

State of New Hampshire Employee Health Benefit Program

Health Reimbursement Arrangement

Benefit Booklet

January 2014

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INTRODUCTION

The State of New Hampshire is pleased to establish this Health Reimbursement Arrangement (HRA) to provide you with additional health coverage benefits through its contract with Employee Benefits Management, Inc. (EBM). The benefits available under this Plan are outlined in this benefit booklet. We will also tell you about other important information concerning the Plan, such as the rules you must satisfy before you become eligible and the laws that protect your rights.

Read this benefit booklet carefully so that you understand the provisions of our Plan and the benefits you will receive. Please direct any questions you have to your Human Resource or Payroll Representative.

I. Benefits & Eligibility

1. What Benefits Are Available?

The State of New Hampshire offers this HRA as an optional benefit program that enables you to earn money to help pay for out-of-pocket medical expenses on an annual basis. The HRA has two components - \$200 in a tax-free HRA for completing the Health Assessment Tool (Health Assessment HRA) and up to \$300 in a tax-free HRA for completing Health Rewards Program health promotion activities (Health Rewards HRA). Note: All employees must complete the Health Assessment Tool (HAT) to be eligible for the Health Rewards HRA (see eligibility details below).

The HRA allows you to be reimbursed by the State for co-payments, deductibles, vision exam and eyewear expenses and co-insurance paid out-of-pocket for covered expenses under your group medical and prescription drug plan that are incurred by you or your dependents.

2. What Are the Eligibility Requirements of Our Plan?

In order to be eligible for the Health Assessment HRA you must be a subscribing member of the State's group medical and prescription drug plan. To earn the \$200 tax-free incentive you must complete the HAT.

In order to be eligible for the Health Rewards HRA you must be a subscribing member of the State's group medical and prescription drug plan and have completed the HAT. To earn up to \$300 in tax-free incentives you must participate in qualified health promotion activities.

In addition to the subscribing members mentioned above, a state employee who is independently eligible to enroll in the State's plan but is enrolled as a dependent (either as a spouse or adult child) on a subscribing state employee's plan will be eligible for the Health

Rewards HRA once he or she has completed the HAT. To earn up to \$300 in tax-free incentives the enrolled dependent must participate in qualified health promotion activities. Such employees are not eligible for the Health Assessment HRA but must complete the HAT in order to be eligible for the Health Rewards HRA.

3. Are There Any Employees Who Are Not Eligible?

Retirees are not eligible for either HRA.

Executive Branch state employees who are covered by the collective bargaining agreements negotiated by the New England Police Benevolent Association (NEPBA) Local 40, 45, 260, 265 or 270, New Hampshire Troopers Association (NHTA) and Teamsters Local 633 are not eligible for the Health Rewards HRA incentives. Members of these unions are eligible for a different Health Reward benefit and should contact their Human Resource or Payroll Representative for further details.

4. What is the Health Assessment Tool or HAT?

The HAT is a confidential questionnaire that evaluates your overall well-being. This assessment gathers information about all the factors that influence your well-being, including physical, emotional and financial health and social connectivity. You can complete the HAT online through www.anthem.com.

5. What are Health Promotion Activities?

Once you have taken the HAT, you can earn up to \$300, in \$100 increments, in a Health Rewards HRA when you complete health promotion activities. More information on these health promotion activities is available at http://admin.state.nh.us/wellness/Wellness_RewardProgram.html.

II. Additional Plan Rules

1. When is My Entry Date?

Your entry date for the Health Assessment HRA and the Health Rewards HRA is the day you complete the HAT during the applicable Plan Year.

You must complete your HAT to be eligible for either HRA. Your Health Assessment HRA (\$200) may be used for expenses incurred on or after the date you completed your HAT. Your Health Rewards HRA (up to three increments of \$100) may be used for expenses incurred on or after the completion of each Health Promotion Activity.

