REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
DENTAL PROCEDURES MEDICAL OR HOSPITAL ANESTHESIA	RSA 415:18-g RSA 420-B:8-ee	I. Each insurer that issues or renews any policy of group or blanket accident or health insurance providing benefits for medical or hospital expenses, shall provide to each group, or to the portion of each group comprised of certificate holders of such insurance who are residents of New Hampshire, coverage for the medically necessary hospital or surgical day care facility charges and administration of general anesthesia administered by a licensed anesthesiologist or anesthetist for dental procedures performed on a covered person who: (a) **Is a child under the age of 13** who is determined by a licensed dentist in conjunction with a licensed physician to have a dental condition of significant dental complexity which requires certain dental procedures to be performed in a surgical day care facility or hospital setting; or (b) Is a person who has exceptional medical circumstances or a developmental disability as determined by a licensed physician which place the person at serious risk.	**Yes:** **No:** **Explain:**
DIABETES TREATMENT	RSA 415:18-f RSA 420-B:8-k	Each insurer that issues or renews any policy, plan or contract of group or blanket accident or health insurance providing benefits for medical or hospital expenses, shall provide coverage for medically appropriate and necessary outpatient self-management training and educational services, medically appropriate or necessary insulin, oral agents and equipment used to treat diabetes, medically appropriate or necessary equipment used to treat diabetes. Insulin Limit - $30 for 30 day supply.	**Yes:** **No:** **Explain:**
ACCIDENTAL DENTAL 3 MONTHS	RSA 420-J:6-e RSA 415:18-bb	**420-J:6-e Coverage for Medically Necessary Dental Services. –** Health carriers shall provide coverage for medically necessary dental services resulting from an accidental injury to sound natural teeth and gums when the course of treatment for the accidental injury is received or authorized within 3 months of the date of the injury. Treatment made necessary due to injury to the jaw and oral structures other than teeth shall be covered without time limit. Coverage under this section shall be subject to such other terms and conditions of the policy that may apply. **415:18-bb Coverage for Medically Necessary Dental Services. –** Each insurer that issues or renews any policy of group or blanket accident or health insurance providing benefits for medical or hospital expenses, shall provide to certificate holders of such insurance, who are residents of this	**Yes:** **No:** **Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
PRICE OF FILLING PRESCRIPTIONS	RSA 415:26	I. A pharmacy benefits manager or insurer shall require a contracted pharmacy to charge an enrollee or insured person the pharmacy's usual and customary price of filling the prescription or the contracted copayment, whichever is less. II. Once it has settled a claim for filling a prescription for an enrollee or insured person and notified the pharmacy of the amount the pharmacy benefits manager or insurer shall pay to the pharmacy for that prescription, the pharmacy benefits manager or insurer shall not lower the amount to be paid to the pharmacy by the pharmacy benefits manager or the insurer for such settled claim;	**Yes: No:** **Explain:**
RECONSTRUCTIVE SURGERY	RSA 417-D:2-b	Every insurer subject to this chapter that provides individual or group coverage for mastectomy surgery shall provide coverage for reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the patient elects reconstruction and in the manner chosen by the patient and the physician.	**Yes: No:** **Explain:**
REIMBURSEMENT FOR AMBULANCE SERVICE PROVIDERS	RSA 415:18-v	Each insurer that issues or renews any policy of group or blanket accident or health insurance that constitutes health coverage under RSA 420-G:2, IX, and that provides benefits for medically necessary ambulance services shall reimburse the ambulance service provider directly or by a check payable to the insured and the ambulance service provider subject to the terms and conditions of the policy, plan, or contract. Nothing in this section shall preclude an insurer from negotiating with and subsequently entering into a contract with a non-participating ambulance provider that establishes rates of reimbursement for emergency medical services.	**Yes: No:** **Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
