MAKING A DIFFERENCE THROUGH CARING AND INNOVATION

NEW HAMPSHIRE
Local Government Center
HealthTrust

Flexible Benefits

City of Dover

Plan Year 2013-2014

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This booklet summarizes benefit options offered through the City of Dover, HealthTrust, and all other insurers. It is not a complete statement of the terms and conditions under which benefits are available. This booklet is intended to describe benefits that are offered as accurately as possible. Benefits are set forth in and governed by all applicable coverage certificates, along with any and all endorsements and riders.

In the event of any discrepancy between this booklet and the actual terms and conditions of those documents, the documents will govern. This booklet does not constitute a contract, or an offer to form a contract, and is not binding on any party.

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Your Flexible Benefits

For many years the city, as well as most other employers, designed benefit programs to meet the needs of the average employee. But times and lifestyles have changed. There is no "typical" city employee. Families change, needs change, and personal goals change. The city benefit plan is there to change with you.

This booklet describes the benefits the city offers, how they work, and how you can take full advantage of what is available to you. You are strongly encouraged to read through this booklet and compare the plans to choose the benefits that best fit your needs.

Your benefits are an important part of your total compensation package, which includes far more than your paycheck. The city invests significant money and resources into providing you with a benefit package that is valuable and cost-effective for everyone. That's why the city has focused on providing a flexible benefit package—one that allows you to have a greater voice in how your benefit dollars are spent and that can be tailored to meet your individual needs and budget.

For example, each year you have the opportunity to change your benefits based on your and your family's needs for the coming year. With a flexible benefits plan, you can choose to:

- Keep the same benefit package you had last year,
- Enroll in additional benefits, or
- Opt out of selected benefits, and either use that savings to offset the cost of other benefits or receive additional cash compensation.

It's all about being flexible, without sacrificing the health and welfare of you and your family.

Benefits of Pre-Tax Withdrawals

One of the most attractive features of our benefit program is that you can pay for many of your benefits using pre-tax dollars. This means that your premium cost for many of your benefits is deducted from your pay before taxes are withheld. This reduces your taxable income and actually saves you money.

In other words, your share of the cost of your health and dental insurance (your premium cost) and any contributions you make to the healthcare flexible spending and/or dependent care reimbursement accounts are withheld from your pay before taxes are deducted. This means your taxes are calculated using a ***lower*** figure—thereby reducing your federal income and Social Security tax responsibility.

Because of this, your total lifetime income will likely be reduced. While there's no effect on your eligibility to receive Social Security benefits, your total lifetime earnings will be lowered and someday your Social Security benefit may be slightly reduced. However, the tax savings you realize now should more than make up for the difference. If you have any questions, you are encouraged to speak with your tax advisor.

Your state retirement system contribution and pension will not be similarly affected by salary redirection because these figures are determined using your gross wages.

For more information—and an example of how pre-tax withdrawals can save you money—see the Flexible Spending Accounts section later in this booklet.

A Range of Benefits

The city is offering you benefits in each of the following areas:

- Health plans (including prescription drug coverage for medications purchased at a CVS Caremark participating retail pharmacy and through the CVS Caremark Mail Service Pharmacy),
- Health management programs,
- Vision plan,
- Dental plans,
- Life insurance,
- Disability insurance, and
- Healthcare flexible spending account and dependent care reimbursement account.

Eligibility

All regular full-time city employees working a minimum of 30 hours per week are eligible for participation in the flexible benefit plan beginning on the first day of the month following the date of hire as an eligible employee.

Proof of Relationship Requirement

Dover's benefit programs provide coverage for city employees as well as specific members of their families. The city pays a significant portion of the cost of medical and dental coverage, including the cost of coverage for family members. Because of this, you are required to submit "proof of relationship" in order to cover your spouse and children. If you request medical and/or dental coverage for your spouse and/or child/children, you must show proof of relationship and sign the proof of relationship form, available from the Payroll Benefits Administrator. In order to provide proof of relationship, you must have a certified copy—with the embossed seal or official stamp of the certifying entity—of one of the following documents:

- State-issued birth certificates, or
- State-issued marriage certificates.

The following documents are considered *unacceptable* proof of relationship:

- Birth certificates issued by a hospital,
- Baptismal records,
- Communion records,
- Marriage certificates issued by a church, and
- Marriage licenses, which do not reflect that a marriage actually took place.

Coverage for a Spouse

If you would like to cover your spouse through your city-sponsored medical and/or dental plan, you must provide a copy of your marriage certificate.

Coverage for Children

If you would like to cover your dependent child(ren) through your city-sponsored medical and/or dental plan, the required documents depend on your relationship to the child(ren).

- ***Natural children:*** You must provide a copy of each child's certified birth certificate reflecting you as a parent of the child.
- ***Stepchildren:*** You must provide a copy of:
  - Each child's certified birth certificate reflecting your spouse as a parent of the child, and
  - A certified copy of your marriage certificate reflecting your marriage to one of the natural parents of the child.
- ***Adopted children:*** You must provide a copy of the adoption papers reflecting you as an adoptive parent of the child.
- ***Any other child:*** You must provide a copy of guardianship papers or other legal documentation reflecting that you are both legally and financially responsible for the child.

If the Birth Certificate Does Not Reflect a Father's Name. In the case of "John Doe" birth certificates — that is, a certificate of birth that does not reflect a father's name:

- If the mother identified on the birth certificate is the city employee, such a certificate is acceptable.
- If the city employee is male, the male employee can add the child only by providing an amended birth certificate reflecting the male employee to be the father of the child.

Coverage Begins

If the documentation described in this section is not provided at the time you request the coverage for your spouse or children, such coverage will be extended for a period of three months.

If the required documentation is not provided within three months, coverage for the spouse and/or child(ren) will be terminated as of the last day of the three-month period. A spouse or child who is removed from coverage may be added at the next open enrollment period, provided the applicable documentation is submitted at that time.

Annual Open Enrollment

Each year, you will have the opportunity to re-enroll in the flexible benefit plan. Called the annual open enrollment period, this is the time when you can change your benefits for the coming year (July 1 through June 30).

Along with this booklet, you will receive applications for the various health and dental programs available through the city. You will need to complete and submit an application, and your selected health or dental option application if you are making a change, at the enrollment session. Any changes you make must be received by the open enrollment deadline; otherwise, the benefits you had the year before will carry forward. The exception is with the healthcare flexible spending account and the dependent care reimbursement account. You must re-enroll in either or both accounts each year; re-enrollment is not automatic.

Once you make your benefit elections for the coming year, they go into effect at the start of the plan year (July 1) and remain in effect until the plan year ends (June 30). For the healthcare flexible spending account and dependent care reimbursement account, plan elections remain in effect until the grace period ends, 2 ½-months after the close of the plan year.

You ***may not*** change your elections during the plan year unless you experience a qualified change in family status, as described on page 7. In the event of a change in family status, the Payroll Benefits Administrator should be notified immediately.

Cash Benefit in Lieu of Participation in Health and Dental Plans

If you choose to "opt out" of the city-sponsored health and/or dental plan, you may receive a percentage of the amount the city would have contributed toward the cost of your medical and dental coverage. (Refer to your applicable collective bargaining agreement for details.) If you were eligible for family coverage, you will receive payment based on the city's share of the two-person or family plan, whichever is greater.

You can make the decision to opt out of the city plans each year during the annual open enrollment period, generally held each spring. New employees can make that decision at the time of hire.

In order to opt out, you must provide proof of coverage—for yourself and any family members who would have been eligible for coverage through the city plans—in a non-city or Dover school health and/or dental insurance plan. In addition, you must submit a signed health and/or dental insurance election waiver, available from the Payroll Benefits Administrator.

If you choose the cash benefit, you will receive it as a bonus in your paycheck. Payments to new employees will be pro-rated, based on when coverage would have begun. If you terminate your employment with the city before receiving the bonus, you will receive a pro-rated payment as part of your severance amount.

If you opt out and experience a qualified change in status during the year, you may enroll in the applicable city plan. To enroll, you must complete and return an application to the Payroll Benefits Administrator 30 days before the status change. Your coverage will become effective on the first of the month following the date of the change.

Plan Year

The plan year runs from July 1 through June 30.

Qualified Changes in Family Status

After you enroll, your benefit elections generally stay in effect for the entire plan year. If you experience a qualified change in family status, you ***may*** be eligible to make changes to some of your benefits. Note that not all qualified changes will allow you to make changes to your health plan; see the Payroll Benefits Administrator for more information. Generally, qualified changes in family status include:

- Marriage,
- Divorce or legal separation,
- Birth of a child, adoption, or placement for adoption,
- A court-issued decree requiring you or your spouse to provide coverage for a child—or absolving you from providing coverage—following a divorce, legal separation, annulment, or change in legal custody,
- Death in the immediate family,
- Change in your or your spouse's employment status (e.g., going from full-time to part-time status and losing your benefits eligibility, or taking an unpaid leave of absence),
- Dependent no longer qualifies as benefits-eligible by reaching age 26,
- Change of your home address to outside the medical plan service area for which you are enrolled,
- Your spouse's employer holds open enrollment at a time other than your employer—and, as a result of its benefit offerings, you would like to make a change (if this affects you, first check with your employer to ensure this scenario is recognized as a qualified change in status),
- You or your spouse becomes eligible or ineligible for Medicare,
- The premium amount for a healthcare plan significantly increases, and your employer makes available another health plan with similar coverage,
- The coverage under a health plan is significantly curtailed or ends, and your employer makes available another health plan with similar coverage, or
- Changes made pursuant to the special enrollment rules of the *Health Insurance Portability and Accountability Act of 1996* (HIPAA).

It is ***your*** responsibility to make any changes to your benefit elections within 30 days in advance of the date of the status change. Your change will be in effect for the remainder of the plan year.

Any changes you make must be consistent with your change in family status. For example, if you have a child, you may add your child to your medical plan, but you may not change medical plans.

Health Plan Options

Health coverage helps protect you and your family from medical expenses that can result from accident or illness. It gives you the peace of mind that comes from knowing you and your family can get necessary medical care with limited personal financial liability.

A variety of healthcare plans are being offered through HealthTrust:

- Anthem Blue Cross and Blue Shield JW Plan,
- Anthem Blue Cross and Blue Shield Comp 100 Plan,
- Anthem Blue Cross and Blue Shield BlueChoice® Three-Tier Plan, and
- Matthew Thornton Blue® HMO Plan.

When you enroll in any of these HealthTrust-sponsored plans, you are eligible for additional HealthTrust benefits—including health management programs, healthy living resources, and vision coverage—as described later in this booklet.

No matter which plan you choose, the plan will pay you, your selected doctor, or the hospital for covered medical services according to the provisions of your *Subscriber Certificate*.

Please note that Anthem Blue Cross and Blue Shield (Anthem BCBS) provides services for administrative claims payment only, and does not assume any financial risk or obligation with respect to claims.

In addition, preventive care services are covered at 100 percent when accessed through an Anthem BCBS network provider.

