Town of Plaistow
145 Main Street
Plaistow, NH 03865
TEL: 603-382-5200
FAX: 603-382-7183

2024 Employee Benefit Information

Pay Day & Timesheets
Pay day is Thursday of each week. Timesheets are to be submitted to the Finance Office no later than 10AM Monday, unless otherwise specified, and signed by your supervisor. The work week begins on Sunday and ends on Saturday each week.

Beginning the first day of the month, following thirty (30) days of employment, the Town provides the following insurance benefits to Full-Time Employees:

HealthTrust Basic Life Insurance policy with a 1 ½ times salary benefit.

HealthTrust Short-Term and Long-Term Disability Insurance

(HealthTrust Basic Life, Short-Term and Long-Term Disability Insurance are Town paid benefits that the employee does not contribute to.)

Health & Dental Plan coverage: *(Optional)*

Company Monthly Rates:	**Single**	**2-Person**	**Family**
A. **HealthTrust Lumenos**	$1016.38	$2032.77	$2744.24
B. **HealthTrust Access Blue**	$1247.04	$2494.08	$3367.00
C. **Delta Dental Plan**	$ 50.49	$ 94.54	$ 174.47

HealthTrust Lumenos, Access Blue and Delta Dental plans are offered to Non-Union personnel.

D. **Plaistow Police Teamster's Union:** Allegiant Care *(Health & Dental)*	$ 974.00	$2047.00	$2598.00
E. **Plaistow Non-Police Union:** Allegiant Care *(Health & Dental)*	$ 974.00	$2047.00	$2598.00

The Town pays 85% of all the above Health/Dental coverage and the employee is responsible for 15% through payroll deduction. You may waive health insurance

coverage with a buyout option as described in the personnel plan and collective bargaining agreements. HealthTrust rates are effective January 1st annually. Allegiant Care rates are effective July 1st annually.

New Hampshire Retirement System (NHRS)

NH Retirement Membership is a condition of employment and NHRS contributions are mandatory for full-time employees for an individual who meets the requirements as indicated at NHRS Membership Eligibility for Groups I & II as indicated below. https://www.nhrs.org/employers/employer-resources/hr-personnel-resources/membership-eligibility.

Group I (Employees and Teachers)
Group II (Permanent Police and Firefighter)

You may review Member Benefits, FAQ's and Governance of the retirement system at www.nhrs.org.

Deductions:
Regular Employees have 7% deducted from pay and the Municipality contributes 13.85%. of earnings.
Police Department Employees have 11.55% deducted from pay and the Municipality contributes 31.28% of earnings.
Fire Department Employees have 11.8% deducted from pay and the Municipality contributes 30.35% of earnings.

NHRS enrollment starts on day one of employment, with deductions starting with the first paycheck.

Regular Employees are guided by the Personnel Plan and Teamsters by their contract. Copies of the appropriate document are provided on or by your first day of work.

The Town also offers **voluntary** participation in the following benefits:

457 Retirement Plan with Variable Annuity Life Insurance Company
The Sales Representative can be reached at 800-448-2542. Group #63515.

AFLAC Accident Insurance
The Sales Representative John Amero can be reached at 978-269-4338.

HealthTrust

LIFE, LONG-TERM DISABILITY (LTD), AND/OR SHORT-TERM DISABILITY (STD) APPLICATION AND CHANGE FORM

WELCOME TO HEALTHTRUST

Use this form to change your beneficiary(ies) as well as to enroll in or change your disability and/or life insurance coverage. If you only need to change your mailing address, do not complete this form; instead, call HealthTrust's Enrollee Services Department at 800.527.5001 and notify your employer.

BE SURE TO FILL OUT EACH SECTION COMPLETELY. Failure to complete each section in full could delay the start of coverage.

HOW TO COMPLETE THIS FORM

Remove this cover sheet before you begin.

STEP 1	**EMPLOYEE INFORMATION** Complete this section with your personal information, using your full legal name. Select the type of HealthTrust-sponsored life and/or disability coverage you are requesting. Please limit your selection to only those coverages offered by your employer and for which you are eligible. Some life and disability coverages may require evidence of insurability. You will not be eligible for any amount greater than the evidence of insurability requirement if you do not submit an *Evidence of Insurability* form; this form may be obtained from your employer or HealthTrust. You will be added for an amount greater than the evidence of insurability requirement once approved. For more information, refer to your certificate of coverage.
STEP 2	**REASON FOR COMPLETING APPLICATION** Use this section to indicate the reason(s) for completing form.
STEP 3	**BENEFICIARY INFORMATION** Please name your beneficiary(ies) for your life and/or disability coverages. If you wish to name a different beneficiary(ies) for your life, long-term disability (LTD), and/or short-term disability (STD) coverages, attach a separate piece of paper containing all necessary information. Otherwise, your beneficiary(ies) will be the same for all coverages. You may name more than one beneficiary. If you specify benefit percentages, the total must equal 100 percent. If you do not specify benefit percentages, benefits will be paid in equal shares. If you do not name a beneficiary(ies) – or if neither your primary nor contingent beneficiary(ies) survive you – benefits will be paid in order of survivorship shown in your certificate of coverage. Your primary beneficiary(ies) are the person(s) you name to receive benefits. Your contingent beneficiary(ies) are the person(s) you name to receive benefits if your primary beneficiary(ies) do not survive you.
STEP 4	**EMPLOYEE SIGNATURE** Sign and date this form; return completed form to your employer (retain the pink copy for your records).
STEP 5	**EMPLOYER USE ONLY** Employer must review this form and verify that steps 1-4 are completed. Employer must complete this section and forward to HealthTrust for processing at: PO Box 617, Concord, NH 03302, or through the Secure Message Center in your Secure Member Portal (SMP) account, email enrolleeservices@healthtrustnh.org or fax 603.226.2988

LIFE, LONG-TERM DISABILITY (LTD), AND/OR SHORT-TERM DISABILITY (STD) APPLICATION AND CHANGE FORM

EMPLOYEE INFORMATION

STEP 1

Last Name	First Name	MI
Social Security #	Date of Birth	Gender ☐ Male ☐ Female
Mailing Address		Telephone
City	State	Zip
Employer Name		

Marital Status

- ☐ Single
- ☐ Married
- ☐ Widowed
- ☐ Divorced/Legally Separated

TYPE OF COVERAGE REQUESTED (check)