SCALP HAIR PROTHESIS	RSA 415:18-d I	Each insurer that issues or renews any policy of group or blanket accident or health insurance providing benefits for medical or hospital expenses and which also provides coverage for other prostheses, shall provide to each group, or to the portion of each group comprised of certificate holders of such insurance who are residents of this state and whose principal place of employment is in this state, coverage for expenses for scalp hair prostheses worn for hair loss suffered as a result of alopecia areata, alopecia totalis, alopecia medicamentosa resulting from the treatment from any form of cancer or leukemia, or permanent loss of scalp hair due to injury. Such coverage, however, shall be subject to a written recommendation by the treating physician stating that the hair prosthesis is a medical necessity. Such coverage shall be subject to the same limitations and guidelines as other prostheses, provided, that such coverage for alopecia medicamentosa shall not exceed $350 per year.	**Yes: No:** **Explain:**
SUMMARY PLAN DESCRIPTION OF CONTINUATION RIGHTS (SEPARATE DOCUMENT)	RSA 415:18 XVI (f)	(1) The carrier shall provide, at the time of commencement of coverage under the health benefit plan, a summary plan description to each eligible member or subscriber of the rights provided under this section. (2) Notice of the right to continue coverage also shall be set forth in each master policy and individual certificate of coverage.	**Yes: No:** **Explain:**
		SECTION 5 GENERAL PROVISIONS	

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
NON-RENEWAL	RSA 415:18 I.(e) NHCAR Part Ins 401.08 (b)(8)	A provision stating the conditions under which the insurer may decline to renew the policy.	**Yes: No:** **Explain:**
CANCELLATION OR NON-RENEWAL OF GROUP CONTRACTS	RSA 415:18-b RSA 420-B:8-c	The notice of cancellation or nonrenewal or offer of renewal, except for non-payment of premium, shall be delivered to the group policyholder or mailed to the group policyholder's last address as shown in the records of the insurer at least 45 days prior to the renewal date of the contract. Notice of cancellation for lack of participation, if permitted by the terms of the policy, shall be delivered to the group policyholder or mailed to the group policyholder's last address as shown in the records of the insurer, at least 30 days prior to the effective date of the cancellation.	**Yes: No:** **Explain:**
NOTICE OF LOSS	RSA 415:18 I (h)	A provision that written notice of sickness or of injury must be given to the insurer within 20 days after the date when such sickness or injury occurred. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.	**Yes: No:** **Explain:**
PROOF OF LOSS	RSA 415:18 I.(i)	Written proof of such loss must be furnished to the insurer within one year after the date of such loss in the case of a group Medicare supplement insurance policy or certificate and within 90 days after the date of such loss in the case of any other group accident and health insurance policy or certificate. In the case of claim for loss of time for disability, written proof of such loss must be furnished to the insurer within 30 days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of such disability must be furnished to the insurer at such intervals as the insurer may reasonably require. Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as was reasonably possible.	**Yes: No:** **Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
FORMS FOR PROOF OF LOSS	RSA 415:18 I (j)	A provision that the insurer will furnish to the policyholder such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of 15 days after the insurer receives notice of any claim under the policy, the person making such claim shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.	**Yes: No:** **Explain:**
PHYSICAL EXAMINATION OR AUTOPSY	RSA 415:18 I (k)	A provision that the insurer shall have the right and opportunity to examine the person of the insured when and so often as it may reasonably require during the pendency of claim under the policy and also the right and opportunity to make an autopsy in case of death where it is not prohibited by law.	**Yes: No:** **Explain:**
LEGAL ACTION	RSA 415:18 I (n)	A provision that no action at law or in equity shall be brought to recover on the policy prior to the expiration of 60 days after proof of loss has been filed in accordance with the requirements of the policy and that no such action shall be brought at all unless brought within 3 years from the expiration of the time within which proof of loss is required by the policy.	**Yes: No:** **Explain:**
GRACE PERIOD	RSA 415:18 I (p)	A provision that the policyholder is entitled to a grace period of 31 days for the payment of any premium due except the first, during which grace period the coverage shall continue in force	**Yes: No:** **Explain:**
PART-TIME EMPLOYEES	RSA 415:18 I (q)	A provision that the insurer shall not exclude part-time employees. A part-time employee shall be any employee who regularly works a minimum of at least 15 hours per week.	**Yes: No:** **Explain:**