How to Select Your Health Plan

While all of the plans offered provide a high level of benefits, they differ in how you access services, how specific benefits and services are covered, and how claims are filed.

If you have medical coverage through your spouse, you may choose single coverage or "opt out" of participating in one of the city-sponsored plans. If you opt out, you will receive a portion of the monthly premium savings, which you can use to offset the cost of other benefits or receive as a cash bonus in your paycheck. To opt out, you must provide proof of insurance elsewhere. For more information, refer to the section *Cash Benefit in Lieu of Participation in Health and Dental Plans*.

Because health coverage is one of the most costly benefits, you will want to choose your coverage carefully. Remember, it's your responsibility to keep the city informed of any changes in the number of your dependents.

Comparison of Health Plans

The following are brief summaries of the health plans available to you. The summaries are intended to point out similarities and differences among the options. They are not complete descriptions of each plan. Once you choose a plan, detailed information about the plan will be sent to you. If you have questions about the plans before enrolling, contact HealthTrust at 800.527.5001 or the city Payroll Benefits Administrator.
The city offers three types of plans:

- ***Traditional plans***—The Anthem BCBS JW Plan and Comp 100 Plan are traditional medical plans that pay for covered medical services regardless of your choice of physician or hospital.

- ***Point-of-service (POS) plan***—The BlueChoice Three-Tier Plan combines the freedom of a traditional plan with the cost savings of a health maintenance organization. Members may choose to receive care coordinated by their primary care provider (PCP) or may seek care outside of the network at a lower benefit level.
- ***Health maintenance organization (HMO)***—With the Matthew Thornton Blue HMO plan, you select a PCP to manage all of your medical care, including hospitalizations and referrals to specialists. Any care not coordinated by your PCP generally is not covered. However, you do have the ability to access care directly from a Matthew Thornton participating OB/GYN provider for all your routine OB/GYN care.

Now, let's look at each type of plan in more detail.

Traditional Plans—JW Plan and Comp 100 Plan

The city offers you two choices of traditional plans—the Anthem BCBS JW Plan and Comp 100 Plan.

Anthem Blue Cross and Blue Shield JW Plan

The Anthem BCBS JW Plan is a traditional indemnity plan that offers comprehensive, affordable coverage and the flexibility to use the doctor or hospital of your choice. The JW Plan covers you for hospitalization, surgery, routine doctor visits, preventive care, prescription drugs, and more.

With the JW Plan, most care is covered at 100 percent without a deductible. That means eligible charges for inpatient hospital care, surgery, x-rays, lab work, even MRIs are all covered—without a deductible.

After you pay for the first two visits per person per calendar year, you're covered for up to 10 visits up to the maximum allowable benefit per person per calendar year for doctor office visits, including behavioral health and chiropractic care.

Preventive care services are paid in full, which means it's affordable to take advantage of routine physical exams and well-child care.

Immunizations, lab fees, Pap smears, mammograms and PSA screenings are also covered at 100 percent.

The maximum allowable benefit (MAB) is the amount that the plan contract allows for a particular service in your geographical area. If a non-participating healthcare provider charges more than the maximum allowable benefit, you are responsible for the difference, which does not apply to the annual out-of-pocket limit.

With some care—such as therapy and any office visits beyond the first 12—you or your family must first meet a major medical deductible ($100 per person/$200 per family) and share in the cost of your care, with the plan paying 80 percent. Once you reach the annual out-of-pocket maximum ($500 per person/$1,400 per family), the plan pays 100 percent of the maximum allowable benefit for eligible expenses for the remainder of the year.

In addition, some covered expenses—such as prescription drugs, private-duty nursing, and ambulance services—are subject to a major medical deductible. In these cases, you will be responsible for the first $100 of covered charges, then the plan will pay 80 percent of the next $2,000 and 100 percent of any additional covered charges each calendar year. Your maximum out-of-pocket expense each year for this type of covered service is $500 per person/$1,400 per family.

Although the JW plan does not require you to stay in network, there are certain advantages to using an Anthem BCBS-participating provider. For example, Blue Cross and Blue Shield hospitals and physicians will process claims for you. A directory of participating providers is available at *www.healthtrustnh.org* by clicking on HealthTrust—My Benefits > Provider Directories or by calling Anthem BCBS at 800.225.2666 or HealthTrust at 800.527.5001.

For more information about how the indemnity plan covers specific services, refer to the comparison chart at the center of this booklet.

Anthem Blue Cross and Blue Shield Comp 100 Plan

The Anthem BCBS Comp 100 is a traditional indemnity plan that offers comprehensive, affordable coverage and the flexibility to use the doctor or hospital of your choice. Comp 100 covers you for hospitalization, surgery, routine doctor visits, preventive care, prescription drugs, and more.

With Comp 100, most care is covered at 80 percent after you meet a calendar-year deductible ($100 per person/$200 per family). When you reach an annual out-of-pocket maximum ($500 per person/$1,000 per family), the plan pays 100 percent of the maximum allowable benefit for eligible expenses for the remainder of the year.

The maximum allowable benefit (MAB) is the amount that the plan contract allows for a particular service in your geographical area. If a non-participating healthcare provider charges more than the maximum allowable benefit, you are responsible for the difference, which does not apply to the annual out of pocket limit.

When you use a participating provider, you're also covered at 100 percent up to the maximum allowable benefit for preventive care. In many cases, this means there isn't a charge to take advantage of routine:

- Physical exams,
- Newborn care,
- Immunizations,
- PSA screenings,
- Gynecological exams, and
- Mammograms.

When you—or a covered family member—needs care, simply go to the doctor or hospital of your choice. Although the Comp 100 does not require you to stay in network, there are certain advantages to using an Anthem BCBS-participating provider. A directory of participating providers is available at *www.healthtrustnh.org* by clicking on HealthTrust—My Benefits > Provider Directories, or by calling Anthem BCBS at 800.225.2666 or HealthTrust at 800.527.5001.

For more information about how Comp 100 covers specific services, refer to the comparison chart at the center of this booklet.

Additional Benefits with Traditional Coverage Plans

In addition to the benefits described earlier, all traditional coverage plans include the following:

- ***Chiropractic benefit***—Benefits are provided for office visits and diagnostic x-rays, subject to appropriate benefit guidelines and applicable deductible and coinsurance, whenever acute or chronic symptoms are present because of illness or injury. Services must be provided by a participating chiropractor. No benefits will be provided for the services of a non-participating chiropractor.
- ***Clinical social worker benefit***—Benefits are provided for psychological evaluation, individual and group psychotherapy, and family counseling by a clinical social worker who is certified by the New Hampshire Board of Examiners of Psychologists. This benefit is subject to all applicable deductible and coinsurance amounts.

Managed Care

While most of the health plan options available to you include types of managed care, you take a more active role in participating in your healthcare when you choose a traditional plan. If you choose the POS or HMO plan (described on the following pages), your PCP ensures that any managed care guidelines are followed.

If you choose a traditional plan, it is your responsibility to ensure that you abide by the following managed care guidelines when you receive certain services from a provider who does not participate in the Anthem BCBS network or from any provider outside of New Hampshire.

If you need any of the following services, you must precertify your care by calling 800.531.4450. If you fail to follow these guidelines, your benefits will be reduced and you could be responsible for up to $1,000, in addition to any applicable deductible and coinsurance amounts.

The following chart outlines the inpatient services affected by managed care guidelines and illustrates what you need to do to ensure you get the highest level of coverage.

Type of Inpatient Service	What You Need to Do
Planned or scheduled hospital admission	Call at least 7 days before your admission. If the date of your admission changes, call as soon as possible.
Emergency or unscheduled hospital admission	Call within 48 hours (or the next working day) after your admission.

Point-of-Service (POS) Plan—BlueChoice® Three-Tier

The city offers you a point-of-service (POS) plan—the Anthem BCBS BlueChoice Three-Tier plan. A POS plan offers many attractive features of network-type plans, with the added flexibility of being able to obtain care from the provider of your choice. Here's how it works.

Each time you need care, you choose the level of benefits your care will be covered at:

1. ***Option 1—when your PCP provides or arranges your care.*** With this coverage option, you select a PCP for each covered family member. When you use your PCP to provide or coordinate your care, you receive 100 percent coverage for most services with only a $5 copayment for office visits. You pay the least in out-of-pocket expenses under this option. For preventive case services, the copayment is waived.
2. ***Option 2—when you seek care directly from a BlueChoice provider.*** You may also elect to see a participating specialist without first going to see your PCP. In this case, office visits are covered at 100 percent with a higher copayment of $15. Most of your other care is covered at 80 percent. You still receive certain discounts and coverage advantages, but you pay a little more out of pocket.
3. ***Option 3—when you seek care from any out-of-network provider.*** If you choose to go outside the BlueChoice network, you're still covered. In this case, your care is generally covered at 80 percent after you meet your calendar-year deductible ($150 individual/$450 family). This option offers you the most freedom and control, and you still receive substantial benefits. However, you share in more of the cost for your services. Under this option, you are responsible for managed care and precertification requirements.

Either way, your care is covered and you are able to decide which coverage option works best for you.

While most routine services are covered as explained above, behavioral health and substance abuse treatment, routine vision, routine OB/GYN services, and chiropractic services are exceptions. You do not need a referral when seeking these services; however, if you seek care outside the BlueChoice network, your out-of-pocket expenses will be higher.

You can change your PCP at any time by calling BlueChoice Customer Service at 800.438.9672. The change will be effective at the time of the call.

In addition to providing medical coverage, your BlueChoice plan provides benefits for the services of a dentist or oral surgeon for the treatment of temporomandibular joint syndrome (TMJ), gingivectomy for up to four quadrants, and the removal of bone-impacted teeth.

For more information about how the three-tier plan covers specific services, refer to the comparison chart at the center of this booklet.

Health Maintenance Organization (HMO)—Matthew Thornton Blue®

In addition, the city makes available a health maintenance organization (HMO).

With the Matthew Thornton Blue HMO, you must choose a PCP who provides or arranges for all your medical care, usually with other healthcare providers in the HMO network. You should think of your PCP as your "family doctor"—the person you always see first for all your medical care (except in a life-threatening emergency). In most cases, your PCP will be able to take care of your medical problem.

You can change your PCP at any time by calling Matthew Thornton Customer Service at 800.870.3057. The change will be effective at the time of the call.

In exchange for arranging most care through your PCP, you receive a comprehensive healthcare plan that features:

- ***No deductibles or coinsurance*** (except for durable medical equipment),
- ***Inpatient hospital care*** that is covered in full,
- ***Office visits*** that are covered after only a $5 copayment—without any claim forms,
- ***Medical and surgical care*** that is covered in full,
- ***Preventive coverage,*** such as routine physical examinations and immunizations that are covered in full, and
- ***Worldwide coverage for emergency and urgently needed care.***

It is important to remember that your PCP must provide, authorize, or arrange for your medical care in order for benefits to be paid.