Life Coverage

- ☐ Basic Life
- ☐ Supplemental Life
- ☐ Dependent Life

Disability Coverage

- ☐ Long-Term Disability
- ☐ Short-Term Disability

STEP 2

REASON FOR COMPLETING FORM

- ☐ New Enrollee
- ☐ Benefit Change
- ☐ Part Time to Full Time
- ☐ Other _____
- ☐ Name Change
- ☐ Change in Beneficiary ONLY

Actual Date of Event _____

BENEFICIARY INFORMATION

STEP 3

Name of Beneficiary	Date of Birth	Relation to Employee	Social Security #	Benefit Percentage
Primary Beneficiary				%
Primary Beneficiary				%
Primary Beneficiary				%
				Total: 100%
Contingent Beneficiary				%
Contingent Beneficiary				%
				Total: 100%

ENROLLEE SIGNATURE

STEP 4

I hereby authorize HealthTrust and my employer to institute the action(s) indicated on this form. If my employer requires a contribution for this coverage, this authorizes the appropriate payroll deductions. I understand that the ef fective date and termination date of my membership will be determined by HealthTrust and my employer in accordance with the plan rules. I understand that I must sign this form for claims to be processed and beneficiary designation(s) to be made valid. By signing this application, I at test to the accuracy and truthfulness and will provide documentation to HealthTrust upon request.

Enrollee Signature_____ Date ___/___/___

EMPLOYER USE ONLY

STEP 5

Date of Hire	Date of Rehire	Billing Group Name	
Full-Time Number of Hours	Part-Time Number of Hours	Base Annual Salary	Employee Job Title

Basic Life Coverage	Additional Life Coverage	Long-Term Disability Coverage	Short-Term Disability Coverage
Class Number	☐ Supplemental	Class Number	Class Number
Effective Date of Coverage	☐ Dependent	Effective Date of Coverage	Effective Date of Coverage
Basic Life Benefit Amount		Benefit Administrator Signature/Stamp	Date
Supplemental Life Benefit Amount			

HealthTrust

HealthTrust
Benefit Advantage

Town of Plaistow
Flexible Benefits Plan – *Enrollment Form*

First Name_____ Last Name_____ MI____ Gender____ Date of Birth_____ Marital Status_____

Social Security # _____ Home Telephone_____ Cell Phone_____ Personal E-mail_____

Mailing Address_____ City_____ State____ Zip_____

Premium Conversion (Pre Tax Payroll Deduction of Insurance Premiums)

I understand that by electing this option my share of the premium under the plan or plans chosen below will be deducted from my paycheck on a **pre-tax** basis. If I do not elect Premium Conversion, my share of the premium under the plan or plans will be deducted from my paycheck on an **after-tax** basis. If my premium obligation increases or decreases during the Plan Year, my salary reduction will be adjusted automatically. The amount or amounts of my required premium contribution for each plan has been provided to me by my employer in other plan materials.

☐ **I hereby elect to participate in Premium Conversion for the following plan or plans (check all that apply):** ☐ **Medical** ☐ **Dental**

Cash Opt Out

By electing this option, I am accepting cash in lieu of participation in the following plans (check all that apply). I understand this cash benefit is subject to federal income plus FICA and Social Security taxes, and I won't be eligible to receive benefits under any of the plans for which I elect the cash opt-out. The amount or amounts of this cash benefit has been provided to me by my employer in other plan materials. ☐ **I hereby elect the Cash Opt-out benefit in lieu of participation in the following plan or plans:** ☐ **Medical**

Health Flexible Spending Account (Health FSA) Election

I understand that by electing this option, my election amount will be deducted from my paycheck on a pre-tax basis in equal installments throughout the plan year, and this account will only reimburse IRS-eligible healthcare expenses that have not been reimbursed under any other plan.

☐ **I do** ☐ **I do not** **want to participate in the Health FSA.**

$_____ X _____ = $_____
Per Pay Period Election Amount # of Pay Periods Total Election Amount

Minimum Contribution Amount $100 Maximum Contribution Amount $2,500

Dependent Care Assistance Plan Account (Dependent Care Account) Election

I understand that by electing this option, my election amount will be deducted from my paycheck on a pre-tax basis in equal installments throughout the plan year, and this account will only reimburse IRS-eligible dependent care expenses that have not been reimbursed under any other plan. I understand that the IRS requires the Tax ID or the Social Security number of my daycare provider when applying for reimbursement from my Dependent Care Account.

☐ **I do** ☐ **I do not** **want to participate in the Dependent Care Account.**

X = $
Employee Per Pay Period Election # of Pay Periods Annual Employee Election

Minimum Employee Contribution $0 Maximum Employee Contribution $5,000

Salary Reduction Agreement and Signature

I also understand and agree to the following:

- The total amount or amounts stated above will be deducted from my paychecks on a pre-tax basis in equal installments throughout the Plan Year. I understand that this will lower my gross pay and, consequently, Social Security earnings for tax purposes.
- My elections, including any above stated salary reduction amount or amounts, must remain in effect until the end of the Plan Year or my employment termination date, whichever occurs first. However, in the event of a change in my family or employment status (i.e. marriage, divorce, birth, paid or unpaid leave of absence, change in hours, etc.), I may be allowed to change or revoke my election or elections and salary reduction amount or amounts in accordance with plan rules.
- I will be obligated to re-pay any mistaken payments I receive from the Plan in accordance with the Plan terms.
- My Health FSA will reimburse IRS-eligible healthcare expenses up to my annual election amount minus any amounts previously reimbursed. I (or my spouse if applicable) cannot make contributions to a Health Savings Account (HSA) while I am participating in the Health FSA.
- My Dependent Care Account will reimburse IRS-eligible dependent care expenses only up to my account balance at the time of my request.
- IRS regulations require that I use all of my designated Health FSA funds and all of my Dependent Care Account funds during the Plan Year (or during the 2½ month grace period immediately following the Plan Year if permitted by the Plan) **or forfeit remaining balances.**

Employee Signature _____ **Date** _____

Employer Information

Annual Open Enrollment ☐ Or New Hire ☐ If New Hire, Date of Hire:_____ Effective Date:_____ Date of First Payroll:_____ Payroll Calendar: 12-Month (52 pays) ☐

HealthTrust
Benefit Advantage

Town of Plaistow

Flexible Benefits Plan – *Debit Card Enrollment Form*

First Name _____ Last Name _____ MI _____

Debit Card

The Benefit Advantage Debit Card is a debit card option that is part of the Health FSA or Dependent Care Account. Employees participating in the Health FSA or Dependent Care Account may elect to use debit cards to obtain direct reimbursement of Qualifying Expenses, subject to applicable substantiation requirements. If I don't elect a debit card, I will submit a Reimbursement Form to request reimbursement.

