State of New Hampshire Insurance Department

REVIEW REQUIREMENTS CHECKLIST FOR LARGE GROUP MAJOR MEDICAL

LINE OF BUSINESS: Group Health **TOI CODES: H16G through HOrg02G**

INSTRUCTIONS FOR SERFF FILINGS CHECKLIST:

A. For ALL filings, the Submissions Requirements Checklist MUST be completed, signed 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/Certificate
    b. Riders, endorsements or amendments
    c. Applications
    d. Advertising
    e. Annual Actuarial Certification
C. RATES are required to be filed in accordance with NHCAR Part Ins 401.13 (m) and NHCAR Part Ins 4100. Additional requirements may be necessary, depending on the Type of Insurance (TOI).
D. Grandfathered plans must be filed separately from non-grandfathered plans.

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

TABLE OF CONTENTS

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
		SECTION 1 GENERAL REQUIREMENTS	
SCOPE	NHCAR Part Ins 401.01 (b)	(b) This chapter shall apply to all licensed writers of life, accident and health insurance in this state, including health service organizations and health maintenance organizations, and shall also apply to life settlement providers.	**Yes: No: Explain:**
HOME OFFICE	NHCAR Part Ins 401.13 (b)	(b) All submissions shall be made by the home office of the company.	**Yes: No: Explain:**
RETALIATORY FEES-EFT	NHCAR Part Ins 401.13 (j)	(j) With respect to any submission of a company domiciled in a state or country where the state insurance department or comparable agency requires foreign or alien insurers to pay any fees for the filing or examination of policy forms, the submission shall include an EFT payment of the retaliatory fee due to the state of New Hampshire pursuant to RSA 400-A:35.	**Yes: No: Explain:**
SUBMISSIONS	NHCAR Part Ins 401.13 (d)	(d) All submissions and associated fees shall be submitted electronically through SERFF and electronic funds transfer (EFT) pursuant to Ins 3101	**Yes: No: Explain:**
THIRD PARTY SUBMISSIONS	NHCAR Part Ins 401.13 (c)	(c) In instances where a filing is being made on behalf of a company, a letter or other documentation authorizing the firm to file on behalf of the company shall be attached to the supporting documentation tab in SERFF.	**Yes: No: Explain:**
		SECTION 2 FILING REQUIREMENTS	
ADVERTISING	NHCAR Part Ins 2601 Advertising Checklist	Advertisement requirements for accident and health insurance, other than Medicare supplement.	**Yes: No: Explain:**
DEFINITIONS	RSA 420-G:2 RSA 420-J:3	Comprehensive or major medical definitions. Managed care definitions.	**Yes: No: Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
	Bulletin Ins 08-067-AB	Categories of Coverage – Group - A group health plan may not be marketed or sold to any group other than a large employer group, a small employer group. Also, per federal FAQ #8, group coverage provided by non-employer groups (associations) is prohibited. "Coverage that is provided to associations but is not related to employment is not considered group coverage under 45 CFR part 144 through 148. The coverage is considered coverage in the individual market, regardless of whether it is considered group coverage under state law. http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/qa_hmr.html	
ENGLISH & TRANSLATIONS OF FOREIGN LANGUAGE DOCUMENTS	NHCAR Part Ins 401.04	(p) All policy forms filed with the commissioner shall be written in the English language. (q) An insurer may also provide applicants and insureds with a policy, application, or other forms in a language other than English if the non-English version of the policy, application, or other form, that has not been reviewed by the commissioner: (1) Is a certified translation of a policy, application, or other form that has been filed with and approved by the commissioner; (2) Is accompanied by a certification written in English that the non-English version is a complete and accurate translation of the English form filed; (3) Is in the same format as the English version; (4) Contain***s*** a disclosure, both in the non-English language and in English, that is attached to the front of the policy, application, or other forms, including a statement that: a. The policy, application, or other form is a translation that has not been approved by the commissioner; and b. The English version of the policy, application, or other forms shall control in any disputes, complaints, or litigation; and (5) Identifies the English form number that corresponds to the non-English version***.*** (r) If an insurer offers a non-English policy, application, or other form in accordance	**Yes: No: Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
		with (q), the insurer shall file the translator certification and disclosure required by (q)(2) and (q)(4) with the commissioner as an information filing. (s) This paragraph shall not prohibit an insurer from advertising or providing information related to the policy or claims with translations to consumers in a language other than English. (t) If there is a dispute between the English version and the non-English version, the English version shall control and the non-English version shall carry a disclaimer in the non-English language to this effect. The insurance policy is controlling and any advertisements or informational materials used by an insurer shall not be construed to modify or change the insurance policy.	
