps for your home.
- Widening doorways at entrances or exits to your home.
- Widening or otherwise modifying hallways and interior doorways.
- Installing railings, support bars, or other modifications to bathrooms.
- Lowering or modifying kitchen cabinets and equipment.
- Moving or modifying electrical outlets and fixtures.
- Installing porch lifts and other forms of lifts (but elevators generally add value to the house).
- Modifying fire alarms, smoke detectors, and other warning systems.
- Modifying stairways.
- Adding handrails or grab bars anywhere (whether or not in bathrooms).
- Modifying hardware on doors.
- Modifying areas in front of entrance and exit doorways.
- Grading the ground to provide access to the residence.

Only reasonable costs to accommodate a home to a disabled condition are considered medical care. Additional costs for personal motives, such as for architectural or aesthetic reasons, are not medical expenses.

Capital expense worksheet. Use Worksheet A to figure the amount of your capital expense to include in your medical expenses.

Worksheet A. **Capital Expense Worksheet**

Keep for Your Records

Instructions: Use this worksheet to figure the amount, if any, of your medical expenses due to a home improvement.

1. Enter the amount you paid for the home improvement	**1.**	
2. Enter the value of your home immediately after the improvement	**2.**	
3. Enter the value of your home immediately before the improvement	**3.**	
4. Subtract line 3 from line 2. This is the increase in the value of your home due to the improvement.	**4.**	
• If line 4 is more than or equal to line 1, you have no medical expenses due to the home improvement; stop here.		
• If line 4 is less than line 1, go to line 5.		
5. Subtract line 4 from line 1. These are your medical expenses due to the home improvement.	**5.**	

Example. You have a heart ailment. On your doctor's advice, you install an elevator in your home so that you will not have to climb stairs. The elevator costs $8,000. An appraisal shows that the elevator increases the value of your home by $4,400. You figure your medical expense as shown in the filled-in example of Worksheet A.

Worksheet A. **Capital Expense Worksheet—Illustrated**

Keep for Your Records

Instructions: Use this worksheet to figure the amount, if any, of your medical expenses due to a home improvement.

1. Enter the amount you paid for the home improvement	**1.**	*8,000*
2. Enter the value of your home immediately after the improvement	**2.**	*124,400*
3. Enter the value of your home immediately before the improvement	**3.**	*120,000*
4. Subtract line 3 from line 2. This is the increase in the value of your home due to the improvement.	**4.**	*4,400*
• If line 4 is more than or equal to line 1, you have no medical expenses due to the home improvement; stop here.		
• If line 4 is less than line 1, go to line 5.		
5. Subtract line 4 from line 1. These are your medical expenses due to the home improvement.	**5.**	*3,600*

Operation and upkeep. Amounts you pay for operation and upkeep of a capital asset qualify as medical expenses, as long as the main reason for them is medical care. This rule applies even if none or only part of the original cost of the capital asset qualified as a medical care expense.

Example. If, in the previous example, the elevator increased the value of your home by $8,000, you would have no medical expense for the cost of the elevator. However, the cost of electricity to operate the elevator and any costs to maintain it are medical expenses as long as the medical reason for the elevator exists.

Improvements to property rented by a person with a disability. Amounts paid to buy and install special plumbing fixtures for a person with a disability, mainly for medical reasons, in a rented house are medical expenses.

Example. John has arthritis and a heart condition. He cannot climb stairs or get into a bathtub. On his doctor's advice, he installs a bathroom with a shower stall on the first floor of his two-story rented house. The landlord did not pay any of the cost of buying and installing the special plumbing and did not lower the rent. John can include in medical expenses the entire amount he paid.

Car

You can include in medical expenses the cost of special hand controls and other special equipment installed in a car for the use of a person with a disability.

Special design. You can include in medical expenses the difference between the cost of a regular car and a car specially designed to hold a wheelchair.

Cost of operation. The includible costs of using a car for medical reasons are explained under *Transportation*, later.

Chiropractor

You can include in medical expenses fees you pay to a chiropractor for medical care.

Christian Science Practitioner

You can include in medical expenses fees you pay to Christian Science practitioners for medical care.

Contact Lenses

You can include in medical expenses amounts you pay for contact lenses needed for medical reasons. You can also include the cost of equipment and materials required for using contact lenses, such as saline solution and enzyme cleaner. See *Eyeglasses* and *Eye Surgery*, later.

Crutches

You can include in medical expenses the amount you pay to buy or rent crutches.

Dental Treatment

You can include in medical expenses the amounts you pay for the prevention and alleviation of dental disease. Preventive treatment includes the services of a dental hygienist or dentist for such procedures as teeth cleaning, the application of sealants, and fluoride treatments to prevent tooth decay. Treatment to alleviate dental disease include services of a dentist for procedures such as X-rays, fillings, braces, extractions, dentures, and other dental ailments. But see *Teeth Whitening* under *What Expenses Are Not Includible*, later.

Diagnostic Devices

You can include in medical expenses the cost of devices used in diagnosing and treating illness and disease.

Example. You have diabetes and use a blood sugar test kit to monitor your blood sugar level. You can include the cost of the blood sugar test kit in your medical expenses.

Disabled Dependent Care Expenses

Some disabled dependent care expenses may qualify as either:

- Medical expenses, or
- Work-related expenses for purposes of taking a credit for dependent care. (See Publication 503, Child and Dependent Care Expenses.)

You can choose to apply them either way as long as you do not use the same expenses to claim both a credit and a medical expense deduction.

Drug Addiction

You can include in medical expenses amounts you pay for an inpatient's treatment at a therapeutic center for drug addiction. This includes meals and lodging at the center during treatment.

Drugs

See *Medicines*, later.

Eye Exam

You can include in medical expenses the amount you pay for eye examinations.

Eyeglasses

You can include in medical expenses amounts you pay for eyeglasses and contact lenses needed for medical reasons. See *Contact Lenses*, earlier, for more information.

Eye Surgery

You can include in medical expenses the amount you pay for eye surgery to treat defective vision, such as laser eye surgery or radial keratotomy.

Fertility Enhancement

You can include in medical expenses the cost of the following procedures to overcome an inability to have children.

- Procedures such as *in vitro* fertilization (including temporary storage of eggs or sperm).
- Surgery, including an operation to reverse prior surgery that prevented the person operated on from having children.

Founder's Fee

See *Lifetime Care—Advance Payments*, later.

Guide Dog or Other Service Animal

You can include in medical expenses the costs of buying, training, and maintaining a guide dog or other service animal to assist a visually impaired or hearing disabled person, or a person with other physical disabilities. In general, this includes any costs, such as food, grooming, and veterinary care, incurred in maintaining the health and vitality of the service animal so that it may perform its duties.

Health Institute

You can include in medical expenses fees you pay for treatment at a health institute only if the treatment is prescribed by a physician and the physician issues a statement that the treatment is necessary to alleviate a physical or mental defect or illness of the individual receiving the treatment.

Health Maintenance Organization (HMO)

You can include in medical expenses amounts you pay to entitle you, your spouse, or a dependent to receive medical care from an HMO. These amounts are treated as medical insurance premiums. See *Insurance Premiums*, later.

Hearing Aids

You can include in medical expenses the cost of a hearing aid and batteries, repairs, and maintenance needed to operate it.

Home Care

See *Nursing Services*, later.

Home Improvements

See *Capital Expenses*, earlier.

Hospital Services

You can include in medical expenses amounts you pay for the cost of inpatient care at a hospital or similar institution if a principal reason for being there is to receive medical care. This includes amounts paid for meals and lodging. Also see *Lodging*, later.

Insurance Premiums

You can include in medical expenses insurance premiums you pay for policies that cover medical care. Medical care policies can provide payment for treatment that includes:

- Hospitalization, surgical services, X-rays,
- Prescription drugs and insulin,
- Dental care,
- Replacement of lost or damaged contact lenses, and
- Long-term care (subject to additional limitations). See *Qualified Long-Term Care Insurance Contracts* under *Long-Term Care*, later.

If you have a policy that provides payments for other than medical care, you can include the premiums for the medical care part of the policy if the charge for the medical part is reasonable. The cost of the medical part must be separately stated in the insurance contract or given to you in a separate statement.

Health coverage tax credit. If, during 2012, you were an eligible trade adjustment assistance (TAA) recipient, alternative TAA (ATAA) recipient, reemployment TAA (RTAA) recipient, or Pension Benefit Guaranty Corporation (PBGC) pension recipient, you must complete Form 8885 before completing Schedule A, line 1. When figuring the amount of insurance premiums you can deduct on Schedule A, do not include:

- Any amounts you included on Form 8885, line 4,
- Any qualified health insurance premiums you paid to "U.S. Treasury–HCTC," or
- Any health coverage tax credit advance payments shown in box 1 of Form 1099-H.

Employer-Sponsored Health Insurance Plan

Do not include in your medical and dental expenses any insurance premiums paid by an employer-sponsored health insurance plan unless the premiums are included in box 1 of your Form W-2, Wage and Tax Statement. Also, do not include any other medical and dental expenses paid by the plan unless the amount paid is included in box 1 of your Form W-2.

Example. You are a federal employee participating in the premium conversion plan of the Federal Employee Health Benefits (FEHB) program. Your share of the FEHB premium is paid by making a pre-tax reduction in your salary. Because you are an employee whose insurance premiums are paid with money that is never included in your gross income, you cannot deduct the premiums paid with that money.

Long-term care services. Contributions made by your employer to provide coverage for qualified long-term care services under a flexible spending or similar arrangement must be included in your income. This amount will be reported as wages in box 1 of your Form W-2.

Retired public safety officers. If you are a retired public safety officer, do not include as medical expenses any health or long-term care insurance premiums that you elected to have paid with tax-free distributions from a retirement plan. This applies only to distributions that would otherwise be included in income.

Health reimbursement arrangement (HRA). If you have medical expenses that are reimbursed by a health reimbursement arrangement, you cannot include those expenses in your medical expenses. This is because an HRA is funded solely by the employer.

Medicare A

If you are covered under social security (or if you are a government employee who paid Medicare tax), you are enrolled in Medicare A. The payroll tax paid for Medicare A is not a medical expense.

If you are not covered under social security (or were not a government employee who paid Medicare tax), you can voluntarily enroll in Medicare A. In this situation you can include the premiums you paid for Medicare A as a medical expense.

Medicare B

Medicare B is a supplemental medical insurance. Premiums you pay for Medicare B are a medical expense. Check the information you received from the Social Security Administration to find out your premium.

Medicare D

Medicare D is a voluntary prescription drug insurance program for persons with Medicare A or B. You can include as a medical expense premiums you pay for Medicare D.

Prepaid Insurance Premiums

Premiums you pay before you are age 65 for insurance for medical care for yourself, your spouse, or your dependents after you reach age 65 are medical care expenses in the year paid if they are:

1. Payable in equal yearly installments or more often, and
2. Payable for at least 10 years, or until you reach age 65 (but not for less than 5 years).

Unused Sick Leave Used To Pay Premiums

You must include in gross income cash payments you receive at the time of retirement for unused sick leave. You also must include in gross income the value of unused sick leave that, at your option, your employer applies to the cost of your continuing participation in your employer's health plan after you retire. You can include this cost of continuing participation in the health plan as a medical expense.

If you participate in a health plan where your employer automatically applies the value of unused sick leave to the cost of your continuing participation in the health plan (and you do not have the option to receive cash), do not include the value of the unused sick leave in gross income. You cannot include this cost of continuing participation in that health plan as a medical expense.

Insurance Premiums You Cannot Include

You cannot include premiums you pay for:

- Life insurance policies,
- Policies providing payment for loss of earnings,
- Policies for loss of life, limb, sight, etc.,
- Policies that pay you a guaranteed amount each week for a stated number of weeks if you are hospitalized for sickness or injury,
- The part of your car insurance that provides medical insurance coverage for all persons injured in or by your car because the part of the premium providing insurance for you, your spouse, and your dependents is not stated separately from the part of the premium providing insurance for medical care for others, or
- Health or long-term care insurance if you elected to pay these premiums with tax-free distributions from a retirement plan made directly to the insurance provider and these distributions would otherwise have been included in income.

Taxes imposed by any governmental unit, such as Medicare taxes, are not insurance premiums.

Coverage for nondependents. Generally, you cannot deduct any additional premium you pay as the result of including on your policy someone who is not your spouse or dependent, even if that person is your child under age 27. However, you can deduct the additional premium if that person is:

- Your child whom you do not claim as a dependent because of the rules for children of divorced or separated parents,
- Any person you could have claimed as a dependent on your return except that person received $3,800 or more of gross income or filed a joint return, or
- Any person you could have claimed as a dependent except that you, or your spouse if filing jointly, can be claimed as a dependent on someone else's 2012 return.

Also, if you had family coverage when you added this individual to your policy and your premiums did not increase, you can enter on line 1 the full amount of your medical and dental insurance premiums.

Intellectually and Developmentally Disabled, Special Home for

You can include in medical expenses the cost of keeping a person who is intellectually and developmentally disabled in a special home, not the home of a relative, on the recommendation of a psychiatrist to help the person adjust from life in a mental hospital to community living.

Laboratory Fees

You can include in medical expenses the amounts you pay for laboratory fees that are part of medical care.

Lactation Expenses

See *Breast Pumps and Supplies*, earlier.

Lead-Based Paint Removal

You can include in medical expenses the cost of removing lead-based paints from surfaces in your home to prevent a child who has or had lead poisoning from eating the paint.

These surfaces must be in poor repair (peeling or cracking) or within the child's reach. The cost of repainting the scraped area is not a medical expense.

If, instead of removing the paint, you cover the area with wallboard or paneling, treat these items as capital expenses. See *Capital Expenses*, earlier. Do not include the cost of painting the wallboard as a medical expense.

Learning Disability

See *Special Education*, later.

Legal Fees

You can include in medical expenses legal fees you paid that are necessary to authorize treatment for mental illness. However, you cannot include in medical expenses fees for the management of a guardianship estate, fees for conducting the affairs of the person being treated, or other fees that are not necessary for medical care.

Lifetime Care—Advance Payments

You can include in medical expenses a part of a life-care fee or "founder's fee" you pay either monthly or as a lump sum under an agreement with a retirement home. The part of the payment you include is the amount properly allocable to medical care. The agreement must require that you pay a specific fee as a condition for the home's promise to provide lifetime care that includes medical care. You can use a statement from the retirement home to prove the amount properly allocable to medical care. The statement must be based either on the home's prior experience or on information from a comparable home.

Dependents with disabilities. You can include in medical expenses advance payments to a private institution for lifetime care, treatment, and training of your physically or mentally impaired child upon your death or when you become unable to provide care. The payments must be a condition for the institution's future acceptance of your child and must not be refundable.

Payments for future medical care. Generally, you cannot include in medical expenses current payments for medical care (including medical insurance) to be provided substantially beyond the end of the year. This rule does not apply in situations where the future care is purchased in connection with obtaining lifetime care of the type described earlier.

Lodging

You can include in medical expenses the cost of meals and lodging at a hospital or similar institution if a principal reason for being there is to receive medical care. See *Nursing Home*, later.

You may be able to include in medical expenses the cost of lodging not provided in a hospital or similar institution. You can include the cost of such lodging while away from home if all of the following requirements are met.

1. The lodging is primarily for and essential to medical care.
2. The medical care is provided by a doctor in a licensed hospital or in a medical care facility related to, or the equivalent of, a licensed hospital.
3. The lodging is not lavish or extravagant under the circumstances.
4. There is no significant element of personal pleasure, recreation, or vacation in the travel away from home.

The amount you include in medical expenses for lodging cannot be more than $50 for each night for each person. You can include lodging for a person traveling with the person receiving the medical care. For example, if a parent is traveling with a sick child, up to $100 per night can be included as a medical expense for lodging. Meals are not included.

Do not include the cost of lodging while away from home for medical treatment if that treatment is not received from a doctor in a licensed hospital or in a medical care facility related to, or the equivalent of, a licensed hospital or if that lodging is not primarily for or essential to the medical care received.

Long-Term Care

You can include in medical expenses amounts paid for qualified long-term care services and premiums paid for qualified long-term care insurance contracts.

Qualified Long-Term Care Services

Qualified long-term care services are necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, rehabilitative services, and maintenance and personal care services (defined later) that are:

1. Required by a chronically ill individual, and
2. Provided pursuant to a plan of care prescribed by a licensed health care practitioner.

