

State of New Hampshire Insurance Department

CHECKLIST FOR STAND ALONE DENTAL- INDIVIDUAL

LINE OF BUSINESS: DENTAL INDIVIDUAL

TOI CODES: H10I

As additional guidance is forthcoming from the US Department of Health and Human Services, and the New Hampshire Insurance Department, those changes will be incorporated into this checklist.

Stand Alone Dental plans to be utilized outside the Marketplace only to supplement medical plans, such that the medical plans will comply with federal requirements to offer all ten Essential Health Benefits outside the Marketplace as required under the Public Health Services Act, must follow the Marketplace certification filing process as described within this Bulletin. [Bulletin Ins 13-007-AB](#)

INSTRUCTIONS FOR SERFF FILINGS CHECKLIST:

- A. For ALL filings, the [Submissions Requirements Checklist](#) MUST be completed and attached to the supporting documentation tab.
- B. For a FORM filing, the completion of additional sections below must be completed, depending on the forms submitted.
 - a. Policy
 - b. Riders, endorsements or amendments
 - c. Applications
 - d. Advertising and marketing
 - e. Annual Actuarial Certification
- C. RATES are required to be filed in accordance with [NHCAR Part Ins 401.12 \(o\)](#) and [NHCAR Part Ins 4100](#). Additional requirements may be necessary, depending on the Type of Insurance (TOI).

This checklist **MUST** be completed to assist in the submission and review of forms submitted to the New Hampshire Insurance Department. It is not intended to be an all inclusive listing of required provisions, rather guidance for areas of frequent questions and areas needing special attention. All New Hampshire Statutes and Rules are available at:

http://www.gencourt.state.nh.us/rules/state_agencies/ins.html
<http://www.gencourt.state.nh.us/rsa/html/NHTOC/NHTOC-XXXVII.htm>

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Important Notes:

- **Stand Alone Dental Plan (SADP) Issuers should submit their applications with their rate and form filings between May 20, 2013 and June 30, 2013. SADP plans must comply with the NH dental benchmark plan: FEDVIP pediatric dental.**
- **Stand alone dental plans are not subject to the insurance market reform provisions of the Affordable Care Act such as guaranteed availability and renewability of coverage. Dental carriers will be able to make premium adjustments upon consumer enrollment, but must indicate that rates are not guaranteed for QHPs offered on the FFM.**
- **Stand alone dental are excluded from cost-sharing reduction (CSR) requirements.**
- **For plan year 2014, Stand alone dental plans are not required to be accredited or submit accreditation information.**
- **Variability is not permitted within cost-sharing schedules.**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
SECTION 1 GENERAL REQUIREMENTS			
ADVERTISING	<u>NHCAR Part Ins 2600</u> <u>Federal Health Insurance Marketplace</u>	<p>Advertising Guidelines</p> <p>Health Insurance Marketplace branding guides</p> <p>All issuers and plans must comply with state laws and regulations regarding marketing by health insurance issuers. QHP issuers must inform consumers in QHP marketing materials that the QHP is certified by the Marketplace. The QHP issuer cannot inform consumers that the certification of a QHP implies any form of further endorsement or support of the QHP.</p> <p>NHID will require prior approval of plan marketing material and an attestation that the issuer meets all Marketing Standards. If NHID determines through its regulatory efforts that unfair or discriminatory marketing is occurring, NHID will enforce through use of state remedies, including decertification for QHPs.</p> <p>Advertising and Marketing rules for Health Insurance and HMOs can be found in <u>NHCAR Part Ins 2601</u>. Statute authority for HMO advertising is found at <u>RSA 420-B:8 VI</u>.</p> <p>Health Insurance Marketplace branding guide and logo for QHPs are found at: <u>http://marketplace.cms.gov/GetOfficialResources/marketplace-brand-guide.pdf</u></p>	<p>YES: NO:</p> <p>PAGE # OR IF NO:</p>