While your PCP needs to coordinate most of your care, there are times when another specialist, healthcare professional, or hospital may be required. In these cases, your PCP will develop a treatment plan, refer you to the appropriate medical help, and make sure the care you get is appropriate and medically necessary. It's important to remember that your PCP must provide, authorize, or arrange for your medical care—otherwise, care received outside the network is not covered.

There are exceptions. While routine OB/GYN services, routine vision care, chiropractic care, as well as treatment for behavioral healthcare and substance abuse do not require PCP approval, you must use a network provider to receive benefits.

For more information about how Matthew Thornton Blue covers specific services, refer to the comparison chart at the center of this booklet.

Prescription Drug Coverage

All of the available HealthTrust plans provide coverage for short-term prescription drugs purchased at retail pharmacies and longer-term maintenance medications you receive through the mail.

Coverage for Short-Term Prescriptions

When you need a short-term prescription, the amount you pay depends on the plan you choose and the type of prescription you need, as outlined below:

Plan	How Your Benefit Works
Traditional Plans (JW and Comp 100)	Prescription drug coverage is provided through Express Scripts. Show your ID card at any network pharmacy and your prescription is covered at 80 percent, once you meet your calendar-year deductible, which is your major medical deductible under the JW Plan. Because your claim is transmitted electronically from the pharmacy, there aren't any claim forms. When appropriate, you will receive an *Explanation of Benefits* (EOB) and reimbursement in the mail.
Anthem BCBS BlueChoice Three-Tier Matthew Thornton HMO	Show your CVS Caremark card at a network pharmacy and pay only $3 for generic prescriptions and $15 for brand-name prescriptions for up to a 34-day supply.

Coverage for Maintenance Medications

If you use a maintenance medication, you can lower your out-of-pocket costs and receive up to a 90-day supply through the CVS Caremark Mail Service Pharmacy. The amount you pay per prescription depends on the plan you choose and the type of prescription you need, as outlined below:

Plan	How Your Benefit Works
Traditional Plans (JW and Comp 100)	You pay a $1 copayment for each prescription.
Anthem BCBS BlueChoice Three-Tier Matthew Thornton HMO	You pay a $1 copayment for each prescription.

To use the mail service, simply ask your doctor to prescribe needed medication for a 90-day supply plus refills. Send the completed *Mail Service Order Form*, the original prescription, and payment to CVS Caremark. (Forms and envelopes are available from the city.)

You are eligible to fill up to three 34-day supplies of a maintenance medication at a retail pharmacy. You will be required to use the CVS Caremark Mail Service Pharmacy for any future refills of the medication. Otherwise, you will be responsible for 100 percent of the cost of the prescription.

Generic Equivalent Program

Generally, there are two names for prescription drugs: the brand name and its generic equivalent, which is often less expensive. Generic drugs may differ in color, size, or shape, but the Food and Drug Administration (FDA) requires that they meet the same standards for safety, strength, purity, and quality as the brand-name alternatives.

If you choose to fill a prescription with a brand-name drug when a generic equivalent is available, you will be required to pay the generic copayment plus the cost difference between the brand-name medication and its generic form.

However, if your doctor specifically wants you to receive a brand-name drug, ask that he or she write "dispense as written" or similar instructions on the prescription, and you will be responsible only for the brand-name copayment.

Specialty Drug Program

The CVS Caremark Specialty Pharmacy is designed to provide the personalized care, education, and support that specialty medications require to be fully effective. The CVS Caremark's Specialty Pharmacy services include:

- Access to an on-call pharmacist 24 hours a day, seven days a week,
- Convenient delivery directly to your home or doctor's office,
- Medicine- and disease-specific education and counseling, and
- Online support through *www.caremark.com/specialty*, including disease-specific information as well as interactive areas to submit questions to pharmacists and nurses.

All specialty medications are provided by the CVS Caremark Specialty Pharmacy. You will be responsible for 100 percent of the cost of your prescription if you purchase specialty medications through any other source.

Slice of Life

At HealthTrust, we take health and safety seriously. That's why our *Slice of Life* health management program is designed to help you and your enrolled family members get and stay healthy. We are confident that the *Slice of Life* tools and resources (described here) will help you take steps toward living a healthy lifestyle; becoming as active and productive as you can be; as well as enjoying an enhanced quality of life.

For more information about Slice of Life*, call HealthTrust at 800.527.5001 or send an email to enrolleeservices@nhlgc.org.*

onmyway™ Health Assessment

Onlife Health is HealthTrust's partner in providing and administering your *onmyway™* Health Assessment (HA). This confidential questionnaire is one of the most advanced tools in the market for determining individual health risk and only takes 10 – 15 minutes to complete.

- The confidential questionnaire is in compliance with applicable privacy laws.
- Starting January 1, 2013, the HA is available to all HealthTrust medically-covered enrollees and spouses as well as retirees, and may be completed any time during the year.
- Dependent children are not eligible to take an HA, but can participate in the *Health Awareness Program* once the covered enrollee completes their HA.
- Once the HA is completed:
  - Online participants have immediate access to a *Personal Wellness Report* and, if applicable, can compare it to previous years' reports.
  - Participants will receive a $75 incentive for online completion of the HA and $50 for completing its paper version. Please note that 2013 will be the final year that the paper version is available.
  - Participants may log into the password-protected ***Live on*** Web Portal at ***www.onlifehealth.com*** where they can access a personalized dashboard that links to self-directed educational courses, interactive health resources, goal trackers and social networking, as well as an e-messaging feature to engage in health coaching.
  - Enrollees and covered dependents qualify for up to $200 in the *Health Awareness Program.*
  - Covered spouses must complete their own HA to be eligible for the *Health Awareness Program*.

At HealthTrust, we encourage all medically-covered enrollees and spouses as well as retirees to complete or update the HA, which is an integral part of the *Slice of Life* program.

Health Awareness Program

Your success is also ours. That's the philosophy behind HealthTrust's *Health Awareness Program.* We recognize that good health depends on managing weight and stress, eating a variety of nutritious foods every day, and getting regular exercise. So we've created a program that rewards you for taking the necessary steps, challenges you to pursue your goals, and supports your efforts to live a healthier lifestyle.

- HealthTrust medically-covered enrollees, spouses and retirees qualify for *Health Awareness Program* annual reimbursement of up to **$100 for physical activity** (including self-reported*) and up to **$100 for non-physical activity classes and training** after completion of the ***onmyway***™ Health Assessment. Covered dependent children age 18 and older are also eligible for this annual reimbursement once the enrollee completes the ***onmyway***™ Health Assessment.
    - Self-reported physical activity requires a minimum of 30 minutes of physical activity at least 12 times per month.
- Covered dependent children under age 18 will continue to qualify for up to $200 in *Health Awareness Program* annual reimbursement once the enrollee completes the ***onmyway***™ Health Assessment.

Physical Activity Reimbursement
Participants can receive **up to $100 annually** for a combination of self-reported physical activity (SRPA) and physical activity classes using the *Health Awareness Program Request Form*.

Self-Reported Physical Activity (SRPA)
- 30 minutes of physical activity on a minimum of 12 calendar days per month
- SRPA participants may receive up to $25 per quarter
- SRPA Request Form must be submitted 4 times per year and the submission deadline is 2 calendar months from the end of March, June, September and December

Physical Activity Classes
- Participant must attend at least 75% of the program
- Submit the Class/Training Reimbursement Request Form (signed by instructor), along with a program description (brochure or printed off website) and payment receipt
- Submission deadline for class reimbursement is 2 calendar months from the end of the class or program

Non-Physical Activity Classes/Training Reimbursement
Receive **up to $100 annually** for non-physical activity classes using the *Health Awareness Program Request Form*. This reimbursement opportunity can be used to address nutrition, stress management, tobacco cessation and other health/safety related topics. Combination programs that incorporate physical activity with nutrition or stress management fall into this category.

- Receive up to $100 for classes related to nutrition, stress management, tobacco cessation, and other health/safety related topics
- Combination programs that incorporate physical activity with nutrition, stress management or injury prevention (such as yoga, personal training) are eligible
- Non-physical activity class requirements:
    - Participant must attend at least 75% of the program
    - Submit the Class/Training Reimbursement Request Form (signed by the instructor), along with a program description (brochure or printed off website) and payment receipt
    - Submission deadline for class reimbursement is 2 calendar months from the end of the class or program

Covered **dependent children under age 18 qualify for up to $200** in *Health Awareness Program* reimbursement (with no breakout of physical activity vs. non-physical activity requirement).

- Dependents under age 18 may receive up to $200 for classes if the enrollee has completed an HA
- Reimbursement is available for eligible group classes, sports clinics or camps that have a start and end date with instruction provided. Team sports and private classes are not eligible.
  - Examples of approved classes include karate, babysitting classes, CPR / first aid, diabetes education
  - Examples of non-eligible activities include: AAU or sports teams / leagues, one-on-one programs, self-reported physical activity
- Submission deadline for class reimbursement is 2 calendar months from the end of the class or program

To request *Health Awareness Program* reimbursement, complete and submit a *2013 Health Awareness Program Request Form* (downloadable from our website's Health Awareness page) or call Enrollee Services at 800.527.5001 to request one.

Onlife Health & Live on Web Portal

Onlife Health is HealthTrust's continuing partner in providing the *Slice of Life* health management program and is dedicated to engaging and guiding people to make lasting changes in their lives. Onlife Health will provide and administer the 2013 Health Assessment (HA) tool plus a *Personal Wellness Report* to all HA participants along with optional health coaching. In 2013, health coaching can be accessed telephonically and also through Onlife Health's ***Live on*** Web Portal via e-messaging.

- The ***Live on*** Web Portal is available to all HA participants and is:
  - Password-protected and provides HA participants with a personalized dashboard that links to self-directed educational courses, interactive health resources and goal trackers, plus social networking.
  - Specifically designed to help HealthTrust medically-covered enrollees, spouses and retirees meet personal health goals related to nutrition, weight management, physical activity, stress and tobacco use.
  - Accredited by the Utilization Review Accreditation Commission for consumer education and support, and the National Committee for Quality Assurance for wellness and health promotion.
- HealthTrust medically-covered enrollees, spouses and retirees can visit ***www.onlifehealth.com***:
  - Anytime to get an overview of Onlife Health, the HA and health coaching services.
  - After completing the HA on or after January 1, 2013 to log into the ***Live on*** Web Portal for access to a personalized dashboard of health-related information and engaging with health coaches through confidential e-messaging.

In 2013 we will introduce enhanced Life Points which will give participants the opportunity to win one of ten $1,000 quarterly sweepstakes *(200 Life Points equals one entry into the sweepstakes)*

Life Points– Here are examples of ways participants can earn Life Points and become eligible for the quarterly sweepstakes!

- Biometric Health Screening – **50 Points / once per year**
- Contact with Health Coach – **50 Points / once per quarter**
- Complete Health Coaching Goal – **50 Points / once per quarter**
- Self-directed Course Completion – **100 Points / once per quarter**
- Use an Online Tracker in the Portal – **5 Points daily / up to 4 times a week**
- Preventive MD visits* – **200 Points / once per year**
- Disease Management Engagement – **100 Points / once per quarter**

*Preventive MD visits include: annual physicals, mammogram, pap test, bone density testing (women), prostate cancer screening, colonoscopy.