CONTESTABILITY	RSA 415:18 I (r)	A provision that the validity of the policy shall not be contested except for nonpayment of premiums, after it has been in force for 2 years from its date of issue; and that no statement made by a person shall be used in contesting the validity of the insurance, unless it is contained in a written instrument signed by the person making such statement	**Yes: No:** **Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
MATERNITY COVERAGE	) Pregnancy Discrimination Act of 1978, amending Title VII of the Civil Rights Act of 1964.	Maternity and pregnancy must be covered the same as any other illness or disability. Employer group coverage shall not provide benefits that are discriminatory regarding pregnancy. (Federal law supersedes state law.) Maternity coverage is an essential health benefit.	**Yes: No:** **Explain:**
OPEN ENROLLMENT	RSA 415:18 XII (c) RSA 420-G:8 III HIPAA 1996 Sec. 701(f)	Once a group or blanket policy has been issued, the insurer shall provide the group with an annual open enrollment period for late enrollees. III. A large employer employee, who has met any employer imposed waiting period and is otherwise eligible for health coverage, may enroll within 31 days. If a person does not enroll at this time, that person is a late enrollee. (a) Each large employer group shall have an open enrollment period during which late enrollees may enroll and shall not be required to submit evidence of insurability based on medical conditions. Group health plans must allow eligible enrollees to enroll in health coverage under Special Enrollment Periods as prescribed under Section 701(f) of the Health Insurance Portability and Accountability Act of 1996.	**Yes: No:** **Explain:**
PREMIUMS RENEWAL INCREASE	NHCAR Part Ins 401.08 (b)(7)	In the event of any renewal rate increase, insurers shall provide policyholders with prior notice of any such increase such that: b. A 60 days notice is provided for policies subject to RSA 420-G;	**Yes: No:** **Explain:**
COORDINATION OF BENEFITS	NHCAR Part Ins 1904	Ins 1904.01 Scope. This part applies to all group or blanket insurance plans subject to RSA 415, RSA 420-A and RSA 420-B.	**Yes: No:** **Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
DISCONTINUANCE AND REPLACEMENT OF GROUP ACCIDENT AND HEALTH COVERAGE	NHCAR Part Ins 2201.03 (b)(1) NHCAR Part Ins 2201.09	Requirements in the case of discontinuance of group health coverage for active recipients of mental health services. Requirements for Notice of Discontinuance. Any notice of discontinuance shall comply with the provisions of RSA 415:18 and RSA 420-G.	**Yes: No:** **Explain:**
EXTENSION OF BENEFITS		Every group policy, contract or certificate shall provide a reasonable provision for extension of benefits in the event of total disability at the date of discontinuance of the group policy, contract or certificate as required by the following paragraphs of this section, at least 12 months for major medical.	**Yes: No:** **Explain:**
IDENTIFICATION CARDS (EXPENSE-BASED MEDICAL, DENTAL AND PRESCRIPTION DRUGS)		The card shall contain at a minimum the following: (1) The insurance company name; (2) Subscriber or member name; (3) Subscriber or member identification number; (4) A telephone number and website for customer service inquiries. 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: (1) Clearly visible; and (2) In a font size no less than the member's name on the member identification card.	**Yes: No:** **Explain:**
MANAGED CARE GUIDE	NHCAR Part Ins 2703.04 (a)	Ins 2703.04 Notice of Right to External Review. (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: (1) The publications shall be attached to the policy, certificate, membership booklet, or other evidence of coverage provided to covered persons;	**Yes: No:** **Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
MANAGED CARE LAW	RSA 420-J	Section 420-J:5 Grievance Procedures Section 420-J:6-a Obstetrical-Gynecological Coverage. Section 420-J:6-b Self-referrals for Chiropractic Care. Section 420-J:7-b Prescription Drugs	**Yes: No:** **Explain:**
PATIENTS' BILL OF RIGHTS	RSA 415:18 XIV RSA 420-B:8-m RSA 151:21	An insurer issuing policies of group insurance shall provide to each new certificate holder who is a resident of this state a copy of the patients' bill of rights law under RSA 151:21, verbatim.	**Yes: No:** **Explain:**
PORTABILITY, AVAILABILITY, AND RENEWABILITY OF HEALTH COVERAGE	RSA 420-G	Section 420-G:6 Guaranteed Issue and Renewability. Section 420-G:8 Open Enrollment and Late Enrollment. Section 420-G:9 Minimum Participation Requirements.	**Yes: No:** **Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