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
TRANSPARENCY IN COVERAGE	45 CFR 156.220	<p>In accordance with 45 CFR 156.220, a QHP issuer must submit, in an accurate and timely manner, the following information to the Exchange, HHS and the State insurance commissioner, as well as to the public:</p> <ul style="list-style-type: none"> (1) Claims payment policies and practices; (2) Periodic financial disclosures; (3) Data on enrollment; (4) Data on disenrollment; (5) Data on the number of claims that are denied; (6) Data on rating practices; (7) Information on cost-sharing and payments with respect to any out-of-network coverage; and (8) Information on enrollee rights under title I of the Affordable Care Act. 	YES: NO: PAGE # OR IF NO:
ASSUMPTIONS/ MERGERS/ REDOMESTICATIONS AND DEMUTUALIZATION, ETC		Coordination with NHID Examinations Division is required. Forms must be filed for approval.	YES: NO: PAGE # OR IF NO:
COVER PAGE (Form Number)	NHCAR Part Ins 401.03 (a)	Form number in lower left hand corner of face page	YES: NO: PAGE # OR IF NO:
READABILITY NON-ENGLISH POLICIES		English version of forms must be approved. If there is a discrepancy between the foreign language form and the English version, the approved English version will control.	YES: NO: PAGE # OR IF NO:

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
ENROLLMENT PERIODS	45 CFR 155.410(b) ; 45 CFR 155.420	<p>Standard Enrollment Periods As defined through 45 CFR 155.410(b), the initial enrollment period for the Individual market begins October 1, 2013 and extends through March 31, 2014. For benefit years beginning on or after January 1, 2015, the annual open enrollment period begins October 15 and extends through December 7 of the preceding calendar year.</p> <p>Special Enrollment Periods As stated in 45 CFR 155.420, enrollees in the individual market must be given access to special enrollment periods of 60 days from the date of a triggering event, with effective dates consistent with 45 CFR 155.420(b).</p>	YES: NO: PAGE # OR IF NO:
SECTION 2 APPLICATIONS			
APPLICATION		Federal Marketplace application must be attached to the supporting documentation tab for informational purposes.	YES: NO: PAGE # OR IF NO:
HOME OFFICE BOX	RSA 415:11	H.O. Box - No alteration of any written application for insurance, by erasure, insertion or otherwise, shall be made by any person other than the applicant without his written consent, and the making of any such alteration without the consent of the applicant shall be a misdemeanor.	YES: NO: PAGE # OR IF NO:

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
SECTION 3 POLICY FORM			
DISCLOSURE COVER PAGE REQUIREMENT	NHCAR Part Ins 1901.07 (a)(23)	<p>All dental plan policies shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy the following:</p> <p style="text-align: center;">"Notice to Buyer: This policy provides dental benefits only."</p>	YES: NO: PAGE # OR IF NO:
JURISDICTION AND ID CARDS	RSA 400-A:15-c NHCAR Part Ins 1901.09	<p>Identification of Health Coverage Under the Jurisdiction of the Insurance Commissioner. – All health coverage as defined in RSA 420-G:2, IX and prescription drug and dental benefits offered separately as described in RSA 420-G:2, IX(j) shall be identified as being under the jurisdiction of the insurance commissioner. Such identification shall be clearly printed on a member's identification card and the policy issued to an insured after January 1, 2010. The commissioner shall adopt rules, pursuant to RSA 541-A, designating the form and manner of the identification required under this section.</p> <p>(c) Identify, on all member identification cards or benefit guarantee cards, that the benefit plan represented on the card is under the jurisdiction of the New Hampshire insurance commissioner pursuant to RSA 400-A:15-c, so that the term "insured" shall be printed on the member identification card so that it is:</p> <ul style="list-style-type: none"> (1) Clearly visible; and (2) In a font size no less than the member's name on the member identification card. 	YES: NO: PAGE # OR IF NO:
FREE LOOK	NHCAR Part Ins. 401.05 (b) (11)	<p>The following provision shall appear in a conspicuous place on the face page of all accident and health policies except for nonrenewable travel insurance policies written for terms of less than one year:</p> <p>"This policy may, at any time within 30 days after its receipt by the policyholder, be returned by delivering it or mailing it to the company or the agent through whom it was purchased. Immediately upon such delivery or mailing, the policy will be deemed void from the beginning, and any premium paid on it will be refunded."</p>	YES: NO: PAGE # OR IF NO:

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
REFUND UPON CANCELLATION	RSA 415:6 I (14)	Refund upon cancellation: After the policy has been continued beyond its original term, the insured may cancel the policy at any time by written notice, delivered or mailed to the insurer or the insurer's representative. Such cancellation shall become effective upon receipt by the insurer or the insurer's representative, or on such later date as may be specified in such notice by the insured. If the insured cancels, the insurer shall promptly return any unearned portion of the premium paid, but in any event shall return the unearned portion of the premium within 30 days. The earned premium shall be computed on a pro-rata basis. Cancellation shall be without prejudice to any claim originating prior to the effective date of the cancellation.	YES: NO: PAGE # OR IF NO:
GRACE PERIOD	RSA 415:6 I (3) 45 CFR 156.270	A provision as follows: Grace Period: A grace period of _____ (insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force. Enrollees receiving advance payment of premium tax credits are allowed a 3-month grace period following nonpayment of premium, subject to the conditions of 45 CFR 156.270	YES: NO: PAGE # OR IF NO:
INCONTESTABILITY	RSA 415:6 I (2)	A provision as follows: Time Limit on Certain Defenses: (a) After 2 years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such 2-year period.	YES: NO: PAGE # OR IF NO:
LEGAL ACTION	RSA 415:6 I (11)	A provision as follows: Legal Actions: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.	YES: NO: PAGE # OR IF NO:

