**Summary Plan Description**

**For**

**The Benefit Plan of the New Hampshire Bankers Association Insurance Trust**

**Effective January 1, 2020**

**(Schedules Updated effective January 1, 2021)**

**TABLE OF CONTENTS**

[Introduction 1](#_Toc343068749)

[What is the purpose of this Summary Plan Description? 1](#_Toc343068750)

[What is the purpose of the Plan? 1](#_Toc343068751)

[How is the Plan funded? 1](#_Toc343068752)

[What other documents explain my Benefits under the Plan? 1](#_Toc343068753)

[Eligibility for Plan Benefits 2](#_Toc343068754)

[Who can participate in the Plan? 2](#_Toc343068755)

[What happens if both you and your spouse participate in the Plan? 2](#_Toc343068756)

[Who can be dependents covered under the Plan? 2](#_Toc343068757)

[Enrollment 3](#_Toc343068758)

[How do I enroll in the Plan? 3](#_Toc343068759)

[How do I enroll my dependent under a “Qualified Medical Child Support Order”? 3](#_Toc343068760)

[Contributions 3](#_Toc343068761)

[How much do I have to pay toward the insurance premium? 3](#_Toc343068762)

[What if I take leave under the Family and Medical Leave Act? 3](#_Toc343068763)

[Coverage 4](#_Toc343068764)

[When does your coverage begin? 4](#_Toc343068765)

[When does your dependent’s coverage begin? 4](#_Toc343068766)

[Can I be covered during a family or medical leave absence? 4](#_Toc343068767)

[When does coverage end for me or my eligible dependents? 5](#_Toc343068768)

[Summary of Health Benefits 5](#_Toc343068769)

[What Health Benefits are provided under the Plan? 5](#_Toc343068770)

[Am I required to obtain health care from specific providers? 6](#_Toc343068771)

[When will I be required to pay part of the cost for Health Benefits? 6](#_Toc343068772)

[What sorts of limits apply to Health Benefits provided under the Plan and what rules and procedures must I follow to obtain Health Benefits under the Plan? 6](#_Toc343068773)

[What are my rights if the Plan provides me with maternity or newborn infant coverage? 6](#_Toc343068774)

[What are my rights if the Plan provides me with mental health benefits? 7](#_Toc343068775)

[What are my rights if the Plan provides me with coverage for a mastectomy? 7](#_Toc343068776)

[COBRA Continuation of Health Coverage 7](#_Toc343068777)

[What is COBRA Continuation Coverage? 7](#_Toc343068778)

[Who is a “Qualified Beneficiary”? 7](#_Toc343068779)

[When can I elect Continuation Coverage? 8](#_Toc343068780)

[What is a “Qualifying Event”? 8](#_Toc343068781)

[How much does Continuation Coverage cost? 9](#_Toc343068782)

[When does Continuation Coverage become effective once elected? 9](#_Toc343068783)

[When does the Continuation Coverage end? 9](#_Toc343068784)

[What are my Continuation Coverage rights if I am absent for duty in the uniformed services? 10](#_Toc343068785)

[Can I convert to an individual Health Benefit policy once my Continuation Coverage ends? 10](#_Toc343068786)

[Certificates of Health Coverage 11](#_Toc343068787)

[What are certificates of Coverage? 11](#_Toc343068788)

[What is the purpose of a Certificate of Coverage? 11](#_Toc343068789)

[How can I get a Certificate of Coverage when any Health Benefits coverage under this Plan Terminates? 11](#_Toc343068790)

[When Plan Benefits may be Reduced, Forfeited or Denied 11](#_Toc343068791)

[Under what circumstances may Plan Benefits be reduced, forfeited or Denied? 11](#_Toc343068792)

[HIPAA Privacy Rights 11](#_Toc343068793)

[What are my HIPAA privacy rights? 11](#_Toc343068794)

[Plan Sponsor, Plan Administrator, and Participating Employers 12](#_Toc343068795)

[Who Sponsors and Administers the Plan? 12](#_Toc343068796)

[Does my Employer Sponsor and Participate in the Plan? 12](#_Toc343068797)

[Who are the Trustees of the Trust that Administers the Plan? 12](#_Toc343068798)

[What is the Plan number? 12](#_Toc343068799)

[When does the Plan year end? 13](#_Toc343068800)

[Who is the agent designated for service of process? 13](#_Toc343068801)

[Filing Claims 13](#_Toc343068802)

[Who is the Claims Administrator? 13](#_Toc343068803)

[How do I file a claim for benefits with the Claims Administrator? 13](#_Toc343068804)

[How do I appeal my benefits claim if it is denied in whole or in part? 13](#_Toc343068805)

[Amendment or Termination of Plan 13](#_Toc343068806)

[Can the Plan be amended or terminated? 13](#_Toc343068807)

[ERISA Rights 14](#_Toc343068808)

