NEW HAMPSHIRE HEALTH PLAN

This policy is issued to You by the New Hampshire Health Plan in accord with New Hampshire law. This policy is modified by the Schedule and the riders attached hereto. The premium You paid and the application You completed and our reliance on your answers to the application questions have put this policy in force as of the Policy Date. That date is shown on the Schedule. A copy of your application is attached.

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Dependent children under the age of 26 shall also be covered under this policy. For the purposes hereof, “dependent” means your child by blood or by law, who: (1) is less than 26 years of age; (2) is unmarried; (3) is a resident of New Hampshire or is enrolled as a student at a public or private institution of higher education; and (4) is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or entitled to benefits under Title XVIII of the Federal Social Security Act, Public Law 89-97, 42 U.S.C. 1395 et seq.

Any party who has entered into a civil union with You shall be covered under this policy so long as such party is otherwise eligible for coverage under this policy and provided that such civil union is recognized under applicable New Hampshire law.

PART A. 10-DAY RIGHT TO EXAMINE POLICY

We want You to fully understand and be entirely satisfied with your policy. This policy may, at any time within 10 days after its receipt by You, be returned by delivering it or mailing it to us or the agent through whom it was purchased. Immediately upon such delivery or mailing, the policy will be deemed void from the beginning, and any premium paid on it will be refunded to You.

PART B. PLEASE READ YOUR APPLICATION

Please read the copy of your application. If anything in it is not correct or has been left out, You should tell us. Your policy was issued on the basis that all information in the application is correct and complete. If not, your policy may not be valid.

PART C. RENEWAL AGREEMENT

We will renew your policy each time You pay your premium until the earliest of:

(a) the date the Lifetime Maximum Benefit has been paid to You under the policy;
(b) the date You are no longer a resident of the State of New Hampshire;
(c) the date You request coverage under this policy to terminate;
(d) the date of your death;
(e) the date New Hampshire statutes require cancellation of this policy; or
(f) the second of two successive inquiries made by the plan concerning your eligibility or place of residence to which You do not reply. You will have 90 days to respond to each inquiry.

For the purposes of the preceding paragraph, termination of coverage shall result for any of your dependents and any civil union partner, as applicable, if any of clauses (a) through (f) apply to such person.

Grace Period: Your premium must be paid on or before the date it is due or during the 31-day grace period that follows, subject to the right of the insurer to cancel in accordance with the cancellation provision hereof. This policy stays in force during the grace period.

We may cancel or refuse to renew the policy upon the occurrence of any event listed in clauses (a) through (f) above.

Cancellation; Refusal to Renew: We will inform you of a cancellation or refusal to renew this policy by written notice delivered to You, or mailed to your last address as shown by our records, stating when, not less than 30 days thereafter (unless cancellation is effective immediately pursuant to the terms of this policy), such cancellation or refusal to renew shall be effective. Any cancellation or refusal to renew, if for reasons other than nonpayment of premium and other than specified in any time limits for certain defenses, shall be effected only if also effected on all policyholders of the same class. No such action shall be taken without prior written approval of the insurance commissioner. We shall have the burden of proof that the classification of risk involved therein is reasonable and nondiscriminatory.

PART D. UNPAID PREMIUM; PREMIUM CHANGES; POLICY CHANGES

UNPAID PREMIUM

Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

PREMIUM CHANGES

Subject to the premium rate guarantees described below, the premium rates may change at attained ages (the current premium rates for the various age groups are set forth on the Schedule) and the premium may also change on the basis of a revised schedule of rates. Such changes will be applied only when the same changes are made on all policies of this Form, with the same provisions and benefits, issued to persons of the same classification living in the same geographic area of your state at the time of change, but in any case shall be subject to the premium rate guarantees described below. We will notify You at least 30 days in advance of any such changes.

[**For any policy issued or renewed prior to July 1, 2008, and for any policy renewing off-anniversary between July 1, 2008 and December 31, 2008, the following provision shall be inserted**:

Six Month Premium Rate Guarantee

The premium rate is guaranteed for periods of six months; provided, however, that after the one year anniversary of the effective date of such policy, the "twelve month premium rate guarantee" described in the following paragraph will apply.

Twelve Month Premium Rate Guarantee

Commencing January 1, 2009, for each policy, any change to the premium rate will only be made on each yearly anniversary date of the policy and each premium rate will be guaranteed for a period of twelve months.]

[**For every other policy and for every policy as of January 1, 2009, the following provisions shall be inserted**:

Any change to the premium rate will only be made on each yearly anniversary date of the policy and each premium rate will be guaranteed for a period of twelve months.]

POLICY CHANGES

Any provision of this policy is subject to change as determined by the New Hampshire Health Plan. You will receive written notice of any policy changes in advance. You can change to a higher Deductible for the same plan type at any time upon written notification to the Administrator. The effective date of the change will be the first day of the month that follows the month during which your request was made. If You increase your Deductible, the new Deductible must be met for all services and supplies received as of the effective date of the change. This means that if You had met your lower Deductible and then change to a higher Deductible, for services and supplies received as of the effective date of the change, You would not receive benefit payments until the increase in Deductible is met.

Because your Deductible is part of your Out-of-Pocket Maximum, increasing your Deductible also increases your Out-of-Pocket Maximum. This means that if You had met your lower Out-of-Pocket Maximum and then increase your Deductible, for services and supplies received as of the effective date of the change, You would not receive the 100 percent payment until the increase in the Out-of-Pocket Maximum is met.

PART E. PREEXISTING CONDITION LIMITATION

Benefits are not payable for Expenses incurred for preexisting conditions during the first 9 continuous months of coverage following the Policy Date. After such nine-month period, benefits will be payable on the same basis as any other condition.

A preexisting condition is a condition for which symptoms existed within three months prior to the Policy Date that would cause a person to seek diagnosis, care or treatment; or for which medical advice, treatment or service was recommended by or received from a Physician within three months prior to the Policy Date; or for a pregnancy existing on the Policy Date.

NOTE: In determining whether a preexisting condition limitation applies, we will credit the time an Insured Person was previously covered under Creditable Coverage if the Creditable Coverage was continuous to a date not more than 63 days prior to the date the application was received by us. Any break in coverage of less than 63 days will not be considered in determining whether coverage was continuous.

PART F. DEFINITIONS

The following definitions apply throughout this policy unless stated otherwise.

"Administrator" means the high risk pool administrator as selected by us from time to time.

"Ambulance" means a specially designed and equipped vehicle used only for transporting the sick and injured. It must have customary safety and life saving equipment such as first-aid supplies and oxygen equipment. The vehicle must be operated by trained personnel and licensed as an Ambulance.

"Average Semiprivate Room Charge" means the Hospital's or skilled nursing facility's average daily charge for a semiprivate room. In the event the Hospital or skilled nursing facility has only private rooms, "the Average Semiprivate Room Charge" means 80% of the most common daily room charge.

"Biologically-Based Mental Illness" means schizophrenia and other psychotic disorders, schizoaffective disorder, major depressive disorder, bipolar disorder, anorexia nervosa and bulimia nervosa, obsessive-compulsive disorder, panic disorder, pervasive developmental disorder or autism, chronic post-traumatic stress disorder.

"Calendar Year" begins on January 1 and ends on December 31.

"Clean Claim" means a claim for payment of covered expenses that is submitted to us on our standard claim form using the most current published procedural codes, with all the required fields completed with correct and complete information in accordance with our filing requirements.

"Confinement" means needed Confinement as a resident inpatient because of Injuries or Sickness. It must be for a period of at least 24 consecutive hours. A Physician must recommend and supervise the Confinement.