Personalized Health Coaching

Trying to get healthy? You don't have to do it alone. With a dedicated Health Coach on your side, you will have the support and motivation you need to meet your health goals. Onlife's Health Coach Center is staffed by qualified nurses, dieticians and exercise physiologists who can act as your personal coach.
This confidential program offers:

- Individualized programming based on your needs and HA results,
- Flexible, customized telephone coaching and educational materials, and
- Programs anchored by a personalized health coach/participant relationship.

Coaches can:

- Help you target specific health risks and set attainable goals,
- Support your efforts with encouragement and motivation, and
- Monitor your progress and provide timely feedback.

Additional Support Topics including Menopause, Asthma, Preventative Health and others. You can work with an Onlife Health Coach online or by telephone.

Coaches are available from 8 a.m. through 11 p.m. Monday through Friday, and from 10 a.m. through 5 p.m. Saturday. To speak with a coach, call 866.564.5237.

Biometric Health Screenings

HealthTrust strongly believes that when individuals "know their numbers" they are more likely to improve their health. With that thought in mind the reward for biometric health screening will increase in 2013 from $25 to $50 when completed with your Health Assessment (HA).

In 2013 you will have two options for obtaining your biometric health screening numbers:

1. New for 2013 – plan to attend one of 14 HealthTrust sponsored regional biometric screening sites; or
2. Complete the biometric health screening form with your Primary Care Provider (PCP) at your annual preventive care visit.

HealthTrust will partner with Occupational Health & Wellness Management (OHWM) to host 14 regional biometric screening sites that will allow enrollees, retirees and spouses with HealthTrust medical coverage to attend an event close to where they work or live. OHWM medical professionals will administer the screenings that will include a finger stick to measure Total Cholesterol and Ratio, HDL Cholesterol, and Glucose. Blood Pressure and BMI (Body Mass Index) will also be measured. It will be necessary for participants to have their Anthem ID card with them.

By participating in the regional biometric health screening enrollees, spouses and retirees will have a brief health coaching session to review their individual results, which will also be sent directly to Onlife Health to be loaded into their HA. If the participant has already completed their HA, it will be updated and a new wellness report will be created.

The screening will be free of charge to HealthTrust medically-covered enrollees, retirees and spouses with an Anthem ID card.

If you prefer to work with your PCP, please follow the steps below:

- Schedule your lab work prior to meeting with your PCP so you can discuss your results at your annual preventive care visit.
- Bring the *Biometric Health Screening Form* (found in your activation kit or online) to your annual preventive care visit and complete the form with your provider; don't forget to have your provider sign/stamp the completed form.
- The *Biometric Health Screening Form* **must be completed in 2013** and returned to Health Solutions, a third-party vendor and successful manager of biometric health screening programs for more than 20 years, by **November 30, 2013**.
- Health Solutions will confidentially process your biometric screening results and share them with Onlife Health for incorporation into your 2013 HA.

Slice of Life Newsletters

The *Slice of Life* and *Slice of Life for Seniors* newsletters are mailed quarterly to homes of HealthTrust subscribers. These publications aim to help you and your family members improve your health and become smarter healthcare consumers. Published by OnLife Health—a third-party vendor and health risk assessment leader—in compliance with applicable privacy laws. *Slice of Life* and *Slice of Life for Seniors* also can be read online by visiting *www.healthtrustnh.org*.

Note: Please see the Payroll Benefits Administrator if you have any questions regarding the plan options available to you.

	Anthem BCBS	
	Plan JW[1,2]	***Comp 100[1,2]***
Calendar-Year Deductible	$ 100 per person (major medical only) $ 200 per family (major medical only)	$ 100 per person $ 200 per family
Calendar-Year Out-of-Pocket Maximum	$ 500 per person (major medical only) $1,400 per family (major medical only)	$ 500 per person $1,000 per family
Preventive Care Routine physical exams for babies	Covered at 100%	Covered at 100%
Routine physical exams for children and adults, one annual gynecological exam	Covered at 100%	Covered at 100%
Immunizations for children and adults, mammograms, Pap smears, lead screenings, PSA screenings	Covered at 100%	Covered at 100%
Nutrition counseling	Covered at 100%	Covered at 80% after deductible
Diabetes management program	Covered at 100%	Covered at 100%
Outpatient Care Office visits	You pay for the first two visits per person per calendar year. Next 10 visits per person per calendar year covered at 100%. All other visits covered at 80%[3]	Covered at 80% after deductible
Surgery, laboratory and allergy tests, x-rays, ultrasounds, injections, allergy injections	Covered at 100%	Covered at 80% after deductible
Maternity care	Covered at 100%	Covered at 80% after deductible
CT scans, MRIs, chemotherapy	Covered at 100%	Covered at 80% after deductible
Inpatient Hospital Care	Covered at 100%	Covered at 80% after deductible
Chiropractic Care	You pay for the first two visits per person per calendar year. Next 10 visits per person per calendar year covered at 100%. All other visits covered at 80%[3,4]	Covered at 80% after deductible
Durable Medical Equipment	Covered at 80% after deductible	Covered at 80% after deductible
Physical, Occupational and Speech Therapy	Covered at 80% after deductible	Covered at 80% after deductible
Hospice Care	Covered at 100%[4]	Covered at 80% after deductible[4]
Emergency Room Care	Covered at 100% if life-threatening, otherwise covered at 80% after deductible	Covered at 80% after deductible
Routine Vision Care Routine exams	Discounts available	Discounts available
Frames and lenses	Discounts available	Discounts available
Behavioral Healthcare and Substance Abuse Treatment	*Outpatient:* You pay for each of the first two visits per person per calendar year. Next 15 visits per person per calendar year covered at 100%. All other visits covered at 80% after deductible *Inpatient:* Covered at 100%	Covered at 80% after deductible
Maximum Lifetime Benefit	None	None
Prescription Drugs	*Short-term:* Covered at 80% after deductible *Long-term:* Covered at 100% after $1 copay, up to a 90-day supply through the CVS Caremark Mail Service Phar	

[1] Benefits are limited to the maximum allowable benefit (MAB), which is the amount that the plan contract allows for a particular service in your geographical area. If a non-network healthcare provider charges more than the major medical deductible. [4] Through network providers. [5] Any combination of Option 1, 2, or 3 benefits counts toward this limit. [6] Once every calendar year for children 18 years old and younger, once every two calendar years

Slice of Life *and* 360° Health *are part of all plans. This chart is intended for summary purposes only. Details of coverage are set forth in separate documents, which govern these benefit plans.*

	Anthem BCBS BlueChoice Three-Tier		
	Option 1 *When Your PCP Provides or Arranges Your Care*	***Option 2*** *When You Seek Care Directly from a BlueChoice Provider*	***Option 3[1, 2]*** *When You Seek Care from Any Out-of-Network Provider*
	None	None	$ 150 per person $ 450 per family
	None	$ 600 per person $1,800 per family	$1,050 per person $3,150 per family
	Covered at 100%	Covered at 100%	Covered at 80% after deductible, up to age 2
	Covered at 100%	Covered at 100%	Covered at 80% after deductible *(includes children age 2 and older)*
	Covered at 100%	Covered at 100%	Covered at 100%
	Covered at 100%	Covered at 100%	Covered at 80% after deductible
	Covered at 100%	Not covered	Not covered
	Covered at 100% after $5 copayment	Covered at 100% after $15 copayment	Covered at 80% after deductible
	Covered at 100%	Covered at 100%[6]	Covered at 80% after deductible
	Prenatal/postpartum office visits: Covered at 100%. *Delivery*: Covered at 100%	*Prenatal/postpartum office visits:* Covered at 100%. *Delivery*: Covered at 80%	*Prenatal/postpartum office visits:* Covered at 100%. *Delivery:* Covered at 80% after deductible
	Covered at 100%	Covered at 80%	Covered at 80% after deductible
	Covered at 100%	Covered at 80%	Covered at 80% after deductible
	Covered at 100% after $5 copayment X-rays: Covered at 100%	Not applicable	Covered at 80% after deductible *X-rays:* Covered at 80% after deductible
	Covered at 100%	Covered at 80%	Covered at 80% after deductible
	Covered at 100%	Covered at 80%	Covered at 80% after deductible
	Covered at 100%	Covered at 80%	Covered at 80% after deductible
	Covered at 100% after $25 copay per visit (waived if admitted)	ER charge covered at 100% after $25 copay per visit (waived if admitted). Other eligible charges covered at 80%. Lab and x-rays covered at 100%	ER charge covered at 100% after $25 copay per visit (waived if admitted). Other eligible charges covered at 80% after deductible
	Covered at 100%[6]	Not applicable	Covered at 80% after deductible [6]
	$40 reimbursement every two calendar years[5]	Not applicable	$40 reimbursement every two calendar years[5]
	Outpatient: Covered at 100% after $5 copayment *Inpatient:* Covered at 100%	Not applicable	Covered at 80% after deductible
	None	None	None
macy	*Short-term:* Covered at 100% after $3 copay for generic, $15 copay for brand-name, up to 34-day supply *Long-term:* Covered at 100% after $1 copay, up to 90-day supply through the CVS Caremark Mail Service Pharmacy		

MAB, you are responsible for the difference, which does not apply to the calendar-year out-of-pocket maximum. [2] Managed care requirements apply. [3] Out-of-pocket costs for the first two visits are applied to the calendar-year thereafter.

Note: Please see the Payroll Benefits Administrator if you have any questions regarding the plan options available to you.

	Matthew Thornton Blue
	When Your PCP Provides or Arranges Your Care
Calendar-Year Deductible	None
Calendar-Year Out-of-Pocket Maximum	None
Preventive Care Routine physical exams for babies	Covered at 100%
Routine physical exams for children and adults, one annual gynecological exam	Covered at 100% *(For annual OB/GYN exams, no PCP referral required)*
Immunizations for children and adults, mammograms, Pap smears, lead screenings, PSA screenings	Covered at 100%
Nutrition counseling	Covered at 100%
Diabetes management program	Covered at 100%
Outpatient Care Office visits	Covered at 100% after $5 copay per visit
Surgery, laboratory and allergy tests, x-rays, ultrasounds, injections, allergy injections	Covered at 100%
Maternity care	Covered at 100%
CT scans, MRIs, chemotherapy	Covered at 100%
Inpatient Hospital Care	Covered at 100%
Chiropractic Care	Covered at 100% after $5 copay per visit, up to 12 visits per person per calendar year; PCP referral not required[1] *X-rays:* Covered at 100%
Durable Medical Equipment	Covered at 80%
Physical, Occupational and Speech Therapy	Covered at 100% after $5 copay per visit[2]
Hospice Care	Covered at 100%
Emergency Room Care	Covered at 100% after $25 copay per visit *(waived if admitted)*
Routine Vision Care Routine exams	Covered at 100%[1,3]
Frames and lenses	$40 reimbursement every calendar year
Behavioral Healthcare and Substance Abuse Treatment	*Outpatient:* Covered at 100% after $5 copay per visit *Inpatient:* Covered at 100%
Maximum Lifetime Benefit	None
Prescription Drugs	*Short-term:* Covered at 100% after $3 copay for generic, $15 copay for brand-name, up to 34-day supply *Long-term:* Covered at 100% after $1 copay, up to 90-day supply through the CVS Caremark Mail Service Pharmacy

[1] Through network providers. [2] Up to a combined maximum of 60 visits per person, per calendar year. This limit applies to services received in an office or in the outpatient department of a hospital or skilled nursing facility. [3] Once every calendar year for children 18 years old and younger, once every two calendar years thereafter.

