Adopt Ins 6205 to read as follows:

PART Ins 6205 ANCILLARY HEALTH MINIMUM STANDARDS FOR BENEFITS FOR DISABILITY INCOME PROTECTION COVERAGE

Statutory Authority: RSA 400-A:15, I; RSA 415-A:2 and 3; 29 CFR 2560.503

Ins 6205.01 Applicability and Scope. Ins 6205 shall apply to all individual and group ancillary health policies and certificates that provide coverage for disability income protection which are not covered under other rules and are delivered or issued for delivery in this state on and after the initial effective date of this part.

Ins 6205.02 Definitions.

(a) "Activities of daily living (ADL)" means activities related to personal care, such as bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, continence, and eating.

(b) "Adverse benefit determination" means a denial, reduction, termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including any such denial, reduction, termination of, or failure to provide or make payment that is based on a determination of a participant's or claimant's eligibility to participate in a plan and including a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

(c) "Bathing" means washing oneself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower.

(d) "Beneficiary" means the person or persons designated as such in the application.

(e) "Benefit period" means the length of time for which a disabled insured receives periodic income benefit amounts under the policy.

(f) "Catastrophic disability benefit" means a supplemental benefit in addition to any other disability benefit amounts. The benefit shall be triggered by an inability of the insured to perform, due to injury or sickness, a maximum of 2 ADLs. The benefit shall also be triggered by the cognitive impairment of the insured.

(g) "Cognitive impairment" means a deficiency in the insured's short or long-term memory, orientation as to person, place, and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

(h) "Concurrent disability" means one continuous period of disability that is caused or is continued by more than one injury or sickness.

(i) "Conditionally renewable" means that renewal of the policy is based on certain conditions.

(j) "Contagious disease(s)" means a condition that the Division of Communicable Disease Control of the Centers for Disease Control and Prevention works to promptly identify, prevent, and control. This includes infectious diseases that pose a threat to public health, including emerging and reemerging infectious diseases, vaccine preventable agents, bacterial toxins, bioterrorism, and pandemics.

(k) "Continence" means the ability to maintain control of bowel and bladder function or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for catheter or colostomy bag.

(l) "Cost of living index" means an index used to measure the rate of change over time of the cost of living, such as the Consumer Price Index for Urban Wage Earners and Clerical Workers published by the United States Department of Labor.

(m) "Death benefits" means the benefit to be paid due to the death of the insured resulting from an injury or sickness.

(n) "Disability" means that due to injury or sickness, the insured meets the definition of partial disability, residual disability, or total disability, or the insured meets other disability benefit triggers specified in the policy or certificate.

(o) "Disability income protection coverage" means a policy or certificate that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury.

(p) "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.

(q) "Earnings" means the amount of income received by an insured.

(r) "Eating" means feeding oneself by getting food into the body from a receptacle, such as a plate, cup, table, or by a feeding tube or intravenously.

(s) "Elimination period" means the length of time an insured shall wait from the commencement of disability for the insured as defined in the policy before periodic income benefit amounts are paid under the policy.

(t) "Hands-on assistance" means physical assistance without which an insured or spouse, as applicable, would not be able to perform an ADL.

(u) "Integration" means income from other sources, as permitted under these rules, that is factored into the calculation of income to determine the amount of disability benefits paid under the policy or certificate. Integration does not mean coordination of benefits.

(v) "Occupation" means a position or professional calling for which a person receives or is eligible to receive remuneration.

(w) "Partial disability" means that due to an injury or sickness, the insured is unable to perform one or more, but not all, of the substantial and material duties of an occupation for which he or she is qualified by reason of education, training, or experience or the inability to perform all of the substantial and material duties of an occupation for which he or she is qualified by reason of education, training, or experience for as long as usually required. The term shall also include residual disability.

(x) "Presumptive disability" means total and permanent loss of any one of the following 6 body functions which shall be sufficient to trigger any benefits based upon presumptive disability:

(1) Speech;

(2) Hearing in both ears;

(3) Sight in both eyes;

(4) Use of both arms;

(5) Use of both legs; or

(6) Use of one arm and one leg.