READABILITY & BOOKMARKS	RSA 420-H:5 NHCAR Part Ins 401.13 (h)	I (a) The text achieves a minimum score of 40 on the Flesch reading ease test or an equivalent score on any other comparable test as provided in paragraph III; (b) It is printed, except for specification pages, schedules and tables, in not less than 10 point type, one point leaded; (c) The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the text of the policy or to any endorsements or riders; and (d) It contains a table of contents or an index of the principal sections of the policy, if the policy has more than 3,000 words printed on 3 or fewer pages of text, or if the policy has more than 3 pages regardless of the number of words. (h) All policy forms containing 3,000 or more words or printed on 3 or more pages shall contain a table of contents or an index of the principal sections of the policy and shall be electronically bookmarked.	**Yes: No:** **Explain:**
REPRESENTATIONS	NHCAR Part Ins 401.12 (a) (1)	The declarative portion of the application, if any, shall imply a representation of facts to the best of	**Yes: No:** **Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
		the applicant's knowledge. "I represent," or "To the best of my knowledge and belief," shall be examples of such wording. Wording implying a warranty shall be prohibited. "I Certify" shall be such an example.	
STATEMENT OF VARIABILITY REQUIRED	NHCAR Part Ins 401.13(p)	All variable language shall be identified by the use of brackets, accompanied by a statement of variability, and attached on the supporting document tab in SERFF which shall describe the full range of variability. Variable language shall not be approved if the variable language prevents review of the policy for compliance with minimum standards or the requirements of RSA 415:2.	**Yes: No: Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
SECTION 3 RULES APPLICIABLE TO ALL FORMS			
COVER PAGE - COMPANY INFORMATION	NHCAR Part Ins 401.04	(b) Each policy and certificate shall recite on the back page or specifications page the: (1) Full corporate or legal title of the company, association, exchange or society; (2) Official home address, including city and state or province; (3) Administrative office address if different from address in (2) above; (4) Toll-free telephone number of the company and, if available, a facsimile number and website address.	**Yes: No:** **Explain:**
COVER PAGE BRIEF DESCRIPTION	NHCAR Part Ins 401.04	(c) Each policy and certificate shall provide a brief description of the nature of the policy, as follows: (1) The brief description shall be printed on: a. The face page, specifications page, or the back page if the policy form has a full size cover page.	**Yes: No:** **Explain:**
COVER PAGE JURISDICTION	RSA 400-A:15-c NHCAR Part Ins 401.04 (o)	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 commissioner. Such identification shall be clearly printed on a member's identification card and the policy issued to an insured after January 1, 2010. All policy forms and certificates issued on or after January 1, 2010 that provide coverage as defined in RSA 420-G:2, IX. or prescription drug and dental benefits offered separately as described in RSA 420-G:2, IX. (j), issued on or after January 1, 2010, shall clearly state that the benefit plan or coverage represented by the policy is under the jurisdiction of the New Hampshire insurance commissioner pursuant to RSA 400-A:15-c.	**Yes: No:** **Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
COVER PAGE - IMPORTANT NOTICE (Bold Font)		IMPORTANT INFORMATION This endorsement reflects the known requirements for compliance under The Affordable Care Act as passed on March 23, 2010. 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 your health insurance policy.	
GENERAL PROVISIONS DEPENDENT	RSA 415:5 I (3)(a) RSA 420-B:8-aa I (HMO) RSA 420-J:8-d (managed care)	“Dependent child" shall include a subscriber's child by blood or by law, who is under age 26.	**Yes: No:** **Explain:**
GENERAL PROVISIONS DISABLED DEPENDENT	RSA 415:5 I (3-a)(a) RSA 415:18 V (a) RSA 420-J:8-d (managed care)	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. If such coverage is continued in accordance with this subparagraph, such dependent shall be entitled upon the termination of such incapacity to coverage offered by the New Hampshire high risk pool under RSA 404-G;	**Yes: No:** **Explain:**
GENERAL PROVISIONS DISABLED DEPENDENT – MICHELE’S LAW *(If coverage is provided for students*	RSA 415:5 I (3-a)(b) RSA 415:18 V (b) RSA 420-B:8-q (HMO)	If the coverage for dependent children includes coverage for dependent children who are full-time students, as defined by the appropriate educational institution, beyond the age of 18, such dependent coverage shall include coverage for a dependent's medically	**Yes: No:** **Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
age 26 or older)		necessary leave of absence from school for a period not to exceed 12 months or the date on which coverage would otherwise end pursuant to the terms and conditions of the policy, whichever comes first. Any breaks in the school semester shall not disqualify the dependent child from coverage under this subparagraph. Documentation and certification of the medical necessity of a leave of absence shall be submitted to the insurer by the student's attending physician and shall be considered prima facie evidence of entitlement to coverage under this subparagraph. The date of the documentation and certification of the medical necessity of a leave of absence shall be the date the insurance coverage under this subparagraph commences;	
GENERAL PROVISIONS NON-RENEWAL	RSA 415:18 I.(e)	A provision stating the conditions under which the insurer may decline to renew the policy.	**Yes: No: Explain:**
GENERAL PROVISIONS CANCELLATION OR NON-RENEWAL OF GROUP CONTRACTS	RSA 415:18-b	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:**
GENERAL PROVISIONS 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	**Yes: No: Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
		to give such notice and that notice was given as soon as was reasonably possible.	

