State of New Hampshire

INSTRUCTIONS FOR SMALL GROUP MAJOR MEDICAL FILINGS CHECKLIST

LINE OF BUSINESS: GROUP HEALTH **TOI CODES: H16G and HOrg02G**

Select one:
Off Exchange Only ☐
Both on and Off Exchange ☐

See additional federal guidance from the 2022 Draft Letter to Issuers, 2022 Fact Sheet, and the New Hampshire Insurance Department guidance in the 2022 Bulletin . Please note that the New Hampshire benchmark plan is Matthew Thornton Blue, supplemented by the FEDVIP Pediatric Dental Plan High Option.

A. **For ALL filings, the Submissions Requirements Checklist MUST be completed and attached to the supporting documentation tab.**
B. **For a FORM filing, the completion of additional sections below must be completed, depending on the forms submitted.**
    a. **Policy/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 401.14 (m) and NHCAR Part Ins 4100. Additional requirements may be necessary, depending on the Type of Insurance (TOI).**
D. **Requirements apply to both Qualified Health Plans (QHPs) and non-QHP individual filings, unless otherwise noted.**
E. **Grandfathered plans, as defined in 75 FR 34537, must be filed separately.**
F. **QHP Submissions are to be in accordance with QHP Application instructions found here.**

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

http://www.gencourt.state.nh.us/rules/state_agencies/ins.html
http://www.gencourt.state.nh.us/rsa/html/NHTOC/NHTOC-XXXVII.htm
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SECTION 1 AFFORDABLE CARE ACT REQUIREMENTS		
REQUIREMENT	DESCRIPTION OF REQUIREMENT	COMPLIANCE
SERVICE AREA	NHID will allow issuers to choose their service area(s), except that requested service areas may not be smaller than a county.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
RATING AREA	NH has established one statewide rating area for all plans offered in the small group market. This means issuers may not vary premiums by regions within the state.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
NETWORK ADEQUACY	Per **RSA 420-J:7 I** and **INS 2701** A health carrier shall maintain a network that is sufficient in numbers, types, and geographic location of providers to ensure that all services to covered persons will be accessible without unreasonable delay. Medical QHP issuers must also provide to the Insurance Department the Network Adequacy Provider File, and a NH specific excel template for NH standards they know they do not meet and provide a justification. These two items can be **found here.** Additionally, a health carrier shall make its provider directory available online and hard copy upon request of enrollees in accordance with 45 CFR 156.230(b) and the September 25, 2014 NHID Bulletin entitled **"Transparency in Provider Network Directory and Formulary Information."** Issuers are reminded to consult the 20210 Final Letter to Issuers in the Federally Facilitated Exchanges **CMS 2022 Draft Letter to Issuers** regarding federal requirements for **provider directories.**	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
ACTUARIAL VALUE	NHID will require issuers to submit the completed actuarial value calculator provided by the Center for Consumer Information and Insurance Oversight (CCIIO) to verify compliance with AV standards. NHID will also require issuers to submit an actuarial certification, along with screen shots of plan variations. The actuary shall certify that either the AV calculator accommodated the plan design or specify the methodology used to accommodate the plan for calculation purposes. In the event accommodation was necessary, the actuary shall certify that such accommodations were in accordance with generally accepted actuarial principles and practices and compliant with the terms set forth in the applicable federal regulations.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
COST SHARING	For Plan Year 2021 the 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 year's 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. Annual deductible limits and Maximum Out-Of-Pocket Limits have not yet been announce by the IRS. The Department will notify carriers upon issue.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

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PEDIATRIC AGE	According to §156.115(a)(6), issuers must provide coverage for pediatric services until **at least** the end of the month in which the enrollee turns 19. We encourage issuers to cover services under the pediatric services EHB category beyond the 19th birthday month if non-coverage of those services after that time would negatively affect care.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
TRANSPARENCY IN COVERAGE	In accordance with 45 CFR 156.220 and 45 CFR 155.1040, a QHP issuer must submit, in an accurate and timely manner, the following information to the Marketplace, HHS and the State insurance commissioner, as well as to the public: (1) Claims payment policies and practices; (2) Periodic financial disclosures; (3) Data on enrollment; (4) Data on disenrollment; (5) Data on the number of claims that are denied; (6) Data on rating practices; (7) Information on cost-sharing and payments with respect to any out-of-network coverage; and (8) Information on enrollee rights under title I of the Affordable Care Act.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
RATE FILING	Rate filings must comply with **NHCAR Part Ins 4100** and **RSA 420-G:4**.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
PLAN VARIATIONS	The carrier will complete the rate and benefit templates. NHID will require an attestation of compliance with federal Plan Variation Standards, and are subject to review and approval by NHID. Schedule of Benefits and Summary of Benefits and Coverage must be completed for each plan variation.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
HEALTH INSURANCE MARKET REFORM RULES	Issuers must comply with Health Insurance Market Reform rules put in place under the Affordable Care Act and codified in 45 CFR Parts 80, 147, and 155 including:	

SECTION 1 AFFORDABLE CARE ACT REQUIREMENTS		
REQUIREMENT	DESCRIPTION OF REQUIREMENT	COMPLIANCE
	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).	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
	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. (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. (g) Submit a description of covered benefits and cost-sharing provisions at least annually, in accordance with 45 CFR 156.210(b).	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