(y) "Pre-disability earnings" means the measurement of earnings of an insured just before disability began in order to provide an accurate and fair measure of earnings of an insured just before disability began.

(z) "Recurrent disability" means a disability that occurs within a specified period of time immediately following a prior period of disability and which is due to the same or related cause applicable to the prior period of disability.

(aa) "Rehabilitation" means a program of receiving services that is geared toward aiding an insured to better perform his or her occupation or any occupation for which he or she is qualified by reason of education, training, or experience.

(ab) "Relevant to a claimant's claim" means, when used in reference to a document, record, or other information, that the document, record, or other information:

(1) Was relied upon in making the benefit determination;

(2) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;

(3) Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination; or

(4) Constitutes a statement of policy or guidance with respect to the carrier's policy concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

(ac) "Substantial and material duties" means the important tasks, functions, and operations generally required for an occupation that cannot be reasonably omitted or modified. This term shall be permitted to include an insured's ability to work on a regular work schedule for a specified number of hours.

(ad) "Substantial assistance" means assistance or stand-by help required to perform ADLs.

(ae) "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

(af) "Total disability":

(1) A general definition of total disability shall not be more restrictive than one requiring that the individual who is totally disabled not be engaged in any employment or occupation for which he or she is or becomes qualified by reason of education, training, or experience, and is not in fact engaged in any employment or occupation for wage or profit;

(2) Total disability shall be permitted to be defined in relation to the inability of the person to perform duties but shall not be based solely upon an individual's inability to:

a. Perform "any occupation whatsoever", "any occupational duty", "any and every duty of his or her occupation", or other phrases of similar import;

b. Engage in a training or rehabilitation program; or

c. Perform activities of daily living (ADLs);

(3) An insurer shall be permitted to require the complete inability of the person to perform all of the substantial and material duties of his or her regular occupation or words of similar import; and

(4) An insurer shall be permitted to require care by a physician other than the insured or a member of the insured's immediate family.

(ag) "Transferring" means moving into or out of a bed, chair, or wheelchair.

Ins 6205.03 Minimum Standards for Benefits for All Disability Income Policies.

(a) A disability income policy shall provide a benefit for at least total disability. Disability income policies providing benefits only for partial, residual, catastrophic, or any disabilities less than total disability shall not be permitted. At the company's option, a disability income policy shall be permitted to provide coverage for disabilities in addition to a required benefit for total disability.

(b) The benefits for total or partial disability income policies shall be permitted to be triggered by any of the following:

(1) The insured is terminally ill with a life expectancy of 12 months or less, as certified by a physician;

(2) The insured is unable to perform a specified number of ADLs. The insurance company shall not require the inability to perform more than two ADLs to trigger benefits;

(3) The insured is cognitively impaired, suffering significant and irreversible deterioration or loss of intellectual capacity, as measured by clinical evidence and standardized tests commonly accepted for use in the medical community;

(4) The insured is confined as an inpatient in a skilled nursing home or rehabilitation facility where a daily room and board charge is made;

(5) The insured is receiving home health care or hospice care; or

(6) The insured is a risk for transmitting a contagious disease, and the ability to perform the substantial and material duties of the insured's occupation is restricted by a state licensing board or by another appropriate government authority because of the risk of transmission of a contagious disease to others with whom the insured may be in contact.

(c) For a contagious disease trigger, if all contagious diseases are not covered in a disability income policy, the policy shall specify which contagious diseases are covered.

(d) The trigger for the start of any elimination period shall be the commencement of disability for the insured as defined in the policy.

(e) A policy that is guaranteed renewable or conditionally renewable shall describe the conditions for renewability in the policy. For conditionally renewable policies, a company shall be permitted to decline to renew on the basis of class, geographic area, or for stated reasons other than the deterioration of the insured's health.

(f) All policies shall contain a provision on earnings which identifies the various income sources or components that are considered earnings and those that are not. The provision on earnings shall exclude benefits such as formal sick pay plans, individual and group disability income insurance plans, and retirement plans.