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
GENERAL PROVISIONS 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:**
GENERAL PROVISIONS 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:**
GENERAL PROVISIONS 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:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
GENERAL PROVISIONS 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:**
GENERAL PROVISIONS 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:**
GENERAL PROVISIONS 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:**
GENERAL PROVISIONS 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:**
GENERAL PROVISIONS MATERNITY COVERAGE	RSA 415:18 I (s) 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 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.	**Yes: No: Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
		(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.	

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
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:**
SECTION 4 MANDATES			
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:**
90-DAY SUPPLY OF COVERED PRESCRIPTION DRUGS	RSA 420-J:7-b VIII NH MANDATE	An insurer issuing or renewing accident and health insurance policies shall allow its covered persons to purchase (retail or mail order) an up-to-90-day supply of covered	**Yes: No:** **Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
		prescription drugs on the covered person's health plan formulary at one time at a pharmacy of the insured's choice within the insurer's network, provided that the insured can demonstrate that such drug has been taken by the insured for a continuous period of one year and provided that such drug is not subject to the health plan's utilization management, prior authorization, or pre-certification requirements. Controlled substances as defined by the USDEA are not subject to this paragraph. Nothing in this paragraph shall be construed to limit the health benefit plan's ability to establish co-payments, coinsurance deductibles, or other member cost shares. A retail pharmacy dispensing a 90-day supply of covered prescription drugs under this paragraph shall comply with any specified terms, conditions, and [price] reimbursement rate which the health benefit plan may require for mail order pharmacies that fill 90-day prescriptions.	

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
ADOPTED CHILDREN	RSA 415:22-a NH MANDATE	All group health insurance policies which provide coverage for a family member of the insured shall 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.	**Yes: No:** **Explain:**
CONTINUATION RIGHTS	RSA 415:18 XVI	Carriers shall provide continuation of coverage when an individual covered by a plan of group health insurance or a health maintenance organization that provides medical, hospital, dental, and/or surgical expense benefits, loses coverage under the plan. Continuation coverage shall be identical to the coverage provided to other similarly situated members of the group that are still covered by the plan. Periods of coverage shall be as follows: When any individual loses coverage under a group health insurance plan for any reason except dismissal from employment for gross misconduct or carrier termination, coverage shall continue subject to this section for a period of 18 months, unless the individual is eligible for coverage under the following: Whenever the entire group is terminated, coverage shall continue subject to this section for a period of 39 weeks. An individual who is determined to be disabled within the first 60 days of the date such individual loses coverage shall be entitled to 29 months of continuation coverage. Coverage shall continue subject to this section for a period of 36 months is any individual loses coverage under a group health insurance plan for one of the following reasons:	**Yes: No:** **Explain:**
CONTINUATION RIGHTS-CONTINUED		Death of a covered employee, divorce or legal separation of the covered employee or, if the employee's former	

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
		spouse has been covered pursuant to RSA 415:18 VII-b, the first occurring of any of the following events: The remarriage of the covered employee; the death of the covered employee; the 3-year anniversary of the final decree of divorce or legal separation; or such earlier time as provided by such decree; A substantial loss of coverage by retirees and dependents within one year of the employer filing for protection under the bankruptcy provisions of Title 11 of the United States Code; or A dependent child ceasing to be a dependent child.	**Yes: No: Explain:**
	RSA 415:18 VII-a	Surviving spouse age 55 or older – When the surviving spouse, divorced spouse, or legally separated spouse is 55 years of age or older and loses coverage because of the death, divorce or legal separation of the covered employee, coverage shall continue subject to this section until such time as the spouse becomes eligible for participation in another employer-sponsored group plan, or becomes eligible for Medicare. Any employee whose compensation includes group hospital or surgical expense insurance or major medical expense insurance for other than specific diseases or accidents only the premiums for which are paid in full or in part by an employer including the state of New Hampshire,	