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
ENTIRE CONTRACT	RSA 415:6 I (1)	A provision as follows: Entire Contract; Changes: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.	YES: NO: PAGE # OR IF NO:
CLAIM NOTICE	RSA 415:6 I (5)	A provision as follows: Notice of Claim: Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at _____ (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.	YES: NO: PAGE # OR IF NO:
PROOF OF LOSS	RSA 415:6 I (7)	A provision as follows: Proofs of Loss: Written proof of loss must be furnished to the insurer at its office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within one year after the date of such loss in the case of a Medicare supplement insurance policy and within 90 days after the date of such loss in the case of any other accident and health insurance policy. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.	YES: NO: PAGE # OR IF NO:

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
TIME PAYMENT OF CLAIM	RSA 415:6 (8) RSA 415:6-h	<p>A provision as follows: Time of Payment of Claims: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid ____ (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.</p> <p>Clean written claim must be paid in 30 days; clean electronic claim must be paid within 15 days.</p>	YES: NO: PAGE # OR IF NO:
DEPENDENT	RSA 415:5 I (3-a)	<p>In the event a carrier elects to provide coverage for dependent children, the term "dependent child" shall include a subscriber's child by blood or by law, who is under age 26.</p>	YES: NO: PAGE # OR IF NO:
DISABLED DEPENDENT	RSA 415:5 I (3-a) (a)	<p>(3-a)(a) The coverage of any family member insured by such policy, pursuant to subparagraph (3), who is mentally or physically incapable of earning his or her own living on the date as of which such dependent's status as a covered family member would otherwise expire because of age, shall continue under such policy while such policy remains in force or is replaced by another policy as long as such incapacity continues and as long as said dependent remains chiefly financially dependent on the policyholder or the employee or his or her estate is chargeable for the care of said dependent, provided that due proof of such incapacity is received by the insurer within 31 days of such expiration date.</p>	YES: NO: PAGE # OR IF NO:
ANESTHESIA	FEDVIP	<p>Deep sedation, general anesthesia and intravenous conscious sedation in conjunction with surgical or operative procedures, regardless of age.</p>	YES: NO: PAGE # OR IF NO:

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
NEWBORN	RSA 415:22	<p>I. All individual and group health insurance policies providing coverage on a provision of service or an expense incurred basis shall also provide that the health insurance benefits applicable for children are payable with respect to a newly born child of the insured or subscriber or a newly born child of a dependent child of the insured or subscriber from the moment of birth.</p> <p>II. Coverage for newly born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.</p> <p>III. If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child and payment of the required premium or fee must be furnished to the insurer or nonprofit service or indemnity corporation within 31 days after the date of birth in order to have the coverage continue beyond such 31-day period. Unless the policy or contract specifically provides that grandchildren of the insured or subscriber are eligible for coverage, coverage for newly born children of a dependent child of the insured or subscriber shall not continue beyond the initial 31-day period following birth. Nor shall such newly born children be considered dependents of the insured for any purpose addressed in this title.</p>	<p>YES: NO:</p> <p>PAGE # OR IF NO:</p>
ADOPTIVE	RSA 415:22-a	<p>All individual and group health insurance policies which provide coverage for a family member of the insured shall, as to such family member's coverage, also provide that health insurance benefits applicable for children are payable with respect to any minor from the date such minor is placed in the custody of the insured pursuant to an adoption proceeding under the provisions of RSA 170-B. Such health insurance benefits shall terminate upon dismissal or withdrawal of the petition for adoption.</p>	<p>YES: NO:</p> <p>PAGE # OR IF NO:</p>
WAITING PERIOD		<p>Issuers are allowed to include up to a 24-month waiting period for medically necessary orthodontia services for both Stand alone pediatric dental and embedded medical product that includes pediatric dental.</p>	<p>YES: NO:</p> <p>PAGE # OR IF NO:</p>