(g) In the calculation of pre-disability earnings:

(1) Earnings just before disability began shall be permitted to be considered on a periodic basis so long as the periodic basis is consistent with the treatment of other terms referring to an insured's earnings used in the policy and used to arrive at certain disability policy benefit payment amounts for a claim;

(2) For earnings of an insured which occurred in excess of one year but no more than 5 years just prior to the disability for which the claim is made, the provision shall include policy language which allows for use of the highest level of earnings during a calendar year or consecutive 12-month basis of an insured occurring during the period in excess of one year but no more than 5 years just prior to the disability for which claim is made; and

(3) The company shall not consider earnings of an insured which occurred in excess of 5 years just prior to the disability for which claim is made in determining prior earnings.

(h) A policy shall be permitted to exclude coverage due to sickness, treatment, or medical condition arising out of incarceration.

(i) A policy shall be permitted to exclude disability that results from normal pregnancy or childbirth. Such limitation or exclusion shall not apply to complications of pregnancy as diagnosed by a physician.

(j) A policy shall be permitted to contain a "return of premium" or "cash value benefit" so long as the return of premium or cash value benefit is not reduced by an amount greater than the aggregate of claims paid under the policy and the insurer demonstrates that the reserve basis for the policies is adequate.

(k) A policy shall be permitted to contain a provision relating to recurrent disabilities, but a provision relating to recurrent disabilities shall not specify that a recurrent disability be separated by a period greater than 6 months, for a policy with a benefit period of 5 years or less, or up to one year, for a policy with a benefit period greater than 5 years.

(l) If a policy provides for catastrophic disability:

(1) Benefits shall:

a. Pay a monthly periodic income benefit amount in addition to any other disability benefit amounts, and:

1. The minimum benefit shall be one year of monthly periodic income and shall exclude any time devoted to satisfaction of elimination periods; or

2. Instead of a monthly periodic benefit, a single lump sum benefit of no less than $1,000 shall be permitted;

b. Only be directly related to income losses of the insured on account of catastrophic disability due to injury or sickness; and

c. Not directly or indirectly provide any coverage for long-term care services and shall contain a prominent disclosure of this fact;

(2) Elimination periods for catastrophic disability coverage shall not be longer than one year if the insured meets the benefit triggers for 2 or more types of disability, one of which is catastrophic disability; and

(3) Required benefit triggers include:

a. Inability of the insured to perform, due to injury or sickness, a maximum of 2 ADLs; or

b. The cognitive impairment of the insured; and

(4) Other triggers shall be permitted, such as the loss of 2 arms or 2 legs, as long as they are described in the policy.

(m) If a policy provides for concurrent disability, benefits shall be paid as if the concurrent disability was caused by one injury or one sickness. In no event shall an insured be considered to have more than one continuous period of disability at the same time.

(n) If a policy provides for partial disability:

(1) The benefit trigger shall be permitted to be described in terms of a reasonable reduction in the insured's time worked expressed as hours per week or otherwise due to disability as follows:

a. In order to trigger benefits, an insured shall be working at least 20 percent but no more than 80 percent of the time worked just before a disability began;

b. The benefit shall be permitted to be stated in terms of paying a stated percentage of the total disability periodic income benefit amount, and the stated percentage of the total disability periodic income benefit amount shall be no less than 20 percent and no greater than 80 percent;

c. An insured working greater than 80 percent of time worked just before a disability began shall be permitted to be deemed ineligible for partial disability benefits; or

d. An insured working less than 20 percent of time worked just before a disability began or earning less than 20 percent of prior earnings shall be considered working 0 percent or a 100 percent reduction in average prior earnings for the claim time period, subject to satisfaction of all policy terms and conditions by the insured; or

(2) Alternatively, the benefit trigger shall be permitted to be described in terms of a reasonable reduction in the insured's earnings due to disability as follows:

a. An insured shall be earning at least 20 percent but no more than 80 percent of prior earnings, and:

1. The benefit shall be permitted to be stated in terms of paying a stated percentage of the total disability periodic income benefit amounts, and the stated percentage of the total disability periodic income benefit amount shall be no less than 20 percent and no greater than 80 percent;

2. If the reduction in earnings of an insured for a claim time period equals or exceeds 80 percent of average prior earnings, calculated for a comparable time period, then the insured's reduction of average prior earnings shall be considered a

