Important Disclosure Information New Hampshire Addendum

Certain state laws require the disclosure of additional information. Described below is additional information applicable New Hampshire residents enrolled in the plan:

Patients' Bill of Rights

The policy describing the rights and responsibilities of each patient admitted to the facility shall include, as a minimum, the following:

I. The patient shall be treated with consideration, respect, and full recognition of the patient's dignity and individuality, including privacy in treatment and personal care and including being informed of the name, licensure status, and staff position of all those with whom the patient has contact, pursuant to **RSA 151:3-b**.

II. The patient shall be fully informed of a patient's rights and responsibilities and of all procedures governing patient conduct and responsibilities. This information must be provided orally and in writing before or at admission, except for emergency admissions. Receipt of the information must be acknowledged by the patient in writing. When a patient lacks the capacity to make informed judgments the signing must be by the person legally responsible for the patient.

III. The patient shall be fully informed in writing in language that the patient can understand, before or at the time of admission and as necessary during the patient's stay, of the facility's basic per diem rate and of those services included and not included in the basic per diem rate. A statement of services that are not normally covered by Medicare or Medicaid shall also be included in this disclosure.

IV. The patient shall be fully informed by a health care provider of his or her medical condition, health care needs, and diagnostic test results, including the manner by which such results will be provided and the expected time interval between testing and receiving results, unless medically inadvisable and so documented in the medical record, and shall be given the opportunity to participate in the planning of his or her total care and medical treatment, to refuse treatment, and to be involved in experimental research upon the patient's written consent only. For the purposes of this paragraph "health care provider" means any person, corporation, facility, or institution either licensed by this state or otherwise lawfully providing health care services, including, but not limited to, a physician, hospital or other health care facility, dentist, nurse, optometrist, podiatrist, physical therapist, or psychologist, and any officer, employee, or agent of such provider acting in the course and scope of employment or agency related to or supportive of health care services.

V. The patient shall be transferred or discharged after appropriate discharge planning only for medical reasons, for the patient's welfare or that of other patients, if the facility ceases to operate, or for nonpayment for the patient's stay, except as prohibited by Title XVIII or XIX of the Social Security Act. No patient shall be involuntarily discharged from a facility because the patient becomes eligible for Medicaid as a source of payment.

VI. The patient shall be encouraged and assisted throughout the patient's stay to exercise the patient's rights as a patient and citizen. The patient may voice grievances and recommend changes in policies and services to facility staff or outside representatives free from restraint, interference, coercion, discrimination, or reprisal.

VII. The patient shall be permitted to manage the patient's personal financial affairs. If the patient authorizes the facility in writing to assist in this management and the facility so consents, the assistance shall be carried out in accordance with the patient's rights under this subdivision and in conformance with state law and rules.

VIII. The patient shall be free from emotional, psychological, sexual and physical abuse and from exploitation, neglect, corporal punishment and involuntary seclusion.

IX. The patient shall be free from chemical and physical restraints except when they are authorized in writing by a physician for a specific and limited time necessary to protect the patient or others from injury. In an emergency, restraints may be authorized by the designated professional staff member in order to protect the patient or others from injury. The staff member must promptly report such action to the physician and document same in the medical records.

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X. The patient shall be ensured confidential treatment of all information contained in the patient's personal and clinical record, including that stored in an automatic data bank, and the patient's written consent shall be required for the release of information to anyone not otherwise authorized by law to receive it. Medical information contained in the medical records at any facility licensed under this chapter shall be deemed to be the property of the patient. The patient shall be entitled to a copy of such records upon request. The charge for the copying of a patient's medical records shall not exceed $15 for the first 30 pages or $.50 per page, whichever is greater; provided that copies of filmed records such as radiograms, x-rays, and sonograms shall be copied at a reasonable cost.

XI. The patient shall not be required to perform services for the facility. Where appropriate for therapeutic or diversional purposes and agreed to by the patient, such services may be included in a plan of care and treatment.

XII. The patient shall be free to communicate with, associate with, and meet privately with anyone, including family and resident groups, unless to do so would infringe upon the rights of other patients. The patient may send and receive unopened personal mail. The patient has the right to have regular access to the unmonitored use of a telephone.

XIII. The patient shall be free to participate in activities of any social, religious, and community groups, unless to do so would infringe upon the rights of other patients.

XIV. The patient shall be free to retain and use personal clothing and possessions as space permits, provided it does not infringe on the rights of other patients.

XV. The patient shall be entitled to privacy for visits and, if married, to share a room with his or her spouse if both are patients in the same facility and where both patients consent, unless it is medically contraindicated and so documented by a physician. The patient has the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, including choice of room and roommate, except when the health and safety of the individual or other patients would be endangered.