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
CONTINUATION RIGHTS-CONTINUED	RSA 415:18 VII-b	its political subdivisions, or municipal corporations, or paid by payroll deduction, may pay the premiums as they become due directly to the policyholder whenever the employee's compensation is suspended or terminated directly or indirectly as the result of a strike, lockout, or other labor dispute for a period not exceeding 6 months and at the rate and coverages as the policy provides. VII-b. Any group accident and health insurance policy covering a resident of New Hampshire shall contain the following provisions: (a) Upon a final decree of divorce or legal separation, if one spouse is a member of a group accident and health insurance policy, the former spouse who is a family member or eligible dependent under said policy prior to the date of the decree shall be and remain eligible for group benefits as a family member or eligible dependent under said policy, without additional premium or examination, as if said decree had not been issued. Such eligibility shall not be required if the decree expressly provides otherwise. (b) The former spouse shall be eligible for coverage pursuant to this section through the member's participation in a group accident and health insurance policy, while such policy remains in force or is replaced by another group policy covering the member, until the earliest of the following events occurs: (1) The 3-year anniversary of the final decree of divorce or legal separation; (2) The remarriage of the former spouse; (3) The remarriage of the member; (4) The death of the member; or (5) Such earlier time as provided by the final decree of divorce or legal separation.	**Yes: No:** **Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
CONTINUATION RIGHTS-CONTINUED		(c) Upon the occurrence of the earliest of the events set forth in subparagraph (b), other than remarriage of the former spouse, the former spouse shall have the right to continuation coverage under RSA 415:18, XVI. An insurance carrier may charge a premium for the former spouse's continuation coverage under this subparagraph, in accordance with RSA 415:18, XVI. The former spouse shall request enrollment under RSA 415:18, XVI, in writing, within 30 days after the first occurring of the events set forth in subparagraph (b), provided that the former spouse may not request enrollment upon remarriage of the former spouse. If the first occurring event is the member's remarriage or death, the former spouse may request enrollment under RSA 415:18, XVI, in writing, within 30 days after receiving notice of said event. (d) In the event of the former spouse's remarriage, the former spouse shall notify the insurance carrier, in writing, within 30 days after the date of remarriage, and the effective date of termination of the former spouse's eligibility pursuant to this section shall be the date of remarriage. (e) The member or former spouse shall submit to the insurance carrier evidence of the former spouse's eligibility under this section within 30 days after the final decree of divorce or legal separation. If the group accident and health insurance policy existing as of the date of the decree is replaced by another group policy covering the member that is issued by a different insurance carrier, said carrier may request that the member or former spouse submit evidence of the former spouse's eligibility under this section within 30 days of the effective date of the member's coverage under the replacement policy.	**Yes: No:** **Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
CONTINUATION RIGHTS-CONTINUED		A former spouse's coverage under the member's group accident and health insurance policy pursuant to this section shall be effective as of the date of the final decree of divorce or legal separation in the case of a then existing policy, or, in the case of a replacement policy, the effective date of the member's coverage under such policy. (f) The former spouse shall notify the insurance carrier, in writing, of any address other than the member's address to which notices and correspondence pertaining to the former spouse's coverage should be mailed, including but not limited to notice of cancellation and any right to reinstate coverage, and the carrier shall use such address until it receives written notice from the former spouse of a change. (g) Upon termination of the eligibility of a former spouse for group coverage pursuant to this section, said former spouse may apply for individual coverage or the high risk pool, whichever is applicable. (h) Eligibility of a former spouse for group coverage pursuant to this section exists independent of any right to continuation of coverage under RSA 415:18, XVI. To the extent that there is a conflict between this paragraph and RSA 415:18, XVI with respect to eligibility for group coverage upon a final decree of nullity, divorce or legal separation, the provisions that confer greater rights on the former spouse shall apply unless the decree expressly provides otherwise.	**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:**
COVERAGE FOR BIOLOGICALLY-BASED MENTAL ILLNESSES	RSA 417-E NH MANDATE ESSENTIAL HEALTH	E:1 III. Treatment and diagnosis of certain biologically-based mental illnesses under the same terms and conditions and which are no less	**Yes: No:** **Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
	BENEFITS	extensive than coverage provided for any other type of health care for physical illness**.** The following mental illnesses, as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association, shall be covered under this section: (a) Schizophrenia and other psychotic disorders. (b) Schizoaffective disorder. (c) Major depressive disorder. (d) Bipolar disorder. (e) Anorexia nervosa and bulimia nervosa. (f) Obsessive-compulsive disorder. (g) Panic disorder. (h) Pervasive developmental disorder or autism. (i) Chronic post-traumatic stress disorder**.**	
COVERAGE FOR CLINICAL TRIALS	RSA 415:18-l II. NH MANDATE	A policy, plan, or contract subject to this section shall provide coverage for all medically necessary routine patient care costs incurred as a result of a treatment being provided in accordance with a clinical trial to the extent such costs would be covered for non-investigational treatments if the treatment is being provided or the studies are being conducted in a phase I, phase II, phase III, or phase IV clinical trial for cancer or the treatment is being provided for any other life-threatening condition.	**Yes: No:** **Explain:**
COVERAGE FOR CERTIFIED MIDWIVES	RSA 415:18-q NH MANDATE	Each insurer that issues or renews any policy of group or blanket accident or health insurance providing maternity benefits shall also provide to each group, or to the portion of each group comprised of certificate holders of such insurance who are residents of this state, coverage consistent with the terms and conditions of the policy for services rendered by a midwife certified under RSA 326-D. Such coverage shall be subject to each	**Yes: No:** **Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
		insurer's standards and mechanisms for credentialing and contracting pursuant to RSA 420-J:4 and RSA 420-J:8 respectively, where applicable, and contingent upon services being provided in a licensed health care facility or at home and within the scope of practice of a certified midwife. Benefits provided shall not be subject to any greater co-payment, deductible, or coinsurance than any other similar benefits provided by the insurer.	

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
COVERAGE FOR CHILDREN'S EARLY INTERVENTION THERAPY SERVICES	RSA 415:18-s NH MANDATE	Each insurer that issues or renews any individual policy, plan, or contract of accident or health insurance providing benefits for medical, rehabilitation, or hospital expenses, shall provide to certificate holders of such insurance, who are residents of this state, coverage for expenses arising from the services of licensed and credentialed occupational therapists, physical therapists, speech-language pathologists, and clinical social workers working with children from birth to 36 months of age with an identified developmental disability and/or delay as long as the providing therapist receives a referral from the child's primary care physician if applicable. The benefits may have a cap of $3,200 per child per year not to exceed $9,600 by the child's third birthday	**Yes: No:** **Explain:**
COVERAGE FOR EARLY REFILLS OF PRESCRIPTION EYE DROPS	RSA 415:18-z	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 certificate holders of such insurance, who are residents of this state, coverage for one early refill of a prescription for eye drops if the following criteria are met: (a) For prescription eye drops dispensed as a 30-day supply, the enrollee requests the refill no earlier than 21 days after the later of the following dates: (1) The date the original prescription was dispensed to the enrollee; or (2) The date that the most recent refill of the prescription was dispensed to the enrollee; (b) For prescription eye drops dispensed as a 90-day supply, the enrollee requests the refill no earlier than 63 days after the later of the following dates: (1) The date the original prescription was dispensed to the enrollee; or (2) The date that the most recent refill of the prescription was dispensed to the enrollee;	**Yes: No:** **Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
		(c) The prescribing health care provider indicated on the original prescription that a specific number of refills are authorized; (d) The refill requested by the enrollee does not exceed the number of refills indicated on the original prescription; (e) The prescription has not been refilled more than once during the 30-day or 90-day period prior to the request for an early refill; and (f) The prescription eye drops are a covered benefit under the enrollee's health plan. II. Benefits provided under this section shall not be subject to any greater copayment, deductible, or coinsurance than any other similar benefits provided by the insurer.	