Chronically ill individual. An individual is chronically ill if, within the previous 12 months, a licensed health care practitioner has certified that the individual meets either of the following descriptions.

1. He or she is unable to perform at least two activities of daily living without substantial assistance from another individual for at least 90 days, due to a loss of functional capacity. Activities of daily living are eating, toileting, transferring, bathing, dressing, and continence.
2. He or she requires substantial supervision to be protected from threats to health and safety due to severe cognitive impairment.

Maintenance and personal care services. Maintenance or personal care services is care which has as its primary purpose the providing of a chronically ill individual with needed assistance with his or her disabilities (including protection from threats to health and safety due to severe cognitive impairment).

Qualified Long-Term Care Insurance Contracts

A qualified long-term care insurance contract is an insurance contract that provides only coverage of qualified long-term care services. The contract must:

1. Be guaranteed renewable,
2. Not provide for a cash surrender value or other money that can be paid, assigned, pledged, or borrowed,
3. Provide that refunds, other than refunds on the death of the insured or complete surrender or cancellation of the contract, and dividends under the contract must be used only to reduce future premiums or increase future benefits, and
4. Generally not pay or reimburse expenses incurred for services or items that would be reimbursed under Medicare, except where Medicare is a secondary payer, or the contract makes *per diem* or other periodic payments without regard to expenses.

The amount of qualified long-term care premiums you can include is limited. You can include the following as medical expenses on Schedule A (Form 1040).

1. Qualified long-term care premiums up to the amounts shown below.
   a. Age 40 or under – $350.
   b. Age 41 to 50 – $660.
   c. Age 51 to 60 – $1,310.
   d. Age 61 to 70 – $3,500.
   e. Age 71 or over – $4,370.
2. Unreimbursed expenses for qualified long-term care services.

Note. The limit on premiums is for each person.

Also, if you are an eligible retired public safety officer, you cannot include premiums for long-term care insurance if you elected to pay these premiums with tax-free distributions from a qualified retirement plan made directly to the insurance provider and these distributions would otherwise have been included in your income.

Meals

You can include in medical expenses the cost of meals at a hospital or similar institution if a principal reason for being there is to get medical care.

You cannot include in medical expenses the cost of meals that are not part of inpatient care. Also see *Weight-Loss Program* and *Nutritional Supplements*, later.

Medical Conferences

You can include in medical expenses amounts paid for admission and transportation to a medical conference if the medical conference concerns the chronic illness of yourself, your spouse, or your dependent. The costs of the medical conference must be primarily for and necessary to the medical care of you, your spouse, or your dependent. The majority of the time spent at the conference must be spent attending sessions on medical information.

The cost of meals and lodging while attending the conference is not deductible as a medical expense.

Medical Information Plan

You can include in medical expenses amounts paid to a plan that keeps medical information in a computer data bank and retrieves and furnishes the information upon request to an attending physician.

Medicines

You can include in medical expenses amounts you pay for prescribed medicines and drugs. A prescribed drug is one that requires a prescription by a doctor for its use by an individual. You can also include amounts you pay for insulin. Except for insulin, you cannot include in medical expenses amounts you pay for a drug that is not prescribed.

Imported medicines and drugs. If you imported medicines or drugs from other countries, see *Medicines and Drugs From Other Countries*, under *What Expenses Are Not Includible,* later.

Nursing Home

You can include in medical expenses the cost of medical care in a nursing home, home for the aged, or similar institution, for yourself, your spouse, or your dependents. This includes the cost of meals and lodging in the home if a principal reason for being there is to get medical care.

Do not include the cost of meals and lodging if the reason for being in the home is personal. You can, however, include in medical expenses the part of the cost that is for medical or nursing care.

Nursing Services

You can include in medical expenses wages and other amounts you pay for nursing services. The services need not be performed by a nurse as long as the services are of a kind generally performed by a nurse. This includes services connected with caring for the patient's condition, such as giving medication or changing dressings, as well

as bathing and grooming the patient. These services can be provided in your home or another care facility.

Generally, only the amount spent for nursing services is a medical expense. If the attendant also provides personal and household services, amounts paid to the attendant must be divided between the time spent performing household and personal services and the time spent for nursing services. For example, because of your medical condition you pay a visiting nurse $300 per week for medical and household services. She spends 10% of her time doing household services such as washing dishes and laundry. You can include only $270 per week as medical expenses. The $30 (10% × $300) allocated to household services cannot be included. However, certain maintenance or personal care services provided for qualified long-term care can be included in medical expenses. See *Maintenance and personal care services* under *Long-Term Care*, earlier. Additionally, certain expenses for household services or for the care of a qualifying individual incurred to allow you to work may qualify for the child and dependent care credit. See Publication 503, Child and Dependent Care Expenses.

You can also include in medical expenses part of the amount you pay for that attendant's meals. Divide the food expense among the household members to find the cost of the attendant's food. Then divide that cost in the same manner as in the preceding paragraph. If you had to pay additional amounts for household upkeep because of the attendant, you can include the extra amounts with your medical expenses. This includes extra rent or utilities you pay because you moved to a larger apartment to provide space for the attendant.

Employment taxes. You can include as a medical expense social security tax, FUTA, Medicare tax, and state employment taxes you pay for an attendant who provides medical care. If the attendant also provides personal and household services, you can include as a medical expense only the amount of employment taxes paid for medical services as explained earlier. For information on employment tax responsibilities of household employers, see Publication 926, Household Employer's Tax Guide.

Operations

You can include in medical expenses amounts you pay for legal operations that are not for unnecessary cosmetic surgery. See *Cosmetic Surgery* under *What Expenses Are Not Includible*, later.

Optometrist

See *Eyeglasses*, earlier.

Organ Donors

See *Transplants*, later.

Osteopath

You can include in medical expenses amounts you pay to an osteopath for medical care.

Oxygen

You can include in medical expenses amounts you pay for oxygen and oxygen equipment to relieve breathing problems caused by a medical condition.

Physical Examination

You can include in medical expenses the amount you pay for an annual physical examination and diagnostic tests by a physician. You do not have to be ill at the time of the examination.

Example. Beth goes to see Dr. Hayes for her annual check-up. Dr. Hayes does a physical examination and has some lab tests done. Beth can include the cost of the exam and lab tests in her medical expenses, if her insurance does not cover the cost.

Pregnancy Test Kit

You can include in medical expenses the amount you pay to purchase a pregnancy test kit to determine if you are pregnant.

Prosthesis

See *Artificial Limb* and *Breast Reconstruction Surgery*, earlier.

Psychiatric Care

You can include in medical expenses amounts you pay for psychiatric care. This includes the cost of supporting a mentally ill dependent at a specially equipped medical center where the dependent receives medical care. See *Psychoanalysis*, next, and *Transportation*, later.

Psychoanalysis

You can include in medical expenses payments for psychoanalysis. However, you cannot include payments for psychoanalysis that is part of required training to be a psychoanalyst.

Psychologist

You can include in medical expenses amounts you pay to a psychologist for medical care.

Special Education

You can include in medical expenses fees you pay on a doctor's recommendation for a child's tutoring by a teacher who is specially trained and qualified to work with

children who have learning disabilities caused by mental or physical impairments, including nervous system disorders.

You can include in medical expenses the cost (tuition, meals, and lodging) of attending a school that furnishes special education to help a child to overcome learning disabilities. A doctor must recommend that the child attend the school. Overcoming the learning disabilities must be a principal reason for attending the school, and any ordinary education received must be incidental to the special education provided. Special education includes:

- Teaching Braille to a visually impaired person,
- Teaching lip reading to a hearing disabled person, or
- Giving remedial language training to correct a condition caused by a birth defect.

You cannot include in medical expenses the cost of sending a problem child to a school where the course of study and the disciplinary methods have a beneficial effect on the child's attitude if the availability of medical care in the school is not a principal reason for sending the student there.

Sterilization

You can include in medical expenses the cost of a legal sterilization (a legally performed operation to make a person unable to have children). Also see *Vasectomy*, later.

Stop-Smoking Programs

You can include in medical expenses amounts you pay for a program to stop smoking. However, you cannot include in medical expenses amounts you pay for drugs that do not require a prescription, such as nicotine gum or patches, that are designed to help stop smoking.

Surgery

See *Operations*, earlier.

Telephone

You can include in medical expenses the cost of special telephone equipment that lets a person with a hearing or speech disability communicate over a regular telephone. This includes teletypewriter (TTY) and telecommunications device for the deaf (TDD) equipment. You can also include the cost of repairing the equipment.

Television

You can include in medical expenses the cost of equipment that displays the audio part of television programs as subtitles for persons with a hearing disability. This may be the cost of an adapter that attaches to a regular set. It also may be the part of the cost of a specially equipped television that exceeds the cost of the same model regular television set.

Therapy

You can include in medical expenses amounts you pay for therapy received as medical treatment.

Transplants

You can include in medical expenses amounts paid for medical care you receive because you are a donor or a possible donor of a kidney or other organ. This includes transportation.

You can include any expenses you pay for the medical care of a donor in connection with the donating of an organ. This includes transportation.

Transportation

You can include in medical expenses amounts paid for transportation primarily for, and essential to, medical care.

You can include:

- Bus, taxi, train, or plane fares or ambulance service,
- Transportation expenses of a parent who must go with a child who needs medical care,
- Transportation expenses of a nurse or other person who can give injections, medications, or other treatment required by a patient who is traveling to get medical care and is unable to travel alone, and
- Transportation expenses for regular visits to see a mentally ill dependent, if these visits are recommended as a part of treatment.

Car expenses. You can include out-of-pocket expenses, such as the cost of gas and oil, when you use a car for medical reasons. You cannot include depreciation, insurance, general repair, or maintenance expenses.

If you do not want to use your actual expenses for 2012, you can use the standard medical mileage rate of 23 cents a mile.

You can also include parking fees and tolls. You can add these fees and tolls to your medical expenses whether you use actual expenses or the standard mileage rate.

Example. In 2012, Bill Jones drove 2,800 miles for medical reasons. He spent $500 for gas, $30 for oil, and $100 for tolls and parking. He wants to figure the amount he can include in medical expenses both ways to see which gives him the greater deduction.

He figures the actual expenses first. He adds the $500 for gas, the $30 for oil, and the $100 for tolls and parking for a total of $630.

He then figures the standard mileage amount. He multiplies 2,800 miles by 23 cents a mile for a total of $644. He then adds the $100 tolls and parking for a total of $744.

Bill includes the $744 of car expenses with his other medical expenses for the year because the $744 is more than the $630 he figured using actual expenses.

Transportation expenses you cannot include. You cannot include in medical expenses the cost of transportation in the following situations.

- Going to and from work, even if your condition requires an unusual means of transportation.
- Travel for purely personal reasons to another city for an operation or other medical care.
- Travel that is merely for the general improvement of one's health.
- The costs of operating a specially equipped car for other than medical reasons.

Trips

You can include in medical expenses amounts you pay for transportation to another city if the trip is primarily for, and essential to, receiving medical services. You may be able to include up to $50 for each night for each person. You can include lodging for a person traveling with the person receiving the medical care. For example, if a parent is traveling with a sick child, up to $100 per night can be included as a medical expense for lodging. Meals are not included. See *Lodging*, earlier.

You cannot include in medical expenses a trip or vacation taken merely for a change in environment, improvement of morale, or general improvement of health, even if the trip is made on the advice of a doctor. However, see *Medical Conferences*, earlier.

Tuition

Under special circumstances, you can include charges for tuition in medical expenses. See *Special Education*, earlier.

You can include charges for a health plan included in a lump-sum tuition fee if the charges are separately stated or can easily be obtained from the school.

Vasectomy

You can include in medical expenses the amount you pay for a vasectomy.

Vision Correction Surgery

See *Eye Surgery*, earlier.

Weight-Loss Program

You can include in medical expenses amounts you pay to lose weight if it is a treatment for a specific disease diagnosed by a physician (such as obesity, hypertension, or heart disease). This includes fees you pay for membership in a weight reduction group as well as fees for attendance at periodic meetings. You cannot include membership dues in a gym, health club, or spa as medical expenses, but you can include separate fees charged there for weight loss activities.

You cannot include the cost of diet food or beverages in medical expenses because the diet food and beverages substitute for what is normally consumed to satisfy nutritional needs. You can include the cost of special food in medical expenses only if:

1. The food does not satisfy normal nutritional needs,
2. The food alleviates or treats an illness, and
3. The need for the food is substantiated by a physician.

The amount you can include in medical expenses is limited to the amount by which the cost of the special food exceeds the cost of a normal diet. See also *Weight-Loss Program* under *What Expenses Are Not Includible,* later.

Wheelchair

You can include in medical expenses amounts you pay for an autoette or a wheelchair used mainly for the relief of sickness or disability, and not just to provide transportation to and from work. The cost of operating and maintaining the autoette or wheelchair is also a medical expense.

Wig

You can include in medical expenses the cost of a wig purchased upon the advice of a physician for the mental health of a patient who has lost all of his or her hair from disease.

X-ray

You can include in medical expenses amounts you pay for X-rays for medical reasons.

What Expenses Are Not Includible?

Following is a list of some items that you cannot include in figuring your medical expense deduction. The items are listed in alphabetical order.

Baby Sitting, Childcare, and Nursing Services for a Normal, Healthy Baby

You cannot include in medical expenses amounts you pay for the care of children, even if the expenses enable you, your spouse, or your dependent to get medical or dental treatment. Also, any expense allowed as a childcare credit cannot be treated as an expense paid for medical care.

Controlled Substances

You cannot include in medical expenses amounts you pay for controlled substances (such as marijuana, laetrile, etc.). Such substances may be legalized by state law. However, they are in violation of federal law and cannot be included in medical expenses.

Cosmetic Surgery

Generally, you cannot include in medical expenses the amount you pay for unnecessary cosmetic surgery. This includes any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease. You generally cannot include in medical expenses the amount you pay for procedures such as face lifts, hair transplants, hair removal (electrolysis), and liposuction.

You can include in medical expenses the amount you pay for cosmetic surgery if it is necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease.

Example. An individual undergoes surgery that removes a breast as part of treatment for cancer. She pays a surgeon to reconstruct the breast. The surgery to reconstruct the breast corrects a deformity directly related to the disease. The cost of the surgery is includible in her medical expenses.

Dancing Lessons

You cannot include in medical expenses the cost of dancing lessons, swimming lessons, etc., even if they are recommended by a doctor, if they are only for the improvement of general health.

Diaper Service

You cannot include in medical expenses the amount you pay for diapers or diaper services, unless they are needed to relieve the effects of a particular disease.

Electrolysis or Hair Removal

See *Cosmetic Surgery*, earlier.

Flexible Spending Account

You cannot include in medical expenses amounts for which you are fully reimbursed by your flexible spending account if you contribute a part of your income on a pre-tax basis to pay for the qualified benefit.

Funeral Expenses

You cannot include in medical expenses amounts you pay for funerals.

Future Medical Care

Generally, you cannot include in medical expenses current payments for medical care (including medical insurance) to be provided substantially beyond the end of the year. This rule does not apply in situations where the future care is purchased in connection with obtaining lifetime care or long-term care of the type described at *Lifetime Care—Advance Payments* or *Long-Term Care*, earlier under *What Medical Expenses Are Includible.*

Hair Transplant

See *Cosmetic Surgery*, earlier.

Health Club Dues

You cannot include in medical expenses health club dues or amounts paid to improve one's general health or to relieve physical or mental discomfort not related to a particular medical condition.

You cannot include in medical expenses the cost of membership in any club organized for business, pleasure, recreation, or other social purpose.

Health Coverage Tax Credit

You cannot include in medical expenses amounts you pay for health insurance that you use in figuring your health coverage tax credit. For more information, see *Health Coverage Tax Credit*, later.

Health Savings Accounts

You cannot include in medical expenses any payment or distribution for medical expenses out of a health savings account. Contributions to health savings accounts are deducted separately. See Publication 969.

