INSTRUCTIONS FOR INDIVIDUAL MAJOR MEDICAL FILINGS CHECKLIST

LINE OF BUSINESS: INDIVIDUAL HEALTH **TOI CODES: H16I and HOrg02I**

Select one:

Off Exchange Only ☐

Both on and Off Exchange ☐

See additional federal guidance from the 2017 Letter to Issuers, and also the New Hampshire Insurance Department guidance in the 2017 Bulletin found here. Please note that the New Hampshire benchmark plan is Matthew Thornton Blue, and is supplemented by the FEDVIP Pediatric Dental Plan High Option.

A. For ALL filings, the **Submissions Requirements Checklist** MUST be completed and attached to the supporting documentation tab.
B. For a FORM filing, the completion of additional sections below must be completed, depending on the forms submitted.
    a. Policy/Certificate
    b. Riders, endorsements or amendments
    c. Applications
    d. Advertising
    e. Annual Actuarial Certification
C. RATES are required to be filed in accordance with **NHCAR Part Ins 401.12 (o)** and **NHCAR Part Ins 4100**. Additional requirements may be necessary, depending on the Type of Insurance (TOI).
D. Requirements apply to both Qualified Health Plans (QHPs) and non-QHP individual filings, unless otherwise noted.
E. Grandfathered plans, as defined in **75 FR 34537**, must be filed separately.
F. QHP Submissions are to be in accordance with QHP Application instructions found **here**.

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

http://www.gencourt.state.nh.us/rules/state_agencies/ins.html
http://www.gencourt.state.nh.us/rsa/html/NHTOC/NHTOC-XXXVII.htm

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All individual health major medical submissions to NH must be made via SERFF through the Form/Rate Filing and Plan Management modules. Plan Binders must be complete submissions, as no partial or incomplete submissions will be accepted. Corresponding forms filings must be referenced in the Associate Schedule Items. Please see **SERFF Plan Management Instruction Manual** for further instructions on binder submission.

CMS has published detailed instructions for the completion and validation of templates. It is the issuer's responsibility to accurately and thoroughly complete the templates. For 2017, the NHID will require an attestation from issuers that all CMS QHP tools have been run and errors resolved prior to submission of data templates. NHID will require the state generated **attestation form** at the time of filing, and submissions will not be reviewed until such time as attestations are received noting satisfactory results. If issuers receive an "unmet" when running a tool but believe they are still compliant, they must submit the excel tool's results tab and add an "explanations" column for their justification. Both the attestation form and excel spreadsheet must be uploaded to the Supporting Documents tab in the binder.

SECTION 1 AFFORDABLE CARE ACT REQUIREMENTS

REQUIREMENT	DESCRIPTION OF REQUIREMENT	COMPLIANCE
SERVICE AREA	NHID will allow issuers to choose their service area(s), except that requested service areas may not be smaller than a county.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
RATING AREA	NH has established one statewide rating area for all plans offered in the individual market. This means issuers may not vary premiums by regions within the state.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
NETWORK ADEQUACY	Per **RSA 420-J:7 I** and **INS 2701** A health carrier shall maintain a network that is sufficient in numbers, types, and geographic location of providers to ensure that all services to covered persons will be accessible without unreasonable delay. Medical QHP issuers must also provide to the Insurance Department the Network Adequacy package, **found here**, which consists of: Network Adequacy Attestations, Summary and Supplemental Response Forms, and the uniform Network Data template, in both excel spreadsheet and text file where applicable. For QHP filings only, networks must include Essential Community Providers per 45 CFR 156.230, 45 CFR 155.1050 and 45 CFR 156.235, and 79 FR 13744. Additionally, a health carrier shall make its provider directory available online and hard copy upon request of enrollees in accordance with 45 CFR 156.230(b) and the September 25, 2014 NHID Bulletin entitled **"Transparency in Provider Network Directory and Formulary Information."** Issuers are reminded to consult the 2017 Letter to Issuers in the FFM	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

SECTION 1 AFFORDABLE CARE ACT REQUIREMENTS

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	regarding federal requirements for **provider directories.**	
ACTUARIAL VALUE	NHID will require issuers to submit the completed actuarial value calculator provided by the Center for Consumer Information and Insurance Oversight (CCIIO) to verify compliance with AV standards. NHID will also require issuers to submit an actuarial certification, along with screen shots of plan variations. The actuary shall certify that either the AV calculator accommodated the plan design or specify the methodology used to accommodate the plan for calculation purposes. In the event accommodation was necessary, the actuary shall certify that such accommodations were in accordance with generally accepted actuarial principles and practices and compliant with the terms set forth in the **2017 Benefit and Payment Parameters**.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
COST SHARING	For Plan Year 2017 the maximum annual limitation on cost sharing is $7,150 for self only coverage and $14,300 for other than self-only/ family coverage as outlined in the **2017 Benefit and Payment Parameters**. As clarified in previous years guidance, even when family coverage is purchased (and therefore the overall limit is $14,300), no individual enrollee in the coverage can be required to spend more than $7,150 in cost sharing for care attributable to that individual enrollee. IRS limits for qualified HDHPs eligible for HSAs are $6,550 for self-only, and $13,100 for family coverage, per **IRS Rev Proc 2016-28**. Note from 2017: **Letter to Issuers page 51: No EHB out of network cost sharing for zero cost sharing plan except for closed panel HMOs**	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
PEDIATRIC AGE	According to §156.115(a)(6), issuers must provide coverage for pediatric services until **at least** the end of the month in which the enrollee turns 19. We encourage issuers to cover services under the pediatric services EHB category beyond the 19th birthday month if non-coverage of those services after that time would negatively affect care.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