XVI. The patient shall not be denied appropriate care on the basis of race, religion, color, national origin, sex, age, disability, marital status, or source of payment, nor shall any such care be denied on account of the patient's sexual orientation.

XVII. The patient shall be entitled to be treated by the patient's physician of choice, subject to reasonable rules and regulations of the facility regarding the facility's credentialing process.

XVIII. The patient shall be entitled to have the patient's parents, if a minor, or spouse, or next of kin, or a personal representative, if an adult, visit the facility, without restriction, if the patient is considered terminally ill by the physician responsible for the patient's care.

XIX. The patient shall be entitled to receive representatives of approved organizations as provided in **RSA 151:28**.

XX. The patient shall not be denied admission to the facility based on Medicaid as a source of payment when there is an available space in the facility.

XXI. Subject to the terms and conditions of the patient's insurance plan, the patient shall have access to any provider in his or her insurance plan network and referral to a provider or facility within such network shall not be unreasonably withheld pursuant to **RSA 420-J:8, XIV**.

Continuing Health Care Benefits

Continuing Coverage for Dependent Students on Medical Leave of Absence

If your dependent child who is eligible for coverage and enrolled in this plan by reason of his or her status as a full-time student at a postsecondary educational institution ceases to be eligible due to:

- a medically necessary leave of absence from school; or
- a change in his or her status as a full-time student, resulting from a serious **illness** or **injury**, such child's coverage under this plan may continue.

Coverage under this continuation provision will end when the first of the following occurs:

- The end of the [12 - 36 month] period following the first day of your dependent child's leave of absence from school, or a change in his or her status as a full-time student;
- Your dependent child's coverage would otherwise end under the terms of this plan;
- Dependent coverage is discontinued under this plan; or
- You fail to make any required contribution toward the cost of this coverage.

To be eligible for this continuation, the dependent child must have been enrolled in this plan and attending school on a full-time basis immediately before the first day of the leave of absence.

To continue your dependent child's coverage under this provision you should notify [your employer] [**Aetna**] as soon as possible after your child's leave of absence begins or the change in his or her status as a full-time student.

Documentation and certification of the **medical necessity** of the leave of absence shall be submitted to **Aetna** by the student's treating **physician** and shall be considered evidence of entitlement to coverage. The medical leave of absence shall begin on the date the documentation and certification of the **medical necessity** were obtained from the **physician**.

Important Note:

If at the end of this [12 month] continuation period, your dependent child's leave of absence from school (or change in full-time student status) continues, such child may qualify for a further continuation of coverage under the Handicapped Dependent Children provision of this plan. Please see the section, *Handicapped Dependent Children*, for more information.

Handicapped Dependent Children

[Life Insurance, Accidental Death and Personal Loss Coverage, and Health Expense Coverage, including dental coverage,] for your fully handicapped dependent child may be continued past the maximum age for a dependent child. However:

- [Life Insurance and Accidental Death and Personal Loss Coverage may not be continued if the child has been issued an individual life conversion policy.]
- [Life Insurance and Accidental Death and Personal Loss Coverage may not be continued if at the time you become eligible for dependent coverage under this plan your child's age has exceeded the maximum age for dependent children under this plan, even if your child was covered under a prior group plan on the day before this plan takes effect.]
- [Health Expense Coverage may not be continued if the child has been issued an individual medical conversion policy by the New Hampshire High Risk Pool.]

Your child is fully handicapped if:

- He or she is not able to earn his or her own living because of a mental or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children under your plan; and
- He or she depends chiefly on you for support and maintenance; or you or your estate is chargeable for the child's care.

Proof that your child is fully handicapped must be submitted to **Aetna** no later than [31 - 120 days] after the date your child reaches the maximum age under your plan.

Coverage will cease on the first to occur of:

- Cessation of the handicap.
- Your child ceases to be financially dependent on you; or you or your estate is no longer chargeable for your dependent's care.
- Premiums cease to be paid for your child's coverage.
- Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age under your plan.

If:

- any health coverage for dependents under this plan replaces health coverage under any group or blanket plan; and
- the prior plan contained a handicapped dependent children provision;

then any child to whom that provision applied who was covered under the prior plan on the day before the effective date of this Plan will be entitled to coverage under this Plan subject to terms of this provision.

Any child whose coverage is continued under this section will be entitled to an option to select an individual policy issued by the New Hampshire High Risk Pool if the incapacity ceases.

Important Note:

Your dependent may be eligible to convert to a personal policy. Please see the section, *Converting to an Individual Health Insurance Policy* for more information.

