State of New Hampshire Insurance Department
SHORT TERM LIMITED DURATION INDIVIDUAL HEALTH FILINGS
REVIEW REQUIREMENTS CHECKLIST

LINE OF BUSINESS: INDIVIDUAL HEALTH **TOI CODES: H16I Sub TOI H16I.004**

INSTRUCTIONS FOR SERFF FILINGS CHECKLIST:

A. For ALL filings, the Submissions Requirements Checklist MUST be completed and attached to the supporting documentation tab.
B. For a FORM filing, the completion of additional sections below must be completed, depending on the forms submitted.
    a. Policy/Certificate
    b. Riders, endorsements or amendments
    c. Applications
    d. Advertising
    e. Annual Actuarial Certification
C. RATES are required to be filed in accordance with NHCAR Part Ins 401.13 (m) and NHCAR Part Ins 4100. Additional requirements may be necessary, depending on the Type of Insurance (TOI).

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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REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
SECTION 1 GENERAL REQUIREMENTS			
SCOPE	**RSA 415:5 III**	III. Nonrenewable, individual health insurance policies which provide medical, hospital, or major medical expense benefits for a specified term may be delivered or issued for delivery to any person in this state for purposes of providing short-term, interim coverage only and no such policy shall provide coverage for a specified term in excess of 6 months, nor shall any such policy be issued in this state to a person who was previously covered under short-term medical policies providing in total more than 540 days of coverage within the preceding 24-month period.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
ADVERTISING	**NHCAR Part Ins 2601**	Advertisement requirements for accident and health insurance, other than Medicare supplement.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
DEFINITIONS	**RSA 420-J:3**	General accident and health definitions. Managed care definitions	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
READABILITY	**RSA 420-H:5**	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.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

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SECTION 2 APPLICATIONS			
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:**
DISCLOSURES (FEDERAL)	https://www.gpo.gov/fdsys/pkg/FR-2018-02-21/pdf/2018-03208.pdf	(a) With respect to policies having a coverage start date before January 1, 2019, displays prominently in the contract and in any application materials provided in connection with enrollment in such coverage in at least 14 point type: "This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage. Also, this coverage is not "minimum essential coverage." If you don't have minimum essential coverage for any month in 2018, you may have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month."	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

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		(b) With respect to policies having a coverage start date on or after January 1, 2019, displays prominently in the contract and in any application materials provided in connection with enrollment in such coverage in at least 14 point type: "This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage."	
PRODUCER SIGNATURE	**RSA 402:82**	RSA 402:82 Claim Forms and Applications. – II. No insurance company or producer shall accept an application for workers' compensation, property or casualty insurance, or life, accident and health insurance unless the application includes: (a) A written or electronic signature of the producer, unless the transaction does not involve a producer; and (b) A written or electronic signature of the applicant. In the case of group life, accident, or health insurance, the certificate holder insured under the group health policy is not the applicant.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

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SECTION 3 POLICY/CERTIFICATE FORM			
COVER PAGE COMPANY INFORMATION	**NHCAR Part Ins 401.03**	(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:**
COVER PAGE BRIEF DESCRIPTION	**NHCAR Part Ins 401.04**	(c) Each policy and certificate shall provide a brief description of the nature of the policy, as follows: (1) The brief description shall be printed on: a. The face page, specifications page, or the back page, if the policy form has a full size cover page; or b. On the specifications page so that the description is visible, if the policy form has less than a full size cover page;	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
GENERAL PROVISIONS DEPENDENT	**RSA 415:5 I (3)(a)**	"Dependent child" shall include a subscriber's child by blood or by law, who is under age 26.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

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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. If such coverage is continued in accordance with this subparagraph, such dependent shall be entitled upon the termination of such incapacity to coverage offered by the New Hampshire high risk pool under RSA 404-G;	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
GENERAL PROVISIONS DISABLED DEPENDENT – MICHELE'S LAW (If coverage is provided for students age 26 or older)	RSA 415:5 I (3-(a)(b) RSA 420-J:6-d	If the coverage for dependent children under subparagraph (3) 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:**

