ambetter. FROM | nh healthy families.

# 2017 Evidence of Coverage

Ambetter.NHhealthyfamilies.com

**THIS CONTRACT REFLECTS THE KNOWN REQUIREMENTS FOR COMPLIANCE UNDER THE AFFORDABLE CARE ACT AS PASSED ON MARCH 23, 2010. AS ADDITIONAL GUIDANCE IS FORTHCOMING FROM THE US DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND THE NEW HAMPSHIRE INSURANCE DEPARTMENT, THOSE CHANGES WILL BE INCORPORATED INTO YOUR HEALTH INSURANCE POLICY.**

# AMBETTER FROM NH HEALTHY FAMILIES
# UNDERWRITTEN BY CELTIC INSURANCE COMPANY

Home Office: 77 West Wacker Drive, Suite 1200
Chicago, Illinois 60601
Phone No. 1-844-265-1278
Ambetter.NHhealthyfamilies.com

Administrative Offices: Ambetter from NH Healthy Families, 2 Executive Park Drive
Bedford, NH 03110
Claims Office: P.O. Box 26110 Little Rock, AR 72221

Individual Major Medical Expense Insurance Contract

In this *contract, "you"* or *"your"* will refer to the *member* named on the Schedule of Benefits, and *"we," "our,"* or *"us"* will refer to Ambetter from NH Healthy Families.

## AGREEMENT AND CONSIDERATION

*We* issued this *contract* in consideration of the application and the payment of the first premium. A copy of *your* application is attached and is made a part of the *contract*. *We* will pay benefits to *you*, the *member*, for covered *benefits* as outlined in this *contract*. Benefits are subject to *contract* definitions, provisions, limitations and exclusions.

## GUARANTEED RENEWABLE

*You* may keep this *contract* in force by timely payment of the required premiums. However, *we* may refuse renewal if: (1) *we* refuse to renew all policies issued on this form, with the same type and level of benefits, to residents of the state where *you* then live; or (2) there is fraud or an intentional material misrepresentation made by or with the knowledge of a *member* in filing a claim for *contract* benefits.

Annually, *we* may change the rate table used for this *contract* form. Each premium will be based on the rate table in effect on that premium's due date. The contract plan, and age of *members,* type and level of benefits, and place of residence on the premium due date are some of the factors used in determining *your* premium rates. We have the right to change premiums, however, all premium rates charged will be guaranteed for a rating period of at least 12 months.

At least 60 days' notice of any plan to take an action or make a change permitted by this clause will be delivered to *you* at *your* last address as shown in *our* records. *We* will make no change in *your* premium solely because of claims made under this *contract* or a change in a *member's* health. While this *contract* is in force, *we* will not restrict coverage already in force.

**As a cost containment feature, this contract contains prior authorization requirements. This contract may require a referral from a *primary care provider* for care from a specialist provider. Benefits may be reduced or not covered if the requirements are not met. Please refer to the Schedule of Benefits and the Prior Authorization Section.**

**THIRTY DAY RIGHT TO RETURN CONTRACT**

Please read your *contract* carefully. This contract may, at any time within 30 days after its receipt by the contract holder, be returned by delivering it or mailing it to the company or the agent through whom it was purchased. Immediately upon such delivery or mailing, the contract will be deemed void from the beginning, and any premium paid on it will be refunded.

**IMPORTANT INFORMATION**

This contract reflects the known requirements for compliance under The Affordable Care Act as passed on March 23, 2010. As additional guidance is forthcoming from the US Department of Health and Human Services, and the New Hampshire Insurance Department, those changes will be incorporated into your health insurance contract.

The coverage represented by this contract is under the jurisdiction of the New Hampshire Insurance Commissioner.

*This contract does not include pediatric dental services. Pediatric dental coverage is included in some health plans, but can also be purchased as a standalone product. Please contact your insurance carrier or producer, or seek assistance through Healthcare.gov, if you wish to purchase pediatric dental coverage or a stand-alone dental services product.*

Should this *contract* be purchased Off the Exchange, then any and all references to Exchange or Marketplace are not applicable.

Additionally, should you have purchased this policy through the marketplace Premium Assistance Program, all language regarding pediatric benefits are not applicable. Aside from the section entitled, Coverage for a Newborn Child, pediatric benefits are not provided for members enrolled through the Premium Assistance Program.

Celtic Insurance Company

Anand Shukla
SVP, Individual Health – Celtic Insurance Company

# TABLE OF CONTENTS

# INTRODUCTION

Welcome to Ambetter from NH Healthy Families! This *contract* has been prepared by *us* to help explain *your* coverage. Please refer to this *contract* whenever *you* require medical services.
It describes:

- How to access medical care.
- What health services are covered by *us*.
- What portion of the healthcare costs *you* will be required to pay.

This *contract*, the Schedule of Benefits, the application as submitted to the exchange, and any amendments or riders attached shall constitute the entire contract under which *covered services* and supplies are provided or paid for by *us*.

This *contract* should be read and re-read in its entirety. Since many of the provisions of this *contract* are interrelated, you should read the entire *contract* to get a full understanding of your coverage. Many words used in the *contract* have special meanings, are *italicized* and are defined for you. Refer to these definitions in the Definitions section for the best understanding of what is being stated. This *contract* also contains exclusions, so please be sure to read this *contract* carefully.

**How to Contact Us**
Ambetter from NH Healthy Families
2 Executive Park Drive
Bedford, NH 03110

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. EST, Monday through Friday
Member Services **1-844-265-1278**
TDD/TTY line **1-855-742-0123**
Emergency **911**
24/7 Nurse Advice Line **1-844-265-1278**

**Interpreter Services**
Ambetter from NH Healthy Families has a free service to help our *members* who speak languages other than English. This service is very important because *you* and your *physician* must be able to talk about *your* medical or behavioral health concerns in a way *you* both can understand.

*Our* interpreter services are provided at no cost to *you*. We have representatives that speak Spanish and have medical interpreters to assist with other languages. *Members* who are blind or visually impaired and need help with interpretation can call Member Services for an oral interpretation.

To arrange for interpretation services, call Member Services at 1-844-265-1278 (TDD/TTY 1-855-742-0123).

# MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

1. Recognizing and respecting *you* as a *member*.
2. Encouraging open discussions between you, and *your provider(s)*.
3. Providing information to help *you* become an informed healthcare consumer.
4. Providing access to *covered services* and *our network providers*.
5. Sharing *our* expectations of *you* as a *member*.
6. Providing coverage regardless of age, ethnicity or race, religion, gender, sexual orientation, national origin, physical or mental disability, and/or expected health or genetic status.

*You* have the right to:

1. Participate with *your providers* in making decisions about *your* healthcare. This includes working on any treatment plans and making care decisions. *You* should know any possible risks, problems related to recovery, and the likelihood of success. *You* shall not have any treatment without consent freely given by *you* or your legally authorized surrogate decision-maker. *You* will be informed of *your* care options.
2. Know who is approving and who is performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
3. Receive the benefits for which *you* have coverage.
4. Be treated with respect and dignity.
5. Privacy of *your* personal health information, consistent with state and federal laws, and *our* policies.
6. Receive information or make recommendations, including changes, about *our* organization and services, *our* network of *providers*, and *your* rights and responsibilities.
7. Candidly discuss with *your physician* and *medical practitioners* appropriate and *medically necessary* care for *your* condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from your *primary care provider* about what might be wrong (to the level known), treatment and any known likely results. Your *primary care provider* can tell you about treatments that may or may not be covered by the plan, regardless of the cost. *You* have a right to know about any costs *you* will need to pay. This should be told to *you* in words *you* can understand. When it is not appropriate to give *you* information for medical reasons, the information can be given to a legally authorized person. *Your physician* will ask for your approval for treatment unless there is an *emergency* and your life and health are in serious danger.
8. Make recommendations regarding member's rights, responsibilities and policies.
9. Voice *complaints* or *grievances* about: *our* organization, any benefit or coverage decisions *we* (or *our* designated administrators) make, *your* coverage, or care provided.
10. Refuse treatment for any condition, *illness* or disease without jeopardizing future treatment, and be informed by *your physician*(s) of the medical consequences.
11. Participate in matters of the organization's policy and operations.

12. See *your* medical records.
13. Be kept informed of *covered* and non-covered *services*, program changes, how to access services, *primary care provider* assignment, providers, advance directive information, referrals and authorizations, benefit denials, member rights and responsibilities, and *our* other rules and guidelines. *We* will notify *you* at least 60 days before the *effective date* of the modifications. Such notices shall include:
    a. Any changes in clinical review criteria; or
    b. A statement of the effect of such changes on the personal liability of the *member* for the cost of any such changes.
14. A current list of *network providers*.
15. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
16. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, race, creed, sex, sexual preference, national origin or religion.
17. Access *medically necessary* urgent and *emergency* services 24 hours a day and seven days a week.
18. Receive information in a different format in compliance with the Americans with Disabilities Act, if *you* have a disability.
19. Refuse treatment to the extent the law allows. *You* are responsible for *your* actions if treatment is refused or if the *primary care provider*'s instructions are not followed. *You* should discuss all concerns about treatment with your *primary care provider*. *Your primary care provider* can discuss different treatment plans with *you*, if there is more than one plan that may help *you*. *You* will make the final decision.
20. Select *your primary care provider* within the *network*. *You* also have the right to change your *primary care provider* or request information on *network providers* close to your home or work.
21. Know the name and job title of people giving you care. *You* also have the right to know which *physician* is your *primary care provider*.
22. An interpreter when *you* do not speak or understand the language of the area.
23. A second opinion by a *network physician*, if *you* believe your *network provider* is not authorizing the requested care, or if *you* want more information about *your* treatment.
24. Make advance directives for healthcare decisions. This includes planning treatment before *you* need it.
25. Advance directives are forms *you* can complete to protect *your* rights for medical care. They can help your *primary care provider* and other providers understand *your* wishes about your health. Advance directives will not take away *your* right to make *your* own decisions and will work only when *you* are unable to speak for yourself. Examples of advance directives include:
    a. Living Will
    b. Health Care Power of Attorney
    c. "Do Not Resuscitate" Orders. Members also have the right to refuse to make advance directives. *You* should not be discriminated against for not having an advance directive.

You have the responsibility to:

1. Read this *contract* in its entirety.
2. Treat all healthcare professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about *your* health. *You* should make it known whether *you* clearly understand *your* care and what is expected of *you*. *You* need to ask questions of your *physician* until *you* understand the care *you* are receiving.
4. Review and understand the information *you* receive about *us*. *You* need to know the proper use of *covered services*.
5. Show *your* I.D. card and keep scheduled appointments with *your physician*, and call the *physician*'s office during office hours whenever possible if *you* have a delay or cancellation.
6. Know the name of *your* assigned *primary care provider*. *You* should establish a relationship with *your physician*. You may change your *primary care provider* verbally or in writing by contacting *our* Member Services Department.
7. Read and understand to the best of *your* ability all materials concerning *your* health benefits or ask for help if *you* need it.
8. Understand *your* health problems and participate, along with *your* healthcare professionals and *physicians* in developing mutually agreed upon treatment goals to the degree possible.
9. Supply, to the extent possible, information that *we* and/or *your* healthcare professionals and *physicians* need in order to provide care.
10. Follow the treatment plans and instructions for care that *you* have agreed on with *your* healthcare professionals and *physician*.
11. Tell *your* healthcare professional and *physician* if *you* do not understand *your* treatment plan or what is expected of *you*. *You* should work with your *primary care provider* to develop treatment goals. If *you* do not follow the treatment plan, *you* have the right to be advised of the likely results of *your* decision.
12. Follow all health benefit plan guidelines, provisions, policies and procedures.
13. Use any emergency room only when *you* think you have a medical *emergency*. For all other care, *you* should call *your primary care provider*.
14. Provide all information about any other medical coverage *you* have upon enrollment in this plan. If, at any time, *you* get other medical coverage besides this coverage, *you* must tell *us*.
15. Pay *your* monthly premium, all *deductible amounts, copayment amounts*, or *coinsurance percentages* at the time of service.