SECTION 1 AFFORDABLE CARE ACT REQUIREMENTS		
REQUIREMENT	DESCRIPTION OF REQUIREMENT	COMPLIANCE
	Single Risk Pool *Small Group Market*. Per 45 CFR 156.80, a health insurance issuer must consider the claims experience of all enrollees in all health plans (other than grandfathered health plans) subject to section 2701 of the Public Health Service Act and offered by such issuer in the small group market in a state, including those enrollees who do not enroll in such plans through the Marketplace, to be members of a single risk pool. **Out of Pocket Maximums** The maximum out-of-pocket expenses (MOOP) for in-network services allowed for High Deductible Health Plans (HDHPs) to qualify for a 2022 HSA has not yet been released by the IRS. The Department will notify the issuers once the information is released by the IRS.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
ENROLLMENT PERIODS	**Standard Employee Enrollment Periods** Annual enrollment periods for SHOP are on a rolling basis for a 12 month period, as per **45 CFR 155.725**, and amended by **81 FR 12347.** **Special Enrollment Periods** Employees who experience certain life events as outlined in **45 CFR 155.725 (j)** and **45 CFR 155.420 (d)**, must be given access to special enrollment periods of either 30 or 60 days from the date of a triggering event, with effective dates consistent with 45 CFR 155.725 (j) (3). Issuers are urged to consult new guidance from CMS regarding SEP's: **https://www.healthcare.gov/sep-list/**	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
TERMINATION OF SHOP ENROLLMENT OR COVERAGE	Termination of SHOP must be in accordance with **45 CFR 155.735.**	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

SECTION 2 ESSENTIAL HEALTH BENFITS, STATE REQUIREMENTS, AND FEDVIP DENTAL AND VISION

ESSENTIAL HEALTH BENEFITS

REQUIREMENT	DESCRIPTION OF REQUIREMENT	COMPLIANCE
	Please note the Essential Health Benefit (EHB) benchmark plan for plan year 2021 is Matthew Thornton Blue; plan materials can be found at: **https://www.cms.gov/cciio/resources/data-resources/ehb.html**. Pediatric dental is supplemented by the **FEDVIP dental plan**. Carriers must comply with the Mental Health Parity and Addiction Equity Act (MHPAEA) requirements. Plan binder templates contain the EHB and Pharmacy Formulary. The templates must be completed and attached to the filing. NH will require an attestation of compliance with the EHB formulary standards.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
	Ambulatory patient services	
	Medical Exams	**YES** ☐
	Telemedicine Visits	**YES** ☐
	Injections (including allergy injections)	**YES** ☐
	Office Surgery	**YES** ☐
	Anesthesia	**YES** ☐
	Early Childhood Intervention Therapy Services (For children up to age 3)	**YES** ☐
	Colonoscopy	**YES** ☐
	Management of Therapy	**YES** ☐
	Hemodialysis	**YES** ☐
	Chemotherapy	**YES** ☐
	Radiation Therapy	**YES** ☐
	Infusion Therapy	**YES** ☐
	TMJ Surgery and limited Oral Surgery	**YES** ☐
	Accidental Dental	**YES** ☐
	Hearing Aids	**YES** ☐
	Non-prescription Enteral Formulas and Low Protein Foods	**YES** ☐
	Emergency services	
	Emergency Room Charges	**YES** ☐
	Network Urgent Care Facility Charge	**YES** ☐
	Physician Fee, Labs, X-Rays, CT Scan, MRI, Medical Supplies, Etc.	**YES** ☐
	Ambulance	**YES** ☐
	Hospitalization	
	Semi-Private Room and Board	**YES** ☐
	Diagnostic Tests	**YES** ☐
	Supplies	**YES** ☐
	Medication	**YES** ☐
	Other Ancillary Services for medical, surgical, and maternity admissions	**YES** ☐
	Skilled Nursing Facility Care	**YES** ☐

	Physician In-Hospital Care (Such as surgery, anesthesia, maternity care and physical, occupational, and speech therapy)	**YES** ☐
	Durable Medical Equipment, Supplies, Prosthetics	**YES** ☐
	Diagnostic Labs (furnished in any medical facility other than a physician's office or independent laboratory)	**YES** ☐
	Diagnostic X-Rays (Including ultrasounds, MRI, MRA, CT Scan, CTA, PET, and SPECT)	**YES** ☐
	Coverage for Obesity and Morbid Obesity – Bariatric Surgery	**YES** ☐
	Facility Fees (for use of a hospital outpatient department or ambulatory surgery center; for medical, surgical, and maternity admissions)	**YES** ☐
	Maternity and newborn care	
	Maternity Hospitalization	**YES** ☐
	Operating room for Delivery of a Baby	**YES** ☐
	Physician Services for Delivery of a Baby, including circumcision	**YES** ☐
	Ultrasounds	**YES** ☐
	Maternity Care (Prenatal and postpartum visits)	**YES** ☐
	Mental health and substance use disorders, including behavioral health treatment (MHPAEA)	
	Mental Health Outpatient/Office Visits	**YES** ☐
	Substance Abuse Outpatient/Office Visits	**YES** ☐
	Medical Detoxification	**YES** ☐
	Substance Abuse Rehabilitation	**YES** ☐
	Prescription drugs	
	Covered Medications, Diabetic Supplies, and Contraceptive Devices purchased at a network retail or mail order pharmacy	**YES** ☐
	Rehabilitative and habilitative services and devices	
	Physical Rehabilitation Therapy	**YES** ☐
	Physical Therapy	**YES** ☐
	Occupational Therapy	**YES** ☐
	Speech Therapy	**YES** ☐
	Cardiac Rehabilitation	**YES** ☐
	Chiropractic Care	**YES** ☐
	Laboratory services	
	Diagnostic Labs (including allergy testing)	**YES** ☐
	Preventive and wellness services including chronic disease management as per the Grade A and B Recommendations of the United States Preventive Services Task Force and HRSA, with no cost-sharing by the covered person. This includes preventive drugs and prep drugs for preventive services.	
	Immunizations for babies, children, and adults	**YES** ☐
	Routine Physical Exams for babies, children, and adults	**YES** ☐
	Annual Gynecological Exams	**YES** ☐
	Family Planning Visits	**YES** ☐
	Annual Care Plans for Members with Chronic Illnesses	**YES** ☐