"Creditable Coverage" means any public or private health insurance or health benefit plan, whether insured or self-insured. Creditable Coverage does not include coverage provided under:

(a) accident-only or disability income insurance;
(b) coverage issued as a supplement to liability insurance;
(c) liability insurance, including general liability insurance and automobile liability insurance;
(d) Worker's Compensation insurance;
(e) automobile medical-payment insurance:
(f) coverage for on-site medical clinics;
(g) other similar insurance coverage, specified in rules, under which benefits for medical care are secondary to other insurance benefits;
(h) If offered separately:
    (1) limited scope dental or vision benefits;
    (2) long-term care, nursing home care, Home Health Care, community-based care or any combination thereof;
    (3) Prescription Drug benefits; or
    (4) other similar, limited benefits;
(i) If offered as independent, noncoordinated benefits:
    (1) specified disease or illness benefits; or
    (2) hospital or surgical indemnity benefits; and

(j) If offered as a separate insurance policy, Medicare supplemental health insurance, coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code, and similar supplemental coverage.

"Dependent" means a dependent child insured under this policy.

"Electronic Claim" means the transmission of data for purposes of payment of covered Expenses in an electronic data format specified by us.

"Expense" means Expense incurred for the Medically Necessary Covered Services and Supplies listed in the Benefits provision. The services and supplies must be ordered or prescribed by a Physician as needed for diagnosis or treatment in the United States. Amounts in excess of the usual and customary charges in the geographic area involved (as determined by us) are not considered Expense. Expense for a service or supply is considered incurred on the date it is received.

An "Experimental or Investigative" service or supply is a service or supply that meets any of the following criteria:

(a) If a drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
(b) If a drug, device, treatment or procedure, or the protocol or informed consent document utilized with the drug, device, treatment or procedure, was subject to review and approval by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval for Experimental or Investigative treatment; or
(c) If Reliable Evidence shows that a drug, device or medical treatment or procedure is the subject of ongoing phase I, II or III clinical trials, or under study to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with the standard means of treatment or diagnosis; or
(d) If Reliable Evidence shows that the consensus of opinion among experts regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with the standard means of treatment or diagnosis.

"Home Health Care" means Medically Necessary services received from a Home Health Care Agency. Such services must: (a) be part of a written Home Health Care plan prescribed and set up by your Physician; (b) be received while not confined in a Hospital or nursing home; and (c) be in lieu of Hospital or nursing home Confinement. The Home Health Care Agency must be certified as such by Medicare or licensed as such by the state. Home Health Care services are limited to nursing care provided by a registered nurse (RN) or licensed practical nurse (LPN), and physical or speech therapy provided by a licensed therapist.

"Home Health Care Agency" means a home health agency, which has been certified under Title XVIII of the Social Security Act.

"Hospital" means any of the following places: (a) a place licensed or recognized as a general Hospital by the proper authority of the state in which it is located; (b) a place recognized as a general Hospital by the Joint Commission on the Accreditation of Hospitals; or (c) a place certified as a Hospital by Medicare. Not included is a Hospital or institution or a part of a Hospital or institution which is licensed or used principally as a clinic, continued care or extended care facility, skilled nursing facility, convalescent home, rest home, nursing home or home for the aged.

"Hospice Care Program" means a program for meeting the special needs of a terminally ill Insured Person and his or her immediate families, by providing support and care during the illness and bereavement:

(a) to individuals who have no reasonable prospect of cure and, as estimated by a Physician, have a life expectancy of less than six months; and
(b) to the immediate families of those individuals.

"Injury" means an accidental bodily Injury which is not excluded by the Preexisting Condition Limitation provision.

"Insured Person" means You, your spouse or civil union partner, and your Dependents, as the case may be, who are insured under this policy.

"Intensive Care Facility" means that part of a Hospital which is designated as such (whether it be a general Intensive Care Facility or any type of specialized Intensive Care Facility such as a coronary care unit, neonatal facility or renal care unit). It must be permanently equipped and staffed to provide greater care for critically ill or injured patients than what can be had in other rooms of the Hospital. A part of the care must be constant observation by a staff of registered graduate nurses (RNs). Their duties must be confined to such part of the Hospital.

"Low Protein Modified Food Products" means a food product that is specially formulated to have less than one gram of protein per serving and intended to be used under the direction of a Physician for the dietary treatment of inherited diseases of amino acids and/or organic acids. It does not include a natural food that is naturally low in protein.

"Medical Emergency" means a severe condition which:

(a) results in symptoms which occur suddenly and unexpectedly; and
(b) requires immediate Physician's care to prevent serious jeopardy of an Insured Person's health, bodily functions, or serious dysfunction of any bodily organ or part.

A "Medically Necessary" service or supply means one which: (a) is appropriate and consistent with the diagnosis in accord with accepted standards of community practice; (b) is not Experimental or Investigative; (c) could not have been omitted without adversely affecting an Insured Person's condition or quality of medical care; and (d) is delivered at the lowest and most appropriate level of care and not primarily for the sake of convenience.

"Mental or Nervous Disease" means any Mental or emotional disease or disorder of any kind which includes but is not limited to: neurosis, psychoneurosis, psychopathy or psychosis and Biologically-Based Mental Illnesses.

"Normal Childbirth" or "Normal Pregnancy" means childbirth or pregnancy free of complications.

"Non-Preferred Provider" means a provider of covered services who is not participating in our PPO (Preferred Provider Organization) program.

"Other Medical Insurance" includes: (a) any other health insurance policy; (b) all Hospital and medical Expense benefits paid or payable under any workers' compensation coverage; (c) automobile medical payment or liability insurance whether provided on the basis of fault or nonfault; and (d) any Hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program. Other

Medical Insurance includes the above plans regardless of whether provided on an individual, family or group basis through an employer, union, or membership in an association. If coverage is provided by a Blue Cross and Blue Shield Plan or any similar provision-of-service basis, the amount of benefit under such coverage shall be equal to the amount which the service rendered would have cost in the absence of such coverage. Other Medical Insurance DOES NOT include any of the following:

(a) any Hospital indemnity plan providing coverages on a nonexpense-incurred basis;
(b) any cancer and/or specified disease plan; or
(c) any accident only plan.

"Our," "We", "Us" or "NHHP" means the New Hampshire Health Plan.

"Physician" means a person, other than You or a member of Your immediate family, duly licensed and legally qualified to diagnose and treat Sickness and Injuries. He or she must be providing services within the scope of his or her license.

"Preferred Provider" means a provider of covered services who is participating in our PPO (Preferred Provider Organization) program.

"Prosthetic Device" means an artificial limb device to replace, in whole or in part, an arm or leg.

"Reliable Evidence" shall mean: (a) only published articles in the authoritative medical and scientific literature; (b) the written protocol(s) used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or (c) the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

"Sickness" means a Sickness, disease, Biologically-Based Mental Illness, or physical condition, which is not excluded under the Preexisting Condition Limitation provision.

"Skilled Nursing Care Facility" means a place operated pursuant to law to provide skilled nursing care to resident persons. It must have a registered graduate nurse (RN) on call 24 hours a day.

"You" or "Your" means the person named as the Insured on the Schedule.

PART G. BENEFITS

When an Insured Person incurs Expense for a covered Injury or Sickness, we will pay the Specified Percentage shown on the Schedule of such Expense that is in excess of the Deductible until the Out-of-Pocket Expense Maximum is reached (unless stated otherwise). Benefits are limited to: (a) the Lifetime Maximum Benefit (shown on the policy Schedule); and (b) Expense incurred in excess of the Calendar Year Deductible.

NOTE: Benefits payable for certain services and procedures may be less than listed in this section. Please review the Precertification Review and Case Management provisions for a further explanation.

PREFERRED PROVIDER ORGANIZATION REQUIREMENTS. An Insured Person may choose any Physician, Hospital or other health care provider the Insured Person wishes. However, the Insured Person is subject to the Non-Preferred Provider Specified Percentage (shown in the Schedule), Non-Preferred

Provider Deductible (shown in the Schedule) and Non-Preferred Provider Out-of-Pocket Maximum if such Insured Person uses the services of a Non-Preferred Provider rather than a Preferred Provider.