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
COVERAGE FOR HEARING AIDS	RSA 415:18-u NH MANDATE	Insurers are required to cover the cost of a hearing aid for each ear, as needed, as well as related services necessary to assess, select, and fit the hearing aid with a maximum for the hearing aid and related services of no less than $1,500 per hearing aid every 60 months. The insured may choose a higher price hearing aid and pay the difference in cost.	**Yes: No:** **Explain:**
COVERAGE FOR OBESITY AND MORBID OBESITY	RSA 415:18-t NH MANDATE	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 this state, coverage for the diseases and ailments caused by obesity and morbid obesity and treatment for such, including bariatric surgery, when the prescribing physician has issued a written order stating that treatment is medically necessary and in accordance with the patient qualifications and treatment standards set forth by the American Society for Metabolic and Bariatric Surgery or the American College of Surgeons. Such treatment standards may include, but not be limited to, pre-operative psychological screening and counseling, behavior modification, weight loss, exercise regimens, nutritional counseling, and post-operative follow-up, overview, and counseling of dietary, exercise, and lifestyle changes. The covered insured shall be at least 18 years of age. The benefits included in this section shall be subject to the terms and conditions of the policy and shall be no less extensive than coverage provided for similar conditions or illnesses.	**Yes: No:** **Explain:**
COVERAGE FOR OUTPATIENT CONTRACEPTIVES SERVICES AND DEVICES AND PRESCRIPTION	RSA 415:18-i NH MANDATE	**Coverage for Prescription Contraceptive Drugs and Prescription Contraceptive Devices and for Contraceptive Services. –** Each insurer that issues or renews any group policy of accident or health	**Yes: No:** **Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
CONTRACEPTIVES		insurance providing benefits for medical or hospital expenses, which provides coverage for outpatient services 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, coverage for outpatient contraceptive services under the same terms and conditions as for other outpatient services. "Outpatient contraceptive services" means consultations, examinations, and medical services, provided on an outpatient basis and related to the use of contraceptive methods to prevent pregnancy which has been approved by the U.S. Food and Drug Administration. Each insurer that issues or renews any policy of group accident or health insurance providing benefits for medical or hospital expenses which provides a prescription rider shall cover all prescription contraceptive drugs and prescription contraceptive devices approved by the U.S. Food and Drug Administration under the same terms and conditions as other prescription drugs.	
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)	**Yes: No:** **Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
		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.	

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
COVERAGE FOR CERTAIN PROSTHETIC DEVICES	RSA 415:18-n NH MANDATE	I. Each insurer that issues or renews any policy of group or blanket accident or health insurance providing benefits for medical or hospital expenses, except for supplemental policies covering a specified disease or other limited benefit, 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 benefits for prosthetic devices under the same terms and conditions that apply to other durable medical equipment covered under the policy, except as otherwise provided in this section. II. In this section, ""prosthetic device'' means an artificial limb device to replace, in whole or in part, an arm or leg. III. An insurer shall not impose any annual or lifetime dollar maximum on coverage for prosthetic devices other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy.	**Yes: No:** **Explain:**
COVERAGE FOR TELEMEDICINE SERVICES	RSA 415-J:3 NH MANDATE	I. It is the intent of the general court to recognize the application of telemedicine for covered services provided within the scope of practice of a physician or other health care provider as a method of delivery of medical care by which an individual shall receive medical services from a health care provider without in-person contact with the provider. II. An insurer offering a health plan in this state may not deny coverage on the sole basis that the coverage is provided through telemedicine if the health care service would be covered if it were provided through in-person consultation between the covered person and a health care provider. III. Nothing in this section shall be	**Yes: No:** **Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
		construed to prohibit an insurer from providing coverage for only those services that are medically necessary and subject to the terms and conditions of the covered person's policy.	

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
COVERAGE FOR THE COST OF TESTING FOR BONE MARROW DONATION	RSA 415:18-r NH MANDATE	I. Each insurer that issues or renews any policy of group 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 this state and who meet the criteria for testing as established by the Match Registry (the National Marrow Donor Program), coverage for laboratory fee expenses up to $150 arising from human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for utilization in bone marrow transplantation. The testing shall be performed in a facility that is accredited by the American Association of Blood Banks or its successors, or the College of American Pathologists, or its successors, or any other national accrediting body with requirements that are substantially equivalent to or more stringent than those of the College of American Pathologists, and is licensed under the Clinical Laboratory Improvement Act of 1967, 42 U.S.C. section 263a, as amended. At the time of the new testing, the person tested shall complete and sign an informed consent form that also authorizes the results of the test to be used for participation in the National Marrow Donor Program and shall acknowledge a willingness to be a bone marrow donor if a suitable match is found. II. In addition to paragraph I, the testing facility shall not 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 for any portion of the laboratory fee expenses.	**Yes: No:** **Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
COVERAGE FOR TREATMENT OF PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM	RSA 417-E:2 NH MANDATE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT 45 CFR 146.136 45 CFR 147.160 ESSENTIAL HEALTH BENEFITS 2017 NOTICE OF FINAL BENEFIT AND PAYMENT PARAMETERS	I. For the purposes of this chapter, treatment of pervasive developmental disorder or autism as required under RSA 417-E:1, III(h) shall include the following: a) Professional services and treatment programs, including applied behavioral analysis, necessary to produce socially significant improvements in human behavior or to prevent loss of attained skill or function. To be eligible for coverage, applied behavior analysis must be provided by a person professionally certified by the national Behavior Analyst Certification Board or performed under the supervision of a person professionally certified by the national BehaviorAnalyst Certification Board. b) Prescribed pharmaceuticals subject to the same terms and conditions of the policy as other prescribed pharmaceuticals. c) Direct or consultative services provided by a licensed professional including a licensed psychiatrist, licensed advanced practice registered nurse, licensed psychologist, or licensed clinical social worker; and d) Services provided by a licensed speech therapist, licensed occupational therapist, or licensed physical therapist. II. An insurer may require submission of a treatment plan, including the frequency and duration of treatment, signed by the primary care provider, an appropriately credentialed treating specialist, a child psychiatrist, a pediatrician with a specialty in behavioral-developmental pediatrics, a neurologist with a specialty in child neurology, or a licensed psychologist with training in child psychology, that the treatment is medically necessary for the patient and is consistent with nationally recognized treatment standards for the condition such as those set forth by the American Academy of Pediatrics. An insurer may require an updated treatment plan no	**Yes: No:** **Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
		more frequently than on a semi-annual basis. Coverage shall not be denied on the basis that services are habilitative in nature. Under §156.125, which implements the prohibition on discrimination provisions, an issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.	