[What are my ERISA rights? 14](#_Toc343068809)

**Schedule 1** (Account Profile with Plan Summaries for your Employer )

**Schedule 2** (Names, Addresses & Telephone Numbers of Plan’s Trustees)

**Attachment** (Insurance Documents)

# Introduction

## What is the purpose of this Summary Plan Description?

This booklet and the Insurance Documents referenced below describe the basic features of the Benefit Plan of the New Hampshire Bankers Association Insurance Trust (the “**Plan**”) and how the Plan operates. This booklet and the Insurance Documents provide the summary plan description for the Plan (the “**Summary Plan Description**”). This booklet and the Insurance Documents provide only a summary of the basic terms of the Plan, and a brief description of your rights as a participant. They are not a part of the official Plan documents. If there is any conflict between this Summary Plan Description and the official Plan documents, the Plan documents will govern.

## What is the purpose of the Plan?

The Plan is a welfare benefit plan sponsored by the New Hampshire Bankers Association Insurance Trust (the “**Trust**”) and those eligible employers who have elected to adopt the Plan by becoming participating employers in the Trust (“**Participating Employers**”). When your employer (the “**Employer**”) is a Participating Employer, your Employer is entitled to select and offer Plan benefits to its employees who meet certain Plan eligibility requirements described later in this Summary Plan Description, and their eligible dependents as described later in this Summary Plan Description. Your Employer has elected to offer the Plan benefits described on **Schedule 1** to this Summary Plan Description (the “**Benefits**”). If the selected Benefits include group health insurance benefits or supplementary health insurance benefits such as vision, dental, or prescription drug plans, such Benefits are referred to in this Summary Plan Description as a “**Health Benefit**” or “**Health Benefits**”.

## How is the Plan funded?

**The benefits and coverages described in this Summary Plan Description are provided through a trust fund established and funded by a group of employers. Those employers are the Banks that participate in the Trust.**

The Plan is partially funded by insurance contracts (the “**Insurance Policies**”) issued to the trustees of the Trust by insurance companies licensed to conduct insurance business in the State of New Hampshire (“**Insurers**”) and partially self-funded. The health benefits provided by the Plan are self-funded, meaning that the Plan does not purchase an insurance policy for health benefits, but instead obtains the funds necessary to pay health claims from contributions made to the Trust by your Employer and other Eligible Employers who participate in the Trust. These funds are held by the Trust to pay health claims as they become due. For those health benefits that are self-funded, the Plan enters into contracts with a Third-Party Administrator (“**TPA**”) to provide certain insurance services such as enrollment, claims processing and provider networks. Insurance companies often provide TPA services and for purposes of this document, TPAs and Insurers are used interchangeably.

Your Employer may require you to pay a portion of the premiums due under the Insurance Policies that provide your Benefits, or a portion of the contribution made to the Trust for your health benefits. If so, premium payments made by you and contributed by your Employer to the Trust will become an asset of the Trust. These funds are used to pay a portion of the premiums required to obtain the Insurance Policies that fund your Benefits or to pay claims for health benefits. The Trust is not an insurance company or health maintenance organization, but is a Multiple-Employer Welfare Arrangement registered with the New Hampshire Insurance Department.

## What other documents explain my Benefits under the Plan?

The terms of the Plan and your Benefits are summarized in greater detail in written documents prepared by the Insurers who issue the Insurance Policies and the TPA who administers the Plan’s self-insured health claims (collectively the “**Insurance Documents**”) The Insurance Documents are part of this Summary Plan Description, and are incorporated in this Summary Plan Description by this reference. The Insurance Documents summarize certain eligibility requirements contained in the Insurance Policies which you must satisfy in order to obtain Benefits provided under the terms of those Insurance Policies. Your Employer also has its own eligibility requirements which you must satisfy in order to qualify for Plan Benefits. Your Employer’s eligibility requirements are described on **Schedule 1** to this Summary Plan Description. If you have any questions about your Benefits, you should consult with your Employer, the Insurer or TPA identified in the Insurance Documents provided to you by your Employer. You may also contact the Plan Administrator with any questions you may have about your Benefits.

# Eligibility for Plan Benefits

## Who can participate in the Plan?

Employers that participate in the Plan generally impose certain eligibility requirements, such as requiring that you are employed for a certain period of time or that you work a minimum number of hours every week, before you are eligible to receive Benefits. You are eligible to participate in the Plan if you meet your Employer’s eligibility requirements described on **Schedule 1** to this Summary Plan Description; and you meet any eligibility requirements described in the Insurance Documents. Employees who participate in the Plan are called “**Participants**”.

## What happens if both you and your spouse participate in the Plan?

If both you and your spouse are Participants in the Plan, each of you will be covered individually and neither of you can be the dependent of the other for purposes of any Health Benefits or other Benefits provided to you under the Plan. If any Health Benefits or other Benefits provided to you under the Plan provides coverage for dependent children, then your dependent children are covered by either you or your spouse, but not by both of you.