	Nutrition Counseling	**YES**	
	Mammogram	**YES**	
	Pap Smear	**YES**	
	Lead Screening	**YES**	
	Pre-natal and postpartum Visits	**YES**	
	Other routine preventive screening such as total cholesterol, lipids, and diabetic screenings	**YES**	
	Diabetes Screening	**YES**	
	Fluoride Treatments	**YES**	

STATE MANDATES			
REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
COVERAGE FOR CLINICAL TRIALS	**RSA 415:18-l II.** **Essential Health Benefit Requirement**	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: ☐** **Page # or If NO:**
MEDICALLY NECESSARY DENTAL COVERAGE DUE TO ACCIDENTAL INJURY	**RSA 415:18-bb** **RSA 420-J:6-e** RSA 420-B:20	**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 state, coverage for medically necessary dental services resulting from an accidental injury to sound natural teeth and gums . Treatment made necessary due to injury to the jaw and oral structures other than teeth shall be covered without time limit. **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. Treatment made necessary due to injury to the jaw and oral structures other than teeth shall be covered without time limit.	**YES: ☐ NO: ☐** **PAGE # OR IF NO:**
MENTAL HEALTH AND SUBSTANCE ABUSE COVERAGE	**Essential Health Benefit Requirement** **RSA 420-J:15** **RSA 420-J:16** **RSA 420-J:17** **RSA 420-J:18**	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. SUD Definitions SUD Levels of Care Criteria; Attestation Prior Authorization Authorization for Medication-Assisted Treatment	**YES: ☐ NO: ☐** **PAGE # OR IF NO:**

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REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
DENTAL PROCEDURES **MEDICAL OR HOSPITAL – ANESTHESIA**	**RSA 415:18-g (Group)** **RSA 420-B:8-ee (HMO)** **Essential Health Benefit Requirement**	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: ☐** **PAGE # OR IF NO:**
COVERAGE FOR DENTAL PROCEDURES; DENTAL OFFICES	**RSA 415:18-h** **Essential Health Benefits**	I. Each dental insurer or other similar entity, including Delta under RSA 420-F, that issues or renews any policy of group insurance providing benefits for oral surgical procedures, shall provide to each certificate holder who is a resident of New Hampshire coverage for the administration of general anesthesia administered by a licensed dentist for dental procedures performed in a dentist's office 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 complexity which requires the child to receive general anesthesia for the treatment of such condition; 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: ☐** **PAGE # OR IF NO:**
NONPRESCRIPTION ENTERAL FORMULAS	**RSA 415:18-e** **Essential Health Benefits**	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.	**YES ☐ NO ☐** **PAGE # OR IF NO:**

STATE MANDATES			
REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
CONTRACEPTIVE DRUGS AND PRESCRIPTION CONTRACEPTIVE DEVICES AND FOR CONTRACEPTIVE SERVICES	RSA 415:18-i RSA 420-G:8-gg CMS FAQ 12 FINAL RULE	Each insurer that issues or renews any group policy of accident or health 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, including the initial screening provided through a pharmacy pursuant to RSA 318:47-l at a rate established by contract between the pharmacy and the insurer or its pharmacy benefits manager, and related to the use of contraceptive methods to prevent pregnancy which have 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 shall cover all prescription contraceptive drugs and prescription contraceptive devices approved by the U.S. Food and Drug Administration. Coverage shall include contraceptives dispensed in a quantity intended to last for a 12-month period, if prescribed in that quantity. An insurer shall not impose utilization review requirements or other limitations to control the prescribing or dispensing of contraceptives to an amount that is less than a 12-month supply, if that quantity is prescribed. An insurer shall not be required to cover more than one 12-month contraceptive prescription in a single dispensing per plan year. A deductible, copayment, coinsurance, or other cost-sharing requirement shall not be imposed on the coverage of prescription contraceptive drugs and contraceptive devices approved by the FDA under this section. Notwithstanding any other provision of law, if there is a therapeutic equivalent of a drug or device for an FDA-approved contraceptive method, an insurer may impose cost-sharing requirements as long as at least one drug or device for that method is available without cost-sharing; provided that if an individual's provider recommends a particular FDA-approved contraceptive drug or device based on a medical determination, the insurer shall provide coverage for the prescribed contraceptive drug or device without cost-sharing. Nothing in this section shall be construed as altering the terms and conditions of a contract relating to prescription drugs and outpatient services. Notwithstanding any provision of law or rule to the contrary, the coverage under this section shall apply to the medical assistance program, pursuant to RSA 161 and RSA 167.	**YES☐ NO☐** **PAGE # OR IF NO:**