CALENDAR YEAR MAXIMUM. The Calendar Year Maximum (shown in the Schedule) is the amount of benefits payable for Covered Services and Supplies for each Insured Person during a Calendar Year. Expense incurred in excess of the Calendar Year Maximum will not be considered Covered Services and Supplies and will not apply to the Lifetime Maximum Benefit, the Out-of-Pocket Expense Maximum, or to the Deductible for any year.

DEDUCTIBLE. The Deductible is the amount of eligible Expense shown on the Schedule that an Insured Person must satisfy each Calendar Year before benefits are payable for that Calendar Year. All eligible Expense(s) used toward the accumulation of the Deductible in any one Calendar Year must be incurred in that Calendar Year.

Each Insured Person must separately meet the individual Deductible until the first of the following occurs: (1) the Insured Person satisfies the individual Deductible; or (2) the aggregate eligible Expenses of all Insured Persons satisfies an amount equal to two times the individual Deductible (the "aggregate family Deductible"). When an individual Insured Person satisfies the individual Deductible, then benefits will be paid for that Insured Person as shown in the Schedule. After all Insured Persons have satisfied the aggregate family Deductible, then benefits will be paid for all Insured Persons as shown in the Schedule. All eligible Expense used toward the accumulation of the Deductible in any one Calendar Year must be incurred in that Calendar Year.

The following will be used to determine which Expense will be used to satisfy the Calendar Year Deductible:

(a) for all bills received at our claims office at the same time, we will use the date the Expense was incurred and apply those Expenses first incurred to satisfy the Deductible.
(b) for all bills not received at our claims office at the same time, we will use the date the bill was received at our claims office and apply those Expenses in that order to satisfy the Deductible.

Benefits for covered services in an emergency room will be reduced by $100.00 if the emergency room is used for other than emergency care. This $100.00 will not be applied toward satisfying the Deductible or be considered covered Expense.

SPECIFIED PERCENTAGE. The Specified Percentage is the percentage of Expenses we will pay for covered services and supplies after an Insured Person's Deductible has been satisfied in a Calendar Year. Specified Percentage means the Preferred Provider Specified Percentage or the Non-Preferred Provider Specified Percentage. The Preferred Provider Percentage (as shown in the Schedule) applies when an Insured Person uses the services of a Preferred Provider and the Non-Preferred Provider Specified Percentage (as shown in the Schedule) applies when an Insured Person uses the services of a Non-Preferred Provider.

COINSURANCE PERCENTAGE. The Coinsurance Percentage is the percentage of Expenses You will pay for covered services and supplies after an Insured Person's Deductible has been satisfied in a Calendar Year. The Preferred Provider Coinsurance Percentage (as shown in the Schedule) applies when an Insured Person uses the services of a Preferred Provider and the Non-Preferred Provider Coinsurance Percentage (as shown in the Schedule) applies when an Insured Person uses the services of a Non-Preferred Provider. The Insured Person is responsible for the amount of this Coinsurance Percentage until the Stop Loss Limit has been met. The Stop Loss Limit is the amount of Expense incurred in a Calendar Year which is subject to the Coinsurance Percentage.

The Coinsurance Percentage and Stop Loss Limit are shown in the Schedule.

OUT-OF-POCKET MAXIMUM. Out-of-Pocket Maximum means the Preferred Provider Out-of-Pocket Maximum (as shown in the Schedule) or the Non-Preferred Provider Out-of-Pocket Maximum (as shown in the Schedule). The Preferred Provider Out-of-Pocket Maximum applies when an Insured Person uses the services of a Preferred Provider and the Non-Preferred Provider Out-of-Pocket applies when an Insured Person uses the services of a Non-Preferred Provider. In no event will the Out-of-Pocket Maximum be more than the Non-Preferred Provider Out-of-Pocket Maximum.

The Out-of-Pocket Maximum is the Stop Loss Limit multiplied by the Coinsurance Percentage plus the Deductible. That portion of the Expense covered under the Benefits provision, but not paid in full, will apply to this amount unless stated otherwise.

The Out-of-Pocket Maximum is shown on the Schedule. There is only one Out-of-Pocket Maximum for all Insured Persons. The Out-of-Pocket Maximum is limited to two times the deductible amount for each family member.

After You have paid the Out-of-Pocket Maximum, we will pay 100% of any additional covered Expense incurred in the same Calendar Year. This 100% will apply unless stated otherwise.

Any Expense in excess of the Calendar Year Maximum will NOT be considered Covered Services and Supplies. Therefore, those Expenses will NOT be applied to the Out-of-Pocket Maximum.

COVERED SERVICES AND SUPPLIES

Inpatient Medical/Surgical Services

1. Hospital Confinement – Hospital room and board, general nursing care and any other Hospital-furnished inpatient medical services and supplies. The following conditions apply:

   (a) When confined to a semiprivate or private room, Expense will not include room and board charges in excess of the Hospital's Average Semiprivate Room Charge. The Expense in excess of the Hospital's Average Semiprivate Room Charge will not be used toward satisfying the Deductible or the Out-of-Pocket Expense Maximum or be considered covered Expense.
   (b) When confined to an Intensive Care Facility, daily Expenses will not include charges in excess of four times the Hospital's Average Semiprivate Room Charge. Expense in excess of these amounts will not be used toward satisfying the Deductible or the Out-of-Pocket Expense Maximum or be considered covered Expense.

   While confined in an Intensive Care Facility, no benefits will be paid for any other room and board charges. In addition, charges for Hospital-furnished services and supplies that are maintained in or considered an overall part of an Intensive Care Facility will be considered Intensive Care Facility charges.

2. Diagnostic Services including, but not limited to: (a) laboratory; (b) X-ray; and (c) magnetic resonance imaging (MRI).

3. Skilled Nursing Care Facility – The first 60 days in a Calendar Year for Skilled Nursing Care Facility Confinement will be considered a covered service or supply. Charges in excess of one half of the Average Semiprivate Room Charge will not be considered covered Expense. Expense in excess of 60

days of skilled nursing Confinement in a Calendar Year will not be used toward satisfying the Deductible or the Out-of-Pocket Expense Maximum or be considered a covered Expense.

Benefits are payable only if Skilled Nursing Care Facility Confinement:

(a) begins within 30 days from the last day of Hospital Confinement which lasts at least three days in a row (this does not apply to readmission to a Skilled Nursing Care Facility if such readmission occurs within 60 days of the previous Skilled Nursing Care Facility discharge date); and
(b) is under the supervision of a Physician.

4. Short-Term Physical Rehabilitation services.

   Benefits are only payable for facility charges and Physician/professional services.

5. Services of a Physician and professional services such as, but not limited to: (a) Physician visits; (b) consultations; and (c) surgery.

6. Services of a physical, speech or occupational therapist acting under the direction of a Physician.

7. Cardiac/Pulmonary Rehabilitation.

Outpatient Medical/Surgical Services

1. Physician's office visits and related Expenses such as, but not limited to: (a) consultations; (b) medical treatments; (c) injections (including allergy injections and therapeutic injections); and (d) surgery in the Physician's office.

2. Outpatient facility care (Hospital and ambulatory surgical center), physical and professional services (such as surgery, anesthesia and therapy management).

3. Outpatient medical services and supplies, including, but not limited to: (a) physical examinations; (b) consultations; (c) Prescription Drugs; and (d) physical and professional services (such as surgery, anesthesia and therapy management).

4. Outpatient physical rehabilitation services. Covered services include: (a) physical therapy; (b) occupational therapy; (c) speech therapy; and (d) cardiac/pulmonary rehabilitation. Benefits for physical therapy, occupational therapy and speech therapy combined are limited to 25 visits in a Calendar Year, except as such therapy is otherwise covered under the "Developmental Disabilities" provision contained in this policy.