Do you want to use a debit card? (Debit cards expire after 3 years.)

☐ **Yes. If yes,** →

☐ **No. If no, continue to signature**

☐ **I did not have a debit card in the prior plan year and want to request one (no charge)**

☐ **I had a debit card in the prior plan year and:**

- ☐ **I want to continue using my current card(s) in the new plan year (no charge)**
- ☐ **I want to continue using my current card(s) and order an additional set ($5 charge)**

☐ **I had a debit card in the prior plan year but need a replacement set (i.e. lost card). I understand my prior card will be cancelled. ($5 charge)**

Debit Card Required Receipt Information

All charges made to the Card are only *conditionally reimbursed* until related receipts are received and approved by HealthTrust per Internal Revenue Service (IRS) regulations. Documentation of the expense* should be submitted to HealthTrust within **14 days** of using the Card to pay for an approved FSA expense. This can be in the form of a bill, receipt of payment (from provider or insurer), explanation of benefits or a written statement from an independent, third party noting the service incurred and its expense amount.

*Documentation is not required if the expense equals the co-payment 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, the IRS requires that the Card work only at discount stores, department stores and supermarkets that can identify FSA-eligible items at checkout; therefore, documentation of those purchases is not required.

All receipts submitted to HealthTrust should include the following IRS-required information:

- Name and address of service provider
- Date service and expense were incurred
- Name of person receiving the service
- Detailed description of service provided
- Amount charged for service

Credit card slips from the Benefit Advantage Debit Card transactions cannot be submitted as receipts because they typically do not include all of the information noted above. Also, if your employer allows over-the-counter items to be covered under your FSA plan, receipts must have each item's name printed on them; handwritten item names are not acceptable.

Debit Card Agreement and Signature

I also understand and agree to the following:

- If I request a replacement card(s) or additional card(s), I am authorizing a fee of $5 to be debited from my account.
- I certify that the debit card will only be used to pay for my IRS-eligible healthcare and/or dependent care expenses or those of my spouse or dependent(s) that have not been reimbursed, and I will not seek reimbursement for such expenses under any other plan.
- I understand that I am required to submit and retain paper substantiation for all expenses charged to the debit card unless otherwise permitted by the FSA Administrator in accordance with applicable IRS rules.
- I understand that the debit card will draw from prior Plan Year balances during the Grace Period, if applicable, and then draw from current Plan Year balances
- I understand and agree that misuse of the debit card will result in suspension or permanent revocation of the card and I will be obligated to repay any ineligible expenses that have been reimbursed.

Employee Signature _____ **Date** _____

Be sure to attach this form to the Flexible Benefits Plan Enrollment Form

MEDICAL AND/OR DENTAL APPLICATION AND CHANGE FORM

HealthTrust

Please use this form to enroll in or change your medical and/or dental coverage. Be sure to complete this entire form. If you only need to change your mailing address, do not complete this form; instead, log in to your account on HealthTrust's Secure Enrollee Portal (SEP), click on "Enrollment/Membership Info" and scroll to the bottom of the page and click on "Update your Membership Information."

BE SURE TO FILL OUT EACH SECTION COMPLETELY. Include information on all your eligible family members at initial enrollment and when making changes. Failure to complete each section in full could delay the start of coverage.

PRIMARY CARE PROVIDER (PCP) SELECTION

When you enroll in a BlueChoice® or Access Blue New England℠ medical plan, each member of your family must choose their own PCP to coordinate medical care. Your PCP can be a family or general practitioner, an internist, or a pediatrician (for children). To access a Provider Directory, visit www.healthtrustnh.org and click on the medical icon, then click on the orange button with your plan type. Should you decide to change your PCP after initially enrolling with HealthTrust, do not fill out this form. Instead, call the Anthem Member Services number on the back of your medical ID card.

DENTAL COVERAGE

- Dependent children are generally eligible for coverage as of the first of the month following their second birthday. In order for your children to be covered, you must enroll them at that time; coverage is not automatic.
- You are required to enroll for a 12-month period. Voluntary cancellations or membership downgrades are not allowed during this period unless you terminate employment, your dependent is no longer eligible, or you experience a qualified family status change.

HOW TO COMPLETE THIS FORM

STEP 1	**ENROLLEE (EMPLOYEE) INFORMATION** Complete this section with your personal information, using your full legal name. Select the type of HealthTrust-sponsored medical and/or dental coverage you are requesting and the membership type for each. Please limit your selection to only those coverages offered by your employer and for which you are eligible. If you are applying for the Medicare Supplemental plan, please complete the *Retiree Medical and/or Dental Application and Change Form.*
STEP 2	**REASON FOR COMPLETING FORM** Use this section to indicate the reason(s) for completing form. If you are a current HealthTrust enrollee making a change to your existing membership, you must include the actual date of event. Please see your employer or call HealthTrust to obtain additional forms that are required for divorce/legal separation or retirement.
STEP 3	**ENROLLEE AND DEPENDENT INFORMATION** Complete this section as your membership should appear at HealthTrust. If you need additional space, use the *Additional Dependent(s) Information* section on the last page of this form. • If you are enrolling a dependent child age 26 or older who is disabled, complete a *Certification for a Mentally or Physically Disabled Child Over Maximum Age* form available through your employer or at www.healthtrustnh.org. **Your dependent child will not be added to your coverage until approval of incapacitated status has been received by HealthTrust.** • If your HealthTrust-sponsored medical plan requires a PCP, you must provide a PCP name and PCP ID number (including all characters) for you and each of your covered dependents; indicate if you are a current patient.
STEP 4	**OTHER INSURANCE COVERAGE INFORMATION** Complete this section if you or a covered family member will have other coverage along with this plan or are transferring from another group medical or dental plan. If you choose to cover some, but not all of your eligible dependents, proof of other group coverage for those dependents you are not covering may be required.
STEP 5	**ENROLLEE SIGNATURE** Sign and date this form; return completed form to your employer.
STEP 6	**EMPLOYER USE ONLY** Employer must review form and verify that steps 1-5 are completed. Employer must complete this section and send via a secure message to HealthTrust Enrollee Services by logging in to your account on HealthTrust's Secure Member Portal and clicking on Message Center; forward to HealthTrust for processing at: PO Box 617, Concord, NH 03302; email to: enrolleeservices@healthtrustnh.org; or fax to: 603.226.2988

Questions? Please call us at 800.527.5001, Monday through Friday, 8:30 a.m. to 4:30 p.m.