2. When Will I Receive My Debit Card?

Upon completion of the HAT you will receive two debit cards in the mail. The employee's name will appear on both cards. If applicable, the additional card you receive can be used by your spouse or dependent age 18 years or older. Your Health Rewards HRA can be accessed using the same debit card you receive upon completion of the HAT.

If you have an existing debit cards, funds will be loaded to those cards upon completion of the HAT. New cards will not be received.

3. When Are Expenses Considered Incurred?

Expenses are considered "incurred" when the service is performed or when an item is purchased, not necessarily when it is paid for. Any amounts reimbursed to you under the HRA may not be claimed as a deduction on your personal income tax return nor reimbursed by other health plan coverage including your flexible spending account.

4. When Must Expenses Be Incurred?

Expenses must be incurred for the Health Assessment HRA on or before December 31 of each Coverage Period. Expenses must be incurred for the Health Rewards HRA on or before December 31 of each Coverage Period. However, the remaining Health Rewards HRA funds earned during 2014 will rollover once to 2015 so expenses for 2014 and 2015 must be incurred on or before December 31, 2015.

Please note that you do not need to be an HRA participant in 2015 to be eligible for a rollover from the 2014 Health Rewards HRA. You must, however, still be an active state employee.

5. When Will I Receive Payments From the Plan?

Health Assessment HRA funds will be available 7-14 days after HAT completion between January 1 and December 31 of each Coverage Period. Health Rewards HRA funds will be available 7-14 days after an activity has been submitted between January 1 and December 31 of each Coverage Period.

Certain costs are covered at the point of service with your debit card. During the course of the Coverage Period, you may also submit requests for reimbursement of expenses you have incurred. However, you must make your requests for reimbursements no later than March 31st after the end of the Plan year. Combined Services LLC (CSLLC) or EBM can provide you with acceptable forms for submitting these requests for reimbursement (see Claim Information below for more details). In addition, you must submit to CSLLC proof of the expenses you have incurred and that they have not been paid by any other health plan coverage. If the request qualifies as a benefit or expense that the HRA has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, reimbursements made

from the HRA are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes.

6. How Does My HRA Relate to My Health FSA?

If an expense is reimbursable under both your HRA and your Health FSA, your Health Assessment HRA is looked to first, your Health FSA second and your Health Rewards HRA third. Some expenses may be covered only by your Health FSA, (if you have elected to participate in the Health FSA) in which case your HRA cannot be used.

7. What Happens If I Terminate Employment?

If you are the subscribing member and your employment is terminated during the Plan Year for any reason, your participation in the HRA will cease, your debit card access will end and any unused amounts are forfeited. However, if you elect COBRA continuation coverage through the State's medical benefits administrator, Anthem Blue Cross and Blue Shield, you will continue to have access to this benefit for the length of time you remain enrolled in your medical benefits as a COBRA participant. *Please note: upon termination, you will need to pay co-payments, deductibles and co-insurance up front and submit a paper claim for reimbursement as the debit card will no longer be available to you during your COBRA period.*

If you are taking part in the HRA as a state employee enrolled as a dependent on a subscribing state employee's plan (see question 2 on page 4) and your employment is terminated for any reason, you will no longer be independently eligible to take part in the HRA, your participation in the HRA will cease, your debit card access will end and any unused amounts are forfeited. If you remain enrolled as a dependent on a subscribing state employee's plan, you will still have access to the subscriber's HRA benefit.

III. Claim Information

1. How do I Submit a Claim?

Certain costs are covered at the point of service with your debit card. However, when you have a claim to submit for payment, you must:

- (1) Obtain a claim form from: www.combinedservices.com/pages/formdownloads.php or by calling CSLLC at 1-888-227-9745, ext. 2040.
- (2) Complete the employee portion of the form.
- (3) Attach copies of all bills from the service provider for which you are requesting reimbursement.