SECTION 1 AFFORDABLE CARE ACT REQUIREMENTS

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TRANSPARENCY IN COVERAGE	In accordance with 45 CFR 156.220 and 45 CFR 155.1040, a QHP issuer must submit, in an accurate and timely manner, the following information to the Marketplace, HHS and the State insurance commissioner, as well as to the public: (1) Claims payment policies and practices; (2) Periodic financial disclosures; (3) Data on enrollment; (4) Data on disenrollment; (5) Data on the number of claims that are denied; (6) Data on rating practices; (7) Information on cost-sharing and payments with respect to any out-of-network coverage; and (8) Information on enrollee rights under title I of the Affordable Care Act.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
RATE FILING	Rate filing information must be submitted to NHID by April 8 for both on and **off exchange plans** via the URRT (Unified Rate Review Template). Rate filings must comply with **NHCAR Part Ins 4100** and **RSA 420-G:4**.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
PLAN VARIATIONS FOR INDIVIDUALS ELIGIBLE FOR COST SHARING	The carrier will complete the rate and benefit templates. NHID will require an attestation of compliance with federal Plan Variation Standards, and are subject to review and approval by NHID. Schedule of Benefits and Summary of Benefits and Coverage must be completed for each plan variation. See the 2017 Plan Year QHP Issuer Bulletin and **April 6, 2015 FAQ** posted by the Department for more information regarding SOB & SBC requirements.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
HEALTH INSURANCE MARKET REFORM RULES	Issuers must comply with Health Insurance Market Reform rules put in place under the Affordable Care Act and codified in 45 CFR Parts 80, 147, and 155 including:	
	Guaranteed Availability of Coverage (a) A health insurance issuer must offer coverage, in accordance with 45 CFR 147.104(a), to any individual or employer in New Hampshire, including all products that are approved for sale in the applicable market, and must accept any individual or employer that applies for coverage through any of those products. (b) Enrollment periods and effective dates of coverage must be established in accordance with 45 CFR 147.104(b). (c) Health insurance issuers that offer coverage through network plans may impose limits specified in 45 CFR 147.104(c).	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

SECTION 1 AFFORDABLE CARE ACT REQUIREMENTS

REQUIREMENT	DESCRIPTION OF REQUIREMENT	COMPLIANCE
	(d) Health insurance issuers may impose financial capacity limits in accordance with 45 CFR 147.104(d). (e) A health insurer and its officials, employees, agents, and representatives must comply with marketing and non-discrimination requirements in 45 CFR 147.104(e).	
	Guaranteed Renewability of Coverage (a) A health insurance issuer must renew coverage in accordance with 45 CFR 147.106(a). (b) Pursuant to 45 CFR 147.106(b), a health insurance issuer may discontinue coverage only in the event of non-payment of premiums, fraud, if the plan sponsor violates applicable rules, if the plan is terminated, if enrollees move outside the plan's service area, or if association membership ceases. (c) A health insurance issuer may discontinue offering a health insurance product only if the issuer follows procedures described at 45 CFR 147.106(c). (d) A health insurance issuer may discontinue offering all health insurance products if the issuer follows procedures specified in 45 CFR 147.106(d). (e) Uniform modifications of coverage at the time of renewal are permitted in accordance with 45 CFR 147.106(e). (f) A health insurance issuer that offers student health coverage is not required to renew coverage for individuals who are no longer students or dependents of students, per 45 CFR 147.145. (g) Submit a description of covered benefits and cost-sharing provisions at least annually, in accordance with 45 CFR 156.210(b).	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
	Single Risk Pool a) *Individual Market*. Per 45 CFR 156.80, A health insurance issuer must consider the claims experience of all enrollees in all health plans (other than grandfathered health plans) subject to section 2701 of the Public Health Service Act and offered by such issuer in the individual market in a state, including those enrollees who do not enroll in such plans through the Marketplace, to be members of a single risk pool.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
	Catastrophic Plans a) Issuers may offer a plan with catastrophic-level coverage, as defined in 45 CFR 156.155, in the individual market. A catastrophic plan may not impose any cost-sharing requirements for preventive services. **Out of Pocket Maximums**	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

SECTION 1 AFFORDABLE CARE ACT REQUIREMENTS

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	Per IRS Revenue Procedure 2016-28, the maximum out-of-pocket expenses (MOOP) for in-network services allowed for High Deductible Health Plans (HDHPs) to qualify for a 2017 HSA for both a one-person plan is $6,550, and for a family plan is $13,100. Schedules with MOOPs greater than the IRS limit are not HSA compatible. Per the 2016 HHS Notice of Benefit and Payment Parameters, no one person can exceed the self-only MOOP in a family ($7,150 in 2017). For calendar year 2017, the annual limitation on HSA deductions under IRS regulations for an individual with self-only coverage under a high deductible health plan is $3,400. For calendar year 2017, the annual limitation on deductions under IRS regulations for an individual with family coverage under a high deductible health plan is $6,750.	YES NO PAGE # OR IF NO:
ENROLLMENT PERIODS	**Standard Enrollment Periods** The **open enrollment period** for the Individual market begins November 1, 2016 and extends through January 31, 2017. **Special Enrollment Periods** As stated in **45 CFR 155.420,** enrollees in the individual market must be given access to special enrollment periods of 60 days from the date of a triggering event, with effective dates consistent with 45 CFR 155.420(b). Issuers are urged to consult new guidance from CMS regarding SEP's: **https://www.healthcare.gov/sep-list/**	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

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

ESSENTIAL HEALTH BENEFITS

REQUIREMENT	DESCRIPTION OF REQUIREMENT	COMPLIANCE
	Please note the Essential Health Benefit (EHB) benchmark plan for plan year 2017 is Matthew Thornton Blue; plan materials can be found at: **https://www.cms.gov/cciio/resources/data-resources/ehb.html**. Pediatric dental is supplemented by the **FEDVIP dental plan**. Carriers must comply with the Mental Health Parity and Addiction Equity Act (MHPAEA) requirements. Plan binder templates contain the EHB and Pharmacy Formulary. The templates must be completed and attached to the filing. NH will require an attestation of compliance with the EHB formulary standards.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
	Ambulatory patient services	**YES** ☐
	Medical Exams	**YES** ☐
	Telemedicine Visits	**YES** ☐
	Injections (including allergy injections)	**YES** ☐
	Office Surgery	**YES** ☐
	Anesthesia	**YES** ☐
	Early Childhood Intervention Therapy Services (For children up to age 3)	**YES** ☐
	Colonoscopy	**YES** ☐
	Management of Therapy	**YES** ☐
	Hemodialysis	**YES** ☐
	Chemotherapy	**YES** ☐
	Radiation Therapy	**YES** ☐
	Infusion Therapy	**YES** ☐
	TMJ Surgery and limited Oral Surgery	**YES** ☐
	Accidental Dental	**YES** ☐
	Hearing Aids	**YES** ☐
	Non-prescription Enteral Formulas and Low Protein Foods	**YES** ☐
	Emergency services	**YES** ☐
	Emergency Room Charges	**YES** ☐
	Network Urgent Care Facility Charge	**YES** ☐
	Physician Fee, Labs, X-Rays, CT Scan, MRI, Medical Supplies, Etc.	**YES** ☐
	Ambulance	**YES** ☐
	Hospitalization	**YES** ☐
	Semi-Private Room and Board	**YES** ☐
	Diagnostic Tests	**YES** ☐
	Supplies	**YES** ☐