Form #HT035
Revision Date: 11/15/2022

MEDICAL AND/OR DENTAL APPLICATION AND CHANGE FORM

ENROLLEE (EMPLOYEE) INFORMATION

STEP 1

Last Name	First Name		MI
Mailing Address	City	State	Zip
Telephone	Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced/Legally Separated ☐ Other: _____		
Employer Name			

TYPE OF COVERAGE AND MEMBERSHIP REQUESTED (check)

Medical Type			Medical Membership	Dental Type	Dental Membership
☐ High Deductible Health Plan (HDHP) ☐ Access Blue HDHP* ☐ Lumenos Preferred Blue ☐ Open Access HDHP	☐ HMO* ☐ Access Blue New England ☐ Site of Service Access Blue New England	☐ Open Access PPO ☐ POS (BlueChoice)*	☐ Single ☐ Two-Person ☐ Family	Dental Option #_____	☐ Single ☐ Two-Person ☐ Family

*A PCP must be selected for HMO and is strongly recommended for POS.

STEP 2

REASON FOR COMPLETING FORM

- ☐ New Enrollee
- ☐ Benefit Change
- ☐ Open Enrollment
- ☐ Name Change
- ☐ Marriage
- ☐ Birth/Adoption
- ☐ Death
- ☐ Divorce/Legal Separation
- ☐ Dependent No Longer Eligible (**complete step 4**): _____ Dependent Name
- ☐ Loss of Other Coverage (explain & **complete step 4**): _____
- ☐ Part-Time to Full-Time
- ☐ Election of COBRA Coverage
- ☐ Other (explain): _____

Actual Date of Event:

ENROLLEE AND DEPENDENT INFORMATION (Complete this section as your membership should appear)

STEP 3

NAME (First, MI, Last)	Social Security #	Date of Birth Month/Day/Year	Relation to Enrollee	Gender	Enroll(ed) in Medical	Enroll(ed) in Dental	Primary Care Provider (for HMO or POS Medical Type) PCP ID# *(Find on www.healthtrustnh.org)*	Primary Care Provider (for HMO or POS Medical Type) First/Last Name/City/State
Employee Name			Self	☐ M ☐ F	☐	☐		
Spouse Name			Spouse	☐ M ☐ F	☐	☐		
Dependent Child Name**				☐ M ☐ F	☐	☐		
Dependent Child Name**				☐ M ☐ F	☐	☐		
Dependent Child Name**				☐ M ☐ F	☐	☐		

**If you are enrolling a dependent child age 26 or older who is disabled, complete a *Certification for a Mentally or Physically Disabled Child Over Maximum Age* form available through your employer or at *www.healthtrustnh.org*.

OTHER MEDICAL INSURANCE COVERAGE INFORMATION (Complete if enrollment is due to loss/gain of other coverage.)

STEP 4

- Do you or your family have medical coverage through another group or employer? ☐ Y ☐ N
- Are you or another dependent transferring coverage from another medical carrier? ☐ Y ☐ N
- Name of Insurance Company
- Effective Date | Termination Date
- Are you or any of your dependents eligible for Medicare? ☐ Y ☐ N
  Member Name _____
  Part A (Hospital) Effective Date
  Part B (Medical) Effective Date

OTHER DENTAL INSURANCE COVERAGE INFORMATION (Complete if enrollment is due to loss/gain of other coverage.)

- Do you or your family have dental coverage through another group or employer? ☐ Y ☐ N
- Are you or another dependent transferring coverage from another dental carrier? ☐ Y ☐ N
- Name of Insurance Company
- Effective Date | Termination Date
- Medicare Claim Number _____
  Is coverage due to end-stage renal disease? ☐ Y ☐ N

ENROLLEE SIGNATURE

STEP 5

I hereby authorize HealthTrust and my employer to institute the enrollment(s) indicated on this form. If my employer requires a contribution for this coverage, this authorizes the appropriate payroll deductions. I understand that the effective date and termination date of my membership will be determined by HealthTrust and my employer in accordance with the plan rules. I understand that I must sign this form for claims to be processed. By signing this application, I attest to the accuracy and truthfulness and will provide documentation to HealthTrust upon request. I understand that any misrepresentation affecting the above named Enrollee's and/or Dependents' eligibility may result in retroactive cancellation of the medical and/or dental coverage and any charges incurred will be my liability. I understand it is my responsibility to notify my employer immediately when any Dependent no longer meets eligibility requirements of the plan.

Enrollee Signature_____ Date _____

EMPLOYER USE ONLY

STEP 6

Date of Hire	Date of Rehire	☐ Full-Time	☐ Part-Time Number of Hours Weekly	☐ COBRA
Billing Group Name			Employee Job Title	
Medical Group/Carrier Number	☐ HRA	Effective Date of Coverage	Benefits Administrator Signature/Stamp	Date _____
Dental Group/Carrier Number		Effective Date of Coverage		

Please complete section A, as necessary, and return with your application.

Enrollee Name _____ Employer Name _____

A. ADDITIONAL DEPENDENT(S) INFORMATION – If you are enrolling more than three dependent children, please complete the information below.

NAME (First, MI, Last)	Social Security #	Date of Birth Month/Day/Year	Relation to Enrollee	Gender	Enroll(ed) in		Primary Care Provider (for HMO or POS Medical Type)	
					Medical	Dental	PCP ID# *(Find on Anthem.com)*	First/Last Name/City/State
Dependent Child Name**				☐M ☐F	☐	☐		
Dependent Child Name**				☐M ☐F	☐	☐		
Dependent Child Name**				☐M ☐F	☐	☐		
Dependent Child Name**				☐M ☐F	☐	☐		
Dependent Child Name**				☐M ☐F	☐	☐		
Dependent Child Name**				☐M ☐F	☐	☐		

**If you are enrolling a dependent child age 26 or older who is disabled, complete a *Certification for a Mentally or Physically Disabled Child Over Maximum Age* form available through your employer or at www.healthtrustnh.org.