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GENERAL PROVISIONS **NOTICE OF LOSS**	RSA 415:6 I (5)	A provision as follows: Notice of Claim: Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at _____ (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer. (In a policy providing a loss-of-time benefit which may be payable for at least 2 years, an insurer may at its option insert the following between the first and second sentences of the above provision: Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least 2 years, he shall, at least once in every 6 months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of 6 months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of 6 months preceding the date on which such notice is actually given.)	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
GENERAL PROVISIONS **PROOF OF LOSS**	RSA 415:6 I (7)	A provision as follows: Proofs of Loss: Written proof of loss must be furnished to the insurer at its office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within one year after the date of such loss in the case of a Medicare supplement insurance policy and within 90 days after the date of such loss in the case of any other accident and health insurance policy. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

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GENERAL PROVISIONS CLAIM FORMS	RSA 415:6 I (6)	A provision as follows: Claim Forms: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.	YES: ☐ NO: ☐ PAGE # OR IF NO:
GENERAL PROVISIONS PHYSICAL EXAMINATION OR AUTOPSY	RSA 415:6 I (10)	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:
GENERAL PROVISIONS LEGAL ACTION	RSA 415:6 I (11)	A provision as follows: Legal Actions: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.	YES: ☐ NO: ☐ PAGE # OR IF NO:
GENERAL PROVISIONS GRACE PERIOD	RSA 415:6 I (3)	A provision that the policyholder is entitled to a grace period of 31 days for the payment of any premium due except the first, during which grace period the coverage shall continue in force	YES: ☐ NO: ☐ PAGE # OR IF NO:
GENERAL PROVISIONS CONTESTABILITY	RSA 415:6 I (2)	A provision as follows: Time Limit on Certain Defenses: (a) After 2 years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such 2-year period.	YES: ☐ NO: ☐ PAGE # OR IF NO:
GENERAL PROVISIONS MATERNITY COVERAGE	RSA 415:6-d	A provision that a maternity benefits rider will be made available at the insured's request, if maternity care is not covered under the policy.	YES: ☐ NO: ☐ PAGE # OR IF NO:

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GENERAL PROVISIONS EQUITABLY ENTITLED	RSA 415:6 I (9)	If any indemnity of this policy or certificate shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $ (insert an amount which shall not exceed $1,000), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
GENERAL PROVISIONS PAYMENT OF CLAIMS	RSA 415:6-h	I. (a) Each insurer that issues or renews any individual policy of 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:**

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GENERAL PROVISIONS - REINSTATEMENT	RSA 415:6 I (4)	(4) A provision as follows: Reinstatement: If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained on or after the date of reinstatement and loss due to such sickness as may begin on or after the date of reinstatement. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
GENERAL PROVISIONS INSURANCE WITH THIS INSURER	RSA 415:6 II (3)	A provision as follows: Other Insurance in This Insurer: If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured be in force concurrently herewith, making the aggregate indemnity for ___(insert type of coverage or coverages) in excess of $ ___ (insert maximum limit of indemnity or indemnities) the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to his estate. or, in lieu thereof: Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to the one such policy elected by the insured, his beneficiary or his estate, as the case may be, and the insurer will return all premiums paid for all other such policies.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

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GENERAL PROVISIONS INSURANCE WITH OTHER INSURERS	RSA 415:6 II (4)	A provision in all nongroup policies as follows: Insurance with Other Insurers: If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or an expense incurred basis, payment shall not be prorated or reduced. If such a case, the insured shall be entitled to payment from both insurers.	YES: ☐ NO: ☐ PAGE # OR IF NO:
PRESCRIPTION DRUG CARDS	RSA 415:6-k RSA 420-J:7-b	I. Each insurer that issues or renews any individual policy of 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 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:

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NATUROPATHY PROVIDERS; PAYMENT FOR EQUIVALENT TYPES OF SERVICE	RSA 415:6-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 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:**
NEWBORN CHILDREN	RSA 415:22 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. Coverage for the newborn will be considered coverage under the insured without additional cost sharing requirements to the newborn until such time the newborn is enrolled as a dependent child for which premium, if required, is payable.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

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ADOPTED CHILDREN	RSA 415:22-a	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:**
RECONSTRUCTIVE SURGERY	RSA 417-D:2-b	Every insurer subject to this chapter that provides individual or group coverage for mastectomy surgery shall provide coverage for reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the patient elects reconstruction and in the manner chosen by the patient and the physician.	**YES:** ☐ **NO:** ☐ **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 shall receive medical services from a health care provider without in-person contact with the provider. II. An insurer offering a health plan in this state may not deny coverage on the sole basis that the coverage is provided through telemedicine if the health care service would be covered if it were provided through in-person consultation between the covered person and a health care provider. III. Nothing in this section shall be 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:**

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PRE-EXISTING CONDITIONS	RSA 415-A:5	I. If an insurer or a nonprofit hospital or medical service association elects to use a simplified application form for a policy other than a Medicare supplement policy, with or without a question as to the applicant's health at the time of application, but without any questions concerning the insured's health history or medical treatment history, the policy, 9 months after the date of enrollment, must cover any loss occurring from any preexisting condition not specifically excluded from coverage by terms of the policy and, except as so provided, the policy shall not include wording that would permit a defense based upon preexisting conditions.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
PRESCRIPTION EXCEPTION PROCESS	RSA 420-J:7-b II	Every health benefit plan that provides prescription drug benefits shall maintain an expeditious exception process, not to exceed 48 hours, by which covered persons may obtain coverage for a medically necessary non-formulary prescription drug. The exception process shall begin when the prescribing provider has provided the health benefit plan with the clinical rationale for the exception.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
PATIENTS' BILL OF RIGHTS	RSA 415:6-f RSA 151:21	Any insurer issuing policies of individual insurance shall provide to each new certificate holder who is a resident of this state a copy of the patients' bill of rights law under RSA 151:21.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

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SECTION 4 MANDATED COVERAGE			
90-DAY SUPPLY OF COVERED PRESCRIPTION DRUGS	**RSA 420-J:7-b VIII** **RSA 415:6-aa**	An insurer issuing or renewing accident and health insurance policies shall allow its insureds to purchase an up-to-90-day supply of covered prescription drugs on the covered person's health plan formulary at one time, 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.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
COVERAGE OF CERTAIN PSYCHIATRIC AND PSYCHOLOGICAL SERVICES	**RSA 415:6-b** **RSA 420-J:6-c**	No accident or health insurance policy issued, renewed or continued on or after January 1, 1993, shall contain any provision denying insurance benefits for psychiatric or psychological services, including psychological examinations, solely because they are rendered to an insured or a dependent in compliance with the lawful order of any court of this state. Benefits for such services shall be at least as favorable as for other psychiatric or psychological services, including psychological examinations, and shall be subject to the same dollar limits, deductibles, co-payments and co-insurance factors and to terms and conditions of the policy or certificate, including any managed care provisions.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

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COVERAGE FOR NONPRESCRIPTION ENTERAL FORMULAS	RSA 415:6-c	I. Each insurer that issues or renews any individual policy 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 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. Such coverage shall be provided when the prescribing physician has issued a written order stating that the enteral formula is needed to sustain life, is medically necessary, and is the least restrictive and most cost effective means for meeting the needs of the patient. II. Each insurer that issues or renews any individual policy 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 provision of nonprescription enteral formulas and food products required for persons with inherited diseases of amino acids and organic acids. Such coverage shall be provided when the prescribing physician has issued a written order stating that the enteral formula or food product is medically necessary and is the least restrictive and most cost effective means for meeting the needs of the patient. Coverage for inherited diseases of amino acids and organic acids shall, in addition to the enteral formula, include food products modified to be low protein in an amount not to exceed $1,800 annually for any insured individual. III. The benefits included in this section shall not be subject to any greater deductible than any other benefits provided by the insurer. The coinsurance required by the enrolled participant shall not exceed the amount allowed under the contract for the reasonable and customary charge for the service provided.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