NOTE: Let *our* Member Services department know if *you* have any changes to *your* name, address, or family members covered under this *contract*.

**Your Provider Directory**

A listing of *network providers* is available online at Ambetter.NHhealthyfamilies.com. *We* have plan *physicians*, *hospitals*, and other *medical practitioners* who have agreed to provide *you* healthcare services. You can find any of our *network providers* by visiting our website and using the "Find a Provider" function. There *you* will have the ability to narrow *your* search by provider specialty, zip code, gender, whether or

not they are currently accepting new patients, and languages spoken. *Your* search will produce a list of providers based on *your* search criteria and will give *you* other information such as address, phone number, office hours, and qualifications.

At any time, you can request a printed copy of the provider directory at no charge by calling Member Services at 1-844-265-1278 (TDD/TTY 1-855-742-0123). In order to obtain benefits, *you* must designate a *network provider* or each *member. We* can also help *you* pick a *primary care provider* (PCP). We can make your choice of *primary care provider* effective on the next business day.

Call the *primary care provider*'s office if you want to make an appointment. If *you* need help, call Member Services at 1-844-265-1278 (TDD/TTY 1-855-742-0123). *We* will help *you* make the appointment.

**Your Member ID Card**

When *you* enroll, *we* will mail you a *member* ID card to *you* within 5 business days of *our* receipt of *your* completed enrollment materials, which includes receipt of your initial binder payment. This card is proof that *you* are enrolled in an Ambetter from NH Healthy Families plan and is valid once your binder payment has been paid and enrollment processing is complete. *You* need to keep this card with *you* at all times. Please show this card every time *you* go for any service under the *contract*.

The ID card will show *your* name, *member* ID#, and *copayment amounts* required at the time of service. If *you* do not get your ID card within a few weeks after *you* enroll, please call Member Services at 1-844-265-1278 (TDD/TTY 1-855-742-0123). *We* will send *you* another card.

**Our Website**

*Our* website helps *you* get the answers to many of *your* frequently asked questions. *Our* website has resources and features that make it easy to get quality care. *Our* website can be accessed at Ambetter.NHhealthyfamilies.com/. It also gives *you* information on *your* benefits and services such as:

1. Finding a *network provider*.
2. Programs to help *you* get and stay healthy.
3. A secure portal for *you* to check the status of *your* claims.
4. Online form submission.
5. Member Rights and Responsibilities.
6. Notice of Privacy Practices.
7. Current events and news with your Ambetter plan.
8. Selecting a *Primary Care Provider*.
9. Deductible and Co-payment Accumulators.
10. Making your payment.

If *you* have material modifications (examples include a change in life event (marriage, death) or family status), or questions related to *your* health insurance coverage, contact the Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596.

**Quality Improvement**

*We* are committed to providing quality healthcare for *you* and *your* family. *Our* primary goal is to improve *your* health and help *you* with any illness or disability. *Our* program is consistent with National Committee

on Quality Assurance (NCQA) standards and Institute of Medicine (IOM) priorities. To help promote safe, reliable, and quality healthcare, *our* programs include:

1. Conducting a thorough check on *physicians* when they become part of the *provider network*.
2. Monitoring *member* access to all types of healthcare services.
3. Providing programs and educational items about general healthcare and specific diseases.
4. Sending reminders to *members* to get annual tests such as a physical exam, cervical cancer screening, breast cancer screening, and immunizations.
5. Monitoring the quality of care and developing action plans to improve the healthcare *you* are receiving.
6. A Quality Improvement Committee which includes *network providers* to help us develop and monitor our program activities.
7. Investigating any *member* concerns regarding care received.

For example, if *you* have a concern about the care *you* received from your *network physician* or service provided by *us*, please contact the Member Services Department.

*We* believe that getting *member* input can help make the content and quality of *our* programs better. *We* conduct a *member* survey each year that asks questions about *your* experience with the healthcare and services *you* are receiving.

# DEFINITIONS

In this contract, italicized words are defined. Words not italicized will be given their ordinary meaning.

Wherever used in this contract:

***Acute rehabilitation*** means two or more different types of therapy provided by one or more rehabilitation licensed practitioners and performed for three or more hours per day, five to seven days per week, while the *member* is confined as an inpatient in a *hospital*, *rehabilitation facility*, or *extended care facility*.

***Advanced premium tax credit*** means the tax credit provided by the Affordable Care Act to help you afford health coverage purchased through the Exchange. Advance payments of the tax credit can be used right away to lower your monthly premium costs. If you qualify, you may choose how much advance credit payments to apply to your premiums each month, up to a maximum amount. If the amount of advance credit payments you get for the year is less than the tax credit you're due, you'll get the difference as a refundable credit when you file your federal income tax return. If your advance payments for the year are more than the amount of your credit, you must repay the excess advance payments with your tax return.

***Adverse benefit determination*** means a determination by *us* or *our* designee utilization review entity that a pre-service authorization request or a post-service claim request for an admission, availability of care, continued stay or other healthcare service has been reviewed and, based upon the information provided, does not meet *our* requirements for *medical necessity*, appropriateness, healthcare setting, level of care or effectiveness, and the requested service is therefore denied, reduced, or terminated.

***Allogeneic bone marrow transplant*** or ***BMT*** means a procedure in which bone marrow from a related or non-related donor is infused into the transplant recipient and includes peripheral blood stem cell transplants.

***Applied behavior analysis*** means the design, implementation, and evaluation of environmental modifications using behavioral
stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

***Autism spectrum disorder*** means autism spectrum disorder as defined by the most recent editions of the Diagnostic and Statistical Manual of Mental Disorders.

***Autologous bone marrow transplant*** or ***ABMT*** means a procedure in which the bone marrow infused is derived from the same person who is the transplant recipient and includes peripheral blood stem cell transplants.

***Bereavement counseling*** means counseling of *members* of a deceased person's *immediate family* that is designed to aid them in adjusting to the person's death.

***Calendar Year*** is the period beginning on the initial effective date of this contract and ending December 31 of that year. For each following year it is the period from January 1 through December 31.

***Case Management*** is a program in which a registered nurse, known as a case manager, assists a *member* through a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and healthcare benefits available to a *member*. Case management is instituted at the sole option of us when mutually agreed to by the *member* and the *member's physician*.

***Center of Excellence*** means a *hospital* that:

1. Specializes in a specific type or types of *listed transplants* or other services such as cancer, bariatric or infertility; and
2. Has agreed with *us* or an entity designated by *us* to meet quality of care criteria on a cost efficient basis. The fact that a *hospital* is a *network provider* does not mean it is a *Center of Excellence.*

***Claimant*** is the member or member's authorized representative who has contacted the plan to file a grievance or appeal or who has contacted the New Hampshire Insurance Department to file an external review.

***Coinsurance*** is the percentage of *covered service expenses* that must be paid by you after the deductible. This percentage is shown on the Schedule of Benefits.

***Coinsurance percentage*** means the percentage of *covered service expenses* that are payable by *you*.

***Complaint*** means any expression of dissatisfaction expressed to the insurer by the claimant, or a claimant's authorized representative, about an insurer or its providers with whom the insurer has a direct or indirect contract.

***Complications of pregnancy*** means:

1. Conditions whose diagnoses are distinct from pregnancy, but are adversely affected by pregnancy or are caused by pregnancy and not, from a medical viewpoint, associated with a normal pregnancy. This includes: ectopic pregnancy, spontaneous abortion, eclampsia, missed abortion, and similar medical and surgical conditions of comparable severity; but it does not include: false labor, preeclampsia, edema, prolonged labor, *physician* prescribed rest during the period of pregnancy, morning sickness, and conditions of comparable severity associated with management of a difficult pregnancy, and not constituting a medically classifiable distinct complication of pregnancy.
2. An *emergency* caesarean section or a *non-elective caesarean section*.

***Continuous loss*** means that *covered service expenses* are continuously and routinely being incurred for the active treatment of an *illness* or *injury*. The first *covered service expense* for the *illness* or *injury* must have been incurred before insurance of the *member* ceased under this *contract*. Whether or not *covered service expenses* are being incurred for the active treatment of the covered *illness* or *injury* will be determined by *us* based on generally accepted current medical practice.

***Contract*** when *italicized,* means this *contract* issued and delivered to *you*. It includes the attached pages, the applications, and any amendments.

***Copayment, Copay, or Copayment amount*** means the amount of *covered expenses* that must be paid by a *covered person* for each service that is subject to a *copayment amount* (as shown in the Schedule of Benefits), before benefits are payable for remaining *covered expenses* for that service under the *contract*.

***Cosmetic treatment*** means treatments, procedures, or services that change or improve appearance without significantly improving physiological function and without regard to any asserted improvement to the psychological consequences or socially avoidant behavior resulting from an *injury*, *illness*, or congenital anomaly. Cosmetic treatment does not include reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child that has resulted in a functional defect.

***Cost sharing percentage*** means the percentage of *covered services* that are payable by *us*.

***Cost-sharing reductions*** means reductions in cost sharing for an eligible individual enrolled in a silver level plan in the Health Insurance Marketplace or for an individual who is an American Indian and/or Alaskan Native enrolled in a *QHP* in the Health Insurance Marketplace.

***Covered service*** or ***covered service expenses*** means services, supplies or treatment as described in this *contract* which are performed, prescribed, directed or authorized by a *physician.* To be a *covered service* the service, supply or treatment must be

1. Incurred while the *member's* insurance is in force under this *contract*;
2. Covered by a specific benefit provision of this *contract*; and
3. Not excluded anywhere in this *contract*.

***Custodial Care*** is treatment designed to assist a *member* with activities of daily living and which can be provided by a layperson and not necessarily aimed at curing or assisting in recovery from a sickness or bodily injury.

Custodial care includes but is not limited to the following:

1. Personal care such as assistance in walking, getting in and out of bed, dressing, bathing, feeding and use of toilet;
2. Preparation and administration of special diets;
3. Supervision of the administration of medication by a caregiver;
4. Supervision of self-administration of medication; or
5. Programs and therapies involving or described as, but not limited to, convalescent care, rest care, *sanatoria care*, educational care or recreational care.

Such treatment is custodial regardless of who orders, prescribes or provides the treatment.

***Deductible amount*** means the amount of *covered service expenses*, shown in the Schedule of Benefits, that must actually be paid during any calendar year before any benefits are payable. The family deductible amount is two times the individual deductible amount. For family coverage, the family deductible amount can be met with the combination of any one or more *members*' *eligible expenses*. The *deductible amount* does not include any copayment amounts.

***Dental expenses*** means *surgery* or services provided to diagnose, prevent, or correct any ailments or defects of the teeth and supporting tissue and any related supplies or oral appliances. Expenses for such treatment are considered *dental expenses* regardless of the reason for the services.

***Dependent member*** means *your* lawful *spouse, civil union partner* and/or an *eligible child*, by blood or law, who is under age 26*.*

***Durable medical equipment*** means items that are used to serve a specific diagnostic or therapeutic purpose in the treatment of an *illness* or *injury*, can withstand repeated use, are generally not useful to a person in the absence of *illness* or *injury*, and are appropriate for use in the patient's home.