Enrollee Signature _____ Date _____

Town of Plaistow

HealthTrust		Access Blue (AB20) RX Benefit: RX10/20/45/3K	Lumenos 2500 (LUMENOS2500) RX Benefit: Lumenos RX	
		Network Benefits (1)	Network Benefits	Out-of-Network Benefits (2)
Cost Sharing	Visit Copayment	$20 per visit	N/A	
	Specialty Visit Copayment	$20 per visit	N/A	
	Walk-In Center or Retail Clinic Copayment	$20 per visit	N/A	
	Urgent Care Facility Copayment	$50 per visit	N/A	
	Emergency Room Copayment	$100 per visit	N/A	
	Standard Deductible	N/A	$2,500 per Member, per year; $5,000 per 2-person or family per year (3)	
	Standard Coinsurance	N/A	N/A	30%
	Coinsurance Maximum	N/A	N/A	$2,500 per Member, per year; $5,000 per 2-person or family per year (3)
	Durable Medical Equipment	You pay 20%	Standard Deductible	Standard Deductible and Coinsurance
	Out-of-Pocket Limit	$3,000 per Member, per year; $6,000 per family, per year (4)	$2,500 per Member, per year; $5,000 per 2-person or family per year (4)	$5,000 per Member, per year; $10,000 per family, per year (4) (3)
Inpatient	Inpatient Services; Medical, Surgical and Maternity Admissions	You pay $0	Standard Deductible	Standard Deductible and Coinsurance plus any balances
Preventive Care	Immunizations, cancer screenings: mammograms, pap smears, routine colonoscopy; routine physical exams, nutrition counseling, diabetes management program, routine hearing exams (one exam each year)	You pay $0	You pay $0	Standard Deductible and Coinsurance plus any balances
	Routine Eye Exams (one exam per year 18 years and younger; once every two years thereafter)	You pay $0	You pay $0	Standard Deductible and Coinsurance plus any balances
Eyewear	Frames/Lenses	$40 reimbursement per Member, per year	N/A	

Town of Plaistow

HealthTrust		Access Blue (AB20) RX Benefit: RX10/20/45/3K	Lumenos 2500 (LUMENOS2500) RX Benefit: Lumenos RX	
		Network Benefits (1)	Network Benefits	Out-of-Network Benefits (2)
Outpatient	Medical exams, telemedicine and online visits, consultations, medical treatments	Visit Copayment or Specialty Visit Copayment	Standard Deductible	Standard Deductible and Coinsurance plus any balances
	Injections (except allergy injections)	You pay $0	Standard Deductible	Standard Deductible and Coinsurance plus any balances
	Allergy Injections	You pay $0	Standard Deductible	Standard Deductible and Coinsurance plus any balances
	Surgery and anesthesia	You pay $0	Standard Deductible	Standard Deductible and Coinsurance plus any balances
	Laboratory tests (including allergy testing)	You pay $0	Standard Deductible	Standard Deductible and Coinsurance plus any balances
	X-ray tests (including ultrasound)	You pay $0	Standard Deductible	Standard Deductible and Coinsurance plus any balances
	MRA, MRI, PET, SPECT, CT Scan, and CTA	You pay $0	Standard Deductible	Standard Deductible and Coinsurance plus any balances
	Medical Supplies, Chemotherapy, Infusion Therapy, and Drugs	You pay $0	Standard Deductible	Standard Deductible and Coinsurance plus any balances
	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."	Standard Deductible	Standard Deductible and Coinsurance plus any balances
Emergency Room and Urgent Care	Use of the emergency room (copayment waived if you are admitted)	Emergency Room Copayment	Standard Deductible	Standard Deductible and Coinsurance plus any balances
	Use of an Urgent Care Facility	Urgent Care Facility Copayment	Standard Deductible	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	Standard Deductible	Standard Deductible and Coinsurance plus any balances
	Laboratory and x-ray tests	You pay $0	Standard Deductible	Standard Deductible and Coinsurance plus any balances
	Ambulance Services - must be medically necessary	You pay $0	Standard Deductible	

Town of Plaistow

HealthTrust		Access Blue (AB20) RX Benefit: RX10/20/45/3K	Lumenos 2500 (LUMENOS2500) RX Benefit: Lumenos RX	
		Network Benefits (1)	Network Benefits	Out-of-Network Benefits (2)
Outpatient Physical Rehab	Physical, Occupational and Speech Therapy	Specialty Visit Copayment, up to a combined maximum of 60 visits per Member, per year	Standard Deductible, up to a combined maximum of 60 visits per Member, per plan year (5)	Standard Deductible and Coinsurance plus any balances
	Cardiac Rehabilitation Visits	Specialty Visit Copayment	Standard Deductible	Standard Deductible and Coinsurance plus any balances
	Chiropractic Care	Specialty Visit Copayment, Unlimited visits	Standard Deductible, Unlimited visits	Standard Deductible and Coinsurance plus any balances
	X-ray tests performed by a chiropractor	You pay $0	Standard Deductible	Standard Deductible and Coinsurance plus any balances
	Acupuncture	Specialty Visit Copayment, Unlimited visits	Standard Deductible, Unlimited visits	Standard Deductible and Coinsurance plus any balances
Home Care	Physician Services (medical exams, injections, medical treatments, surgery and anesthesia, telemedicine and online visits)	Visit Copayment or Specialty Visit Copayment	Standard Deductible	Standard Deductible and Coinsurance plus any balances
	Home Health Agency Services	You pay $0	Standard Deductible	Standard Deductible and Coinsurance plus any balances
	Hospice	You pay $0	Standard Deductible	Standard Deductible and Coinsurance plus any balances
Behavioral Health Care	Outpatient Behavioral Healthcare (Mental Health, Substance Use Care, and Applied Behavioral Analysis)	Visit Copayment or Specialty Visit Copayment, Unlimited visits	Standard Deductible, Unlimited visits	Standard Deductible and Coinsurance plus any balances
	Inpatient Behavioral Healthcare (Mental Health and Substance Use Care)	You pay $0	Standard Deductible	Standard Deductible and Coinsurance plus any balances

Town of Plaistow

HealthTrust		Access Blue (AB20) RX Benefit: RX10/20/45/3K	Lumenos 2500 (LUMENOS2500) RX Benefit: Lumenos RX	
		Network Benefits (1)	Network Benefits	Out-of-Network Benefits (2)
Prescription Drugs	Prescription Drugs	Retail Pharmacy: $10 generic, $20 preferred brand-name, $45 non-preferred brand-name for up to 34-day supply through CVS Caremark's participating retail pharmacies. Maintenance Choice: $10 generic, $20 preferred brand-name, $45 non-preferred brand-name for up to 90-day supply through CVS Caremark's Mail Service Pharmacy or at a CVS Pharmacy.	In Network: Standard Deductible. Out-of-Network: Standard Deductible and Coinsurance, plus any balances. (6)	
Resource Links		Medical Benefit Cost Sharing Prescription Benefit Summary	Medical Benefit Cost Sharing Lumenos RX Info	

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

(2) Benefits are limited to the Maximum Allowable Amount (MAA). Under Out-of-Network Benefits, You may be responsible for paying the difference between the MAA and charge. Self-referred care may require preauthorization/precertification from Anthem.

