This document contains important information regarding your health plan. The following notifications are included:

- **Women’s Health and Cancer Rights Act, page 1**
- **Newborns’ and Mothers’ Health Protection Act, page 2**
- **Children’s Health Insurance Program Reauthorization Act, page 3**
- **Medicare Part D Prescription Drug Coverage, page 4 & 5**

For more information regarding your health plan please contact: Sara Sawyer at 603-230-3503.

For details on your health insurance plan such as copayments, coinsurance and covered benefits, please see the Anthem Summary of Benefits included with your open enrollment kit.

---

**Women’s Health and Cancer Rights Act (WHCRA)**

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- 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.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Please see your Anthem summary of benefits for the deductible and coinsurance amounts.
Newborns’ and Mothers’ Health Protection Act (NMHPA)

The Newborns’ and Mothers’ Health Protection Act of 1996 (the Newborns’ Act), signed into law on September 26, 1996, requires plans that offer maternity coverage to pay for at least a 48-hour hospital stay following childbirth (96-hour stay in the case of a cesarean section).

This law was effective for group health plans for plan years beginning on or after January 1, 1998.

On October 27, 1998, the Department of Labor, in conjunction with the Departments of the Treasury and Health and Human Services, published interim regulations clarifying issues arising under the Newborns’ Act. The changes made by the regulations are effective for group health plans for plan years beginning on or after January 1, 1999.

The Newborns’ Act and its regulations provide that health plans and 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 (who may be a physician or nurse midwife) may decide, after consulting with the mother, to discharge the mother or newborn child earlier.

The Newborns’ Act, and its regulations, prohibits incentives (either positive or negative) that could encourage less than the minimum protections under the Act as described above.

A mother cannot be encouraged to accept less than the minimum protections available to her under the Newborns’ Act and an attending provider cannot be induced to discharge a mother or newborn earlier than 48 or 96 hours after delivery.

The type of coverage provided by the plan (insured or self-insured) and state law will determine whether the Newborns’ Act applies to a mother’s or newborn’s coverage.

The Newborns’ Act provisions always apply to coverage that is self-insured. If the plan provides benefits for hospital stays in connection with childbirth and is insured, whether the plan is subject to the Newborns’ Act depends on State law. Based on a recent preliminary review of State laws, if the coverage is in Wisconsin and several U.S. territories, it appears that the Federal Newborns’ Act applies to the plan. If the coverage is in any other state or the District of Columbia, it appears that State law applies in lieu of the Federal Newborns’ Act.
**Medicaid and the Children’s Health Insurance Program (CHIP)**

Maine, Massachusetts and New Hampshire
Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer’s health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer’s plan. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

---

**If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2012. You should contact your State for further information on eligibility –**

<table>
<thead>
<tr>
<th>STATE</th>
<th>Program(s)</th>
<th>Website</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MASSACHUSETTS</strong> – Medicaid and CHIP</td>
<td>Website: <a href="http://www.mass.gov/MassHealth">http://www.mass.gov/MassHealth</a> Phone: 1-800-462-1120</td>
<td><strong>NEW HAMPSHIRE</strong> – Medicaid Website: <a href="http://www.dhhs.nh.gov/ombp/index.htm">www.dhhs.nh.gov/ombp/index.htm</a> Phone: 603-271-5218</td>
<td></td>
</tr>
</tbody>
</table>

*To view additional States that have added a premium assistance program since January 31, 2012, or for more information on special enrollment rights, you can contact either:*

- U.S. Department of Labor
  Employee Benefits Security Administration
  [www.dol.gov/ebsa](http://www.dol.gov/ebsa)
  1-866-444-EBSA (3272)

- U.S. Department of Health and Human Services
  Centers for Medicare & Medicaid Services
  [www.cms.hhs.gov](http://www.cms.hhs.gov)
  1-877-267-2323, Ext. 61565
Medicare Part D Prescription Drug Coverage

Employees, their spouses and other dependents who will be or currently are 65 years old or older within the next year—PLEASE READ

If you or any of your dependents are Medicare Part D eligible and considering enrolling in the Community College System of NH Prescription Drug Coverage, please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Community College System of NH and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Community College System of NH has determined that the prescription drug coverage offered by Anthem is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

The information on the following page will help you better understand how and when you can join a Medicare Drug Plan if you so choose.
Medicare Part D Prescription Drug Coverage

Joining a Medicare Drug Plan-
You can join a Medicare drug plan when you first become eligible for Medicare and each year from OCTOBER 15th until DECEMBER 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special enrollment Period (SEP) to join a Medicare drug plan.

Your Current Coverage and a Medicare Drug Plan-
If you decide to join a Medicare drug plan, your current Community College System of NH coverage will not be affected. Please see your Summary of Benefits plan description for more detail to compare the plan provisions/options between your current Community College System of NH plan and the Medicare Part D coverage. You may also contact the Human Resources Department for more information and answers to your questions.

If you decide to join a Medicare drug plan and drop your Community College System of NH coverage, be aware that you and your dependents may or may not be able to get this coverage back, see your Summary of Benefits plan description for verification.

When Will You Pay a Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Community College System of NH and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a Penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.