Continuation of Coverage on a Loss of Coverage Due to a Bankruptcy Proceeding

If your health coverage [including dental coverage] as a retired employee would terminate or be substantially eliminated due to your former Employer commencing a bankruptcy proceeding under Title 11, United States Code, or within the 12 month period prior to or following such a proceeding, you may be eligible to elect to continue coverage for yourself and your dependents or your dependents may each be eligible to elect to continue his or her own coverage.

Written request for such continuation must be made within 45 days of the later of the date Aetna notifies you or your dependents of the right to continue and the date bankruptcy proceedings begin. The request must include an agreement to pay up to 102 percent of the cost to this Plan. Premium payments must be continued.

Coverage will not be continued beyond the first to occur of:

- The end of a 36 month period which starts on the date coverage would otherwise terminate.
- The date you or your dependent becomes eligible for like coverage under this Plan.
- The end of the period for which any required contribution was made.
- The date of the first Medicare open enrollment period following the date you or your dependent became ineligible for the group plan.

Continuation of Coverage Due to a Labor Dispute

If your coverage under this Plan would cease because you cease work due to a strike, lockout or a labor dispute, and if the New Hampshire Insurance Code applies, you can arrange to continue your coverage (except Accidental Death and Personal Loss, Temporary Disability, Long Term Disability and Comprehensive Dental Expense Coverages) during your absence from work. Coverage may continue for up to 6 months after the date your compensation is suspended or terminated because of a strike, lockout or labor dispute.

Continuation will cease when the first of these events occurs:

- You fail to make the required contributions to your Employer.
- Your Employer fails to make the required contributions to Aetna.
- You go to work full time for another employer.
- The strike, lockout or labor dispute ends.
- The 6 month continuation period ends. However, after this 6-month period, you shall have the right to continue the benefits being continued under this paragraph for an additional 12 months as if you originally had elected the extension period provided under the Continuing Health Care Benefit section subject to the same conditions. At the end of the additional 12 months, you shall have the right, if the group insurance is no longer available, to obtain coverage from the high risk pool. Please see the section, *Converting to an Individual Health Insurance Policy* for more information.

The monthly premium required by Aetna for each person's coverage will be the applicable rate in effect on the date you cease work. Aetna has the right to change premium rates under the terms of this Plan subject to 60 days notice.

Continuing Health Care Benefits

Part I

When an individual loses Health Expense Coverage [including dental coverage] under this plan for any reason, except gross misconduct; coverage may be continued for you and your eligible dependents.

You must request continuation within 45 days of the later of the date Aetna notifies you of the right to continue and the date coverage would otherwise terminate. The request must include an agreement to pay up to 102 percent of the cost to this Plan. Premium payments must be continued.

Coverage will not be continued beyond the first to occur of:

- The end of an 18 month period which starts on the date coverage would otherwise terminate; However, if you or your dependent provide notice to your Employer that you or your dependent has been determined to be disabled under Title II or XVI of the Social Security Act within the first 60 days your coverage would have otherwise terminated, except for this section, coverage for you and your dependents will be continued, unless terminated for another reason, until the end of a 29 month period which starts on the date coverage would have otherwise terminated.
- The date you become eligible for like group benefits.
- The end of the period for which any required contributions have been made.

Coverage for a dependent will not be continued beyond the date it would otherwise terminate.

Part II

If Health Expense Coverage would terminate because of discontinuance of the coverage involved as to employees of the Eligible Class of which you were a member, coverage, except Comprehensive Dental Expense Coverage, may be continued for you and your eligible dependents. You must request continuation within 45 days of the later of the date Aetna notifies you of the right to continue and the date coverage would otherwise terminate. The request must include an agreement to pay up to 102 percent of the cost to this Plan. Premium payments must be continued.

Coverage will cease on the first to occur of:

- The date you are eligible for like group benefits.
- The end of the period for which any contributions have been made.

- The end of a period equal to 39 weeks, less the number of weeks your coverage was continued under this Plan during a strike, lockout or labor dispute. However, if coverage is being continued in accordance with Part I at the time coverage terminates as to your Eligible Class, coverage will be continued for up to the remainder of the 18 or 29 month period specified in Part I.

Part III

If any coverage being continued under Part I or Part II ceases because coverage has been continued for the maximum period, a personal policy issued by the New Hampshire High Risk Pool may be applied for. This must be done within 31 days of the date coverage ceases.