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

	Annual Care Plans for Members with Chronic Illnesses	**YES** ☐
	Nutrition Counseling	**YES** ☐
	Mammogram	**YES** ☐
	Pap Smear	**YES** ☐
	Lead Screening	**YES** ☐
	Pre-natal and postpartum Visits	**YES** ☐
	Other routine preventive screening such as total cholesterol, lipids, and diabetic screenings	**YES** ☐
	Diabetes Screening	**YES** ☐
	Fluoride Treatments	**YES** ☐

STATE MANDATES			
REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
MINIMUM STANDARDS	**NHCAR Part Ins 1901.06**	Minimum standards for accident and health coverages.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
COVERAGE FOR CLINICAL TRIALS	**RSA 415:18-l II.** **Essential Health Benefit Requirement**	A policy, plan, or contract subject to this section shall provide coverage for all medically necessary routine patient care costs incurred as a result of a treatment being provided in accordance with a clinical trial to the extent such costs would be covered for non-investigational treatments if the treatment is being provided or the studies are being conducted in a phase I, phase II, phase III, or phase IV clinical trial for cancer or the treatment is being provided for any other life-threatening condition.	**YES:** ☐ **NO:** ☐ **Page # or If NO:**
MEDICALLY NECESSARY DENTAL COVERAGE DUE TO ACCIDENTAL INJURY	**RSA 420-G: 5 VIII** **Essential Health Benefit Requirement**	VIII. Health carriers shall provide coverage for medically necessary dental services resulting from an accidental injury to sound natural teeth and gums when the course of treatment for the accidental injury is received or authorized within 3 months of the date of the injury. Treatment made necessary due to injury to the jaw and oral structures other than teeth shall be covered without time limit. Coverage hereunder shall be subject to such other terms and conditions of the policy that may apply.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
MENTAL HEALTH AND SUBSTANCE ABUSE COVERAGE	**Essential Health Benefit Requirement**	Coverage must comply with federal Mental Health Parity and Addiction Equity Act requirements. Benefits, cost sharing and managed care requirements must be the same as for any other medical or surgical coverage.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
DENTAL PROCEDURES **MEDICAL OR HOSPITAL – ANESTHESIA**	**RSA 415:18-g** **Essential Health Benefit Requirement**	I. Each insurer that issues or renews any policy of group or blanket accident or health insurance providing benefits for medical or hospital expenses, shall provide to each group, or to the portion of each group comprised of certificate holders of such insurance who are residents of New Hampshire, coverage for the medically necessary hospital or surgical day care facility charges and administration of general anesthesia administered by a licensed anesthesiologist or anesthetist for dental procedures performed	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

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		on a covered person who: a) Is a child who is determined by a licensed dentist in conjunction with a licensed physician to have a dental condition of significant dental complexity which requires certain dental procedures to be performed in a surgical day care facility or hospital setting; or b) Is a person who has exceptional medical circumstances or a developmental disability as determined by a licensed physician which place the person at serious risk.	

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REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
COVERAGE FOR DENTAL PROCEDURES; DENTAL OFFICES	**RSA 415:18-h** **Essential Health Benefits**	I. Each dental insurer or other similar entity, including Delta under RSA 420-F, that issues or renews any policy of group insurance providing benefits for oral surgical procedures, shall provide to each certificate holder who is a resident of New Hampshire coverage for the administration of general anesthesia administered by a licensed dentist for dental procedures performed in a dentist's office on a covered person who: a) Is a child who is determined by a licensed dentist in conjunction with a licensed physician to have a dental condition of significant complexity which requires the child to receive general anesthesia for the treatment of such condition; or b) Is a person who has exceptional medical circumstances or a developmental disability as determined by a licensed physician which place the person at serious risk.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
NONPRESCRIPTION ENTERAL FORMULAS	**RSA 415:6-c** **Essential Health Benefits**	Each insurer that issues or renews any policy of group or blanket accident or health insurance providing benefits for medical or hospital expenses, shall provide coverage for the provision of nonprescription enteral formulas for the treatment of impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, or motility of the gastrointestinal tract. Coverage for inherited diseases of amino acids and organic acids shall, in addition to the enteral formula, include food products modified to be low protein.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
DIABETES TREATMENT	**RSA 415:6-e** **Essential Health Benefits**	Each insurer that issues or renews any individual policy, plan, or contract of accident or health insurance providing benefits for medical or hospital expenses, shall provide to certificate holders of such insurance, who are residents of this state, coverage for medically appropriate and necessary outpatient self-management training and educational services, pursuant to a written order of a primary care physician or practitioner, including but not limited to medical nutrition therapy for the treatment of diabetes, provided by a certified, registered or licensed health care professional with expertise in diabetes, subject to the terms and conditions of the policy. Each insurer that issues or renews any individual policy, plan, or contract of accident or health insurance providing benefits for medical or hospital expenses which provides a prescription rider shall cover medically appropriate or necessary insulin, oral agents and equipment used to treat diabetes subject to the terms and conditions of the policy. Each insurer that issues or renews any individual policy, plan, or contract of accident or health insurance providing benefits for medical or hospital expenses which provides for durable medical equipment coverage shall provide coverage for medically appropriate or necessary	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

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		equipment used to treat diabetes subject to the terms and conditions of the policy.	

STATE MANDATES			
REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
OFF-LABEL PRESCRIPTION DRUG	RSA 415:6-g **Essential Health Benefits**	I. No insurer that issues or renews any individual policy of accident or health insurance providing benefits for medical or hospital expenses and providing coverage for prescription drugs shall exclude coverage for any such drug for a particular indication on the ground that the drug has not been approved by the Food and Drug Administration (FDA) for that indication, if such drug is recognized for treatment of such indication in one of the standard reference compendia or in the medical literature as recommended by current American Medical Association (AMA) policies. II. Any coverage of a drug required by this section shall also include medically necessary services associated with the administration of the drug. III. Nothing in this section requires: a) Coverage for any drug if the FDA has determined its use to be contraindicated for the treatment of the particular indication for which the drug has been prescribed; b) Coverage for experimental or investigational drugs not approved for any indication by the FDA; and c) Reimbursement or coverage for any drug not included on the drug formulary or list of covered drugs specified in a health plan, contract, or policy.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
PROMPT PAYMENT TIME LIMIT	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.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