Slice of Life *and* 360° Health *are part of all plans. This chart is intended for summary purposes only. Details of coverage are set forth in separate documents, which govern these benefit plans.*

LifeResources—Member Assistance Program — 800.759.8122

From time to time, everyone can benefit from some assistance in dealing with personal concerns and issues. The LifeResources—Member Assistance Program is available to help you and members of your household with:

- Improving communication skills,
- Locating child care and elder care services,
- Coping with stressful situations,
- Finding answers to common parenting questions,
- Managing depression and anxiety, and
- Resolving couples' conflicts.

In addition, the LifeResources—Member Assistance Program offers free legal and financial consultations on topics such as:

- Creating a budget,
- Credit counseling,
- Buying or selling your home,
- Divorce and custody matters,
- Retirement and college planning, and
- Preparing income tax returns.

While there is never any cost to any employee for the LifeResources—Member Assistance Program services, if your needs go beyond a consultation, a 25 percent discount on hourly attorney fees is available.

The LifeResources — Member Assistance Program's website provides more personal and professional assistance tools. To explore all that's available, log onto www.allonehealtheap.com (enter "healthtrust" as the username and "member" as the password).

360° Health

As a healthcare management program designed by Anthem BCBS, *360° Health* offers preventive care resources, wellness information, care management programs, and special discounts on healthy living products and services. *360° Health* is available to you and your family members who are covered by an HealthTrust-sponsored medical plan. *360° Health* includes:

- Future Moms Program
  - ➢ $50 Babies "R US" gift card
- Chronic Care Management
  - ➢ Assists individuals with chronic medical conditions to manage their condition.
- Large Case Management
  - ➢ Provides clinical support, including discharge planning, concurrent review during hospitalization and identifies community resources as a result of an accident or illness.
- 24/7 Nurseline - 800.544.1901 (toll free)
  - ➢ Speak to an experienced registered nurse—day or night—to discuss symptoms you're experiencing, how to get the right care in the right setting and more.
- *Staying Healthy Reminders*
  - ➢ Mail-based program the that includes five preventive health screening reminders

To use these resources — and learn about others that may be available — visit the "Health & Wellness" section of *www.anthem.com* or call the toll-free number on your medical ID card.

360° Health *is administered by Anthem BCBS and subject to change at any time. Please note that certain offerings listed on www.anthem.com are not available to HealthTrust subscribers and their covered family members, as similar programs are offered through the* Slice of Life *health management program or through CVS Caremark, HealthTrust's prescription benefit manager.*

eLearning

We understand the high costs of travel and the work demands of today's busy employees and officials that make travel to training difficult. In an effort to bring training to the Member where and when it's most convenient, HealthTrust has developed eLearning options which provide access to relevant, high-quality training from any computer with a high-speed Internet connection. Our eLearning programs are produced by staff members who know the specific needs of local government (including school) employees in New Hampshire.

The Academy

The Academy, our online and blended learning platform, currently offers dozens of complimentary online courses that are accessible anytime of the day or night. All courses, which cover a wide variety of areas pertinent to New Hampshire local government, offer informational presentations, helpful resources, quizzes and certificates of completion. Visit *www.lgcacademy.org* for course listings and registration information.

HealthTrust Webinars

Our webinars offer content-rich, live online training that's topic-specific and hosted by our Health and Safety Advisors. These one-hour sessions allow participants to ask questions and create a truly interactive learning experience. In addition to monthly offerings, we can also provide on-demand webinars on timely issues affecting local government. Visit the Calendar of Events section of *www.healthtrustnh.org* to check for new additions.

Group Health Management Programs

LifeResources - Member Assistance Program®
In addition to providing employees and family members with assistance around specific issues, the LifeResources - Member Assistance Program also provides supervisors and member groups with assistance on personnel issues. Services include:

- Employee orientation
- Supervisor training/consultation
- Life management seminars
- Critical incident stress management
- Assistance with Department of Transportation mandated substance abuse testing
- Sexual harassment training

Flu Vaccine Programs
HealthTrust provides a reimbursement program for on-site flu shot clinics for health insured members. The program offers the option of utilizing HealthTrust's vendors or the member group's own in-house personnel to deliver the service.

On-site Health and Safety Workshops
HealthTrust offers many educational one-hour workshops to all groups enrolled in a HealthTrust-sponsored medical plan. Following is a sample of workshops available:

- Understanding Your Health
- Back Care
- Nutrition 101

Health and Safety Coordinator Academy
The Health and Safety Department at the Local Government Center has been working on an exciting and innovative new resource that will challenge Member Groups to become healthier and safer in the years to come. The Health and Safety Coordinator Academy certification program will provide group leaders with the knowledge and resources to implement worksite health and safety programs. Academy participants will acquire the skills to guide their co-workers in developing awareness of important issues that affect their health and safety both at work and at home.

Health and Safety Advisor Support
HealthTrust has a strong support services for health and safety management coordinators in its member groups. This includes the quarterly Wellness Coordinator Connection newsletters, annual training and a variety of materials to assist with their wellness planning efforts.

Consultation Services
Our Health and Safety Advisors are available to coach and guide member groups in designing and implementing health and safety programs. This can include health risk and interest assessment, lifestyle claims analysis and more.

Retiree Health Coverage

State law requires that all retirees be eligible for enrollment—at their own cost—in a city group health or dental plan. Like active employees, retirees are eligible to change their plan option each year during the annual open enrollment period.

Health coverage is provided at a reduced cost or at no cost for a retiree who:

- Was employed as of the eligibility date specified in the applicable collective bargaining agreement, ***and***
- Has 20 years of continuous regular full-time service with the city, ***and***
- Is under a qualifying union agreement that has a provision allowing for reduced-cost or no-cost coverage for retirees, and that coverage will remain effect until the retiree's death.

Any spouse or dependents covered by the retiree's health benefit at the time of the retiree's death can continue coverage at their own expense as long as they remain eligible for an HealthTrust-sponsored plan. Please note that dependent children are not eligible for continued coverage once the retiree and surviving spouse are both deceased.

The city will continue to pay the supplemental portion of the health coverage for retirees who become eligible for Medicare, but the city is not responsible for the federal Medicare portion.

Employees who are hired after the eligibility date specified in their applicable collective bargaining agreement have the option of participating in an employer-sponsored 457 program, which allows for an incentive payment of up to a 10 percent match from the city, to the maximum amount specified in the applicable collective bargaining agreement.

All current employees eligible for the paid retiree health coverage may instead choose to enroll in the employer-sponsored 457 savings program and receive an incentive payment of up to a 50 percent match from the city, to the maximum amount specified in the applicable collective bargaining agreement.

Summary of Retiree Health Coverage

The following is a summary overview of retiree health benefits. For more information, please contact the Payroll Benefits Administrator or HealthTrust at 800.527.5001.

In addition to providing active employees and their families with health benefits coverage, HealthTrust also provides retiree medical and dental benefits to enrollees of participating HealthTrust groups (i.e., groups that offer benefits through HealthTrust).

To be eligible for any of these benefits, you must meet eligibility guidelines. If you qualify for retiree coverage, your spouse and dependent children also will be eligible for coverage. You may qualify as a retiree in any of the following four ways. Either:

1. You end your employment with the City of Dover and you are immediately eligible for benefits from the New Hampshire Retirement System (NHRS). Receipt of Social Security benefits or income from personal retirement accounts, such as an individual retirement account, does not qualify for this definition; or
2. You end your employment with the City of Dover and you are entitled to a deferred vested retirement benefit (a benefit that will begin at a later date) through the NHRS. In this case, you will be considered a retiree when your pension payment begins; or
3. You end your employment with the City of Dover when you are at least 60 and you no longer are actively employed; or
4. You end your employment with the City of Dover when you are at least age 50, you had worked for one or more local government units for 10 or more years, and you are no longer actively employed.

As a general rule, to be eligible for retiree health benefits, you must be enrolled in an HealthTrust-sponsored medical or dental plan offered by the city immediately prior to your retirement. ***In addition, it is important to note that employees who retire on or after July 1, 2000, will be eligible for only those benefits they were enrolled in at the time they retired.*** For example, if you retired on or after July 1, 2000, and as an active employee were enrolled in medical coverage but not dental coverage, you will be eligible only for retiree medical coverage—not retiree dental coverage. (There are exceptions to this rule for disability retirement. Please contact HealthTrust at 800.527.5001 for more information.)

Retiree participants younger than age 65—including your enrolled spouse and eligible dependent children, as well as yourself—generally are eligible for the same health benefit plans as active employees.

Retiree participants age 65 and older as well as other Medicare-eligible retirees can choose to:

- Enroll in one of the HealthTrust Medicare Supplemental Plans offered by the city at that time, or
- Remain on their current plan with Medicare paying primary for the retiree participant only.

The Medicare Supplemental Plans are designed to supplement the benefits available to you through Medicare Parts A and B. There is a Medicare Supplemental Plan with prescription drug coverage, and for those who wish to enroll in the Medicare Part D prescription drug program, there is a Medicare Supplemental Plan without prescription drug coverage. Your covered spouse will have these same plan options available when he/she turns 65 and/or becomes eligible for Medicare coverage.

Note to Employees Working Past the Age of 65: If you are actively employed with the city at age 65 and beyond, you will continue to be covered the same as any other active employee.

In this case, you should decline coverage for Medicare Part B. If you do not, you may automatically be enrolled and charged the monthly premium. At the time you do retire, you should be certain to contact the Social Security Administration promptly and enroll in Medicare Part B.

Failure to enroll within certain timeframes may subject you to significant penalties. Contact your local branch office of the Social Security Administration for further information.

EyeMed Vision Care Plan

Routine eye care is an important part of your overall health. That's why HealthTrust includes vision coverage as part of all our medical plans. Through the EyeMed Vision Care plan, you and your family can receive discounts on exams, frames, lenses, contact lenses, and vision-correctional surgery.

One of the most attractive features is that there is no need to enroll—coverage is automatic when you enroll in an HealthTrust-sponsored medical plan.

In addition, most products don't have annual limits—in other words, you can use your EyeMed discount on frames, plastic lenses, and contact lenses each and every time you purchase them.