***Effective date*** means the applicable date a *member* becomes covered under this contract for *covered services*.

***Eligible child*** means the child of a covered person, if that child is less than 26 years of age. As used in this definition, "child" means:

1. A natural child;
2. A legally adopted child;
3. A child placed with *you* for adoption; or
4. A child for whom legal guardianship has been awarded to *you* or *your spouse*.

It is *your* responsibility to notify the Exchange if *your* child ceases to be an *eligible child*. *You* must reimburse *us* for any benefits that *we* pay for a child at a time when the child did not qualify as an *eligible child*.

***Eligible expense*** means a *covered service expense* as determined below.

1. For *network providers*: When a *covered service expense* is received from a *network provider*, the *eligible expense* is the contracted fee with that provider.
2. For *non-network providers*:
    a. When a *covered service* is received from a *non-network provider* as a result of an *emergency,* the *eligible expense* is the negotiated fee, if any, that the provider has agreed to accept as payment in full (*you* will not be billed for the difference between the negotiated fee and the provider's charge). However, if the provider has not agreed to accept a negotiated fee as payment in full, the *eligible expense* is the greatest of the following:
        i. the amount that would be paid under Medicare,
        ii. the amount for the covered service calculated using the same method we generally use to determine payments for out-of-network services, or
        iii. the contracted amount paid to in-network providers for the covered service. If there is more than one contracted amount with in-network providers for the covered service, the amount is the median of these amounts.
    b. When a *covered service expense* is received from a *non-network provider* as approved or authorized by *us*, the *eligible expense* is the negotiated fee, if any, that the provider has agreed to accept as payment in full (*you* will not be billed for the difference between the negotiated fee and the provider's charge). If there is no negotiated fee agreed to by the provider with *us,* the *eligible expense* is the amount that would be paid under Medicare (*you* may be billed for the difference between the amount paid under Medicare and the provider's charge).

c. When a *covered service* is received from a *non-network provider* because there is no *network provider* with appropriate training and experience, the *eligible expense* is the lesser of (1) the negotiated fee, if any, that has been mutually agreed upon by *us* and the provider; or (2) the provider's billed charge.

***Emergency*** means a medical condition manifesting itself by a sudden, and at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide immediate medical attention would result in:

1. Placing the health of the *member* or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

***Essential Health Benefits*** are defined by federal and state law and refer to benefits in at least the following categories: ambulatory patient services, emergency services, hospitalization, , maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care. Essential Health Benefits provided within this *contract* are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime and/or annual dollar maximum.

***Expedited grievance*** means a *grievance* where any of the following applies:

1. The duration of the standard resolution process will result in serious jeopardy to the life or health of the *claimant* or the ability of the claimant to regain maximum function;
2. In the opinion of a *physician* with knowledge of the claimant's medical condition, the claimant is subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *grievance*; and
3. A *physician* with knowledge of the claimant's medical condition determines that the *grievance* shall be treated as an *expedited grievance*.

***Experimental*** *or* ***investigational treatment*** means medical, surgical, diagnostic, or other healthcare services, treatments, procedures, technologies, supplies, devices, drug therapies, or medications that, after consultation with a medical professional, *we* determine to be:

1. Under study in an ongoing clinical trial as set forth in the United States Food and Drug Administration (*USFDA*) regulation, regardless of whether the trial is subject to *USFDA* oversight;
2. An *unproven service;*
3. Subject to *USFDA* approval, and:
    a. It does not have *USFDA* approval;
    b. It has *USFDA* approval only under its Treatment Investigational New Drug regulation or a similar regulation;
    c. It has *USFDA* approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a *USFDA*-approved drug is a use that is determined by *us* to be:
        i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;

ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or
iii. Not an *unproven service;* or

d. It has *USFDA* approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the *USFDA* or has not been determined through peer reviewed medical literature to treat the medical condition of the *member.*

4. Experimental or investigational according to the provider's research protocols.

Items (3) and (4) above do not apply to phase III or IV *USFDA* clinical trials.

***Extended care facility*** means an institution, or a distinct part of an institution, that:

1. Is operated pursuant to law as a *hospital*, *extended care facility*, or *rehabilitation facility* by the state in which it operates;
2. Is regularly engaged in providing 24-hour skilled nursing care under the regular supervision of a *physician* and the direct supervision of a registered nurse;
3. Maintains a daily record on each patient;
4. Has an effective utilization review plan;
5. Provides each patient with a planned program of observation prescribed by a *physician;* and
6. Provides each patient with active treatment of an *illness* or *injury*, in accordance with existing *generally accepted standards of medical practice* for that condition.

*Extended care facility* does not include a facility primarily for rest, the aged, treatment of *substance abuse, custodial care,* nursing care, or for care of *mental disorders* or the mentally incompetent.

***Generally accepted standards of medical practice*** are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials.

If no credible scientific evidence is available, then standards that are based on *physician* specialty society recommendations or professional standards of care may be considered. *We* reserve the right to consult medical professionals in determining whether a healthcare service, supply, or drug is *medically necessary* and is a *covered service expense* under the *contract*. The decision to apply *physician* specialty society recommendations, the choice of medical professional, and the determination of when to use any such opinion, will be determined by *us*.

***Grievance*** means any dissatisfaction with an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed in writing in any form to the insurer by, or on behalf of, a claimant including any of the following:

1. Provision of services;
2. Determination to reform or rescind a contract;
3. Determination of a diagnosis or level of service required for evidence-based treatment of autism spectrum disorders; and
4. Claims practices.

***Habilitation*** means ongoing, *medically necessary*, therapies provided to patients with developmental disabilities and similar conditions who need habilitation therapies to achieve functions and skills never

before acquired, including services and devices that improve, maintain, and lessen the deterioration of a patient's functional status over a lifetime and on a treatment continuum.

***Hearing care professional*** means a person who is a licensed audiologist, a licensed hearing instrument dispenser, or a licensed *physician*.

***Hearing instrument*** or ***hearing aid*** means any instrument or device designed, intended, or offered for the purpose of improving a person's hearing and any parts, attachments, or accessories, including ear molds. Batteries, cords, and individual or group auditory training devices and any instrument or device used by a public utility in providing telephone or other communication services are excluded.

***Hearing instrument dispenser*** means a person who is a *hearing care professional* that engages in the selling, practice of fitting, selecting, recommending, dispensing, or servicing of hearing instruments or the testing for means of hearing instrument selection or who advertises or displays a sign or represents himself or herself as a person who practices the testing, fitting, selecting, servicing, dispensing, or selling of hearing instruments.

***Home health aide services*** means those services provided by a home health aide employed by a *home healthcare agency* and supervised by a registered nurse, which are directed toward the personal care of a *member.*

***Home healthcare*** means care or treatment of an *illness* or *injury* at the *member's* home that is:

1. Provided by a *home healthcare agency*; and
2. Prescribed and supervised by a *physician*.

***Home healthcare agency*** means a public or private agency, or one of its subdivisions, that:

1. Operates pursuant to law as a *home healthcare agency*;
2. Is regularly engaged in providing *home healthcare* under the regular supervision of a registered nurse;
3. Maintains a daily medical record on each patient; and
4. Provides each patient with a planned program of observation and treatment by a *physician,* in accordance with existing standards of medical practice for the *injury* or *illness* requiring the *home healthcare.*

***Hospice*** means an institution that:

1. Provides a *hospice care program*;
2. Is separated from or operated as a separate unit of a *hospital, hospital*-related institution, *home healthcare agency,* mental health facility, *extended care facility,* or any other licensed healthcare institution;
3. Provides care for the *terminally ill;* and
4. Is licensed by the state in which it operates.

***Hospice care program*** means a coordinated, interdisciplinary program prescribed and supervised by a *physician* to meet the special physical, psychological, and social needs of a *terminally ill member* and those of his or her *immediate family.*

***Hospital*** means an institution that:

1. Operates as a *hospital* pursuant to law;
2. Operates primarily for the reception, care, and treatment of sick or injured persons as *inpatients*;
3. Provides 24-hour nursing service by registered nurses on duty or call;
4. Has staff of one or more *physicians* available at all times;
5. Provides organized facilities and equipment for diagnosis and treatment of acute medical, surgical, or mental conditions either on its premises or in facilities available to it on a prearranged basis; and
6. Is not primarily a long-term care facility; an *extended care facility*, nursing, rest, *custodial care*, or convalescent home; a halfway house, transitional facility, or *residential treatment facility;* a place for the aged, drug addicts, alcoholics, or runaways; a facility for wilderness or outdoor programs; or a similar establishment.

While confined in a separate identifiable *hospital* unit, section, or ward used primarily as a nursing, rest, *custodial care* or convalescent home, *rehabilitation facility*, *extended care facility,* or *residential treatment facility,* halfway house, or transitional facility, a *member* will be deemed not to be confined in a *hospital* for purposes of this *contract*.

***Illness*** means a sickness, disease, or disorder of a *member*. *Illness* does not include learning disabilities, attitudinal disorders, or disciplinary problems. All *illnesses* that exist at the same time and that are due to the same or related causes are deemed to be one *illness*. Further, if an *illness* is due to causes that are the same as, or related to, the causes of a prior *illness*, the *illness* will be deemed a continuation or recurrence of the prior *illness* and not a separate *illness*.

***Immediate family*** means the parents, *spouse*, children, or siblings of any *member*, or any person residing with a *member*.

***Injury*** means accidental bodily damage sustained by a *member* that is the direct cause of the condition for which benefits are provided, independent of disease or body infirmity or any other cause that occurs while this contract is in force. All *injuries* due to the same accident are deemed to be one *injury*.

***Inpatient*** means that services, supplies, or treatment, for medical, behavioral health and substance abuse, are received by a person who is an overnight resident patient of a *hospital* or other facility, using and being charged for room and board.

***Intensive care unit*** means a Cardiac Care Unit, or other unit or area of a *hospital*, that meets the required standards of the Joint Commission on Accreditation of *Hospital*s for Special Care Units.

***Intensive day rehabilitation*** means two or more different types of therapy provided by one or more *rehabilitation licensed practitioners* and performed for three or more hours per day, five to seven days per week.

***Loss*** means an event for which benefits are payable to a *member* under this *contract*. *Expenses* incurred prior to this *contract*'s effective date are not covered, however, *expenses* incurred beginning on the effective date of insurance under this *contract* are covered.

***Listed transplant*** means one of the following procedures and no others:
1. Heart transplants;

2. Lung transplants;
3. Heart/lung transplants;
4. Kidney transplants;
5. Liver transplants;
6. Bone marrow transplants for the following conditions:
    a. *BMT* or *ABMT* for Non-Hodgkin's Lymphoma;
    b. *BMT* or *ABMT* for Hodgkin's Lymphoma;
    c. *BMT* for Severe Aplastic Anemia;
    d. *BMT* or *ABMT* for Acute Lymphocytic and Nonlymphocytic Leukemia;
    e. *BMT* for Chronic Myelogenous Leukemia;
    f. *ABMT* for Testicular Cancer;
    g. *BMT* for Severe Combined Immunodeficiency;
    h. *BMT* or *ABMT* for Stage III or IV Neuroblastoma;
    i. *BMT* for Myelodysplastic Syndrome;
    j. *BMT* for Wiskott-Aldrich Syndrome;
    k. *BMT* for Thalassemia Major;
    l. *BMT* or *ABMT* for Multiple Myeloma;
    m. *ABMT* for pediatric Ewing's sarcoma and related primitive neuroectodermal tumors, Wilm's tumor, rhabomyosarcoma, medulloblastoma, astrocytoma and glioma;
    n. *BMT* for Fanconi's anemia;
    o. *BMT* for malignant histiocytic disorders; and
    p. *BMT* for juvenile onset Leukemia.