## Who can be dependents covered under the Plan?

If any Health Benefits or other Benefits provided to you under the Plan provides coverage for your dependents, then your dependents are eligible for such Benefits. You should carefully review your Insurance Documents to determine whether they make your dependents eligible for any Benefits offered to you under the Plan. If your Insurance Documents make your dependents eligible for any Benefits, you should carefully read the definition of “dependents” included in the Insurance Documents.

Although the terms of your Insurance Documents will control, for purposes of any Health Benefits offered under your Plan, your “**dependents**” will generally include:

* your legal spouse, unless you are legally separated, or your spouse is an employee who is covered by the Plan; and
* your children who are under the age of 26.

Although the terms of your Insurance Documents will control, for purposes of any Health Benefits offered under your Plan, your “**children**” will generally include a natural child; a step-child; an adopted child; or a child for which you have legal guardianship. Although the terms of your Insurance Documents will control, for purposes of any Health Benefits offered under your Plan, your “dependents” generally will not be eligible to receive any Health Benefits or other Benefits under the Plan if the dependent is on active full-time military duty in the armed forces of any country.

# Enrollment

## How do I enroll in the Plan?

To enroll, you must comply with the enrollment procedure outlined in the Insurance Documents governing the Benefits for which you are eligible. Generally, enrollment is permitted during the first 30 days after you or your dependents become eligible, or during annual enrollment.

If you or any eligible dependents do not enroll for any Health Benefits during either of these enrollment periods, you may be able to enroll under the special enrollment rules that apply to Health Benefits when an eligible individual initially declines coverage and later wishes to elect it. Generally, special enrollment for Health Benefits is available if (1) you initially declined coverage because you had other health care coverage that you have now lost through no fault of your own; or (2) since declining coverage initially, you have acquired a new dependent (through marriage or the birth or adoption of a child) and wish to cover that person. In the former case, you must have given (in writing) the alternative coverage as your reason for waiving coverage under this Plan when you declined to participate. In either case, as long as you meet the necessary requirements, you can enroll both yourself and all eligible dependents in the Plan within 30 days after (1) you lose your alternative coverage, or (2) the date of your marriage or the birth, adoption, or placement for adoption of your child. In addition, if you or any eligible dependents become ineligible for coverage under a Medicaid or a Children’s Health Insurance Program (“**CHIP**”) or become eligible for group health plan premium assistance under Medicaid or CHIP, and are otherwise eligible to enroll in any Health Benefits provided under the Plan, then a special enrollment period may be available to you and your eligible dependents which you may exercise by requesting Health Benefits coverage no later than 60 days after the date on which (1) you or your eligible dependent becomes eligible for such Medicaid or Chip premium assistance, or (2) such eligibility is lost (for reasons other than non-payment). See the Plan Administrator for details about special enrollment for Health Benefits.

## How do I enroll my dependent under a “Qualified Medical Child Support Order”?

A Qualified Medical Child Support Order (QMCSO) is an order by a court for one parent to provide a child or children with health insurance. If you have enrolled for Health Benefits, you and your beneficiaries are entitled to obtain a copy of the Plan’s QMCSO procedures without cost. Requests may be made to your Employer, the Plan Administrator or the Insurer providing Health Benefits. If the Plan Administrator receives a QMCSO for your child or children, and your Benefits under the Plan include Health Benefits, the Plan administrator will contact you concerning the Plan procedures for such an order.

# Contributions

## How much do I have to pay toward the insurance premium or contribution for Benefits?

Specific information about the amount you must pay toward your Benefits will be provided to you before you enroll in the Plan by your Employer, whether you enroll during your initial enrollment period, during annual enrollment, or under any applicable special enrollment rules.

## What if I take leave under the Family and Medical Leave Act?

If you use your leave under the Family and Medical Leave Act (“**FMLA**”), you may choose to continue any Health Benefits provided to you under the Plan during your leave of absence, or you may choose to suspend any such Health Benefit coverage during your leave. If you continue such Health Benefit coverage during your leave, then you are required to pay the employee's portion of the contribution for the Health Benefit coverage. If you voluntarily terminate your employment for reasons outside your control, you may be required to reimburse the Company for the employer portion of the contribution for the Health Benefit coverage. If you decide to take a FMLA absence, contact the Plan Administrator for further information regarding continuation or suspension of any applicable Health Benefits, and election forms.

# Coverage

## When does your coverage begin?

In order to obtain coverage for Benefits offered to you under the Plan, you must meet the eligibility requirements described in the “Eligibility” section and you must complete the Benefits enrollment process described in the “Enrollment” section. If you are eligible for Benefits, your coverage begins on the day you complete all enrollment requirements.