100 percent reduction in average prior earnings for the claim time period subject to satisfaction of all policy terms and conditions by the insured; or

3. If the reduction in earnings of an insured for a claim time period is less than 20 percent of average prior earnings, calculated for a comparable time period, it shall be permitted to result in no benefits being paid; or

b. The reduction in earnings of an insured shall be measured by comparing earnings for a claim time period to average prior earnings, calculated for a comparable time period, and:

1. The percentage of the total disability periodic income benefit amounts paid shall be calculated by subtracting current earnings for a claim time period from average prior earnings, calculated for a comparable period of time, and placing this difference as the numerator over average prior earnings, calculated for a comparable time period, as the denominator. This fraction shall be converted to a percentage, and the percentage multiplied by the total disability periodic income benefit amounts to arrive at the partial or residual disability benefit paid for a claim time period; or

2. Alternatively, this shall be permitted to be expressed as a formula, such as the difference between prior earnings and current earnings divided by prior earnings, multiplied by the total disability periodic income benefit amounts; and

(3) Partial or residual disability benefits shall be permitted to be predicated upon a qualification period during which the insured shall be totally disabled before partial or residual disability benefits are paid, and:

a. The qualification period shall be permitted to be in lieu of the elimination period or in addition to the elimination period, but the combined elimination period and qualification period, if any, for partial or residual disability benefits shall not exceed that for total disability; and

b. An insurer shall be permitted to require care by a physician other than the insured or a member of the insured's immediate family.

(o) If a policy provides for both total disability benefits and partial disability benefits, only one elimination period shall be required.

(p) If a policy provides for presumptive disability:

(1) Benefits shall consist of any one of the following:

a. Payment of additional monthly periodic income benefits or lump sum benefit amounts related to income losses of the insured, always additional to other disability benefits paid under the policy, subject to satisfaction of all policy terms and conditions by the insured;

b. Waiver of any elimination period under the policy;

c. Waiver of any requirement of care by a physician under the policy;

d. Waiver of any time periods to access waiver of premium benefits under the policy; or

e. Waiver of usual benefit triggers to access benefits for total disability, partial disability, or residual disability under the policy; and

(2) A policy shall be permitted to provide more than one of the 5 benefits listed in (1) above based upon the presumptive disability of the insured, so long as the other benefits:

a. Are in addition to all other disability benefits of the policy;

b. Do not replace other disability benefits of the policy; and

c. Are always more favorable to an insured than just providing other disability benefits under the policy.

(q) If a policy provides benefits for which a beneficiary may be designated, the policy shall contain a beneficiary provision. The provision shall state that, unless the owner designates an irrevocable beneficiary, the right to change the beneficiary is reserved to the owner, and the consent of the beneficiary shall not be required to:

(1) Terminate or assign the policy;

(2) Change the beneficiary; or

(3) Make any other changes in the policy.

(r) If a cost of living index is included in a policy, the index shall be specified, and the company shall notify the insured in advance of any changes, such as discontinuance, substantial changes to the index, or a substitute index. If the index is temporarily delayed, the company shall be permitted to compute the value of any benefits due during the period the index is unavailable using any method that takes into consideration the most recently available information with respect to the index. Once the index becomes available, the company shall adjust any future benefits payable to reflect any benefit overpayments or underpayments made while the index was unavailable.

(s) In all circumstances in which an insurer does not request information about an applicant's health history or medical treatment in the application process, the policy shall cover the loss consistent with RSA 415-A:5(I). A disability income protection policy or certificate shall be permitted to exclude coverage for a loss due to a preexisting condition for a period up to 24 months following the issuance of the policy or certificate, where the policy or certificate is issued on a guaranteed issue basis.

(t) Termination of the policy or certificate shall be without prejudice to a continuous loss that commenced while the policy or certificate was in force, pursuant to Ins 6101. The continuous total disability of the insured shall be a condition for the extension of benefits beyond the period the policy was in force, limited to the earlier of either the duration of the benefit period, if any, or payment of the maximum benefits.

Ins 6205.04 Additional Minimum Standards for Benefits for Individual Policies.

