

**State of New Hampshire
Employee Health Benefit Program**

Health Reimbursement Arrangement (HRA)

Benefit Booklet

January 2016

Table of Contents

The HRA Benefit & Eligibility.....	3
Benefit Available	3
Eligibility Requirements	3
Plan Entry Date	3
Coverage Period.....	3
Termination of Employment.....	3
Plan Provisions	3
Eligible Expenses.....	3
Incurred Expenses.....	4
Availability and Accessing HAT HRA Funds.....	4
HRA Debit Card	4
Coordination of the HAT HRA with Medical Flexible Spending Accounts (FSA).....	4
Claim Information	4
Methods of Submitting a Request for Reimbursement (Claim)	4
How to Submit a Claim Using a Debit Card	5
How to Submit a Claim Using a Paper Claim Form via Mail or Fax.....	5
How to Submit a Paperless Claim Using the ASIFlex Secure Portal.....	5
How to Submit a Claim Using the ASIFlex Mobile App.....	5
Deadline to Submit a Claim.....	5
Receiving Payment from a Claim.....	6
Claims Adjudication, Denial and Appeals Process	6
Continuation Coverage Rights Under COBRA	7
Uniformed Services Employment and Reemployment Rights Act (USERRA).....	12
Newborn and Mothers Health Protection Act	12
National Medical Support Notices	12
General Plan Information	12

The State of New Hampshire offers a Health Reimbursement Arrangement (HRA) to provide participants with additional health coverage benefits through its contract with Application Software, Inc. (ASIFlex). The benefits available under this Plan are outlined in this benefit booklet. This booklet will also explain other important information concerning the Plan, such as the rules that must be satisfied before one becomes eligible and the laws that protect participant rights.

This benefit booklet should be read carefully to understand the provisions of the Plan and the benefits participants will receive. Additional questions can be answered by contacting agency Human Resources or Payroll Representatives.

The HRA Benefit & Eligibility

Benefit Available

The State of New Hampshire offers an optional benefit program that enables participants to earn \$200 deposited into a tax-free HRA for completing the Anthem Healthy Life Styles Well-Being Assessment or Health Assessment Tool (HAT) online at www.anthem.com.

The HAT is a confidential questionnaire that evaluates a respondent's overall well-being by gathering personal information about physical, emotional and financial health as well as social connectivity.

Eligibility Requirements

In order to be eligible for the HAT HRA a participant must first complete the Anthem Healthy Life Styles Well-being Assessment (HAT) and be an active employee or an active COBRA participant and be the primary subscriber on the State's group medical and prescription drug plan. A State employee who is a spouse or dependent on another State employee's group medical benefit plan is not eligible to earn \$200 for completing the HAT.

Retirees from the State of New Hampshire are not eligible to earn \$200 for completing the HAT.

Plan Entry Date

The Plan entry date for the HAT HRA is the date in which the HAT is completed during the applicable Plan Year. The HAT HRA may be used for expenses incurred on or after the date in which the HAT is completed throughout the Coverage Period.

Coverage Period

The Coverage Period is date range in which the expenses must be incurred to be reimbursed by the HAT HRA. The Coverage Period begins on the date the HAT is completed and ends on the last day of the calendar year (December 31) in which the HAT was completed as long as the participant maintains the primary subscriber status and eligibility in the group medical and prescription drug plan throughout the Coverage Period. The Coverage Period ends when the participant no longer meets the eligibility requirements or December 31, whichever is earlier.

Termination of Employment

If the primary subscriber's employment is terminated during the Plan Year for any reason, participation in the HRA will cease, debit card access will end and any unused amounts are forfeited. However, if the primary subscriber elects COBRA continuation coverage through the State's medical benefits administrator, Anthem Blue Cross and Blue Shield, access to this benefit will continue for the length of time enrolled in the medical benefits as a COBRA participant.

Note: Upon termination, a participant will need to pay co-payments, deductibles and co-insurance up front and submit a paper claim to request reimbursement as the HRA debit card will no longer be available during the COBRA period.

Plan Provisions

Eligible Expenses

Participants are reimbursed by the State through the HAT HRA for co-payments, deductibles, vision exam and

eyewear expenses and co-insurance paid out-of-pocket for covered expenses under the State's group medical and prescription drug plans. The expenses may be incurred by the participant or any of their covered dependents.

Expenses eligible for reimbursement must be incurred during the Coverage Period.

Incurred Expenses

Expenses are considered "incurred" when the product or service is performed or rendered, not necessarily when it is paid. Amounts reimbursed under the HRA may not be claimed as a deduction on personal income tax returns nor reimbursed by other health plan coverage including the medical flexible spending account (Medical FSA).

Availability and Accessing HAT HRA Funds

The \$200 incentive for completing the HAT is deposited into the HAT HRA and available for reimbursement of eligible expenses approximately 14 days from the date the HAT was completed. If the expense is incurred prior to the availability of HAT HRA funds at ASIFlex but within the Coverage Period, participants may request reimbursement from the HAT HRA through the claims submission process. See the section titled 'Claim Information' below for more information on the claims submission process.

