



NEW HAMPSHIRE
Health Plan

This policy is issued to you by the New Hampshire Health Plan in accord with New Hampshire law. 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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PART A. 10-DAY RIGHT TO EXAMINE POLICY

We want you to fully understand and be entirely satisfied with your policy. If you are not satisfied for any reason, you may return this policy to us or your agent within 10 days of its receipt. We will then refund any premiums you have paid. This policy will then be considered never to have been issued.

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 eligible for coverage in the New Hampshire Health Plan;
- (c) 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;
- (d) the date New Hampshire statutes require cancellation of this policy; or
- (e) the date you have access to any accident and health insurance through an employer sponsored group, including continuation of group coverage as either an employee or an eligible dependent.

If nonrenewed, we will mail notice of nonrenewal to the last address shown on our records at least 30 days prior to the renewal date and will return any unused premium to you. Your premium must be paid on the date it is due or during the 31 day grace period that follows.

PART D. PREMIUM CHANGES

The premium rates may change at attained ages. 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. We will notify you in advance of any such changes. The premium changes may be made on any renewal date.

**THIS POLICY IS RENEWABLE AS STATED IN THE RENEWAL AGREEMENT.
MAJOR MEDICAL POLICY
PREMIUMS MAY BE CHANGED ONLY AS STATED IN PART D.**

POLICY CHANGE

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 next renewal date following the date of your request. 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.

"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.

"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.

"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.

"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. 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.

"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.

"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.

"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 your 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 your 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.

"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" or "Us" 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.

"Sickness" means a Sickness, disease 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 you incur 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 Managed Care Techniques for a further explanation.

PREFERRED PROVIDER ORGANIZATION REQUIREMENTS. You may choose any Physician, Hospital or other health care provider you wish. However, you are 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 you use 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 must be satisfied 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.

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 your 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 you use the services of a Preferred Provider and the Non-Preferred Provider Specified Percentage (as shown in the Schedule) applies when you use 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 your Deductible has been satisfied in a Calendar Year. The Preferred Provider Coinsurance Percentage (as shown in the Schedule) applies when you use the services of a Preferred Provider and the Non-Preferred Provider Coinsurance Percentage (as shown in the Schedule) applies when you use the services of a Non-Preferred Provider. You are 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 you use the services of a Preferred Provider and the Non-Preferred Provider Out-of-Pocket applies when you use 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.

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 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).
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.
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 you 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; or
 - (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 you are 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 your 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, 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 you.

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

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

We will also provide benefits for 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. The donor benefits are limited to \$25,000.00 in your lifetime.

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 your 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 you have 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 you have 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 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. 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.

11. Complications of pregnancy.
12. Inpatient and Outpatient Mental and Nervous and Alcohol and Drug Abuse Treatment. The combined maximum benefit for these treatments in a Calendar Year and in your lifetime are listed in the Schedule.
13. Prosthetic Devices.

Preventive Care

1. Routine physical examinations (including one annual gynecological examination and pap smear).
2. Immunizations.
3. 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.

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 you are 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 you:

- (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, you 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 your 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. MANAGED CARE TECHNIQUES

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; and (i) organ and tissue transplants.

Definitions

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

"Admission Information" means the following information which you and/or the attending Physician must provide to the 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 you 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 -- You and/or the attending Physician must notify and give the appropriate admission or medical information to the Utilization Review Panel (Panel) by phone (see your policyowner identification card) at least seven days before the Confinement or medical procedure. Within one day after the Panel receives the required information, the Panel will notify you, the Physician and, if applicable, the facility of any Confinement or medical procedure which is certified as Medically Necessary.

If the 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 Managed Care Techniques provision.