***Loss of Minimum essential coverage*** means in the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time the coverage is terminated as a result of loss of eligibility regardless of whether the individual is eligible for or elects COBRA continuation coverage. Loss of eligibility does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan. Loss of eligibility for coverage includes, but is not limited to:

1. Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status such as attaining the maximum age to be eligible as a dependent child under the plan, death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
2. In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area whether or not within the choice of the individual;
3. In the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area whether or not within the choice of the individual, and no other benefit package is available to the individual;
4. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the covered individual;
5. In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time employer contributions towards the employee's

or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent, and

6. In the case of an employee or dependent who has coverage that is COBRA continuation coverage, the conditions are satisfied at the time the COBRA continuation coverage is exhausted. An individual who satisfies the conditions for special enrollment, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions.

***Managed drug limitations*** means limits in coverage based upon time-period, amount or dose of a drug, or other specified predetermined criteria.

***Manipulative Therapy*** means treatment applied to the spine or joint structures to correct vertebral or joint malposition and to eliminate or alleviate somatic dysfunction including, but not limited to, manipulation, myofacial release or soft tissue mobilization. Treatment must demonstrate pain relief and continued improvement in range of motion and function and cannot be performed for maintenance care only. *Manipulative therapy* is not limited to treatment by manual means.

***Maximum out-of-pocket*** amount is the sum of the *deductible amount*, *prescription drug deductible amount* (if applicable), *copayment amount* and coinsurance percentage of *covered service expense*, as shown in the Schedule of Benefits. After the *maximum out-of-pocket amount* is met for an individual, Ambetter from NH Healthy Families pays 100% of *eligible expenses* for that individual. The family *maximum out-of-pocket amount* is two times the individual maximum out-of-pocket amount. For family coverage, the family maximum out-of-pocket amount can be met with the combination of any one or more covered persons' *eligible expenses*. A covered person's maximum out-of-pocket will not exceed the individual maximum out-of-pocket amount.

***Maximum therapeutic benefit*** means the point in the course of treatment where no further improvement in a *member's* medical condition can be expected, even though there may be fluctuations in levels of pain and function.

***Medical practitioner*** includes but is not limited to a *physician*, nurse anesthetist, *physician*'s assistant, physical therapist, or midwife. The following are examples of providers that are NOT *medical practitioners*, by definition of the *contract:* rolfer, hypnotist, perfusionist, massage therapist or sociologist. With regard to medical services provided to a *member*, a *medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

***Medically necessary*** or ***medical necessity*** means any medical service, supply or treatment authorized by a *physician* to prevent, stabilize, diagnose or treat a *member's illness,* or *injury* which:

1. Is consistent with the symptoms or diagnosis;
2. Is provided according to generally accepted medical practice standards;
3. Is not *custodial care*;
4. Is not solely for the convenience of the *physician* or the *member*;
5. Is not *experimental or investigational*;
6. Does not exceed the scope, duration, or intensity of that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment; and
7. When specifically applied to a *hospital* confinement, it means that the diagnosis and treatment of *your* medical symptoms or conditions cannot be safely provided as an outpatient.

Charges incurred for treatment not *medically necessary* are not *eligible expenses*.

***Medically stabilized*** means that the person is no longer experiencing further deterioration as a result of a prior *injury* or *illness* and there are no acute changes in physical findings, laboratory results, or radiologic results that necessitate acute medical care. Acute medical care does not include *acute rehabilitation*.

***Medicare participating practitioner*** means a *medical practitioner* who is eligible to receive reimbursement from Medicare for treating Medicare-eligible individuals.

***Member*** or ***Covered Person*** means an individual covered by the health plan including an enrollee, subscriber or policyholder.

***Mental disorder*** is a behavioral, emotional or cognitive pattern of functioning in an individual that is associated with distress, suffering, or impairment in one or more areas of life – such as school, work, or social and family interactions

***Necessary medical supplies*** mean medical supplies that are:

1. Necessary to the care or treatment of an *injury* or *illness*;
2. Not reusable or *durable medical equipment*; and
3. Not able to be used by others.

***Necessary medical supplies*** do not include first aid supplies, cotton balls, rubbing alcohol, or like items routinely found in the home.

***Network*** means a group of *medical practitioners* and providers who have contracts that include an agreed upon price for healthcare expenses.

***Network eligible expense*** means the *eligible expense* for services or supplies that are provided by a *network provider*. For facility services, this is the *eligible expense* that is provided at and billed by a *network* facility for the services of either a *network* or *non-network provider*. *Network eligible expense* includes benefits for *emergency* health services even if provided by a *non-network provider*.

***Network provider*** means a *medical practitioner* who is identified in the most current list for the *network* shown on *your* identification card.

***Non-elective caesarean section*** means:

1. A caesarean section where vaginal delivery is not a medically viable option; or
2. A repeat caesarean section.

***Non-network provider*** means a *medical practitioner* who is <u>NOT</u> identified in the most current list for the *network* shown on *your* identification card. Services received from a *non-network provider* are not covered, except as specifically stated in this contract.

***Other plan*** means any plan or contract that provides insurance, reimbursement, or service benefits for *hospital*, surgical, or medical expenses. This includes payment under group or individual insurance policies, premises medical pay, nonprofit health service plans, health maintenance organization subscriber

contracts, self-insured group plans, prepayment plans, and Medicare when the *member* is enrolled in Medicare. *Other plan* will not include Medicaid.

***Out-of-pocket expenses*** mean those expenses that a *member* is required to pay that qualify as *covered service expenses*.

***Outpatient Contraceptive Services*** means consultations, examinations, and medical services, provided on an outpatient basis and related to the use of contraceptive methods to prevent *pregnancy* which has been approved by the U.S. Food and Drug Administration.

***Outpatient surgical facility*** means any facility with a medical staff of *physicians* that operates pursuant to law for the purpose of performing *surgical procedures*, and that does not provide accommodations for patients to stay overnight. This does not include facilities such as: acute-care clinics, *urgent care centers*, ambulatory-care clinics, free-standing emergency facilities, and *physician* offices.

***Pain management program*** means a program using interdisciplinary teams providing coordinated, goal-oriented services to a *member* who has chronic pain that significantly interferes with physical, psychosocial, and vocational functioning, for the purpose of reducing pain, improving function, and decreasing dependence on the healthcare system. A *pain management program* must be individualized and provide physical *rehabilitation*, education on pain, relaxation training, and medical evaluation.

***Period of extended loss*** means a period of consecutive days:

1. Beginning with the first day on which a *member* is a *hospital inpatient;* and
2. Ending with the 30th consecutive day for which he or she is not a *hospital inpatient.*

***Pervasive Developmental Disorder*** means a neurological condition, including but not limited to Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

***Physician*** means a licensed medical practitioner who is practicing within the scope of his or her licensed authority in treating a bodily injury or sickness and is required to be covered by state law. A *physician* does **NOT** include someone who is related to a *member* by blood, marriage or adoption or who is normally a member of the *member's* household.

***Post-service claim*** means any claim for benefits for medical care or treatment to which the terms of the plan do not condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining the medical care.

***Practice of fitting, dispensing, servicing, or sale of hearing*** instruments means the measurement of human hearing with an audiometer, calibrated to the current American National Standard Institute standards, for the purpose of making selections, recommendations, adoptions, services, or sales of hearing instruments including the making of earmolds as a part of the hearing instrument.

***Pre-service claim*** means any claim for benefits for medical care or treatment that requires the approval of the plan in advance of the claimant obtaining the medical care.

***Pregnancy*** means the physical condition of being pregnant, but does not include *complications of pregnancy*.

***Prescription drug*** means any medicinal substance whose label is required to bear the legend "RX only."

***Prescription drug deductible amount*** means the amount of *covered service expenses*, shown in the Schedule of Benefits, if applicable, that must actually be paid during any calendar year before any *prescription drug* benefits are payable. The family *prescription drug deductible amount* is two times the individual *prescription drug deductible amount*. For family coverage, once a *covered person* has met the individual *prescription drug deductible amount*, any remaining family *prescription drug deductible amount* can be met with the combination of any one or more covered persons' *eligible expenses*.

***Prescription order*** means the request for each separate drug or medication by a *physician* or each authorized refill or such requests.

***Primary care provider*** means a *physician* who is a family practitioner, general practitioner, pediatrician, or internist or an advanced practice registered nurse who is licensed by the New Hampshire board of nursing in the advance practice categories of family practice, internal medicine or pediatrics.

***Proof of loss*** means information required by *us* to decide if a claim is payable and the amount that is payable. It includes, but is not limited to, claim forms, medical bills or records, other plan information, and *network* re-pricing information. *Proof of loss* must include a copy of all Explanation of Benefit forms from any other carrier.

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

***Provider facility*** means a *hospital, rehabilitation facility*, or *extended care facility*.

***Qualified health plan*** or ***QHP*** means a health plan that has in effect a certification that it meets the standards described in subpart C of part 156 issued or recognized by each Health Insurance Marketplace through which such plan is offered in accordance with the process described in subpart K of part 155.

***Qualified Individual*** means, with respect to an Health Insurance Marketplace, an individual who has been determined eligible to enroll through the Health Insurance Marketplace in a *qualified health plan* in the individual market.

***Reconstructive surgery*** means *surgery* performed on an abnormal body structure caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease in order to improve function or to improve the patient's appearance, to the extent possible.

***Rehabilitation*** means care for restoration including by education or training of one's prior ability to function at a level of *maximum therapeutic benefit*. This type of care must be *acute rehabilitation*, *sub-acute rehabilitation*, or *intensive day rehabilitation*, and it includes *rehabilitation therapy* and *pain management programs*. An *inpatient* hospitalization will be deemed to be for *rehabilitation* at the time the patient has been *medically stabilized* and begins to receive *rehabilitation therapy* or treatment under a *pain management program*.

***Rehabilitation facility*** means an institution or a separate identifiable *hospital* unit, section, or ward that:

1. Is licensed by the state as a *rehabilitation facility*; and
2. Operates primarily to provide 24-hour primary care or *rehabilitation* of sick or injured persons as *inpatients*.

*Rehabilitation facility* does not include a facility primarily for rest, the aged, long term care, assisted living, *custodial care,* nursing care*,* or for care of the mentally incompetent.

***Rehabilitation licensed practitioner*** means, but is not limited to, a *physician*, physical therapist, speech therapist, occupational therapist, or respiratory therapist. A *rehabilitation licensed practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

***Rehabilitation therapy*** means physical therapy, occupational therapy, speech therapy, or respiratory therapy.

***Rescission*** of a contract means a determination by an insurer to withdraw the coverage back to the initial date of coverage.

***Residence*** means the physical location where *you* live. If *you* live in more than one location, and *you* file a United States income tax return, the physical address, not a P.O. Box, shown on *your* United States income tax return as *your* residence will be deemed to be *your* place of residence. If *you* do not file a United States income tax return, the *residence* where *you* spend the greatest amount of time will be deemed to be *your* place of *residence*.

***Residential treatment facility*** means a facility that provides, with or without charge sleeping accommodations, and:

1. Is not a *hospital, extended care facility,* or *rehabilitation facility;* or
2. Is a unit whose beds are not licensed at a level equal to or more acute than skilled nursing.

***Respite care*** means home healthcare services provided temporarily to a *member* in order to provide relief to the *member's immediate family* or other caregiver.

***Scalp Hair Prostheses*** means artificial substitutes for scalp hair that are made specifically for a specific *member*.