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COVERAGE FOR CERTAIN PROSTHETIC DEVICES	**RSA 415-6:j** **Essential Health Benefits**	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:**
	RSA 415:18-d **Essential Health Benefit**	Coverage for expenses for scalp hair prostheses worn for hair loss suffered as a result of alopecia areata, alopecia totalis, alopecia medicamentosa resulting from the treatment from any form of cancer or leukemia, or permanent loss of scalp hair due to injury. Such coverage, however, shall be subject to a written recommendation by the treating physician stating that the hair prosthesis is a medical necessity. Such coverage shall be subject to the same limitations and guidelines as other prostheses.	
PRESCRIPTION DRUG CARDS	**RSA 415:6-k**	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	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

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		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.	
	NHCAR Part Ins 1901.09	**Member Identification Card** All health carriers providing coverage as defined in RSA 420-G:2, IX. and prescription drug and dental benefits offered separately as described in RSA 420-G:2, IX. (j) shall on or after January 1, 2010 issue: (a) Printed "John/Jane Doe" member identification cards or benefit guarantee cards as evidence of coverage of membership. (b) The card, which shall contain at a minimum the following: (1) The insurance company name; (2) Subscriber or member name; (3) Subscriber or member identification number; and (4) A telephone number and website for customer service inquiries. (c) Identify, on all member identification cards or benefit guarantee cards, that the benefit plan represented on the card is under the jurisdiction of the New Hampshire insurance commissioner pursuant to RSA 400-A:15-c, so that the term "insured" shall be printed on the member identification card so that it is: (1) Clearly visible; and (2) In a font size no less than the member's name on the member identification card.	

STATE MANDATES			
REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
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:**
COVERAGE FOR THE COST OF TESTING FOR BONE MARROW DONATION	**RSA 415:6-m**	Each insurer that issues or renews any individual policy, plan, or contract of accident or health insurance providing benefits for medical or hospital expenses, shall provide to certificate holders of such insurance, who are residents of this state, and who meet the criteria for testing as established by the Match Registry (the National Marrow Donor Program), coverage for laboratory fee expenses up to $150 arising from human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for utilization in bone marrow transplantation. The testing shall be performed in a facility that is accredited by the American Association of Blood Banks or its successors, or the College of American Pathologists, or its successors, or any other national accrediting body with requirements that are substantially equivalent to or more stringent than those of the College of American Pathologists, and is licensed under the Clinical Laboratory Improvement Act of 1967, 42 U.S.C. section 263a, as amended. At the time of the new testing, the person tested shall complete and sign an informed consent form that also authorizes the results of the test to be used for participation in the National Marrow Donor Program and shall acknowledge a willingness to be a bone marrow donor if a suitable match is found. II. In addition to paragraph I, the testing facility shall not bill, charge, collect a deposit from, seek payment or reimbursement from, or have recourse against a covered person or a person acting on behalf of the covered person for any portion of the laboratory fee expenses.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
COVERAGE FOR CHILDREN'S EARLY INTERVENTION THERAPY SERVICES	**RSA 415:6-n** **Essential Health Benefits**	Each insurer that issues or renews any individual policy, plan, or contract of accident or health insurance providing benefits for medical, rehabilitation, or hospital expenses, shall provide to certificate holders of such insurance, who are residents of this state, coverage for expenses arising from the services of licensed and credentialed occupational therapists, physical therapists,	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

STATE MANDATES			
REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
		speech-language pathologists, and clinical social workers working with children from birth to 36 months of age with an identified developmental disability and/or delay as long as the providing therapist receives a referral from the child's primary care physician if applicable.	

STATE MANDATES			
REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
COVERAGE FOR OBESITY AND MORBID OBESITY	**RSA 415:6-o** **Essential Health Benefits**	Each insurer that issues or renews any individual policy, plan, or contract of accident or health insurance providing benefits for medical or hospital expenses, shall provide to certificate holders of such insurance, who are residents of this state, coverage for the diseases and ailments caused by obesity and morbid obesity and treatment for such, including bariatric surgery, when the prescribing physician has issued a written order stating that treatment is medically necessary and in accordance with the patient qualifications and treatment standards set forth by the American Society for Metabolic and Bariatric Surgery or the American College of Surgeons. Such treatment standards may include, but not be limited to, pre-operative psychological screening and counseling, behavior modification, weight loss, exercise regimens, nutritional counseling, and post-operative follow-up, overview, and counseling of dietary, exercise, and lifestyle changes. The covered insured shall be at least 18 years of age. The benefits included in this section shall be subject to the terms and conditions of the policy and shall be no less extensive than coverage provided for similar conditions or illnesses.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
COVERAGE FOR HEARING AIDS	**RSA 415:6-p** **Essential Health Benefits**	Insurers are required to cover the cost of a hearing aid for each ear, as needed, as well as related services necessary to assess, select, and fit the hearing aid.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
REIMBURSEMENT FOR AMBULANCE SERVICE PROVIDERS	**RSA 415:6-q**	Each insurer that issues or renews any policy of group or blanket accident or health insurance that constitutes health coverage under RSA 420-G:2, IX, and that provides benefits for medically necessary ambulance services shall reimburse the ambulance service provider directly or by a check payable to the insured and the ambulance service provider subject to the terms and conditions of the policy, plan, or contract. Nothing in this section shall preclude an insurer from negotiating with and subsequently entering into a contract with a non-participating ambulance provider that establishes rates of reimbursement for emergency medical services.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
NATUROPATHY PROVIDERS; PAYMENT FOR EQUIVALENT TYPES OF SERVICE	**RSA 415:6-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	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

STATE MANDATES			
REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
		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.	