2. For an Emergency Confinement or Medical Procedure -- If you are confined or receive a medical procedure as a result of a Medical Emergency, then you and/or the attending Physician must notify and give the appropriate admission or medical information to the Panel 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 Panel receives the required information, the Panel will notify you, 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 Panel will phone the attending Physician to determine whether you require further Hospital Confinement. On the same business day, you, 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 \$500.00 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 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 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 you incur 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 your Physician and accepted by us to provide Medically Necessary and appropriate care in a cost-effective setting. It is your 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	Disorders of the immune system
Amputations	Inflammatory diseases of the central nervous system
Burns	Intestinal disorders
Chemotherapy	Multiple fractures, with or without other system involvement
Chronic infections	Myoneural disorders
Chronic liver disease	Organ and tissue transplants
Chronic pulmonary diseases and conditions	Paralytic disorders
Coagulation defects	Radical surgeries
Coma	Renal diseases
Conditions related to diabetes mellitus	Spinal cord injuries
Demyelinating diseases of the central nervous system	Tumors, malignant or unspecified
Diseases related to intracranial hemorrhage or occlusion	

PART J.

EXCEPTIONS AND LIMITATIONS

Expense does not include:

- (a) Expense for dental care or treatment, except for such care or treatment due to accidental Injury to sound, natural teeth;
- (b) Expense for Temporomandibular 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 refraction's, 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, 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;
- (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; or
- (z) Expense for chiropractic services.

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 you are totally disabled because of covered Injuries or Sickness on the date insurance ends, coverage for that 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.

PART L. NONDUPLICATION OF BENEFITS

This 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. 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: You must give us written notice of claim within 20 days after a loss occurs or starts, or as soon as is reasonably possible. You may give the notice or you may have someone do it for you. The notice should give your name and policy number as shown on the Schedule. Notice should be mailed to us at the address on your current identification card. This does not waive the Managed Care Techniques.

CLAIM FORMS: When we receive your notice, we will send you forms for filing proof of loss. If we do not send them within 15 days, you can meet the proof of loss requirement by giving us a written statement of what happened. We must receive this statement within the time given for filing proof of loss.

PROOF OF LOSS: You must give us written proof of your loss within 90 days after the date of the loss or as soon as is reasonably possible. Proof must, however, be furnished no later than 12 months from the time it is otherwise required, except in the absence of legal capacity.

PART N. PAYMENT OF CLAIMS

All benefits will be paid to You, Your beneficiary or Your estate within 45 days upon receipt of a Clean Claim or 15 days upon receipt of an Electronic Claim. If the claim is denied or pending, We will notify You or Your 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.

Benefits for loss of life, if any, will be paid to Your beneficiary (Your estate if no beneficiary is named). Other benefits unpaid at Your death will be paid, at Our option, to Your estate or Your beneficiary.

If any benefits are payable to Your estate, to a minor or to any person not legally able to give a valid release, We may pay up to \$1,000 to any relative of Yours who We find entitled to the payment. Payment made in good faith shall fully discharge Us to the extent of the payment.

PART O. EFFECTIVE DATE

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

PART P. TERM OF COVERAGE

Your coverage 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 your 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: Your 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 you.

Entire Contract; Changes: This policy, and any attachments, is the entire contract of insurance. No agent may change it in any way. Only we can approve a change. Any such change must be shown in your policy.

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 riders attached to this policy. In applying them the word "rider" will be used for the word "policy".

Reinstatement: Your policy will lapse if you do not pay your premium before the end of the grace period. If we later accept a premium and do not require an application for reinstatement, that payment will put this policy back in force. If we require an application for reinstatement, this policy will be put back in force when we approve it. If we do not approve it, this policy will be put back in force on the 45th day after the date of the application, unless we give you prior written notice of this disapproval. The reinstated policy only covers loss due to an Injury or Sickness after the date of reinstatement. In all other respects you and we have the same rights under this policy as were in effect before it lapsed. 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.

Grace Period: Your premium must be paid on or before the date it is due or during the 31-day grace period that follows. This policy stays in force during your grace period. You always have your grace period unless we write and tell you it does not apply. However, claims will not be paid unless and until the due premium has been paid.

Physical Examinations and Autopsy: We, at our Expense, may have you examined when and as often as is reasonable while a claim is pending. We may also have an autopsy done (at our Expense) 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 on 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: You cannot bring a legal action to recover under your policy for at least 60 days after you have given us written proof of loss. You cannot start such an action more than three years after the date proof of loss is required.

Schedule: The Schedule and information it shows is a part of this policy as if it preceded the execution clause.