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REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
DIABETES TREATMENT	**RSA 415:18-f** **RSA 420-B:8-k** **Essential Health Benefits**	Each insurer that issues or renews any individual policy, plan, or contract of 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 medically appropriate and necessary outpatient self-management training and educational services, pursuant to a written order of a primary care physician or practitioner, including but not limited to medical nutrition therapy for the treatment of diabetes, provided by a certified, registered or licensed health care professional with expertise in diabetes, subject to the terms and conditions of the policy. Each insurer that issues or renews any individual 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 conditions of the policy. Each insurer that issues or renews any individual 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. Insulin Limit - $30 for 30 day supply.	**YES** ☐ **NO** ☐ **PAGE # OR IF NO:**
PROHIBITION ON BALANCE BILLING; PAYMENT FOR REASONABLE VALUE OF SERVICES	**RSA 329:31-B**	I. When a commercially insured patient is covered by a managed care plan as defined under RSA 420-J:3, XXV, a health care provider performing anesthesiology, radiology, emergency medicine, or pathology services shall not balance bill the patient for fees or amounts other than copayments, deductibles, or coinsurance, if the service is performed in a hospital or ambulatory surgical center that is in-network under the patient's health insurance plan. This prohibition shall apply whether or not the health care provider is contracted with the patient's insurance carrier. II. Pursuant to paragraph I, fees for health care services submitted to an insurance carrier for payment shall be limited to a commercially reasonable value, based on payments for similar services from New Hampshire insurance carriers to New Hampshire health care providers. III. In the event of a dispute between a provider and an insurance carrier relative to the reasonable value of a service under this section, the insurance commissioner shall have exclusive jurisdiction under RSA 420-J:8-e to determine if the fee is commercially reasonable. The provider and the insurance carrier shall each make best efforts to resolve any dispute prior to applying to the insurance commissioner for resolution, which shall include presenting to the other party evidence supporting its contention that the fee level it is proposing is commercially reasonable. The department of insurance may require the parties to engage in mediation prior to rendering a decision.	

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OFF-LABEL PRESCRIPTION DRUG	**RSA 415:18-j** RSA 420-B:20 **Essential Health Benefits**	I. No insurer that issues or renews any individual policy of 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 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. II. Any coverage of a drug required by this section shall also include medically necessary services associated with the administration of the drug. III. Nothing in this section requires: a) Coverage for any drug if the FDA has determined its use to be contraindicated for the treatment of the particular indication for which the drug has been prescribed; b) Coverage for experimental or investigational drugs not approved for any indication by the FDA; and c) Reimbursement or coverage for any drug not included on the drug formulary or list of covered drugs specified in a health plan, contract, or policy.	**YES ☐ NO: ☐** **PAGE # OR IF NO:**

STATE MANDATES			
REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
PROMPT PAYMENT TIME LIMIT	RSA 415:18-k	I. (a) Each insurer that issues or renews any policy of group 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). (c) Payment of a claim shall be considered to be made on the date a check was issued or electronically transferred. The insurer shall mail checks no later than 5 business days after the date a check was issued. Failure to mail a check within 5 business days shall constitute a violation subject to enforcement under RSA 415:20.	**YES☐ NO☐** **PAGE # OR IF NO:**
INSURANCE REIMBURSEMENT FOR EMERGENCY MEDICAL SERVICES	RSA 417-F:2	**417-F:2 Claims Processing. –** An insurer retrospective review of a claim for reimbursement for emergency services shall include consideration of presenting symptoms, along with final diagnosis, and shall give due consideration to the definitions of emergency medical condition and emergency services in RSA 420-J:3.	

STATE MANDATES			
REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
COVERAGE FOR CERTAIN PROSTHETIC DEVICES	**RSA 415:18-n Essential Health Benefits**	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. IV. An insurer shall not apply amounts paid for prosthetic devices to any annual or lifetime dollar maximum applicable to other durable medical equipment covered under the policy other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy.	**YES ☐ NO: ☐** **PAGE # OR IF NO:**
	RSA 415:18-d Essential Health Benefits	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.	

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 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. III. A new uniform prescription drug information card, as required under this section, shall be issued by an insurer upon enrollment of new members and when reissuing a new card to current members when there is a change in the certificate holder's pharmacy coverage that affects data contained on the card.	**YES ☐ NO: ☐** **PAGE # OR IF NO:**
	RSA 420-J:7-b V. VI. & VII.	V. Every health benefit plan that provides coverage for prescription drugs or devices, or administers such a plan, or which contracts with an entity providing such prescription drug coverage, including but not limited to pharmacy benefit manager companies, shall issue to covered persons 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 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 covered person'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. VI. All subscriber health insurance cards issued after January 1, 2004 shall contain the information required under paragraph V. VII. A new uniform prescription drug information card, as required under paragraph V, shall be issued by health benefit plan upon enrollment of new members and when reissuing a	

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		new card to current members when there is a change in the covered person's pharmacy coverage that affects data contained on the card.	
COVERAGE FOR CERTIFIED MIDWIVES	RSA 415:18-q RSA 420-B:8-p	Each insurer that issues or renews any policy, of group 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 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.	**YES ☐ NO ☐** **PAGE # OR IF NO:**
DEFINITION OF PHYSICIAN PSYCHIATRIST SUPERVISED PA	RSA 415:18-a I (9)	**415:18-a Coverage for Mental or Nervous Conditions and Treatment for Chemical Dependency Required. –** I. (a) 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 whose principal place of employment is in this state, coverage for expenses arising from the treatment of mental illnesses and emotional disorders which, in the professional judgment of:…. (9) Licensed, psychiatrist-supervised physician assistants	