Household Help

You cannot include in medical expenses the cost of household help, even if such help is recommended by a doctor. This is a personal expense that is not deductible. However, you may be able to include certain expenses paid to a person providing nursing-type services. For more information, see *Nursing Services*, earlier under *What Medical Expenses Are Includible*. Also, certain maintenance or personal care services provided for qualified long-term care can be included in medical expenses. For more information, see *Long-Term Care*, earlier under *What Medical Expenses Are Includible.*

Illegal Operations and Treatments

You cannot include in medical expenses amounts you pay for illegal operations, treatments, or controlled substances whether rendered or prescribed by licensed or unlicensed practitioners.

Insurance Premiums

See *Insurance Premiums* under *What Medical Expenses Are Includible*, earlier.

Maternity Clothes

You cannot include in medical expenses amounts you pay for maternity clothes.

Medical Savings Account (MSA)

You cannot include in medical expenses amounts you contribute to an Archer MSA. You cannot include expenses you pay for with a tax-free distribution from your Archer MSA. You also cannot use other funds equal to the amount of the distribution and include the expenses. For more information on Archer MSAs, see Publication 969.

Medicines and Drugs From Other Countries

In general, you cannot include in your medical expenses the cost of a prescribed drug brought in (or ordered shipped) from another country. You can only include the cost of a drug that was imported legally. For example, you can include the cost of a prescribed drug the Food and Drug Administration announces can be legally imported by individuals.

You can include the cost of a prescribed drug you purchase and consume in another country if the drug is legal in both the other country and the United States.

Nonprescription Drugs and Medicines

Except for insulin, you cannot include in medical expenses amounts you pay for a drug that is not prescribed.

Example. Your doctor recommends that you take aspirin. Because aspirin is a drug that does not require a physician's prescription, you cannot include its cost in your medical expenses.

Nutritional Supplements

You cannot include in medical expenses the cost of nutritional supplements, vitamins, herbal supplements, "natural medicines," etc. unless they are recommended by a medical practitioner as treatment for a specific medical condition diagnosed by a physician. Otherwise, these items are taken to maintain your ordinary good health, and are not for medical care.

Personal Use Items

You cannot include in medical expenses the cost of an item ordinarily used for personal, living, or family purposes unless it is used primarily to prevent or alleviate a physical or mental defect or illness. For example, the cost of a toothbrush and toothpaste is a nondeductible personal expense.

In order to accommodate an individual with a physical defect, you may have to purchase an item ordinarily used as a personal, living, or family item in a special form. You can include the excess of the cost of the item in a special form over the cost of the item in normal form as a medical expense. (See *Braille Books and Magazines* under *What Medical Expenses Are Includible*, earlier.)

Swimming Lessons

See *Dancing Lessons*, earlier.

Teeth Whitening

You cannot include in medical expenses amounts paid to whiten teeth. See *Cosmetic Surgery*, earlier.

Veterinary Fees

You generally cannot include veterinary fees in your medical expenses, but see *Guide Dog or Other Service Animal* under *What Medical Expenses Are Includible*, earlier.

Weight-Loss Program

You cannot include in medical expenses the cost of a weight-loss program if the purpose of the weight loss is the improvement of appearance, general health, or sense of well-being. You cannot include amounts you pay to lose weight unless the weight loss is a treatment for a specific disease diagnosed by a physician (such as obesity, hypertension, or heart disease). If the weight-loss treatment is not for a specific disease diagnosed by a physician, you cannot include either the fees you pay for membership in a weight reduction group or fees for attendance at periodic meetings. Also, you cannot include membership dues in a gym, health club, or spa.

You cannot include the cost of diet food or beverages in medical expenses because the diet food and beverages substitute for what is normally consumed to satisfy nutritional needs.

See *Weight-Loss Program* under *What Medical Expenses Are Includible*, earlier.

How Do You Treat Reimbursements?

You can include in medical expenses only those amounts paid during the tax year for which you received no insurance or other reimbursement.

Insurance Reimbursement

You must reduce your total medical expenses for the year by all reimbursements for medical expenses that you receive from insurance or other sources during the year. This includes payments from Medicare.

Even if a policy provides reimbursement only for certain specific medical expenses, you must use amounts you receive from that policy to reduce your total medical

expenses, including those it does not provide reimbursement for.

Example. You have insurance policies that cover your hospital and doctors' bills but not your nursing bills. The insurance you receive for the hospital and doctors' bills is more than their charges. In figuring your medical deduction, you must reduce the total amount you spent for medical care by the total amount of insurance you received, even if the policies do not cover some of your medical expenses.

Health reimbursement arrangement (HRA). A health reimbursement arrangement is an employer-funded plan that reimburses employees for medical care expenses and allows unused amounts to be carried forward. An HRA is funded solely by the employer and the reimbursements for medical expenses, up to a maximum dollar amount for a coverage period, are not included in your income.

Other reimbursements. Generally, you do not reduce medical expenses by payments you receive for:

- Permanent loss or loss of use of a member or function of the body (loss of limb, sight, hearing, etc.) or disfigurement to the extent the payment is based on the nature of the injury without regard to the amount of time lost from work, or
- Loss of earnings.

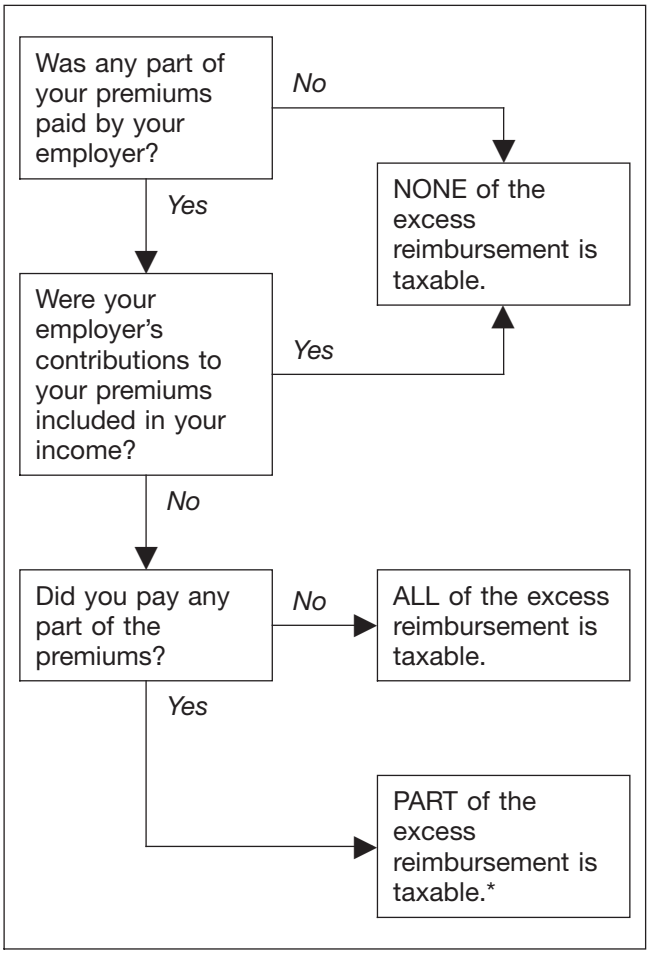
You must, however, reduce your medical expenses by any part of these payments that is designated for medical costs. See *How Do You Figure and Report the Deduction on Your Tax Return*, later.

For how to treat damages received for personal injury or sickness, see *Damages for Personal Injuries,* later.

What If Your Insurance Reimbursement Is More Than Your Medical Expenses?

If you are reimbursed more than your medical expenses, you may have to include the excess in income. You may want to use Figure 1 to help you decide if any of your reimbursement is taxable.

Figure 1. **Is Your Excess Medical Reimbursement Taxable?**



*See *Premiums paid by you and your employer.*

Premiums paid by you. If you pay either the entire premium for your medical insurance or all the costs of a plan similar to medical insurance and your insurance payments or other reimbursements are more than your total medical expenses for the year, you have excess reimbursement. Generally, you do not include the excess reimbursement in your gross income. However, gross income does include total payments in excess of $310 a day ($113,460 for 2012) for qualified long-term care services.

Premiums paid by you and your employer. If both you and your employer contribute to your medical insurance plan and your employer's contributions are not included in your gross income, you must include in your gross income the part of your excess reimbursement that is from your employer's contribution.

If you are not covered by more than one policy, you can figure the amount of the excess reimbursement you must include in gross income using Worksheet B. If you are covered under more than one policy, see *More than one policy*, later.

Worksheet B. **Excess Reimbursement Includible in Income When You Have Only One Policy**

Keep for Your Records

Instructions: Use this worksheet to figure the amount of excess reimbursement you must include in income when both you and your employer contributed to your medical insurance and your employer's contributions are not included in your gross income.

1. Enter the amount contributed to your medical insurance for the year by your employer.	**1.**	
2. Enter the total annual cost of the policy.	**2.**	
3. Divide line 1 by line 2	**3.**	
4. Enter the amount of excess reimbursement.	**4.**	
5. Multiply line 3 by line 4. This is the amount of the excess reimbursement you must include as other income on Form 1040, line 21.	**5.**	

Example. You are covered by your employer's medical insurance policy. The annual premium is $2,000. Your employer pays $600 of that amount, which is not included in your gross income, and the balance of $1,400 is taken out of your wages. You receive $500 excess reimbursement for your medical expenses. The part of the excess reimbursement you receive under the policy that is from your employer's contributions is figured as follows.

Worksheet B. **Excess Reimbursement Includible in Income When You Have Only One Policy—Illustrated**

Keep for Your Records

Instructions: Use this worksheet to figure the amount of excess reimbursement you must include in income when both you and your employer contributed to your medical insurance and your employer's contributions are not included in your gross income.

1. Enter the amount contributed to your medical insurance for the year by your employer.	**1.**	*600*
2. Enter the total annual cost of the policy.	**2.**	*2,000*
3. Divide line 1 by line 2	**3.**	*.30*
4. Enter the amount of excess reimbursement.	**4.**	*500*
5. Multiply line 3 by line 4. This is the amount of the excess reimbursement you must include as other income on Form 1040, line 21.	**5.**	*150*

You must include in your gross income 30% (.30) of $500, or $150, of the excess reimbursement you received for medical expenses under the policy.

Premiums paid by your employer. If your employer or your former employer pays the total cost of your medical insurance plan and your employer's contributions are not included in your income, you must report all of your excess reimbursement as other income.

More than one policy. If you are covered under more than one policy, the cost of at least one of which is paid by both you and your employer, you must first divide the medical expenses among the policies to figure the excess reimbursement from each policy. Then divide the policy costs to figure the part of any excess reimbursement that is from your employer's contribution. Any excess reimbursement that is due to your employer's contributions is includible in your income.

You can figure the part of the excess reimbursement that is from your employer's contribution by using Worksheet C. Use Worksheet C only if both you and your employer paid part of the cost of at least one policy. If you had more than one policy, but you did not share in the cost of at least one policy, do not use Worksheet C.

Worksheet C. **Excess Reimbursement Includible in Income When You Have More Than One Policy**

Keep for Your Records

Instructions: Use this worksheet to figure the amount of excess reimbursement you must include as income on your tax return when a) you are reimbursed under two or more health insurance policies, b) at least one of which is paid for by both you and your employer, and c) your employer's contributions are not included in your gross income. If you and your employer did not share in the cost of at least one policy, do not use this worksheet.

1. Enter the reimbursement from your employer's policy.	**1.**	
2. Enter the reimbursement from your own policy.	**2.**	
3. Add lines 1 and 2	**3.**	
4. Divide line 1 by line 3.	**4.**	
5. Enter the total medical expenses you paid during the year. If this amount is at least as much as the amount on line 3, stop here because there is no excess reimbursement.	**5.**	
6. Multiply line 4 by line 5	**6.**	
7. Subtract line 6 from line 1	**7.**	
8. Enter employer's contribution to the annual cost of the employer's policy.	**8.**	

9.	Enter total annual cost of the employer's policy.	**9.**	
10.	Divide line 8 by line 9. This is the percentage of your total excess reimbursement you must report as other income.	**10.**	
11.	Multiply line 7 by line 10. This is the amount of your total excess reimbursement you must report as other income on Form 1040, line 21.	**11.**	

Example. You are covered by your employer's health insurance policy. The annual premium is $1,200. Your employer pays $300 and the balance of $900 is deducted from your wages. You also paid the entire premium ($250) for a personal health insurance policy.

During the year, you paid medical expenses of $3,600. In the same year, you were reimbursed $2,400 under your employer's policy and $1,600 under your own personal policy. The amount you must report as other income is figured as follows.

Worksheet C. **Excess Reimbursement Includible in Income When You Have More Than One Policy—Illustrated**

Instructions: Use this worksheet to figure the amount of excess reimbursement you must include as income on your tax return when a) you are reimbursed under two or more health insurance policies, b) at least one of which is paid for by both you and your employer, and c) your employer's contributions are not included in your gross income. If you and your employer did not share in the cost of at least one policy, do not use this worksheet.

1.	Enter the reimbursement from your employer's policy.	**1.**	*2,400*
2.	Enter the reimbursement from your own policy.	**2.**	*1,600*
3.	Add lines 1 and 2	**3.**	*4,000*
4.	Divide line 1 by line 3	**4.**	*.60*
5.	Enter the total medical expenses you paid during the year. If this amount is at least as much as the amount on line 3, stop here because there is no excess reimbursement.	**5.**	*3,600*
6.	Multiply line 4 by line 5	**6.**	*2,160*
7.	Subtract line 6 from line 1	**7.**	*240*
8.	Enter employer's contribution to the annual cost of the employer's policy.	**8.**	*300*
9.	Enter total annual cost of the employer's policy.	**9.**	*1,200*
10.	Divide line 8 by line 9. This is the percentage of your total excess reimbursement you must report as other income.	**10.**	*.25*
11.	Multiply line 7 by line 10. This is the amount of your total excess reimbursement you must report as other income on Form 1040, line 21.	**11.**	*60*

What If You Receive Insurance Reimbursement in a Later Year?

If you are reimbursed in a later year for medical expenses you deducted in an earlier year, you generally must report the reimbursement as income up to the amount you previously deducted as medical expenses.

However, you do not report as income the amount of reimbursement you received up to the amount of your medical deductions that did not reduce your tax for the earlier year.

For more information about the recovery of an amount that you claimed as an itemized deduction in an earlier year, see *Recoveries* in Publication 525, Taxable and Nontaxable Income.

What If You Are Reimbursed for Medical Expenses You Did Not Deduct?

If you did not deduct a medical expense in the year you paid it because your medical expenses were not more than 7.5% of your AGI, or because you did not itemize deductions, do not include the reimbursement, up to the amount of the expense, in income. However, if the reimbursement is more than the expense, see *What If Your Insurance Reimbursement Is More Than Your Medical Expenses*, earlier.

Example. Last year, you had $500 of medical expenses. You cannot deduct the $500 because it is less than 7.5% of your AGI. If, in a later year, you are reimbursed for any of the $500 of medical expenses, you do not include that amount in your gross income.

How Do You Figure and Report the Deduction on Your Tax Return?

Once you have determined which medical expenses you can include, figure and report the deduction on your tax return.

What Tax Form Do You Use?

You report your medical expense deduction on Schedule A, Form 1040. You cannot claim medical expenses on Form 1040A, U.S. Individual Income Tax Return, or Form 1040EZ, Income Tax Return for Single and Joint Filers With No Dependents. An example of a filled-in medical and dental expense part of Schedule A is shown.

How Do You Figure Your Deduction?

To figure your medical and dental expense deduction, complete lines 1 through 4 of Schedule A, Form 1040, as follows:

Line 1. Enter the amount you paid for medical expenses after reducing the amount by payments you received from insurance and other sources.

Line 2. Enter your AGI from Form 1040, line 38.

Line 3. Multiply the amount on line 2 (AGI) by 7.5% (.075) and enter the result.

Line 4. If line 3 is more than line 1, enter -0-. Otherwise, subtract the amount on line 3 from the amount on line 1. This is your deduction for medical and dental expenses.

Example. Bill and Helen Jones belong to a group medical plan and part of their insurance is paid by Bill's employer. They file a joint return, and their AGI is $33,004. The following list shows the net amounts, after insurance reimbursements, that Bill and Helen paid this year for medical expenses.

1. For themselves, Bill and Helen paid $375 for prescription medicines and drugs, $337 for hospital bills, $439 for doctor bills, $295 for hospitalization insurance, $380 for medical and surgical insurance, and $33 for transportation for medical treatment, which totals $1,859.
2. For Grace Taylor (Helen's dependent mother), they paid $300 for doctors, $300 for insulin, and $175 for eyeglasses, which totals $775.
3. For Betty Jones (Bill's dependent sister), they paid $450 for doctors and $350 for prescription medicines and drugs, which totals $800.