In addition, Android and iPhone Mobile apps are available for download at <http://www.combinedservices.com/pages/flexiblebenefitsparticipants.php>

You can use the app to check available balances, submit claim requests, use a mobile device's camera to send receipts and documentation for claims, substantiation, and receive account balances and selected alerts via text message on any mobile device.

2. How is My Claim Adjudicated?

A Claim is defined as any request for an HRA benefit, made by a claimant or by a representative of a claimant that complies with the Plan's reasonable procedure for making benefit Claims. The times listed below are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. Unless otherwise noted, "days" means calendar days.

Notification of whether Claim is accepted or denied	5 business days
Extension due to matters beyond the control of the Plan	15 days
Notification of Extension	15 days
Response by Participant	45 days
Review of Claim denial	60 days

The Third Party Claims Processor will provide written or electronic notification of any Claim denial. The notice will state:

- (a) The specific reason or reasons for the denial.
- (b) Reference to the specific Plan provisions on which the denial was based.
- (c) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.
- (e) A description of the Plan's review procedures and the time limits applicable to such procedures.
- (f) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claim.
- (g) If the denial was based on an internal rule, guideline, protocol or other similar criterion, the specific rule, guideline, protocol or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or

criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When you receive a denial, you will have 180 days following the date of the denial in which to appeal the decision. You may submit written comments, documents, records and other information relating to the Claim. If you request, you will be provided, free of charge, reasonable access to and copies of, all documents, records and other information relevant to the claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record or other information shall be considered relevant to a Claim if it:

- (a) Was relied upon in making the Claim determination;
- (b) Was submitted, considered or generated in the course of making the Claim determination, without regard to whether it was relied upon in making the Claim determination;
- (c) Demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that Claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants;
- (e) Or constituted a statement of policy or guidance with respect to the Plan concerning the denied Claim.

The review will take into account all comments, documents, records and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial Claim determination. The review will not afford deference to the initial denial and will be conducted by someone who is neither the individual who made the adverse determination nor a subordinate of that individual.

IV. General Plan Information

1. General Plan Information

New Hampshire State Employees Health Reimbursement Arrangement is the name of the Plan.

The State of New Hampshire has assigned Plan Number 509 to your Plan.

The provisions of your amended Plan become effective 01/01/2014. Your plan was originally effective on 01/01/2008.

The Plan Year is the 12-month period beginning 01/01 and ending 12/31.

2. Employer Information

Your Employer's name and address and identification number are:

State of New Hampshire
25 Capitol Street
Concord, NH 03301
02-6000618

3. Plan Administrator Information

The name, address and business telephone number of your Plan's Administrator are:

State of New Hampshire
Department of Administrative Services
25 Capitol Street
Concord, NH 03301
(603) 271-3261

The Plan Administrator is responsible for the administration of the Plan and maintains plan documents. Your Human Resource or Payroll Representative will also answer any questions you may have about the Plan. The Plan Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Administrator are conclusive and binding. You may contact the Administrator for any further information about the Plan.

4. Contractor Information

The name, address and business telephone number of the State's Contractor are:

Employee Benefits Management, Inc.
174 S Freeport Rd, Suite 1-C
Freeport, ME 04032
(800) 639-4025

5. Third Party Claims Processor Information

The name, address and business telephone number of the Third Party Claims Processor are:

Physical Address:

Combined Services LLC
Two Delta Drive, Suite 301
Concord, NH 03301
Main Line: (603) 227-2000
Toll Free: (888) 227-9745

Mailing Address:

Combined Services LLC
P.O. Box 1320
Concord, NH 03302-1320

The Third Party Claims Processor is responsible for the actual claims adjudication and review process on behalf of the Plan Administrator.

6. Third Party COBRA Administrator Information

The name, address and business telephone number of the Third Party COBRA Administrator are:

Anthem Blue Cross and Blue Shield
P.O. Box 660350
Dallas, TX 75266-0350
(866) 599-3059

The Third Party COBRA Administrator is responsible for handling eligibility and enrollment in COBRA continuation coverage.