HRA Debit Card

For participant convenience, the State will provide, at no cost, through ASIFlex, an initial set of two (2) debit cards that can be used to access HAT HRA dollars at point of sale or service. Approximately three weeks following the completion of the HAT, the participant will receive the debit cards via US postal service. The primary subscriber's name will appear on both cards. If applicable, the extra card may be used by a covered spouse or dependent age 18 years or older.

The debit cards are good for five (5) years from the date of issue. Debit cards should be saved from year to year for future use. The same ASIFlex debit cards may be used to access the medical flexible spending account (Medical FSA), if elected, through ASIFlex. Agency Human Resources or Payroll Representatives can provide additional information on the Medical FSA.

There is a \$5.00 replacement fee per set of debit cards after the initial set is issued. The fee will be charged to the HAT HRA account or other ASIFlex account that has an existing balance.

Coordination of the HAT HRA with Medical Flexible Spending Accounts (FSA)

In order to provide the convenience of using the same debit card to access both HAT HRA and Medical FSA accounts, it was necessary for the State to establish the order of accounts to which expenses would be applied. If an expense is reimbursable under both the HAT HRA and the Medical FSA, the HAT HRA will pay first. Once the HAT HRA funds are exhausted, the balance due will be applied to the Medical FSA balance. Agency Human Resources or Payroll Representatives can provide additional information on the Medical FSA.

In the event an expense may be covered only by the Medical FSA, for example, dental expenses, the charge should be applied to the appropriate account automatically. Participants may need to contact ASIFlex to adjudicate expenses as desired or clearly identify the desired account on the claim documentation.

Claim Information

A claim is defined as a request for reimbursement from the HAT HRA, made by a participant or by a representative claimant of a participant that complies with the Plan's reasonable procedure for making benefit Claims.

Methods of Submitting a Request for Reimbursement (Claim)

A participant may submit a request for reimbursement or claim directly to ASIFlex using any of the following methods:

- Swiping the ASIFlex debit card where and how Visa is accepted at point of service or sale;
- Mailing a completed paper claim form to ASIFlex via US Postal Service;
- Faxing a completed paper claim form to ASIFlex at (877) 879 – 9038;

- Logging into the ASIFlex secure portal and filing a paperless claim at www.asiflex.com; or
- Going mobile through the ASIFlex mobile app found on the App Store or Google Play.

How to Submit a Claim Using a Debit Card

Certain costs are covered at the point of sale or service with the debit card and therefore a claim form is not required to access HAT HRA funds. However, it may be necessary for ASIFlex to request proof of eligible expense to confirm the HAT HRA funds are being used in accordance with plan provisions. Participants should save all itemized receipts and/or have access to medical or pharmacy online receipts (explanation of benefits or EOBs) in the event ASIFlex requests proof that the expense is recognized as a covered expense under the medical or pharmacy benefit.

How to Submit a Claim Using a Paper Claim Form via Mail or Fax

1. If a paper claim form is needed, a participant can download the form at www.asiflex.com.
2. Complete the employee portion of the form.
3. Attach copies of all bills from the service provider for which reimbursement is requested. Participants may also be required to submit proof that the expenses is recognized as a covered expense under the medical or pharmacy benefit.
4. Mail the completed claim and documentation to:
ASIFlex
P.O. Box 6044
Columbia, MO 65205-6044

Or fax the completed claim and documentation to 877-879-9038.

How to Submit a Paperless Claim Using the ASIFlex Secure Portal

A participant may submit paperless reimbursement requests online at www.asiflex.com. In order to do so, the participant is required to establish a personal ASIFlex online account. If assistance is needed in setting up an account, including establishing a username and password, call ASIFlex Customer Service toll free at (800) 659 – 3035.

1. Once online, go to Account Detail to log in and follow the prompts to file a claim.
2. All documentation including bills from the service provider and proof that the expenses is recognized as a covered expense under the medical or pharmacy benefit must be scanned as a PDF document and attached to the online claim.

How to Submit a Claim Using the ASIFlex Mobile App

A participant can download and install the ASIFlex mobile app at www.asiflex.com or by searching “asiflex” in the App Store or Google Play. The participant must establish a personal online account in order to use the mobile app.

1. Log on the mobile app using the chosen username, secure image, and password.
2. Click ‘File a New Claim’ and select the appropriate plan year and plan type.
3. Click on ‘Add to Claim’ and complete the form and click ‘Add.’
4. Click ‘File Claim’ and click ‘Take New Picture’ or ‘Select from Gallery.’
5. After taking picture or attaching from the Gallery, click ‘Continue.’
6. Sign the claim and click ‘Submit Claim.’

Deadline to Submit a Claim

Claims for expenses incurred during the Coverage Period may be submitted to ASIFlex on or before March 31 of the next calendar year.

Receiving Payment from a Claim

If the request for reimbursement qualifies as an eligible expense and the documentation is in good order, the participant will receive payment soon thereafter. Reimbursement is generally not subject to federal income tax or withholding provided the HAT HRA funds are used for eligible expenses. Nor is reimbursement subject to Social Security taxes.