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COVERAGE FOR DIABETES SERVICES AND SUPPLIES.	**RSA 415:6-e**	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.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

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OFF-LABEL PRESCRIPTION DRUGS	RSA 415:6-g	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: (a) 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; or (b) As a condition of coverage, impose use of an alternative drug not approved by the FDA for the indication being treated, unless such alternative drug is recognized for treatment of such indication in one of the standard reference compendia or in the medical literature. An override of such condition of coverage shall be expeditiously granted consistent with RSA 420-J:7-b, II whenever the prescriber can demonstrate that the alternative drug: (1) Has been ineffective in the treatment of the insured's medical condition in the past; (2) Is expected to be ineffective based on the known relevant physical or mental characteristics of the insured and the known characteristics of the drug regimen; (3) Will cause or will likely cause an adverse reaction or other physical harm to the insured; or (4) Is not in the insured's best interest, based on medical necessity consistent with RSA 420-J:7-b, II. 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:**

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COVERAGE FOR CERTAIN PROSTHETIC DEVICES	RSA 415:6-j	I. Each insurer that issues or renews any individual policy 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 provision of 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:**
COVERAGE FOR CERTIFIED MIDWIVES	RSA 415:6-l	Each insurer that issues or renews any individual policy, plan, or contract of accident or health insurance providing maternity benefits, shall also provide to 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:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
COVERAGE FOR THE COST OF TESTING FOR BONE MARROW DONATION	**RSA 415:6-m**	I. 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:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
COVERAGE FOR CHILDREN'S EARLY INTERVENTION THERAPY SERVICES	RSA 415:6-n	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 specified in rules adopted pursuant to RSA 171-A:18, IV as long as the providing therapist receives a referral from the child's primary care physician if applicable. The benefits included in this section may be subject to deductibles, copayments, coinsurance, or other terms and conditions of the policy, and may have a cap of $3,200 per child per year not to exceed $9,600 by the child's third birthday. 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:**
COVERAGE FOR OBESITY AND MORBID OBESITY	RSA 415:6-o	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:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
COVERAGE FOR HEARING AIDS AND RELATED SERVICES	**RSA 415:6-p**	Each insurer that issues or renews any individual policy or certificate for delivery in this state, or contract of accident or health insurance providing benefits for medical or hospital expenses, shall provide coverage for the professional services associated with the practice of fitting, dispensing, servicing, or sale of hearing instruments or hearing aids. The benefits included in this section shall not be subject to any greater deductible or coinsurance or copay than any other benefits provided by the insurer. Insurers are required to cover the cost of a hearing aid for each ear, as needed, as well as related services necessary to assess, select, and fit the hearing aid with a maximum for the hearing aid and related services of no less than $1,500 per hearing aid every 60 months. The insured may choose a higher price hearing aid and pay the difference in cost. The hearing aid shall be prescribed and dispensed by a licensed audiologist or hearing instrument specialist. Notwithstanding any provision of law or rule to the contrary, the coverage under this section shall not apply to the medical assistance program, pursuant to RSA 161 and RSA 167	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
