2017 HEALTH & DENTAL PLAN OPTIONS

Town Administrator Shaun Mulholland

TOWN OF ALLENSTOWN 16 School St. Allenstown N.H.

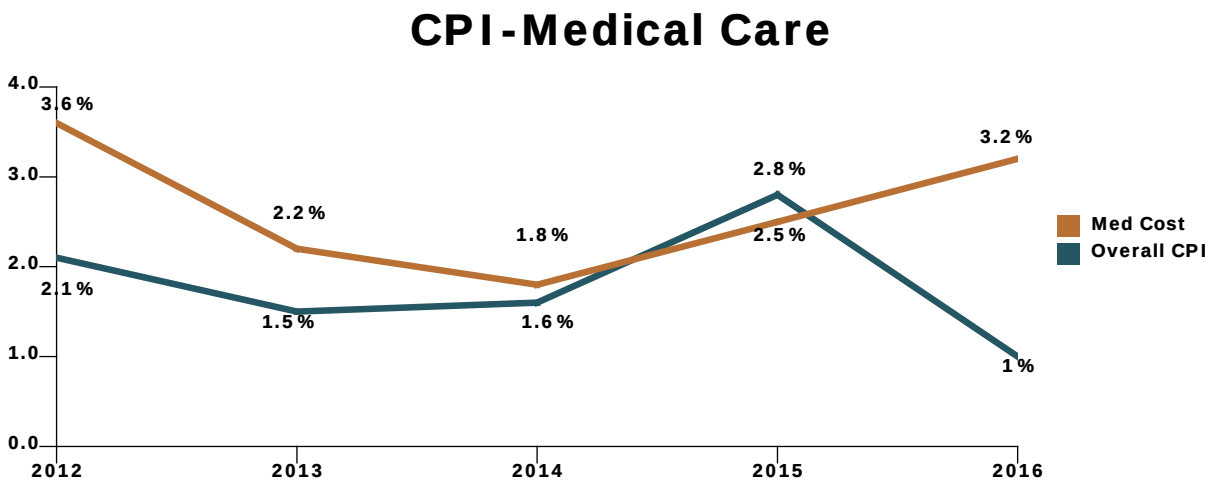
INTRODUCTION

The Suncook Valley Regional Town's Association (SVRTA) generated an RFP for health and dental insurance for the seven towns/entities it serves to take effect on January 1st, 2017. The RFP was sent to the three public health insurance pools serving municipalities (NH Health Trust, School Care and NH Inter-Local Trust. NH Health Trust and School Care both submitted proposals. NH Inter-Local Trust indicated they were not in a position at this time to submit a proposal. Proposals were due on June 13th, 2016.

NH Health Trust made a presentation to officials and employees on July 7th, 2016. School Care made a similar presentation to officials on July 13th, 2016. Both entities provided premium prices as they existed at the time of the RFP submission deadline. Health Trust will provide new rates at the end of October which will take effect on January 1st, 2017. School Care provided costs which will be in effect until June 30th, 2017. The rates for July 1st, 2017 will not be available until mid-November.

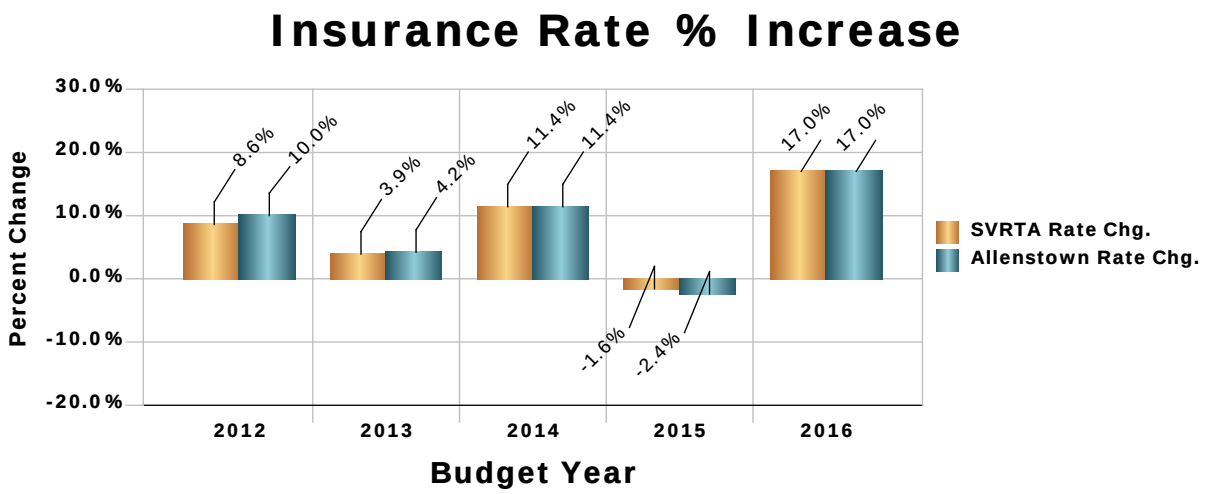
Insurance costs are a national issue. There are four major inter-relating factors which impact health and dental insurance coverage. These are the cost of medical services, premium rates, covered services and the impending excise tax on health insurance employer/employee premium costs commonly referred to as the "Cadillac Tax".

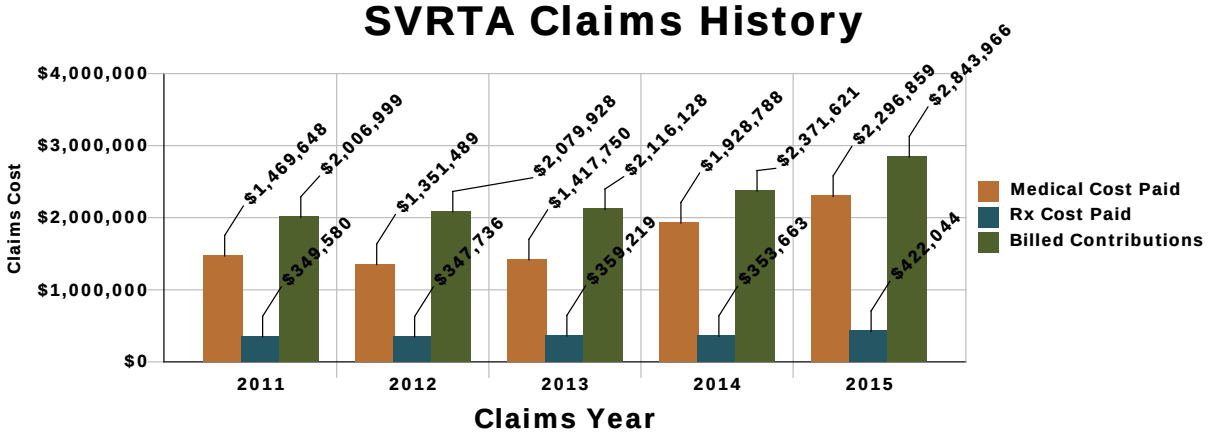
Cost of Medical Services. The cost of medical services has increased at a rate higher than the overall consumer price index.



Consumer Price Index for medical care costs for the Northeast Region. Percentage for 2016 is through May.
Consumer Price Index for US for all items. Percentage for 2016 is through May.

Premium Rates. The cost of health insurance premium rates has grown at a rate faster than the inflation cost of medical services. The rate change from 2015 to 2016 was just over 17%. This was due to a higher claims volume within the SVRTA group. This was partially offset by the much larger NH Health Trust group pool.





Covered Services. The primary purpose of health & dental insurance is to provide coverage for the services employees and their families need to stay healthy. The Town provided the Blue Choice plans through NH Health Trust and its insurance carrier Anthem Blue Cross/Blue Shield until the end of 2014. The Blue Choice plan was a Point of Service (POS) plan. The cost of this plan increased at a rate which was not sustainable by the Town. The Town chose to offer the HMO plans for the 2015/2016 contract with NH Health Trust. The plans offered by the Town in 2015/2016 included the POS plan however the cost share was approximately 60% Town/40% Employee. The two HMO plans provided the 80%/20% cost share. The Town provided the same dollar amount toward the POS plan that it provided for the HMO plans. Employees had a choice to select the POS plan however they would be responsible for the increased cost share.