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COVERAGE FOR THE COST OF TESTING FOR BONE MARROW DONATION	RSA 415:18-r	Each insurer that issues or renews any individual policy, plan, or contract of 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, 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 ☐** **PAGE # OR IF NO:**
COVERAGE FOR CHILDREN'S EARLY INTERVENTION THERAPY SERVICES	RSA 415:18-s RSA 420-B:8-r **Essential Health Benefits**	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. No Cost Sharing permitted: non-HSA; Deductible allowed: HSA plans.	**YES: ☐ NO: ☐** **PAGE # OR IF NO:**

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COVERAGE FOR OBESITY AND MORBID OBESITY	**RSA 415:18-t** **RSA 420-B:20 Essential Health Benefits**	Each insurer that issues or renews any individual policy, plan, or contract of 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 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:☐** **PAGE # OR IF NO:**
COVERAGE FOR HEARING AIDS	**RSA 415:18-u Essential Health Benefits**	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.	**YES:☐ NO:☐** **PAGE # OR IF NO:**
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:☐** **PAGE # OR IF NO:**
NATUROPATHY PROVIDERS; PAYMENT FOR EQUIVALENT TYPES OF SERVICE	**RSA 415:18-w**	Each insurer that issues or renews any policy, plan, or contract of accident or health insurance providing benefits for medical or hospital expenses may provide to persons covered by 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 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**. 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☐** **PAGE # OR IF NO:**

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NEWBORN CHILDREN	RSA 415:22 RSA 420-B:8-j BULLETIN INS 17-001-AB	I. All individual 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:** ☐ **PAGE # OR IF NO:**
ADOPTED CHILDREN	RSA 415:22-a RSA 420-B:8-g	All individual 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:** ☐ **PAGE # OR IF NO:**
LOW-DOSE MAMMOGRAPHY COVERAGE	RSA 417-D:2 **Essential Health Benefits** BULLETIN INS 16-018-AB	Any policy of accident and health insurance providing benefits for hospital expense, medical-surgical expense, or major medical expense shall provide: (a) a baseline 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.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

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PREGNANCY, DELIVERY, AND POSTPARTUM COVERAGE	**RSA 417-D:2-a** **Essential Health Benefits**	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 bed rest 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. 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.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

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REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
RECONSTRUCTIVE SURGERY	**RSA 417-D:2-b Essential Health Benefits**	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 ☐** **PAGE # OR IF NO:**
COVERAGE FOR TELEMEDICINE SERVICES	**RSA 415-J:3**	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 at an originating site shall receive medical services which are clinically appropriate for delivery through telemedicine from a health care provider at a distant site 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 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.	**YES: ☐ NO: ☐** **PAGE # OR IF NO:**
COVERAGE FOR BIOLOGICALLY-BASED MENTAL ILLNESSES	**RSA 417-E:1 MENTAL HEALTH PARITY AND ADDITION EQUITY ACT** **45 CFR 146.136** **45 CFR 147.160** **Essential Health Benefits**	III. Treatment and diagnosis of certain biologically-based mental illnesses under the same terms and conditions and which are no less 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.	**YES ☐ NO: ☐** **PAGE # OR IF NO:**

COVERAGE FOR TREATMENT OF PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM	**RSA 417-E:2** **MENTAL HEALTH PARITY AND ADDITION EQUITY ACT** **45 CFR 146.136** **45 CFR 147.160** **Essential Health Benefits**	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 Behavior Analyst 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 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. PLEASE NOTE: The limits stated in RSA 417-E:2, III are preempted by the Mental Health Parity and Addiction Act (MHPAEA) which prohibits large group insurance from imposing annual dollar limits on mental health benefits that are less favorable than any such limits imposed on medical/surgical benefits. The Affordable Care Act further extended these MHPAEA protections to the small group and individual markets. These limits will not be permitted. III. The policy, contract, or certificate may limit coverage for applied behavior analysis to $36,000 per year for children 0 to 12 years of age, and $27,000 from ages 13 to 21. An insurer may not apply payments for coverage unrelated to autism spectrum disorders to any maximum benefit established under this paragraph.	**YES: ☐ NO: ☐** **PAGE # OR IF NO:**

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EXCLUSIONS FOR PRE-EXISTING CONDITIONS – PROHIBITED	RSA 420-G:7	420-G:7 Preexisting Condition Exclusion Periods. – A health carrier shall not impose any preexisting condition exclusion with respect to coverage in the individual, small group, or large group market.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
AVAILABILITY, AND RENEWABILITY OF HEALTH COVERAGE	RSA 420-G:6 V, VI and VII. RSA 420-G:4	Federal law requires that carriers accept all applicants. Variations in premium rating factors cannot be health-related, and can only be based on geographic rating area, individual/family coverage, age (variation cannot exceed 3:1 for adults), and tobacco use (variation cannot exceed 1.5:1). Renewability is guaranteed, subject to the conditions and requirements of RSA 420-G:6.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
MANAGED CARE LAW	RSA 420-J:5 RSA 420-J:6-a RSA 420-J:6-b RSA 420-J:7-b	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 – Including Drug Deletions & Exception Process	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
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:** ☐ **PAGE # OR IF NO:**
PRESCRIPTION EXCEPTION PROCESS AND PRIOR AUTHORIZATION	RSA 420-J:7-b II & III 45 CFR 156.122(c)	45 CFR 156.122(c) requires health plans to have a process to allow an enrollee to request and gain access to clinically appropriate drugs not otherwise covered by the health plan. The process must include: • an internal review; federal regulations require the carrier to make a determination and notify the enrollee no later than 72 hours following receipt of the request, however, RSA 420-J:7-b requires that the process not exceed 48 hours), • an external review, • the ability to expedite the reviews (must make determination and notify the enrollee no later than 24 hours following receipt of the request). • In the event that an exception request is granted, the excepted drug(s) are treated as an EHB including counting any cost-sharing towards the plan's annual limitation on cost-sharing.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