## When does your dependent’s coverage begin?

If the Benefits offered to you under the Plan permit you to obtain coverage for your dependents, your Insurance Documents will describe when dependent coverage begins. Generally, in order for dependent coverage to begin with respect to any Health Benefits or other Benefits for which your dependents are eligible, you must notify the human resources officer or department of your Employer in writing within 30 days of the occurrence of the following events:

* the date of your enrollment, as long as you enroll all eligible dependents within 30 days of your eligibility date;
* the date of birth of any eligible dependent that is a newborn; or
* the date you become legally obligated to furnish financial support to your adopted child.

Special enrollment rules apply in certain instances, so please contact the human resources officer or department of your Employer as promptly as you are able to do so in order to obtain additional information about how and when you may enroll any eligible dependents. You may also contact the Plan Administrator or the Insurer providing Health Benefits.

## Can I be covered during a family or medical leave absence?

If you take family or medical leave under the terms of the Family and Medical Leave Act of 1993 (FMLA), you have the option to continue Health Benefit coverage during your absence or suspend coverage while you are on FMLA leave. To continue coverage, you must continue to pay any insurance premiums your Employer requires you to pay for your Benefits. If you fail to pay any required premiums, your coverage will terminate. If you choose to continue Health Benefit coverage during your absence, you and your dependents will be covered under the Plan while you are absent from work. The Health Benefit coverage will continue as if you were actively working until the earlier of the expiration of your FMLA leave or the date you give notice to your Employer that you will not return from your leave.

However, if you choose to suspend Health Benefit coverage during your absence, you and your eligible dependents will become covered immediately upon your return to work without being required to give evidence of insurability. Also, you and your eligible dependents will be excluded from any preexisting requirements applicable to the Health Benefits.

## When does coverage end for me or my eligible dependents?

The Insurance Documents will describe when coverage ends for you or any of your dependents that are eligible for coverage. Generally, coverage under the Plan for you or any of your eligible dependents will automatically end as soon as:

* the number of hours you work for your Employer is reduced below the minimum required for eligibility;
* You or your eligible dependents become ineligible for Benefits for any other reason stated in the Insurance Documents;
* Benefits coverage for you or your eligible dependents ends for any reason described in the termination of coverage rules included in the Insurance Documents;
* your employment with your Employer terminates;
* You fail to pay any insurance premiums that your Employer requires you to pay for Benefits provided to you or your eligible dependents under the Plan;
* you commence military service;
* you take a leave of absence that does not constitute a family or medical leave for purposes of the FMLA; or
* the Plan terminates.

If any Health Benefit coverage provided to you or your eligible dependents under the Plan ends for any reason, you and your eligible dependents may continue coverage as described in the “COBRA Continuation of Health Coverage” section.

# Summary of Health Benefits

## What Health Benefits are provided under the Plan?

If the Benefits offered to you under the Plan by your Employer include Health Benefits and you enroll in Health Benefits coverage, your Employer will provide you with a detailed schedule summarizing those Health Benefits (the “**Schedule of Health Benefits**”). The Insurance Documents provided to you by your Employer include the name and address of the Insurer providing Health Benefits coverage. If you have enrolled for Health Benefits, you and your beneficiaries are entitled to obtain copies of the Schedule of Health Benefits without cost. Requests may be made to your Employer, the Plan Administrator, or the Insurer providing the Health Benefits.

Your Employer is required to notify you if membership in a health maintenance organization (“**HMO**”) is a Health Benefit option for you to consider. If an HMO plan is available, your Employer is required to supply, at your request or at the request of your spouse or any dependent eligible to receive Health Benefits as a result of your employment, written materials concerning (1) the nature of services provided to members; (2) the conditions pertaining to eligibility to receive services and circumstances under which services may be denied; (3) the procedures to be followed in obtaining such services; and (4) the procedures available for the claims for services which are denied in whole or in part. Requests for these materials may also be addressed to the Plan Administrator.

## Am I required to obtain health care from specific providers?

The Schedule of Health Benefits describes Plan rules regarding the network of providers from whom Participants may obtain Health Benefits, including the Plan’s “in-network” and “out of network” providers, the conditions and limits that apply to primary care providers or specialty or emergency care, and certain Plan provisions that may require you to obtain preauthorization or utilization review as a condition to obtaining certain Health Benefits. If you have enrolled for Health Benefits, you and your beneficiaries are entitled to obtain a provider list without cost. Requests may be made to your Employer, the Plan Administrator or the Insurer providing the Health Benefits.

## When will I be required to pay part of the cost for Health Benefits?

The Schedule of Health Benefits describes the costs you must pay as a Participant in any Health Benefits coverage provided to you under the Plan. Your costs will include the following:

* the portion of the premiums for Health Benefits that your Employer requires you to pay to be eligible for Health Benefits; and
* all deductibles, co-insurance, and co-payment amounts that you must pay (in addition to your share of the premium cost for Health Benefits).