The shift in plans from the POS plan to the HMO plan shifted more costs onto employees and their families. The office co-pays doubled from $10 to $20, ER visits doubled from $50 to $100. The prescription drug plan increased from $1/$5/$10 to $10/$25$/40 ($10/$40/$70 for mail order 90 day supply). The number of visits to specialists that were covered by insurance were reduced in half in some cases. Although the reduction in premium rates reduced the employee costs enough to make up for

many but not all of the additional costs passed onto employees due to the additional co-pays and other costs passed onto employees.

Excise Tax. The excise tax on medical insurance plans is a component of the Patient Affordability Care Act commonly known as the ACA or Affordable Care Act. The tax is a 40% excise tax on health insurance plans which cost more than designated amounts. The threshold amounts were set at $10,200 for a single plan and $27,500 for a two person or family plan. Plans with premiums higher than that are to be subject to the tax for those amounts in excess of the threshold levels. The tax was scheduled to take effect in 2018 however the federal government has delayed the imposition of the tax until 2020. The threshold amounts included the amount the employer and employee paid for premiums as well as employer/employee contributions to Health Savings Accounts (HSA), Health Reimbursement Accounts (HRA) and Healthcare Flexible Spending Accounts (FSA). If the Town continued to provide the POS plans the plan was projected to be subject to the tax in 2018. The calculations were based on a projected 6.8% average increase in rates. We know from experience rates have increased at a far faster rate.

The threshold amounts are supposed to be indexed starting in 2018. However it is still unknown what index will be used. Will it be the CPI, Medical CPI or some other factor? The present HMO plan offered by the Town is not projected to exceed the threshold amounts however that calculation is still based on the same 6.8% inflator each year. We will need to continue to monitor the rates as we approach the new date for imposition of the excise tax.

HEALTH TRUST PROPOSAL

NH Health Trust is the present provider of health and dental insurance for the SVRTA communities. Health Trust serves over 70,000 people with 350 insured groups. Health Trust provides POS, HMO and High Deductible Health Care plans through Anthem Blue Cross/Blue Shield of New England. Northeast Delta Dental is the dental care provider. The Town presently offers the POS plan BC2T10+, HMO plan AB20 and HMO plan AB15IPED health insurance plans. All of our employees are presently on the HMO Plan AB20. The dental plan is the Option 1 plan. There are 32 employees enrolled in the medical insurance plan and 33 in the dental insurance plan. The Town also offers Medicare plans to retired employees and their spouses. The Medicare plan premiums are billed directly to retiree directly from Health Trust. The premiums are paid for by the retiree with no subsidy from the Town.

Health Trust will continue to offer the same range of plans as before. The proposal includes some new options which offer lower premiums. These lower cost plans would involve deductibles as well as changes in copays. These plans are designed to enhance consumerism with plan users. The ABSOS Plan or Site of Service plan offers the most significant reduction in premium costs. *See full Health Trust proposal for details.*

SCHOOL CARE PROPOSAL

School Care provides health and dental insurance as a public entity pool to 25,000 people. This public entity pool was created in 1995. School Care provides coverage to school districts, municipalities and counties within NH. School Care provides a range of health insurance plans similar to Health Trust. The health and dental care provider is Cigna. The plans offered are basically two types, traditional plans and consumer driven plans. All of the plans are open access allowing for self-referral without a PCP referral

similar to Health Trust. School Care offers a traditional HMO (Green Plan) and a hybrid plan (Red Plan). They are no longer offering a POS plan. The consumer driven plans have deductibles which can be matched with a Health Reimbursement Account (HRA). The Yellow Plan with the Choice Fund has a built in HRA. School Care does limit the HRA contribution amounts to 50%. The reason for this is to enhance medical consumerism by plan users.

School Care also offers medicare coverage plans with a similar arrangement that Health Trust has for direct billing of retirees. The Cigna provider network is extensive throughout the country for health insurance. The dental provider network is smaller than the Northeast Delta Dental network employees presently have access to.

School Care utilizes Benefit Strategies as a third party contractor to manage their FSA and Choice Fund HRA programs.

See full School Care proposal for details.

GENERAL COMPARISONS AND CONTRASTS

The entities provide many programs which are consistent.

1. The plans offered by both entities are compliant with the provision of the ACA.
2. The entities provide Employee Assistance Programs (EAP).
3. Wellness programs designed to reduce the need for medical services.
4. Preventative care is covered at no additional cost and no copay.
5. Both have tiered prescription drug programs with mail order options at a savings.
6. The dental care plans are very similar in regards to what is covered.

There are some clear differences between the proposals.

1. School Care has a large Cigna nationwide provider network. The Anthem Blue Access Network is a New England wide network.
2. School Care's plans provide the same programs throughout all of their plans while Health Trust plans can be modified to meet the specific needs of large group participants.
3. Health Trust provides transitional care for families of employees who are deceased while employed with the town. The plan provides lifetime coverage for spouses and qualified dependents of employees who are deceased as a result of a work related injury.
4. School Care has a 20% coinsurance on all of its plans (other than the Green Plan) for most services. Health Trust has coinsurance for durable medical equipment on its HMO plans and a 30% coinsurance on Lumenos plans for out of network services.
5. Both have out of pocket maximums. School Care's amounts are lower while Health Trust amounts are considerably higher.
6. Health Trust allows for a calendar budget cost period whereas School Care operates on a July to June calendar which coincides with schools.
7. School Care provides for a built in HRA on its Yellow Plan. Health Trust manages an FSA however it does not provide for an HRA. Both entities work with third party providers for HRAs and Health Saving Accounts (HSA).

The SVRTA will need to decide which vendor it will contract with to provide health & dental insurance for its employees. The plan comparison sheets are provided as appendices to this document. I will try to summarize the options for consideration based upon cost and services provided.

The plan comparisons make certain assumptions.

A. The employee/employer premium cost share remains at the present 80% employer and 20% employee.
B. The employee will participate in a Flexible Spending Account (FSA) to pay for copays, deductibles and coinsurance costs. The employer will not contribute to the FSA. The employer will pay for the cost of management fees for the FSA. There are residual savings to the employer as the money the employee places in an FSA is not subject to the FICA costs. Those employees who chose not to participate in the FSA would be responsible for the gap costs associated with each plan.
C. The employer will pay for the cost of a Health Reimbursement Account (HRA) to pay for the employer's portion of the deductible. HRAs allow for the employer to pay for actual medical costs as submitted by the employee or directly to the third party administrator. Not all employees use the full value of the deductible as they may not have medical needs which incur this cost.
D. Premium costs are based on present rates. New rates will take effect on January 1st, 2017 for Health Trust and July 1st, 2017 for School Care. We will not know the new rates until the end of October for Health Trust and the middle of November for School Care.

Note to the Reader-It is helpful to have Appendix 1, 2,3 and 4 as separate documents to conduct a side by side comparison.

HEALTH TRUST PLANS

Health Trust offers a variety of plans as well as custom plans which can be created. Three plans were examined for comparison purposes. The plans are two HMO plans and the high deductible plan. All plans have the same prescription drug plan of $10/$25/$40 for a 30 day supply and $10/$40/$70 for a 90 day mail order supply.

See Appendix 2 and 3.

HT OPTION 1- AB20

The AB20 plan is an HMO plan which is the plan all of our employees presently subscribe to.

Deductible: None.

Out of Pocket Maximum: $5,000 per member per year/$10,000 per family per year.

$1,600 per member per year/$3,200 per family per year for prescription drugs.

Copays: Yes

Coinsurance: 20% on durable medical equipment only.

HT OPTION 2-ABSOS

Deductible: $100 on durable medical equipment.

$1,000 per member per year/$3,000 per family per year

Out of Pocket Maximum: $5,000 per member per year/$10,000 per family per year.

$1,600 per member per year/$3,200 per family per year for prescription drugs.

Copays: Yes, copay for specialty visit only is $20 more than HT OPTION 1.

Coinsurance: 20% on durable medical equipment only.

This option covers 20 Physical, Occupational and Speech Therapy visits per year per member compared to the 60 visits in HT OPTION 1. This plan covers the costs of services at specified providers within the Anthem Network (*see Appendix 6 & 7)*. This selected list of providers have been determined to be the most cost effective providers in the network in a given area and yet provide the same quality of service. When a member chooses not to utilize the specified provider in their area, the member pays the additional cost for services.