5. Diagnostic services such as, but not limited to: (a) CT scan; (b) MRI; and (c) allergy testing.

6. Chemotherapy, dialysis, radiation therapy and immunosuppressant drug therapy.

7. Medical Supplies – (a) blood and blood plasma; (b) artificial eyes or limbs; (c) surgical dressings, casts, splints, trusses, braces, crutches or heart pacemakers; (d) rental or purchase (at our option) of a wheelchair or hospital-type bed (no rental charge in excess of the rental charge for standard manually operated equipment will be considered Expense); (e) rental or purchase (at our option) of mechanical equipment required for respiratory paralysis; (f) chemstrips; and (g) rental or purchase (at our option) of durable medical equipment for therapeutic use.

8. Emergency room. Benefits include charges for: (a) use of an emergency room; (b) Physician's fees; (c) surgery; and (d) medical supplies and drugs, laboratory and X-ray.

Other Covered Services

1. Ambulance Services. When an Insured Person cannot be safely transported by any other means, we will cover Expenses for the following Ambulance services:

   (a) transportation to the closest Hospital or from one Hospital to another for Medically Necessary care;

   (b) transportation to the closest Hospital with appropriate facilities for Medically Necessary outpatient care for an Injury or Sickness resulting from an accident or a Medical Emergency; and

   (c) when there is no Hospital in the local area that can provide covered services, we will cover Ambulance transportation to the closest Hospital outside the local area which can provide Medically Necessary covered services. We will only pay benefits when evidence clearly shows that the Hospital to which the Insured Person is transported is the closest one having the appropriate specialized treatment facilities, equipment or staff Physicians.

   LIMITATION ON AIR AMBULANCE. Ground Ambulance is usually the approved method of transportation. We will only pay benefits for an air Ambulance when terrain, distance or an Insured Person's physical condition requires the services of an air Ambulance.

2. Home Health Care. Benefits for Home Health Care are limited to two visits per day and 100 visits in a Calendar Year.

3. Hospice Care. Benefits are payable for the following services: (a) inpatient care services; (b) Physician services; or (c) home hospice care services. Such services must be provided by a Hospital, related institution, home health agency, hospice or other licensed facility under a Hospice Care Program.

   Benefits for the above are limited as follows:

   (a) counseling (other than bereavement counseling) for Your immediate family not to exceed $500.00 per family (the immediate family includes Your spouse or partner to a civil union, children and parents);
   (b) bereavement counseling for Your immediate family not to exceed $100.00 per family; and
   (c) Expense covered under (a) or (b) will be treated as Expense incurred by an Insured Person.

   Once the above maximums have been paid, any further Expense for hospice care will not be used toward satisfying the Deductible or the Out-of-Pocket Expense Maximum or be considered covered Expense.

4. Durable medical equipment supplies. This benefit is limited to $5,000.00 in a Calendar Year.

5. Organ or tissue transplants. The following types of organ or tissue transplants are covered by this policy:

   (a) cornea;
   (b) heart;

(c) heart/lung;
(d) kidney;
(e) kidney/pancreas;
(f) pancreas;
(g) liver;
(h) bone marrow;
(i) single lung;
(j) double lung; and
(k) small bowel.

We will also provide benefits for the testing to identify suitable donor, acquisitions of organ from a donor, storage Expense and transportation costs incurred and directly related to the donation of an organ used in a covered organ transplant procedure. We will also provide reimbursement for the medical expenses of a live donor to the extent that benefits remain and are available after benefits for your own expenses have been paid. The aggregate donor benefits are limited to $25,000 in an Insured Person's lifetime.

With respect to bone marrow transplantation, such benefits shall include human leukocyte antigen testing (histocompatibility locus antigen testing) for A, B, and DR antigens. 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.

6. Temporomandibular Joint Dysfunction (TMJ). Benefits for Temporomandibular Joint Dysfunction are, subject to all policy provisions, payable **except** for: crowns which correct vertical dimension; splints, orthopedic repositioning appliances, biteplates and equilibration treatments (including splint equilibration and adjustments); bite, functional or occlusal registration, with or without splints, and kinesiographic analysis; any orthodontic treatment, including extraction of teeth; and study models, except for the complete model made necessary when surgical intervention is completed. Surgical charges for correction of orthognathic conditions are covered. Benefits are limited to $1,000.00 in an Insured Person's lifetime. Charges for those services and supplies not covered will not be used toward satisfying the Deductible or Out-of-Pocket Expense Amount or be considered covered Expense.

7. Breast Reconstruction. If an Insured Person has mastectomy surgery and elect reconstruction, we will pay the Expense incurred for:

   (a) reconstruction of the breast on which the surgery has been performed; and
   (b) surgery and reconstruction of the other breast to produce a symmetrical appearance; in the manner chosen by the patient and the Physician.

8. Nonprescription Enteral Formulas. Benefits will be payable for the Expense incurred for nonprescription enteral formulas and food products required for the treatment of inherited diseases of amino acids, organic acids, or for impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, or mobility of the gastrointestinal tract.

Coverage for inherited diseases of amino acids and organic acids shall include Low Protein Modified Food Products in an amount not to exceed $1,800.00 annually.

Such coverage shall be provided when the prescribing Physician has issued a written order stating that the enteral formula is needed to sustain life, is Medically Necessary, is the least restrictive, and the most cost effective means for meeting the needs of the patient.

9. Diabetes Treatment. If an Insured Person has insulin using, non-insulin using or gestational diabetes, we will pay benefits for the following:

   (a) outpatient self-management training and educational services including medical nutrition therapy;
   (b) medically appropriate or necessary insulin, oral agents and equipment used to treat diabetes; and
   (c) medically appropriate or necessary equipment used to treat diabetes.

   Benefits will not be paid for outpatient self-management training and education services (including but not limited to medical nutrition therapy for the treatment of diabetes) unless pursuant to a written order of a Physician and provided by a certified, registered or licensed health care professional with expertise in diabetes.

10. Growth therapy treatment. Coverage for growth therapy is limited to $10,000 in your lifetime.

11. Oxygen and rented equipment for its use in or out of the Hospital. The outpatient benefit is limited to $5,000.00 in a Calendar Year.

12. Complications of pregnancy.

13. Inpatient and Outpatient Mental and Nervous and Alcohol and Drug Abuse Treatment. The combined maximum benefits for these treatments in a Calendar Year and in the Insured Person's lifetime are listed in the Schedule.

14. Prosthetic Devices. There is no annual or lifetime dollar maximum on coverage for prosthetic devices other than the annual or lifetime dollar maximums that apply in the aggregate to all items and services covered under this policy.

15. Developmental Disabilities. Services of licensed and credentialed occupational therapists, physical therapists, speech-language pathologists, and clinical social workers working with children from birth to 36 months of age with an identified developmental disability or delay as long as the providing therapist receives a referral from the child's primary care physician as contemplated by this policy.

Preventive Care

1. Mammograms. Benefits are limited as follows:

   (a) one baseline mammogram for an insured female between the ages of 35 and 40; and
   (b) one low-dose mammogram on an annual basis for an insured female 40 years of age and older.

"Low-dose Mammography" means the X-ray examination of the breast. The equipment used must be designed specifically for mammography, including, but not limited to, an X-ray tube, filter, compression device, screens, films and cassettes, with a radiation exposure which is diagnostically valuable and within recommended guidelines.

2. Routine physical examinations (including one annual gynecological examination and pap smear).

3. Immunizations.

4. Prostatic specific antigen tests. This benefit is limited to one test in a Calendar Year.

5. Lead screening. This benefit is limited to one screening in a Calendar Year.

PART H. THIRD-PARTY RESPONSIBILITY

If an Insured Person is injured through the act or omission of a third party, and if benefits are paid under this policy due to the Injury, then to the extent any recovery by such Insured Person:

(a) against a third party is made; and
(b) is attributable to the same Injury;

we shall be entitled to reimbursement for all such benefits paid by us. We may file a lien for such payment. Upon request, such Insured Person must complete and return to us the required forms.