## What sorts of limits apply to Health Benefits provided under the Plan and what rules and procedures must I follow to obtain Health Benefits under the Plan?

The Schedule of Health Benefits describes the limits that apply to the coverage provided to you as a Participant in any Health Benefits coverage provided to you under the Plan. These limits will include the following:

* any annual or lifetime caps or other limits on Health Benefits;
* the extent to which preventative services are covered under the Plan without cost to you;
* whether, and under what circumstances, existing and new drugs are covered under the Plan; and
* whether, and under what circumstances, coverage is provided for medical tests, devices and procedures.

## What are my rights if the Plan provides me with maternity or newborn infant coverage?

If the Benefits offered to you under the Plan include Health Benefits and those Health Benefits provide maternity or newborn infant coverage, then you have certain rights under the Newborns’ and Mothers’ Health Protection Act of 1996 (the “**Newborns’ Act**”). The Newborns’ Act provides that group health plans and health insurance issuers may not restrict a mother’s or newborn’s benefits for a hospital length of stay that is connected to childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the attending provider may, after consulting with the mother, discharge the mother or newborn child earlier. Under the Newborn’s Act, plans and insurers may not require that a provider obtain authorization from the plan or the insurer for prescribing a length of stay that does not exceed 48 hours (or 96 hours in the case of a cesarean section). The coverage required under the Newborn’s Act is subject to the same, deductible, co-insurance and co-payment requirements applicable to other Health Benefits provided under the Plan.

## What are my rights if the Plan provides me with mental health benefits?

If the Benefits offered to you under the Plan include Health Benefits and those Health Benefits provide coverage for mental health or substance use disorder benefits, then you have certain rights under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), and the Mental Health Parity Act of 1996 (“**MHPA ‘96**”). MHPA ‘96 required parity with respect to aggregate lifetime and annual dollar limits for mental health benefits. MHPAEA expands those provisions to include substance use disorder benefits. Thus, under MHPAEA group health plans and issuers may not impose a lifetime or annual dollar limit on mental health or substance use disorder benefits that is lower than the lifetime or annual dollar limit imposed on medical/surgical benefits. MHPAEA also requires group health plans and health insurance issuers to ensure that financial requirements (such as copays and deductibles), and quantitative treatment limitations (such as visit limits), applicable to mental health or substance use disorder benefits are generally no more restrictive than the requirements or limitations applied to medical/surgical benefits. The MHPAEA regulations also require plans and issuers to ensure parity with respect to non-quantitative treatment limitations (such as medical management standards).

## What are my rights if the Plan provides me with coverage for a mastectomy?

If the Benefits offered to you under the include Health Benefits and those Health Benefits provide coverage for mastectomies, then you have certain rights under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). Under WHCRA, group health plans, insurance companies and health maintenance organizations (HMOs) offering mastectomy coverage also must provide coverage for certain services relating to the mastectomy in a manner determined in consultation with your attending physician and you. This required coverage includes all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses and treatment of physical complications of the mastectomy, including lymphedema. The coverage required under WHCRA is subject to the same, deductible, co-insurance and co-payment requirements applicable to other Health Benefits provided under the Plan.

# COBRA Continuation of Health Coverage

## What is COBRA Continuation Coverage?

If you or a Qualified Beneficiary loses Health Benefit coverage under the Plan because of a Qualifying Event, you or your Qualified Beneficiary may be eligible to continue Health Benefit coverage for a limited period. This continuation of any Health Benefit Coverage that you receive under the Plan is called “**Continuation Coverage**”. The law that requires Continuation Coverage to be offered is the Consolidated Omnibus Budget Reconciliation Act of 1985 (“**COBRA**”).

## Who is a “Qualified Beneficiary”?

A Qualified Beneficiary is either you or any eligible dependent covered under any Health Benefits offered to you under the Plan.

## When can I elect Continuation Coverage?

You may elect Continuation Coverage once your regular Health Benefit coverage ends due to a Qualifying Event as described in the next question. Generally, you must elect the Continuation Coverage within 60 days from the end of your regular Health Benefit coverage or your Health Benefits coverage will not continue. In addition, during the same 60-day period, each Qualified Beneficiary may make his or her own election for Continuation Coverage whether you elect it or not. If the election is not completed within the applicable 60-day period, there will be no Continuation Coverage and there will be no further rights to elect such Continuation Coverage. However, the election period will be extended to 60 days from the date on which your Employer gives you any notice of your rights to Continuation Coverage which is required under COBRA.