This plan presumes the employee will fund a FSA for a minimum of $500 to cover the deductible and the employer will provide an HRA up to the amount needed ($500-Single, $2,000 2-person & family) to cover the cost of the remaining deductible.

HT OPTION 3-LUMENOS

Deductible: $2,500 per member per year/$5,000 per 2-person or family per year.

Out of Pocket Maximum: $5,000 per member per year/$10,000 per family per year.

Copays: No

Coinsurance: 20% on durable medical equipment only. 30% on out of network costs only once OOP maximum is met.

This plan option does not have copays just deductibles. Once the deductibles are met all costs are paid in full if they are in the Anthem Network for the services covered in the plan. There is a coinsurance cost of 30% for any costs outside the network after the deductible has been met.

This plan presumes the employee will fund a FSA (a minimum of $500-single, $1,000 2-person & family) to cover the deductible and the employer will provide an HRA up to the amount needed ($2,000-single, $4,000 2-person & family) to cover the cost of the remaining deductible.

SCHOOL CARE OPTIONS

School Care offers a variety of plans. Four plans were examined for comparison purposes. The plans are one HMO plan and three high deductible plans. All plans cover the same services with different cost shares.

See Appendix 4

SC OPTION 1-RED PLAN

The Red plan is an HMO plan which is the plan which is most similar to the Health Trust AB20 plan we have now.

Deductible: $250 per member per year/$500 per 2-person & family per year.

Out of Pocket Maximum: $1,000 per member per year/$2,000 per family per year.

$2,000 per member per year/$4,000 per family per year for prescription drugs.

Copays: Yes

Coinsurance: 20% on all services except prescription drugs, preventative care and behavioral health out patient. Coinsurance applies to services until the OOP maximum is reached only

The prescription drug plan is tiered at $10/$30/$65 for a 30 day supply and $10/$30/$65 for a 90 day mail order supply.

This plan presumes the employee will fund a FSA (a minimum of $250-single, $500 2-person & family) to cover the deductible.

SC OPTION 2-YELLOW w/CHOICE FUND

This plan is a consumer driven high deductible plan with a built in HRA managed by third party Benefits Strategy. The employee would be responsible for the deductible through an FSA.

Deductible: $1,250 per member per year/$2,500 per 2-person & family per year.

Out of Pocket Maximum: $2,000 per member per year/$4,000 per family per year.

Copays: No

Coinsurance: 20% on all services except prescription drugs and preventative care. Coinsurance applies to services until the OOP maximum is reached only

The prescription drug plan is not tiered like the RED Plan. Prescription drugs are subject to the deductible and 10% coinsurance until the OOP maximum is reached ($75 max after deductible).

SC OPTION 3-YELLOW PLAN

This plan is the same as the YELLOW Plan above without the Choice Fund built in HRA. The employee would be responsible for half of the deductible to be paid through an FSA and the employer would be responsible for the other half through and HRA.

Deductible: $1,250 per member per year/$2,500 per 2-person & family per year.

Out of Pocket Maximum: $2,000 per member per year/$4,000 per family per year.

Copays: No

Coinsurance: 20% on all services except prescription drugs and preventative care. Coinsurance applies to services until the OOP maximum is reached only.

The prescription drug plan is not tiered like the RED Plan. Prescription drugs are subject to the deductible and 10% coinsurance until the OOP maximum is reached ($75 max after deductible).

SC OPTION 4-ORANGE PLAN

The ORANGE Plan is very similar to the YELLOW Plan except that the deductible is higher.

Deductible: $2,000 per member per year/$4,000 per 2-person & family per year.

Out of Pocket Maximum: $4,000 per member per year/$8,000 per family per year.

Copays: No

Coinsurance: 20% on all services except prescription drugs and preventative care. Coinsurance applies to services until the OOP maximum is reached only.

The prescription drug plan is not tiered like the RED Plan. Prescription drugs are subject to the deductible and 10% coinsurance until the OOP maximum is reached ($75 max after deductible). Some generic preventative drugs are no cost.

This plan could be matched by an FSA or Health Savings Account (HSA) for the employee portion of the cost. The employer could match the FSA with an HRA. If an HSA is utilized the employee and the employer could both contribute to the HSA.

SCHOOL CARE OR HEALTH TRUST?

A careful examination of plans provided by both entities indicates the Health Trust plans are still a better value for the employee and the employer. If you examine the total cost of services covered the Health Trust plans provide for a better schedule of services for the cost of the premium. The coinsurance costs of the School Care plans add additional costs to employees up to the OOP maximum. There is no resultant savings to employees for these plans other than for those employees and their family members who do not use medical services. My recommendation would be to continue with the Health Trust Plans.

WHICH HEALTH TRUST PLAN TO OFFER?

HT OPTION 1 AB20 provides the most options and coverage for employees.

HT OPTION 2 ABSOS provides and overall reduction in cost to employees and the employer. Employees who do not use medical services would be able to roll over the $500 in FSA contributions into the next year. The FSA contribution is tax exempt for the employee and exempt for the employee/employer for the FICA contribution. The HRA contribution is for actual medical costs incurred. If employees use no or a small amount of the contribution the employer saves on this cost. The employer is only liable up to

the maximum amount of the HRA contribution. The FSA amounts would be used first before the HRA funds are drawn upon. HRA funds which are not used are returned to the employer. Employees are provided an incentive to use the less cost site of service approved medical providers within the Anthem network. Employees would have to pay the additional costs over what would be covered by the SOS provider for the same service. The smaller network within the network may result in some employees traveling a little further for services than they do now. Employees would have to weigh the benefit of the SOS network for a given service versus the travel costs. Either way this plan provides choice to the employee. Specialty copay visits double from $20 per visit to $40. The number of physical, occupational and speech therapy visits per year would be reduced from 60 to 20. All other provisions are the same was the present AB20 Plan.

HT OPTION 3-Lumenos Plan is more expensive for employees and the employer under the model we have used in this analysis. Employees and family members who utilize little or no medical services benefit from the lower costs as the deductible portion would not be utilized. However for those employees and families who do use more medical services they will incur more of the costs. The proposed HRA and FSA benefit the employer and the employee for employees utilizing limited medical services. The first $1,000 in deductible would be paid by the employee. Costs attributed to the HRA would be for actual medical costs incurred. Some employees will not reach the full deductible amount which results in a savings in the HRA account for the employer.

DENTAL CARE PLANS

The dental care plans have not changed significantly in cost or coverage. I would recommend continuation of the existing dental plan.

SUMMARY

The Board of Selectmen will need to determine which plan or plans it will offer, what the cost share will be and for those plans with deductibles how much of the deductible will be covered by an HRA or similar IRS established health account. Assuming the SVRTA chooses to award the proposal to Health Trust the Board can continue to offer the AB20 plan or any of the other plans under the models used in the comparison or some version thereof.