STATE MANDATES			
REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
NEWBORN CHILDREN	RSA 415:22	I. All individual health insurance policies providing coverage on an expense incurred basis shall provide that the health insurance benefits applicable for children are payable with respect to a newly born child of the insured or subscriber or a newly born child of a dependent child of the insured or subscriber from the moment of birth. III. Unless the policy or contract specifically provides that grandchildren of the insured or subscriber are eligible for coverage, coverage for newly born children of a dependent child of the insured or subscriber shall not continue beyond the initial 31-day period following birth. Nor shall such newly born children be considered dependents of the insured for any purpose addressed in this title.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
ADOPTED CHILDREN	RSA 415:22-a	All individual health insurance policies which provide coverage for a family member of the insured shall also provide that health insurance benefits applicable for children are payable with respect to any minor from the date such minor is placed in the custody of the insured pursuant to an adoption proceeding.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
LOW-DOSE MAMMOGRAPHY COVERAGE	RSA 417-D:2 **Essential Health Benefits**	Any policy of accident and health insurance providing benefits for hospital expense, medical-surgical expense, or major medical expense shall provide: (a) a baseline mammogram for women 35 to 39 years of age. (b) a mammogram every 1 to 2 years, even if no symptoms are present, for women 40 to 49 years of age. (c) an annual mammogram for women 50 years of age or older.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
PREGNANCY, DELIVERY, AND POSTPARTUM COVERAGE	RSA 417-D:2-a **Essential Health Benefits**	Coverage during pregnancy and delivery and the postpartum period: I. The length of hospital stay and the number of postpartum visits shall be determined by the attending health care provider based on clinical information that demonstrates that the mother and infant are clinically stable based on nationally accepted guidelines pursuant to paragraph IV and that appropriate care for the mother and newborn can be provided for upon discharge. The length of stay shall not be determined by the health insurer or the hospital based on economic criteria. II. Upon notification of the pregnancy by the insured to the insurer, the insurer shall inform the pregnant woman in writing regarding the insurer's prenatal, maternity, and postpartum benefits, including but not limited to prenatal visits, diagnostic tests, prenatal education, hospital length of stay, postpartum care, homemaker services, and contraceptive counseling and referrals. III. The insurer shall pay for medically necessary prenatal homemaker services when a woman is confined to bed rest or her activities of daily living are otherwise restricted on the recommendation of her attending health care provider who shall consult with the applicable case manager. IV. Any length of hospital stay shorter than the current minimum nationally accepted guidelines for perinatal care, such as Guidelines for Perinatal Care prepared by the American Academy	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

STATE MANDATES			
REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
		of Pediatrics and the American College of Obstetricians and Gynecologists, shall be at the recommendation of the attending health care provider in consultation with the mother. In such cases the insurer shall pay for at least 2 postpartum visits. During one such visit, the collection of an adequate sample from the newborn for screening for genetic and metabolic diseases shall take place in accordance with RSA 132 and applicable rules. V. Postpartum visits shall include a physical assessment of mother and infant. The assessment shall include but not be limited to: infant nutrition and feeding, infant behavior, family interactions, safety and injury prevention, infant and maternal health promotion, and community resources. Providers of postpartum visits shall be licensed health care providers experienced in perinatal care. VI. The insurer shall pay for appropriate medically necessary postpartum homemaker services as determined by the attending health care provider who shall consult with the applicable case manager.	

STATE MANDATES			
REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
RECONSTRUCTIVE SURGERY	**RSA 417-D:2-b** **Essential Health Benefits**	Every insurer subject to this chapter that provides individual or group coverage for mastectomy surgery shall provide coverage for reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the patient elects reconstruction and in the manner chosen by the patient and the physician.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
COVERAGE FOR TELEMEDICINE SERVICES	**RSA 415-J:3**	I. It is the intent of the general court to recognize the application of telemedicine for covered services provided within the scope of practice of a physician or other health care provider as a method of delivery of medical care by which an individual 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:**
COVERAGE FOR BIOLOGICALLY-BASED MENTAL ILLNESSES	**RSA 417-E:1** **MENTAL HEALTH PARITY AND ADDITION EQUITY ACT** **45 CFR 146.136** **45 CFR 147.160** **Essential Health Benefits**	III. Treatment and diagnosis of certain biologically-based mental illnesses under the same terms and conditions and which are no less extensive than coverage provided for any other type of health care for physical illness. The following mental illnesses, as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association, shall be covered under this section: (a) Schizophrenia and other psychotic disorders. (b) Schizoaffective disorder. (c) Major depressive disorder. (d) Bipolar disorder. (e) Anorexia nervosa and bulimia nervosa. (f) Obsessive-compulsive disorder. (g) Panic disorder. (h) Pervasive developmental disorder or autism. (i) Chronic post-traumatic stress disorder.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
COVERAGE FOR TREATMENT OF PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM	**RSA 417-E:2** **MENTAL HEALTH PARITY AND ADDITION EQUITY ACT** **45 CFR 146.136**	I. For the purposes of this chapter, treatment of pervasive developmental disorder or autism as required under RSA 417-E:1, III(h) shall include the following: a) Professional services and treatment programs, including applied behavioral analysis, necessary to produce socially significant improvements in human behavior or to prevent loss of attained skill or function. To be eligible for coverage, applied behavior analysis must be provided by a person professionally certified by the national Behavior Analyst	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

STATE MANDATES			
REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
	45 CFR 147.160 **Essential Health Benefits** **2017 NOTICE OF FINAL BENEFIT AND PAYMENT PARAMETERS**	Certification Board or performed under the supervision of a person professionally certified by the national Behavior Analyst Certification Board. b) Prescribed pharmaceuticals subject to the same terms and conditions of the policy as other prescribed pharmaceuticals. c) Direct or consultative services provided by a licensed professional including a licensed psychiatrist, licensed advanced practice registered nurse, licensed psychologist, or licensed clinical social worker; and d) Services provided by a licensed speech therapist, licensed occupational therapist, or licensed physical therapist. II. An insurer may require submission of a treatment plan, including the frequency and duration of treatment, signed by the primary care provider, an appropriately credentialed treating specialist, a child psychiatrist, a pediatrician with a specialty in behavioral-developmental pediatrics, a neurologist with a specialty in child neurology, or a licensed psychologist with training in child psychology, that the treatment is medically necessary for the patient and is consistent with nationally recognized treatment standards for the condition such as those set forth by the American Academy of Pediatrics. An insurer may require an updated treatment plan no more frequently than on a semi-annual basis. Coverage shall not be denied on the basis that services are habilitative in nature. Under §156.125, which implements the prohibition on discrimination provisions, an issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.	