(a) In individual policies issued with benefit periods of less than 6 months, the application of an elimination period alone or in conjunction with a qualification period shall not result in the postponement of payment of periodic income benefit amounts to a disabled insured in excess of 45 days from the commencement of a disability.

(b) In individual policies issued with benefit periods of 6 months to one year, the application of an elimination period alone or in conjunction with a qualification period shall not result in the postponement of payment of periodic income benefit amounts to a disabled insured in excess of 90 days from the commencement of a disability.

(c) Individual policies shall provide for at least 3 consecutive months of periodic income benefits.

(d) Individual policies shall include a relation of earnings to insurance provision that complies with RSA 415:6, II(6).

(e) Individual policies shall be permitted to include a provision regarding the integration of its benefits with social insurance benefits including Federal Social Security or any similar federal, state, or local government law, workers' compensation, occupational disease laws, and state disability benefit plans, subject to the following:

(1) If the policy includes such integration, the policy shall describe which other social insurance benefits shall be subject to the integration and how the integration shall be administered;

(2) The policy shall state that a minimum disability benefit shall be paid under the policy, regardless of the benefits received from social insurance benefits, and the minimum monthly amount shall not be less than required under RSA 415:6, II(6); and

(3) The policy shall not offset, or in any other manner reduce, any benefit under the policy by the amount of, or in proportion to, any cost of living increase in social insurance benefits received by the insured.

(f) Individual policies shall include a description of the process for appealing and resolving benefit determinations which shall comply with Ins 1001.

Ins 6205.05 Additional Minimum Standards for Benefits for Group Coverage.

(a) In group certificates, the elimination period shall be specified in the certificate, and:

(1) The elimination period for a long-term disability benefits plan shall be permitted to be integrated with the benefit period of the short term disability benefits plan;

(2) The elimination period shall be permitted to be integrated with the period of paid time off, including salary continuation or sick leave available to the covered person, but shall not require use of accumulated vacation leave;

(3) The length of time required to satisfy the elimination period shall be permitted to consist of consecutive units of time; and

(4) The certificate shall be permitted to specify a separate elimination period for injury and a separate elimination period for sickness.

(b) Group coverage shall provide for at least 4 weeks of periodic income benefits, for coverage with short term benefit periods up to one year, and 12 months of periodic income benefits, for coverage with long-term benefit periods in excess of one year.

(c) Group disability benefits payable under the certificate shall be permitted to be reduced:

(1) Only by the following other benefits or income sources from:

a. Federal Social Security, Canada Pension Plan, the Quebec Pension Plan disability and retirement benefits, and the Railroad Retirement Act, including benefits that a spouse or child receives as a result of the covered person's disability. If disability begins after the start of a retirement benefit, benefits shall be permitted to be reduced on account of such retirement benefit;

b. Any benefits under a workers' compensation act, except for medical or death benefits, any federal or state occupational disease or injury law, and income received under the Admiralty and Maritime Law; the Maritime Doctrine of Maintenance, Wages, and Cure; the Doctrine of Unseaworthiness; and the Jones Act;

c. Disability benefits under state disability plans;

d. Disability and retirement benefits under a government plan, including state and municipal public employee plans and state teachers plans;

e. Disability and retirement benefits under plans provided by the covered person's policyholder, employer, or collective bargaining unit, as applicable. Such reduction shall be permitted to be limited to employer contributions and some types of retirement plans shall be permitted to be excluded;

f. Another group disability income policy or plan to the extent that such policy or plan covers the same pre-disability income;

g. Lost income benefits through no-fault vehicle insurance;

h. Employer salary continuation plan, sick pay, accumulated sick leave, vacation pay, severance, or other similar paid time off plans;

i. Secondary employment. However, if disability begins after an increase in secondary employment income, the disability benefit shall be permitted to be reduced on account of such increase;

j. Unemployment compensation;

k. Individual insurance disability plans to the extent that cumulative benefits payable would exceed pre-disability earnings;

l. Earnings from any work performed. Such reduction shall be permitted to be calculated differently for the specified months of a return to work period to encourage return to work;

m. Amounts received by a covered person from a third party, minus legal fees, in connection with lost income due to a disability which the covered person suffers because of an act of omission of the third party, and:

1. If the amount received from the third party does not specify the lost income amount, the company shall estimate the amount using a percentage of the settlement amount based on the covered person’s pre-disability earnings, prorated to cover the period for which the settlement or judgment was made;

2. If the certificate includes both this right to reduce benefits or income on account of a third party settlement and a subrogation right, the certificate shall state that, with regard to any specific claim, if the insurance company elects to reduce a disability benefit on account of other benefits or incomes for amounts received, minus legal fees, for lost income due to a disability because of an act of omission of the third party, the insurance company shall not be permitted to elect subrogation for that same claim; and

3. Amounts received from compromises as a result of a claim for any one of the sources referenced in (1)a. – m. above;

(2) The certificate shall specify which reductions shall be dollar for dollar and which shall be based on a formula specified in the certificate;

(3) The certificate shall be permitted to state that if a covered person is eligible for other benefits or income, the insurance company reserves the right to reduce the disability benefit available under the certificate as if the covered person is receiving such benefits or income and to estimate the amount, and:

a. Estimated reductions based on the benefits or income specified in Ins 6205.04(e)(1) shall not be permissible if the covered person provides evidence of application for benefits and agrees in writing to repay any overpayment; and

b. Benefits or income from a retirement plan and lost income benefits from no-fault vehicle insurance or third-party settlements shall not be subject to estimation; and

(4) The certificate shall be permitted to state that reductions specified in (3) above shall not result in a disability benefit payment for less than a specified minimum amount in the certificate.

Ins 6205.06 Prohibited Policy Provisions.

(a) Disability income benefits shall not require the loss to commence less than 30 days after the date of accident nor shall any policy that the insurer cancels or refuses to renew require that it be in force at the time the disability commences, if the accident occurred while the coverage was in force.

(b) Policies providing disability income protection shall not in any way condition benefit payments for total disability on "continuous confinement within doors" or language of similar import.

(c) No policy of health and accident insurance shall contain a provision that the disability period shall be considered to commence with the date on which written notice is actually received by the company.

(d) Disability income benefits shall be not be reduced because of an increase in benefits paid under the Social Security Act as prohibited under RSA 415:6, I(13) and RSA 415:18, I(o).

Ins 6205.07 Required Disclosure Provisions. Disclosure provisions shall be provided in accordance with Ins 6201.05. In addition, individual policies shall provide the following brief descriptions on the cover page:

(a) A statement whether the policy is conditionally renewable, guaranteed renewable, or non-cancellable;

(b) A conspicuous statement indicating preexisting condition limitations or exclusions may apply;

(c) For a policy with a benefit period of less than 6 months, a conspicuous statement indicating that the policy provides a limited duration of benefits and specify the duration;

(d) A statement as to any benefit limits or reductions due to attainment of certain ages; and

(e) Whether the policy is participating or non-participating.

Ins 6205.08 Outline of Coverage. An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Ins 6205. The items included in the outline of coverage shall appear in the sequence prescribed:

[COMPANY NAME]

DISABILITY INCOME PROTECTION COVERAGE

OUTLINE OF COVERAGE

(1) Read Your Policy Carefully—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(2) Disability income protection coverage is designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

(3) [A brief specific description of the benefits contained in this policy.]

(4) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in paragraph (3) above.]

(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

Ins 6205.09 Group Disability Insurance Claim Processing Standards.

(a) Health carriers that offer disability benefits shall establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations, hereinafter collectively referred to as claims procedures. The claims procedures shall be deemed by the department to be reasonable only if:

(1) They contain a description of all procedures, including any procedures for obtaining prior approval as a prerequisite for obtaining a benefit, such as preauthorization procedures or utilization review procedures and the applicable time frames as part of a summary plan description;

(2) They do not contain any provision, and are not administered in a way, that unduly inhibits or hampers the initiation or processing of claims for benefits. A provision or practice that requires payment of a fee or costs as a condition to making a claim or to appealing an adverse benefit determination would be considered by the department to unduly inhibit the initiation and processing of claims for benefits, as would the denial of a claim for failure to obtain a prior approval under circumstances that would make obtaining such prior approval impossible or where application of the prior approval process could seriously jeopardize the life or health of the claimant;

(3) They do not preclude an authorized representative of a claimant from acting on behalf of such claimant in pursuing a benefit claim or appeal of an adverse benefit determination. Nevertheless, a plan shall be permitted to establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a claimant; and

(4) They contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing policy documents and that, where appropriate, the provisions in the policy have been applied consistently with respect to similarly situated claimants.