Cancellation by You; Noncancellation by Us Subject to Our Right to Refuse Renewal: You may cancel this policy as of the end of any month. Cancellation will be effective as of the end of the month in which we receive your written notice, or on a later date you may specify. Upon cancellation, we shall promptly return any unearned premium within 30 days of the cancellation effective date. Cancellation will not affect an existing claim. We may not cancel this policy, but may refuse to renew as specified herein.



APPEALS PROCESS NOTICE

INTERNAL APPEAL PROCESS

If you wish to appeal an adverse decision, our internal appeal process involves two levels:

First Level Appeal (Standard Review)

A **First Level Appeal** will be reviewed by a medical doctor in the same or similar specialty that normally handles this type of case. All medical information submitted will be reviewed and the specialist will speak with your attending physician. You or your provider may submit additional written materials to NHHP at the address shown at the end of this notice. A decision will then be rendered and you will be notified.

You or your representative may also submit a grievance concerning any matter other than an adverse determination. A written decision will be issued to you or your representative within 20 business days after receiving a grievance and all information necessary for the review of the grievance. The person or persons reviewing the grievance will not be the same person or persons who made the initial decision or handled the matter that is the subject of the grievance. If a decision cannot be made within 20 business days due to circumstances beyond NHHP's control, NHHP may take up to an additional 10 business days to issue a written decision.

Second Level Appeal (Standard Review)

In any case where the First Level Appeal review process does not resolve a difference of opinion between you or your provider and NHHP, you or your provider may submit a grievance in writing or by telephone (unless the provider is prohibited from filing a grievance by federal or other state law). NHHP will review it as a **Second Level Appeal**.

- 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. NHHP will provide at least one clinical peer who has the appropriate expertise to review a grievance involving an adverse determination.
- The review panel will issue a written decision to you within 5 business days of completing the review meeting. Upon your concurrence, a copy of the decision will be forwarded to the Insurance Department.

If you should choose to appear in person before authorized representatives of NHHP, the procedures for conducting a second level appeal review are as follows:

- The review panel will schedule and hold a review meeting within 45 business days of receiving your request for a second level review. You will be notified in writing at least 15 business days in advance of the review date.
- At your request, NHHP will provide you with all the relevant information that is not confidential or privileged.
- The review panel will issue a written decision to you within 5 business days of completing the review meeting.

First Level Appeal (Expedited Review)

NHHP will establish written procedures for the expedited review of a grievance in a situation where the time frame of the standard grievance procedures would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function.

- Expedited reviews will be evaluated by an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed. The clinical peer or peers will not have been involved in the initial adverse determination.
- NHHP will provide expedited review to all requests concerning an admission, availability of care, continued stay or health care service if you have received emergency services but have not been discharged from a facility. Adverse determinations made on a retrospective basis may only be appealed through the standard grievance process. All necessary information, including NHHP's decision will be transmitted to you or your physician by NHHP via telephone, facsimile or the most expeditious method available.

- NHHP will make a decision and notify the covered person as expeditiously as your medical condition requires, but in no event more than 72 hours after the review is commenced.
- If the expedited review is a concurrent review determination, the service shall be continued without liability to you until you have been notified of the determination. NHHP will provide a written confirmation of the decision concerning an expedited review within 2 business days of providing notification of the decision, if the initial notification was not in writing.

Second Level Appeal (Expedited Review)

In any case where the First Level Appeal review process does not resolve a difference of opinion between you or your provider and NHHP, you or your provider may submit a grievance in writing or by telephone (unless the provider is prohibited from filing a grievance by federal or other state law). NHHP will review it as a **Second Level Appeal**. In conducting the review, NHHP shall adhere to time frames that are reasonable under the circumstances.

EXTERNAL REVIEW PROCESS

An independent **External Review Process** through the Department of Insurance is available to you if the **Second Level Appeal** does 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.

Standard External Review

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 (CBA/EBPA), Care Review Unit
37 Industrial Drive
Exeter, New Hampshire 03833-4593
Toll-Free number 1-800-578-3272

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
56 Old Suncook Road
Concord, New Hampshire 03301-5151
Telephone (603) 271-2261
Toll free (800) 852-3416