(3) 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.

(4) The Out-of-Pocket Limit includes all Deductibles, Coinsurance, and Copayments You pay during a year for medical and prescription expenses under this medical plan and Your HealthTrust prescription benefit program. It does not include your premium, amounts over the Maximum Allowed Amount, penalties, or charges for noncovered services. Once the combined Out-of-Pocket Limit is satisfied, You will not have to pay additional Deductibles, Coinsurance, or Copayments for the rest of the year.

(5) Any combination of Network Benefits and Out-of-Network Benefits counts toward this limit.

(6) As required by law, "Preventive Care" pharmacy services are covered in full when furnished by a Network Pharmacy with a prescription from Your physician. In addition, as permitted by IRS Notice 2019-45, covered prescription insulin drugs for individuals diagnosed with diabetes are not subject to any Standard Deductible and/or Standard Coinsurance, but are subject to cost sharing of up to $30 for each 30-day supply.

Please note that throughout this chart any reference to year means plan year. Plan year is January 1 through December 31.
This chart is intended for summary purposes only. Details of coverage are set forth in separate documents, which govern these plans.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.healthtrustnh.org or call 1-800-527-5001. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-833-388-1239 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. There are no deductibles for any services covered under this plan.	See the Common Medical Events chart below for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**For medical expenses and prescription expenses combined: $3,000** individual/**$6,000** family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, out-of-network expenses and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. Access Blue New England. See www.anthem.com or call 1-833-388-1239 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No. You do not need a referral to see a network specialist.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay per visit	Not covered	Virtual visits (Telehealth) benefits available
	Specialist visit	$20 copay per visit	Not covered	Virtual visits (Telehealth) benefits available
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered (unless at in-network facility or an emergency department)	--------none--------
	Imaging (CT/PET scans, MRIs)	No charge	Not covered (unless at in-network facility or an emergency department)	--------none--------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 1-888-726-1631 or www.caremark.com	Generic drugs	$10/prescription (retail) $10/prescription (mail service)	Your copay and any balance billing.	There is a limit of a 34 day supply at retail and a 90 day supply at mail service. Limitations may apply to specific drugs and programs. You pay the network copay when using a CVS Caremark participating pharmacy.
	Preferred brand drugs	$20/prescription (retail) $20/prescription (mail service)	Your copay and any balance billing.	
	Non-preferred brand drugs	$45/prescription (retail) $45/prescription (mail service)	Your copay and any balance billing.	
	Specialty drugs	No coverage (retail); Prescription copay (mail service)	Not covered	Specialty drugs are available through preferred mail service only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	--------none--------
	Physician/surgeon fees	No charge	Not covered (unless at in-network facility)	--------none--------

* For more information about limitations and exceptions, see the plan or policy document at www.healthtrustnh.org.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$100 copay per visit	Covered as In-Network	Copay waived if admitted
	Emergency medical transportation	No charge	Covered as In-Network	--------none--------
	Urgent care	$50 copay per visit	Covered as In-Network	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	--------none--------
	Physician/surgeon fees	No charge	Not covered (unless at in-network facility)	--------none--------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit $20 copay per visit Other Outpatient No charge	Office Visit Not covered Other Outpatient Not covered (unless at in-network facility)	Virtual visits (Telehealth) benefits available
	Inpatient services	No charge	Not covered (unless at in-network facility)	--------none--------
If you are pregnant	Office visits	$20 copay for initial visit	Not covered	Copay applies only to initial visit
	Childbirth/delivery professional services	No charge	Not covered (unless at in-network facility)	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	No charge	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	--------none--------
	Rehabilitation services	$20 copay per visit	Not covered (unless at in-network facility)	Coverage for physical, speech and occupational therapy services is limited to 60 combined visits per member per year.
	Habilitation services	$20 copay per visit	Not covered (unless at in-network facility)	All rehabilitation and habilitation visits count towards your rehabilitation limit.
	Skilled nursing care	No charge	Not covered (unless	Maximum of 100 days per member per

* For more information about limitations and exceptions, see the plan or policy document at www.healthtrustnh.org.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
			at in-network facility)	year.
	Durable medical equipment	20% coinsurance	Not covered	--------none--------
	Hospice services	No charge	Not covered (unless at in-network facility)	--------none--------
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to one exam per year.
	Children's glasses	Not covered	Not covered	$40 reimbursement per member per year for frames and lenses.
	Children's dental check-up	Not covered	Not covered	--------none--------

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental check-up
- Long-term care
- Non-Emergency/Urgent Care when traveling outside the U.S.
- Private duty nursing
- Routine foot care unless medically necessary
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (unlimited medically necessary visits)
- Bariatric surgery
- Chiropractic care (unlimited medically necessary visits)
- Hearing aids (limited to one hearing aid per ear each time a prescription changes or every five years)
- Infertility treatment
- Routine eye care (Adult) (limit of one exam every two years)

* For more information about limitations and exceptions, see the plan or policy document at www.healthtrustnh.org.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

For Medical Claims:
Anthem Blue Cross and Blue Shield
ATTN: Grievance and Appeals
PO BOX 518
North Haven, CT 06473-0518

For Prescription Drug Claims:
Prescription Claim appeals MC109
CVS Caremark
PO Box 52084
Phoenix, AZ 58072-2084

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at www.healthtrustnh.org.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:

Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$70**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) coinsurance	0%
Other coinsurance	20%

This EXAMPLE event includes services like:

Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drug
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,020**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) coinsurance	0%
Other coinsurance	20%

This EXAMPLE event includes services like:

Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$260**

The plan would be responsible for the other costs of these EXAMPLE covered services.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.healthtrustnh.org or call 1-800-527-5001. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-833-385-9056 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$2,500** individual/**$5,000** family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes, preventive care is not subject to the deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For **network** benefits: **$2,500** individual/**$5,000** family. For out-of-network benefits: **$5,000** individual/**$10,000** family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, out-of-network expenses and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. Lumenos. See www.anthem.com or call 1-833-385-9056 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	30% coinsurance	Virtual visits (Telehealth) benefits available
	Specialist visit	0% coinsurance	30% coinsurance	Virtual visits (Telehealth) benefits available
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	30% coinsurance (unless at in-network facility or an emergency department)	--------none--------
	Imaging (CT/PET scans, MRIs)	0% coinsurance	30% coinsurance (unless at in-network facility or an emergency department)	--------none--------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **1-888-224-4896** or **www.anthem.com**.	Generic drugs	0% coinsurance	30% coinsurance	Coinsurance after deductible applies to retail and mail service. Covers up to a 90 day supply retail and mail service.
	Preferred brand drugs	0% coinsurance	30% coinsurance	
	Non-preferred brand drugs	0% coinsurance	30% coinsurance	
	Specialty drugs	0% coinsurance	30% coinsurance	--------none--------
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	30% coinsurance	--------none--------
	Physician/surgeon fees	0% coinsurance	30% coinsurance (unless at in-network facility)	--------none--------

* For more information about limitations and exceptions, see the plan or policy document at www.healthtrustnh.org.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	--------none--------
	Emergency medical transportation	0% coinsurance	0% coinsurance	--------none--------
	Urgent care	0% coinsurance	0% coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	30% coinsurance	--------none--------
	Physician/surgeon fees	0% coinsurance	30% coinsurance (unless at in-network facility)	--------none--------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit 0% coinsurance Other Outpatient 0% coinsurance	Office Visit 30% coinsurance Other Outpatient 30% coinsurance (unless at in-network facility)	Virtual visits (Telehealth) benefits available
	Inpatient services	0% coinsurance	30% coinsurance (unless at in-network facility)	--------none--------
If you are pregnant	Office visits	0% coinsurance	30% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	0% coinsurance	30% coinsurance (unless at in-network facility)	
	Childbirth/delivery facility services	0% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	30% coinsurance	--------none--------
	Rehabilitation services	0% coinsurance	30% coinsurance (unless at in-network facility)	Coverage for physical, speech and occupational therapy services is limited to 60 combined visits per member per year.
	Habilitation services	0% coinsurance	30% coinsurance (unless at in-network facility)	All rehabilitation and habilitation visits count towards your rehabilitation limit.
	Skilled nursing care	0% coinsurance	30% coinsurance (unless at in-network facility)	Maximum of 100 days per member per year.
	Durable medical equipment	0% coinsurance	30% coinsurance	--------none--------
	Hospice services	0% coinsurance	30% coinsurance (unless at in-network facility)	--------none--------

* For more information about limitations and exceptions, see the plan or policy document at www.healthtrustnh.org.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	0% coinsurance	30% coinsurance	Limited to one exam per year.
	Children's glasses	Not covered	Not covered	--------none--------
	Children's dental check-up	Not covered	Not covered	--------none--------

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental check-up
- Long-term care
- Non-Emergency/Urgent Care when traveling outside the U.S.
- Private duty nursing
- Routine foot care unless medically necessary
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (unlimited medically necessary visits)
- Bariatric surgery
- Chiropractic care (unlimited medically necessary visits)
- Hearing aids (limited to one hearing aid per ear each time a prescription changes or every five years)
- Infertility treatment
- Routine eye care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

Anthem Blue Cross and Blue Shield
ATTN: Grievance and Appeals
PO BOX 518
North Haven, CT 06473-0518

* For more information about limitations and exceptions, see the plan or policy document at www.healthtrustnh.org.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at www.healthtrustnh.org.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2,500
Specialist copayment	$0
Hospital (facility) *coinsurance*	0%
Other *coinsurance*	0%

This EXAMPLE event includes services like:

Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,560**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,500
Specialist copayment	$0
Hospital (facility) *coinsurance*	0%
Other *coinsurance*	0%

This EXAMPLE event includes services like:

Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drug
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,520**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2,500
Specialist copayment	$0
Hospital (facility) *coinsurance*	0%
Other *coinsurance*	0%

This EXAMPLE event includes services like:

Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,500**

The plan would be responsible for the other costs of these EXAMPLE covered services.

LifeResources
EMPLOYEE ASSISTANCE PROGRAM | Available through HealthTrust

Confidential Emotional Support

Our highly trained clinicians will listen to your concerns and help you or your family members with any issues, including:

- Anxiety, depression, stress
- Grief, loss and life adjustments
- Relationship/marital conflicts

Work-Life Solutions

Our specialists provide qualified referrals and resources for just about anything on your to-do list, such as:

- Finding child and elder care
- Hiring movers or home repair contractors
- Planning events, locating pet care

Legal Guidance

Talk to our attorneys for practical assistance with your most pressing legal issues, including:

- Divorce, adoption, family law, wills, trusts and more

Need representation? Get a free 30-minute consultation and a 25% reduction in fees.

Financial Resources

Our financial experts can assist with a wide range of issues. Talk to us about:

- Retirement planning, taxes
- Relocation, mortgages, insurance
- Budgeting, debt, bankruptcy
- WellthSource℠ digital financial education and planning tools

Online Support

GuidanceResources® Online is your 24/7 link to vital information, tools and support. Log on for:

- Articles, podcasts, videos, slideshows
- On-demand trainings
- "Ask the Expert" personal responses to your questions

Well-Being Coaching

Connect today with one of our certified personal coaches. Their one-on-one services are available over the phone or via video link and cover a variety of issues, including:

- Tackling burnout and work-life balance
- Developing self-compassion and resiliency
- Improving sleep and more

Interactive Digital Tools

Our digital self-care platform offers interactive Computerized Cognitive Behavioral Therapy (CCBT) tools and resources. Log on for:

- Guided programs for anxiety, depression, mindfulness, sleep, stress and more
- Personalized, guided resources and motivational support
- Secure access through GuidanceResources® Online

ComPsych
GuidanceResources® Worldwide

Contact Us... Anytime, Anywhere

No-cost, confidential solutions to life's challenges.

LifeResources offers someone to talk to and resources to consult whenever and wherever you need them.

The LifeResources Employee Assistance Program (EAP) is available to employees and retirees of Member Groups that offer HealthTrust medical coverage and their eligible dependents and household members.

Call: 800.759.8122 | **TRS:** Dial 711

The LifeResources toll-free number gives you direct, 24/7 access to a GuidanceConsultant℠ who will answer your questions and, if needed, refer you to a counselor or other resources.

Online: Log in to your account on HealthTrust's Secure Enrollee Portal and click on the LifeResources button. You can also visit guidanceresources.com or download the apps listed below and enter the Web ID – **LIFERESOURCES** – to create your username and password.