ORAL ANTI-CANCER THERAPIES	RSA 415:6-t	I. No insurer that issues or renews any individual policy, plan, or contract of accident or health insurance providing benefits for anti-cancer medications that are injected or intravenously administered by a health care provider and patient administered anti-cancer medications, including but not limited to those orally administered or self-injected, shall require a higher copayment, deductible, or coinsurance amount for patient administered anti-cancer medication than it requires for injected or intravenously administered anti-cancer medications, regardless of the formulation or benefit category determination by the policy or plan. II. An insurer shall not comply with paragraph I by: (a) Increasing the copayment, deductible, or coinsurance amount required for injected or intravenously administered anti-cancer medication that are covered under the policy or plan. (b) Reclassifying benefits with respect to anti-cancer medications. III. In this section, "anti-cancer medication" means drugs and biologics that are used to kill, slow, or prevent the growth of cancerous cells. IV. If the cost-sharing requirements for orally administered anti-cancer medications do not exceed $200 per prescription fill, the health plan shall be deemed in compliance with this section. VI. This section shall apply only to oral anti-cancer medications where an intravenously administered or injected anti-cancer medication is not medically appropriate.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
COVERAGE FOR EARLY REFILLS OF PRESCRIPTION EYE DROPS	RSA 415:6-u	I. 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 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**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
COVERAGE FOR BLOOD LEAD TESTING	**RSA 415:6-v**	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 persons covered by 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**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
COVERAGE FOR PRESCRIPTION CONTRACEPTIVE DRUGS AND PRESCRIPTION CONTRACEPTIVE DEVICES AND FOR CONTRACEPTIVE SERVICES.	**RSA 415:6-w**	Each insurer that issues or renews any individual policy 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 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 individual policy of accident or health insurance providing benefits for medical or hospital expenses shall cover all prescription contraceptive drugs and contraceptive devices approved by the U.S. Food and Drug Administration. Coverage for contraceptive services shall be 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.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
PRICE OF FILLING PRESCRIPTIONS	**RSA 415:26**	I. A pharmacy benefits manager or insurer shall require a contracted pharmacy to charge an enrollee or insured person the pharmacy's usual and customary price of filling the prescription or the contracted copayment, whichever is less.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO**
OBSTETRECAL-GYNECOLOGICAL COVERAGE	**RSA 420-J:6-a**	I. Health plans shall not require prior authorization by a covered person's primary care provider for coverage of the following services provided by participating providers who specialize in obstetrics and gynecology: (a) Maternity care; (b) An annual gynecological visit; and (c) Follow-up care for obstetrical or gynecological conditions identified during such maternity care or annual gynecological visit. II. Health plans may establish reasonable requirements for participating obstetricians and gynecologists to communicate with the covered person's primary care provider regarding the covered person's condition, treatment, and any need for follow-up care.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
SELF-REFERRALS FOR CHIROPRACTIC CARE	**RSA 420-J:6-b**	A health benefit plan under this chapter offering chiropractic benefits shall provide benefits to a covered person who utilizes services of a chiropractic provider (doctor of chiropractic) by self-referral for 12 visits under the following conditions: I. Unless otherwise provided for by the health benefits plan, self-referral visits shall not apply to wellness care visits. II. A covered person may utilize the services of a doctor of chiropractic as defined in RSA 316-A, without discrimination relative to access and fees, subject to the terms and conditions of the policy. III. The health benefit plan shall fully disclose to the certificate holder in clear and understandable language the exact terms and conditions of each option that the certificate holder has purchased along with the co-payments or other cost-sharing features of each option. IV. Within 10 working days of the first visit or consultation, the doctor of chiropractic shall send to the health benefit plan, or its designee, the chiropractic case findings. This shall be sufficient documentation for the initial 12 visits. V. After 12 self-referral visits, a covered person who is continuing chiropractic care may be subject to utilization review from the health plan, or its designee, for the purpose of continued care. A provider of the same specialty shall be consulted when making any utilization review determination under this section. VI. If the chiropractic provider recommends care beyond 12 visits, the participating doctor of chiropractic shall send to the insurer, or its designee, documentation containing information on the covered person's progress and necessity of care as well as a care plan for extended chiropractic care. The care recommendation shall be deemed authorized if the health benefit plan does not respond to the care recommendation within 7 business days. If the doctor of chiropractic fails to provide the required documentation, the insured or its covered person shall not be liable to the chiropractic provider for any unpaid fees.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