***Service Area*** means a geographical area, made up of counties, where we have been authorized by the State of New Hampshire to sell and market our health plans. This is where the majority of our Participating Providers are located where you will receive all of your healthcare services and supplies. You can receive precise service area boundaries from our website or our Member Services department.

***Specialist physician*** means a *physician* who is not a *primary care provider.*

***Spouse*** means *your* lawful wife or husband.

***Sub-acute rehabilitation*** means one or more different types of therapy provided by one or more *rehabilitation licensed practitioners* and performed for one-half hour to two hours per day, five to seven

days per week, while the *member* is confined as an *inpatient* in a *hospital*, *rehabilitation facility*, or *extended care facility*.

***Substance abuse*** means alcohol, drug or chemical abuse, overuse, or dependency.

***Surgery*** or ***surgical procedure*** means:
1. An invasive diagnostic procedure; or
2. The treatment of a *member's illness* or *injury* by manual or instrumental operations, performed by a *physician* while the *member is under general or local anesthesia.*

***Surveillance tests for ovarian cancer*** means annual screening using:
1. CA-125 serum tumor marker testing;
2. Transvaginal ultrasound; or
3. Pelvic examination.

***Terminal illness counseling*** means counseling of the *immediate family* of a *terminally ill* person for the purpose of teaching the *immediate family* to care for and adjust to the *illness* and impending death of the *terminally ill* person.

***Terminally ill*** means a *physician* has given a prognosis that a *member* has six months or less to live.

***Third party*** means a person or other entity that is or may be obligated or liable to the *member* for payment of any of the *member's* expenses for *illness* or *injury*. The term *"third party"* includes, but is not limited to, an individual person; a for-profit or non-profit business entity or organization; a government agency or program; and an insurance company. However, the term *"third party"* will not include any insurance company with a contract under which the *member* is entitled to benefits as a named insured person or an insured *dependent* of a named insured person except in those jurisdictions where statutes or common law does not specifically prohibit *our* right to recover from these sources.

***Tobacco use*** or ***use of tobacco*** means use of tobacco by individuals who may legally use tobacco under federal and state law on average four or more times per week and within no longer than the six months immediately preceding the date application for this *contract* was completed by the *member*, including all tobacco products but excluding religious and ceremonial uses of tobacco.

***Unproven service(s)*** means services, including medications, that are determined not to be effective for treatment of the medical condition, and/or not to have a beneficial effect on health outcomes, due to insufficient and inadequate clinical evidence from *well-conducted randomized controlled trials* or *well-conducted cohort studies* in the prevailing published peer-reviewed medical literature.
1. *"Well-conducted randomized controlled trials"* means that two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received; and
2. *"Well-conducted cohort studies"* means patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

***Urgent care center*** means a facility, not including a *hospital emergency* room or a *physician's* office, that provides treatment or services that are required:
1. To prevent serious deterioration of a *member's* health; and

2. As a result of an unforeseen *illness, injury,* or the onset of acute or severe symptoms.

***Utilization review*** means a process used to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, healthcare services, procedures, or settings. Areas of review may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

# DEPENDENT MEMBER COVERAGE

**Dependent Eligibility**
*Your dependent members* become eligible for insurance on the latter of:

1. The date *you* became covered under this *contract;* or
2. The date of marriage to add a spouse; *or*
3. The date of a newborns birth; or
4. The date that an adopted child is placed with a *covered person* for the purposes of adoption or a *covered person* assumes total or partial financial support of the child.

**Effective Date for Initial Dependents**
The *effective date* for *your* initial *dependents,* if any, is shown on the Schedule of Benefits. Only *dependent members* included in the application for this *contract* will be covered on *your effective date*.

**Coverage for a Newborn Child**
An *eligible child* born to a *covered person* will be covered from the time of birth until the 31st day after its birth. The newborn child will be covered from the time of its birth for nursery care, and *loss* due to *injury* and *illness*, including *loss* from complications of birth, premature birth, medically diagnosed congenital defect(s), and birth abnormalities.

Additional premium will be required to continue coverage beyond the 31st day after the date of birth of the child. If notice of the newborn is given to *us* by the Marketplace within the 31 days from birth, an additional premium for coverage of the newborn child will be charged for not less than 31 days after the birth of the child.. If notice is given by the Marketplace within 60 days of the birth of the child, the contract may not deny coverage of the child due to failure to notify *us* of the birth of the child or to pre-enroll the child. Coverage of the child will terminate on the 31st day after its birth, unless *we* have received notice by the Marketplace of the child's birth whether or not you have notified *us*.

**Coverage for an Adopted Child**
An *eligible child* legally placed for adoption with a *covered person* will be covered from the date of *placement* until the 31st day after *placement,* unless the *placement* is disrupted prior to legal adoption and the child is removed from *your* or *your spouse's* custody.

The child will be covered on the same basis as any other dependent.

Additional premium will be required to continue coverage beyond the 31st day following *placement* of the child and where the issuer is notified by the Marketplace. The required premium will be calculated from the date of *placement* for adoption. Coverage of the child will terminate on the 31st day following *placement*, unless *we* have received both: (A) Notification of the addition of the child from the Marketplace within 60 days of the birth or placement and (B) any additional premium required for the addition of the child within 90 days of the date of *placement.*

As used in this provision, *"placement"* means the the date that *you* or *your spouse* assume physical custody of the child for the purpose of adoption pursuant to an adoption proceeding.

**Adding Other Dependents**

If *you* apply in writing for insurance on a *dependent* and *you* pay the required premiums, then the *effective date* will be the first day of the first full calendar month after the date notice is received.

# ONGOING ELIGIBILITY

**For All Members**
A *member's* eligibility for coverage under this *contract* will cease on the earlier of:

1. The date that a *member* accepts any direct or indirect contribution or reimbursement, by or on behalf of an employer, for any portion of the premium for coverage under this *contract*;
2. The date a *member's* employer and a *member* treat this *contract* as part of an employer-provided health plan for any purpose, including tax purposes; or
3. The primary *member* residing outside the *Service Area* or moving permanently outside the *Service Area* of this plan.

**For Dependents**
A *dependent* will cease to be a *member* at the end of the premium period in which he or she ceases to be *your dependent member*. For *eligible children*, the Exchange will send a termination letter with an Effective Date the last day of the month the dependent turns 26. All enrolled *dependent members* will continue to be covered until the age limit listed in the definition of *eligible child*.

A *member* will not cease to be a *dependent eligible child* solely because of age if the *eligible child* is:

1. Not capable of self-sustaining employment due to mental handicap or physical handicap that began before the age limit was reached; and
2. Mainly dependent on the primary *member* for support.

**Open Enrollment**
There will be an open enrollment period for coverage. The Open Enrollment period begins November 1, 2016 and extends through January 31, 2017. *Individuals* who enroll prior to December 15, 2016 will have an effective date of coverage on January 1, 2017. *Individuals* who enroll between the first and fifteenth day of any subsequent month during the initial open enrollment period, will have a coverage effective date of the first day of the following month. *Individuals* who enroll between the sixteenth and last day of the month between December 2016 and January 31, 2017, will have a coverage effective date of the first day of the second following month.

The Health Insurance Marketplace may provide a coverage *effective date* for a *Qualified individual* earlier than specified in the paragraphs above, provided that either:

1. The *Qualified individual* has not been determined eligible for *advance payments of the premium tax credit* or *cost-sharing reductions*; or
2. The *Qualified individual* pays the entire premium for the first partial month of coverage as well as all cost sharing, thereby waiving the benefit of *advance payments of the premium tax credit* and *cost-sharing reduction* payments until the first of the next month. Starting in 2016, *we* will send written annual open enrollment notification to each *member* no earlier than September 1st and no later than September 30th.

**Special and Limited Enrollment**
A *Qualified individual* has 60 days to report a qualifying event to the Exchange and could be granted a 60 day Special Enrollment Period as a result of one of the following events:

1. A *Qualified individual* or *dependent loses minimum essential coverage*;
2. A *Qualified individual* gains a dependent or becomes a *dependent* through marriage, birth, adoption or placement for adoption;

3. An individual, who was not previously a citizen, national, or lawfully present individual gains such status;
4. A *Qualified* individual's enrollment or non-enrollment in a *qualified health plan* is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Health Insurance Marketplace or HHS, or its instrumentalities as evaluated and determined by the Health Insurance Marketplace. In such cases, the Health Insurance Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
5. An enrollee adequately demonstrates to the Health Insurance Marketplace that the *qualified health plan* in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
6. An individual is determined newly eligible or newly ineligible for *advance payments of the premium tax credit* or has a chance in eligibility for *cost-sharing reductions*, regardless of whether such individual is already enrolled in a *qualified health plan*;
7. A *Qualified individual* or enrollee gains access to new *qualified health plan* as a result of a permanent move;
8. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
9. An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a *qualified health plan* or change from one *qualified health plan* to another one time per month; or
10. A *Qualified individual* or enrollee demonstrates to the Health Insurance Marketplace, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Health Insurance Marketplace may provide.

*Qualified individuals* that enroll between the first and fifteenth day of the month will have a coverage *effective date* of the first day of the following month. *Qualified individuals* that enroll between the sixteenth and last day of the month will have a coverage *effective date* of the first day of the second following month.

In the case of birth, adoption or placement for adoption, the coverage is effective on the date of birth, adoption or placement for adoption, but *advance payments of the premium tax credit* and *cost-sharing reductions*, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month. In the case of marriage, or in the case where a *qualified individual* loses minimum essential coverage, the *effective date* is the first day of the following month.

# PREMIUMS

**Premium Payment**
Each premium is to be paid on or before its due date. The initial premium must be paid prior to the 20th of the month in which coverage is effective.

**Grace Period**
When a *member* is receiving a premium subsidy:
After the first premium is paid, a grace period of 3 months from the premium due date is given for the payment of premium. Coverage will remain in force during the grace period. If full payment of premium is not received within the grace period, coverage will be terminated as of the last day of the first month during the grace period.

*We* will continue to pay all appropriate claims for *covered services* rendered to the *member* during the first month of the grace period, and may pend claims for *covered services* rendered to the *member* in the second and third month of the grace period. *We* will notify HHS of the non-payment of premiums, the *member*, as well as providers of the possibility of denied claims when the *member* is in the second and third month of the grace period. *We* will continue to collect advanced premium tax credits on behalf of the *member* from the Department of the Treasury, and will return the advanced premium tax credits on behalf of the *member* for the second and third month of the grace period if the *member* exhausts their grace period as described above. A *member* is not eligible to re-enroll once terminated, unless a *member* has a special enrollment circumstance, such as a marriage or birth in the family or during annual open enrollment periods.

When a *member* is not receiving a premium subsidy:
Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. There is a one (1) month grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the Contract will stay in force; however, claims may pend for *covered services* rendered to the *member* during the grace period. *We* will notify HHS, as necessary, of the non-payment of premiums, the *member*, as well as providers of the possibility of denied claims when the *member* is in the grace period.

**Reinstatement**

If *your contract* lapses due to nonpayment of premium, it may be reinstated provided:

1. *We* receive from *you* a written application for reinstatement within one year after the date coverage lapsed; and
2. The written application for reinstatement is accompanied by the required premium payment.

Premium accepted for reinstatement may be applied to a period for which premium had not been paid. The period for which back premium may be required will not begin more than 60 days before the date of reinstatement.

The Rescissions provision will apply to statements made on the reinstatement application, based on the date of reinstatement.

In all other respects, *you* and *we* will have the same rights as before *your contract* lapsed.