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	RSA 420-J:7-b NHCAR Part Ins 2704 and Ins 2705	IV. Every health benefit plan that provides prescription drug benefits shall maintain, as part of its records, all of the following information, which shall be made available to the commissioner upon request: the complete drug formulary or formularies of the plan, if the plan maintains a formulary, including a list of the prescription drugs on the formulary of the plan by major therapeutic category with an indication of whether any drugs are preferred over the other drugs. 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. IV-b. Every health benefit plan that provides prescription drug coverage shall also provide notice of additions to the plan list or formulary to all covered persons at least annually. However, the requirements of this paragraph shall not apply to any health benefit plan that adds prescription drugs to its plan list or formulary upon approval by the federal Food and Drug Association. IV-c (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.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
90-DAY SUPPLY OF COVERED PRESCRIPTION DRUGS	**RSA 420-J:7-b VIII**	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 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.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
PATIENTS' BILL OF RIGHTS	**RSA 415:18 XIV** **RSA 151:21** **RSA 420-B:8-m**	Any 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:** ☐ **PAGE # OR IF NO:**

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REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
IDENTIFICATION CARDS	RSA 400-A:15-C	**Identification of Health Coverage Under the Jurisdiction of the Commissioner. –** All health coverage as defined in RSA 420-G:2, IX and prescription drug and dental benefits offered separately as described in RSA 420-G:2, IX(j) shall be identified as being under the jurisdiction of the commissioner. Such identification shall be clearly printed on a member's identification card and the policy issued to an insured after January 1, 2010. The commissioner shall adopt rules, pursuant to RSA 541-A, designating the form and manner of the identification required under this section.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
EMERGENCY ROOM BOARDING	RSA 417-F:4	**417-F:4 Reimbursement for Emergency Room Boarding. –** Following the completion of an involuntary admission certificate for a patient meeting the criteria under RSA 135-C:27 and not rescinded under RSA 135-C:29-a, the insurer shall pay the acute care hospital a per diem day rate required to board and care for the patient, to be contracted between the insurer and acute care hospital, for each day the insured is waiting in an acute care medical hospital located in the state for admission for psychiatric treatment at New Hampshire Hospital, a community-based designated receiving facility, or a voluntary admission. The day rate required to board and care for the patient may be billed for up to 21 consecutive days or discharge, whichever is sooner, and shall be renewed as needed for patient protection. The rate is deemed to cover all costs incurred by a hospital for the boarding and non-medical care of the insured and shall not be billed to the insured. This does not preclude a hospital from billing for other medically necessary services.	
ACCIDENTAL DENTAL PRE-EXISTING CONDITIONS	RSA 420-J:6-e	**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. 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.	

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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 if any individual loses coverage under a group health insurance plan for one of the following reasons: Death of a covered employee, divorce or legal separation of the covered employee or, if the employee's former 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. 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.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

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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:** ☐ **PAGE # OR IF NO:**
EXTENSION OF BENEFITS	**NH Benchmark Plan**	Every group policy, contract or certificate issued, under which the level of benefits is altered, modified or amended 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 at least 12 months for major medical, and at least 90 days for all others.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
DISCONTINUANCE AND REPLACEMENT OF GROUP ACCIDENT AND HEALTH COVERAGE	**NH Benchmark Plan**	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:** ☐ **PAGE # OR IF NO:**
INFERTILITY	**RSA 417-G:2**	**Note: Per RSA 417:G-2, IV, this section is not applicable to SHOP plans** I. Each health carrier that issues or renews any group policy, plan, or contract of accident or health insurance providing benefits for medical or hospital expenses, shall provide to certificate holders of such insurance coverage for the diagnosis of the etiology of infertility. II. Each health carrier that issues or renews any group policy, plan, or contract of accident or health insurance providing benefits for medical or hospital expenses, shall provide to certificate holders of such insurance coverage for medically necessary fertility treatment. Enrollees shall be provided coverage for evaluations, laboratory assessments, medications, and treatments associated with the procurement of donor eggs, sperm, and embryos. III. Each health carrier that issues or renews any group policy, plan, or contract of accident or health insurance providing benefits for medical or hospital expenses, shall provide to certificate holders of such insurance coverage for fertility preservation when a person is expected to undergo surgery, radiation, chemotherapy, or other medical treatment that is recognized by medical professionals to cause a risk of impairment of fertility. Coverage under this section shall include coverage for standard fertility preservation services, including the procurement and cryopreservation of embryos, eggs, sperm, and reproductive material determined not to be an experimental infertility procedure. Storage shall be covered from the time of cryopreservation for the duration of the policy term. Storage offered for a longer period of time, as approved by the health carrier, shall be an optional benefit.	