Continuation of Coverage For Your Spouse/Former Spouse

Part I

If Health Expense Coverage [including dental coverage] for your dependent spouse would terminate due to divorce (or legal separation), the former spouse may continue to be covered. The former spouse is eligible for coverage while policy remains in force or is replaced by another policy covering the member. Premium payments must be continued. Coverage will not continue beyond the first to occur:

- 3-year (36 month) anniversary of final decree of the divorce or legal separation;
- Remarriage of former spouse;
- Remarriage of member;
- Death of member; or
- Such earlier time provided in final divorce or legal separation.

Part II

If Health Expense Coverage [including dental coverage] for your former spouse would terminate because of one of the reasons listed under Part I, the former spouse may continue coverage, except in the case where former spouse remarries. The former spouse must make written request for coverage within 30 days from the first occurring event as listed above, except in the case where former spouse remarries. The former spouse is eligible for coverage for an additional 36 months. If former spouse is 55 years or older, coverage must continue until spouse is eligible under another employer-based group plan or becomes eligible for Medicare.

Except for when former spouse is age 55 or older, coverage will not be continued beyond the first to occur:

- The end of the 36-month period; or
- The end of the period for which required contributions have been made; or

Part III

If any coverage continued under Part I or Part II, former spouse may be eligible for coverage under New Hampshire's high risk pool.

Continuation of Coverage For Your Dependents After Your Death

If you should die while covered under any part of this Plan, any Health Expense Coverage [including dental coverage] then in force for your dependents may be continued.

Written request for such continuation must be made within 45 days of the later of the date Aetna notifies your dependents of the right to continue and the date coverage would otherwise terminate. The request must include an agreement to pay up to 102 percent of the cost to this Plan. Premium payments must be continued.

Any dependent's coverage will not continue beyond the first to occur of:

- The end of a 36 month period which starts on the date of your death; except that if the coverage involved discontinues during such 36 month period as to employees of the Eligible Class of which you were a member, coverage will be continued, unless terminated for another reason, until the later of:
  - 39 weeks from the date of such discontinuance; and
  - the remainder of the 36 month period on the date of such discontinuance.
- The date the dependent becomes eligible for like group benefits.
- The end of the period for which any required contributions have been made.

Coverage may also be provided under this Plan for your child, born after your death, as long as coverage for your other dependents is being continued.

If any coverage being continued ceases because coverage has been continued for the maximum period, a personal policy issued by the New Hampshire High Risk Pool may be applied for. This must be done within 31 days of the date coverage ceases.

Continuation of Coverage For Your Child

If Health Expense Coverage [including dental coverage] for your child would terminate because the child ceases to meet this Plan's definition of dependent, such child may continue the coverage then in force.

Written request for such continuation must be made within 45 days of the later of the date Aetna notifies the child of the right to continue and the date coverage would otherwise terminate. The request must include an agreement to pay up to 102 percent of the cost to this Plan. Premium payments must be continued.

Coverage will not continue beyond the first to occur of:

- The end of a 36 month period which starts on the date the child ceases to meet this Plan's definition of dependent; except that if the coverage involved discontinues during such 36 month period as to employees of the Eligible Class of which you are a member, coverage will be continued, unless terminated for another reason, until the later of:
  - 39 weeks from the date of such discontinuance; and
  - the remainder of the 36 month period on the date of such discontinuance.
- The date the child becomes eligible for like group benefits.
- The end of the period for which any required contributions have been made.

If any coverage being continued ceases because coverage has been continued for the maximum period, a personal policy issued by the New Hampshire High Risk Pool may be applied for. This must be done within 31 days of the date the coverage ceases.

Continuation of Coverage For Your Dependents After You Become Eligible For Medicare

If coverage for your dependents would terminate because you become eligible for Medicare, any Health Expense Coverage [including dental coverage] then in force for your dependents may be continued.

Written request for such continuation must be made within 45 days of the later of the date Aetna notifies your dependents of the right to continue and the date coverage would otherwise terminate. The request must include an agreement to pay up to 102 percent of the cost to this Plan. Premium payments must be continued.

Coverage for a dependent will not continue beyond the first to occur of:

- The end of a 36 month period which starts on the date you become eligible for Medicare; except that if the coverage involved discontinues during such 36 month period as to employees of the Eligible Class of which you were a member, coverage will be continued, unless terminated for another reason, until the later of:
  - 39 weeks from the date of such discontinuance; and
  - the remainder of the 36 month period on the date of such discontinuance.
- The date the dependent becomes eligible for like group benefits.
- The end of the period for which any required contributions have been made.

If any coverage being continued ceases because coverage has been continued for the maximum period, a personal policy issued by the New Hampshire High Risk Pool may be applied for. This must be done within 31 days of the date coverage ceases.