NETWORK ADEQUACY	**RSA 420-J:7** **NHCAR Part Ins 2701** **Network Adequacy Files** **Public FTP Site** **NHID Provider File Template** **NHID Resource File**	Managed care plans as defined in RSA 420-J:3 XXV shall comply with network adequacy standards. The NH Network Provider Template shall accompany the Form/Rate filing. If a network is leased, the name of the network and proof of compliance will be required at the time of the filing.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
MEDICATION SYNCHRONIZATION	RSA 415:27 RSA 420-J:19	I. An individual or group health insurance plan or policy providing prescription drug coverage in New Hampshire, shall permit and apply a prorated, daily cost-sharing rate to covered prescriptions for a chronic condition that are dispensed by an in network pharmacy for less than a 30-day supply if the prescriber and pharmacist determine the fill or refill to be in the best interest of the patient for the management or treatment of a chronic, long-term care condition and the patient requests or agrees to less than a 30-day supply for the purpose of synchronizing the patient's medications. For the purposes of this paragraph, the insured's or enrollee's maintenance prescription drugs to be synchronized shall meet all of the following requirements: (a) They are covered by the policy, certificate, or contract described in this chapter. (b) They are used for the management and treatment of a chronic, long-term care condition and have authorized refills that remain available to the insured or enrollee. (c) Except as otherwise provided in this paragraph, they are not a controlled substance included in schedules II-V. (d) They meet all utilization management requirements specific to the maintenance-prescription drugs at the time of the request to synchronize the insured's or enrollee's multiple, maintenance-prescription drugs. (e) They are of a formulation that can be effectively split over required short-fill periods to achieve synchronization. (f) They do not have quantity limits or dose-optimization criteria or requirements that will be violated when synchronizing the insured's or enrollee's multiple, maintenance-prescription drugs. II. The plan or policy described in paragraph I shall apply a prorated, daily cost-sharing rate for maintenance-prescription drugs that are dispensed by an in-network pharmacy for the purpose of synchronizing the insured's or enrollee's multiple, maintenance-prescription drugs. III. The plan or policy described in paragraph I shall not reimburse or pay any dispensing fee that is prorated. The insurer shall only pay or reimburse a dispensing fee that is based on each maintenance-prescription drug dispensed. IV. A synchronization shall only occur once per year per maintenance prescription drug.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
MANAGED CARE STANDARDS	RSA 420-J	As applicable, including coverage for Mental Health and Substance Abuse Disorders	**YES:** ☐ **NO:** ☐ **Page # or If NO**
WOMEN'S HEALTH	RSA 417-D	Mammography, including 3-D mammography; Pregnancy, Delivery and Postpartum coverage; and Reconstructive breast surgery "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**
APPEALS AND GRIEVANCES MANAGED CARE RIGHTS TO EXTERNAL REVIEW	RSA 420-J:5, 5-a, 5-b, 5-c, 5-e NHCAR Part Ins 2703 Consumer Guide Application for Independent External Review	Grievance procedures and external review rights and procedures are specified. External review notice requirements Consumer Guide to External Review and Application Form for Independent External Review.	**YES:** ☐ **NO:** ☐ **Page # or If NO:**

State of New Hampshire Insurance Department
SHORT TERM LIMITED DURATION INDIVIDUAL HEALTH FILINGS
REVIEW REQUIREMENTS CHECKLIST

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
SECTION 5 RATES			
RATES	**NHCAR Part Ins 4100**	REQUIREMENTS FOR ACCIDENT AND HEALTH INSURANCE RATE SUBMISSIONS	**YES:** ☐ **NO:** ☐ **Page # or If NO:**
RATES	**NHCAR Part Ins 401.13 (m)**	Policies, certificates and rates shall be submitted together to the department.	**YES: NO:** **Page # or If NO:**

NEW HAMPSHIRE INSURANCE DEPARTMENT NOTES:
Statute Link (RSA 415, RSA 417-D, RSA 420-J) Index
Regulation Link (NHCAR PART INS 400, Ins 4100) Index