Bill and Helen add all their medical and dental expenses together ($1,859 + $775 + $800 = $3,434). They figure their deduction on the medical and dental expenses part of Schedule A, Form 1040.

Recordkeeping. For each medical expense, you should keep a record of:

- The name and address of each person you paid, and
- The amount and date of each payment.

You can keep a record like the following.

Record of medical expenses

	Name of person paid	Address of person paid	Amount paid	Date paid	Transportation (mileage, taxi, etc.)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					

You should also keep a statement or itemized invoice showing the following.

- What medical care was received.
- Who received the care.
- The nature and purpose of any other medical expenses.
- Who the other medical expenses were for.
- The amount of the other medical expenses and the date of payment.

Do not send these records with your return.

Sale of Medical Equipment or Property

If you deduct the cost of medical equipment or property in one year and sell it in a later year, you may have a taxable gain. The taxable gain is the amount of the selling price that is more than the adjusted basis of the equipment or property.

The adjusted basis is the portion of the cost of the equipment or property that you could not deduct because of the 7.5% limit used to compute the medical deduction. Use Worksheet D, later, to figure the adjusted basis of the equipment or property.

Worksheet D. **Adjusted Basis of Medical Equipment or Property Sold**

Keep for Your Records

Instructions: Use this worksheet if you deducted the cost of medical equipment or property in one year and sold the equipment or property in a later year. This worksheet will give you the adjusted basis of the equipment or property you sold.

1.	Enter the cost of the equipment or property.	**1.** _____
2.	Enter your total includible medical expenses for the year you included the cost in your medical expenses.	**2.** _____
3.	Divide line 1 by line 2	**3.** _____
4.	Enter 7.5% of your AGI for the year the cost was included in your medical expenses ($15,000 x .075).	**4.** _____
5.	Multiply line 3 by line 4. If your allowable itemized deductions for the year you purchased the equipment or property were not more than your AGI for that year, stop here. This is the adjusted basis of the equipment or property. If your allowable itemized deductions for the year you purchased the equipment or property were more than your AGI for that year, complete lines 6 through 11.	**5.** _____
6.	Subtract line 5 from line 1	**6.** _____
7.	Enter your total allowable itemized deductions for the year the cost was included in your medical expenses.	**7.** _____
8.	Divide line 6 by line 7	**8.** _____
9.	Enter your AGI for the year the cost was included in your medical expenses.	**9.** _____
10.	Subtract line 9 from line 7	**10.** _____
11.	Multiply line 8 by line 10.	**11.** _____
12.	Add line 5 to line 11. If your allowable itemized deductions for the year you purchased the equipment or property were more than your AGI for that year, this is the adjusted basis of the equipment or property.	**12.** _____

Next, use Worksheet E to figure the total gain or loss on the sale of the medical equipment or property.

Worksheet E. **Gain or Loss On the Sale of Medical Equipment or Property**

Keep for Your Records

Instructions: Use the following worksheet to figure total gain or loss on the sale of medical equipment or property that you deducted in an earlier year.

1.	Enter the amount that the medical equipment or property sold for.	**1.** _____
2.	Enter your selling expenses	**2.** _____
3.	Subtract line 2 from line 1	**3.** _____
4.	Enter the adjusted basis of the equipment or property from Worksheet D, line 5, or line 12, if applicable.	**4.** _____
5.	Subtract line 4 from line 3. This is the total gain or loss from the sale of the medical equipment or property.	**5.** _____

If you have a loss, it is not deductible. If you have a gain, it is includible in your income. The part of the gain that is a recovery of an amount you previously deducted is taxable as ordinary income. Enter it on Form 1040, line 21. Any part of the gain that is more than the recovery of an amount you previously deducted is taxable as a capital gain. Enter it on Form 8949, Sales and Other Dispositions of Capital Assets, and Schedule D (Form 1040), Capital Gains and Losses.

For more information about the recovery of an amount that you claimed as an itemized deduction in an earlier year, see *Recoveries* in Publication 525.

Example. You have a heart condition and difficulty breathing. Your doctor prescribed oxygen equipment to help you breathe. Last year, you bought the oxygen equipment for $3,000. You itemized deductions and included it in your medical expense deduction.

Last year you also paid $10,750 for deductible medical services and $6,400 for other itemized deductions. Your AGI was $15,000.

Taking into account the 7.5% limit on medical expenses, your allowable itemized deductions totaled $19,025, figured as follows:

Oxygen equipment	3,000
Medical services	10,750
Total medical expenses	13,750
7.5% of AGI (.075 × $15,000)	–1,125
Allowable medical expense deduction	12,625
Other itemized deductions	6,400
Allowable itemized deductions	19,025

You figure your adjusted basis as shown on the filled-in Worksheet D.

Worksheet D. **Adjusted Basis of Medical Equipment or Property Sold—Illustrated**

Keep for Your Records

Instructions: Use this worksheet if you deducted the cost of medical equipment or property in one year and sold the equipment or property in a later year. This worksheet will give you the adjusted basis of the equipment or property you sold.

1.	Enter the cost of the equipment or property.	**1.**	3,000
2.	Enter your total includible medical expenses for the year you included the cost in your medical expenses.	**2.**	13,750
3.	Divide line 1 by line 2	**3.**	.218
4.	Enter 7.5% of your AGI for the year the cost was included in your medical expenses ($15,000 x .075).	**4.**	1,125
5.	Multiply line 3 by line 4. If your allowable itemized deductions for the year you purchased the equipment or property were not more than your AGI for that year, stop here. This is the adjusted basis of the equipment or property. If your allowable itemized deductions for the year you purchased the equipment or property were more than your AGI for that year, complete lines 6 through 11.	**5.**	245
6.	Subtract line 5 from line 1	**6.**	2,755
7.	Enter your total allowable itemized deductions for the year the cost was included in your medical expenses.	**7.**	19,025
8.	Divide line 6 by line 7	**8.**	.145
9.	Enter your AGI for the year the cost was included in your medical expenses.	**9.**	15,000
10.	Subtract line 9 from line 7	**10.**	4,025
11.	Multiply line 8 by line 10.	**11.**	584
12.	Add line 5 to line 11. If your allowable itemized deductions for the year you purchased the equipment or property were more than your AGI for that year, this is the adjusted basis of the equipment or property.	**12.**	829

This year you sold the oxygen equipment for $2,025 and you had selling expenses of $25. You must report on this year's tax return part of the $2,000 as ordinary income. To compute the part of the sales price that is taxable, you must determine the gain by subtracting the total adjusted basis from the selling price.

Worksheet E. **Gain or Loss On the Sale of Medical Equipment or Property—Illustrated**

Keep for Your Records

Instructions: Use the following worksheet to figure gain or loss on the sale of medical equipment or property that you deducted in an earlier year.

1.	Enter the amount that the medical equipment or property sold for.	**1.**	2,025
2.	Enter your selling expenses	**2.**	25
3.	Subtract line 2 from line 1	**3.**	2,000
4.	Enter the adjusted basis of the equipment or property from Worksheet D, line 5, or line 12, if applicable.	**4.**	829
5.	Subtract line 4 from line 3. This is the total gain or loss from the sale of the medical equipment or property.	**5.**	1,171

Damages for Personal Injuries

If you receive an amount in settlement of a personal injury suit, part of that award may be for medical expenses that you deducted in an earlier year. If it is, you must include that part in your income in the year you receive it to the extent it reduced your taxable income in the earlier year. See *What If You Receive Insurance Reimbursement in a Later Year*, discussed earlier under *How Do You Treat Reimbursements.*

Example. You sued this year for injuries you suffered in an accident last year. You sought $10,000 for your injuries and did not itemize your damages. Last year, you paid $500 for medical expenses for your injuries. You deducted those expenses on last year's tax return. This year you settled your lawsuit for $2,000. Your settlement did not itemize or allocate the damages. The $2,000 is first presumed to be for the medical expenses that you deducted. The $500 is includible in your income this year because you deducted the entire $500 as a medical expense deduction last year.

Future medical expenses. If you receive an amount in settlement of a damage suit for personal injuries, part of that award may be for future medical expenses. If it is, you

must reduce any future medical expenses for these injuries until the amount you received has been completely used.

Example. You were injured in an accident. You sued and sought a judgment of $50,000 for your injuries. You settled the suit for $45,000. The settlement provided that $10,000 of the $45,000 was for future medical expenses for your injuries. You cannot include the first $10,000 that you pay for medical expenses for those injuries.

Workers' compensation. If you received workers' compensation and you deducted medical expenses related to that injury, you must include the workers' compensation in income up to the amount you deducted. If you received workers' compensation, but did not deduct medical expenses related to that injury, do not include the workers' compensation in your income.

Impairment-Related Work Expenses

If you are a person with disabilities, you can take a business deduction for expenses that are necessary for you to be able to work. If you take a business deduction for these impairment-related work expenses, they are not subject to the 7.5% limit that applies to medical expenses.

You have a disability if you have:

- A physical or mental disability (for example, blindness or deafness) that functionally limits your being employed, or
- A physical or mental impairment (for example, a sight or hearing impairment) that substantially limits one or more of your major life activities, such as performing manual tasks, walking, speaking, breathing, learning, or working.

Impairment-related expenses defined. Impairment-related expenses are those ordinary and necessary business expenses that are:

- Necessary for you to do your work satisfactorily,
- For goods and services not required or used, other than incidentally, in your personal activities, and
- Not specifically covered under other income tax laws.

Where to report. If you are self-employed, deduct the business expenses on the appropriate form (Schedule C, C-EZ, E, or F) used to report your business income and expenses.

If you are an employee, complete Form 2106, Employee Business Expenses, or Form 2106-EZ, Unreimbursed Employee Business Expenses. Enter on Schedule A (Form 1040), line 28, that part of the amount on Form 2106, line 10, or Form 2106-EZ, line 6, that is related to your impairment. Enter the amount that is unrelated to your impairment on Schedule A (Form 1040), line 21. Your impairment-related work expenses are not subject to the 2%-of-adjusted-gross-income limit that applies to other employee business expenses.

Example. You are blind. You must use a reader to do your work. You use the reader both during your regular working hours at your place of work and outside your regular working hours away from your place of work. The reader's services are only for your work. You can deduct your expenses for the reader as business expenses.

Health Insurance Costs for Self-Employed Persons

If you were self-employed and had a net profit for the year, you may be able to deduct, as an adjustment to income, amounts paid for medical and qualified long-term care insurance on behalf of yourself, your spouse, your dependents, and your children who were under age 27 at the end of 2012. For this purpose, you were self-employed if you were a general partner (or a limited partner receiving guaranteed payments) or you received wages from an S corporation in which you were more than a 2% shareholder. The insurance plan must be established under your trade or business and the deduction cannot be more than your earned income from that trade or business.

You cannot deduct payments for medical insurance for any month in which you were eligible to participate in a health plan subsidized by your employer, your spouse's employer or an employer of your dependent or your child under age 27 at the end of 2012. You cannot deduct payments for a qualified long-term care insurance contract for any month in which you were eligible to participate in a long-term care insurance plan subsidized by your employer or your spouse's employer.

If you qualify to take the deduction, use the Self-Employed Health Insurance Deduction Worksheet in the Form 1040 instructions to figure the amount you can deduct. But if any of the following applies, do not use that worksheet.

- You had more than one source of income subject to self-employment tax.
- You file Form 2555, Foreign Earned Income, or Form 2555-EZ, Foreign Earned Income Exclusion.
- You are using amounts paid for qualified long-term care insurance to figure the deduction.

If you cannot use the worksheet in the Form 1040 instructions, use the worksheet in Publication 535, Business Expenses, to figure your deduction.

If, during 2012, you were an eligible trade adjustment assistance (TAA) recipient, alternative TAA (ATAA) recipient, reemployment TAA (RTAA) recipient, or Pension Benefit Guaranty Corporation pension recipient, see the instructions for Form 8885 to figure the amount to enter on line 1 of the worksheet.

When figuring the amount you can deduct for insurance premiums, do not include amounts paid for health insurance coverage with retirement plan distributions that were tax-free because you are a retired public safety officer.

Where to report. You take this deduction on Form 1040, line 29. If you itemize your deductions and do not claim 100% of your self-employed health insurance costs on line 29, include any remaining premiums with all other medical expenses on Schedule A (Form 1040), subject to the 7.5% limit.

Child under age 27. If the insurance policy covers your nondependent child who was under age 27 at the end of 2012, you can claim the premiums for that coverage on Form 1040, line 29. If you cannot claim 100% of your self-employed health insurance costs on line 29, any excess amounts attributable to that child are not eligible to be claimed on Schedule A (Form 1040).

Generally, family health insurance premiums do not increase if coverage for an additional child is added. If this is the situation, no allocation would be necessary. If the premiums did increase (such as where coverage was expanded from single to family to add the non-dependent child), you can allocate the amount on line 29 to the non-dependent child and any excess amounts not attributable to that child would be eligible to be claimed on Schedule A.

Example 1. Naomi is self-employed in 2012 and has self-only coverage for health insurance. Her premium for that coverage was $5,000 for the year. She changes to family coverage only to add her 26-year-old nondependent child to the plan. Her health insurance premium increases to $10,000 for the year. After completing the Self-Employed Health Insurance Deduction Worksheet for Form 1040, line 29, she can only deduct $4,000 on line 29. The $4,000 is allocable to the nondependent child. On Schedule A, she can only claim the $5,000 allocable to her coverage. She cannot claim the $1,000 excess premiums allocable to the nondependent child.

Example 2. The facts are the same as in Example 1, except that Naomi had family coverage when she added her 26-year-old nondependent child to the policy. There was no increase in the $10,000 premium. In this case, she could claim $4,000 on line 29 and $6,000 on Schedule A.

More information. For more information, see Publication 535.

COBRA Premium Assistance

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides that if you were covered under a group health plan and you would lose coverage because of a qualifying event, you should be allowed an opportunity to elect COBRA continuation health coverage under the plan. If there was no available election, your employer or the plan was subject to an excise tax. You can be required to pay the full premium for the COBRA continuation coverage.

If you are an assistance eligible individual, you pay 35% of the premium otherwise payable for this coverage and are treated as having paid the full premium. You are an assistance eligible individual if:

- You are a qualified beneficiary as a result of an involuntary termination that occurred during the period beginning on September 1, 2008, and ending on May 31, 2010, or had a reduction of hours during that period, which was followed by a termination of your employment that occurred after March 1, 2010, and before June 1, 2010,
- You are eligible for COBRA continuation coverage related to the qualifying event occurring during the period beginning on September 1, 2008, and
- You elect the coverage.

A qualified beneficiary is generally any individual who is covered under a group health plan on the day before the involuntary termination. This includes the covered employee, the employee's spouse, and the employee's dependent.

The premium assistance (the 65% reduction of the premium) applies to the first period of coverage beginning after February 16, 2009. The reduction applies until the earliest of:

1. The first date the assistance eligible individual becomes eligible for other group health plan coverage or Medicare coverage,
2. The date that is 15 months after the first day of the first month for which the reduced premium applies to the individual, or
3. The date the individual ceases to be eligible for COBRA continuation coverage.

The premium assistance is not included in your gross income. However, if your modified adjusted gross income (AGI) is more than $125,000 ($250,000 if married filing jointly) but not more than $145,000 ($290,000 if married filing jointly), your income tax for the year is increased by a percentage of the premium assistance. Use *Worksheet F* to figure the amount you must include as tax on your return. If your modified AGI is more than $145,000 ($290,000 if married filing jointly), your income tax for the tax year is increased by the total premium assistance. Include the increase in your income tax on Form 1040, line 60, or Form 1040NR, line 59. On the dotted line next to that line, enter the amount of the tax and identify it as "COBRA."

Worksheet F. **Recapture of COBRA Premium Assistance for Higher Income Taxpayers**

Keep for Your Records

Instructions: Use the following worksheet to figure the taxable portion of your COBRA premium if your modified AGI (line 3 below) is more than $125,000 ($250,000 if married filing jointly) but less than $145,000 ($290,000 if married filing jointly).