STATE MANDATES			
REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
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; (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.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
BLOOD LEAD TESTING	RSA 415:18-aa	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 costs of blood lead testing conducted pursuant to RSA 130-A:5-a. Benefits provided under this section shall not be subject to any greater co-payment, deductible, or coinsurance than any other similar benefits provided by the insurer.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

FEDVIP DENTAL AND VISION			
REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
FEDVIP HIGH OPTION DENTAL BENEFITS	**45 CFR 156 Appendix B** **FEDVIP Plan Details** **Essential Health Benefit**	Class A (Basic) Services – preventive and diagnostic, includes fluoride treatment for children under age 5.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
		Class B (Intermediate) Services – includes minor restorative services	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
		Class C (Major) Services – includes major restorative, endodontic, and prosthodontic services	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
		Class D Services – orthodontic No waiting period permitted	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
FEDVIP HIGH OPTION VISION BENEFITS	**Essential Health Benefit**	**Routine Eye Exams** (including dilation, if professionally indicated)	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
		Standard Eyeglass Lenses (Contact lenses may be obtained in lieu of glasses) Optional Lens Treatments	**YES** ☐ **NO** ☐ **PAGE # OR IF NO:**
		Frames Collection Frames Non-Collection Frame	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
		Contact Lenses	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

SECTION 3 GENERAL REQUIREMENTS			
REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
DEFINITIONS	RSA 420-G:2 RSA 420-J:3	Comprehensive or major medical definitions. Managed care definitions.	**YES ☐ NO: ☐** **PAGE # OR IF NO:**
READABILITY and BOOKMARKING	RSA 420-H:5 NHCAR Part Ins 401.14 (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: ☐** **PAGE # OR IF NO:**

SECTION 3 GENERAL REQUIREMENTS			
REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
NON-ENGLISH VERSIONS	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) Contains 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 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.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

SECTION 3 GENERAL REQUIREMENTS			
REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
ADVERTISING	45 CFR 156.225(a) 45 CFR 156.225(b) NHCAR Part Ins 2600 Federal Health Insurance Marketplace Advertising Checklist	Advertising Guidelines Advertising must comply with **NHCAR Part 2600**. However, in order to clarify the requirements for filing advertisements with the Department, we are implementing the following procedure: • **For PY2020, Advertising materials for all plans submitted for certification must be filed with the Department in SERFF "prior to use".** • Neither marketing practices nor benefit designs may have the effect of discouraging the enrollment of individuals with significant health needs. • Advertising materials include webpages and social media posts. • Requested Filing Mode should be "Informational". The Department reserves the right to review all advertisements, whether submitted or not, in order to protect consumers in the event such advertising is determined to be misleading or inaccurate. In the event there is information presented that would lead a reasonable consumer to believe that a policy confers a greater benefit than stated in the approved policy or certificate, the carrier will be held accountable, as per Bulletin Ins 14-015-AB**.** As a reminder, insurance carriers are responsible for the advertisements utilized by their appointed producers. The NHID **advertising attestation** must be attached to the supporting documentation tab of the **Binder**, and does not need to be included in subsequent filings.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

SECTION 4 APPLICATIONS			
REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
APPLICATION	**NHCAR Part Ins. 401.12 (f)**	Federal Marketplace application must be attached to the supporting documentation tab for informational purposes. Non-marketplace applications must be attached to the forms schedule tab for review and approval.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
REPRESENTATIONS	**NHCAR Part Ins 401.12 (a)**	The declarative portion of the application, if any, shall imply a representation of facts to the best of 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.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
HOME OFFICE BOX	**RSA 415:11**	H.O. Box - No alteration of any written application for insurance, by erasure, insertion or otherwise, shall be made by any person other than the applicant without his written consent, and the making of any such alteration without the consent of the applicant shall be a misdemeanor.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

SECTION 5 POLICY FORM			
REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
COVER PAGE **COMPANY INFORMATION**	NHCAR Part Ins 401.04 (b)	(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:** ☐ **PAGE # OR IF NO:**
COMPANY STANDING		The Company is in "Good Standing" with the State of New Hampshire. A copy of a current New Hampshire license and NHID Certificate of Compliance is required.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
COVER PAGE **BRIEF DESCRIPTION**	NHCAR Part Ins 401.04 (c)	(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:** ☐ **PAGE # OR IF NO:**
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.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
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** ☐ **PAGE # OR IF NO:**
GENERAL PROVISIONS **DISABLED DEPENDENT**	RSA 415:5 I (3-a)(a)	The coverage of any family member insured by such policy, pursuant to subparagraph (3), who is mentally or physically incapable of earning his or her own living on the date as of which such dependent's status as a covered family member would otherwise expire because of age, shall continue under such policy while such policy remains in force or is replaced by another policy as long as such incapacity continues and as long as said dependent remains chiefly financially dependent on the policyholder or the employee or his or her estate is chargeable for the care of said dependent, provided that due proof of such incapacity is received by the insurer within 31 days of such expiration date.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

SECTION 5 POLICY FORM			
REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
GENERAL PROVISIONS DISABLED DEPENDENT – MICHELE'S LAW (IF COVERAGE IS PROVIDED FOR STUDENTS AGE 26 OR OLDER)	RSA 415:18 V (b) RSA 420-B:8-q RSA 420-J:6-d	If the coverage for dependent children under paragraph IV 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 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.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
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 to give such notice and that notice was given as soon as was reasonably possible.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
GENERAL PROVISIONS PROOF OF LOSS	RSA 415:18 I (i)	Written proof of such loss must be furnished to the insurer within 90 days after the date of such loss in the case of any other group accident and health insurance policy or certificate. 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:** ☐ **PAGE # OR IF NO:**
GENERAL PROVISIONS CLAIM FORMS	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:** ☐ **PAGE # OR IF NO:**
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:** ☐ **PAGE # OR IF NO:**