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
DENTAL PROCEDURES MEDICAL OR HOSPITAL ANESTHESIA	RSA 415:18-g NH MANDATE	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 6 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 NH MANDATE	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.	**Yes: No:** **Explain:**
DIABETES TREATMENT – CONTINUED		Each insurer that issues or renews any group policy, plan, or contract of accident or health insurance providing benefits for medical or hospital expenses which provides a prescription rider shall cover medically appropriate or necessary insulin, oral agents and equipment used to treat diabetes subject to the terms and	**Yes: No:** **Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
		conditions of the policy. Each insurer that issues or renews any group policy, plan, or contract of accident or health insurance providing benefits for medical or hospital expenses which provides for durable medical equipment coverage shall provide coverage for medically appropriate or necessary equipment used to treat diabetes subject to the terms and conditions of the policy.	

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
DISCONTINUANCE AND REPLACEMENT OF GROUP ACCIDENT AND HEALTH COVERAGE	NHCAR Part Ins 1906.02 (a) NHCAR Part Ins 1906.04	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	NHCAR Part Ins 1906.05	(a) Every group policy, contract or certificate subject to this rule issued on or after the effective date of this rule, or under which the level of benefits is altered, modified or amended on or after the effective date of this rule, 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, and at least 90 days for all others.	**Yes: No:** **Explain:**
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	**Yes: No:** **Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
		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.	

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:**
IDENTIFICATION CARDS (EXPENSE-BASED MEDICAL, DENTAL AND PRESCRIPTION DRUGS)	NHCAR Part Ins 1901.09	(b) 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. (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: (1) Clearly visible; and (2) In a font size no less than the member's name on the member identification card.	**Yes: No:** **Explain:**
LOW-DOSE MAMMOGRAPHY COVERAGE	RSA 417-D:2. NH MANDATE	Any policy of accident and health insurance providing benefits for hospital expense, medical-surgical expense, or major medical expense shall provide: (a) a baseline	**Yes: No:** **Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
		mammogram for women 35 to 39 years of age. (b) a mammogram every 1 to 2 years, even if no symptoms are present, for women 40 to 49 years of age. (c) an annual mammogram for women 50 years of age or older.	

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
MANAGED CARE GUIDE	NHCAR Part Ins 2700	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:**
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:**
MAXIMUM OUT OF POCKET COST SHARING LIMIT	PPACA, Section 1302(c)(1) 2018 Benefit and Payment Parameters IRS Revenue Proc. 2017-37	The cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in 2014 shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively, for taxable years beginning in 2014. For plan years beginning in 2018, the maximum out of pocket limit for an individual is $7350, and for a family is $14,700. The proposed maximum out of pocket limit for plan years beginning in 2019 is $7,900 for individual coverage, and $15,800 for family coverage. HSA limits for 2019(Pending) HSA limits for 2018: For calendar year 2018, a "high deductible health plan" is defined under § 223(c)(2)(A) as a health plan	**Yes: No:** **Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
		with an annual deductible that is not less than $1,350 for self-only coverage or $2,700 for family coverage, and the annual out-of-pocket expenses (deductibles, co-payments, and other amounts, but not premiums) do not exceed $6,650 for self-only coverage or $13,300 for family coverage.	