**Note: Due to the Coronavirus pandemic, the Department of Labor has extended the election period for qualifying COBRA Beneficiaries. Specifically, if your Qualifying Event occurs at any time between March 1, 2020 and the date that the Coronavirus national emergency is declared over, your deadline to elect COBRA coverage is the later to occur of 60 days from the end of your coverage (as describe above) or 60 days after the end of the national emergency.**

## What is a “Qualifying Event”?

 A “Qualifying Event” occurs when:

* you die;
* your employment with your Employer ends for any reason other than your gross misconduct;
* your work hours are reduced to less than the minimum number hours per week required to meet your Employer’s eligibility requirements (If you take an FMLA leave of absence and do not return to active employment, the Qualifying Event of termination of employment occurs at the earlier of the end of the leave or the date that you give notice to your Employer that you will not be returning to your job.);
* you divorce or legally separate from your spouse;
* you become entitled to receive Medicare benefits under Social Security (You are not “entitled” to Medicare until you have actually completed the Medicare enrollment and you have been notified your Medicare coverage is in effect); or
* if your children are eligible dependents with Health Benefit coverage under the Plan, a qualifying event occurs with respect to your covered dependent child when that child ceases to be a dependent that is eligible for Health Benefit coverage.

It is your obligation to inform your Employer of the occurrence of any Qualifying Event within 60 days of the event, other than a change in your employment status because of death, termination of employment, or reduction in hours. Your Employer has the obligation to notify the Plan Administrator of (1) any change in your employment status as a result of death, termination of employment, or reduction in hours; and (2) provided that you notify your Employer of the occurrence of any other Qualifying Event, the occurrence of that Qualifying Event.

If your Qualified Beneficiaries elect Continuation Coverage following a reduction in your hours or the termination of your employment for other than gross misconduct, and during the 18 months of Continuation Coverage any of your Qualified Beneficiaries experiences a second Qualifying Event, such Qualified Beneficiary will be entitled to elect a total of 36 months of Continuation Coverage beginning from the date the initial 18 month Continuation Coverage period began. To receive this additional Continuation Coverage, you or your Qualified Beneficiary must notify your Employer of the second Qualifying Event within 60 days of the event.

## How much does Continuation Coverage cost?

If you elect Continuation Coverage, your Employer may require you to pay up to 102% of the applicable cost for the period of coverage. If the contributions are being paid for a disabled individual, then your Employer may require you to pay up to 102% of the applicable contribution for the first 18 months and up to 150% of the applicable contribution for the 19th month through the 29th month. You may pay such contribution monthly and your first contribution is due and payable 45 days after you make the initial election for coverage.

## When does Continuation Coverage become effective once elected?

Assuming the required contributions have been timely paid, Continuation Coverage is retroactive to the date you lost regular coverage under the Plan due to the occurrence of a Qualifying Event.

## When does the Continuation Coverage end?

You will be able to continue coverage for up to 18 months after the date of your reduction in hours or your termination of employment for reasons other than gross misconduct. If during this 18-month period, the Social Security Administration determines you were disabled at the time of your Qualifying Event, you may extend your coverage up to 29 months from the date of the Qualifying Event. If you were entitled to Medicare benefits at the date of your Qualifying Event, then you and each of your dependents may elect separately to continue coverage up to 36 months.

Continuation coverage is available for up to 36 months to the following persons:

* your spouse, if you and your spouse are divorced or legally separated and your spouse is no longer covered under the Plan;
* your dependent child, if your child loses coverage because the child is no longer your dependent;
* your dependents, if you die; and
* your dependents, if you become entitled to Medicare.

 Continuation Coverage automatically ends after the following:

* the date your Employer no longer provides any group health coverage to any of its employees;
* 30 days after the due date of your contribution and the contribution was not paid;
* the date the Qualified Beneficiary becomes covered under another group health plan that does not contain a preexisting condition clause;
* the date the Qualified Beneficiary becomes entitled to Medicare; or
* for disabled Qualified Beneficiaries, the date the Social Security Administration determines that the Qualified Beneficiary is no longer disabled.

## What are my Continuation Coverage rights if I am absent for duty in the uniformed services?

If you leave employment with your Employer to serve in the uniformed services, the Uniformed Services Employment and Reemployment Rights Act (“**USERRA**”) may provide you and your eligible dependents with certain rights to continue any Health Benefits coverage provided under the Plan. If your employment is interrupted because of uniformed services, your Employer will supply you with additional information regarding your rights to continue Health Benefits coverage under this Plan and other USERRA rights. Generally speaking, these USERRA rights include the right to continue existing Health Benefits coverage for up to 24 months while in the uniformed services; and if you do not elect to continue coverage during such service, the right to have Health Benefits coverage reinstated if you return to employment following honorable discharge, within the time periods prescribed by law. Generally, no waiting periods or exclusions will be imposed in connection with such reinstatement, other than for service-connected illnesses or injuries. Under USERRA, the “**uniformed services**” are the Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency. COBRA coverage will run concurrently with, and not in addition to, any continuation coverage elected under USERRA or other applicable law.