PRESCRIPTION DRUGS PRIOR AUTHORIZATION	RSA 420-J:7-b NHCAR Part Ins 2705	IV-c. (a) Beginning July 1, 2017, all health insurers, health maintenance organizations, health services corporations, medical services corporations, and preferred provider programs may, when requiring prior authorization for a prescription drug, use and accept the prior authorization paper forms or electronic standard described in this paragraph. (b) Beginning December 31, 2017, all health insurers, health maintenance organizations, health services corporations, medical services corporations, and preferred provider programs shall, when requiring prior authorization for a prescription drug, use and accept only the prior authorization paper forms or electronic standard described in this paragraph. Ins 2705.04 Format of Uniform Prior Authorization Forms. Ins 2705.05 Use of Uniform Prior Authorization Forms and Electronic Standard for Prescription Drug Benefits. Ins 2705.06 Standards for Electronic Authorization Processes.	**Yes: No:** **Explain:**
PRESCRIPTION DRUG CLAIM PROCESSING	NHCAR Part Ins 2704.05	(a) Every health carrier that provides prescription benefits as a covered benefit under a health benefit plan shall ensure that prescription benefit claims are adjusted and paid in accordance with the requirements of Ins 1001 and RSA 420-J:8-a. (b) Any health carrier or pharmacy benefits manager shall require all participating pharmacies to charge any covered person the lesser of: (1) The pharmacy's usual and customary price for filling the prescription; or (2) The contracted copayment.	**Yes: No:** **Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
PROMPT PAYMENT TIME LIMIT	RSA 415:18-k	I. (a) Each insurer that issues or renews any policy of group or blanket accident or health insurance providing benefits for medical or hospital expenses for its insured persons shall pay for services rendered by New Hampshire health care providers within 30 calendar days upon receipt of a clean non-electronic claim or 15 calendar days upon receipt of a clean electronic claim. (b) When the insurer is denying or pending the claim, the insurer shall have 15 calendar days upon receipt of an electronic claim or 30 days upon receipt of a non-electronic claim to notify the health care provider or certificate holder of the reason for denying or pending the claim and what, if any, additional information is required to adjudicate the claim. Upon the insurer's receipt of the requested additional information, the insurer shall adjudicate the claim within 45 calendar days. If the required notice is not provided, the claim shall be treated as a clean claim and shall be adjudicated pursuant to subparagraph (a).	**Yes: No:** **Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
SECTION 6 FEDERAL REGULATION			
ESSENTIAL HEALTH BENEFITS		You must identify which benchmark plan that you are using in order for us to identify EHBs and ascertain that there are no dollar limits being applied. Please attach the benchmark plan's certificate of coverage as well as the benefits schedule to the supporting documentation tab for informational purposes only. In a recently-finalized rule, CMS stated that group health plans (and health insurance coverage offered in connection with such plans) and grandfathered individual market coverage that are not required to provide EHB may select among any of the 51 EHB base-benchmark plans identified under 45 CFR 156.100 and selected by a State or the District of Columbia and the FEHBP base-benchmark plan, as applicable for plan years beginning on or after January 1, 2017, for purposes of determining which benefits cannot be subject to annual and lifetime dollar limits. Benchmark plan information is available at: https://www.cms.gov/cciio/resources/data-resources/ehb.html. Please see the rule at: https://www.gpo.gov/fdsys/pkg/FR-2015-11-18/pdf/2015-29294.pdf, page 72200.	**Benchmark for EHB:**
		An actuarial certification that the plan design chosen by the employer provides Minimum Essential Coverage and meets the Minimum Value standard is required in order to support the statement in the Summary of Benefits and Coverage.	**Yes: No:** **Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
COVERAGE OF PREVENTATIVE SERVICES	Public Health Services Act Section 2713 ESSENTIAL HEALTH BENEFITS	Provide benefits for and prohibit the imposition of cost-sharing requirements with respect to, the following: 1) Evidenced-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved; 2) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved; 3) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA, to the extent not already included in certain recommendations of the USPSTF.	**Yes:** **No:** **Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