**Misstatement of Age**
If a *member's* age has been misstated, the benefits may be adjusted based on the relationship of the premium paid to the premium that should have been paid, based on the correct age.

**Change or Misstatement of Residence**
If *you* change *your residence*, *you* must notify the Exchange of *your* new *residence* within 60 days of the change. As a result your premium may change and you may be eligible for a Special Enrollment Period. See the section on Special Enrollment Periods for more information.

**Misstatement of Tobacco Use**
The answer to the tobacco question on the application is material to *our* correct underwriting. If a *member's use of tobacco* has been misstated on the *member's* application for coverage under this *contract, we* have the right to rerate the contract back to the original effective date.

# MAJOR MEDICAL EXPENSE BENEFITS

**Deductible**
The *deductible amount* means the amount of *covered service expenses* that must be paid by all *members* before any benefits are payable. If on a family plan, if one member of the family meets his or her deductible, benefits for that *member* will be paid.

**Coinsurance Percentage**
We will pay the applicable *coinsurance percentage* in excess of the applicable deductible for a service or supply that:

1. Qualifies as a *covered service expense* under one or more benefit provisions; and
2. Is received while the *member's* insurance is in force under the *contract* if the charge for the service or supply qualifies as an *eligible expense*.

When the annual out-of-pocket maximum has been met, additional *covered service expenses* will be payable at 100%.

The amount payable will be subject to:

1. Any specific benefit limits stated in the *contract*;
2. A determination of *eligible expenses*; and
3. Any reduction for expenses incurred at a *non-network provider*. Please refer to the information on the Schedule of Benefits.

**Note:** The bill *you* receive for services or supplies from a *non-network provider* may be significantly higher than the *eligible expenses* for those services or supplies. In addition to the *deductible amount* and *coinsurance percentage*, *you* are responsible for the difference between the *eligible expense* and the amount the provider bills *you* for the services or supplies. Any amount *you* are obligated to pay to the provider in excess of the *eligible expense* will not apply to *your deductible amount* or out-of-pocket maximum.

**Primary Care Physician**
In order to obtain benefits, *you* must designate a *network primary care provider* for each *member. You* may select any *network primary care provider* who is accepting new patients. However, you may not change your selection more frequently than once each month. If *you* do not select a *network primary care provider* for each *member,* one will be assigned. *You* may obtain a list of *network primary care providers* at *our* website or by contacting our Member Services department.

*Your network primary care provider* will be responsible for coordinating all covered health services and making referrals for services from other *network providers. You* do not need a referral from *your network primary care provider* for obstetrical or gynecological treatment and may seek care directly from a *network* obstetrician or gynecologist.

*You* may change *your network primary care provider* by submitting a written request, online at *our* website, or by contacting *our* office at the number shown on *your* identification card. The change to *your network primary care provider* of record will be effective no later than 30 days from the date *we* receive *your* request.

**Network Availability**
*Your network* is subject to change. The most current *network* may be found online at our website or by contacting *us* at the number shown on *your* identification card. . A *network* may not be available in all areas. If *you* move to an area where *we* are not offering access to a *network*, the *network* provisions of the *contract* will no longer apply. In that event, benefits will be calculated based on the *eligible service expense*, subject to the *deductible amount* for *network providers*. *You* will be notified of any increase in premium.

**Coverage Under Other Contract Provisions**
Charges for services and supplies that qualify as *covered service expenses* under one benefit provision will not qualify as *covered service expenses* under any other benefit provision of this *contract.*

**Ambulance Service Benefits**
*Covered service expenses* will include ambulance services for local transportation:

1. To the nearest *hospital* that can provide services appropriate to the *member's illness* or *injury*, in case of *emergency*.
2. To the nearest neonatal special care unit for newborn infants for treatment of *illnesses*, *injuries*, congenital birth defects, or complications of birth that require that level of care.
3. Transportation between hospitals when approved by Ambetter from NH Healthy Families.

Benefits for air ambulance services are limited to:

1. Services requested by police or medical authorities at the site of an *emergency*; or
2. Those situations in which the *member* is in a location that cannot be reached by ground ambulance.

Exclusions:
No benefits will be paid for:

1. Expenses incurred for ambulance services covered by a local governmental or municipal body, unless otherwise required by law;
2. Non-*emergency* air ambulance;
3. Air ambulance:
    a. Outside of the 50 United States and the District of Columbia;
    b. From a country or territory outside of the United States to a location within the 50 United States or the District of Columbia; or
    c. From a location within the 50 United States or the District of Columbia to a country or territory outside of the United States; or
4. Ambulance services provided for a *member's* comfort or convenience.
5. Non-emergency transportation excluding ambulances (for example- transport van, taxi).

**Autism Spectrum Disorder Expense Benefit**
*Covered service expenses* for *autism spectrum disorder* include *coverage* for the diagnosis of autism spectrum disorders and for the *treatment of autism spectrum disorders*.

- Upon request by *us*, a *provider* of treatment for autism spectrum disorders shall furnish medical records, clinical notes, or other necessary data that substantiate that initial or continued medical treatment is *medically necessary* and is resulting in improved clinical status. When treatment is anticipated to require continued services to achieve demonstrable progress, *we* may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated outcomes

stated as goals, and the frequency by which the treatment plan will be updated.

- When making a determination of medical necessity for a treatment modality for autism spectrum disorders, *we* will make the determination in a manner that is consistent with the manner used to make that determination with respect to other diseases or illnesses covered under this *contract*, including an appeals process. During the appeals process, any challenge to *medical necessity* must be viewed as reasonable only if the review includes a *physician* with expertise in the most current and effective treatment modalities for autism spectrum disorders. Coverage for *medically necessary* early intervention services must be delivered by certified early intervention specialists.
- Habilitation services, for members with a diagnosis of *autism spectrum disorder*, at a minimum shall include: applied behavior analysis that is intended to develop, maintain, and restore the functioning of an individual.

**Clinical Trials for Cancer and Other Life-Threatening Illnesses**

*Covered service expenses* for the routine patient care costs incurred by a member enrolled in an approved clinical trial related to cancer, including leukemia, lymphoma, and bone marrow stem cell disorders, or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted, if the member's *physician* determines that:

1. There is no clearly superior noninvestigational treatment alternative; and
2. Available clinical or preclinical data provide a reasonable expectation that the treatment provided in the clinical trial will be at least as effective as any noninvestigational alternative.

*Covered service expenses* include the costs of:

1. prevention, diagnosis, treatment, and palliative care of cancer or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted;
2. medical care for an approved clinical trial related to cancer or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted, that would otherwise be covered under a healthcare insurance plan if the medical care were not in connection with an approved clinical trial;
3. items or services necessary to provide an investigational item or service;
4. the diagnosis or treatment of complications;
5. a drug or device approved by the United States Food and Drug Administration without regard to whether the United States Food and Drug Administration approved the drug or device for use in treating a patient's particular condition, but only to the extent that the drug or device is not paid for by the manufacturer, distributor, or provider of the drug or device;
6. services necessary to administer a drug or device under evaluation in the clinical trial; and
7. transportation for the patient that is primarily for and essential to the medical care.

*Covered service expenses* do not include:

1. a drug or device that is associated with the clinical trial that has not been approved by the United States Food and Drug Administration;
2. housing, companion expenses, or other nonclinical expenses associated with the clinical trial;
3. an item or service provided solely to satisfy data collection and analysis and not used in the clinical management of the patient;
4. an item or service excluded from coverage under the patient's healthcare insurance plan; and
5. an item or service paid for or customarily paid for through grants or other funding.

The coverage required by this section is subject to the standard contract provisions applicable to other benefits, including deductible and coinsurance.

**Diabetic Care**
Benefits are available for *medically necessary* services and supplies used in the treatment of diabetes.

*Covered service expenses* include, but are not limited to, exams including podiatric exams; routine foot care such as trimming of nails and corns; laboratory and radiological diagnostic testing; self-management equipment, and supplies such as urine and/or ketone strips, blood glucose monitor supplies, glucose strips for the device, and syringes or needles; orthotics and diabetic shoes; urinary protein/microalbumin and lipid profiles; educational health and nutritional counseling for self-management, eye examinations, and prescription medication;

**Durable Medical Equipment (DME), Devices and Supplies**
The following are Covered Services when *medically necessary*:

Orthopedic Appliances: Orthopedic appliances, which are attached to an impaired body segment for the purpose of protecting the segment or assisting in restoration or improvement of its function.

Exclusions: arch supports, including custom shoe modifications or inserts and their fittings except for therapeutic shoes, modifications and shoe inserts for severe diabetic foot disease; and orthopedic shoes that are not attached to an appliance.

Ostomy Supplies: Ostomy supplies for the removal of bodily secretions or waste through an artificial opening. Quantities that are greater than CMS guidelines may require Prior Authorization by us.

*Durable Medical Equipment*: Durable Medical Equipment is equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is useful only in the presence of an illness or injury and used in the Member's home. Durable Medical Equipment includes: standard *hospital* beds, standard non-motorized wheelchairs, wheelchair cushion, standard walkers, crutches, canes, glucose monitors, external insulin pumps, oxygen, and oxygen equipment. All Durable Medical Equipment must receive prior authorization. We will determine if equipment is made available on a rental or purchase basis. At our option, we may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider we authorize before the purchase.
*Hearing Aids:* For the professional services associated with the practice of fitting, dispensing, servicing, or sale of hearing instruments or *hearing aids*. The benefits includes the cost of a *hearing aid* for each ear, as needed, as well as related services necessary to assess, select, and fit the *hearing aid*, as needed;

*Prosthetic Devices*: Prosthetic devices are items which replace all or part of an external body part, or function thereof.

When authorized in advance, repair, adjustment or replacement of appliances and equipment is covered.

Exclusions: take-home dressings and supplies following hospitalization; any other supplies, dressings, appliances, devices or services which are not specifically listed as covered above**;** replacement or repair

of appliances, devices and supplies due to loss, breakage from willful damage, neglect or wrongful use, or due to personal preference.

Diabetic Supplies: including insulin syringes, lancets, urine testing reagants, blood glucose monitoring reagants and insulin.

**Habilitation, Rehabilitation and Extended Care Facility Expense Benefits**
*Covered service expenses* include expenses incurred for *habilitation* or *rehabilitation* services or confinement in an *extended care facility*, subject to the following limitations:

1. *Covered service expenses* available to a *member* while confined primarily to receive *habilitation* or *rehabilitation* are limited to those specified in this provision;
2. *Rehabilitation* services or confinement in a *rehabilitation facility* or *extended care facility* must begin within 14 days of a *hospital* stay and be for treatment of, or *rehabilitation* related to, the same *illness* or *injury* that resulted in the *hospital* stay;
3. *Covered service expenses* for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *extended care facility* for:
    a. Daily room and board and nursing services;
    b. Diagnostic testing; and
    c. Drugs and medicines that are prescribed by a *physician*, must be filled by a licensed pharmacist, and are approved by the U.S. Food and Drug Administration;
4. *Covered service expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation licensed practitioners.*
5. Coverage for a Skilled Nursing Facility is limited to 100 days per year.
6. *Habilitation* and *Rehabilitation* Services are limited to 20 visits per year per therapy (Occupational Therapy, Physical Therapy and Speech Therapy).
7. Coverage for Cardiac Rehabilitation.

See the Schedule of Benefits for benefit levels or additional limits.

Care ceases to be *rehabilitation* upon *our* determination of any of the following:

1. The *member* has reached *maximum therapeutic benefit*;
2. Further treatment cannot restore bodily function beyond the level the *member* already possesses;
3. There is no measurable progress toward documented goals; and
4. Care is primarily *custodial care*.