STATE MANDATES			
REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
EXCLUSIONS FOR PRE-EXISTING CONDITIONS – PROHIBITED	PPACA Section 1101	According to general reform initiated under Affordable Care Act Section, preexisting condition exclusions are prohibited for all non-grandfathered group health plans and health insurance issuers effective for plan years starting on or after January 1, 2014.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
OUTLINE OF COVERAGE	NHCAR Part Ins 1901.07(g)	Outline of Coverage is required for the following: Individual Major Medical/Comprehensive Coverage. The format and order is specified in the rule.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
AVAILABILITY, AND RENEWABILITY OF HEALTH COVERAGE	RSA 420-G:6 IV, V, VI and VII. RSA 420-G:4	Federal law requires that carriers accept all applicants. Variations in premium rating factors cannot be health-related, and can only be based on geographic rating area, individual/family coverage, age (variation cannot exceed 3:1 for adults), and tobacco use (variation cannot exceed 1.5:1). Renewability is guaranteed, subject to the conditions and requirements of RSA 420-G:6.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
MANAGED CARE LAW	RSA 420-J	Section 420-J:5 Grievance Procedures Section 420-J:6-a Obstetrical-Gynecological Coverage. Section 420-J:6-b Self-referrals for Chiropractic Care. Section 420-J:7-b Prescription Drugs	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
MANAGED CARE GUIDE	NHCAR Part Ins 2700	**Ins 2703.04 Notice of Right to External Review.** (a) Health carriers shall provide to covered persons the insurance department's "**Managed Care Consumer Guide to External Appeal**" and the insurance department's "**Request for Independent External Appeal of a Health Care Decision**" in each of the following circumstances: (1) The publications shall be attached to the policy, certificate, membership booklet, or other evidence of coverage provided to covered persons;	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
PRESCRIPTION EXCEPTION PROCESS	RSA 420-J:7-b II 45 CFR 156.122(c)	45 CFR 156.122(c) requires health plans to have a process to allow an enrollee to request and gain access to clinically appropriate drugs not otherwise covered by the health plan. The process must include: • an internal review; federal regulations require the carrier to make a determination and notify the enrollee no later than 72 hours following receipt of the request, however, RSA 420-J:7-b	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

STATE MANDATES			
REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
		requires that the process not exceed 48 hours, • an external review, • the ability to expedite the reviews (must make determination and notify the enrollee no later than 24 hours following receipt of the request). • In the event that an exception request is granted, the excepted drug(s) are treated as an EHB including counting any cost-sharing towards the plan's annual limitation on cost-sharing.	

STATE MANDATES			
REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
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 insured's to purchase (retail or mail order) an up-to-90-day supply of covered prescription drugs on the covered person's health plan formulary at one time, provided that the insured can demonstrate that such drug has been taken by the insured for a continuous period of one year and provided that such drug is not subject to the health plan's utilization management, prior authorization, or pre-certification requirements. Controlled substances as defined by the USDEA are not subject to this paragraph.	**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:**
IDENTIFICATION CARDS	NHCAR Part Ins 1901.09	(b) The card shall contain at a minimum the following: 1) The insurance company name; 2) Subscriber or member name; 3) Subscriber or member identification number; 4) A telephone number and website for customer service inquiries. (c) Identify, on all member identification cards or benefit guarantee cards, that the benefit plan represented on the card is under the jurisdiction of the New Hampshire insurance commissioner pursuant to RSA 400-A:15-c, so that the term "insured" shall be printed on the member identification card so that it is: 1) Clearly visible; and 2) In a font size no less than the member's name on the member identification card.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
COVERAGE FOR PRESCRIPTION CONTRACEPTIVE DRUGS, CONTRACEPTIVE DEVICES AND CONTRACEPTIVE SERVICES	RSA 415:18-i **Essential Health Benefit**	Each insurer that issues or renews any group policy of accident or health insurance providing benefits for medical or hospital expenses, which provides coverage for outpatient services shall provide to each group, or to the portion of each group comprised of certificate holders of such insurance who are residents of this state, coverage for outpatient contraceptive services under the same terms and conditions as for other outpatient services. "Outpatient contraceptive services'' means consultations, examinations, and medical services, provided on an outpatient basis and related to the use of contraceptive methods to prevent pregnancy which has been approved by the U.S. Food and Drug Administration. Each insurer that issues or renews any policy of	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

STATE MANDATES			
REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
		group accident or health insurance providing benefits for medical or hospital expenses which provides a prescription rider shall cover all prescription contraceptive drugs and prescription contraceptive devices approved by the U.S. Food and Drug Administration under the same terms and conditions as other prescription drugs. Nothing in this section shall be construed as altering the terms and conditions of a contract relating to prescription drugs and outpatient services. Note: This mandate applies to prescription contraceptive drugs, devices and contraceptive services for both genders.	

FEDVIP PEDIATRIC DENTAL AND PEDIATRIC VISION			
REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
FEDVIP **HIGH OPTION DENTAL BENEFITS**	**45 CFR 156 Appendix B** **FEDVIP Plan Details** **Essential Health Benefit**	Class A (Basic) Services – preventive and diagnostic, includes fluoride treatment for children under age 5.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
		Class B (Intermediate) Services – includes minor restorative services	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
		Class C (Major) Services – includes major restorative, endodontic, and prosthodontic services	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
		Class D Services – orthodontic Maximum 24 month waiting period	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
PEDIATRIC VISION	**Essential Health Benefit**	**Routine Eye Exams** (including dilation, if professionally indicated)	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
		Standard Eyeglass Lenses (Contact lenses may be obtained in lieu of glasses) Optional Lens Treatments	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
		Frames Collection Frames Non-Collection Frame	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
		Contact Lenses	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

SECTION 3 GENERAL REQUIREMENTS

REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
ADVERTISING	45 CFR 156.225(a) 45 CFR 156.225(b)	Advertising Guidelines Health Insurance Marketplace branding guides	**YES:** ☐ **NO:** ☐
	NHCAR Part Ins 2600	Marketing practices must not discourage the enrollment of individuals with significant health needs.	**PAGE # OR IF NO:**
	Federal Health Insurance Marketplace	Advertising materials for all plans, including indemnity licensed products, must be submitted to the Department for review and approval in accordance with the requirements under this bulletin.	
	2017 Letter to Issuers Bulletin Ins 14-015-AB	The Affordable Care Act and subsequent regulations grant the Department authority to review marketing materials, including advertisements, and ensure that materials are not false, misleading or discriminatory. This authority is in addition to existing authority under state law, discussed further below. The Department will review marketing materials to ensure that that marketing practices or benefit designs will not have the effect of discouraging the enrollment of individuals with significant health needs in QHPs. QHP issuers must inform consumers in QHP marketing materials that the QHP is certified by the Marketplace. The QHP issuer cannot inform consumers that the certification of a QHP implies any form of further endorsement or support of the QHP. For 2017 QHP certification purposes, the NHID requires issuers to file advertisements "prior to use," in accordance with RSA 420-B:8, VI. In Bulletin INS-14-015 NHID interpreted "review and approval prior to use" in RSA 420-B:8 Forms of Evidence of Coverage to mean: Before an HMO uses any materials meeting the definition of advertising in RSA 420-B:1 I, the HMO shall file materials with the Department for review. Issuers must submit advertisements in SERFF in the filing mode of "Information Only" as appropriate with the filing type marked as "Advertising." Per NHCAR Part Ins 401.03, all forms, including webpages and other social media, must have a form number in the lower left hand corner. Advertising containing cost-sharing and benefit information will be reviewed prior to approval, and issuers must be prepared to participate in the process.	