Appendix 1

HEALTH COST COMPARISON

Preimum Cost				Annual Employee Cost			Annual Employer Cost				TOTAL
		Monthly	Annual	Premium 20%	FSA	TOTAL	Employer 80%	HRA	Mgt. Fees	Total	
HEALTH TRUST PLANS											
AB20	Single	$734	**$8,808**	$1,762		**$1,762**	$7,046			**$7,046**	**$8,808**
	2-Person	$1,468	**$17,616**	$3,523		**$3,523**	$14,093			**$14,093**	**$17,616**
	Family	$1,981	**$23,772**	$4,754		**$4,754**	$19,018			**$19,018**	**$23,772**
ABSOS	Single	$592	**$7,104**	$1,421	$500	**$1,921**	$5,683	$500	$103	**$6,286**	**$8,207**
	2-Person	$1,183	**$14,196**	$2,839	$500	**$3,339**	$11,357	$2,000	$103	**$13,460**	**$16,799**
	Family	$1,597	**$19,164**	$3,833	$500	**$4,333**	$15,331	$2,000	$103	**$17,434**	**$21,767**
Lumenos	Single	$618	**$7,416**	$1,483	$500	**$1,983**	$5,933	$2,000	$103	**$8,036**	**$10,019**
	2-Person	$1,236	**$14,832**	$2,966	$1,000	**$3,966**	$11,866	$4,000	$103	**$15,969**	**$19,935**
	Family	$1,669	**$20,028**	$4,006	$1,000	**$5,006**	$16,022	$4,000	$103	**$20,125**	**$25,131**
SCHOOL CARE PLANS											
Red	Single	$701	**$8,412**	$1,682	$250	**$1,932**	$6,730		$73	**$6,803**	**$8,735**
	2-Person	$1,401	**$16,812**	$3,362	$500	**$3,862**	$13,450		$73	**$13,523**	**$17,385**
	Family	$1,892	**$22,704**	$4,541	$500	**$5,041**	$18,163		$73	**$18,236**	**$23,277**
Yellow C	Single	$678	**$8,136**	$1,627	$250	**$1,877**	$6,509		$73	**$6,582**	**$8,459**
	2-Person	$1,356	**$16,272**	$3,254	$500	**$3,754**	$13,018		$73	**$13,091**	**$16,845**
	Family	$1,830	**$21,960**	$4,392	$500	**$4,892**	$17,568		$73	**$17,641**	**$22,533**
Yellow	Single	$594	**$7,128**	$1,426	$625	**$2,051**	$5,702	$625	$146	**$6,473**	**$8,524**
	2-Person	$1,189	**$14,268**	$2,854	$1,250	**$4,104**	$11,414	$1,250	$146	**$12,810**	**$16,914**
	Family	$1,605	**$19,260**	$3,852	$1,250	**$5,102**	$15,408	$1,250	$146	**$16,804**	**$21,906**
Orange	Single	$523	**$6,276**	$1,255	$1,000	**$2,255**	$5,021	$1,000	$146	**$6,167**	**$8,422**
	2-Person	$1,046	**$12,552**	$2,510	$2,000	**$4,510**	$10,042	$2,000	$146	**$12,188**	**$16,698**
	Family	$1,412	**$16,944**	$3,389	$2,000	**$5,389**	$13,555	$2,000	$146	**$15,701**	**$21,090**

Town of Allenstown - Benefit Comparison

Single	$734; $1,468; $1,981	$632; $1,263; $1,705	$592; $1,183; $1,597
2 Person			
Family			

HealthTrust

		Access Blue (AB20)	Access Blue (AB15/40IPDED)	Access Blue Site of Service (ABSOS20/40/1KDED)
		Network Benefits (2)	Network Benefits (2)	Network Benefits (2)
Cost Sharing	PCP Visit Copayment	$20 per visit	$15 per visit	$20 per visit
	Specialty Visit Copayment	$20 per visit	$40 per visit	$40 per visit
	Emergency Room Copayment	$100 per visit	$250 per visit	$100 per visit
	Urgent Care Facility Copayment	$50 per visit	$125 per visit	$50 per visit
	Standard Deductible	N/A	$1,000 per Member, per year; $3,000 per family, per year	$1,000 per Member per year; $3,000 per family per year
	Standard Coinsurance	N/A	N/A	N/A
	Coinsurance Maximum	N/A	N/A	N/A
	Durable Medical Equipment	You pay 20%	You pay 20% after separate $100 per Member, per year deductible	You pay 20% after separate $100 per Member, per year deductible
	Out-of-Pocket Limit (1)	$5,000 per Member, per year; $10,000 per family, per year	$5,000 per Member, per year; $10,000 per family, per year	$5,000 per Member, per year; $10,000 per family, per year
Inpatient	Inpatient Services; medical, surgical and maternity admissions	You pay $0	Standard Deductible	Standard Deductible
Preventive Care	Immunizations, cancer screenings: mammograms, pap smears, routine colonoscopy; routine physical exams, nutrition counseling, routine hearing exams (one exam each year)	You pay $0	You pay $0	You pay $0
	Routine Eye Exams (one exam per calendar year 18 years and younger; once every two years thereafter)	You pay $0	You pay $0	You pay $0
Eyewear	Frames/Lenses	$40 reimbursement per Member, per year	N/A	N/A
Outpatient	Medical exams, telemedicine and online visits, consultations, medical treatments	Visit Copayment or Specialty Visit Copayment	Visit Copayment or Specialty Visit Copayment	Visit Copayment or Specialty Visit Copayment
	Outpatient surgery, laboratory, x-rays, ultrasounds	You pay $0	You pay $0 (3)	Standard Deductible (4)
	MRA, MRI, PET, SPECT, CT Scan, CTA, Chemotherapy, medical supplies and drugs	You pay $0	Standard Deductible	Standard Deductible
	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" or "Outpatient Facility 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" or "Outpatient Facility 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" or "Outpatient Facility Care."
Emergency Room and Urgent Care	Use of the emergency room (copayment waived if you are admitted)	Emergency Room Copayment	Emergency Room Copayment	Emergency Room Copayment
	Use of an urgent care facility	Urgent Care Facility Copayment	Urgent Care Faciltiy Copayment	Urgent Care Facility Copayment
	Physician's fee, surgery, MRA, MRI, PET, SPECT, CT Scan, CTA, medical supplies and drugs while in the emergency room	You pay $0	Standard Deductible	Standard Deductible
	Laboratory and x-ray tests while in the emergency room	You pay $0	You pay $0	Standard Deductible
	Ambulance Services - must be medically necessary	You pay $0	Standard Deductible	Standard Deductible
Outpatient Physical Rehab	Physical, Occupational and Speech Therapy	Specialty Visit Copayment, up to a combined maximum of 60 visits per Member, per year	Specialty Visit Copayment, up to a combined maximum of 60 visits per Member, per year	Specialty Visit Copayment, up to 20 visits per therapy per Member, per year
	Cardiac Rehabilitation Visits	Specialty Visit Copayment	Specialty Visit Copayment	Specialty Visit Copayment
	Chiropractic Care	Specialty Visit Copayment, up to 12 visits per Member, per year	Specialty Visit Copayment, up to 12 visits per Member, per year	Specialty Visit Copayment, up to 12 visits per Member, per year
	X-ray tests performed by a chiropractor	You pay $0	You pay $0	Standard Deductible

Town of Allenstown - Benefit Comparison

HealthTrust

		Access Blue (AB20)	Access Blue (AB15/40IPDED)	Access Blue Site of Service (ABSOS20/40/1KDED)
		Network Benefits (2)	**Network Benefits (2)**	**Network Benefits (2)**
Behavioral Health Care	**Outpatient Behavioral Healthcare and Substance Abuse Treatment**	Visit Copayment or Specialty Visit Copayment, Unlimited visits	Visit Copayment or Specialty Visit Copayment, Unlimited visits	Visit Copayment or Specialty Visit Copayment, Unlimited visits
	Inpatient Behavioral Healthcare and Substance Abuse Treatment	You pay $0	Standard Deductible	Standard Deductible
Prescription Drugs	**Prescription Drugs**	Retail Pharmacy: $10 generic, $25 preferred brand-name, $40 non-preferred brand-name for up to 34-day supply through CVS Caremark's participating retail pharmacies. Mail Service: $10 generic, $40 preferred brand-name, $70 non-preferred brand-name for up to 90-day supply through CVS Caremark's mail service pharmacy. Out-of-Pocket Limit: $1,600 per Member per year; $3,200 per family per plan year. (5)	Retail Pharmacy: $10 generic, $25 preferred brand-name, $40 non-preferred brand-name for up to 34-day supply through CVS Caremark's participating retail pharmacies. Mail Service: $10 generic, $40 preferred brand-name, $70 non-preferred brand-name for up to 90-day supply through CVS Caremark's mail service pharmacy. Out-of-Pocket Limit: $1,600 per Member per year; $3,200 per family per plan year. (5)	Retail Pharmacy: $10 generic, $25 preferred brand-name, $40 non-preferred brand-name for up to 34-day supply through CVS Caremark's participating retail pharmacies. Mail Service: $10 generic, $40 preferred brand-name, $70 non-preferred brand-name for up to 90-day supply through CVS Caremark's mail service pharmacy. Out-of-Pocket Limit: $1,600 per Member per year; $3,200 per family per plan year. (5)

(1) Includes all Deductibles, Coinsurance, and Copayments you pay during a year. It does not include Your premium, penalties, amounts over the Maximum Allowable Amount (MAA) or charges for noncovered services. 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.

(2) Referrals are not required for care provided within the Access Blue New England Network.

(3) Deductible may apply for some services when surgery is performed in a hospital outpatient department, ambulatory surgical center or hemodialysis center.