Definition:
As used in this provision, *"provider facility"* means a *hospital, rehabilitation facility*, or *extended care facility*.

**Home Healthcare Expense Benefits**
*Covered service expenses* for *home healthcare* are limited to the following charges:

1. *Home health aide services*;
2. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home healthcare;*
3. I.V. medication and pain medication;
4. Hemodialysis, and for the processing and administration of blood or blood components;
5. *Necessary medical supplies*; and
6. Rental of *medically necessary durable medical equipment*.

Charges under (3) are *covered service expenses* to the extent they would have been *covered service expenses* during an *inpatient hospital* stay.

At *our* option, *we* may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider *we* authorize before the purchase.

Limitations:
*Covered service expenses* for *home health aide services* will be limited to:
1. Seven visits per week; and
2. A *calendar year* maximum of 60 visits.

Each eight-hour period of *home health aide services* will be counted as one visit.

Exclusion:
No benefits will be payable for charges related to *custodial care,* or educational care, under the Home Healthcare Expense Benefits.

**Hospice Care Expense Benefits**
This provision only applies to a *terminally ill member* receiving *medically necessary* care under a *hospice care program*.

The following are *covered service expenses* under this provision:
1. Room and board in a *hospice* while the *member* is an *inpatient;*
2. Occupational therapy;
3. Speech-language therapy;
4. The rental of medical equipment while the *terminally ill member* is in a *hospice care program* to the extent that these items would have been covered under the *contract* if the *member* had been confined in a *hospital;*
5. Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management;
6. Counseling the *member* regarding his or her *terminal illness;*
7. *Terminal illness counseling* of members of the *member's immediate family;* and
8. *Bereavement counseling*.

Benefits for *hospice inpatient,* home or outpatient care are available to a *terminally ill member* for one continuous period up to 180 days in a *member's* lifetime. For each day the *member* is confined in a *hospice,* benefits for room and board will not exceed the most common semiprivate room rate of the *hospital* or nursing home with which the *hospice* is associated.

Exclusions and Limitations:
Any exclusion or limitation contained in the *contract* regarding:
1. An *injury* or *illness* arising out of, or in the course of, employment for wage or profit;
2. *Medical necessity* of services or supplies, to the extent such services or supplies are provided as part of a *hospice care program;* or

3. Expenses for other persons, to the extent those expenses are described above, will not be applied to this provision.

**Respite Care Expense Benefits**
Respite care is covered on an *inpatient*, home or *outpatient* basis to allow temporary relief to family members from the duties of caring for a Covered Person under Hospice Care. Respite days that are applied toward the Deductible are considered benefits provided and shall apply against any Maximum Benefit limit for these services. See your Schedule of Benefits for coverage limits.

**Infertility Services**
Covered services for infertility services are limited to diagnostic test to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy and semen analysis. Benefits are included to treat the underlying medical conditions that cause infertility (such as endometriosis, obstructed fallopian tubes and hormone deficiency).

**Mammography Coverage**
Typical breast cancer screening mammography, which includes the following:

a. If the *member* is at least thirty-five (35) years of age but less than forty (40) years of age and a female, coverage for at least one (1) baseline breast cancer screening mammography performed upon *member* before she becomes forty (40) years of age; or
b. If the *member* is less than forty (40) years of age and a woman at risk, one (1) typical breast cancer screening mammography performed upon the *member* every year; or
c. If the enrollee is at least forty (40) years of age and a female, one (1) typical breast cancer screening mammography performed upon the *member* every year; and
d. Any additional mammography views that are required for proper evaluation; and
e. Ultrasound services, if determined *medically necessary* by the *physician* treating the *member*.

**Mental Health and Substance Use Disorder Benefits**
Cenpatico Behavioral Health, LLC (Cenpatico) oversees the delivery and oversight of covered behavioral health and substance use disorder services for NH Healthy Families. Mental health services will be provided on an inpatient and outpatient basis and include treatable mental disorders. These disorders affect the member's ability to cope with the requirements of daily living. If you need mental health and/or substance use disorder treatment, you may choose any provider participating in Cenpatico's provider network and do not need a referral from your PCP in order to initiate treatment. Deductibles, copayment or coinsurance amounts and treatment limits for covered mental health and substance use disorder benefits will be applied in the same manner as physical health service benefits.

*Covered services* for mental health and substance use disorder are included on a non-discriminatory basis for all Members for the diagnosis and treatment of mental, emotional, and/or substance use disorders, including *pervasive developmental disorders*. Diagnoses known as "V Codes" are *eligible expenses* only when billed as a supporting diagnosis. Treatment is limited to services prescribed by your *Physician* in accordance with a treatment plan.

When making coverage determinations, Cenpatico utilizes established level of care guidelines and *medical necessity* criteria that are based on currently accepted standards of practice and take into account legal and

regulatory requirements. Cenpatico utilizes "Interqual" criteria for mental health determinations and "ASAM" criteria for *substance abuse* determinations. Services should always be provided in the least restrictive clinically appropriate setting. Any determination that requested services are not *medically necessary* will be made by a qualified licensed mental health professional.

Covered *Inpatient*, Intermediate and Outpatient mental health and/or substance use disorder services are as follows:

Inpatient

1. *Inpatient* treatment;
2. *Inpatient* detoxification treatment;
3. Observation;
4. Crisis Stabilization;
5. Rehabilitation; and
6. Electroconvulsive Therapy (ECT).

Intermediate

1. Partial Hospitalization Program (PHP)
2. Intensive Outpatient Program (IOP); and
3. Day treatment.

Outpatient

1. Traditional outpatient services, including individual and group therapy services;
2. Medication management services;
3. *Autism Spectrum Disorders;*
4. Telemedicine*;* and
5. Psychological Testing.

Expenses for these services are covered, if *medically necessary* and may be subject to prior authorization. Please see the Schedule of Benefits for more information regarding services that require prior authorization and specific benefit, day or visit limits, if any.

**Miscellaneous Medical and Surgical Expense Benefits**

Medical *covered service expenses* are limited to charges:

1. Made by a *hospital* for:
    a. Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate;
    b. Daily room and board and nursing services while confined in an *intensive care unit*.
    c. *Inpatient* use of an operating, treatment, or recovery room;
    d. Outpatient use of an operating, treatment, or recovery room for *surgery;*
    e. Services and supplies, including drugs and medicines, which are routinely provided by the *hospital* to persons for use only while they are *inpatients; and*
    f. *Emergency* treatment of an *injury* or *illness*, even if confinement is not required.
2. For *surgery* in a *physician's* office or at an *outpatient surgical facility,* including services and supplies;
3. For services received for urgent care, including facility charges at an *urgent care center*.
4. Made by a *physician* for professional services, including *surgery;*

5. Made by an assistant surgeon, limited to 20 percent of the *eligible expense* for the *surgical procedure;*
6. For the professional services of a *medical practitioner;*
7. For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies;*
8. For diagnostic testing using radiologic, ultrasonographic, or laboratory services. Psychometric, behavioral and educational testing are not included;
9. For chemotherapy and radiation therapy or treatment;
10. For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components;
11. For the cost and administration of an anesthetic;
12. For oxygen and its administration;
13. For *dental expenses* when a *member* suffers an *injury,* that results in:
    a. Damage to his or her sound natural teeth and gums;
    b. Expenses are incurred or treatment is authorized within three months of the accident or as part of a treatment plan that was prescribed by a *physician* and began within three months of the accident. *Injury* to the natural teeth will not include any injury as a result of chewing; and
    c. Treatment made necessary due to injury to the jaw and oral structures other than teeth are covered without time limit;
14. For reconstructive breast surgery charges as a result of a partial or total mastectomy for breast cancer, if the patient elects reconstruction and in the manner chosen by the patient and the *physician*. Coverage includes surgery and reconstruction of the diseased and non-diseased breast, and prosthetic devices necessary, to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas;
15. For *surgery*, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint, as well as removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services;
16. For Chiropractic Care, including office visits for assessment, evaluation, spinal adjustment, *medically necessary manipulative therapy* treatment on an outpatient basis and physiological therapy before (or in conjunction with) spinal adjustment. This benefit is limited to 12 visits per year;
17. For pulse oximetry screening on a newborn;
18. For the following types of tissue transplants:
    a. Cornea transplants;
    b. Artery or vein grafts;
    c. Heart valve grafts;
    d. Prosthetic tissue replacement, including joint replacements; and
    e. Implantable prosthetic lenses, in connection with cataracts;
19. For *outpatient contraceptive services* for any type of drug or device for contraception, which is lawfully prescribed and has been approved by the FDA. Additionally, coverage is required for any outpatient services related to the use of a drug or device intended to prevent *pregnancy*;
20. For dental procedure coverage for the medically necessary facility charges and administration of general anesthesia administered by a licensed anesthesiologist or anesthetist for dental procedures performed on a *member* who:
    a. is a child under the age of 6 who is determined by a licensed dentist in conjunction with a licensed *primary care provider* to have a dental condition of significant dental complexity

which requires certain dental procedures to be performed in a surgical day care facility or *hospital* setting; or

b. is a person who has exceptional medical circumstances or a developmental disability as determined by a licensed *primary care provider* which place the person at serious risk;

21. For the provision of nonprescription enteral formulas and food products required for *members* with inherited diseases of amino acids and organic acids. Such coverage shall be provided when the prescribing *physician* has issued a written order stating that the enteral formula or food product is medically necessary and is the least restrictive and most cost effective means for meeting the needs of the *member*. Coverage for inherited diseases of amino acids and organic acids shall, in addition to the enteral formula, include food products modified to be low protein;
22. For scalp hair prosthesis expenses for hair loss suffered as a result of alopecia areata, alopecia totalis, alopecia medicamentosa resulting from the treatment from any form of cancer or leukemia, or permanent loss of scalp hair due to injury. Such coverage, shall be subject to a written recommendation by the treating *physician* stating that the hair prosthesis is a medical necessity;
23. For children's early intervention therapy for expenses arising from the 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 and/or delay as long as the providing therapist receives a referral from the child's *primary care* *provider* if applicable;
24. For the diseases and ailments caused by obesity and morbid obesity and treatment for such, including bariatric surgery, when the prescribing *physician* has issued a written order stating that treatment is *medically necessary* and in accordance with the *member's* qualifications and treatment standards set forth by the American Society for Metabolic and Bariatric Surgery or the American College of Surgeons. Such treatment standards may include, but not be limited to, pre-operative psychological screening and counseling, behavior modification, weight loss, exercise regimens, nutritional counseling, and post-operative follow-up, overview, and counseling of dietary, exercise, and lifestyle changes. The covered *insured person* shall be at least 18 years of age;
25. For *medically necessary* diagnostic and laboratory and x-ray tests;
26. For telemedicine for *covered services* provided within the scope of practice of a *physician* or other healthcare provider as a method of delivery of medical care by which a *member* shall receive medical services from a healthcare provider without in-person contact with the provider; and
27. For injections, including allergy injections.
28. for Medically Necessary oral surgery, including the following:
    a. Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
    b. Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw bone and is Medically Necessary to attain functional capacity of the affected part.
    c. Oral / surgical correction of accidental injuries as indicated in the "Dental Services" section.
    d. Surgical services as described in the "Temporomandibular Joint (TMJ) and Craniomandibular Joint Services" section.
    e. Treatment of non-dental lesions, such as removal of tumors and biopsies.
    f. Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.
    g. Surgical procedures that are Medically Necessary to correct disorders caused by (or resulting in) a specific medical condition such as degenerative arthritis, jaw fractures or jaw dislocations.
    h. Reconstructive surgery