To take advantage of the plan, simply visit an EyeMed provider. Participants include private optometrists, ophthalmologists, and opticians, as well as national chain retailers Target Optical®, LensCrafters®, Pearle Vision®, and Sears Optical® (note that not all independent franchises may participate in the EyeMed plan; be sure to confirm a provider's participation before receiving services). To find an EyeMed provider near you, call 866.939.3633 or visit *www.healthtrustnh.org* and click on HealthTrust—My Benefits > Provider Directories.

Each time you visit an EyeMed provider, simply show your EyeMed ID card to take advantage of the available discounts.

In addition, you may choose to purchase replacement contact lenses online at competitive prices and have your order delivered to your door. For more information, or to order, visit *www.eyemedcontacts.com*.

This chart highlights how EyeMed covers common procedures and services.

Services	Benefits
Exam (with dilation as necessary)	$ 5 off routine exam $10 off contact lens exam
Frames[1]	35% off the retail price
Standard Plastic Lenses[1,2]	
Single vision	$ 50
Bifocal	$ 70
Trifocal	$105

Along with the benefits outlined here, you are eligible for an additional 20 percent discount on any remaining balance when services or supplies are received from an EyeMed-participating provider.

The benefits outlined here may not be combined with any other discounts or promotional offers, and may be subject to limitations. The discount does not apply to EyeMed's professional services or disposable contact lenses. For more information about limitations and exclusions, call HealthTrust at 800.527.5001.

Lens Options (cost for member, which is then added to the base price of the lens)[1]	
UV coating	$15
Tint (solid and gradient)	$15
Standard scratch-resistance coating	$15
Standard polycarbonate	$40
Standard anti-reflective coating	$45
Standard progressive (add-on to bifocal)	$65
Other add-ons and services	20% off retail price
Contact Lenses (materials only)	
Conventional	15% off retail price
LASIK and PRK Vision-Correctional Procedures[3]	15% off retail price or 5% off promotional pricing

[1] Discounts for frames, lenses, and lens options apply only when purchasing a complete pair of eyeglasses. If frames, lenses, and lens options are purchased separately, members receive 20 percent off the retail price.
[2] Cost may increase outside of New Hampshire.
[3] LASIK and PRK correctional procedures must be provided by the U.S. Laser Vision Network. You must call 877.5LASER6 (552.7376) for pre-authorization and to find a participating provider.

Dental Care Options

The dental plans being offered emphasize reimbursement for preventive dental care. The plans are designed to make it easier for you and your family to receive regular dental treatment, encouraging good oral health.

If you are enrolling your dependents in a dental plan, all dependents over age 2 must be enrolled. Two-person coverage can be selected only by a married employee with no dependent children or by a single-parent employee with one dependent child. Any employee with dental coverage must notify the city Payroll Benefits Administrator within 31 days of the second birthday of any dependent child.

You may visit the dentist of your choice. If you select a participating dentist, the dental office will bill Delta Dental (the dental carrier) directly and will accept Delta Dental's maximum allowance as the fee for your dental procedure. Please note that the deductibles and the maximum annual benefits associated with the plans are applied on a July 1 through June 30 plan year.

You may choose from three dental plans: Base, Mid, and High. With all options, Coverage A services (diagnostic and preventive) are fully paid, at 100 percent of the maximum allowance, and Coverage B services are paid at 80 percent after deductible. Under Mid and High Options only, Coverage C services are paid at 50 percent after deductible. Under the High Option only, Coverage D services (orthodontia) are paid at 50 percent up to a lifetime maximum of $1,000.

What the Plans Cover

Coverage is offered for four types of services: Coverage A (diagnostic and preventive), Coverage B (restorative), Coverage C (prosthodontics), and Coverage D (orthodontia). This section explains what services are covered.

Coverage A Services

- ***Diagnostic***—Evaluations twice in a plan year; full-mouth/panorex x-rays once in a three-year period; bitewing x-rays once each 12-month period; x-rays of individual teeth as necessary.
- ***Preventive***—Cleaning four times in a plan year; fluoride twice in a 12-month period through age 18; space maintainers through age 15; sealants for children through age 18.

Coverage B Services

- ***Restorative***—Amalgam (silver) and resin (white) fillings (anterior and posterior teeth).
- ***Oral surgery***—Surgical and routine extractions.
- ***Endodontics***—Root canal therapy.
- ***Periodontics***—Treatment of gum disease; periodontal prophylaxis (cleaning). Only four cleanings are covered in a plan year. These can be routine (Coverage A) and/or periodontal (Coverage B) but are limited to a total of four cleanings.
- ***Denture repair***—Repair of removable dentures.

- ***Emergency treatment***

Coverage C Services

- ***Prosthodontics***—Bridges, partial and complete dentures; rebase and reline; crowns; onlays; implants. Delta Dental will replace teeth missing before the effective date of a Delta Dental Plan. Full contract benefits are provided.

Coverage D Services

- ***Orthodontics***—Correction of crooked teeth for dependent children to age 19. Coverage D has a separate lifetime maximum.

Delta Dental allows coverage for orthodontic cases in progress when the patient becomes eligible for Coverage D, as long as the patient is still under active treatment (bands).

How the Plans Work

The following chart shows how each available plan—the Base Option, Mid Option, and High Option—pays benefits.

It's important to remember that this information is presented in summary form. Once you enroll, you will receive more detailed information about the plan.

Services	Low Option	Mid Option	High Option
Coverage A services covered at	100%	100%	100%
Coverage B services covered at	80%	80%	80%
Coverage C services covered at	not a benefit	50%	50%
Coverage D services covered at	not a benefit	not a benefit	50%*
Coverage B&C annual deductible per person	$ 25	none	none
Coverage B&C annual deductible per family	$ 75	none	none
Maximum annual benefit per person	$750	$1,000	$1,000

** Coverage D has a separate lifetime maximum of $1,000 per eligible dependent child.*

Retiree Dental Coverage

State law requires that all retirees be eligible for enrollment—at their own cost—in a city group dental plan. Like active employees, retirees are eligible to change their plan option each year during the annual enrollment period. Please note that if a retiree cancels dental coverage, it cannot be reinstated at a later date.

Life Insurance

Providing security for your survivors in the event of your death is an important responsibility. Most people hope to leave behind a positive legacy. That's why the city offers a life insurance program as part of your benefits package.

The city pays 100 percent of the cost of a basic amount of life insurance protection for all full-time employees. Refer to your individual or union contract for more information about the coverage provided to you.

In addition, the plan carries an accidental death and dismemberment (AD&D) policy that increases your benefit if you die as the result of an accident. If you are dismembered, the benefit you receive is proportional to the death benefit. Again, refer to your individual or union contract for more information about the coverage provided to you.

Premiums on life benefits in excess of $50,000 are subject to social security and Medicare taxes. For more information, see your tax advisor.

Voluntary Supplemental Insurance Benefits

The city offers additional insurance choices through payroll deduction. You pay the full cost of any of these benefits you enroll in. In some cases, your contributions can be deducted from your paycheck on a pre-tax basis.

Colonial ValueChoice™ Benefits

Offered through the Colonial Life and Accident Insurance Company, the ValueChoice™ program offers you the value of affordable benefits and the power to choose. When you have ValueChoice, you select benefits you want and need. Any benefits from the programs listed below are paid directly to you to offset out-of-pocket expenses. You can choose from any of the following benefits:

- ***Disability coverage:*** This program provides income protection in the event you are unable to work because of illness or injury. Short-term income protection continues a portion of your income for six- to 24-month periods. In addition, you choose the waiting period (the time before the plan begins to pay benefits) that's right for you—anytime between the first day you are out and the 180th day. There are also on- and off-job options available.
- ***Specified injury coverage.***
- ***Hospital income coverage.***
- ***Cancer coverage.***
- ***Spouse short-term disability.***

If you choose the following, you pay the premiums on an after-tax basis:

- ***Universal life insurance.***
- ***Term life insurance.***

No matter the programs you choose, they all share a number of convenient features.

- Your contributions are deducted from your paycheck, some using pre-tax dollars.
- You can continue your coverage at the same price when you retire or change jobs.
- You can receive benefits regardless of other coverages.
- Coverage is available for your spouse and children.

To contact Colonial, call 207.828.8016.

American Family Life Assurance Company (Aflac)

Aflac offers plans that pay you cash in the event you or a family member suffers an injury, sickness, or illness. Aflac benefits are paid regardless of the amount that any health coverage or workers' compensation plans cover. You and your family can use this money to help with health coverage copayments or deductibles; travel expenses, such as gas or lodging; or to replace the income of a healthy family member who decides to serve as the caregiver. All Aflac plans are portable, and you receive guaranteed renewable coverage for the rest of your life—at today's premiums. Most individual plans cost less than $1 per day. In addition, most claims are paid within four days.

- ***Personal Income Protector Plan*** (paycheck insurance)—Aflac will replace about 60 percent of your wages if you become disabled due to an off-the-job injury, sickness, or illness. The plan also covers complications due to pregnancy and provides benefits for the six or eight weeks after delivery. To be eligible, you must work 30 or more hours per week and earn a minimum of $12,000 per year.
- ***Personal Accident Indemnity Plan***—Aflac's accident plan covers you and your family members 24 hours a day, seven days a week—on or off the job. This plan is designed for those who have a dangerous occupation or for parents with children who play sports.
- ***Maximum Difference Cancer Plan***—As long as cancer plagues the world, Aflac will innovate to fight it. This plan offers a wide range of benefits; including treatment, hospitalization, surgical, home health care and much more.
- ***Specified Health Event*** —This plan covers heart attacks, coronary artery bypass surgery, stroke, kidney failure, coma, paralysis, major burns and organ transplants.

To learn more about any of these plans, contact the city's Aflac representative, Mark Shafer, at 603.749.5753 or mark_shafer@us.aflac.com.

Liberty Mutual Benefits

The city also offers personal lines of insurance—called Group Savings Plus—through Liberty Mutual. These products are not part of the flexible benefit plan and do not receive pre-tax treatment. You may choose to have Liberty Mutual automatically deduct your premium amounts from your checking account.

Additional insurance programs are available through the Group Savings Plus Payroll Deduction Program. You can choose from:

- Automobile insurance,
- Homeowners insurance,
- Valuable possessions protection,
- Many forms of life insurance,
- Yacht and motorboat insurance,
- Personal catastrophe insurance, and
- Protection for seasonal dwellings and recreational vehicles.

After selecting a policy, your payments are automatically deducted from your paycheck. The annual premium is deducted over a 10-month period.

Group Savings Plus Benefits
In addition to the convenience of payroll deduction, the Group Savings Plus plan offers other benefits, including:

- A 10 percent discount for full- and part-time employees as well as retirees,
- No down payment,
- No finance charges or monthly fees,
- 24-hour claims service,
- Professional insurance counseling, and
- Virtually every insurance program you need.