(4) Laboratory tests will cost $0 if performed at a preferred site of service; Outpatient surgery will cost $75 if performed at a preferred site of service. Subject to standard deductible when not performed at a preferred site of service.

(5) Out-of-Pocket Limit Applies Per Plan Year (January Plans: 1/1 through 12/31; July Plans: 7/1 through 6/30).

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

This chart is intended for summary purposes only. Details of coverage are set forth in separate documents, which govern these plans.

HealthTrust

Town of Allenstown
Proposed Rates and Benefit Options
Suncook Valley Regional Towns Combination
Valid 01/01/2016 through 12/31/2016

The proposed alternative plans provided on this comparison may not be available with your current plan offerings. Please note plan changes and guidelines outlined in the proposal.

Current Medical Plans — *Note: BC2T10+ changing to BC2T10 effective 1/1/17.*

Medical Plan Code	BC2T10+	BC2T10	BC2T20	AB20	AB15IPDED
Prescription Plan Code	R10/25/40 M10/40/70	R10/25/40 M10/40/70	R10/25/40 M10/40/70	R10/25/40 M10/40/70	R10/25/40 M10/40/70
single	$819.80	$828.94	$786.12	$733.60	$720.93
2-person	$1,639.61	$1,657.89	$1,572.24	$1,467.19	$1,441.85
family	$2,213.47	$2,238.15	$2,122.53	$1,980.71	$1,946.50
Office Visit Copay	$10	$10	$20	$20	$15
ER Copay	$50	$50	$100	$100	$100
Urgent Care Copay	$50	$50	$50	$50	$50
Standard Deductible[1]	N/A	N/A	N/A	N/A	$500/$1,500
Self-Referred Deductible[2]	$500/$1,500	$250/$500	$250/$500	N/A	N/A
Chiro Visit Max/Copay (Y/N)	25 visits/N	35 visits/N	35 visits/N	12 visits/Y	12 visits/Y
PT, OT, ST Max/Copay (Y/N)	60 visits/N	60 visits/N	60 visits/N[3]	60 visits/Y	60 visits/Y
Durable Medical Equipment	Covered at 80% after $100 deductible	Covered at 80% after $100 deductible	Covered at 80% after $100 deductible	Covered at 80%	Covered at 80% after $100 deductible
$40 eyewear reimbursement	N/A	N/A	N/A	Benefit available once per year	Benefit available once per year
Slice of Life & SmartShopper	Included	Included	Included	Included	Included

1 - Deductible applies on certain services (per person/per family)

2 - Deductible on services accessed without a PCP referral (per person/per family)

3 - Effective 1/1/17, visits are unlimited

Medical Plan Code	MC3	MCNRX*
Prescription Plan Code	R10/25/40 M10/40/70	N/A
single	$491.18	$203.05

*Medicare Supplemental Plan without RX Coverage

Prescription Plan Code	R10/25/40 M10/40/70
Retail Pharmacy Copay (up to 34-day supply)	$10 generic
	$25 preferred brand
	$40 non-preferred brand
Mail Service Copay (up to 90-day supply)	$10 generic
	$40 preferred brand
	$70 non-preferred brand

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.

HealthTrust

Town of Allenstown
Proposed Rates and Benefit Options
Suncook Valley Regional Towns Combination
Valid 01/01/2016 through 12/31/2016

The proposed alternative plans provided on this comparison may not be available with your current plan offerings.
Please note plan changes and guidelines outlined in the proposal.

Medical Plan Code	AB15/40IPDED	ABSOS20/40 1KDED
Prescription Plan Code	R10/25/40 M10/40/70	R10/25/40 M10/40/70
single	$631.35	$591.34
2-person	$1,262.70	$1,182.67
family	$1,704.65	$1,596.61
Office Visit Copay	$15	$20
Specialist Visit Copay	$40	$40
ER Copay	$250	$100
Urgent Care Copay	$125	$50
Standard Deductible[1]	$1,000/$3,000	$1,000/$3,000
Self-Referred Deductible[2]	N/A	N/A
Chiro Visit Max/Copay (Y/N)	12 visits/Y	12 visits/Y
PT, OT, ST Max/Copay (Y/N)	60 visits/Y	20 visits per therapy/Y
Durable Medical Equipment	Covered at 80% after $100 deductible	Covered at 80% after $100 deductible
$40 eyewear reimbursement	N/A	N/A
Slice of Life & SmartShopper	Included	Included

1 - Deductible applies on certain services (per person/per family)

2 - Deductible on services accessed without a PCP referral (per person/per family)

Lumenos High Deductible Health Plan	
Medical Plan Code	Lumenos 2500
single	$618.04
2-person	$1,236.08
family	$1,668.71
Calendar Year Deductible	$2,500/$5,000
In-Network Coinsurance	Covered at 100% after deductible
Out-of-Network Coinsurance	Covered at 70% after deductible
In-Network Out-of-Pocket Maximum	$2,500/$5,000
Out-of-Network Out-of-Pocket Maximum	$5,000/$10,000
Chiro Visit Max	Unlimited
PT, OT, ST Max	60 visits
Anthem's Lumenos High Deductible Health Plans cover routine preventive care at 100% when received from a participating provider.	
Slice of Life & SmartShopper	Included

Prescription Plan Code	R10/25/40 M10/40/70
Retail Pharmacy Copay (up to 34-day supply)	$10 generic
	$25 preferred brand
	$40 non-preferred brand
Mail Service Copay (up to 90-day supply)	$10 generic
	$40 preferred brand
	$70 non-preferred brand

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.

	Plan Suite:	TRADITIONAL HEALTH PLAN SUITE		CONSUMER DRIVEN HEALTH PLAN SUITE		
	Plan Name:	GREEN OPEN ACCESS	RED OPEN ACCESS	YELLOW OPEN ACCESS with Choice Fund	YELLOW OPEN ACCESS without Choice Fund	ORANGE OPEN ACCESS
	Network:	Cigna's National Open Access Network (self referral)	Cigna's National Open Access Network (self referral)	Cigna's National Open Access Network (self referral)	Cigna's National Open Access Network (self referral)	Cigna's National Open Access Network (self referral)
	ESTIMATED Annual Premium for 2016-17	Single: $745.00 2person: $1,490.00 Family: $2,011.50	Single: $700.50 2person: $1,401.00 Family: $1,891.50	Single: $678.00 2person: $1,356.00 Family: $1,830.50	Single: $594.50 2person: $1,189.00 Family: $1,605.00	Single: $523.00 2person: $1,046.00 Family: $1,412.00
Cost Sharing	PCP Visit Copayment	$20 per visit	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum
	Specialty Visit Copayment	$20 per visit	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum
	Emergency Room Copayment	$50 per visit (waived if admitted)	$50 per visit (waived if admitted)	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum
	Urgent Care Facility Copayment	$25 per visit (waived if admitted)	$25 per visit (waived if admitted)	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum
	Standard Deductible	N/A	$250 individual / $500 family (3)	$1,250 individual / $2,500 family (4)	$1,250 individual / $2,500 family (7)	$2,000 individual / $4,000 family (8)
	Embedded Choice Fund (HRA), if activated, pays for eligible OOP expenses during plan year.	N/A	N/A	$1,000 individual / $2,000 family (5)	N/A	N/A
	Standard Coinsurance	20% DME & EPA only	20% medical only	20% medical; 10% pharmacy	20% medical; 10% pharmacy	20% medical; 10% pharmacy
	Coinsurance Maximum	N/A	$750 individual / $1,500 family	$750 individual / $1,500 family	$750 individual / $1,500 family	$2,000 individual / $4,000 family
	Durable Medical Equipment (DME) / External Prosthetic Appliances (EPA)	20%	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum
	Out of Pocket (OOP) Maximum (July 1 - June 30)	$1,000 individual / $2,000 family (1)	$1,000 individual / $2,000 family (1)	Combined Medical & Pharmacy $2,000 individual / $4,000 family (6)	Combined Medical & Pharmacy $2,000 individual / $4,000 family (6)	Combined Medical & Pharmacy $4,000 individual / $8,000 family (6)
Inpatient	Inpatient Services; medical, surgical and maternity admissions	$0	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum
Preventive Care	Routine immunizations, cancer screenings: mammograms, pap smears, routine colonoscopy; routine physical exams, nutrition counseling	$0	$0	$0	$0	$0
	Routine Hearing Exams	$0	$0	$0	$0	$0
	Routine Eye Exams (one every 12 months for all ages)	$0	$0	$0	$0	$0
Eyewear	Frames/Lenses	Discounts Available for Eyewear	Discounts Available for Eyewear	Discounts Available for Eyewear	Discounts Available for Eyewear	Discounts Available for Eyewear
Outpatient	Medical exams, consultations, medical treatments	$20 per visit	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum
	Outpatient surgery, laboratory, x-rays, ultrasounds	$0	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum
	MRA, MRI, PET, SPECT, CT Scan, CTA, Chemotherapy, medical supplies and drugs	$0	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum
	Maternity Care	plan pays 100% after $20 initial visit to confirm pregnancy	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum
rgency Room and Urgent Care	Use of the emergency room	$50 per visit (waived if admitted)	$50 per visit (waived if admitted)	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum
	Use of an urgent care facility	$25 per visit (waived if admitted)	$25 per visit (waived if admitted)	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum
	Physician's fee, surgery, MRA, MRI, PET, SPECT, CT Scan, CTA, medical supplies and drugs while in the emergency room	$0	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum
	Laboratory and x-ray tests while in the emergency room	$0	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum

	Plan Suite:	TRADITIONAL HEALTH PLAN SUITE		CONSUMER DRIVEN HEALTH PLAN SUITE		
	Plan Name:	GREEN OPEN ACCESS	RED OPEN ACCESS	YELLOW OPEN ACCESS with Choice Fund	YELLOW OPEN ACCESS without Choice Fund	ORANGE OPEN ACCESS
Emer	Ambulance Services - must be medically necessary	$0	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum
Outpatient Physical Rehab	Physical, Occupational and Speech Therapy (combined 60 day limit per person per plan year)	$20 per visit	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum
	Cardiac Rehabilitation Visits (included with PT, OT, Speech Therapy above combined 60 day limit per person per plan year)	$20 per visit	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum
	Chiropractic Care (20 days per person per plan year)	$20 per visit	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum
	X-ray tests performed by a chiropractor	No charge after $20 copay	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum
Behavioral Health	Outpatient Behavioral Healthcare and Substance Abuse Treatment	$20 per visit	$0	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum
	Inpatient Behavioral Healthcare and Substance Abuse Treatment	$0	$0	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum	Deductible, 20% coinsurance to OOP maximum
Prescription Drugs	Retail - Generic/Preferred/Non-Preferred (30 day supply)	$10/$30/$65	$10/$30/$65	Deductible, 10% coinsurance to OOP maximum ($75 max after deductible)	Deductible, 10% coinsurance to OOP maximum ($75 max after deductible)	Deductible, 10% coinsurance to OOP maximum ($75 max after deductible)
	Cigna Home Delivery - Generic/Preferred/Non-Preferred (90 day supply)	$10/$30/$65	$0/$30/$65	Deductible, 10% coinsurance to OOP maximum ($75 max after deductible)	Deductible, 10% coinsurance to OOP maximum ($75 max after deductible)	Deductible, 10% coinsurance to OOP maximum ($75 max after deductible)
	Out of Pocket Limit (July 1 - June 30)	$2,000 individual / $4,000 family (2)	$2,000 individual / $4,000 family (2)	Combined Medical & Pharmacy $2,000 individual / $4,000 family (6)	Combined Medical & Pharmacy $2,000 individual / $4,000 family (6)	Combined Medical & Pharmacy $4,000 individual / $8,000 family
Other Benefits	Health Reimbursement Arrangement (HRA)	N/A	N/A	Embedded HRA pays first portion of the deductible (if activated); ER contribution not allowed.	ER may contribute up to 50% of OOP max	ER may contribute up to 50% of Deductible
	Health Savings Account (HSA)	Not Eligible	Not Eligible	Not Eligible	Not Eligible	Eligible
	Employee Assistance Program	Included	Included	Included	Included	Included
	Wellness Program	Included: $800 individual / $400 spouse	Included: $800 individual / $400 spouse	Included: $800 individual / $400 spouse	Included: $800 individual / $400 spouse	Included: $800 individual / $400 spouse
	ESTIMATED Annual Dental Premium for 2016-17	Refer to proposal				
	Dental Benefits	Refer to proposal				

(1) All deductibles, coinsurance, and copayments contribute towards the out-of-pocket maximum, with no one eligible family member responsible for more than his or her individual out-of-pocket maximum. Once the individual or family medical out-of-pocket maximum is satisfied, the plan will pay 100% of the covered medical expenses through the remainder of the plan year.

(2) Applies to in-network pharmacy costs. Retail and Home Delivery copays apply to the pharmacy out-of-pocket maximum per plan year.

(3) After each eligible family member meets his or her individual deductible, covered expenses for that family member will be paid based on the coinsurance level specified until they reach the out-of-pocket maximum per plan year. Or, after the family deductible has been met, covered expenses for each eligible family member will be paid based on the coinsurance level specified until they reach the out-of-pocket maximum per plan year.

(4) All eligible family members contribute towards the family plan deductible. No employer contribution toward the deductible or out-of-pocket maximum is permitted. This plan includes a combined Medical/Pharmacy plan deductible.

(5) Embedded Choice Fund (HRA) is activated by the Subscriber taking the Health Assessment on myCigna.com. Effective date of 7/1/16, subscribers can complete the Health Assessment between 7/1/17 through 8/31/17. Any remaining funds at end of plan year (6/30) will roll to subsequent years up to the out-of-pocket maximum.

(6) Plan deductible contributes towards combined Medical/Pharmacy out-of-pocket maximum. All eligible family members contribute towards the family combined Medical/Pharmacy out-of-pocket maximum. Once the family combined Medical/Pharmacy out-of-pocket maximum has been met, the plan will pay each eligible family member's covered expenses combined Medical/Pharmacy at 100%. Employer contribution toward the out-of-pocket maximum is not permitted.

(7) All eligible family members contribute towards the family plan deductible. Employer Funding (optional) subject to collective bargaining or governance policy, the employer may contribute up to 50% of the out-of-pocket maximum through an HRA, FSA or other legally permissible method. Maximum Employer funding allowed is $1,000 individual / $2,000 family. This plan includes a combined Medical/Pharmacy plan deductible.

(8) All eligible family members contribute towards the family plan deductible. Employer Funding (optional) subject to collective bargaining or governance policy, the employer may contribute up to 50% of the deductible through an HSA, HRA, FSA or other legally permissible method. Maximum Employer funding allowed is $1,000 individual / $2,000 family. This plan includes a combined Medical/Pharmacy plan deductible.

Flexible Spending Account (Section 125)
Health Reimbursement Arrangement (Section 105)

PROPOSAL FOR: Town of Allenstown, NH

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:
    - SSAE16 compliant since 2013 (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 Account & Dependent Care Reimbursement Account.

Plan Installation: **$250.00** (Doubled if proposal acceptance is within **30** days of plan start)

- ✓ Flexible benefit plan design and implementation
- ✓ Customized enrollment forms and educational materials
- ✓ Employee meetings and benefit fair attendance
- ✓ Resolution and plan documents (sample for attorney review)
- ✓ Summary Plan Description for employees

Plan Renewal: **$250.00**

- ✓ Plan design modifications
- ✓ Employee meetings and benefit fair attendance
- ✓ Amend plan documents

Monthly Administration: **$3.75** per Participant per Month

- ✓ A Health FSA and a Dependent Care FSA are considered two separate accounts.
- ✓ In months where the administrative fees do not exceed the monthly minimum, the monthly minimum will apply.
- ✓ If the plan allows a run out period for terminated employees, the fee will continue to be billed for terminated participants until the earlier of: Funds in the account are exhausted, the terminated participant's run out period ends, the plan year ends.

Debit Cards: Annual Debit Card Fee: **$5.00** per set of cards

Additional/Replacement Debit Card Fee: **$5.00** per set of cards

- ✓ Debit cards are sent in sets of two (2)
- ✓ Employees who choose to sign up for the debit card 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 employees.

Non-discrimination Testing: **$400.00** per test per plan

- ✓ Non-discrimination testing is required by the IRS annually and is available through Benefit Strategies upon request.