SECTION 3 GENERAL REQUIREMENTS

REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
		Advertising materials for all Marketplace plans, including indemnity products, require submission to the Department for review. The issuer may commence using all other advertising materials once the filing requirements above have been completed. The Department reserves the right to disapprove any and all filed advertisements, to the extent that they do not conform with the substantive requirements under RSA 420-B:12, or other applicable laws. All issuers should be prepared to participate in a full review of all filed materials, and are reminded that advertisements are subject to a market conduct review if issues arise after use. Issuers are urged to consult the NHID guidance entitled **2015 QHP Certification: Guidance on the Filing of Advertising Materials** (Bulletin INS-14-015) for additional information. If NHID determines through its regulatory efforts that unfair or discriminatory marketing is occurring, NHID will enforce through use of state remedies, including decertification for QHPs. Advertising and Marketing rules for Health Insurance and HMOs can be found in **NHCAR Part Ins 2601.** Statute authority for HMO advertising is found at **RSA 420-B:8 VI**. Health Insurance Marketplace branding guide and logo for QHPs are found at: **https://marketplace.cms.gov/outreach-and-education/marketplace-brand-guide.pdf**	
DEFINITIONS	**NHCAR Part Ins 1901.03** **NHCAR Part Ins 1901.04** **RSA 420-G:2** **RSA 420-J:3**	General accident and health definitions. Comprehensive or major medical definitions. Managed care definitions.	**YES: ☐ NO: ☐** **PAGE # OR IF NO:**

SECTION 3 GENERAL REQUIREMENTS

REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
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:**

SECTION 4 APPLICATIONS

REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
APPLICATION		Federal Marketplace application must be attached to the supporting documentation tab for informational purposes. Non-marketplace applications must be attached to the forms schedule tab for review and approval.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
REPRESENTATIONS	NHCAR Part Ins 401.11 (a) (1)	The declarative portion of the application, if any, shall imply a representation of facts to the best of the applicant's knowledge. "I represent," or "To the best of my knowledge and belief," shall be examples of such wording. Wording implying a warranty shall be prohibited. "I Certify" shall be such an example.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
HOME OFFICE BOX	RSA 415:11	H.O. Box - No alteration of any written application for insurance, by erasure, insertion or otherwise, shall be made by any person other than the applicant without his written consent, and the making of any such alteration without the consent of the applicant shall be a misdemeanor.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

NOTICE OF REPLACEMENT OF COVERAGE	**NHCAR Part Ins 1901.08**	(a) An application form shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other accident and health insurance presently in force. A supplementary application or other form to be signed by the applicant containing the question may be used. (b) Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent shall furnish the applicant, prior to issuance or delivery of the policy, the notice described in (c) below. The insurer shall retain a copy of the notice. A direct response insurer shall deliver to the applicant upon issuance of the policy, the notice described in (d) below. In no event, however, will the notices be required in the solicitation of the following types of policies: accident-only and single-premium nonrenewable policies. (c) The notice required by (b) above for an insurer, other than a direct response insurer, shall provide, in substantially the following form as prescribed.	**YES: ☐ NO: ☐** **PAGE # OR IF NO:**

SECTION 5 POLICY FORM

REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
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:**
COMPANY STANDING		The Company is in "Good Standing" with the State of New Hampshire. A copy of a current New Hampshire license and NHID Certificate of Compliance is required.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
COVER PAGE **BRIEF DESCRIPTION**	**NHCAR Part Ins 401.03**	(c) Each policy and certificate shall provide a brief description of the nature of the policy, as follows: (1) The brief description shall be printed on: a. The face page, specifications page, or the back page if the policy form has a full size cover page.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
COVER PAGE **JURISDICTION**	**RSA 400-A:15-c** **NHCAR Part Ins 401.03 (p)**	All health coverage as defined in RSA 420-G:2, IX and prescription drug and dental benefits offered separately as described in RSA 420-G:2, IX(j) shall be identified as being under the jurisdiction of the commissioner. Such identification shall be clearly printed on a member's identification card and the policy issued to an insured after January 1, 2010.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
COVER PAGE **PPACA DISCLOSURE**	**Bulletin Ins 10-042-AB** **SERFF General Instructions**	**IMPORTANT INFORMATION** **This policy reflects the known requirements for compliance under The Affordable Care Act as passed on March 23, 2010. As additional guidance is forthcoming from the US Department of Health and Human Services, and the New Hampshire Insurance Department, those changes will be incorporated into your health insurance policy.**	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

SECTION 5 POLICY FORM

REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
COVER PAGE **RENEWABILITY**	**NHCAR Part Ins 1901.07 (a) (4)**	(4) Each policy of individual accident and health insurance or group supplemental accident and health insurance shall include a renewal, continuation or nonrenewal provision. The language or specification of the provision shall be consistent with the type of contract to be issued. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.	**YES: ☐ NO: ☐** **PAGE # OR IF NO:**
COVER PAGE **FREE LOOK**	**NHCAR Part Ins 1901.07 (a) (11)**	All policies and certificates, except single-premium nonrenewable policies and as otherwise provided in this paragraph, shall have a notice prominently printed on the first page of the policy or certificate or attached to it stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the policyholder or certificate holder is not satisfied for any reason.	**YES: ☐ NO: ☐** **PAGE # OR IF NO:**
GENERAL PROVISIONS **DEPENDENT**	**RSA 415:5 I (3)(a)** **RSA 420-B:8-aa I (HMO)** **RSA 420-J:8-d (managed care)**	"Dependent child'' shall include a subscriber's child by blood or by law, who is under age 26.	**YES: ☐ NO: ☐** **PAGE # OR IF NO:**
GENERAL PROVISIONS **DISABLED DEPENDENT**	**RSA 415:5 I (3-a)(a)**	The coverage of any family member insured by such policy, pursuant to subparagraph (3), who is mentally or physically incapable of earning his or her own living on the date as of which such dependent's status as a covered family member would otherwise expire because of age, shall continue under such policy while such policy remains in force or is replaced by another policy as long as such incapacity continues and as long as said dependent remains chiefly financially dependent on the policyholder or the employee or his or her estate is chargeable for the care of said dependent, provided that due proof of such incapacity is received by the insurer within 31 days of such expiration date.	**YES: ☐ NO: ☐** **PAGE # OR IF NO:**