For More Information
For inquiries or a no-obligation quotation, call, visit, or write:

Liberty Mutual Insurance Company
828 Central Ave.
Dover, NH 03820
603.749.1045

When contacting Liberty Mutual, identify yourself as a City of Dover employee.

Flexible Spending Accounts

These accounts offer a tax-effective way for you to pay for certain healthcare and dependent care expenses. Two types of accounts are available:

- ***Healthcare flexible spending account***—Pays for eligible healthcare expenses not covered or not paid for by your medical, vision, dental coverage or any other plan, and
- ***Dependent care reimbursement account***—Pays for eligible dependent care or eldercare expenses that are necessary for you and your spouse to work or attend school full time.

During the year, you cannot make contribution changes to either account unless you experience a qualified change in status, as described earlier in this booklet. For more information about a qualified change in status, please contact HealthTrust at 800.527.5001 or email fsa@nhlgc.org.

Each year, you can choose to enroll in either or both accounts — enrollment is ***not*** automatic. In addition, if you have benefit dollars left from the city after you have selected your other benefit plans, you may contribute those dollars to either or both accounts.

Your account contributions are deducted from your pay before federal income or Social Security taxes are withheld, as described in the section *Benefits of Pre-Tax Withdrawals* earlier in this booklet. This can mean significant savings.

For example, let's say you need new glasses, which will cost you $100. Assuming you are in the 15 percent federal income tax bracket, you would need to earn about $130 and pay nearly $30 in Social Security, Medicare, and federal income taxes before you would have the $100 you need for your glasses.

However, if you choose to enroll in a healthcare flexible spending account, you pay for your glasses before taxes are withheld. This means you need to earn only $100 to get your new glasses—and you save $30.

This is an important concept, and your circumstances may differ from those outlined in this very simple example. See the Payroll Benefits Administrator if you need more information.

How the Accounts Work

You may enroll in one or both accounts each year. You must re-enroll for each year that you wish to participate. When you choose to enroll, estimate any expected healthcare and/or dependent care expenses for the coming year, then decide how much to contribute to your account(s). The accounts have contribution limits, as shown in this chart:

Account	Maximum Contribution
Healthcare	$2,500
Dependent care	The lesser of the following: • $5,000 if you are married and file joint tax returns, or if you are single, • $2,500 if you are married and file separately, or • The lower of your or your spouse's earned income*

** If your spouse is a full-time student or is disabled, special rules apply.*

The amount you elect is then deducted from your paycheck in equal installments throughout the year. These pre-tax deductions are deposited in your account(s). After you incur an eligible expense, you request reimbursement from your account.

Healthcare Flexible Spending Account

Your healthcare flexible spending account can be used to reimburse qualifying healthcare expenses that were incurred during the plan year (or during the 2 ½-month grace period immediately following the plan year). A healthcare expense is incurred at the time the service is furnished and not when you are billed, charged for, or pay for the service.

To qualify, the expense:

- Must be medically necessary,
- Must be incurred by the employee or a qualified Internal Revenue Service (IRS)-defined dependent (note that the employee and/or a qualified IRS-defined dependent is not required to be enrolled in an HealthTrust-sponsored health plan in order to receive reimbursement for qualified healthcare expenses through the healthcare flexible spending account), and
- Cannot be reimbursable through a group medical plan or any other source.

Examples of Qualifying Healthcare Expenses

Here is a partial list of expenses eligible for reimbursement through a healthcare flexible spending account:

- The healthcare plan deductible.
- The percentage of covered expenses that your health plan doesn't pay (your coinsurance responsibilities).
- Prescription expenses not covered by your health plan, including copayments.
- Dental expenses not reimbursed under your dental plan.
- Vision expenses, including examinations, lenses, and frames.
- Contact lenses (including solutions)
- LASIK eye surgery.
- Seeing Eye® dogs.
- Hearing expenses, including examinations and hearing aids.
- Physical examinations.
- Chiropractic expenses.
- Psychoanalysis and psychiatric therapy, as well as services provided by a qualified, licensed psychologist not covered by your health plan.
- Learning disability counseling by a licensed professional.
- Inpatient care and treatment (including special schooling, if necessary) for a mental or physical handicap.
- Acupuncture.
- Midwife expenses.
- Special medical equipment, such as wheelchairs, crutches, and orthopedic shoes required because of a medical problem.
- Medicine or other drugs prescribed by a doctor and not covered by your health plan.
- Costs for transportation essential to medical care, such as ambulance service.
- Over-the-counter (OTC) supplies and equipment, such as bandages, cold-hot packs for injuries, nasal strips and reading glasses will still be considered eligible expenses. For complete information on eligible and ineligible OTC expenses, contact the Internal Revenue Service (IRS) at *www.irs.gov*.

- Other medical expenses qualifying as legitimate deductions for federal income tax purposes, except health premiums.

You can view a complete list of eligible healthcare expenses by following the FSA links at *www.healthtrustnh.org*.

Dependent Care Reimbursement Account

Your dependent care reimbursement account can be used only to reimburse qualifying dependent care expenses that were incurred during the plan year (or during the 2 ½-month grace period immediately following the plan year). A dependent care expense is incurred at the time the service is furnished and *not* when you are billed, charged for, or pay for the service.

To qualify, the expense must:

- Be incurred for the care of your qualifying dependent or for related household services,
- Be paid or payable to a qualified provider, and
- Enable a single parent or both spouses to work or attend school on a full-time basis.

A *qualifying dependent* is:

- Someone who qualifies as an eligible dependent for tax purposes and is under the age of 13, or
- A spouse or dependent physically or mentally incapable of self-care and who spends more than one-half of the calendar year in your household.

A *qualifying provider* is an individual providing dependent care services inside or outside your home as long as the individual *is not*:

- Someone you or your spouse may claim as a dependent for federal tax purposes, or
- A dependent care center (such as a summer camp; an after-school, full-time, or adult daycare center; or a nursery school) that is not in compliance with state and local law.

You will be required to furnish the tax identification number (or Social Security Number) of your provider in order to receive pre-tax treatment for his/her fees.

Ineligible Expenses

Examples of expenses that are ineligible for reimbursement through a dependent care reimbursement account include:

- Kindergarten expenses,
- Costs for sending a child to an overnight camp, and
- Costs for transporting a qualifying person to or from your home to the care location.

If you have any questions about eligible or ineligible expenses, contact HealthTrust at 800.527.5001 or e-mail fsa@nhlgc.org.

Important Considerations

The IRS allows your employer to offer the tax-advantaged reimbursement accounts but has imposed several restrictions, as highlighted on the next page:

- ***Use-or-lose rule.*** Each year, you must use all the money set aside in both your accounts or forfeit the money left over. Therefore, it is very important to plan carefully when you decide how much money you want to set aside in each account. Generally, amounts should be used for predictable expenses. For example, working parents with children in daycare usually can count on a certain level of dependent care expenses. Or, if you know that you need a new pair of eyeglasses or braces for your child in the coming year, you can plan to use your healthcare flexible spending account to pay for those expenses. Contributions from one account cannot be transferred to the other account.
- ***Grace period.*** The city has elected to offer the IRS-allowed extension to the reimbursement deadline—known as the *grace period*. The grace period allows you to use any money remaining in either a healthcare flexible spending account and/or dependent care reimbursement account for up to 2 ½ months after the close of the plan year. In other words, you can receive reimbursement for qualified expenses incurred during the plan year *and* during the grace period. After that date, any money remaining in your account(s) is forfeited. You have 90 days after the end of the grace period to submit claims for reimbursement.
- ***You cannot claim the same expenses as deductions on your income taxes.*** You cannot pay for services through one of these tax-advantaged accounts and also deduct the same services on your income taxes. In addition, if you pay for child or dependent care expenses through a dependent care reimbursement account, you cannot also take the Child and Dependent Care Tax Credit for those same expenses. Your maximum allowable expenses for the federal tax credit will be reduced by the amount you are reimbursed through your account. You are strongly encouraged to speak with your tax advisor before enrolling in either or both accounts.
- ***You cannot make changes during the year.*** After you enroll in either or both accounts, you cannot change the amount of your payroll deduction until the next open enrollment period. The only exception is if you experience a change in family status. For more information, contact HealthTrust at 800.527.5001.
- ***Reimbursement accounts affect your Social Security earnings.*** Finally, because you reduce your taxable income by setting aside money in either or both accounts, your Social Security earnings for the year may be reduced. Over time, this may reduce your Social Security benefits. However, the tax savings you receive now should more than make up for the difference.

Before enrolling in either or both accounts, you are strongly encouraged to speak with your tax advisor to discuss how these restrictions can affect you and your family.

Receiving a Payment from Your Flexible Spending Account(s)

When you have an eligible expense, you can apply for a reimbursement from your account in one of three ways. To receive reimbursement, simply:

1. ***Submit a* Flexible Spending Account Reimbursement Form *to HealthTrust.*** Forms are available from the Payroll Benefits Administrator or online at *www.healthtrustnh.org* (just follow the FSA - Enrollees links).
2. ***Use the Benny™ Prepaid Benefits card.*** You may elect to receive a Benny Prepaid Benefits card. The city will pay for you to receive two cards. Additional cards cost $5 annually, which will be deducted from your account. The debit card can be used *only* to pay for eligible expenses. If you misuse the card, it will be permanently revoked and you will be required to repay any reimbursements you received for ineligible expenses.
3. ***Submit your claim online.*** Visit *www.healthtrustnh.org* and follow the FSA - Enrollees link. Instructions are provided to submit required information and to scan, mail or fax related receipts.

When you submit a* Flexible Spending Account Reimbursement Form*, paper substantiation is required. In other words, you must provide an itemized bill or receipt that shows the date the expenses were incurred, the service provided or item purchased, the name of the provider, and the amount you were responsible for. For reimbursement from a dependent care account, you must also include the name and taxpayer identification or Social Security Number of the care provider. Please note that cancelled checks are not acceptable as proof of your expense.

If you use your Benny Prepaid Benefits card, documentation is *not* required if:

- The amount you paid is equal to the copayment for a doctor's visit required by a City of Dover-sponsored medical plan,
- The amount you paid is equal to the copayment for a prescription required by a City of Dover-sponsored prescription drug plan, or
- The retailer you purchased your eligible expense from uses the Inventory Information Approval System to verify that your purchase qualifies as an eligible expense for flexible spending accounts, as determined by the IRS.

If your expense does not meet these criteria, paper substantiation is required, as described above.

Mail or fax your *Flexible Spending Account Reimbursement Form* and/or any required paper substantiation to HealthTrust at:

HealthTrust
Attn: FSA Reimbursement
PO Box 617
Concord, NH 03302
Fax: 603.415.3099

Incomplete forms may be delayed or returned.

Reimbursement is provided on a weekly basis, and the minimum check amount is $20 unless it is the last claim of the plan year. Reimbursement requests are limited to expenses incurred during the plan year and may be submitted for up to 90 days after the plan year ends.

Please note that dependent care expenses will be reimbursed only up to your account balance at the time of your request. Any expenses claimed in excess of your account balance will be carried over and reimbursed when additional funds are credited to your account.