7. Service of Legal Process

The State of New Hampshire is the Plan's agent for service of legal process.

8. Type of Administration

The Plan is a health reimbursement arrangement and the administration is provided through a Third Party Claims Processor. The Plan is self-funded. Benefits are paid from the Employee and Retiree Benefit Risk Management Fund of the State of New Hampshire.

9. Integration with State Employee Health Benefit Plan

This Plan is integrated with your medical and prescription drug coverage.

10. Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are going into or returning from military service, you may have special rights to health care coverage under your HRA under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected by this law, ask your Human Resource or Payroll Representative for further details.

11. Newborn and Mothers Health Protection Act

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

12. National Medical Support Notices

Under Section 401(e) of the Child Support performance and Incentive Act of 1998, the State's group health plan is required to provide benefits for the child of a participant who is a noncustodial parent of the child in accordance with the requirements of any National Medical Support Notice. If the State receives any such notice it is required to notify the State agency issuing the Notice with respect to whether coverage is available for the child in question and the effective date of the coverage or any steps necessary to be taken to effectuate the coverage and provide to the custodial parent (or such substituted official) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

V. Continuation Coverage Rights Under COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain employees and their families covered under the State Employee Health Benefit Program and this HRA will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the HRA would otherwise end. This notice is intended to inform Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law. If you have any questions about COBRA contact your Human Resource or Payroll Representative.

The Plan Administrator or its designee, in this case Anthem Blue Cross and Blue Shield, is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Participants who become Qualified Beneficiaries under COBRA.

1. What is COBRA Continuation Coverage?

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain participants and their eligible family members (called “Qualified Beneficiaries”). The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Arrangement (the “Qualifying Event”). The coverage must be identical to the coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event.

2. Who Can Become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be:

(a) Any individual who, on the day before a Qualifying Event, is covered under the Arrangement by virtue of being on that day either a covered Employee, the spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Arrangement under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(b) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Arrangement as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Arrangement under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term “covered Employee” includes any individual who is provided coverage under the Arrangement due to his or her performance of services for the State of New Hampshire sponsoring the Arrangement. However, this provision does not establish eligibility of these individuals. Eligibility for Plan coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the State of New Hampshire no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

3. What is a Qualifying Event?

A Qualifying Event is any of the following if the health plan provides that the participant would lose coverage under these circumstances:

- (a) The death of a covered Employee.
- (b) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
- (c) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.
- (d) A covered Employee's enrollment in any part of the Medicare program.
- (e) A Dependent child's ceasing to satisfy the Arrangement's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Arrangement).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Arrangement under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the State of New Hampshire, any substantial elimination of coverage under the Arrangement occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Arrangement that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 (“FMLA”) does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Arrangement provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Arrangement during the FMLA leave.

You must notify your Human Resource or Payroll Representative within 30 days of becoming ineligible for health care coverage. You must notify your Human Resource or Payroll Representative within 60 days of the date of divorce or legal separation and within 60 days of the date any enrolled dependent(s) no longer meet the definition of dependent.

4. What Factors Should Be Considered When Determining to Elect COBRA Continuation Coverage?

You should take into account that a failure to continue your group health coverage will affect your rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation coverage may help you avoid such a gap. Second, if you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy, which does not impose such pre-existing condition exclusions. Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse’s employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

5. What is the Procedure for Obtaining COBRA Continuation Coverage?

The Arrangement has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

6. What is the Election Period and How Long Must it Last?

The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Arrangement. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date

the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

Note: If a covered employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he or she and/or his or her family members may qualify for assistance under this special provision should contact the Plan Administrator or its designee for further information.

The Trade Act of 2002 also created a new tax credit for certain TAA-eligible individuals and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

7. Is a Covered Employee or Qualified Beneficiary Responsible for Informing the Plan Administrator of the Occurrence of a Qualifying Event?