SECTION 5 POLICY FORM

REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
GENERAL PROVISIONS **DISABLED DEPENDENT – MICHELE'S LAW** **(IF COVERAGE IS PROVIDED FOR STUDENTS AGE 26 OR OLDER)**	RSA 415:5 I (3-(a)(b)	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:**
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:**

SECTION 5 POLICY FORM

REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
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:**
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) 45 CFR 156.270	A provision that the policyholder is entitled to a grace period of 31 days for the payment of any premium due except the first, during which grace period the coverage shall continue in force. Enrollees receiving advance payment of premium tax credits are allowed a 3-month grace period following nonpayment of premium, subject to the conditions of 45 CFR 156.270	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

SECTION 5 POLICY FORM

REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
GENERAL PROVISIONS **INCONTESTABILITY**	RSA 415:6 I (2) RSA 420-B:8-i	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. A 30 day advance notice is required. HMO - **Incontestable Provision. –** The validity of the contract shall not be contested except for nonpayment of premiums, after it has been in force for 2 years from its date of issue. No statement made by any person covered under the contract relating to insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of 2 years during such person's lifetime, and not unless it is contained in a written instrument signed by the person making such statement. No such provision, however, shall preclude the assertion, at any time, of defenses based upon the person's ineligibility for coverage under the plan or upon other provisions in the plan, except for any provisions establishing, as a requirement of eligibility, the furnishing of satisfactory evidence of insurability to the health maintenance organization.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
GENERAL PROVISIONS **MATERNITY COVERAGE**	**Essential Health Benefit Requirement**	Maternity coverage is required. Prenatal visits and screening, and postpartum care to include breastfeeding support, equipment, and counseling (including screening for post-partum depression) must be provided with no cost sharing.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
GENERAL PROVISIONS **NETWORK BASED HOSPITAL SERVICES**	Bulletin Ins 06-018-AB Bulletin Ins 16-009-AB RSA 420-J:8 RSA 420-B:12	Provider contract standards and prohibition on balance billing.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

SECTION 5 POLICY FORM

REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
SUMMARY OF BENEFITS AND COVERAGE	CMS Guidance	Summaries of Benefits and Coverage (SBCs) must be attached to the forms schedule tab of the Form/Rate filing. Variability is not permitted. Each SBC must contain the following naming convention for both the file name as well as the form number: HIOS Standard Component ID and Plan Variation. Additionally, please indicate the metal level, as well as the designation as applicable, for transparency to the consumer.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

SECTION 5 POLICY FORM

REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
GENERAL PROVISIONS - REINSTATEMENT	**RSA 415:6 I (4) and (4-a)**	(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. (4-a) With respect to policies subject to RSA 420-G, a provision as follows: Reinstatement: If any renewal premium is not paid within the time granted the insured for payment, a subsequent payment of the premium to the insurer or to any agent duly authorized by the insurer to receive 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 receipt for the premium tendered, the policy will be reinstated upon receipt of such application by the insurer or such agent. 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 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. 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:**

SECTION 5 POLICY FORM

REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
GENERAL PROVISIONS INSURANCE WITH SAME 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:**
GENERAL PROVISIONS INSURANCE WITH OTHER INSURERS	**RSA 415:6 II (4)**	A provision in all non-group 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. Provided, however, that the provisions of this subparagraph shall not prohibit the issuance of a "benefits deductible'' on policies determined by the insurance commissioner as major medical policies. The term "benefits deductible'', as used herein, means the value of any benefits provided on an expense incurred basis which are provided with respect to covered medical expenses by any other hospital, surgical or medical insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan, or any other plan or program whether on an insured or uninsured basis. Provided, however, that the term "benefits deductible'' shall not mean the value of benefits provided with respect to medical or liability insurance offered under either a general liability insurance policy or an auto insurance policy.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

SECTION 5 POLICY FORM

REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
GENERAL PROVISIONS **CONTRACEPTIVE COVERAGE**	CMS FAQ 12 FINAL RULE Bulletin Ins 16-009-AB	PHS Act section 2713 and federal regulations require non-grandfathered group health plans and health insurance coverage offered in the individual or group market to provide benefits for and prohibit the imposition of cost-sharing requirements, with respect to women, for evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA, to the extent not already included in certain recommendations of the USPSTF. As stated in Affordable Care Act Implementation FAQs - Set 12, intrauterine devices and implants contraceptive methods under the HRSA Guidelines, and are required to be covered without cost-sharing, if approved by the FDA and prescribed for a woman by her health care provider, subject to reasonable medical management. Additionally, the HRSA guidelines and federal regulations outline that issuers must cover at least one type of contraceptive in each classification of contraceptive, requiring specifically that at least one intrauterine device, and one implant contraceptive method be covered without the imposition of cost-sharing requirements. The NHID will only certify those plan offerings in compliance with the above stated federal requirements, including language in an issuers Summary of Benefits and Coverage that states the following; *"Contraceptive methods approved by FDA and prescribed for a woman by her health care provider, subject to reasonable medical management, will be covered without cost sharing requirements."*	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**
PREMIUMS **RENEWAL INCREASE**	**NHCAR Part Ins 401.07 (b) (9)** **RSA 420G**	In the event of any renewal rate increase, insurers shall provide policyholders with prior notice of any such increase such that: b. A 60 days notice is provided for policies subject to RSA 420-G;	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

SECTION 5 POLICY FORM

REQUIREMENTS	REFERENCE	DESCRIPTION OF REQUIREMENT	COMPLIANCE
COST CONTAINMENT	**Bulletin Ins 05-020-AB**	If a provision provides for a reduction in benefits due to the failure of the insured or the insured's physician to follow required procedures or obtain any necessary authorization, the reduction in benefits or penalty may not be more than 50% of the benefit that would have otherwise been payable, or $1,000.00, whichever is less. With respect to a provision that requires authorization from the insurer prior to a hospital admission, the insurer may, in lieu of a percentage reduction, state that either the benefits payable or eligible charges will be reduced or denied up to a specified dollar amount. In no event shall a policy provision provide for a reduction in benefits or penalty that is greater than $1,000.00.	**YES:** ☐ **NO:** ☐ **PAGE # OR IF NO:**

State of New Hampshire

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

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

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

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

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

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