(b) The claims procedures of group disability coverage for appealing adverse benefit determinations shall be deemed by the department to be reasonable only if:

(1) They do not contain any provision, and are not administered in a way, that requires a claimant to file more than two appeals of an adverse benefit determination prior to bringing a civil action;

(2) To the extent that a carrier offers voluntary levels of appeal, including voluntary arbitration or any other form of dispute resolution, the procedures provide that:

a. The carrier waives any right to assert that a claimant has failed to exhaust administrative remedies because the claimant did not elect to submit a benefit dispute to any such voluntary level of appeal provided by the carrier;

b. The carrier agrees that any statute of limitations or other defense based on timeliness is tolled during the time that any such voluntary appeal is pending;

c. The claims procedures provide that a claimant shall be permitted to elect to submit a benefit dispute to such voluntary level of appeal only after exhaustion of the appeals permitted by this rule;

d. The carrier provides to any claimant, upon request, sufficient information relating to the voluntary level of appeal to enable the claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal, including a statement that the decision of a claimant as to whether or not to submit a benefit dispute to the voluntary level of appeal shall have no effect on the claimant's rights to any other benefits under the plan and information about the applicable rules, the claimant's right to representation, the process for selecting the decision-maker, and the circumstances, if any, that may affect the impartiality of the decision-maker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process; and

e. No fees or costs are imposed on the claimant as part of the voluntary level of appeal; and

(3) The claims procedures do not contain any provision for the mandatory arbitration of adverse benefit determinations, except to the extent that the plan or procedures provide that:

a. The arbitration is conducted as one of the 2 appeals referenced in paragraph (b)(1) of this section; and

b. The claimant is not precluded from challenging the decision under any applicable law.

(c) The claims procedures of group disability coverage for notifying a claimant of a benefit determination shall be deemed reasonable by the department only if:

(1) When a claim is wholly or partially denied, the carrier's procedures require it to notify the claimant of the carrier's adverse benefit determination within a reasonable period of time, but not later than 45 days after the carrier's receipt of the claim, and:

a. This period shall be permitted to be extended for up to 30 days, provided that the carrier both determines that such an extension is necessary due to matters beyond its control and notifies the claimant, prior to the expiration of the initial 45-day period, of the

circumstances requiring the extension of time and the date by which the carrier expects to render a decision;

b. If, prior to the end of the first 30-day extension period, the carrier determines that, due to matters beyond the control of the carrier, a decision shall not be rendered within that extension period, the period for making the determination shall be permitted to be extended for up to an additional 30 days, provided that the carrier notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the carrier expects to render a decision; and

c. In the case of any extension, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information; and

(2) In calculating time periods for benefit determinations:

a. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with the reasonable procedures of a carrier, without regard to whether all the information necessary to make a benefit determination accompanies the filing; and

b. In the event that a period of time is extended due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

(d) The carrier shall provide a claimant with written or, if requested by the claimant, electronic notification of any adverse benefit determination. The notification shall set forth, in a manner calculated to be understood by the claimant:

(1) The specific reason or reasons for the adverse determination;

(2) Reference to the specific policy provisions on which the determination is based;

(3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(4) A description of the carrier's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action following an adverse benefit determination on review;

(5) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the carrier shall either provide a copy of the specific rule, guideline, protocol, or other similar criterion, or explain when the rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination shall be provided; and

(6) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the carrier shall either provide an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the

claimant's medical circumstances, or state that such explanation shall be provided free of charge upon request.