"Third Party" means another person or organization. It does not include general liability and automobile insurance.

Our right of subrogation includes each Insured Person's compliance with any or all of the following:

(a) Make proper and timely applications for any and all Other Medical Insurance for which You may be eligible.
(b) Furnish us with proof of any such applications.
(c) Provide us written authorization to receive information about the status of your applications.
(d) Provide us a copy of the award or other evidence of payment of Other Medical Insurance immediately upon receipt.
(e) Submit written evidence that You have been denied Other Medical Insurance.
(f) Pursue any established appeals process and provide us with evidence of the decision or ruling.
(g) If after the appeals process You are still denied Other Medical Insurance, we may require that You reapply for it from time to time and provide proof of the appeals.
(h) Provide us a copy of the retroactive award or other evidence immediately upon receipt.
(i) Notify us of any change in your status as to your eligibility for, entitlement to or receipt of any Other Medical Insurance. Such notice must be made within 30 days of your status change.

PART I. PRECERTIFICATION REVIEW AND CASE MANAGEMENT

Precertification review is required for: (a) Hospital Confinement; (b) Skilled Nursing Care Facility Confinement; (c) Home Health Care; (d) cardiac/pulmonary rehabilitation; (e) hospice care; (f) infusion therapy; (g) durable medical equipment; (h) prosthetic devices; (i) organ and tissue transplants; (j) maternity care; and (k) any services provided for the treatment of developmental disabilities.

Precertification: In the event that You are covered by more than one plan that requires precertification, You shall obtain precertification from the primary plan. Although the insured shall not be required to obtain precertification from the secondary plan, the secondary plan shall not be required to treat such services as covered services if the services do not meet its certification criteria. The secondary plan shall

not refuse payment for such services solely on the basis that the services were not precertified by the secondary plan.

Definitions

“Utilization Review Panel” means us or a designated reviewing committee named by us.

“Admission Information” means the following information which the Insured Person and/or the attending Physician must provide to the Utilization Review Panel before a period of Confinement is approved:

(a) the diagnosis or reason for the Confinement;
(b) any proposed treatment or surgical procedure; and
(c) the expected days of Confinement.

“Medical Information” means the following information which the Insured Person and/or the attending Physician must provide to the Utilization Review Panel before a medical procedure is approved:

(a) the diagnosis or reason for the medical procedure;
(b) the proposed medical procedure;
(c) the expected follow-up care required by the patient; and
(d) any related information regarding the patient’s history, condition and the proposed medical procedure.

Rules for Precertification Review

1. For a Nonemergency Confinement or Medical Procedure – The Insured Person and/or the attending Physician must notify the plan administrator of the Confinement or procedure, and the attending Physician must give the appropriate Admission Information or Medical Information to the Utilization Review Panel, in each case by phone (see your policyowner identification card) and at least seven days before the Confinement or medical procedure. Within one day after the Utilization Review Panel receives the required Admission Information and Medical Information, the Utilization Review Panel will notify the Insured Person, the Physician and, if applicable, the facility of any Confinement or medical procedure which is certified as Medically Necessary.

   If the Utilization Review Panel does not receive the notice within seven days prior to the Confinement or medical procedure, coverage will be provided as explained in the Effect on Benefits paragraph located at the end of this Precertification Review and Case Management provision.

2. For an Emergency Confinement or Medical Procedure – If the Insured Person is confined or receives a medical procedure as a result of a Medical Emergency, then the Insured Person and/or the attending Physician must notify the plan administrator of the confinement or medical procedure resulting from Medical Emergency, and the attending Physician must give the appropriate Admission Information or Medical Information to the Utilization Review Panel, in each case by phone (see your policyowner identification card): (a) within 48 hours after a weekday Confinement or medical procedure; (b) within 72 hours after a weekend Confinement or medical procedure; or (c) as soon as reasonably possible after that. On the same business day that the Utilization Review Panel receives the required Admission Information and Medical Information, the Utilization Review Panel will notify the Insured Person, the Physician and, if applicable, the facility of any Confinement or medical procedure which is certified as Medically Necessary.

3. For Continued Confinement – Before the approved period of Confinement ends, the Utilization Review Panel will phone the attending Physician to determine whether the Insured Person requires further Hospital Confinement. On the same business day, the Insured Person, the Physician and the Hospital will be notified of any additional days of Confinement which are recommended as Medically Necessary, if any.

Effect on Benefits

1. Expense incurred for a procedure or Confinement which is certified by the Utilization Review Panel as Medically Necessary will be considered in accord with policy provisions.

2. For Expense incurred for a procedure or Confinement for which review does not occur within the time frame specified in the Rules for Precertification Review (except for a medical procedure as a result of a Medical Emergency), benefits will be reduced by the lesser of $500.00 or 50% for each unreviewed procedure or Confinement (including related covered Expenses); however, no benefits will be payable unless the services are Medically Necessary and all other policy requirements are satisfied.

3. For Expense incurred for a procedure or Confinement for which review does occur within the time frame specified in the Rules for Precertification Review, but which is not determined to be Medically Necessary, benefits for all Hospital, surgical, medical and other covered services received as a result of the procedure will not be payable.

When benefits are reduced in accord with part 2 or 3 above:

(a) the $500.00 or 50%, as applicable, reduction for each unreviewed medical procedure or Confinement; or
(b) Expense for a procedure or Confinement which is not Medically Necessary;

will not be used to satisfy any Deductible or be considered a covered Expense.

In accord with policy provisions, benefits will not be payable when the Confinement or medical procedure or any services related to the procedure (including but not limited to X-ray, laboratory services or follow-up Physician's visits):

(a) are not Medically Necessary; and
(b) are not covered by this policy.

Certification does not automatically mean that benefits are payable.

CASE MANAGEMENT

If the Insured Person incurs Expenses as a result of an Injury or Sickness listed below, or as a result of any Injury or Sickness of comparable severity for which an alternate, more cost-effective treatment plan may be developed by us, these Expenses are eligible for consideration under this Case Management Program. This program may include as Covered Services and Supplies some services and supplies otherwise limited, excluded or not specifically shown under the Benefits provision of this policy, but shown in the alternate treatment plan. Benefits payable under this provision will be at least equal to benefits otherwise payable by this policy for the same service or supply and are subject to the Lifetime Maximum.

Definition

"Case Management Program" means a written alternate treatment plan endorsed by the Insured Person's Physician and accepted by us to provide Medically Necessary and appropriate care in a cost-effective setting. It is the Insured Person's final decision to participate in the program. There is no penalty for not participating in the program or for leaving during its course. In either case, any further benefits will be paid in accordance with the other provisions, limits and exceptions of this policy.