The Arrangement will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The State will notify the Plan Administrator or its designee of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

- (a) the end of employment or reduction of hours of employment,
- (b) death of the employee,
- (c) commencement of a proceeding in bankruptcy with respect to the State of New Hampshire, or
- (d) enrollment of the employee in any part of Medicare,

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify your Human Resource or Payroll Representative

or its designee within 60 days after the Qualifying Event occurs, using the State's Online Benefits System. You must provide a copy of your documentation to Your Human Resource or Payroll Representative.

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that coverage would otherwise have been lost (if under your coverage the COBRA period begins on the date of the Qualifying Event, even though coverage actually ends later (e.g., at the end of the month) substitute the appropriate language, e.g. “on the date of the Qualifying Event”). If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

8. Is a Waiver Before the End of the Election Period Effective to End a Qualified Beneficiary’s Election Rights?

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

9. Is COBRA Coverage Available If a Qualified Beneficiary Has Other Group Health Plan Coverage or Medicare?

Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary’s COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

10. When May a Qualified Beneficiary’s COBRA Continuation Coverage Be Terminated?

COBRA coverage will terminate if:

- (a) Timely Payment is not made.

- (b) The State ceases to provide any group health plan to any employee.
- (c) The Qualified Beneficiary becomes covered under another plan or entitled to Medicare benefits.
- (d) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
- (e) The date, after the date of the election that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
- (f) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
 - (1) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
 - (2) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Arrangement can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Arrangement terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Arrangement solely because of the individual's relationship to a Qualified Beneficiary, if the Arrangement's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Arrangement is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

11. What Are the Maximum Coverage Periods for COBRA Continuation Coverage?

- (a) In the case of termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.
- (b) In the case of a covered Employee's enrollment in the Medicare program, divorce or legal separation or death, the maximum coverage period for the spouse and dependent child(ren) is 36 months after the Qualifying Event.

- (1) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or
- (2) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(c) In the case of a loss of “dependent child” status, the maximum coverage period for that child is 36 months after the Qualifying Event.

(d) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(e) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

In certain circumstances, Qualified Beneficiaries entitled to 18 months of continuation coverage may become entitled to a disability extension of an additional 11 months or an extension of an additional 18 months due to the occurrence of a second qualifying event. Contact Anthem Blue Cross and Blue Shield for details.

12. Under What Circumstances Can the Maximum Coverage Period Be Expanded?

If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36-months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36-months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator or its designee and in accordance with the procedures above.

13. How Does a Qualified Beneficiary Become Entitled to a Disability Extension?

A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee’s employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and

before the end of the original 18-month maximum coverage. This notice must be sent to the Plan Administrator or its designee and in accordance with the procedures above.

14. Does the Arrangement Require Payment for COBRA Continuation Coverage?

For any period of COBRA continuation coverage under the Arrangement, Qualified Beneficiaries who elect COBRA continuation coverage may be required to pay up to 102% of the applicable premium. Your employer will inform you of any costs. The Arrangement will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

15. Must the Arrangement Allow Payment for COBRA Continuation Coverage to Be Made in Monthly Installments?

Yes. The health coverage is also permitted to allow for payment at other intervals.

16. What is Timely Payment for COBRA Continuation Coverage?

Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Arrangement by a later date is also considered Timely Payment if either under the terms of the Arrangement, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the State of New Hampshire and the entity that provides benefits on the State's behalf, the State is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Arrangement does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to those providing coverage.

If Timely Payment is made to the Arrangement in an amount that is not significantly less than the amount the Arrangement requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Arrangement's requirement for the amount to be paid, unless the Arrangement notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

17. Must a Qualified Beneficiary Be Given the Right to Enroll in a Conversion Health Plan at the End of the Maximum Coverage Period for COBRA Continuation Coverage?

If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Arrangement will, during the 180 day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Arrangement. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the State of New Hampshire's COBRA Administrator:

Anthem Blue Cross and Blue Shield COBRA and Billing Administration at (866) 599-3059