1.	Enter your AGI (Form 1040, line 38 or Form 1040NR, line 36)	**1.**
2.	Enter the total of any amounts from Form 2555, lines 45 and 50; Form 2555-EZ, line 18; and Form 4563, line 15, and any exclusion of income from American Samoa and Puerto Rico	**2.**
3.	Modified AGI. Add lines 1 and 2	**3.**
4.	Enter $125,000 ($250,000 if married filing jointly)	**4.**
5.	Subtract line 4 from line 3	**5.**
6.	Enter $20,000 ($40,000 if married filing jointly)	**6.**
7.	Divide line 5 by line 6. Enter the result as a decimal (rounded to at least 3 places)	**7.** .
8.	Enter the amount of the COBRA premium assistance* you received in 2012	**8.**
9.	Multiply line 8 by line 7. Enter result here and include it on Form 1040, line 60 or Form 1040NR, line 59. On the dotted line next to that line, enter the amount shown on line 9 and identify it as "COBRA."	**9.**

***Contact your former employer or health insurance plan to obtain the total premium assistance, if unknown.**

You may elect to permanently waive the right to the premium assistance. You will not receive the premium assistance and you will not have to include the assistance in your income tax if your modified AGI is more than $125,000 ($250,000 if married filing jointly). To make this election, give a signed and dated notification (include a reference to "permanent waiver") to the person to whom premiums are payable.

You will not qualify for the health coverage tax credit (discussed next) for any month for which you receive premium assistance.

For more information see Notice 2009-27, available at www.irs.gov/irb/2009-16_irb/ar09.

Health Coverage Tax Credit

If you paid the premiums for qualified health insurance coverage, you may be able to claim the health coverage tax credit (HCTC). If you are eligible, you can get monthly HCTC (advance payments), a yearly HCTC, or a combination of these methods (see *How To Take the Credit*, later). The HCTC is 72.5% of the payments made in 2012.

More information. For a complete discussion of the HCTC, visit IRS.gov and enter "HCTC" in the search box. Also, see Form 8885.

Who Can Take This Credit?

You can take this credit for any month in which all of the following were true on the first day of the month.

1. You were an eligible:
   a. Trade adjustment assistance (TAA) recipient,
   b. Alternative TAA recipient,
   c. Reemployment TAA recipient,
   d. Pension Benefit Guaranty Corporation (PBGC) pension payee, or
   e. You were a qualifying family member of an individual described in a, b, c, or d when he or she enrolled in Medicare, died, or got divorced. See *Family members in certain life events (enrollment in Medicare, death, or divorce)*, later.
2. You paid the premium for qualified health insurance coverage for yourself or a qualifying family member. See *Qualified Health Insurance*, later.
3. You were not imprisoned under federal, state, or local authority.
4. You did not have other specified coverage. See *Other Specified Coverage*, later.

If you were an eligible individual described in 1a, 1b, 1c, or 1d, your state's workforce agency (unemployment office) or the PBGC will notify the HCTC Program that you may be eligible for the credit. When notified, the HCTC Program will mail you an HCTC Eligibility Kit. If you have not received the Eligibility Kit, you may not be an eligible individual and not qualify for the credit. If you believe you are eligible for the HCTC and have not received an Eligibility Kit, go to *IRS.gov* and enter "HCTC" in the search box for information on how to contact the HCTC Program.

CAUTION *It can take the state or PBGC time to notify the HCTC Program about the event. You should make the full premium payments to your health plan until you are enrolled in the HCTC Program. You may be able to claim the yearly HCTC for these premiums when you file your tax return.*

No credit if dependent of another taxpayer. You cannot take this credit if you can be claimed as a dependent on someone else's tax return.

Qualifying Family Member

You can include the premiums you pay for qualified health insurance for qualifying family members in figuring your credit. A qualifying family member is:

- Your spouse (but see *Both spouses eligible* below), or
- Anyone whom you can claim as a dependent on your tax return. (For children whose parents are divorced, see *Children of divorced or separated parents*, later.)

However, anyone who has other specified coverage (defined later) is not a qualifying family member.

Both spouses eligible. Your spouse is not treated as a qualifying family member if all of the following are true.

- You are married at the end of the year.
- You and your spouse are both eligible recipients during the year.
- You file separate tax returns.

Married and living apart. For purposes of this credit, you are not considered married on the last day of the year if all of the following apply.

- You file a separate return.
- Your home is the home for more than half the year of a dependent under age 13 or a dependent who is physically or mentally not able to care for himself or herself.
- You pay more than half the cost of keeping up your home for the year.
- Your spouse does not live in your home for the last 6 months of the year.

Legally separated. You are not considered married if you are legally separated from your spouse under a decree of divorce or separate maintenance.

Children of divorced or separated parents. Under the rules for medical expenses, a child of divorced or separated parents can be treated as a dependent of both parents if certain requirements are met. See *Qualifying Child* under *Whose Medical Expenses Can You Include*, earlier. However, for purposes of the HCTC, only the custodial parent can treat the child as a qualifying family member, even if the other parent can claim the child as a dependent. The custodial parent is the parent having custody for the greater portion of the tax year.

Family members in certain life events (enrollment in Medicare, death, or divorce). Qualifying family members (spouses and dependents) are considered recipients and are eligible to receive the HCTC in the event that the TAA, ATAA, RTAA recipient or PBGC payee enrolls in Medicare, dies, or gets divorced. Qualifying family members can receive the tax credit for up to 24 months from the month of the event, or until January 1, 2014, whichever comes first. Eligible taxpayers who plan to claim this credit because of these life events must call the HCTC Program prior to filing Form 8885 to ensure the form is processed correctly. See *State-qualified health insurance*, later, for the phone number.

Qualified Health Insurance

The following health insurance qualifies for the credit.

- COBRA continuation coverage. (This is coverage that employers with 20 or more employees must offer to employees or former employees and their beneficiaries who have lost coverage because of certain events.) See the caution below.
- Coverage under a group health plan that is available through the employment of your spouse. (But see *Other Specified Coverage*, later.)
- Coverage under a non-group (individual) health insurance plan, if the first day of your coverage started at least 30 days before you left your job that qualified you for TAA, ATAA, RTAA, or PBGC benefits, or the date of Medicare enrollment, death of or divorce from the original TAA recipient or PBGC payee that provided you with extended eligibility as a qualified family member. Individual health insurance does not include any insurance connected with a group health plan of federal or state based health insurance coverage.

COBRA continuation coverage allows individuals who had lost their jobs to receive a reduction in health insurance premiums. You do ***not*** *qualify for the HCTC for any month that you received a reduction in premium.*

Voluntary Employee's Beneficiary Association (VEBA) A health plan purchased through a VEBA that was established through the bankruptcy of your former employer.

State-qualified health insurance. Certain state qualified health insurance can qualify for a credit. To find out which plans are qualified for your state, you can:

- Visit IRS.gov, and type “hctc” in the search box, and then, click on *HCTC: List of State-Qualified Health Plans*, or
- You can call 1-866-628-4282 (tollfree) (or TTY/TDD 1-866-626-4282).

Nonqualified Health Insurance

The following health insurance does not qualify for the credit.

1. Medicare supplemental (Medigap) insurance, Tricare supplemental insurance, or similar supplemental insurance to an employer-sponsored group health plan.
2. Any insurance if substantially all of the coverage is:
   a. Coverage for on-site medical clinics,

b. Hospital indemnity or other fixed indemnity insurance,

c. Accident or disability income insurance (or a combination of the two),

d. Liability insurance,

e. A supplement to liability insurance,

f. Workers' compensation or similar insurance,

g. Automobile medical payment insurance,

h. Credit-only insurance,

i. Limited scope dental or vision benefits,

j. Benefits for long-term care, nursing home care, home health care, community-based care (or any combination), or

k. Coverage for only a specified disease or illness.

3. Coverage under a flexible spending or similar arrangement.

Insurance that covers other individuals. If you have qualified health insurance that covers anyone besides yourself and your qualifying family member(s) (defined earlier), you may not be able to take into account all of your payments. You cannot treat an amount as paid for insurance for yourself and qualifying family members unless all of the following requirements are met.

- The charge for insurance for yourself and qualifying family members is either separately stated in the contract or furnished to you by the insurance company in a separate statement.
- The amount you paid for insurance for yourself and qualifying family members is not more than the charge that is stated in the contract or furnished by the insurance company.
- The amount stated in the contract or furnished by the insurance company is not unreasonably large in relation to the total charges under the contract.

Eligible Coverage Month

Eligibility for the credit is determined on a monthly basis. An eligible coverage month is any month in which, as of the first day of the month, you:

1. Are an eligible recipient or a qualified family member in certain life events (defined earlier),
2. Are covered by qualified health insurance (defined earlier) that you pay for,
3. Do not have other specified coverage (defined later), and
4. Are not imprisoned under federal, state, or local authority.

If you file a joint return, only one spouse has to satisfy the requirements.

COBRA premium assistance. An individual who receives COBRA premium assistance (discussed earlier) for a month is disqualified from receiving the HCTC for that month.

Other Specified Coverage

Even if you or your qualifying family member are otherwise eligible, you or your qualifying family member are not eligible for the credit for a month if, as of the first day of the month, you or your qualifying family member have other specified coverage. Other specified coverage is coverage under the following.

1. Any insurance which constitutes medical care (unless substantially all of that insurance is for benefits listed earlier under (1) or (2) under *Nonqualified Health Insurance*) if at least 50% of the cost of the coverage is paid by an employer (or former employer) of you or your spouse.
2. Any of the following government health programs:
   a. Medicare Part A, B, or C,
   b. Medicaid, or the Children's Health Insurance Program (CHIP),
   c. The Federal Employees Health Benefit Program (FEHBP), or
   d. Tricare, the medical and dental care program for members and certain former members of the uniformed services and their dependents.

Benefits from the Veterans Administration. Entitlement to or receipt of benefits from the Veterans Administration is not other specified coverage.

How To Take the Credit

If you claim this credit, you cannot take the same expenses that you use to figure your HCTC into account in determining your:

- Medical and dental expenses on Schedule A (Form 1040), or
- Self-employed health insurance deduction.

You cannot use payments you made with funds from the following accounts to figure the credit:

- Health Savings Accounts (HSAs), or
- Archer Medical Savings Accounts (MSAs).

Yearly HCTC

The HCTC is 72.5% for payments made in 2012. To claim the yearly HCTC, complete Form 8885, and attach it to your Form 1040, Form 1040NR, U.S. Nonresident Alien Income Tax Return; Form 1040-SS, U.S. Self-Employment Tax Return; or Form 1040-PR, Planilla para la Declaración de la Contribución Federal sobre al Trabajo por Cuenta Propia. You cannot claim the credit on Form

1040A, Form 1040EZ, or Form 1040NR-EZ, U.S. Income Tax Return for Certain Nonresident Aliens With No Dependents.

You may claim the yearly HCTC if you were an eligible recipient and:

- Did not receive monthly HCTC (advanced payments), or
- Received advanced payments and also made eligible payments directly to your health plan.

Required documents. You must attach to your tax return the documents listed in the Form 8885 instructions.

If you *e-file,* you must attach a copy of Form 8885 and the required documents to Form 8453, U.S. Individual Income Tax Transmittal for an IRS *e-file* Return. Mail Form 8453 and the attachments to the address shown in the Form 8453 instructions.

Refundable credit. The HCTC is refundable. You can claim the full credit even if you do not owe any taxes or earn any income. To get the credit, you must:

1. Qualify for the credit, and
2. File a tax return, even if you:
   a. Do not owe any tax,
   b. Did not earn enough money to file a return, or
   c. Did not have income taxes withheld from your pay.

Monthly HCTC

Under monthly HCTC (advance payments), you only pay part of the premium for health insurance and the HCTC Program pays the rest of the premium. The part paid by the HCTC Program is your monthly HCTC.

You pay your part of the premium to the HCTC Program. The program adds the advance payment and pays the total premium to your health plan.

If you want to receive the monthly HCTC, you must fill out the registration form and send it and any supporting documents to the HCTC Program. Once you are enrolled in the HCTC Program, you will receive a monthly invoice stating the amount you must pay to the program and the due date.

If you receive a monthly HCTC, you will get Form 1099-H, Health Coverage Tax Credit (HCTC) Advance Payments. The form shows you the total of your advance payments and for which months payments were made (including months for which reimbursement credits were paid to you). You cannot claim the yearly HCTC for any month for which you received a monthly HCTC.

How To Get Tax Help

You can get help with unresolved tax issues, order free publications and forms, ask tax questions, and get information from the IRS in several ways. By selecting the method that is best for you, you will have quick and easy access to tax help.

Free help with your tax return. Free help in preparing your return is available nationwide from IRS-certified volunteers. The Volunteer Income Tax Assistance (VITA) program is designed to help low-moderate income, elderly, disabled, and limited English proficient taxpayers. The Tax Counseling for the Elderly (TCE) program is designed to assist taxpayers age 60 and older with their tax returns. Most VITA and TCE sites offer free electronic filing and all volunteers will let you know about credits and deductions you may be entitled to claim. Some VITA and TCE sites provide taxpayers the opportunity to prepare their return with the assistance of an IRS-certified volunteer. To find the nearest VITA or TCE site, visit IRS.gov or call 1-800-906-9887 or 1-800-829-1040.

As part of the TCE program, AARP offers the Tax-Aide counseling program. To find the nearest AARP Tax-Aide site, visit AARP's website at *www.aarp.org/money/taxaide* or call 1-888-227-7669.

For more information on these programs, go to IRS.gov and enter “VITA” in the search box.

Internet. You can access the IRS website at IRS.gov 24 hours a day, 7 days a week to:

- *E-file* your return. Find out about commercial tax preparation and *e-file* services available free to eligible taxpayers.
- Check the status of your 2012 refund. Go to IRS.gov and click on *Where’s My Refund.* Information about your return will generally be available within 24 hours after the IRS receives your e-filed return, or 4 weeks after you mail your paper return. If you filed Form 8379 with your return, wait 14 weeks (11 weeks if you filed electronically). Have your 2012 tax return handy so you can provide your social security number, your filing status, and the exact whole dollar amount of your refund.
- *Where's My Refund?* has a new look this year! The tool will include a tracker that displays progress through three stages: (1) return received, (2) refund approved, and (3) refund sent. *Where's My Refund?* will provide an actual personalized refund date as soon as the IRS processes your tax return and approves your refund. So in a change from previous filing seasons, you won't get an estimated refund date right away. *Where's My Refund?* includes information for the most recent return filed in the current year and does not include information about amended returns.
- You can obtain a free transcript online at IRS.gov by clicking on *Order a Return or Account Transcript* under “Tools.” For a transcript by phone, call 1-800-908-9946 and follow the prompts in the recorded message. You will be prompted to provide your SSN or Individual Taxpayer Identification Number (ITIN), date of birth, street address and ZIP code.

- Download forms, including talking tax forms, instructions, and publications.
- Order IRS products.
- Research your tax questions.
- Search publications by topic or keyword.
- Use the Internal Revenue Code, regulations, or other official guidance.
- View Internal Revenue Bulletins (IRBs) published in the last few years.
- Figure your withholding allowances using the IRS Withholding Calculator at www.irs.gov/individuals.
- Determine if Form 6251 (Alternative Minimum Tax—Individuals), must be filed by using our Alternative Minimum Tax (AMT) Assistant available at IRS.gov by typing *Alternative Minimum Tax Assistant* in the search box.
- Sign up to receive local and national tax news by email.
- Get information on starting and operating a small business.

Phone. Many services are available by phone.

