NEW HAMPSHIRE HEALTH PLAN
NON-GROUP MAJOR MEDICAL EXPENSE COVERAGE
OUTLINE OF COVERAGE
FOR
POLICY FORM NHHP MgedCareD 2008-a

(1) READ YOUR POLICY CAREFULLY

This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions, together with the schedule and riders thereto, will control. The policy itself sets forth in detail the rights and obligations of both you and the New Hampshire Health Plan. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(2) OVERVIEW

Individual major medical expense coverage is designed to provide, to persons insured, comprehensive coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations that may be set forth in the policy or the schedule and riders thereto. Basic hospital or basic medical insurance coverage is not provided.

(3) 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 Precertification and Case Management section 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 schedule) is the amount of benefits payable for Covered Services and Supplies 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.

OTHER MEDICAL INSURANCE. 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 coverage on a nonexpense-incurred basis;
(b) any cancer and/or specified disease plan; or
(c) any accident only plan.

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.

The Out-of-Pocket Maximum is shown on the schedule. That portion of the expense covered under the Benefits provision, but not paid in full, will apply to this amount 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.

A brief specific description of the benefits, including dollar amounts, contained in the policy:

Benefit	Amount
a. Daily hospital room and board: Hospital room and board, general nursing care and any other hospital-furnished inpatient medical services and supplies. The following conditions apply: (i) 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. (ii) 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.	Up to $2.5 million life time maximum; subject to annual deductible of $10,000 (in-network), $12,500 (out of network).
b. Miscellaneous hospital services: 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.	Same as a.
c. In-Hospital Surgical services: 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.	Same as a.
d. Anesthesia services: these services are covered under the physicians services.	Same as a.
e. In-hospital medical services: 1. Diagnostic Services including, but not limited to: (a) laboratory; (b) X-ray; and (c) magnetic resonance imaging. 2. 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: (i) 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	Up to $2.5 million life time maximum; subject to annual deductible of $10,000 (in-network), $12,500 (out of network). Further subject to the noted limits.

days of the previous Skilled Nursing Care Facility discharge date); and (ii) is under the supervision of a physician. 3. Short-Term Physical Rehabilitation services. Benefits are only payable for facility charges and physician/professional services. 4. Services of a physician and professional services such as, but not limited to: (a) physician visits; (b) consultations; and (c) surgery. 5. Services of a physical, speech or occupational therapist acting under the direction of a physician. 6. Cardiac/Pulmonary Rehabilitation.	
f. Out-of-hospital care: 1. Outpatient facility care (hospital and ambulatory surgical center), physical and professional services (such as surgery, anesthesia and therapy management). 2. 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). 3. 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 the policy. 4. Diagnostic services such as, but not limited to: (a) CT scan; (b) MRI; and (c) allergy testing. 5. Chemotherapy, dialysis, radiation therapy and immunosuppressant drug therapy. 6. 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.	Up to $2.5 million life time maximum; subject to annual deductible of $10,000 (in-network), $12,500 (out of network). Durable medical equipment is limited to $5,000 a year.
g. Maximum dollar amount for covered charges:	

1. General	In general, calendar year out-of-pocket maximum is $10,000 (in-network), $15,000 (out of network).
2. Prescription Drugs	Calendar year maximum benefit for prescription drug is $10,000.
3. Mental health and alcohol and drug abuse calendar year max of $1,000 and lifetime max of $3,000.	Calendar year maximum of $1,000 and lifetime maximum of $3,000.
h. Other benefits: 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; (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.	Up to $2.5 million life time maximum; subject to annual deductible of $10,000 (in-network), $12,500 (out of network).
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	Up to $2.5 million life time maximum; subject to annual deductible of $10,000 (in-network), $12,500 (out of network).

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 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.	Limited to $5,000 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. 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.	The donor benefits are limited to $25,000 during a 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	Benefits are limited to $1,000 in your lifetime. Charges for those services and

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<tr><td></td><td>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.</td><td>supplies not covered will not be used toward satisfying the Deductible or Out-of-Pocket Expense Amount or be considered covered expense.</td></tr>
<tr><td>7.</td><td>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.</td><td>Up to $2.5 million life time maximum; subject to annual deductible of $10,000 (in-network), $12,500 (out of network).</td></tr>
<tr><td>8.</td><td>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, subject to annual maximum.

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.</td><td>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 annually.</td></tr>
<tr><td>9.</td><td>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 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.</td><td>Up to $2.5 million life time maximum; subject to annual deductible of $10,000 (in-network), $12,500 (out of network).</td></tr>
<tr><td>10.</td><td>Growth therapy treatment.</td><td>Limited to lifetime maximum of $10,000.</td></tr>
<tr><td>11.</td><td>Oxygen and rented equipment for its use in or out of the hospital.</td><td>Limited to $5,000 in a calendar year.</td></tr>
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12. Complications of pregnancy.	Up to $2.5 million life time maximum; subject to annual deductible of $10,000 (in-network), $12,500 (out of network).
13. Inpatient and Outpatient Mental and Nervous and Alcohol and Drug Abuse Treatment.	Calendar year max of $1,000; lifetime max of $3,000.
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.	Up to $2.5 million life time maximum; subject to annual deductible of $10,000 (in-network), $12,500 (out of network).
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.	Up to $2.5 million life time maximum; subject to annual deductible of $10,000 (in-network), $12,500 (out of network).
16. Preventive Care: (i) 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 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," means the X-ray films and cassettes, with a radiation exposure which is diagnostically valuable and within recommended guidelines. (ii) Routine physical examinations (including one annual gynecological examination and pap smear). (iii) Immunizations. (iv) Prostatic specific antigen tests. This benefit is limited to one test in a calendar year. (v) Lead screening. This benefit is limited to one screening in a calendar year.	Up to $2.5 million life time maximum; subject to annual deductible of $10,000 (in-network), $12,500 (out of network).

i. Prescription Drug Benefit	Calendar year maximum of $10,000, subject to annual deductible of $300. Retail Copays: Generic - $10 Preferred - $30 + 20% Brand - $45 +20% Mail Order Copays: Generic - $20 Preferred - $60 + 20% Brand - $90 +20%

THIRD PARTY RESPONSIBILITY

If you are injured through the act or omission of a third party, and if benefits are paid under the 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.

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; and (j) 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 member 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 you 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 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 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 you, 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 you are confined or receive a medical procedure as a result of a medical emergency, then you 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 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 Utilization Review 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 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 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 the 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 the 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 the policy, but shown in the alternate treatment plan. Benefits payable under this provision will be at least equal to benefits otherwise payable by the 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 the 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

EXTENSION OF COVERAGE

If an insured person is totally disabled because of covered injuries or sickness on the date insurance ends, coverage for such 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 an 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.

PREXISTING 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 you were 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.

(4) 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.

(5) 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.

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.

UNPAID PREMIUM; PREMIUM CHANGES; POLICY CHANGES

Unpaid Premium

Upon the payment of a claim under the 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 the 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.