Please note: Fees are based on standard Benefit Strategies communications and file formats. Any special mailings, file modifications or plan rebuilds (changes to the plan once implementation has been completed) may be assessed an additional fee.

Health Reimbursement Arrangement Fee Schedule

Plan Installation: **$250.00** (Doubled if proposal acceptance is within **30** days of plan start)

- ✓ Flexible benefit plan design and implementation
- ✓ Customized educational materials
- ✓ Employee meetings and benefit fair attendance
- ✓ Resolution and plan documents (sample for attorney review)

Plan Renewal: **$250.00**

- ✓ Plan design modifications
- ✓ Employee meetings and benefit fair attendance
- ✓ Amend plan documents

Monthly Administration: **$3.75** per Participant per Month

- ✓ The administrative fee is an estimate until the plan design has been finalized
- ✓ In months where the administrative fees do not exceed the monthly minimum, the monthly minimum will apply.
- ✓ If the plan allows a run out period for terminated employees, the fee will continue to be billed for terminated participants until the earlier of: Funds in the account are exhausted, the terminated participant's run out period ends, the plan year ends.

Non-Discrimination Testing: **$400.00** per test per plan

- ✓ Non-discrimination testing is required by the IRS annually and is available through Benefit Strategies upon request.

HRA AUTOMATIC REIMBURSEMENT METHOD

Along with the claims reimbursement methods listed in this proposal, Benefit Strategies has a direct claims feeds with the following 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*.

- Aetna
- Anthem BCBS New Hampshire**
- Blue Cross Blue Shield Rhode Island
- Neighborhood Health Plan
- Anthem BCBS Maine**
- Blue Cross Blue Shield Massachusetts
- Harvard Pilgrim Health Care
- Tufts Health Plan

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**

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 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. . 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 to an employee's Health Care Reimbursement Account must be under $500 or not more than a 100% match of the employee contributions.
- 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.
- 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.
- Recently the IRS approved an optional "Rollover" which would allow employees to rollover up to $500 from the previous plan year. A plan cannot have both the grace period and rollover.
- Domestic partners are not eligible for their partner's FSA plan.
- Legally married same-sex spouses are eligible for their spouse's FSA plan.

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.
- 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 funds must remain with the originating employer and do not follow an employee to new employment.
  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.

➢ Domestic partners are not eligible for their partner's HRA plan.
➢ Legally married same-sex spouses are eligible for their spouse's HRA plan.

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	
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.

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 quarterly or monthly basis.
- HRAs may pay for expenses including items allowed under Schedule A of an employer'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 filed 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.

Claims Reimbursement Methods

Benefit Strategies generally processes claims on a daily basis. Participants may submit new claims for eligible expenses at any time during the Plan Year. Participants choosing to submit paper 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.

Benefit Strategies offers four easy methods to obtain reimbursement from an account:
***The Benny Card is not recommended for Health Reimbursement Arrangement (HRA) Administration.**

- **Benny Card –** The easiest reimbursement method is the Benefit Strategies Benny Card. The Benny Card looks like a typical credit card. It is a special card, however, which provides your employees with easy access to their reimbursement accounts to pay for IRS qualified health care or dependent care assistance expenses right at the point-of-sale on the date the services are incurred. The card will be accepted only at specific providers such as physician offices, dental offices, pharmacies, hospitals, chiropractors, optometrists, day care providers, etc.

  Once we establish the reimbursement account, the Benny Card will be sent directly to your employees' homes via US mail. (Please Note: The envelope does state "Do Not Throw Away" on the front above the mailing window.) 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 we use the IIAS (Inventory Information Approval System). IIAS is a point-of-sale technology used by retailers who accept debit cards for use with health care reimbursement accounts. An IIAS identifies eligible healthcare 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.

- **Online Reimbursement Request –** Each participant in the plan will be issued a personal login screen at www.benstrat.com. They will be given an option to file claims online where the Participant can upload receipts and submit for reimbursement. Participants choosing this method of payment may also be reimbursed by check or direct deposit.

- **Paper Reimbursement Request Form –** This reimbursement option is for participants who pay their qualified expenses out-of-pocket and submit a completed paper Reimbursement Request Form along with detailed documentation of their expenses to Benefit Strategies. An initial form (which may be copied) will be mailed to each participant. Additional 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 e-mail, fax or mail, and are reviewed and processed daily. Participants choosing to submit paper claims can choose to be reimbursed by check or direct deposit. Confirmations are provided for both forms of payment and will show current transactions and available funds.

- **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.

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:

Claims Funding Options:

- **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.

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.

- **FSA and Commuter Choice –** The FSA and Commuter Choice maintenance deposits are a calculation based on the equivalent of 2 weeks' worth of your participants' 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 client'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). We will collect the proper amount when we receive your signed claims funding agreement and your plan is finalized with enrollments in our system.

There will be a minimum of $250 billed for maintenance deposits falling below this amount.

Benefit Strategies Offers Easy Access to Your Account 24/7!

Online Access

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 after their account has been established with Benefit Strategies. We will send electronic statements to the participants via email and make these statements available for the employer monthly or at any time upon request. If any employees do not have access to the internet they may reach one of our service representatives Monday through Thursday between 8:00am and 6:00pm and Friday between 8:00 am and 5:00 pm ET.

Mobile Access

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

Our automated information center can answer most of your participants' questions. 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. Just call (888) 401-3539 or (603) 647-4666.

WWW.BENSTRAT.COM

1-888-401-FLEX (3539)

Appendix 6

You can save money on outpatient surgery and other procedures through Anthem's Site of Service benefit option.

When your employer chooses the Site of Service benefit option, use one of these ambulatory surgery centers (ASC) to help lower your out-of-pocket costs.

Facility	Dental	Ear, Nose & Throat	Gastroenterology	General	Gynecology	Neurology	Ophthalmology	Oral & Maxillofacial	Orthopedic	Pain Management	Plastic	Podiatry	Urology	Vascular
Androscoggin Valley Hospital Berlin, NH 603-752-2200 avhnh.org		X		X	X				X				X	
Atlantic Plastic Surgery Center Portsmouth, NH 603-431-8819 atlanticplasticsurg.com					X					X	X	X		
Barrington Surgical Care Barrington, NH 603-664-0100 nhpain.com										X				
Bedford Ambulatory Surgery Center Bedford, NH 603-622-3670 bedfordsurgical.com		X	X	X					X	X	X	X	X	X
Capital Orthopedic Surgery Center LLC Concord, NH 603-228-7211 concordortho.com									X					
Capital Orthopedic Surgery Center LLC Derry, NH 603-425-6966 concordortho.com									X					
Cataract and Laser Center Andover, MA 978-475-0959 CLCandover.comcastbiz.net							X				X			
Center for Pain Solutions Nashua, NH 603-577-3003 painsolutionsusa.com										X				
Concord ASC at Horseshoe Pond Concord, NH 603-415-9460 concordasc.com		X		X				X	X	X	X			X

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Facility	Dental	Ear, Nose & Throat	Gastroenterology	General	Gynecology	Neurology	Ophthalmology	Oral & Maxillofacial	Orthopedic	Pain Management	Plastic	Podiatry	Urology	Vascular
Concord Endoscopy Center LLC Concord, NH 603-415-9450 giaofnh.com			X											
Concord Eye Surgery LLC Concord, NH 603-224-6503							X							
Dartmouth Hitchcock Clinic Manchester, NH 603-629-1800 dartmouth-hitchcock.org			X											
Dartmouth Hitchcock Clinic Nashua, NH 603-577-4000 dartmouth-hitchcock.org			X											
Elliot One Day Surgery Center Manchester, NH 603-663-5900 elliot1-day.com	X	X		X	X	X	X	X	X	X	X	X	X	X
Franklin Regional Hospital ASC Franklin, NH 603-934-2060 lrgh.org	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Hillside Surgery Center Gilford, NH 603-524-7514 hillsidesurgerycenter.com		X					X		X	X	X			
Laconia Clinic ASC Laconia, NH 603-527-2760 laconiaclinic.com			X	X	X	X			X			X	X	
Lakes Region General Hospital ASC Laconia, NH 603-524-3211 lrgh.org	X	X	X	X	X	X	X	X	X	X	X	X	X	X

You can save money on outpatient surgery and other procedures through Anthem's Site of Service benefit option.