Eligible for the Case Management Program

Acquired Immune Deficiency Syndrome
Amputations
Burns
Chemotherapy
Chronic infections
Chronic liver disease
Chronic pulmonary diseases and conditions
Coagulation defects
Coma
Conditions related to diabetes mellitus
Demyelinating diseases of the central nervous system
Diseases related to intracranial hemorrhage or occlusion
Disorders of the immune system
Inflammatory diseases of the central nervous system
Intestinal disorders
Multiple fractures, with or without other system involvement
Myoneural disorders
Organ and tissue transplants
Paralytic disorders
Radical surgeries
Renal diseases
Spinal cord injuries
Tumors, malignant or unspecified

PART J. EXCLUSIONS AND LIMITATIONS

Expenses expressly exclude:

(a) Expense for dental care or treatment, except for such care or treatment due to accidental Injury to sound, natural teeth;
(b) Expense for Tempormandibular Joint Dysfunction or surgery to the jaw except for benefits listed in the benefits section of the policy;
(c) Expense for family planning visits;
(d) Expense for nutritional counseling or treatment of obesity not caused by Sickness or Injury;
(e) Expense for any loss, Expense or charge which results from appetite control, weight control or any treatment of obesity not caused by an organic condition;
(f) Expense for routine vision exams, eye refractions, eyeglasses or contact lenses;
(g) Expense for refractive corneal surgery (corneal graphs and cataract surgery are covered);
(h) Expense for routine hearing exams, hearing aids or their fitting;
(i) Expense for convalescent, rest or nursing facilities;

(j) Expense for private duty nursing, except for covered Home Health Care and Hospice Care services;
(k) Expense for Normal Childbirth, Normal Pregnancy or routine well-baby care (except as provided under any maternity benefits of this policy), or elective cesarean section or voluntarily induced abortion;
(l) Expense for sex transformations or the promotion of fertility, including (but not limited to): (1) fertility tests; (2) reversal of surgical sterilization; or (3) direct attempts to cause pregnancy by hormone therapy, artificial insemination, in vitro fertilization or embryo transfer;
(m) Expense for mechanical, animal or other non-human transplants (except for artificial eyes, artificial limbs, or on a temporary basis pending acquisition of "matched" human organ(s)/tissue);
(n) Expense for smoking cessation classes;
(o) Expense for custodial care;
(p) Expense for services or supplies that are Experimental or Investigative;
(q) Expense for routine treatment of feet including orthopedic shoes, foot inserts and support devices for the feet;
(r) Expense for acupuncture;
(s) Expense for biofeedback;
(t) Expense for massage therapy;
(u) Expense for alternative medicine;
(v) Expense for treatment of behavior modification and learning disabilities (other than benefits for developmental disabilities as expressly covered by this policy);
(w) Expense for obesity not caused by Sickness or Injury;
(x) Expense for breast reduction in absence of malignancy (unless otherwise Medically Necessary);
(y) Expense for cosmetic surgery or complications thereof;
(z) Expense for chiropractic services; or
(aa) Expense incurred for services provided or supplies purchased outside the United States, except in the case of a Medical Emergency.

NONDUPLICATION. If a single item of Expense is payable under more than one provision of this policy, payment will be made only under the provision providing the greater benefit, except as explained in the Hospital Outpatient/Out-of-Hospital Medical Services and Supplies portion of the Benefits provision.

PART K. EXTENSION OF COVERAGE

If the Insured Person is totally disabled because of covered Injuries or Sickness on the date insurance ends, coverage for the Insured Person will continue just as if insurance had not ended. However, coverage will not continue beyond three months.

Benefits are payable during this extension on the same basis as if coverage did not end. However, coverage is extended only for those conditions that caused the disability.

If the Insured Person is pregnant on the date insurance ends, benefits are payable for the duration of the pregnancy on the same basis as if coverage did not end.

PART L. NONDUPLICATION OF BENEFITS

Insurance with Other Insurers

If there be Other Medical Insurance, not with the New Hampshire Health Plan, providing benefits for the same loss on other than an expense incurred basis, payment shall not be prorated or reduced. In such a

case, You may be entitled to payment from both insurers. Notwithstanding the foregoing, the New Hampshire Health Plan is the last payor of benefits whenever any other benefit is available. Benefits otherwise payable under this policy shall be reduced by all amounts paid or payable, or reimbursed directly by or under any Other Medical Insurance, whether insured or otherwise. We will not pay benefits for a period in which Other Medical Insurance with an effective date prior to the effective date of this plan was in force.

Whenever the Administrator has allowed benefits to be paid by this plan which have been paid by any Other Medical Insurance, or which were erroneously paid, the Administrator will have the right to recover any such excess payments from the appropriate party.

PART M. HOW TO FILE A CLAIM

NOTICE OF CLAIM: Written notice of claim must be given to us 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 the address on your current identification card, or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer. This does not waive the Precertification Review and Case Management provisions.

CLAIM FORMS: Upon our receipt of a notice of claim from You, we will furnish to You such forms as are usually furnished by us for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice, You 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.

PROOF OF LOSS: You must furnish written proof of loss to us at our 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 we are 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 by You 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 by You 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.

PART N. PAYMENT OF CLAIMS

Time of Payment of Claims: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss via a Clean Claim or an Electronic Claim, all accrued indemnities for loss for which this policy provides periodic payment will be paid on a monthly basis and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

If the claim is denied or pending, We will notify the Insured Person or the Insured Person's health care provider of the reason for denying or pending the claims and what, if any, additional information is required to process the claim. Our failure to comply with the time limits in this section shall not have the effect of requiring coverage for an otherwise non-covered claim.

If any indemnity of this policy shall be payable to the Insured Person's estate, or to such Insured Person or his/her beneficiary who is a minor or otherwise not competent to give a valid release, We may pay such indemnity, up to an amount not exceeding $1000, to any relative by blood or connection by marriage of such Insured Person or his/her beneficiary who is deemed by us to be equitably entitled thereto. Any payment made by Us in good faith pursuant to this provision shall fully discharge Us to the extent of such payment.

Change of Beneficiary: Unless an Insured Person makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to such Insured Person and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

PART O. EFFECTIVE DATE

Coverage is effective as of the Policy Date stated on the Schedule made part of this policy.

PART P. TERM OF COVERAGE

Coverage under this policy starts on the Policy Date at 12:01 a.m., Standard Time where You live. It ends at 12:01 a.m., the same Standard Time, on the First Renewal Date. Each time You renew this policy by paying the premium within the 31-day grace period, the new term begins when the old term ends.

PART Q. POLICY PROVISIONS

Newborn Children: Any Insured Person's children born while this policy is in force will be insured automatically from birth until: (a) the 31st day following birth; or (b) the first day of the second month following birth, whichever is longer. Benefits are not payable for the care and treatment of a newborn well baby following full-term or premature birth. Benefits for a newborn child are payable in the same manner as benefits are paid for the Insured Person.

Entire Contract; Changes: This policy, together with the Schedule and any other attachments, is the entire contract of insurance. No change in this policy shall be valid until approved by one of Our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

Time Limit on Certain Defenses: After two years from the date a person becomes covered under this policy, we cannot use misstatements, except fraudulent misstatements in your application, to void coverage or deny a claim for loss that happens after the two-year period.

The above provisions also apply to the Schedule and any other riders attached to this policy. In applying them, the word "Schedule" or "rider", as applicable, will be used for the word "policy".

Reinstatement: If any renewal premium is not paid within the time granted to You for payment, a subsequent acceptance of premium by us, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if we require an application for reinstatement and issue a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by us or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless we have previously notified You in writing of our disapproval of such application. The reinstated policy shall cover only loss resulting from such 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 Your and we shall have the same rights thereunder as You and we 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 this provision will be used for a period for which premium has not been paid, but not for any period more than 60 days before the date of reinstatement.

Physical Examinations: We, at our Expense, shall have the right and opportunity to examine You when and as often as we may reasonably require during the pendency of a claim hereunder where it is not forbidden by law.

Misstatement of Age: If Your age has been misstated, all benefits payable shall be in the amount the premium paid would have bought at the correct age.

Misstatement of Smoking Status. Subject to the Time Limit for Certain Defenses, if Your smoking status has been misstated, all benefits shall be in the amount the premium paid would have bought at the correct smoking status.

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.

Schedule: The Schedule and information it shows is a part of this policy and incorporated herein.

Refund upon cancellation: After the policy has been continued beyond its original term, You may cancel the policy at any time by written notice, delivered or mailed to us. Such cancellation shall become effective upon our receipt of such written notice, or on such later date as may be specified in such notice by You. If You cancel, we shall promptly return any unearned portion of the premium paid, but in any event shall return the unearned portion of the premium within 30 days.