## Can I convert to an individual Health Benefit policy once my Continuation Coverage ends?

If any Health Benefit coverage provided to you under the Plan terminates, you may be able to convert that Health Benefit coverage to an individual policy. You may be able to convert coverage without proof of good health or waiting periods, provided you are not covered under another qualified group plan. You may be eligible to convert to an individual policy if:

* Your Continuation Coverage expires;
* Your Health Benefit coverage or Continued Coverage ends under the Plan because the Plan is terminated; or
* Your Health Benefit coverage ends under the Plan and you do not have the right to continue coverage as described in “Continuation of Coverage.”

Any right to convert to an individual policy generally will not be available if:

* Continuous coverage is not maintained;
* You have not exhausted your right to continue coverage as described in “Continuation of Coverage;” or
* You are covered under another qualified group plan as defined by state law.

You should contact your Employer or the Plan Administrator to determine whether any such conversion coverage is available to you and any eligible dependents; and if so, how and when you must enroll for such conversion coverage; and the premiums that must be paid for such conversion coverage and when such premiums are due. You may also contact the Insurer providing the Health Benefits.

# Certificates of Health Coverage

## What are certificates of Coverage?

Certificates of coverage are written documents provided by the Insurers who issue the Insurance Policies that provide any Health Benefits you receive under this Plan. The Certificates of Coverage show the type of Health Benefits coverage you or your eligible dependents had and how long the coverage lasted. Under federal law, most group health plans must provide these certificates automatically when a person's coverage terminates. However, if a plan does not give you a certificate, you have the right to request one. Certificates apply both to Plan Participants and to covered dependents.

## What is the purpose of a Certificate of Coverage?

One of the goals of the Health Insurance Portability and Accountability Act of 1996 (“**HIPAA**”) was to make it easier for people changing jobs to keep health insurance, regardless of their health status. The primary purpose of the certificates is to show the amount of “Creditable Coverage” that you had under a prior group plan or other health insurance coverage, because this can reduce or eliminate the length of time that any preexisting condition clause in a new plan otherwise might apply to you.

## How can I get a Certificate of Coverage when any Health Benefits coverage under this Plan Terminates?

The Plan will automatically give you a certificate after you lose any Health Benefits coverage (whether regular coverage or Continuation Coverage) provided to you under the Plan, and will make reasonable efforts to provide on the certificate the names of your dependents who were also covered. In addition, the Plan will provide a certificate for you (or your dependents) upon request if you make the request within two years (24 months) after your coverage terminates. Your Employer, the Plan Administrator or the Insurer providing Health Benefits can give you forms to make such a request.

# When Plan Benefits may be Reduced, Forfeited or Denied

## Under what circumstances may Plan Benefits be reduced, forfeited or denied?

The Insurance Documents provided to you by your Employer when you enroll in the Plan summarize the circumstances under which Plan Benefits may be reduced, forfeited or denied, including as a result of fraud, false statements, or requests for payments to dependents who are no longer eligible. Such circumstances may include an Insurer’s rights to subrogation or reimbursement for payments made under the Plan, including payments made to you or your dependents as a result of fraudulent representations, false statements, or payments to dependents who are no longer eligible.

# HIPAA Privacy Rights

## What are my HIPAA privacy rights?

HIPAA and its applicable regulations require group health plans, including this Plan (if you receive Health Benefits under the Plan), to protect the privacy and security of your confidential health information (as well as that of your eligible dependents who enroll and receive Health Benefits). Pursuant to the HIPAA privacy rules, your Employer and the Plan Administrator will not use or disclose your protected health information (or that of your enrolled eligible dependents who receive Health Benefits) without your (or their) authorization, except for purposes of treatment, payment, health care operations, program administration or as required or permitted by law. Your Employer and the Insurers issuing the Insurance Policies providing you any Health Benefits will give you a notice of privacy practices or privacy notice as part of your Insurance Documents.

# Plan Sponsor, Plan Administrator, and Participating Employers

## Who Sponsors and Administers the Plan?

**Plan Sponsor and Plan Administrator:**

New Hampshire Bankers Association Insurance Trust

**Business address:**

100 North Main Street, Suite 504

P.O. Box 2586

Concord, NH, 03302-2586

**Business telephone number:**

(603) 224-5373

**Federal Employer Identification number:**

02-6005138

## Does my Employer Sponsor and Participate in the Plan?

Only “**Eligible Employers**” who become “**Participating Members**” of the Trust sponsor and participate in the Plan. Generally speaking, only banks that are members of the New Hampshire Bankers Association (“**NHBA**”), and their subsidiaries and affiliates, are Eligible Employers. Other eligible employers include NHBA and, NHBA member institution, Granite State Management and Resources. Banks and other Eligible Employers become Participating Employers and Plan sponsors by subscribing to the Trust and complying with their obligations as subscribers to the Trust. Information about whether a particular employer is a Plan sponsor and, if the employer is a Plan sponsor, the sponsor’s address, may be obtained by Participants and their beneficiaries upon written request to the Plan Administrator.