HEALTH INSURANCE MARKET REFORM RULES APPLICABLE TO NON-GRANDFATHERED LARGE GROUP HEALTH PLAN FILINGS	45 CFR Part 147	Guaranteed Availability of Coverage (a) A health insurance issuer must offer coverage, in accordance with 45 CFR 147.104(a), to any individual or employer in New Hampshire, including all products that are approved for sale in the applicable market, and must accept any individual or employer that applies for coverage through any of those products. (b) Enrollment periods and effective dates of coverage must be established in accordance with 45 CFR 147.104(b). (c) Health insurance issuers that offer coverage through network plans may impose limits specified in 45 CFR 147.104(c). (d) Health insurance issuers may impose financial capacity limits in accordance with 45 CFR 147.104(d). (e) A health insurer and its officials, employees, agents, and representatives must comply with marketing and non-discrimination requirements in 45 CFR 147.104(e). Guaranteed Renewability of Coverage (a) A health insurance issuer must renew coverage in accordance with 45 CFR 147.106(a). (b) Pursuant to 45 CFR 147.106(b), a health insurance issuer may discontinue coverage only in the event of non-payment of premiums, fraud, if the plan sponsor violates applicable rules, if the plan is terminated, if enrollees move outside the plan's service area, or if association membership ceases.	**Yes:** **No:** **Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
HEALTH INSURANCE MARKET REFORM RULES APPLICABLE TO NON-GRANDFATHERED LARGE GROUP HEALTH PLAN FILINGS Continued		(c) A health insurance issuer may discontinue offering a health insurance product only if the issuer follows procedures described at 45 CFR 147.106(c). (d) A health insurance issuer may discontinue offering all health insurance products if the issuer follows procedures specified in 45 CFR 147.106(d). (e) Uniform modifications of coverage at the time of renewal are permitted in accordance with 45 CFR 147.106(e). (f) A health insurance issuer that offers student health coverage is not required to renew coverage for individuals who are no longer students or dependents of students, per 45 CFR 147.145.	**Yes: No:** **Explain:**

MAXIMUM OUT OF POCKET COST SHARING LIMIT	PPACA, Section 1302(c)(1) CMS Final : Notice of Benefit & Payment Parameters	For Plan Year 2022 the proposed maximum annual limitation on cost sharing is $8,700 for self only coverage and $17,400 for other than self-only/ family coverage as outlined in the 2022 Notice of Benefit and Payment Parameters. As clarified in previous years' guidance, even when family coverage is purchased (and therefore the overall limit is $17,400), no individual enrollee in the coverage can be required to spend more than $8,700 in cost sharing for care attributable to that individual enrollee. **HDHP's** Annual HSA Contribution limits for coverage under an HDHP are as follows, per the IRS: Individual - $3650 Family - $7300 Deductible Limits are as follows: Individual - Not less than $1400 Family - Not less than $2800 Maximum Out-Of- Pocket Limits are as follows: Individual - $7050 Family - $14,100	**Yes:** **No:** **Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
		SECTION 7 RATES	
	NHCAR PART Ins 4100	REQUIREMENTS FOR ACCIDENT AND HEALTH INSURANCE RATE SUBMISSIONS	**Yes: No:** **Explain:**
	NHCAR Part Ins 401.14 (m)	Policies, certificates and rates shall be submitted together to the department in the same filing.	**Yes: No:** **Explain:**
		SECTION 8 NETWORK ADEQUACY	
NH NETWORK ADEQUACY RULE	NHCAR Part Ins 2701	The carrier shall file the NHID Network Adequacy Template and the NH Hospital Template annually via SERFF. The template must be completed with contracts currently in place, and not an historical file. Data is required for each county that the carrier is actively marketing. The due date is July 1st or at the time its plans and rates for the upcoming plan year are filed with the Department for review and approval. The carrier shall certify that the provider listing is accurate with provider contracts effective at the time of submission. If there are anticipated losses of in-network that will take place within the following 60 days, the carrier shall disclose this with the network filing. The carrier shall identify any services or locations in which the provider contract excludes services the provider typically performs and that are a covered benefit.	**Yes: No:** **Explain:**
NH TEMPLATES	NHID Network Adequacy Template NHID Resource File Public FTP Site	Templates are attached to the NHID website to assist carriers in providing the data in order to meet the requirements of this part.	**Yes: No:** **Explain:**

CERTIFICATION FOR FORM SUBMISSION FOR COMPLIANCE

I, THE UNDERSIGNED OFFICER OF ____
(Name of Entity)

AM KNOWLEDGEABLE OF HEALTH COVERAGES; HAVE CAREFULLY REVIEWED THE CONTENTS OF THE POLICY FORMS, APPLICATIONS, CERTIFICATES OR OTHER EVIDENCES OF ACCIDENT AND HEALTH 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, CERTIFICATES OR OTHER EVIDENCES OF ACCIDENT AND HEALTH COVERAGE IDENTIFIED IN THE SERFF FILING FOR 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.