(e) Every carrier that offers group disability insurance shall establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the carrier and under which there shall be a full and fair review of the claim and the adverse benefit determination. The claims procedures of a group disability policy shall not be deemed by the department to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures:

(1) Provide a claimant with at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(2) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the carrier who is neither the individual who made the adverse benefit determination that is the subject of the appeal nor the subordinate of such individual;

(3) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(4) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the carrier in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

(5) Provide that the health care professional engaged for purposes of a consultation shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;

(6) Provide claimants with the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

(7) Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits, to include specific information relating to any denial of benefits; and

(8) Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

(f) The carrier shall notify a claimant of the outcome of the review conducted under paragraph (e) above within a reasonable period of time, but not later than 45 days after receipt of the claimant's request for review by the carrier, unless the carrier determines that special circumstances, such as the need to hold a hearing, if the carrier's procedures provide for a hearing, require an extension of time for processing the claim, and:

(1) If the carrier determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 45-day period;

(2) In no event shall such extension exceed a period of 45 days from the end of the initial period; and

(3) The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the carrier expects to render the determination on review.

(g) The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed, in accordance with the procedures the carrier has established pursuant to paragraph (a) of this section, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

(h) The carrier shall provide a claimant with written or, if requested by the claimant, electronic notification of its benefit determination on review. The notification shall set forth, in a manner calculated to be understood by the claimant:

(1) The specific reason or reasons for the adverse determination;

(2) Reference to the specific policy provisions on which the benefit determination is based;

(3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;

(4) A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about such procedures and a statement of the claimant's right to bring a legal action;

(5) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the carrier shall provide the claimant with either the specific rule, guideline, protocol, or other similar criterion or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and shall agree to provide a copy of the rule, guideline, protocol, or other similar criterion free of charge to the claimant upon request;

(6) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the carrier shall provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation shall be provided free of charge upon request; and

(7) The carrier shall include in the notice of adverse benefit determination the statement “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local US department of labor office or the New Hampshire insurance department.”

Ins 6205.10 Failure to Establish and Follow Reasonable Claims Procedures. In the case of the failure of a carrier to establish or follow its claims and appeals procedures, a claimant shall be deemed by the department to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available legal remedies on the basis that the carrier has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

Ins 6205.11 Waiver of Rules.

(a) The commissioner, upon the commissioner's own initiative or upon request by an insurer, shall waive any requirement of this part if such waiver does not contradict the objective or intent of the rule and:

(1) Applying the rule provision would cause confusion or would be misleading to consumers;

(2) The rule provision is in whole or in part inapplicable to the given circumstances;

(3) There are specific circumstances unique to the situation such that strict compliance with the rule would be onerous without promoting the objective or intent of the rule provision; or

(4) Any other similar extenuating circumstances exist such that application of an alternative standard or procedure better promotes the objective or intent of the rule provision.

(b) No requirement prescribed by statute shall be waived unless expressly authorized by law.

(c) Any person or entity seeking a waiver shall make a request in writing.

(d) A request for a waiver shall specify the basis for the waiver and proposed alternative, if any.

APPENDIX

Rule	Specific Statute the Rule Implements
Ins 6205.01	RSA 400-A:15, I; RSA 415-A:2 and 3
Ins 6205.02	RSA 400-A:15, I; RSA 415-A:2 and 3
Ins 6205.03	RSA 400-A:15, I; RSA 415-A:2 and 3
Ins 6205.04	RSA 400-A:15, I; RSA 415:6, II(6); RSA 415-A:2 and 3
Ins 6205.05	RSA 400-A:15, I; RSA 415-A:2 and 3
Ins 6205.06	RSA 400-A:15, I; RSA 415:6, I(13); RSA 415:18, I(o); RSA 415-A:2 and 3
Ins 6205.07	RSA 400-A:15, I; RSA 415-A:2 and 3
Ins 6205.08	RSA 400-A:15, I; RSA 415-A:2 and 3
Ins 6205.09	RSA 400-A:15, I; RSA 415-A:6, II; 29 CFR 2560.503
Ins 6204.10	RSA 400-A:15, I; RSA 415-A:6, II; 29 CFR 2560.503
Ins 6205.11	RSA 400-A:15, I; RSA 541-A:22, IV