Claims Adjudication, Denial and Appeals Process

The claims process is subject to the maximum times listed below. 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 business days
Notification of Extension	15 business days
Response by Participant	45 business days
Review of Claim denial	60 business days

ASIFlex, as 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.
- D. A description of the Plan’s review procedures and the time limits applicable to such procedures.
- E. A statement that the participant or 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.

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 participant or claimant upon request.

When a denial is received, the participant or claimant will have 180 days following the date of the denial in which to appeal the decision. The participant or claimant may submit written comments, documents, records and other information relating to the claim. Upon request, the participant or claimant 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 participants or claimants;
- D. 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 participant or 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.

Continuation Coverage Rights Under COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain employees and their families (Qualified Beneficiaries) covered under the State Employee Health Benefit Program and this Health Reimbursement Arrangement (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.

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 HRA (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 active employees who have not experienced a Qualifying Event.

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.

Qualified Beneficiaries

In general, a Qualified Beneficiary can be:

- A. Any individual who, on the day before a Qualifying Event, is covered under the HRA 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 HRA 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 HRA 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 HRA 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 HRA due to his or her performance of services for the State of New Hampshire sponsoring the HRA. 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.

Qualifying Events under COBRA

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 HRA's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the HRA).

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 HRA 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 HRA 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 HRA 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 HRA 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 HRA during the FMLA leave.

Participants must notify agency Human Resources or Payroll Representative within 30 days of becoming ineligible for health care coverage. Participants must notify agency Human Resources 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.

Electing COBRA Continuation Coverage

A participant should take into account that a failure to continue group health coverage will affect rights under federal law. First, a participant 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 avoid such a gap. Second, if a participant does not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available, the participant will lose the right to convert to an individual health insurance policy, which does not impose such pre-existing condition exclusions. Finally, a participant should take into account special enrollment rights under federal law (HIPAA). A participant has the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. A participant will also have the same special right at the end of COBRA continuation coverage if they get COBRA continuation coverage for the maximum time available.

Obtaining COBRA Continuation Coverage

The HRA 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.

The COBRA Election Period

The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the HRA. The election period must begin no 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 a participant has questions about these new tax provisions, 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.

Notification of a Qualifying Event

The HRA 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), the participant or someone on the participant's behalf must notify the agency Human Resources or Payroll Representative or its designee within 60 days after the Qualifying Event occurs, using the State's designated benefits system. Participants must provide a copy of the documentation to the Human Resources 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 the 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 the participant, 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.

Waiving COBRA Continuation Coverage

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.

COBRA Coverage and 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).

Terminating COBRA Continuation Coverage

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. 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 HRA can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the HRA 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 HRA solely because of the individual's relationship to a Qualified Beneficiary, if the HRA's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the HRA is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

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.
 - 36 months after the date the covered Employee becomes enrolled in the Medicare program; or

- 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.
- F. 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.

Extension of Maximum Coverage Period

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.

COBRA 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.

Payment for COBRA Continuation Coverage

For any period of COBRA continuation coverage under the HRA, Qualified Beneficiaries who elect COBRA continuation coverage may be required to pay up to 102% of the applicable premium. The employer will inform participants of any costs. The HRA will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made. The health coverage is also permitted to allow for payment at other intervals.

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 HRA by a later date is also considered Timely Payment if either under the terms of the HRA, 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 HRA 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 HRA in an amount that is not significantly less than the amount the HRA requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the HRA's requirement for the amount to be paid, unless the HRA 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.

Right to Enroll in a Conversion Health Plan

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 HRA 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 HRA. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

More Information

If a participant has questions about COBRA continuation coverage, contact the State of New Hampshire’s COBRA Administrator:

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

Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

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).

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.

General Plan Information

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

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

The provisions of the amended Plan become effective 01/01/2016. The plan was originally effective on 01/01/2008.

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

Employer Information

The employer’s name and address and identification number are:

State of New Hampshire

Division of Personnel

28 School Street
Concord, NH 03301
02-6000618

Plan Administrator Information

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

State of New Hampshire
Department of Administrative Services,
Division of Personnel
28 School Street
Concord, NH 03301
(603) 271-3261

The Plan Administrator is responsible for the administration of the Plan and maintains plan documents. Agency Human Resources or Payroll Representatives will also answer any questions participants 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.

Participants may contact the Administrator for any further information about the Plan.

Contractor Information

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

ASIFlex, Inc.
201 W. Broadway, Suite 4-C
Columbia, MO 65203
Main Line: 573-442-3035
Toll Free: 800-659-3035

Mailing Address:

ASIFlex
P.O. Box 6044
Columbia, MO 65205-6044

Third Party Claims Processor Information

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

Physical Address:

ASIFlex
201 W. Broadway, Suite 4-C
Columbia, MO 65203
Main Line: 573-442-3035
Toll Free: 800-659-3035

Mailing Address:

ASIFlex
P.O. Box 6044
Columbia, MO 65205-6044

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

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.

Service of Legal Process

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

Type of Administration

The Plan is a health reimbursement arrangement (HRA) 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.

Integration with State Employee Health Benefit Plan

This Plan is integrated with State of New Hampshire medical and prescription drug coverage.