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
MEDICALLY NECESSARY DENTAL COVERAGE DUE TO ACCIDENTAL INJURY	RSA 420-G:5 VIII NH MANDATE	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 hereunder shall be subject to such other terms and conditions of the policy that may apply.	**Yes: No:** **Explain:**
MENTAL HEALTH AND SUBSTANCE USE DISORDER COVERAGE	RSA 415:18-a I. NH MANDATE RSA 417:E RSA 420-B:8-b (HMO) RSA 420-J: 15, 16, 17 & RSA 420-J: 18 ESSENTIAL HEALTH BENEFIT Federal Mental Health Parity and Addiction Equity Act	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 coverage for expenses arising from the treatment of mental illnesses and emotional disorders. (See also RSA 417-E Coverage for Certain Biologically Based Mental Illnesses); Autism Spectrum Disorders. ASAM requirements, prior authorization, and Medication-Assisted Treatment Coverage for expenses arising from treatment for chemical dependency, including alcoholism, shall include both an inpatient and an outpatient benefit for detoxification and rehabilitation. Coverage must comply with federal Mental Health Parity and Addiction Equity Act requirements. Benefits, cost sharing and managed care requirements must be the same as for any other medical or surgical coverage.	**Yes: No:** **Explain:**
MENTAL ILLNESS	RSA 415:18-a II.	In the case of policies or certificates providing benefits for hospital expenses on other than a major medical basis, benefits shall be at least as favorable as benefits provided for any other illness.	**Yes: No:** **Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
NATUROPATHY PROVIDERS; PAYMENT FOR EQUIVALENT TYPES OF SERVICES;	RSA 415:18-w	Each insurer that issues or renews any policy of group or blanket accident or health insurance providing benefits for medical or hospital expenses may provide to each group, or to the portion of each group comprised of certificate holders of such insurance who are residents of this state, coverage for expenses arising from a health service performed by a doctor of naturopathic medicine licensed under RSA 328-E if that particular type of service is within the scope of practice of such doctor and if the insurer would reimburse for that type of service when performed by any other type of health care provider. Such coverage, if provided, shall be subject to each insurer's standards and mechanisms for determining medical necessity, for credentialing pursuant to RSA 420-J:4, and for contracting pursuant to RSA 420-J:8. Any such benefits provided shall not be subject to any greater co-payment, deductible, or coinsurance than any other similar benefits provided by the insurer.	**Yes: No:** **Explain:**
NEWBORN CHILDREN	RSA 415:22 NH MANDATE	I. All group health insurance policies providing coverage on an expense incurred basis shall 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. III. 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.	**Yes: No:** **Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
NEWBORN CHILDREN-Continued	Bulletin Ins 17-001-AB	Accordingly, individual and group health insurance policies or contracts providing coverage on a provision of service or an expense incurred basis shall provide coverage of a newborn child for the first 31 days without payment of additional premium or enrollment of the newborn. However, in order for coverage to be extended beyond 31 days, the company may require the insured member to enroll the newborn within the first 31 days and to pay any required premium for coverage beginning on day 32. Coverage for the newborn will be considered coverage under the insured without additional cost sharing requirements to the newborn until such time the newborn is enrolled as a dependent child for which premium, if required, is payable.	**Yes: No: Explain:**
NON-PRESCRIPTION ENTERAL FORMULAS AND LOW-PROTEIN FOODS	RSA 415:18-e NH MANDATE	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 coverage for the provision of nonprescription enteral formulas for the treatment of impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, or motility of the gastrointestinal tract. Coverage for inherited diseases of amino acids and organic acids shall, in addition to the enteral formula, include food products modified to be low protein in an amount not to exceed $1,800 annually for any insured individual.	**Yes: No: Explain:**
OFF-LABEL PRESCRIPTION DRUG	RSA 415:18-j NH MANDATE	No insurer that issues or renews any policy of group or blanket accident or health insurance providing benefits for medical or hospital expenses and providing coverage for prescription drugs shall exclude coverage for any such drug for a particular indication on the ground that the drug has not been approved by the Food and Drug	**Yes: No: Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
		Administration (FDA) for that indication, if such drug is recognized for treatment of such indication in one of the standard reference compendia or in the medical literature as recommended by current American Medical Association (AMA) policies.	

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
ORAL ANTI-CANCER THERAPIES	RSA 415:18-y NH Mandate	I. No insurer that issues or renews any policy of group or blanket accident or health insurance providing benefits for anti-cancer medications that are injected or intravenously administered by a health care provider and patient administered anti-cancer medications, including but not limited to those orally administered or self-injected, shall require a higher copayment, deductible, or coinsurance amount for patient administered anti-cancer medication than it requires for injected or intravenously administered anti-cancer medications, regardless of the formulation or benefit category determination by the policy or plan. II. An insurer shall not comply with paragraph I by: (a) Increasing the copayment, deductible, or coinsurance amount required for injected or intravenously administered anti-cancer medication that are covered under the policy or plan. (b) Reclassifying benefits with respect to anti-cancer medications.	**Yes: No:** **Explain:**
ORAL ANTI-CANCER THERAPIES-CONTINUED	RSA 415:18-y NH Mandate	III. In this section, "anti-cancer medication" means drugs and biologics that are used to kill, slow, or prevent the growth of cancerous cells. IV. If the cost-sharing requirements for orally administered anti-cancer medications do not exceed $200 per prescription fill, the health plan shall be deemed in compliance with this section. V. For a health care contract that meets the definition of a "high deductible plan" set forth in 26 U.S.C. section 223(c)(2), a carrier shall be exempt from the provisions of paragraphs I-IV until an enrollee's deductible has been satisfied for the year. VI. This section shall apply only to oral anti-cancer medications where an intravenously administered or injected anti-cancer medication is not medically appropriate.	**Yes: No:** **Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
PATIENTS' BILL OF RIGHTS	RSA 415:18 XIV 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.	**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:**
PREGNANCY, DELIVERY, AND POSTPARTUM COVERAGE	RSA 417-D:2-a NH MANDATE	Coverage during pregnancy and delivery and the postpartum period: I. The length of hospital stay and the number of postpartum visits shall be determined by the attending health care provider based on clinical information that demonstrates that the mother and infant are clinically stable based on nationally accepted guidelines pursuant to paragraph IV and that appropriate care for the mother and newborn can be provided for upon discharge. The length of stay shall not be determined by the health insurer or the hospital based on economic criteria. II. Upon notification of the pregnancy by the insured to the insurer, the insurer shall inform the pregnant woman in writing regarding the insurer's prenatal, maternity, and postpartum benefits, including but not limited to prenatal visits, diagnostic tests, prenatal education, hospital length of stay, postpartum care, homemaker services, and contraceptive counseling and referrals. III. The insurer shall pay for medically necessary prenatal homemaker services when a woman is confined to bedrest or her activities of daily living are otherwise restricted on the recommendation of her attending health care provider who shall consult with the applicable case manager.	**Yes: No:** **Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
PREGNANCY, DELIVERY, AND POSTPARTUM COVERAGE Continued	RSA 417-D:2-a NH MANDATE	IV. Any length of hospital stay shorter than the current minimum nationally accepted guidelines for perinatal care, such as Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, shall be at the recommendation of the attending health care provider in consultation with the mother. In such cases the insurer shall pay for at least 2 postpartum visits. During one such visit, the collection of an adequate sample from the newborn for screening for genetic and metabolic diseases shall take place in accordance with RSA 132 and applicable rules. V. Postpartum visits shall include a physical assessment of mother and infant. The assessment shall include but not be limited to: infant nutrition and feeding, infant behavior, family interactions, safety and injury prevention, infant and maternal health promotion, and community resources. Providers of postpartum visits shall be licensed health care providers experienced in perinatal care. VI. The insurer shall pay for appropriate medically necessary postpartum homemaker services as determined by the attending health care provider who shall consult with the applicable case manager. VII. No attending health care provider shall be penalized by an insurer for following the provisions of this section. Insurers shall not deny payment for services that are within standards of good and generally accepted medical practice as reflected by scientific and peer medical literature and recognized within the organized medical community in the state of New Hampshire.	**Yes: No:** **Explain:**
PRESCRIPTION DRUG CARDS	RSA 415:18-o	I. Each insurer that issues or renews any policy of group accident or health insurance which provides coverage for	