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
OUTLINE OF COVERAGE	NHCAR Part Ins 1901.07 (m)	<p>(m) Dental Plans (Outline of Coverage). An outline of coverage in the form prescribed below shall be used in connection with dental plan policies and s. The items included in the outline of coverage shall appear in the sequence prescribed:</p> <p>(1) Read Your policy Carefully. This outline of coverage provides a very brief description of the important features of coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!</p> <p>(2) A brief specific description of the benefits.</p> <p>(3) A description of any provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in (2) above.</p> <p>(4) A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.</p>	YES: NO: PAGE # OR IF NO:
MINIMUM STANDARDS	NHCAR Part Ins 1901.06 (l)	(l) Limited Benefit Health Coverage	YES: NO: PAGE # OR IF NO:
PROHIBITION ON ANNUAL AND LIFETIME DOLLAR LIMITS		Section 2711 of the PHS Act (and its implementing regulations at 45 C.F.R. § 147.126) generally prohibits group health plans and health insurance issuers in the individual and group markets from placing annual or lifetime limits on the dollar value of EHB for any beneficiary. Under 45 C.F.R. § 155.1065 (a)(2), the pediatric dental EHB offered by stand-alone dental plans certified to be offered in the Exchanges must be offered without annual and lifetime limits.	YES: NO: PAGE # OR IF NO:

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
ANNUAL LIMITS ON COST-SHARING – MAXIMUM OUT-OF-POCKET		<p>Under 45 C.F.R. § 156.150(a), rather than meeting the specific dollar limits that apply to cost sharing for comprehensive medical QHPs, stand-alone dental plans certified to be offered inside an Exchange will be required to demonstrate to the Exchange (FFE or otherwise) that they have a reasonable annual limitation on cost-sharing in place. The EHB/Accreditation final rule also clarified that the Exchange is responsible for determining the level for “reasonable.” This does not apply to stand alone dental plans not being offered for the purpose of providing a pediatric dental benefit that supplements major medical QHPs to meet the 10 major medical essential health benefits.</p> <p>EHB final rules defined “reasonable” annual limit on cost sharing that is at or below \$700 for a plan with one child enrollee or \$1,400 for a plan with two or more child enrollees. Again, this limit does not apply to stand alone dental plans not being offered for the purpose of providing a pediatric dental benefit that supplements major medical QHPs to meet the 10 major medical essential health benefits.</p>	<p>YES: NO: PAGE # OR IF NO:</p>
COMPANY STANDING		The Company is in “Good Standing” with the State of New Hampshire.	<p>YES: NO: PAGE # OR IF NO:</p>
NETWORK ADEQUACY	RSA 420-J:7 I	<p>A health carrier shall maintain a network that is sufficient in numbers, types, and geographic location of providers to ensure that all services to covered persons will be accessible without unreasonable delay.</p> <p>For QHPs only, networks must include Essential Community Providers per 45 CFR 156.230 and 45 CFR 156.235.</p>	<p>YES: NO: PAGE # OR IF NO:</p>
SERVICE AREA		NHID will allow the issuers to choose their service area(s), except that requested service areas may not be smaller than a county.	<p>YES: NO: PAGE # OR IF NO:</p>

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
ESSENTIAL HEALTH BENEFITS FEDVIP HIGH OPTION DENTAL BENEFITS	45 CFR 156 Appendix B FEDVIP Plan Details	Class A (Basic) Services – preventive and diagnostic	YES: NO: PAGE # OR IF NO:
		Class B (Intermediate) Services – includes minor restorative services	YES: NO: PAGE # OR IF NO:
		Class C (Major) Services – includes major restorative, endodontic, and prosthodontic services	YES: NO: PAGE # OR IF NO:
		Class D Services - orthodontic	YES: NO: PAGE # OR IF NO:
DELTA DENTAL	RSA 420-F	Laws specific to Delta Dental	YES: NO: PAGE # OR IF NO:
PATIENT'S BILL OF RIGHTS	RSA 415:6-f RSA 151:21	Any insurer issuing policies of individual insurance shall provide to each new policyholder holder who is a resident of this state a copy of the patients' bill of rights law under RSA 151:21	YES: NO: PAGE # OR IF NO:

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
BALANCE BILLING PROHIBITED	RSA 420-J:8	<p>Every contract between a health carrier and a participating provider shall set forth a hold harmless provision specifying protection for covered persons. This provision shall include language substantially as follows:</p> <p>(a) Provider agrees that in no event, including but not limited to nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek payment or reimbursement from, or have recourse against a covered person or a person acting on behalf of the covered person (other than the health carrier or intermediary) for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles, or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons. Nor does this agreement prohibit a provider and a covered person from agreeing to continue services solely at the expense of the covered person, as long as the provider has clearly informed the covered person that the health carrier may not cover or continue to cover a specific service or services.</p>	<p>YES: NO: PAGE # OR IF NO:</p>
APPEALS PROCESS/ MANAGED CARE	RSA 420-J NH CAR Part Ins 2703.04	<p>Grievance Procedures, External Review</p> <p>Notice of Right to External Review.</p> <p>(a) Health carriers shall provide to covered persons the insurance department's "Managed Care Consumer Guide to External Appeal" and the insurance department's "Request for Independent External Appeal of a Health Care Decision" in each of the following circumstances:</p> <p>(1) The publications shall be attached to the policy, membership booklet, or other evidence of coverage provided to covered persons;</p>	<p>YES: NO: PAGE # OR IF NO:</p>

SECTION 4 RATES

<p>RATE SUBMISSIONS</p>	<p>NH CAR PART Ins 4100</p>	<p>REQUIREMENTS FOR ACCIDENT AND HEALTH INSURANCE RATE SUBMISSIONS</p> <ul style="list-style-type: none"> Stand alone dental plans are not required to submit the Unified Rate Review Template for rate increase. Stand alone dental plans are required to offer child-only (under age 19) coverage. Stand alone dental plans may not use the AV Calculator. Instead, they must demonstrate that the Stand alone dental plan offers the pediatric dental EHB at either a low level of coverage with an AV of 70% or a high level of coverage with an AV of 85%, and with a de minis variation of +/-2%. This must be certified by a member of the American Academy of Actuaries. No additional age rating may be included for pediatric dental. 	<p>YES: NO: WHY:</p>
<p>FEDERALLY REQUIRED FORMS</p>		<p>Stand-Alone Dental Plan Actuarial Value Supporting Documentation and Justification</p> <p>Stand-Alone Dental Plans – Description of EHB Allocation</p> <p>Network Access Plan Cover Sheet</p>	<p>YES: NO: YES: NO: YES: NO:</p>

[NEW HAMPSHIRE INSURANCE DEPARTMENT DENTAL NOTES:](#)

STATUTE LINK(S): RSA [415](#), [400](#), [420-F](#), [420-J](#), [INDEX](#)

REGULATION LINK(S): NH CAR PART INS [401](#), [1901](#), [2600](#), [2700](#) & [4100](#), [INDEX](#)

State of New Hampshire

**CERTIFICATION FOR FORM SUBMISSION FOR COMPLIANCE WITH THE PATIENT
PROTECTION AND AFFORDABLE CARE ACT OF 2010**

I, THE UNDERSIGNED OFFICER OF _____

(Name of Entity)

AM KNOWLEDGEABLE OF HEALTH COVERAGES; HAVE CAREFULLY REVIEWED THE CONTENTS OF THE POLICY FORMS, APPLICATIONS, SUBSCRIPTION CERTIFICATES, MEMBERSHIP CERTIFICATES OR OTHER EVIDENCES OF HEALTH CARE COVERAGE IDENTIFIED ON THE ATTACHED COMPLIANCE FILING AS SUBMITTED TO THE NEW HAMPSHIRE COMMISSIONER OF INSURANCE; HAVE READ AND UNDERSTAND EACH OF THE APPLICABLE NEW HAMPSHIRE LAWS AND REGULATIONS; AM AWARE OF THE PENALTIES WHICH MAY BE ENFORCED FOR CERTIFICATION OF A NONCOMPLYING FORM; AND CERTIFY THAT THE POLICY FORMS, APPLICATIONS, SUBSCRIPTION CERTIFICATES, MEMBERSHIP CERTIFICATES OR OTHER EVIDENCES OF HEALTH CARE COVERAGE IDENTIFIED IN THE SERFF FILING FOR PPACA COMPLIANCE FILED WITH THIS CERTIFICATION, PROVIDE ALL REQUIRED BENEFITS AND ARE IN FULL COMPLIANCE WITH ALL NEW HAMPSHIRE INSURANCE LAWS AND REGULATIONS.

(Original Signature of Officer*)

(Title of Officer*)

(Printed Name of Officer*)

(Date)

* If the individual signing the certification is other than the president, vice president, assistant vice president, corporate secretary, assistant corporate secretary, CEO, CFO, COO, general counsel, or an actuary that is also a corporate officer, documentation must be included that shows that this individual has been appointed as an officer of the organization by the Board of Directors.