## Who are the Trustees of the Trust that Administers the Plan?

The Plan is administered by the Trust, acting by and through a board of trustees (“**Trustees**”) elected by the Trust’s Participating Employers, except that responsibility for administration of Benefits claims and appeals has been delegated to the Claims Administrator (as described below). The Trustees of the Trust, together with their business addresses and business telephone numbers, are listed on Schedule 3 to this Summary Plan Description.

## What is the Plan number?

The Plan number assigned by the Plan Administrator is 501.

## When does the Plan year end?

The Plan year is a 12-month period that ends on December 31.

## Who is the agent designated for service of process?

To initiate a legal proceeding to enforce your rights under ERISA, service of process should be made on the Plan Administrator at its business address. In addition, you may make service of legal process on any Plan Trustee at the business address of that Trustee.

# Filing Claims

## Who is the Claims Administrator?

The Insurer whose Insurance Policy funds a particular Plan Benefit (the “**Claims Administrator**”) determines all factual and legal questions with respect to all initial claims for that Benefit. The Claims Administrator will make all decisions regarding entitlement to Benefits and the amounts of Benefits to be paid.

## How do I file a claim for benefits with the Claims Administrator?

Benefits claims must be filed with the Insurer providing those Benefits. The Insurance Documents summarize the procedure you must follow to make a claim for Benefits. Please review the claims procedures carefully, as you or your dependents may be required to obtain pre-authorizations, approvals, or utilization review decisions as a condition to making claims for certain Health Benefits; and may be required to file certain claim forms as a condition to receiving certain Health Benefits and other Benefits. Please contact the Insurer, your Employer or the Plan Administrator for the applicable Benefits claim procedures, which will be furnished to you and your beneficiaries without charge.

## How do I appeal my benefits claim if it is denied in whole or in part?

Appeals of Benefits claims that are denied in whole or in part must be filed with the Insurer providing those Benefits. The Insurance Documents summarize the procedure you must follow to appeal any denial of Benefits. Please contact the Insurer, your Employer or the Plan Administrator for the applicable appeal procedures, which will be furnished to you and your beneficiaries without charge.

# Amendment or Termination of Plan

## Can the Plan be amended or terminated?

Yes. Under the terms of the Plan and Trust, the Trustees of the Plan and the Participating Employers have reserved the right to amend or terminate the Plan at any time. If the Plan is terminated, the Trust requires the Trustee to wind-up and liquidate the assets of the Trust and Plan in the manner required by Internal Revenue Code Section 501(c)(9), which governs Voluntary Employee Benefits Associations (VEBAs). The Trust is a VEBA.

# ERISA Rights

## What are my ERISA rights?

As a Participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“**ERISA**”). ERISA provides that all Plan Participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements (if any), and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor.

     2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if any), and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

     3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

     4. Continue any Health Benefits coverage that you have under the Plan for yourself, spouse, or dependents if there is a loss of coverage under the Plan because of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

     5. Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have Creditable Coverage from another plan. You should be provided a certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage under the Plan.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate your Plan—called “fiduciaries” of the Plan—have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your Employer, your union (if any), or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining benefits under the Plan or exercising your rights under ERISA.

If your claim for a Benefit under this Plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for Benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about this Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210.

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**Schedule 1**

**Please refer to your employer’s Account Profile with Plan Summaries, as amended from time to time, for a description of the plan benefits selected by your employer and eligibility requirements.**

**Schedule 2**

**Names, Business Addresses and Business Telephone Numbers**

**of the Plan’s Trustees**

**1. Name:** Ronald L. Magoon

**Title:** President & CEO, Franklin Savings Bank

**Business address:** PO Box 339

Franklin, NH 03235

**Business telephone number:** 603-934-8331

**2. Name:** Rhonda Caswell

**Title:** VP/Retail & HR Officer, Woodsville Guaranty Savings Bank

**Business address:** 189 Cottage Street.

Littleton, NH 03561

**Business telephone number:** 603-444-5237

**3. Name:** Heidi Patten

**Title:** VP/Retail & HR Officer, Sugar River Bank

**Business address:** 10 N. Main St.

Newport, NH 03773

**Business telephone number:** 603-843-6217

**4. Name:** Jeannine Santosuosso

**Title:** VP / HR Officer, Piscataqua Savings Bank

**Business address:** 15 Pleasant Street

Portsmouth, NH 03801

**Business telephone number:** 603-436-5250

**5. Name:** Kristy Merrill

**Title:** Executive Secretary, New Hampshire Bankers Association Insurance Trust

**Business address:** 100 North Main Street, Suite 504

PO Box 2586

Concord, NH 03302-2586

**Business telephone number:** 603-224-5373