PART R. GRIEVANCE PROCEDURES

INTERNAL APPEAL PROCESS

If you wish to appeal an adverse decision or make a grievance to resolve a dispute with NHHP, you must file an appeal in writing with NHHP at the address shown at the end of this notice identifying the determination or grievance you wish to appeal. You may authorize a representative to pursue a grievance or an appeal for you by submitting to NHHP at the same address a written statement that identifies your representative and states that the representative may act on your behalf regarding the grievance or appeal. Your provider may also assist you with the grievance or appeal and provide information related thereto to NHHP. If, however, your provider files the appeal, or is involved in providing information to NHHP, NHHP is obligated only to provide notification to you or your duly authorized representative of determinations or requests related to the appeal for the notice to be effective. Our appeal process involves two levels of appeal: a first, mandatory, level of appeal after the initial determination, and then a second, mandatory, level of appeal if you are not satisfied with the outcome of the first level of appeal. Our appeal process also provides for an expedited review when your medical circumstances require it. These levels of appeal and the expedited process are outlined below. PLEASE NOTE THAT YOU MAY NOT BRING A LAWSUIT WITH RESPECT TO ANY GRIEVANCE OR DISPUTE WITH NHHP REGARDING AN ADVERSE DETERMINATION UNTIL AFTER YOU HAVE EXHAUSTED BOTH MANDATORY LEVELS OF THIS APPEALS PROCESS, UNLESS OTHERWISE PROVIDED BY APPLICABLE LAW.

Mandatory First Level Appeal.

A mandatory First Level Appeal will be conducted as follows:

I. (a) The persons reviewing the grievance shall not be the same person or persons making the initial determination, and shall not be subordinate to or the supervisor of the person making the initial determination;

(b) For medical necessity appeals at least one person reviewing the appeal will be a practitioner in the same or similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment at issue in the appeal. A practitioner is considered of the same specialty if he or she has similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal. A practitioner is considered of a similar specialty if he or she has experience treating the same problems as those in question in the appeal, in addition to expertise treating similar complications of those problems;

(c) You have 180 days following receipt of a notification of a claim denial to file your appeal;

(d) You may submit written comments, documents, records, and other information relating to the claim without regard to whether those documents or materials were considered in making the initial determination;

(e) We will provide to you, upon request, and without charge, reasonable access to, and copies of all documents, records, and other information relevant to or considered in making the initial adverse claim determination; and

(f) The review shall be a de novo proceeding and shall consider all information, documents, or other material submitted in connection with the appeal without regard to whether the information was considered in making the denial.

II. Appeals Involving Medical Judgment. In addition to the procedures outlined in section I above, if the appeal of a claim denial is based in whole or in part on a medical judgment, the following shall apply:

(a) The review shall be conducted by or in consultation with a health care professional in the same or similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment at issue in the appeal. A practitioner is considered of the same specialty if he or she has similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal. A practitioner is considered of a similar specialty if he or she has experience treating the same problems as those in question in the appeal, in addition to expertise treating similar complications of those problems;

(b) The titles and qualifying credentials of the person conducting the review shall be included in the decision; and

(c) The identity and qualifications of any medical or vocational expert whose advice was considered, without regard to whether it was relied upon in making the initial claim denial, shall be made available to the claimant upon request.

III. Expedited Appeals. In the appeal of a claim for urgent care, a claim involving a matter that would seriously jeopardize the life or health of a covered person or would jeopardize the covered person's ability to regain maximum function, or a claim concerning an admission, availability of care, continued stay or health care service for a person who has received emergency services, but who has not been discharged from a facility, an expedited appeal process is available as follows:

(a) You may submit of information to NHHP by telephone, facsimile, or other expeditious method; and

(b) We will make a determination of the appeal not more than 72 hours after the submission of the request for appeal.

IV. Timing and Notification for Determination on Appeal.

(a) In the case of non-expedited appeal of a pre-service claim or post-service claim, the determination on appeal shall be made within a reasonable time appropriate to the medical circumstances, but in no event more than 15 days after receipt by NHHP of your appeal.

(b) In the case of an expedited appeal related to an urgent care claim, we will make a determination and notify you as expeditiously as your medical condition requires, but in no event more than 72 hours after the appeal is filed. If the expedited review involves ongoing urgent care services, the service shall be continued without liability to you until you have been notified of the determination. Notification to you may be made by telephone, email, facsimile or other expeditious method; NHHP will also provide written confirmation of its decision concerning an expedited review within 2 business days of providing notification of that decision, if the initial notification was not in writing.

(c) The period of time within which a decision shall be rendered on appeal shall begin to run at the time the appeal is filed in accordance with these appeal procedures, without regard to whether all the information necessary to make a determination on appeal is contained in the filing. In the event you fail to submit information necessary to decide the appeal, the period for making the determination on appeal shall be tolled from the date NHHP notifies you in writing of precisely what is required until the date you respond, in writing, to the request. NHHP will notify you of incompleteness as soon as possible; if your appeal involves urgent care, we will notify you of incompleteness no more than 24 hours after the filing of the appeal. In the event that you fail to provide to NHHP within 45-days of date of notification of incompleteness sufficient information to decide the appeal, NHHP may deny the appeal on the basis of incompleteness. NHHP may reopen the appeal upon receipt of the required information.

V. Manner and Content of Notification of Determination on Appeal.

(a) NHHP will provide you with a written determination of the appeal that will include:

(1) The specific reason or reasons for the determination, including reference to the specific provision, rule, protocol, or guideline on which the determination is based;

(2) A statement that the rule, protocol, or guideline governing the appeal will be provided without charge to you upon request;

(3) A statement describing all other dispute resolution options available to you, including, but not limited to, other options for internal review and options for external review and options for bringing a legal action;

(4) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;

(5) If NHHP relied upon an internal rule, guideline, protocol, or other similar criterion in making the claim denial, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the claim denial and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request;

(6) If the claim denial is based on a medical necessity or experimental treatment or similar exclusion or limit, NHHP will provide to you either (i) an explanation of the scientific or clinical judgment for the denial, applying the terms of the plan to the claimant's medical circumstances, or (ii) a statement that such explanation will be provided free of charge upon request;

(7) If the appeal involves an adverse determination, a copy of the notice of the right to external review that includes the specific requirements for filing an external review; and

(8) A statement describing your right to contact the insurance commissioner's office for assistance which shall include the toll-free telephone number and address of the commissioner.

Mandatory Second Level Appeal

In any case where the mandatory First Level Appeal review process does not resolve a difference of opinion between you or your provider and NHHP, you may elect to pursue the appeal with NHHP at a second level of review by requesting, in writing, that NHHP review the appeal or grievance (your provider may assist you or file the appeal on your behalf unless the provider is prohibited from filing a grievance by federal or other state law). NHHP will review it as a mandatory **Second Level Appeal**.

I. With respect to the Second Level Appeal:

(a) This Second Level Appeal is available only after you have completed the mandatory First Level Appeal process; and

(b) The Second Level Appeal process shall be completed within 30 days from the date of the request for the First Level Appeal.

II. A Second Level Appeal will be conducted as follows:

(a) The second level appeal review panel will be established to give those who are dissatisfied with the first level appeal review decision the option to request a second level review. A majority of the panel will be comprised of persons who were not previously involved in the grievance or appeal. The panel will consult with at least one clinical peer who has the appropriate expertise to review a grievance involving the adverse determination.

(b) You have 3 business days following receipt of the decision regarding the First Level Appeal to file your Second Level Appeal.

(c) You and/or your authorized representative(s) may notify NHHP of your choice to appear in person before the review panel. If so, the panel will make reasonable attempts to provide notice to you of the time, and place of the review meeting. You will be notified at least 3 business days in advance of the review meeting date.

(d) At your request, NHHP will provide you with all the relevant information that is not confidential or privileged.