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
		prescription drugs or devices, or which contracts with an entity providing such prescription drug coverage, including but not limited to pharmacy benefit manager companies, shall issue to certificate holders a card or other technology containing uniform prescription drug information. The uniform prescription drug information card or technology shall include all of the fields required by the health insurance provider for claims processing in a clear, readable, and understandable manner on the card or other technology issued, shall include the information required under RSA 400-A:15-c, and shall include, at a minimum, the following information: (a) The name or trademark logo of the insurer and, if another company administers the prescription benefit, the name or trademark logo of the benefit administrator. (b) The certificate holder's name and identification number. (c) All of the electronic transaction routing information required by the insurer or its benefit administrator in order for the pharmacy to electronically process a prescription claim, including but not limited to the BIN number labeled as such or the Processor Control Number labeled as such, or both.	**Yes: No:** **Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
PRESCRIPTION DRUG CARDS Continued	RSA 415:18-o NHCAR Part Ins 1901.09	(a) Printed "John/Jane Doe" member identification cards or benefit guarantee cards as evidence of coverage of membership. (b) The card, which shall contain at a minimum the following: (1) The insurance company name; (2) Subscriber or member name; (3) Subscriber or member identification number; and (4) A telephone number and website for customer service inquiries. (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: (1) Clearly visible; and (2) In a font size no less than the member's name on the member identification card.	**Yes: No:** **Explain:**
PRESCRIPTION EXCEPTION PROCESS	RSA 420-J:7-b II NH MANDATE	Every health benefit plan that provides prescription drug benefits shall maintain an expeditious exception process, not to exceed 48 hours, by which covered persons may obtain coverage for a medically necessary nonformulary prescription drug. The exception process shall begin when the prescribing provider has provided the health benefit plan with the clinical rationale for the exception. A prescription that requires an exception for coverage shall be considered approved if the exception process exceeds 48 hours.	**Yes: No:** **Explain:**
PRESCRIPTION DRUGS FORMULARY CHANGES	RSA 420-J:7-b NH MANDATE	III. Every health plan that provides prescription drug benefits shall notify covered persons affected by deletions to the plan list or plan formulary, provide an explanation of the exception process by which a covered person can access nonformulary medically necessary prescription drugs, and provide a toll-free	**Yes: No:** **Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
		telephone number through which a covered person can request additional information. For purposes of this paragraph, covered persons affected by deletions to the plan list or plan formulary shall include those covered persons for whom the health plan has provided coverage for the deleted prescription drugs during the 12-month period immediately prior to the deletion. Upon notification to covered persons, the health benefit plan shall allow at least 45 days before implementation of any formulary deletions; provided, however, that advance notice shall not be required if the federal Food and Drug Administration has determined that a prescription drug on the health benefit plan's formulary is unsafe. IV-a. Every health benefit plan that provides prescription drug benefits shall provide notice of deletions to the plan list or plan formulary to all covered persons at least annually.	

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 Prior Authorization Processes.	**Yes: No:** **Explain:**
PRESCRIPTION DRUG CLAIM PROCESSING	NHCAR Part Ins 2704.03	(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:**
RECONSTRUCTIVE SURGERY	RSA 417-D:2-b NH MANDATE	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	**Yes: No:** **Explain:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
		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.	

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
SCALP HAIR PROTHESIS	RSA 415:18-d I NH MANDATE	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	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 RATES			
	NHCAR PART Ins 4100	REQUIREMENTS FOR ACCIDENT AND HEALTH INSURANCE RATE SUBMISSIONS	**Yes: No:** **Explain:**
	NHCAR Part Ins 401.13 (m)	POLICIES, CERTIFICATES AND RATES SHALL BE SUBMITTED TOGETHER TO THE DEPARTMENT.	**Yes: No:** **Explain:**

State of New Hampshire

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.

Sign Here

_____ _____
(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.