Anthem BlueCross BlueShield

When your employer chooses the Site of Service benefit option, use one of these ambulatory surgery centers (ASC) to help lower your out-of-pocket costs.

Facility	Dental	Ear, Nose & Throat	Gastroenterology	General	Gynecology	Neurology	Ophthalmology	Oral & Maxillofacial	Orthopedic	Pain Management	Plastic	Podiatry	Urology	Vascular
Lakes Region Urology ASC Laconia, NH 603-524-8660 lrgh.org													X	
Merrimack Valley Endoscopy Center Haverhill, MA 978-521-3235 pmaonline.com			X											
Nashua Ambulatory Surgery Center Nashua, NH 603-882-0950 nashuasurgical.com		X							X	X				
Northeast Surgical Care Newington, NH 603-431-5563 northeastsurgicalcare.com		X					X		X	X				
Novamed Surgery Center of Bedford LLC Bedford, NH 603-627-9540 nheyesurgicenter.com							X							
Novamed Surgery Center of Nashua LLC Nashua, NH 603-882-9800 novamedsurgeryofnashua.com							X							
Orchard Surgical Center LLC Salem, NH 603-685-4346 orchardsurgical.com		X	X	X	X		X	X	X		X	X	X	
PMC Surgical Center, LLC Merrimack, NH 603-424-8866 painmd.com										X				
PMC Surgical Center, LLC Somersworth, NH 603-692-3166 painmd.com										X				

You can save money on outpatient surgery and other procedures through Anthem's Site of Service benefit option.

Anthem BlueCross BlueShield

When your employer chooses the Site of Service benefit option, use one of these ambulatory surgery centers (ASC) to help lower your out-of-pocket costs.

Facility	Dental	Ear, Nose & Throat	Gastroenterology	General	Gynecology	Neurology	Ophthalmology	Oral & Maxillofacial	Orthopedic	Pain Management	Plastic	Podiatry	Urology	Vascular
Portsmouth Regional ASC Portsmouth, NH 603-433-0941 prasc.com		X	X	X	X		X		X	X	X	X	X	
Rye Surgical Center Rye, NH 603-319-1581 nhpain.com										X				
Skyhaven Surgery Center, LLC Rochester, NH 603-509-9161 skyhavensurgery.com			X						X			X	X	
Stratham ASC Stratham, NH 603-772-2076 strathamasc.com		X	X	X	X				X		X	X		
The Surgery Center of Greater Nashua Nashua, NH 603-578-9909 surgerycenternashua.org		X	X	X	X				X			X		
Upper Connecticut Valley Hospital Colebrook, NH 603-237-4971 ucvh.org				X					X				X	
Wentworth Surgery Center Somersworth, NH 603-285-9288 wentworthsurgerycenter.com		**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**		**X**	**X**	

List of facilities and services provided is intended as a guide to the types of surgical procedures that may be provided at the Site of Service facilities. Coverage for procedures offered at facilities varies based on the actual procedure performed and the services covered under your health benefit plan. Contact Anthem customer service for additional information regarding plan coverage prior to services being rendered. This information is provided as a guide only and is subject to change. The list of facilities can also be found on Anthem's *Find a Doctor* tool on anthem.com.

Appendix 7

Anthem BlueCross BlueShield

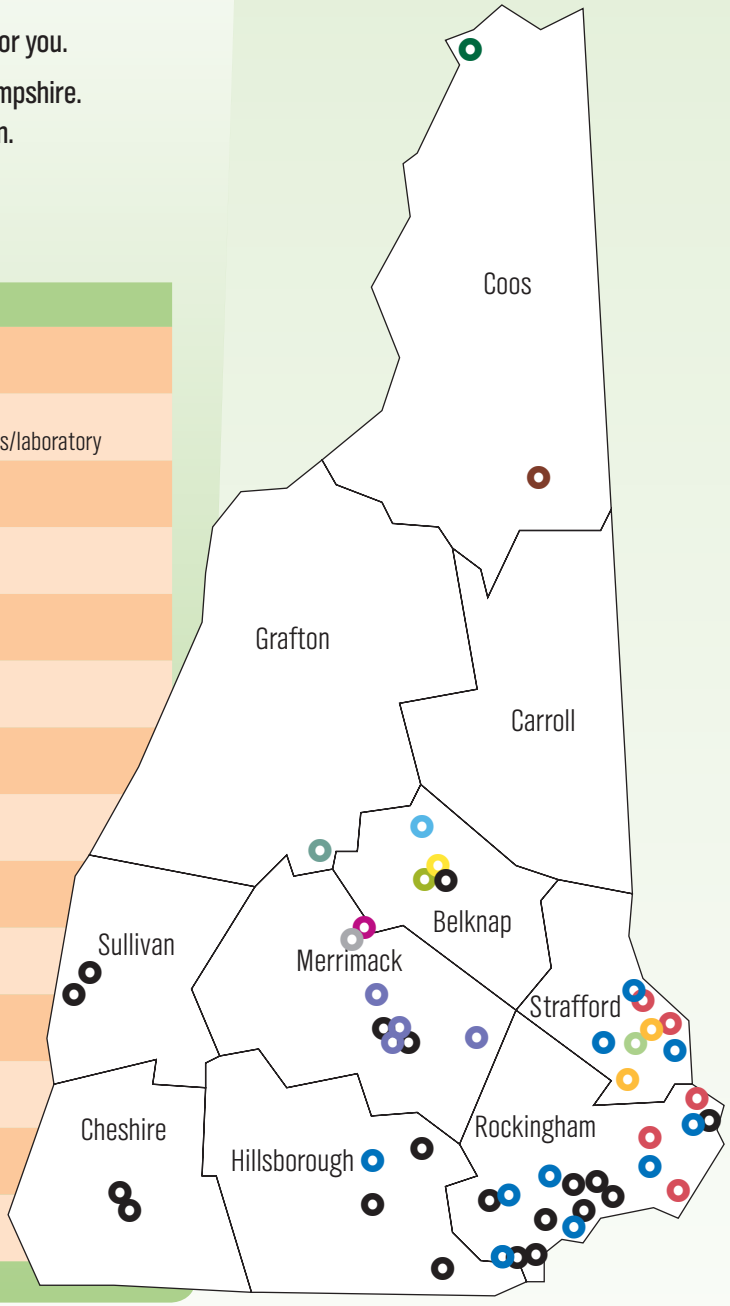
Find a high-quality, Site of Service lab facility today!

Great news! We've got high-quality, Site of Service lab choices for you.

Please take a look at our map and contact list of labs in New Hampshire. As a member, your visits will be covered 100% by your health plan.

For the most up-to-date information or for questions, please **Member Services at 1-800-870-3122**

Name	Phone number/Website
Androscoggin Valley Hospital	1-603-752-2200 avhnh.org
Concord Hospital Independent Outpatient Laboratory	1-603-225-2711 concordhospital.org/services/laboratory
Franklin Regional Hospital Lab	1-603-521-3211 ext. 3243 lrgh.org
Granite State Lab	1-603-330-7057 granitestatelab.com
Interlakes Clinical Laboratory	1-603-521-3211 ext. 3243 lrgh.org
Laboratory Corporation of America	1-855-277-8669 labcorp.com
Laconia Clinic Laboratory	1-603-521-3211 ext. 3243 lrgh.org
Lakes Region General Hospital Lab	1-603-521-3211 ext. 3243 lrgh.org
Newfound Clinical Lab	1-603-521-3211 ext. 3243 lrgh.org
Nordx	1-800-773-5814 nordx.org
Quest Diagnostics Incorporated	1-866-697-8378 questdiagnostics.com
Upper Connecticut Valley Hospital	1-603-237-4971 ucvh.org
Wentworth-Douglass Hospital	1-603-740-2559 wdhospital.com
Westside Clinical Laboratory	1-603-521-3211 ext. 3243 lrgh.org



- Androscoggin Valley Hospital
- Concord Hospital Independent Outpatient Laboratory
- Franklin Regional Hospital Lab
- Granite State Lab
- Interlakes
- LabCorp
- Laconia
- Lakes Region
- Newfound Clinical Lab
- Nordx
- Quest Diagnostics Incorporated
- Upper Connecticut Valley Hospital
- Wentworth-Douglass Hospital
- Westside

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