App: GuidanceNow℠ (EAP)

App: Koa Foundations (CCBT)

Log on today to connect directly with a GuidanceConsultant℠ about your issue or to consult articles, podcasts, videos and other helpful tools.

24/7 Support, Resources & Information

GuidanceResources® Online

KOA Foundations (for CCBT resources)

HealthTrust

Slice of Life
WELLNESS PROGRAM

Powered by: Virgin pulse

Earn up to $475 Pulse Cash per year!

Let's Do This Together

The voluntary HealthTrust Slice of Life wellness program provides you with fun, engaging experiences and resources at your fingertips to help you achieve and maintain optimal health and live your best life.

Who can participate?

HealthTrust Medical Enrollees, covered spouses and Retirees are eligible to participate.

How to join

Log in to your Secure Enrollee Portal (SEP) account at **www.healthtrustnh.org** and click on the Slice of Life button. Or simply download the Virgin Pulse App.

Getting started

You've signed in and registered—now what? Begin by completing your profile and telling us a little bit about yourself. Then start building healthier habits one day at a time.

Personalize your experience

Go to the **Profile** tab and discover the many ways you can customize your wellness program. Choose your email preferences, connect your activity tracker or well-being app and upload a profile picture. Then set your interests by going to **More > Topics of Interest.** Click the **Social** tab to invite friends and family to join you in the portal.

See a clear picture of your health

Personalize your experience by taking the Health Check and participating in a health coaching session.

Start earning rewards

You can earn up to $110 in rewards* **each quarter, or $440 per year**, for participating in activities. See the next page for specific ways to start earning rewards.

You can also **earn an additional $35** by completing the key action steps listed on the next page.

Quarterly earning opportunities

	Points	Pulse Cash
LEVEL 1	3,000	$10
LEVEL 2	8,000	$20
LEVEL 3	15,000	$35
LEVEL 4	24,000	$45
Maximum rewards per quarter		**$110**

Rewards, your way!

You can redeem your Pulse Cash rewards in the Virgin Pulse store for gift cards or fitness accessories, or you can donate what you earn to charity. Pulse Cash is yours to accumulate and redeem when you're ready, and it doesn't expire.

** The amount of any cash and the value of any other wellness incentive rewards received from HealthTrust are taxable to the recipient for federal income tax purposes. Enrollees with Medicomp Three coverage are not eligible to receive rewards for an annual physical or preventive screenings.*

HealthTrust

Home | Health | Benefits | Social | Media | More

How to earn rewards

IT'S SIMPLE! Do healthy things, earn points and get rewards! The points you earn will accumulate each quarter. As you reach a new level, your rewards grow.

Examples of ways to earn

	Complete activity	Earn points
Daily	Take 7,000 steps in a day	70
	Do your Daily Cards	20/card
	Track your Healthy Habits	10/habit
Monthly	Win the promoted Healthy Habit Challenge	200
	Take 7,000 steps (20 days during the month)	400
	Complete 10 Daily Cards in a month	100
Quarterly	Join the HealthTrust challenge	100
	Choose your eating type	250
	Choose your sleep profile	250
Yearly	Set a well-being goal	200
	Add 5 friends	250
	Complete Nicotine-Free Agreement	100

2024 Annual Key Action Rewards

- **Complete the Health Check for $10 Pulse Cash & 500 Points**

  The Health Check asks questions about your current health status and well-being habits. Complete the survey by visiting **Health Check** under the **Health tab**.

- **Complete three Health Coaching Sessions to earn $25 Pulse Cash**

  A coach can be a helping hand when you need it offering resources to keep you accountable and focused. Schedule a coaching session by visiting **Coaching** under the **Health** tab.

- **Complete a Biometric Screening* and earn 1,000 points**

  To access the biometric screening PCP form click on **Reward** from the **Home** tab and scroll down to **Participation**.

Have questions? We're here to help.

- Check out **support.virginpulse.com**
  Live chat: Monday - Friday, 2 am - 9 pm ET
- Give us a call: **888.671.9395**
  Monday - Friday, 8 am - 9 pm ET
- Send us an email: **support@virginpulse.com**

**Enrollees with Medicomp Three coverage are not eligible to receive rewards for screenings with a PCP, but can qualify for points toward their quarterly Pulse Cash reward by having a Biometric Health Screening at a ConvenientMD location.*

Not sure if you can fully participate in this program because of a disability or medical condition? Visit **support.virginpulse.com** and check out the Medical Exceptions section under **My Account**.

HealthTrust

Town of Plaistow, New Hampshire

Human Resource Department

Plaistow Town Hall
145 Main Street
Plaistow, NH 03865

(603) 382-5200 X 204 Office
(603) 382-7183 Fax
Web: www.Plaistow.com

Conditional Medical Waiver Form

If you and your tax dependents are covered under another employer-sponsored group health insurance plan that provides minimum essential coverage in accordance with the Affordable Care Act, you may waive medical coverage and receive an opt-out payment.

To be eligible for the opt-out payment, you must attest that you and all of your tax dependents are enrolled in other group health coverage that provides minimum essential coverage. Although the opt-out payment can be used for any purpose, it is intended to be a form of reimbursement for other health insurance coverage and is taxable.

Date: _____ Employee ID: _____

Department: _____ Position: _____

Employee Name (Last, First MI): _____

Department: _____

Name(s) of Dependents: _____
(Include spouse, if applicable) _____
_____

Medical Coverage Provided By
(Employer Name) _____

Name of Medical Coverage Provider *(Anthem Blue Cross Blue Shield, Cigna, Harvard Pilgrim, etc.)*

_____

Policy/Group Number:

_____

Effective Dates of Coverage: _____

Please provide the Town of Plaistow Human Resources Department a copy of your current insurance card(s) for you and eligible dependents, if applicable. ☐ **Card(s) Received**

Certification

I certify that I have been given the opportunity to elect affordable, minimum essential health coverage from the TOWN OF PLAISTOW and that by signing this form and receiving the opt-out payment I am waiving coverage for myself and my eligible dependents (if applicable). I understand that I will not be eligible to enroll in the TOWN OF PLAISTOW health plan until the next open enrollment period unless I experience a family status change or qualifying event.

I further certify that I and all of my eligible dependents (for whom I am waiving coverage) are enrolled under other affordable employer-sponsored group health minimum essential coverage.

Employee Signature: _____ **Date:** _____