- *Ordering forms, instructions, and publications.* Call 1-800-TAX-FORM (1-800-829-3676) to order current-year forms, instructions, and publications, and prior-year forms and instructions (limited to 5 years). You should receive your order within 10 days.
- *Asking tax questions.* Call the IRS with your tax questions at 1-800-829-1040.
- *Solving problems.* You can get face-to-face help solving tax problems most business days in IRS Taxpayer Assistance Centers (TAC). An employee can explain IRS letters, request adjustments to your account, or help you set up a payment plan. Call your local Taxpayer Assistance Center for an appointment. To find the number, go to www.irs.gov/localcontacts or look in the phone book under *United States Government, Internal Revenue Service*.
- *TTY/TDD equipment.* If you have access to TTY/TDD equipment, call 1-800-829-4059 to ask tax questions or to order forms and publications. The TTY/TDD telephone number is for individuals who are deaf, hard of hearing, or have a speech disability. These individuals can also access the IRS through relay services such as the Federal Relay Service at www.gsa.gov/fedrelay.
- *TeleTax topics.* Call 1-800-829-4477 to listen to pre-recorded messages covering various tax topics.
- *Checking the status of your 2012 refund.* To check the status of your 2012 refund, call 1-800-829-1954 or 1-800-829-4477 (automated *Where's My Refund?* information 24 hours a day, 7 days a week). Information about your return will generally be available within 24 hours after the IRS receives your e-filed return, or 4 weeks after you mail your paper return. If you filed Form 8379 with your return, wait 14 weeks (11 weeks if you filed electronically). Have your 2012 tax return handy so you can provide your social security number, your filing status, and the exact whole dollar amount of your refund. *Where's My Refund?* will provide an actual personalized refund date as soon as the IRS processes your tax return and approves your refund. *Where's My Refund?* includes information for the most recent return filed in the current year and does not include information about amended returns.

Evaluating the quality of our telephone services. To ensure IRS representatives give accurate, courteous, and professional answers, we use several methods to evaluate the quality of our telephone services. One method is for a second IRS representative to listen in on or record random telephone calls. Another is to ask some callers to complete a short survey at the end of the call.

Walk-in. Some products and services are available on a walk-in basis.

- *Products.* You can walk in to some post offices, libraries, and IRS offices to pick up certain forms, instructions, and publications. Some IRS offices, libraries, and city and county government offices have a collection of products available to photocopy from reproducible proofs. Also, some IRS offices and libraries have the Internal Revenue Code, regulations, Internal Revenue Bulletins, and Cumulative Bulletins available for research purposes.
- *Services.* You can walk in to your local TAC most business days for personal, face-to-face tax help. An employee can explain IRS letters, request adjustments to your tax account, or help you set up a payment plan. If you need to resolve a tax problem, have questions about how the tax law applies to your individual tax return, or you are more comfortable talking with someone in person, visit your local TAC where you can talk with an IRS representative face-to-face. No appointment is necessary—just walk in. Before visiting, check www.irs.gov/localcontacts for hours of operation and services provided. If you have an ongoing, complex tax account problem or a special need, such as a disability, an appointment can be requested by calling your local TAC. You can leave a message and a representative will call you back within 2 business days. All other issues will be handled without an appointment. To call your local TAC, go to www.irs.gov/localcontacts or look in the phone book under *United States Government, Internal Revenue Service*.

Mail. You can send your order for forms, instructions, and publications to the address below. You should receive a response within 10 days after your request is received.

Internal Revenue Service
1201 N. Mitsubishi Motorway
Bloomington, IL 61705-6613

Taxpayer Advocate Service. The Taxpayer Advocate Service (TAS) is your voice at the IRS. Its job is to ensure that every taxpayer is treated fairly, and that you know and understand your rights. TAS offers free help to guide you through the often-confusing process of resolving tax problems that you haven't been able to solve on your own. Remember, the worst thing you can do is nothing at all.

TAS can help if you can't resolve your problem with the IRS and:

- Your problem is causing financial difficulties for you, your family, or your business.
- You face (or your business is facing) an immediate threat of adverse action.
- You have tried repeatedly to contact the IRS but no one has responded, or the IRS has not responded to you by the date promised.

If you qualify for help, they will do everything they can to get your problem resolved. You will be assigned to one advocate who will be with you at every turn. TAS has offices in every state, the District of Columbia, and Puerto Rico. Although TAS is independent within the IRS, their advocates know how to work with the IRS to get your problems resolved. And its services are always free.

As a taxpayer, you have rights that the IRS must abide by in its dealings with you. The TAS tax toolkit at www.TaxpayerAdvocate.irs.gov can help you understand these rights.

If you think TAS might be able to help you, call your local advocate, whose number is in your phone book and on our website at www.irs.gov/advocate. You can also call the toll-free number at 1-877-777-4778. Deaf and hard of hearing individuals who have access to TTY/TDD equipment can call 1-800-829-4059. These individuals can also access the IRS through relay services such as the Federal Relay Service at www.gsa.gov/fedrelay.

TAS also handles large-scale or systemic problems that affect many taxpayers. If you know of one of these broad issues, please report it through the Systemic Advocacy Management System at www.irs.gov/advocate.

Low Income Taxpayer Clinics (LITCs). Low Income Taxpayer Clinics (LITCs) are independent from the IRS. Some clinics serve individuals whose income is below a certain level and who need to resolve a tax problem. These clinics provide professional representation before the IRS or in court on audits, appeals, tax collection disputes, and other issues for free or for a small fee. Some clinics can provide information about taxpayer rights and responsibilities in many different languages for individuals who speak English as a second language. For more information and to find a clinic near you, see the LITC page on www.irs.gov/advocate or IRS Publication 4134, *Low Income Taxpayer Clinic List*. This publication is also available by calling 1-800-TAX-FORM (1-800-829-3676) or at your local IRS office.

Free tax services. Publication 910, IRS Guide to Free Tax Services, is your guide to IRS services and resources. Learn about free tax information from the IRS, including publications, services, and education and assistance programs. The publication also has an index of over 100 TeleTax topics (recorded tax information) you can listen to on the telephone. The majority of the information and services listed in this publication are available to you free of charge. If there is a fee associated with a resource or service, it is listed in the publication.

Accessible versions of IRS published products are available on request in a variety of alternative formats for people with disabilities.

DVD for tax products. You can order Publication 1796, IRS Tax Products DVD, and obtain:

- Current-year forms, instructions, and publications.
- Prior-year forms, instructions, and publications.
- Tax Map: an electronic research tool and finding aid.
- Tax law frequently asked questions.
- Tax Topics from the IRS telephone response system.
- Internal Revenue Code—Title 26 of the U.S. Code.
- Links to other Internet-based tax research materials.
- Fill-in, print, and save features for most tax forms.
- Internal Revenue Bulletins.
- Toll-free and email technical support.
- Two releases during the year.
  – The first release will ship the beginning of January 2013.
  – The final release will ship the beginning of March 2013.

Purchase the DVD from National Technical Information Service (NTIS) at www.irs.gov/cdorders for $30 (no handling fee) or call 1-877-233-6767 toll free to buy the DVD for $30 (plus a $6 handling fee).

Index

To help us develop a more useful index, please let us know if you have ideas for index entries. See "Comments and Suggestions" in the "Introduction" for the ways you can reach us.

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Flexible Spending Account (Section 125)
Health Reimbursement Arrangement (Section 105)

PROPOSAL FOR: Town of Allenstown, NH

COBRA Administration • Commuter Choice (Parking and Transit Accounts) • Direct Billing of Special Populations (i.e., retirees, LOAs) • Flexible Spending Accounts (FSA) • Health and Welfare Trusts • Health Reimbursement Arrangements (HRA) • Health Savings Accounts (HSA) • Premium Conversion Plans (Documents Only) • Retiree Benefit Administration • Retirement Medical Savings Accounts (RMSA) • Tuition Reimbursement Services • Wellness Benefit Validation and Reimbursement

Corporate Office:
967 Elm Street
Manchester, NH 03101

www.benstrat.com
Phone: (888) 401-FLEX (3539)
Fax: (603) 647-4668

Benefit Strategies, LLC was founded in February 1989 to provide high quality employee benefit consulting and administration services at a fair price. In the ensuing years, Benefit Strategies has successfully grown to be regarded among the finest employee benefit consulting and administration firms in New England.

What sets Benefit Strategies apart?

- All Benefit Strategies' clients are assigned a dedicated Implementation Specialist for successful on-boarding and a dedicated Account Manager who is able to handle all services
- We have direct carrier feed integration with 7 New England carriers (and more to come!)
- Benefit Strategies takes data integrity and security seriously:
  - 2013 SSAE16 compliant (SAS70 compliant since 2005)
  - A CISSP auditor has rendered a positive CISSP opinion after evaluation of Benefit Strategies' security protocols
  - WISP/ MA 201 CMR 17.00 compliant
  - All employees are HIPAA trained and certified upon hire
- We hold the Certified HSA Administrator designation
- Our investment in technology allows us to monitor how we are meeting our plan administration and customer satisfaction goals

Benefit Strategies services a broad geographical client base and is dedicated to providing superior service at a fair and reasonable price. We provide timely and accurate benefit plan reporting with prompt responses to our clients' telephone/e-mail inquiries and service requests.

Our success is driven from the expertise of our professional staff. We have assembled a team of professionals whose combination of academic and "real world" experience can be invaluable to employers. Their expertise in related disciplines has earned them insight into the benefit needs of both growing and mature companies. This unique combination of credentials and broad based experience allows Benefit Strategies to operate with a confidence and credibility unmatched by any other consulting/administration firm our size.

We encourage you to meet our staff and ask our clients about the unique Benefit Strategies approach. It will become clear that we differ from other benefit consulting and administration firms in the quality of our staff, the extent of our resources, and our overall commitment to thoroughness, creativity, responsiveness, and customer satisfaction.

Flexible Spending Account Fee Schedule

Full Flex Plan Includes:

- ✓ Premium Conversion Plan, Health Care Reimbursement Accounts & Dependent Care Reimbursement Accounts

	First Year	Subsequent Years at Renewal
Plan Installation and Renewal Services:	$500.00	$500.00
✓ Flexible benefit plan design and implementation ✓ Customized electronic enrollment forms and employee communication materials ✓ Informational employee meetings ✓ Resolution and plan documents (sample for attorney review) ✓ Summary Plan Description for employees		
Non-discrimination Testing: (upon request)	$400.00	$400.00
Claims Administration Fee*:	$4.75 per Account per Month	$4.75 per Account per Month
*A health care reimbursement account and a dependent care reimbursement account are considered two separate accounts.	$75.00 per Month Minimum	$75.00 per Month Minimum
Benny Cards: (Debit cards arrive in sets of 2 and accounts are charged annually)	**Initial Set of Cards:** $5.00	**Additional or Replacement Set:** $5.00

Employees who choose to sign up for the Benny Card(s) will have this charge deducted as an eligible pre-tax expense from their Flexible Spending Account annually. Some employers choose to pay for the card fees as an added benefit for their employees.

Custom mailings and services may result in additional fees beyond the fees listed above.

Please note:

- ➢ Domestic partners are not eligible for their partners FSA plan.
- ➢ Legally married same-sex spouses are eligible for their partner's FSA plan.

[redacted]

Health Reimbursement Arrangement Fee Schedule

	First Year	Subsequent Years at Renewal
Plan Installation and Renewal Services:	$400.00 ($350 if taken with FSA)	$400.00 ($350 if taken with FSA)
✓ Flexible benefit plan design and implementation ✓ Informational employee meetings ✓ Plan consent forms ✓ Adoption agreement and plan documents (sample for attorney review) ✓ Summary Plan Description for employees		
Non-Discrimination Testing: (upon request)	$400.00	$400.00
Claims Administration Fee*: *This is an estimate until the plan design is finalized	$4.00 per Account per Month $75.00 per Month Minimum	$4.00 per Account per Month $75.00 per Month Minimum

Please note:

- Domestic partners are not eligible for their partner's HRA plan.
- Legally married same-sex spouses are eligible for their partner's HRA plan.

HRA AUTOMATIC REIMBURSEMENT METHOD

Along with the claims reimbursement methods listed in this proposal, Benefit Strategies has an automatic reimbursement option via claims feeds from seven New England carriers. This allows for processing of HRA reimbursements without the participant having to submit any documentation. Clients may choose to set the HRA up with either direct reimbursement to the participant or to the provider*.

Our current claims feed relationships are with:

- Anthem BCBS New Hampshire
- Anthem BCBS Maine
- Blue Cross Blue Shield Massachusetts
- Blue Cross Blue Shield Rhode Island
- Harvard Pilgrim Health Care
- Neighborhood Health Plan
- Tufts Health Plan

**If you choose the Provider Pay option, please be aware that the Massachusetts Health Safety Net Surcharge applies. When payments are made to Massachusetts hospitals and ambulatory surgical centers, a 1.87% tax is levied. Benefit Strategies will bill clients for the tax and then remit payment directly to the Massachusetts Division of Health Care.*

[redacted]

Flexible Benefit Plans

In the past two decades, the workforce has undergone dramatic changes. More and more families have two full-time workers, both receiving similar packages of benefits from their employers. The traditional benefit plan design limits employees to participating in an employer determined medical and possible dental, life and/or disability insurance plan, and generally provides nothing for the employee who, having coverage through his or her spouse, chooses not to participate. In addition, employees have out-of-pocket expenses associated with co-pays, deductibles, plan limits and non-covered services and products. These traditional benefit packages often fall short of meeting today's employees' needs.

A solution to meeting budgetary constraints, employee needs, and future long range benefit planning is the creative use of a Section 125 Flexible Plan. Section 125 Plan, Flexible Benefit Plan and Cafeteria Plan are synonymous names of the plans. This may range in complexity from a simple plan offering a choice between a single benefit and cash, to a highly structured plan offering choices from a wide menu of benefits.

Following are some typical Flexible Benefit Plan designs:

- **Premium Conversion Plan –** Pre-tax treatment of employee insurance premium contributions
- **Flexible Spending Accounts –** Pre-tax treatment of employee's out-of-pocket medical and dependent care expenses
- **Full Cafeteria Plan –** Employees allocate flexible employer contributions toward a menu of benefit options, buying the benefits they need most

Plan Tax Savings

Assumptions:

- Employee earns $30,000 per year
- Has $1,200 annual Medical Insurance Expense
- Has $500 annual expense for out-of-pocket medical care (RX, co-pays, glasses, etc.)
- Has $5,000 annual expense for Dependent Care Assistance

	Without Section 125	With Section 125
Gross Salary	$30,000	$30,000
Annual Medical Premium Contribution	$0.00	-$1,200
Annual Health Care Reimbursement Account Contribution	$0.00	-$500
Annual Dependent Care Assistance Account Contribution	$0.00	-$5,000
Total Pre-Tax Deduction	$0.00	$6,700
Taxable Salary	$30,000	$23,300
Federal Income Tax (15%)	-$4,500	-$3,495
FICA (7.65%)	-$2,295	-$1,782
State Income Tax (5%)	-$1,500	-$1,165
Total Taxes Paid	$8,295	$6,442
Net Salary	$21,705	$16,858
Expenses (Post Tax)	-$1200 & -$500 & -$5,000	$0.00
Take Home Pay	$15,005	$16,858
Net Savings	**$0.00**	**$1,853**

[redacted]

Flexible Benefit Plan Requirements

Employers sponsoring Section 125 plans, no matter how simple, must comply with federal requirements outlined in the Internal Revenue Code. These requirements include but are not limited to the following:

Plan Must Benefit "Employees" Only – Partners in a Partnership, owners of a S-Corporations, or partners of an LLC may sponsor a Section 125, but cannot participate in the plan themselves, since they are not considered "employees." Owners of a C-Corporation may participate in the plan, subject to non-discrimination rules.

Non-Discrimination Testing – Plans must be scrutinized to ensure that they do not violate any non-discrimination rules nor unfairly benefit key or highly compensated employees. Testing is provided for an additional fee.

Written Plan Document – The document puts in writing the operational aspects of the plan, including eligibility rules, election procedures, benefits available, the Plan Year on which the plan runs, how contributions are made, and how claims are paid. Plan Documents must be updated if employers amend the plan, or if the IRS issues new regulations.

Summary Plan Description – The Summary Plan Description (SPD) is an overview of the complete plan document that is written in easy to read format. You are required to distribute the SPD to all employees and new hires to help explain the program. The SPD must be kept up-to-date with employer changes and current IRS regulations.

Open Enrollment Process – Employees must make their elections to the plan in writing or via an Online Enrollment platform. Each year, plan changes must be reviewed and appropriate new forms and communication materials must be developed. Important: Employees must make their elections carefully and conservatively; they cannot be changed during the plan year. Additionally, the use-it or lose-it rule says money unclaimed from the accounts at the end of the plan year (or the Grace Period*, if selected) is forfeited by employees and returned to the employer to offset their administrative costs.