(e) The review panel will issue a written decision to you within 5 business days of completing the review meeting, but no more than 30 days after you filed your notice of appeal for the First Level Appeal. Upon your concurrence, a copy of the decision will be forwarded to the Insurance Department.

(f) With respect to an appeal that was expedited at the mandatory First Level Appeal, (i) You may file the Second Level Appeal and submit information related thereto to NHHP by telephone, facsimile, or other expeditious method, (ii) NHHP shall conduct the review and adhere to time frames that are reasonable under the circumstances, attempting in good faith to make a determination of the appeal not more than 72 hours after the submission of the request for appeal.

EXTERNAL REVIEW PROCESS

An independent **External Review Process** through the Department of Insurance is available to you if the **First Level Appeal** and the **Second Level Appeal** do not resolve the difference of opinion; if the NHHP has agreed to submit the determination to **External Review** prior to completion of the internal review process; or if you have requested a **First Level Appeal** or a **Second Level Appeal**, standard or expedited review and have not received a decision from the NHHP within the required time frames.

You or your representative must submit the request for an **External Review** in writing to the Commissioner of Insurance within:

(1) 180 days of the date of the **Second Level Appeal** denial decision; or
(2) if there is a failure to make a **First Level Appeal** or a **Second Level Appeal**, standard or expedited review decision that is past due, within 180 days of the date the decision was due.

The cost for the service, supply or drug that is the subject of the adverse determination must be, or is anticipated in a 12-month period to be, equal to or in excess of $400.

The request for an **External Review** must not be for the purpose of pursuing a claim or allegation of health care provider malpractice, professional negligence, or other professional fault.

<u>Standard External Review</u>

Within 7 business days after the date of receipt of a request for an **External Review**, the Commissioner shall complete a preliminary review of the request for an **External Review** to determine whether:
(1) you are or were a covered person under the health benefit plan;
(2) the determination that is the subject of the request for an **External Review** meets the conditions of eligibility; and
(3) you have provided all the information and forms required by the Commissioner that are necessary to process a request for an **External Review**.

Upon completion of the preliminary review, the Commissioner shall immediately notify you or your representative in writing whether the request is complete and whether the request has been accepted for **External Review**.

If the request is not complete, the Commissioner shall inform you or your representative what information or documents are needed to make the request complete and to process the request. You or your representative shall submit such information or documentation within 10 days of being notified that the request was incomplete.

If the request for **External Review** is accepted, the Commissioner shall:

(1) include in the notice provided, a statement that if you wish to submit new or additional information or to present oral testimony via teleconference, such information shall be submitted, and the oral testimony shall be scheduled and presented, within 20 days of the date of issuance of the notice. However, the notice shall also explain that oral testimony shall be permitted only in cases when the Commissioner determines, based on evidence provided by you, that it would not be feasible or appropriate to present only written testimony; and

(2) immediately notify the NHHP in writing of the request for an **External Review** and its acceptance.

If the request for an **External Review** is not accepted, the Commissioner shall inform you or your representative and the NHHP in writing of the reason for its non-acceptance.

At the time a request for **External Review** is accepted, the Commissioner shall select and retain an independent review organization that is certified pursuant to New Hampshire law to conduct the **External Review**. The Commissioner shall not select the same independent review organization for each **External Review**, but shall rotate among the certified independent review organizations, using all organizations equally. The Commissioner may select and retain an independent review organization regardless of the rotation if the Commissioner determines that the use of such independent review organization is necessary for the fair adjudication of the case in question.

Within 10 days after the date of issuance of the notice from the Commissioner of Insurance to the NHHP informing of the request for **External Review** and its acceptance, the NHHP or its designated utilization review organization shall provide to the selected independent review organization and to you all information in its possession that is relevant to the adjudication of the matter in dispute, including but not limited to:

(1) the terms of agreement of the health benefit plan, including the evidence of coverage, benefit summary, or other similar document;

(2) all relevant medical records, including records submitted to the NHHP by you, your representative, or your treating provider;

(3) a summary description of the applicable issues, including a statement of NHHP's final determination;

(4) the clinical review criteria used and the clinical reasons for the determination;

(5) the relevant portions of the NHHP's utilization management plan;

(6) any communications between you and the NHHP regarding the internal review process or the **External Review**; and

(7) all other documents, information, or criteria relied upon by the NHHP in making its determination.

Failure by the NHHP or you to provide the documents and the required information within the specified time frame shall not delay the conduct of the **External Review**.

The selected independent review organization shall review all of the information and documents received from the NHHP and any other information submitted by you or your representative or treating provider with the request for **External Review** and any testimony provided. In addition to the information provided by the NHHP and you or your representative or treating provider, the independent review organization may consider any applicable, generally accepted clinical practice guidelines, studies or research, including those developed or conducted by the federal government, national or professional medical societies, boards, and associations. The independent review organization shall consider anew all previously determined facts, allow the introduction of new information, and make a decision that is not bound by decisions or conclusions made by the NHHP during the internal review process.

The selected independent review organization shall render a decision upholding or reversing the determination of the NHHP and notify you or your representative and the NHHP in writing within 20 days of the date that any new or additional information from you is due pursuant to New Hampshire law. This notice shall include a written review decision that contains a statement of the nature of the grievance, references to evidence or documentation considered in making the decision, findings of fact, and the clinical and legal rationale for the decision, including, as applicable, clinical review criteria and rulings of law.

Expedited External Review

Expedited External Review shall be available when your treating provider certifies to the Commissioner of Insurance that adherence to the time frames specified by New Hampshire law for the **Standard External Review** would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function.

Except to the extent that it is inconsistent with the provisions of an **Expedited External Review**, all requirements for the conduct of the **Standard External Review** process specified by New Hampshire law shall apply to the **Expedited External Review**.

At the time the Commissioner receives a request for an **Expedited External Review**, the Commissioner shall immediately make a determination whether the request meets the standard for **Expedited External Review**, as well as the reviewability requirements set forth in New Hampshire law. If the conditions are met, the Commissioner shall immediately notify the NHHP. If the request is not complete, the Commissioner shall immediately contact you or your representative and attempt to obtain the information or documents that are needed to make the request complete.

The Commissioner shall select and retain an independent review organization that is certified pursuant to New Hampshire law to conduct the **Expedited External Review**.

The NHHP or its designated utilization review organization shall provide or transmit the documents and information specified in New Hampshire law to the selected independent review organization by telephone, facsimile, or any other available expeditious method within one business day of receiving the Commissioner’s notice of the request for **Expedited External Review**.

When handling a review on an expedited basis, the selected independent review organization shall make a decision and notify the NHHP and you as expeditiously as your medical condition requires, but in no event more than 72 hours after the **Expedited External Review** is requested. If this notice is not in writing, within 2 business days after the date of providing this notice, the selected independent review organization shall:

(a) provide written confirmation of the decision to you or your representative and the NHHP; and

(b) include the required information as set forth under the **Standard External Review** notice requirements.

An **Expedited External Review** shall not be provided for determinations made by the NHHP on a retrospective basis.

You shall not be held liable to either the NHHP, the hospital, the physician, or the services provider for the cost of services in excess of the applicable copayment, coinsurance, or deductible incurred, pending the independent review organization's determination of an **Expedited External Review**.

If you would like assistance in filing a grievance you may contact NHHP at:

NHHP
c/o Benefit Management, Inc.
P.O. Box 1090
Great Bend, KS 67530
Toll-Free number 1-877-888-NHHP (6447)

You have the right to contact the Commissioner's Office at any time. If you would like further assistance, you may contact the Commissioner's Office at:

Department of Insurance
21 South Fruit Street, Suite 14
Concord, New Hampshire 03301-2430
Telephone (603) 271-7973
Toll free (800) 852-3416

ATTACHMENTS

Attached as addenda to this Agreement are the Schedule and the certain riders listed in the Schedule. These addenda will be deemed to be incorporated into this policy without further action by the parties.

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