SECTION 5 POLICY FORM			
REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	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: ☐** **PAGE # OR IF NO:**
GENERAL PROVISIONS **GRACE PERIOD**	RSA 415:18 I (p) 45 CFR 156.270	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, unless the policyholder has given the insurer written notice of discontinuance in advance of the period for which payment is due, and in accordance with the terms of the policy. The policy may provide that the policyholder shall be liable to the insurer for the payment of a portion of the premium corresponding to the time within the grace period during which the policy was in force. Enrollees receiving advance payment of premium tax credits are allowed a 3-month grace period following nonpayment of premium, subject to the conditions of 45 CFR 156.270	**YES: ☐ NO: ☐** **PAGE # OR IF NO:**
GENERAL PROVISIONS **INCONTESTABILITY**	RSA 415:18 I (r) RSA 420-B:8-i	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 any person covered under the policy relating to insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of 2 years during such person's lifetime, nor unless it is contained in a written instrument signed by the person making such statement. No such provision, however, shall preclude the assertion, at any time, of defenses based upon the person's ineligibility for coverage under the policy or upon other provisions in the policy, except for any provisions establishing, as a requirement of eligibility, the furnishing of satisfactory evidence of insurability to the insurer. A 30 day advance notice is required.	**YES ☐ NO: ☐** **PAGE # OR IF NO:**
GENERAL PROVISIONS **MATERNITY COVERAGE**	**Essential Health Benefit**	Maternity coverage is required. Prenatal visits and screening, and postpartum care to include breastfeeding support, equipment, and counseling (including screening for post-partum depression) must be provided with no cost sharing.	**YES: ☐ NO: ☐** **PAGE # OR IF NO:**

SECTION 5 POLICY FORM			
REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
GENERAL PROVISIONS NETWORK BASED HOSPITAL SERVICES	Bulletin Ins 06-018-AB Bulletin Ins 16-009-AB RSA 420-J:8 RSA 420-B:12 RSA 329:31-b	Provider contract standards and prohibition on balance billing. RSA 329:31-b, I. When a commercially insured patient is covered by a managed care plan as defined under RSA 420-J:3, XXV, a health care provider performing anesthesiology, radiology, emergency medicine, or pathology services shall not balance bill the patient for fees or amounts other than copayments, deductibles, or coinsurance, if the service is performed in a hospital or ambulatory surgical center that is in-network under the patient's health insurance plan. This prohibition shall apply whether or not the health care provider is contracted with the patient's insurance carrier. II. Pursuant to paragraph I, fees for health care services submitted to an insurance carrier for payment shall be limited to a commercially reasonable value, based on payments for similar services from New Hampshire insurance carriers to New Hampshire health care providers. III. In the event of a dispute between a provider and an insurance carrier relative to the reasonable value of a service under this section, the insurance commissioner shall have exclusive jurisdiction under RSA 420-J:8-e to determine if the fee is commercially reasonable. The provider and the insurance carrier shall each make best efforts to resolve any dispute prior to applying to the insurance commissioner for resolution, which shall include presenting to the other party evidence supporting its contention that the fee level it is proposing is commercially reasonable. The department of insurance may require the parties to engage in mediation prior to rendering a decision.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
SUMMARY OF BENEFITS AND COVERAGE	CMS Guidance & Instructions Sample SBC	Summaries of Benefits and Coverage (SBCs) **must include a web address that links directly to a copy of the individual coverage policy or group certificate of coverage.** • All URL links included on the SBC must link **directly** to the referenced information, such as the specific formulary for that SBC benefit package. • QHP insurers are required to make SBCs available on their website **that accurately reflect each cost-sharing plan variation**, and must include a separate URL in the Plan & Benefits Template linking to the SBC created for each plan variation as part of the QHP data submission. • QHP SBCs must disclose whether or not the QHP pays for abortions for which federal funding is not available. CMS SBC instructions and templates can be found here. • CMS requires each plan variation to be published separately with no variation, so it is the issuer's responsibility to assure accuracy and consistency with the schedules of benefits. The URL in the Plan & Benefits Template must link to the unique SBC.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

SECTION 5 POLICY FORM			
REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
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** ☐ **PAGE # OR IF NO:**
GENERAL PROVISIONS **CONTRACEPTIVE COVERAGE**	Bulletin Ins 16-009-AB	PHS Act section 2713 and federal regulations require non-grandfathered group health plans and health insurance coverage offered in the individual or group market to provide benefits for and prohibit the imposition of cost-sharing requirements, with respect to women, for 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. As stated in Affordable Care Act Implementation FAQs - Set 12, intrauterine devices and implants contraceptive methods under the HRSA Guidelines, and are required to be covered without cost-sharing, if approved by the FDA and prescribed for a woman by her health care provider, subject to reasonable medical management. Additionally, the HRSA guidelines and federal regulations outline that issuers must cover at least one type of contraceptive in each classification of contraceptive, requiring specifically that at least one intrauterine device, and one implant contraceptive method be covered without the imposition of cost-sharing requirements. The NHID will only certify those plan offerings in compliance with the above stated federal requirements, including language in an issuers **Summary of Benefits and Coverage**(SBC) that states the following; *"Contraceptive methods approved by FDA and prescribed for a woman by her health care provider, subject to reasonable medical management, will be covered without cost sharing requirements."*	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
PREMIUMS **RENEWAL INCREASE**	NHCAR Part Ins 401.08 (b) (7) b RSA 420-G	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:** ☐ **PAGE # OR IF NO:**

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

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

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

_____ _____
(Original Signature of Officer*) (Title of Officer*)

_____ _____
(Printed Name of Officer*) (Date)

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