HealthTrust and the City of Dover will try to help you use the reimbursement accounts only for eligible expenses. However, neither bears any responsibility for your taxes. You remain fully accountable to the IRS to prove the eligibility of any expenses you submit.

How You Can Save

Healthcare flexible spending and dependent care reimbursement contributions can save you money because they are made with pre-tax dollars. ***This example is a very simplified illustration of how a family can save. Your actual tax obligation and savings may differ; you are encouraged to speak with your tax advisor before enrolling.***

This example is set in tax year 2011, and profiles a married employee with one child and an annual family income that totals $60,000. This family pays $1,500 out-of-pocket a year in non-covered medical, dental, and vision care expenses, and $4,000 a year for eligible daycare expenses.

	Without Reimbursement Account	With Reimbursement Account
Wages—Employee Wages—Spouse	$35,000 $25,000	$35,000 $25,000
Healthcare flexible spending account contribution Dependent care reimbursement account contribution	$0 $0	$1,500 $4,000
Taxable wages on Form W-2 Standard deduction for 2011 Exemption deduction for 2011 Taxable income	$60,000 $11,600 $11,100 $37,300	$54,500 $11,600 $11,100 $31,800
Income tax* FICA/Medicare tax (5.65%) withheld by employer	$4,745 $3,390	$3,920 $3,079
Combined income and FICA/ Medicare tax savings	N/A	$1,136
Dependent Care Tax Credit**	$800	N/A**
Tax savings***		$336

** In this example, the family is in the 15 percent income tax bracket.*

*** Expenses paid through a reimbursement account, thereby using pre-tax dollars, do not qualify toward medical itemized deductions or the Child and Dependent Care Tax Credit. Tax credit is subject to change.*

**** Changes in deductions, tax rates, and credits may occur, check with your tax advisor.*

457 Deferred Compensation Plan

All employees are eligible for a 457 Deferred Compensation Plan through ICMA Retirement Corporation (ICMA-RC). Simply stated, *deferred compensation* is an Internal Revenue Service (IRS)-approved method for deferring federal and (in most cases) state income taxes on savings until your assets are withdrawn, usually during retirement when you may be in a lower tax bracket.

Under Section 457 of the Internal Revenue Code, each year, you may defer a maximum of 100 percent of your pre-deferral taxable income or an annual dollar limit, whichever is less. For 2013, the amount you can contribute is limited to $17,500.

The IRS also offers two provisions that allow participants to contribute more than the normal maximum contribution amount. These provisions differ substantially and may not be used in the same calendar year.

- ***The Age 50 Catch-Up Provision.**** This allows participants who are age 50 or older during the year to contribute an additional dollar amount annually. This additional contribution is not dependent on your prior years' deferrals to a deferred compensation plan. For 2013, you can contribute up to $5,500 as part of the age 50 catch-up provision.
- ***The Normal Catch-Up Provision.**** This allows participants to make up for eligible contributions not deferred in prior years, permitting contributions up to double the normal maximum in effect for that year. For 2013, you can contribute up to $34,000 as part of the normal catch-up provision.

With the plan, you are allowed to increase, decrease, stop, and restart contributions as often as you wish, without fees or penalties, subject to your employer's approval.

The city retains ownership of your tax-deferred savings until you are eligible to receive benefits (see the section *Withdrawing Your Money* for more information). Federal legislation requires 457 assets to be held in trust for the exclusive benefit of plan participants and/or beneficiaries. This protects your savings from any outside creditors of the employer.

Benefits of ICMA-RC

Investing through ICMA-RC provides you with many convenient features to help you manage your account. These include:

- No early withdrawal penalty.
- 24-hour access to account information via toll-free telephone 800.669.7400 and online at *www.icmarc.org*.
- The ability to transfer assets and allocate future contributions over the phone and the internet.
- Free fund-to-fund transfers among investment options.
- A quarterly combined account statements and performance summaries.
- A quarterly newsletter.

How You Invest

ICMA-RC offers a wide array of investment options. You may choose from VantagePoint Funds or other popular funds offered in the Mutual Fund Series.

The VantagePoint family of funds consists of 26 registered mutual funds, including actively managed funds, index funds, and model portfolio funds, which are sometimes referred to as lifestyle funds. These funds are listed in most major newspapers.

Actively managed funds are based on a multi-management approach. By diversifying across styles, a multi-management approach is designed to produce superior long-term returns, with greater consistency than a single-manager approach.

Index funds provide alternative investment options for those investors who prefer funds that mirror some of the most popular benchmarks across the investment spectrum.

With varying time goals and risk levels, the VantagePoint Model Portfolio Funds provide pre-set diversification and periodic rebalancing for all investors—from the most conservative to aggressive.

One fund available through the VantagePoint family of funds is the VantageTrust PLUS Fund. As one of the largest and most competitive stable value investment options in the industry, the VantageTrust PLUS Fund brings a Aa1 rating on the Moody's Investor Services scale (as of September 30, 2007). This fund may be a good option for investors concerned about volatility, have a short-term goal, or who are currently receiving a distribution from a retirement account. The fund is well diversified; does not carry transfer fees, penalties, or percent-of-balance transfer restrictions; and has 100 percent liquidity (there aren't any maturity dates).

In addition, you can choose from two other fund families:

- ***The Mutual Fund Series.*** This "menu" of popular funds from other fund families is a good complement to VantagePoint Funds.
- ***The Milestone Funds.*** This series of target-based funds corresponds to the date an investor plans to retire and/or begin withdrawing his/her savings. As a "dated" fund approaches its target year—at which time the investor can withdraw money—the fund's asset allocation transfers to more conservative investments.

What a Difference $10 Can Make

A small increase per year in your 457 Deferred Compensation plan can make a significant difference in your account value by the time you retire.

Let's look at the example of John and Mary. They both attend a meeting with their representative and receive a retirement planning checkup. John makes no changes and continues his $25 weekly contribution, while Mary decides to increase her weekly contribution by $10 every year.

	John	Mary
Account value at age 35	$ 1,000	$ 1,000
Weekly contribution at age 35	$ 25	$ 25
Additional weekly contribution	$ 0	$ 10
Account value at age 60	$105,715	$372,652
Account value at age 65	$163,259	$593,318
Mary receives an extra		$430,059

Assumes an 8 percent rate of return.

This example is for illustrative purposes only. It's likely your personal situation will differ. You are encouraged to speak with a tax or retirement planner for individual information.

Withdrawing Your Money

You can withdraw assets from your account under the following conditions:

- When you retire,
- When you leave your job, for any reason,
- If you have a "severe financial hardship," resulting from sudden illness, disability, or accidental property loss, subject to strict IRS guidelines, or
- If you or your employer are eligible to initiate a one-time disbursement of your account, if the balance is $5,000 or less and neither you nor your employer contributed to the account for at least two years.

Upon Retirement

When you retire, you determine the benefit payment schedule that's right for you and your family. You can choose from:

- A lump-sum payment,
- Periodic payments (monthly, quarterly, etc.) over a specified number of years,
- Periodic payments (monthly, quarterly, etc.) over your determined life expectancy,
- Periodic payments of a specified amount per month or per year until the account is exhausted, or
- The purchase of a lifetime annuity.

In addition, you may choose to include an annual automatic cost-of-living adjustment (COLA).

New! Roth IRA

A Roth IRA is a savings vehicle that complements your employer retirement plans by allowing for tax-free earnings and, if needed, flexible withdrawals. The City of Dover's Payroll Roth IRA allows you to make convenient contributions directly from your paycheck.

Why a Roth IRA?

Boost your savings; what are your savings goals?

A Roth IRA can help you:

- Earn additional retirement income
- Set aside money in retirement for travel, gifts or medical care
- Make a down payment on a home
- Pay for a child's college education
- Build an emergency fund

Diversify Your Taxes with Tax-Free Earnings

A Roth IRA helps you manage your tax bill because withdrawals, including all earnings, may be tax-free. This can help offset withdrawals of traditional employer plan and 457 assests which will be subject to taxes. And it may help minimize taxation of Social Security benefits or surcharges on Medicare premiums.

Control and Flexibility

While the longer your Roth IRA is invested the larger the potential tax-free growth, you always retian the full access to your assets. And contributions can always be withdrawn without taxes or penalties.

Summary of the New Hampshire Retirement System (NHRS) Plan

For information regarding NHRS, please contact the Payroll Benefits Administrator or visit the NHRS website, *www.nhrs.org*. You can also contact NHRS by phone at 877.600.0158, or via email at info@nhrs.org.

Other Benefits

In addition to the benefits described in this booklet, the City of Dover also offers the following programs.

Employee Computer Lease/Purchase Program

This program is designed to assist you in acquiring and sharpening your computer literacy skills. It provides a lease/purchase program for the acquisition of personal computer equipment and software similar to what you may be asked to use for city business.

Through payroll deductions, you may lease such equipment from the city and acquire ownership at the termination of the lease.

For further information, contact your supervisor.

Dover Recreation Facility Passes

You and your immediate family members can receive Dover Recreation facility passes. To receive this benefit, you must complete a form and have it signed by your department head.

When applying for the benefit, employees understand that they must get individual passes through the Dover Recreation office before visiting the facilities.

The passes are to be used only during open public times at the Indoor Pool, Jenny Thompson Pool, Butterfield Gym, and Public Skating at the Dover Arena. The passes are only to be used as long as you are on city payroll and covered by association contract provisions.

The Works Health Club

You are eligible for a group rate at The Works Health Club. To sign up, bring your Dover employee ID or a recent pay stub. For more information, contact The Works at 603.742.2163 or *www.theworkshealthclub.com*.

Sherwin-Williams

You are eligible for special group savings. See the Payroll Benefits Administrator for details.

Direct Deposit

Direct deposit is available. See the Payroll Benefits Administrator for details.

Library Card

You are eligible for a City of Dover Public Library card.

Plan Information

Names of plans	City of Dover, flexible benefit plan City of Dover, healthcare flexible spending account plan City of Dover, dependent care reimbursement account plan
Plan sponsor and administrator	City of Dover Municipal Building 288 Central Ave. Dover, NH 03820 603.743.6004
Employer identification number	02-6000230
Plan numbers	501 — Flexible benefit plan 502 — Healthcare flexible spending account plan 503 — Dependent care reimbursement account plan
Type of plan	The flexible benefit plan is under Section 125 of the Internal Revenue Code, allowing a choice between cash and certain qualified benefits.
Plan effective date	July 1, 1992
Plan year	July 1, 2013, through June 30, 2014
Funding	Medical, vision, dental, life, and disability benefits are provided through insurance contracts. Healthcare flexible spending account and dependent care reimbursement account benefits are entirely self-funded by the employer.
For questions or service of legal process, contact	Finance Department Payroll Benefits Administrator City of Dover 603.516.6004

This booklet merely summarizes the benefits provided pursuant to the plan and is not the legally controlling document. All determinations regarding benefit entitlement and plan provisions are based upon the actual plan documents.

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