Flexible Benefit Plan Spending Account Claims Administration – Reimbursement accounts must be established for all eligible employees. Contributions to and claims paid from the account must be accurately recorded. Claims for reimbursement of health and/or day care expenses must be reviewed for eligibility and paid in a timely manner. Expenses must be incurred during the plan year and cannot be eligible for reimbursement from any other source. Expenses are eligible for reimbursement during the plan year, which may include a 2.5 month extension period to incur claims. If all funds are not claimed by the end of the plan year (plus a 90-day grace period) they will be forfeited.

Important Notes:

- **Health Care Reimbursement Account –** The "Uniform Reimbursement" rule requires that the full amount of an employee's annual Health Care Spending election (less previously paid amounts) be available for reimbursement on the first day of the plan year. This can be a liability to the Employer if an employee terminates employment before contributing their full elections.
- **Dependent Care Assistance Account** – Day care expenses reimbursed under this plan are ineligible for deduction on the employee's individual tax return. Further, the employee will be required to supply the Tax ID or Social Security Number of the day care provider to the IRS.
- **Federal Limit On Employer Contributions to Health Care Reimbursement Account** – For plan years starting on September 13, 2013 and later, employer contributions are limited to $500 per Health Care Reimbursement account.
- **Federal Regulations State Health Care Reimbursement Accounts Can Only Be Offered To Employees Who Are Also Offered Group Medical Plan –** For plan years starting on September 13, 2013 and later.

*The Grace Period is an optional extension of the Plan Year, essentially giving the participants 14.5 months to incur claims. The Grace Period runs concurrently with the 90-day run-out to submit claims for reimbursement.

[redacted]

Health Reimbursement Arrangement

A solution to meeting today's budgetary constraints, employee needs, and future long range benefit planning is a Health Reimbursement Arrangement (HRA). Under this strategy, the employer couples a high deductible health insurance plan with an employer-funded reimbursement account.

An employer may purchase a high deductible plan (such as $1,000 or $1,500 deductible) from their insurance carrier and then cede funds toward the deductible down to a range the employees are used to paying (such as $500 or $750 deductible). Premium savings realized by the employer may be as much as 20-50%, leaving funds available to meet deductible expenses as needed.

Benefit Strategies, LLC offers a unique service to administer claims to the level the employer chooses to reimburse. Employers choose the level of benefits they wish, while working to control their monthly premium costs. This can be done using practically any health insurance carrier. With proper plan design, employers have managed to improve cash flow by maintaining control for the reserve portion of their group health insurance premium.

The HRA Advantage

Under Section 105 of the Internal Revenue Code, employers may offer a Health Reimbursement Arrangement (HRA) to their employees as a means of allowing the employer to save money with regard to healthcare plan costs. This is based on the premise that the employer may elect benefit plans with higher deductibles, for example, and redirect the savings they realize to employees to help pay for these higher deductibles.

Employee Advantages:

- Medical expenses reimbursed through an HRA are excludable from employee's gross income and are, therefore, not taxable.
- Employees have an advantage when using an HRA coupled with a high deductible plan. If their total expenses for the year are less than what the employer contributes to their HRA, the employee is allowed to roll or carry over the remaining funds to a future year. There is no limit on the amount of money that can be rolled to the next year, nor is there a limit on how many years a participant may have a rollover. Employees can also choose not to rollover unused funds.
- HRA's may cover current employees, their spouses and taxable dependents, former employees (under COBRA) and dependents, including retirees, if the plan sponsor chooses
- HRA's are not subject to the timing rules of a Flexible Spending Account and can allow mid-year enrollments and reimbursements that cross calendar years or plan years.

Employer Advantages:

- If the employee spends more than what their employer has allocated, the remaining expenses become out of pocket. This will help to curtail expenses from an employer's perspective, as a result of the employee wishing to reduce out of pocket expenses, and thus put the employee in a position where he/she will be more aware of what is covered under their group benefits.
- Unlike a Flexible Spending Account, HRA funds do not need to be available in full at the onset of the plan year.
- Plan maximums credited under the HRA may be increased or decreased by the employer as needs change.
- HRA funds must remain with the originating employer and do not follow an employee to new employment.
- The plan design is very flexible and can be customized to meet the employer's specific needs and requirements.

Health Reimbursement Arrangement Savings

To illustrate the savings that are available from adding a high deductible insurance plan and Health Reimbursement Arrangements to your company's benefits please see the example below.

Assumptions:

- 50 single medical participants
- Currently the cost is $300/month for a medical insurance ($3,600 annually) per single participant
- The new high deductible plan has a $1000 and a cost total of $150 a month per single participant
- The HRA contributions will be $500 per employee from the employer
- Employee is responsible for the first $500
- HRA only pays if the employee has deductible expenses
- Based on the average group the employer can anticipate 20% claims utilization. The exposure is the full amount, but based from the experience approximately 20% will be utilized by participants.

	Without HRA	With HRA
Annual Medical Insurance Deductible	$0.00	$1,000
Annual Medical Insurance Premium for Employer	$180,000 ($300 x 12 months x 50 participants)	$90,000 ($150 x 12 months x 50 participants)
Annual Medical Premium Savings for Employer	$0.00	$90,000
HRA Contributions Paid by Employer	$0.00	$25,000 ($500 x 50 participants)
20% Anticipated Claims Reimbursement	$0.00	$5,000 ($25,000 HRA x 20%)
Annual Employer Savings	**$0.00**	**$85,000 ($90,000-$5,000)**

- **Employee Savings –** Participants will save premium dollars since the medical insurance is lower. They will only have an exposure of $500 of personal funds to meet their deductible. If they don't use it that is money they will save. If an FSA is implemented, additional pre-tax savings can be realized.
- **Employer Savings –** The savings to the employer is realized by purchased a high deductible insurance plan and coupling it with an HRA since the premiums are much less expensive.

[redacted]

Plan Design Flexibility

- The HRA, a defined contribution healthcare plan, does not allow for employee funds. Funding for the HRA must be made solely by the employer.
- The employer decides how much money will be available for each employee in an HRA. The amount is usually the same for all eligible employees, as non-discrimination rules apply to an HRA. The amount may be different, however, depending on coverage level within the employer's benefit plans. An employee with single medical coverage may be eligible for one amount, while an employee with family coverage may be eligible for a different amount, as specified by the plan.
- The employer decides how to allocate the funds and when to make them available. All funds can be available from the first day of the plan or funds can be made available on a per pay period or monthly basis.
- HRAs may pay for expenses including items allowed under Schedule A of an employee's tax return, such as deductibles, coinsurance, co-pays and other cost sharing as defined by you, the employer.
- Employees cannot receive reimbursement for an eligible expense through an HRA and claim it on their tax return. They are allowed only one: write off or be reimbursed.
- Employers may offer both an FSA and an HRA simultaneously to their employees. One plan or the other, not both, reimburses eligible expenses. Employers may choose which account should be depleted first. Employers may also choose to segregate which types of expenses should be reimbursed by one plan or the other.
- An HRA must be available for COBRA continuation on the same basis as other health plans.
- HRAs may not be tied to any salary reduction or deferred compensation program.
- Employees must have no right or option to receive cash or any other benefit other than reimbursement for medical care expenses; otherwise the HRA will be disqualified.
- Employers may also allow or not allow rollovers and limit the amounts that can be rolled over from year to year. If allowing a rollover, funds carried from one year to the next are added into the plan maximum for the following year. The result is an amount available to the employee, which may exceed the designated plan maximum.

Plan Requirements

ERISA – Plans are subject to ERISA. Form 5500 must be filled when a plan has more than 100 participants at the beginning of the plan year. We will provide you reports that will help with the completion of this requirement.

Plan Document – The documents puts in writing the operational aspects of the plan, including eligibility rules, election procedures, benefits available, the Plan Year on which the plan runs, how contributions are made, and how claims are paid. Documents must be updated if employers adopt changes to the plan, or if the IRS issues new regulations.

Summary Plan Description – The SPD is distributed to employers. It puts the information contained in the Plan Document in layman's language. It, too, must be kept up-to-date with employer changes and current IRS regulations.

Federal Regulations Do Not Permit Standalone HRAs– Effective for plan years beginning September 13, 2013 and later, HRAs must be attached to a group health plan.

Claims Reimbursement Methods (FSA, HRA, Commuter Choice)

Benefit Strategies offers several easy methods to obtain reimbursement from an account:

- **Benny Card Method** – ***(Note: Benny Card is not recommended for HRAs)***
  The easiest reimbursement method is to use the Benefit Strategies Benny Card. The Benny Card looks like a typical credit or debit card. However, it is a special card that provides your employees with easy access to their reimbursement accounts to pay for IRS qualified expenses right at the point-of-sale on the date the services are incurred. The card will be accepted only at specific providers. For example, with a Health FSA the card will be turned on to work at physician offices, dental offices, pharmacies, hospitals, chiropractors, optometrists, etc. If the participant is enrolled in Dependent Care FSA, the card will be set to work in day care settings and for Commuter Choice, cards will work for parking and transit facilities. Participants enrolled in one or more FSA and/or Commuter Choice accounts use just one Benny Card; expenses are debited from the appropriate account based on the type of setting that submitted the transaction.

  Once we establish the reimbursement account, the Benny Card will be sent directly to your employees' homes via US mail. The employees are responsible for retaining all documentation of the expenses reimbursed via the card. They may be requested to submit documentation to Benefit Strategies to substantiate a claim. Documentation must show: the date the expense was incurred (not the date paid), the description of the service and/or expense, the name of the vendor and how much is your responsibility. The card is to be used only to pay for IRS eligible expenses incurred during the plan year. Misuse of the card could result in permanent revocation of the card and repayment of ineligible expenses.

  To help out with substantiation of debit card transactions for Health FSAs, we use an IIAS (Inventory Information Approval System). IIAS is a point-of-sale technology used by retailers that accept debit cards issues for use with Health FSAs. An IIAS identifies eligible healthcare account purchases by comparing the UPC or SKU number for the items being purchased against a pre-established list of eligible medical expenses. The list is restricted to "eligible medical expenses" as described in Section 213(d) of the Internal Revenue Code (including eligible non-prescription (other-the-counter) items). By using this technology the card can be accepted at IIAS compliant drug stores and retail stores.

- **Participant Submission Methods** – Benefit Strategies processes claims every business day and pays claims twice per week. Participants may submit new claims for eligible expenses at any time during the Plan Year and run out period. Participants submitting claims can choose to be reimbursed by check or direct deposit. Confirmations are provided for both forms of payment and will show current transaction as well as available funds in the account.

  Online Reimbursement Request – Each participant in the plan will be issued a personal account at www.benstrat.com where they can file claims online. Participants can upload their detailed documentation through the website, or the confirmation page and detailed documentation can be sent to Benefit Strategies via secure e-mail, fax or mail.

  Mobile Application Reimbursement Request – Participants with iPhones, Android phones and tablet devices can download our free mobile application to file claims. Detailed documentation is photographed with the device's camera and uploaded through the mobile application.

  Paper Form Reimbursement Request – Participants can submit a completed paper FSA Reimbursement Request Form along with detailed documentation of their expenses to Benefit Strategies. Forms may be downloaded from Benefit Strategies' website at www.benstrat.com, or may be obtained from Benefit Strategies directly upon request. Claims are accepted via secure e-mail, fax or mail.

Claims Funding

Benefit Strategies, LLC has the ability to provide you numerous funding methodologies giving you flexibility and freedom to continue to use a process similar to the one you may already be using to fund your flexible spending plan (FSA) or health reimbursement arrangement (HRA). You may even find one that will be easier to implement with your payroll and accounting areas.

Benefit Strategies pays claims up front and then settles up after the payments are made. We ask that our clients choose one of the below options to ensure sufficient cash flow for claims payment:

- **EFT Debit –** Allows Benefit Strategies to directly take the money from your operating (or other designated) account via an Electronic Funds Transfer for claims paid to participants that week
- **Weekly ACH –** Allows you to electronically remit your payments to us on a weekly basis for claims paid to participants that week.
- **Claims Paid Invoice –** Allows you to receive an invoice for claims paid during the weekly invoicing cycle, with payment to Benefit Strategies remitted by check within 15 days.

Maintenance Deposit

The maintenance deposit allows Benefit Strategies to begin funding accounts on the first day of the plan while awaiting your payments for the claims incurred. We will collect the Maintenance Deposit once we receive your signed claims funding agreement paperwork and your plan is finalized with enrollments in our system.

- **FSA –** The FSA maintenance deposit is a calculation based on the equivalent of 2 weeks' worth of your participants' FSA annual elections.
- **Commuter Choice –** The Commuter Choice maintenance deposit is a calculation based on the equivalent of 2 weeks' worth of your participants' Commuter Choice annual elections.
- **HRA –** The HRA maintenance deposit is a calculation based on 2 weeks' worth of the estimated HRA usage. Estimated HRA usage is found by taking 40% of the HRA's maximum exposure.

Benefit Strategies will evaluate the maintenance deposit amount at each renewal period. Based on the total elections or maximum exposure at that time, Benefit Strategies reserves the right to bill for additional funds to bring your maintenance deposit current. The maintenance deposit will be maintained on file until such time as you cease to have Benefit Strategies administer these accounts for you (much like a security deposit).

There will be a minimum of $250 billed for maintenance deposits falling below this amount.

Benefit Strategies Offers Administrators and Participants Easy Account Access At Any Time!

Online Access For Administrators and Participants

Information on the activity, transaction history and balance remaining in your participants' reimbursement accounts may be accessed by logging onto Benefit Strategies' website www.benstrat.com. Each participant will receive log on instructions for their account after it has been established with Benefit Strategies. If employees do not have access to the internet they may reach one of our customer service representatives via our toll free number Monday through Thursday between 8:00 AM and 6:00 PM, and Friday between 8:00 AM and 5:00 PM, ET.

Mobile Access For Participants

Participants with iPhones, Android phones and tablet devices can download our free mobile application to access their account information on the go.

Automated Information Center For Participants

Participants calling our toll free number can access the automated information center at any time. Automated answers are available for account balance inquiries, claim disbursement dates, detailed web access instructions, and important filling dates. We have customer service representatives ready to answer any other questions during normal business hours.

WWW.BENSTRAT.COM

1-888-401-FLEX (3539)

[redacted]

Group Dynamic Inc.

THIRD PARTY ADMINISTRATION

HEALTH REIMBURSEMENT ARRANGEMENT

Client-centered Solutions

Appendix 5

GDI Health Reimbursement Arrangement Proposal

Thank you for the opportunity to present you with a proposal for a Health Reimbursement Arrangement (HRA). Health Reimbursement Arrangements are permissible under Sections 105 and 106 of the Internal Revenue Code. These plans were developed in response to a need from employers for a self-funding vehicle to help offset the rising cost of health insurance premiums.

WHY CHOOSE GDI?

Experience and flexibility distinguish GDI in an era of consumer directed health plans. The shift from a traditional health plan is a challenging, but necessary, decision for many employers. GDI's experienced staff works with employers to craft solutions which fit the needs of the organization, and this partnership has created customized plans for clients of all sizes. We have provided several scenarios below which illustrate the experience of our clients.

	# of Employees	Total Group Benefit	Claims Paid	Benefit Remaining	% of Loss
Typical Client	50 - 100	$80,000	$8,000 - $25,000	$72,000 - $55,000	10% - 31%
Manufacturing	125	$170,000	$25,000	$145,000	14%
Financial	106	$92,000	$38,000	$54,000	41%
Construction	13	$10,000	$1,000	$9,000	10%
Education	219	$438,000	$10,000	$428,000	.02%
Small Business	6	$3,000	$1,400	$1,600	47%

Group Dynamic Inc.

PLAN DESIGN

Perhaps the most important decision in establishing a Health Reimbursement Arrangement is choosing the correct plan design. Factors to consider are:

- **Assumption of Risk** - These plans are a form of self insurance so employers need to decide what level of risk they are willing to absorb.
- **Ease of Administration** - The level of complexity in the design can also affect the administration of the plan.
- **Health insurance philosophy** - An employer's long term philosophy may affect the design of the HRA.
- **Integration with other tax-favored programs**, e.g., Flexible Spending Accounts and/or Health Savings Accounts

Here is a typical example of the use of an HRA: A client who has been absorbing cost increases for the last several years on a benefit rich HMO plan decides to switch to a plan with a $2,500/$5,000 single/family deductible. The deductible applies to hospital, out-patient surgical, all laboratory & x-ray services and chiropractic services. Primary care such as office visits and pharmaceuticals are available for relatively low co-payments. The premium savings for this employer is more than enough to risk self-funding one-half of the total deductible (single or family) for each employee enrolled in the plan. An HRA plan is established to provide the necessary legal document and tax-free claim reimbursement.

EMPLOYEE EDUCATION

Once a design is chosen, the process moves to the second most important phase: Educating employees.

Employees need to understand four things:

What does the HRA cover?
What gap does the HRA fill in the health plan?
What documentation will employees receive from the health plan as it relates to claims?
How do I receive a reimbursement from the HRA?

GDI will conduct an educational meeting via webinar or live presentation, provide employees with HRA claim kits and will be available for participants' questions throughout the plan year..

"GDI has really gone above and beyond for both the client and the broker numerous times."

"We are extremely satisfied with the services GDI provides."

Group Dynamic Inc.

IMPLEMENTATION & ONGOING SUPPORT

The successful administration of your plan is our goal. The key components to a successful plan are:

- **Client set up**
  You will be required to complete the attached Request for Services which provides us with the information needed to set up your plan. Your broker and/or GDI Account Executive will be happy to assist you with completing the worksheet. In addition, GDI will need a complete Participant Report and a Summary of Benefits from your health insurance carrier.

- **Document preparation**
  We contract with one of the nation's leading law firms to draft plan documents and summary plan descriptions which comply with all IRS regulations governing such plans. We have NEVER had a client fail an IRS audit of their HRA plan.

- **Funding**
  We have the ability to initiate or receive electronic fund transfers from clients to cover HRA claim reimbursements.

- **Change tools**
  We provide several tools clients can use to communicate staff additions, terminations or status changes.

Requesting Reimbursement

GDI reimburses participants every week for requests received by noon Tuesday, and we make it EASY, with options for submitting reimbursements:

- **Mail**

- **Email**
  Those who have access to scanning technology can scan claim forms and carrier documentation and send via email.

- **Fax**

- **Payment**
  We can reimburse participants via check or direct deposit

- **Reporting**
  We can provide custom reports upon your request, or we can schedule them to suit your needs.

- **Online Tools**
  Administrators can sign on to our website at www.gdynamic.com and get answers to frequently asked questions, request forms, etc.

Requesting Reimbursement cont.

- **Plan Intelligence**
  Much of our success has come from the ability to respond quickly to client needs. Our goal is to use current information to anticipate client needs or to adjust our plan designs.
- **Claims Management**
  The review of claim submissions and denials allows us to focus our educational resources toward areas of need.
- **Compliance Support**
- **Notices**
  Our Chief Compliance Officer will communicate regulatory changes which may impact your plan.
- **Team Support**
  Your GDI team consists of your Account Executive, Account Coordinator and Chief Compliance Officer. The team is always available to answer any compliance questions or concerns. This team is supported by the GDI management team, ensuring you always receive a quick response to your inquiry.
- **Phone Support**
  Every call to our office Monday through Friday, 8:00 am through 5:00 pm (ET) is answered by a customer service representative. You and your employees will never be stuck in the voicemail merry-go-round. Furthermore, we have an on-site Compliance Officer to assist you with challenging compliance situations.

"The claim submitted was promptly and courteously handled. Thank you. Every conversation I have had with your company has been extremely helpful and courteous and much appreciated!"

Group Dynamic Inc.

HRA Administration Services

Plan Type Descriptions for HRA Plans

Please note that Group Dynamic Inc. determines the plan type based upon a review of the health insurance plans intended for use with the HRA. The following are for illustrative purposes.

Plan Type A

The highest complexity and/or highest expected claim volume, including but not limited to:

- HSA qualified high deductible health plans (with HSA or not);
- All plans with calendar year deductible accumulation and a contract renewal date that is off-calendar year.

Plan Type B

Medium complexity and claim volume, including but not limited to:

- Non-HSA qualified plan with multiple services applying to deductible and with deductible accumulation period matching contract renewal date (e.g. calendar year deductible and a January 1 renewal;
- HRA covers all IRS Code Section 213(d) allowed expenses.

Plan Type C

Lowest complexity and/or lowest expected claim volume, including but not limited to:

- Non-HSA qualified plan with reduced number of services applying toward deductible, typically limited to Inpatient Hospital, Outpatient Surgical, high-cost diagnostics;
- Plans with per-event copayments for hospital and diagnostic services as described above;
- Focused benefit such as Dental and/or Vision Care only

Group Dynamic Inc.
THIRD PARTY ADMINISTRATION

Administration Fee Schedule

Health Reimbursement Arrangements

Please note that Group Dynamic Inc. determines the plan type based upon a review of health insurance plans intended for use with the HRA.

Manual Claims

Participant completes and submits a claim form with substantiation

Monthly Claim Administration Fee				Annual Plan Fee
Number of Covered Employees	**Plan A**	**Plan B**	**Plan C**	**All Plans**
<25	**$5.50**	**$5.00**	**$4.00**	**$550** Discount available when multiple products are placed with GDI
25-50	**$5.25**	**$4.75**	**$3.50**	
50-100	**$5.00**	**$4.50**	**$3.25**	
101 – 500	**$4.75**	**$4.25**	**$3.00**	
501+	Plans in excess of 500 covered employees will be reviewed on a case-by-case basis.			

Claim Feeds*

Claim data is provided by the carrier. Assumes HRA reimburses Participants**.

Monthly Claim Administration Fee				Annual Plan Fee
Number of Covered Employees	**Plan A**	**Plan B**	**Plan C**	**All Plans**
<25	**$4.50**	**$4.00**	**$3.00**	**$550** Discount available when multiple products are placed with GDI
25-50	**$4.25**	**$3.75**	**$2.50**	
50-100	**$4.00**	**$3.50**	**$2.25**	
101 – 500	**$3.75**	**$3.25**	**$2.00**	
501+	Plans in excess of 500 covered employees will be reviewed on a case-by-case basis.			

* **Claim Feed Option** is available with certain health carriers. Contact your Territory Manager for details.

** **Pay Provider Costs**: Where a Pay Provider option is available, please add $0.25 to each rate category if GDI pays the provider rather than the participant. Note that payment to the provider can only be done in an electronic claim feed environment.

Group Dynamic Inc.
THIRD PARTY ADMINISTRATION

Health Savings Account (HSA) Guide

This account lets you earn valuable tax benefits while helping you save for, and pay for, medical expenses. You must be covered by a High Deductible Health Plan (HDHP) in order to take advantage of this smart way to manage your health care costs. We've created this easy to follow outline of services, fees and policies to help you understand how this account works. The TD Bank HSA comes with a free, specially-marked TD Bank HSA Visa® Debit Card and HSA checks, free online banking and Live Customer Service 24/7. You may not participate if you are covered by another non-high deductible plan or by Medicare. Contributions may be tax-deductible.

Account opening and usage	Minimum deposit needed to open account	**$25.00** Minimum opening balance waived when employer will be initiating first electronic deposit for Customer.
	Set-up fee	**$20.00**
	Monthly maintenance fee	**$0.00**
	Minimum daily balance to waive monthly maintenance fees	**N/A**
	Pays interest	**Yes**
	ATM fees	**$0.00** For using TD ATMs in the U.S. and Canada
		$3.00 For each withdrawal, transfer, and balance inquiry conducted at a non-TD ATM. The institution that owns the terminal (or network) may assess a fee (surcharge) at the time of your transaction, including balance inquiries.

Overdraft information and fees	Overdraft-paid fee	**$0.00** For each item we pay
	Overdraft-return fee (non-sufficient funds)	**$0.00** For each item we do not pay
	Maximum number of overdraft fees per Business Day	**N/A**
	Sustained overdraft fee	**N/A**
	Overdraft fee threshold	**N/A**

Overdraft options for Customers with debit or ATM cards	**TD Debit Card Advance℠** TD Debit Card Advance is not available on Health Savings accounts. This means your account is set up to decline any ATM or one-time debit card transactions that may overdraw your account.

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Additional account support	**Checks**	
	Money orders	**$5.00**
	Official checks (cashier's check)	**$8.00**
	Account Services	
	Stop payment fee (per item)	**$30.00**
	Printed check images with monthly paper statement (subject to limitations under applicable state laws)	**$2.00**
	Copies	
	Statements with check copies and /or deposit slips only, per statement	**$5.00**
	Deposit reconstruction, per transaction	**$5.00**
	Statements with check copies and deposit reconstructions, per statement	**$25.00**
	Other	
	Cashed or deposited item returned (per item)	**$15.00** For each item you deposit or cash that is returned unpaid. Example: You deposit a check from someone who doesn't have enough money in their account to cover the check. The amount of the check will be subtracted from your balance and you will be charged the cashed or deposited item return fee.
	Distribution restrictions	Distributions not used for qualified medical expenses are considered taxable income subject to an additional 20% IRS penalty. Distributions may also be made penalty-free upon the death or disability of the owner, or upon reaching age 65.
	Levy/legal order	**$125.00**
	ATM/debit card research (per hour)	**$25.00**

Funds transfer and international items	Foreign bank drafts, purchased	**$25.00**
	Foreign currency bank notes	**$7.50** Orders of $250 and above **$17.50** Orders less than $250
	Funds transfer	**$15.00** Incoming wire (domestic and international) **$25.00** Outgoing wire (domestic) **$40.00** Outgoing wire (international), plus exchange rate, taxes and correspondent fee(s)
	International collections items, plus correspondent fee(s)	**$17.50**

TD Bank

America's Most Convenient Bank®

Processing policies	Posting order (The order in which withdrawals and deposits are processed)	**Transactions are processed at the end of each Business Day in the following order; which may not be the order in which they occurred:** 1. Deposits that have become available to you 2. Pending debit card, ATM or electronic transactions that have been authorized but not yet paid 3. Outgoing wire transfers, return deposit items and debit adjustments in highest to lowest dollar order 4. Overdraft fees, other returned item fees and deposit return fees in highest to lowest dollar order 5. Checks, debit card and ATM transactions, all other account fees (except those in #6 below) and all other items in the highest to lowest dollar order 6. Fees, such as monthly maintenance fees, assessed at the end of a statement cycle
	Funds Availability Policy (When funds deposited to your account are available)	• **Wire transfers, electronic deposits and transfers between accounts** – Immediately • **Cash deposits made at any TD Bank Store** – Immediately • **Non-cash deposits made at any TD Bank Store** – The first $100 immediately – Remainder the next Business Day • **Deposits made at TD ATMs (cash or check)** – The first $100 immediately for accounts opened longer than 90 days – Remainder the next Business Day • **Deposits made at non-TD ATMs** – Fifth (5th) Business Day after the date of your deposit • **Deposits made through TD Bank Mobile Deposit** – Next Business Day after the date of your deposit • **If we further delay the ability to withdraw funds** – We will notify you and funds will generally be available no later than the seventh (7th) Business Day after the deposit date. **This represents our general policy.** For specific details, please see the Funds Availability Policy in the Personal Deposit Account Agreement.
	Business Day	A "Business Day" is a non-federal holiday weekday. The end of a Business Day varies by Store, but it is no earlier than 8pm EST.

Dispute resolution	**If you have questions or would like more information** Please visit any of our Stores or call us at **1-888-751-9000**. We will be happy to assist you. In addition, the Personal Deposit Account Agreement governs the terms and conditions of personal deposit account(s) with us. Please refer to the Agreement for additional account information.

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Suncook Valley Combination
Medical Claims All Benefits Rolled up:
Incurred: February 1, 2013 through January 31, 2014 paid February 1, 2013 through March 31, 2014

Month Paid	Medical Paid	Rx Paid	Total Paid	Contracts Single	2-Person	Family	TOTAL Lives	Billed Contributions
Feb-13	$62,608	$25,529	$88,137	60	26	57	340	$170,449
Mar-13	$108,534	$24,773	$133,306	58	26	57	338	$176,778
Apr-13	$112,818	$29,932	$142,751	59	25	56	335	$172,065
May-13	$196,323	$38,008	$234,331	61	25	57	340	$172,190
Jun-13	$132,367	$33,406	$165,774	60	26	58	345	$175,802
Jul-13	$85,806	$31,714	$117,520	57	28	57	342	$179,321
Aug-13	$94,339	$29,847	$124,186	58	28	58	347	$176,447
Sep-13	$81,997	$33,732	$115,730	58	28	57	341	$179,249
Oct-13	$115,161	$28,345	$143,506	59	28	55	335	$176,595
Nov-13	$147,300	$26,599	$173,899	61	29	53	333	$169,896
Dec-13	$77,080	$25,439	$102,519	60	29	54	335	$172,659
Jan-14	$103,168	$31,895	$135,062	61	29	51	325	$194,676
Feb-14	$98,288		$98,288					
Mar-14	$1,960		$1,960					
	$1,417,750	$359,219	$1,776,968	712	327	670	4,056	$2,116,128
							L/R	84.0%

Medical Claims All Benefits Rolled up:
Incurred: February 1, 2012 through January 31, 2013 paid February 1, 2012 through March 31, 2013

Month Paid	Medical Paid	Rx Paid	Total Paid	Contracts Single	2-Person	Family	TOTAL Lives	Billed Contributions
Feb-12	$35,210	$19,697	$54,907	61	33	53	334	$174,096
Mar-12	$87,131	$24,370	$111,501	61	33	53	334	$172,204
Apr-12	$138,383	$35,490	$173,873	62	32	53	333	$172,204
May-12	$95,062	$26,408	$121,470	64	31	52	330	$170,382
Jun-12	$99,959	$29,078	$129,037	63	31	53	333	$170,052
Jul-12	$84,260	$40,174	$124,434	61	30	54	331	$172,258
Aug-12	$95,233	$22,243	$117,476	64	30	56	343	$175,984
Sep-12	$84,088	$28,010	$112,099	64	30	56	343	$175,557
Oct-12	$101,495	$40,976	$142,471	63	30	56	342	$175,557
Nov-12	$91,011	$21,238	$112,250	61	29	57	342	$171,913
Dec-12	$118,123	$23,550	$141,673	61	28	57	340	$179,137
Jan-13	$180,619	$36,501	$217,120	61	26	57	338	$170,585
Feb-13	$123,275		$123,275					
Mar-13	$17,640		$17,640					
	$1,351,489	$347,736	$1,699,224	746	363	657	4,043	$2,079,928
							L/R	81.7%

Suncook Valley Combination

Medical Claims All Benefits Rolled up:

Incurred: February 1, 2011 through January 31, 2012 paid February 1, 2011 through March 31, 2012

				Contracts			TOTAL	Billed
Month Paid	Medical Paid	Rx Paid	Total Paid	Single	2-Person	Family	Lives	Contributions
Feb-11	$38,919	$23,351	$62,270	65	36	53	342	$164,795
Mar-11	$131,806	$30,851	$162,658	67	36	53	344	$167,268
Apr-11	$137,839	$29,549	$167,388	67	36	53	345	$170,227
May-11	$115,763	$31,794	$147,557	66	36	53	344	$168,184
Jun-11	$73,210	$33,099	$106,309	66	36	53	347	$168,793
Jul-11	$116,940	$20,001	$136,941	66	35	54	348	$166,333
Aug-11	$146,069	$35,066	$181,134	67	34	55	350	$170,627
Sep-11	$96,910	$33,284	$130,194	66	32	55	344	$165,513
Oct-11	$157,032	$29,881	$186,913	65	32	54	339	$164,312
Nov-11	$168,544	$20,460	$189,004	65	32	54	338	$159,659
Dec-11	$100,369	$27,159	$127,528	65	32	55	343	$167,710
Jan-12	$104,785	$35,085	$139,870	62	33	53	335	$173,578
Feb-12	$72,968		$72,968					
Mar-12	$8,495		$8,495					
	$1,469,648	$349,580	$1,819,228	787	410	645	4,119	$2,006,999
							L/R	90.6%

Claims in excess of $150,000

Incurred: 2/1/13-1/31/14 paid 2/1/13-3/31/14

Claim Amount	Status of Membership
$187,357	ACTIVE

Incurred: 2/1/12-1/31/13 paid 2/1/12-3/31/13

Claim Amount	Status of Membership
$173,707	ACTIVE

Incurred: 2/1/11-1/31/12 paid 2/1/11-3/31/12

Claim Amount	Status of Membership
NONE	