**Miscellaneous Outpatient Medical Services and Supplies Expense Benefits**

*Covered service expenses* for miscellaneous outpatient medical services and supplies are limited to charges:

1. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs but not the replacement thereof, unless required by a physical change in the *member* and the item cannot be modified. If more than one prosthetic device can meet a *member's* functional needs, only the charge for the most cost effective prosthetic device will be considered a *covered service expense*;
2. For one pair of foot orthotics per year per *member*;
3. For *medically necessary* genetic blood tests;
4. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV);
5. For two mastectomy bras per year if the *member* has undergone a mastectomy;
6. For rental of a standard *hospital* bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator;
7. For the rental cost of one Continuous Passive Motion (CPM) machine per *member* following a joint surgery;
8. For the cost of one wig per *member* necessitated by hair loss due to cancer treatments, traumatic burns, or permanent loss of scalp hair due to injury;
9. Infusion therapy;
10. For one pair of eyeglasses or contact lenses per *member* following a cataract surgery, or if the lens of your eye has been surgically removed or is congenitally absent; and
11. For any other use of a drug approved by the United States Food and Drug Administration when the drug has not been approved by the United States Food and Drug Administration for the treatment of the particular indication for which the drug has been prescribed, provided such drug is recognized for treatment of such indication in one of the standard reference compendia or in the medical literature as recommended by current American Medical Association (AMA) policies. Any coverage of a drug required shall also include medically necessary services associated with the administration of the drug. This benefit shall not be construed to require:
    a. Coverage for any drug if the FDA has determined its use to be contraindicated for the treatment of the particular indication for which the drug has been prescribed;
    b. Coverage for experimental or investigational drugs not approved for any indication by the FDA; and
    c. Reimbursement or coverage for any drug not included on the drug formulary or list of covered drugs specified in this contract.

**Maternity Care**

For maternity care of a *member* the length of *hospital* stay and the number of postpartum visits shall be determined by the attending healthcare provider based on clinical information that demonstrates that the member and infant are clinically stable based on nationally accepted guidelines and that appropriate care for the member and newborn can be provided for upon discharge. The length of stay shall not be determined by NH Healthy Families or the *hospital* based on economic criteria. Any length of *hospital* stay shorter than the current minimum nationally accepted guidelines for perinatal care, such as Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, shall be at the recommendation of the attending healthcare provider in consultation with the member. In such cases NH Healthy Families shall pay for at least 2 postpartum visits. During one such visit, the collection of an adequate sample from the newborn for screening for genetic and metabolic diseases shall take place.

Coverage for Maternity Care includes: outpatient and inpatient pre- and post-partum care including exams, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, childbirth classes, physician services for delivery of a baby, including circumcision, and hospital stays for delivery or other *medically necessary* reasons (less any applicable *copayments*, *deductible amounts*, or *cost sharing percentage*).

Maternity coverage of a home birth by a midwife or nurse midwife is limited to low risk Pregnancy and may be subject to preauthorization requirements.

**Newborns' and Mothers' Health Protection Act Statement of Rights**
If expenses for *hospital* confinement in connection with childbirth are otherwise included as *covered service expenses*, *we* will not limit the number of days for these expenses to less than that stated in this provision.

Under federal law, health insurance issuers generally may not restrict benefits otherwise provided for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, *we* may provide benefits for *covered service expenses* incurred for a shorter stay if the attending provider (e.g., *your physician*, nurse midwife or *physician* assistant), after consultation with the mother, discharges the mother or newborn earlier.

The level of benefits and out-of-pocket costs for any later part of the 48-hour or 96-hour stay will not be less favorable to the mother or newborn than any earlier part of the stay. *We* do not require that a *physician* or other healthcare provider obtain authorization for prescribing a length of stay of up to 48 hours or 96 hours.

**Note:** This provision does not amend the *contract* to restrict any terms, limits, or conditions that may otherwise apply to *covered service expenses* for childbirth.

**Outpatient Prescription Drug Expense Benefits**
*Covered service expenses* in this benefit subsection are limited to charges from a licensed *pharmacy* for:

1. A *prescription drug;*
2. Any drug that, under the applicable state law, may be dispensed only upon the written prescription of a *physician*; and
3. Off-label drugs that are:
    a. Recognized for treatment of the indication in at least one (1) *standard reference compendium*; or
    b. The drug is recommended for a particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
4. *Self-administered human growth hormones to treat children with short stature who have an absolute deficiency in natural growth hormone. Benefits are also available to treat children with short stature who have chronic renal insufficiency and who do not have a functioning renal transplant."*

As used in this section, *Standard Reference Compendia* means (a) The American *Hospital* Formulary Service Drug Information (b) The American Medical Association Drug Evaluation or (c) The United States Pharmacopoeia-Drug Information.

See the Schedule of Benefits for benefit levels or additional limits.

Covered *prescription drugs*, which are not subject to utilization management, prior authorization, or pre-certification requirements, are covered up-to-90-day supply at retail pharmacy's within *our* network. Controlled substances as identified by the United States Drug Enforcement Administration are exempt from this section. The *prescription drugs* received in a 90-day supply may be subject to co-payments, coinsurance deductibles, or other member cost shares.

The appropriate drug choice for a *member* is a determination that is best made by the *member* and his or her *physician. Experimental or investigational treatment* drugs will be covered as defined.

Prescription drug benefits shall maintain an expeditious exception process, not to exceed 48 hours, by which members may obtain coverage for a *medically necessary* nonformulary prescription drug. The exception process shall begin when the prescribing provider has provided the clinical rationale for the exception. The exception process shall begin when the prescribing provider has submitted a request with a clinical rationale for the exception to NH Healthy Families. A prescription that requires an exception for coverage shall be considered approved if the exception process exceeds 48 hours.

A *member*, a *member's* designee or a *member's* prescribing *physician* may request an expedited review based on exigent circumstances. Exigent circumstances exist when a *member* is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug. Within 24 hours of the request being received, we will provide the *member*, the *member's* designee or the *member's* prescribing *physician* with our coverage determination. Should the expedited exception request be granted, we will provide coverage of the non-formulary drug for the duration of the exigency.

Notice and Proof of Loss:
In order to obtain payment for *covered service expenses* incurred at a *pharmacy* for *prescription orders,* a notice of claim and *proof of loss* must be submitted directly to *us.*

Exclusions and Limitations:
No benefits will be paid under this benefit subsection for expenses incurred:

1. For *prescription drugs* for the treatment of erectile dysfunction or any enhancement of sexual performance, unless listed on the formulary;
2. For immunization agents otherwise not required by the Affordable Care Act;
3. For medication that is to be taken by the *member,* in whole or in part, at the place where it is dispensed;
4. For medication received while the *member* is a patient at an institution that has a facility for dispensing pharmaceuticals;
5. For a refill dispensed more than 12 months from the date of a *physician's* order;
6. Due to a *member's* addiction to, or dependency on foods;
7. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs;

8. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are covered on the formulary;
9. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs;
10. For a *prescription drug* that contains an active ingredient(s) that is/are:
    a. Available in and *therapeutically equivalent* to another covered *prescription drug;* or
    b. A modified version of and *therapeutically equivalent* to another covered *prescription drug.* Such determinations may be made up to six times during a *calendar year*, and *we* may decide at any time to reinstate benefits for a *prescription drug* that was previously excluded under this paragraph; and
11. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.

**Pediatric Vision Expense Benefits**
*Covered service expenses by the vision vendor* in this benefit subsection include the following for an *eligible child* under the age of 19 who is a *member*:

1. Routine vision screening, including dilation and with refraction every calendar year.
2. One pair of prescription lenses (single vision, lined bifocal, lined trifocal or lenticular) or initial supply of medically necessary contacts every calendar year, including standard polycarbonate lenses, scratch resistant and anti-reflective coating.
3. One pair of prescription eyeglasses per calendar year.
4. Low vision optical devices including low vision services, and an aid allowance with follow-up care when pre-authorized.

*Covered service expenses* do not include:

1. Visual therapy;
2. Two pairs of glasses as a substitute for bifocals;
3. Replacement of lost or stolen eyewear;
4. Any vision services, treatment or material not specifically listed as a *covered service*; or
5. Out of network care, except when pre-authorized.

**Preventive Care Expense Benefits**
*Covered service expenses* are expanded to include the charges incurred by a *member* for the following preventive health services if appropriate for that *member* in accordance with the following recommendations and guidelines:

1. Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force;
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to an individual;
3. Evidence-informed preventive care and screenings for infants, children, and adolescents, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration; a
4. Additional preventive care and screenings not included in (1) above, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration for women;

5. All FDA-approved contraception methods (identified on www.fda.gov) are approved for members without cost sharing as required under the Affordable Care Act. Members have access to the methods available and outlined on our Drug Formulary or Preferred Drug List without cost share. Some contraception methods are available through a member's medical benefit, including the insertion and removal of the contraceptive device at no cost share to the member; and
6. Covers without cost sharing:
    a. Screening for *tobacco use*; and
    b. For those who *use tobacco* products, at least two (2) cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
        i. Four (4) tobacco cessation counseling sessions of at least ten (10) minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and
        ii. All Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a healthcare provider without prior authorization.

Benefits for preventive health services listed in this provision, except under the administration of reasonable medical management techniques discussed in the next paragraph, are exempt from any deductibles and coinsurance provisions under the *contract* when the services are provided by a *network provider.* Benefits include coverage for smoking cessation counseling and related prescription drugs.

Benefits for *covered service expenses* for preventive care expense benefits may include the use of reasonable medical management techniques authorized by federal law to promote the use of high value preventive services from *network providers*. Reasonable medical management techniques may result in the application of deductibles and coinsurance provisions to services when a *member* chooses not to use a high value service that is otherwise exempt from deductibles and coinsurance provisions when received from a *network provider*.

As new recommendations and guidelines are issued, those services will be considered *covered service expenses* when required by the United States Secretary of Health and Human Services, but not earlier than one year after the recommendation or guideline is issued.

**Transplant Service Expense Benefits**
*Covered service expenses* for transplant expenses:
If *we* determine that a *member* is an appropriate candidate for a *listed transplant,* Medical Benefits *covered service expenses* will be provided for:
1. Pre-transplant evaluation;
2. Pre-transplant harvesting;
3. Pre-transplant stabilization, meaning an *inpatient* stay to medically stabilize a *member* to prepare for a later transplant, whether or not the transplant occurs;
4. High dose chemotherapy;
5. Peripheral stem cell collection;
6. The transplant itself, not including the acquisition cost for the organ or bone marrow except at a *Center of Excellence*;
7. Coverage for laboratory fee expenses up to $150 arising from human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for utilization in bone marrow

transplantation. The testing shall be performed in a facility that is accredited by the American Association of Blood Banks or its successors, or the College of American Pathologists, or its successors, or any other national accrediting body with requirements that are substantially equivalent to or more stringent than those of the College of American Pathologists, and is licensed under the Clinical Laboratory Improvement Act of 1967, 42 U.S.C. section 263a, as amended. At the time of the new testing, the member 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. Pursuant to RSA 451:6-m, II., the testing facility should not balance bill you for any remaining portion of the laboratory fee expenses; and

8. Post-transplant follow-up.

Transplant Donor Expenses:
*We* will cover the medical expenses incurred by a live donor as if they were medical expenses of the *member* if:

1. They would otherwise be considered *covered service expenses* under the *contract;*
2. The *member* received an organ or bone marrow of the live donor; and
3. The transplant was a *listed transplant.*

Ancillary "Center Of Excellence" Benefits:
A *member* may obtain services in connection with a *listed transplant* from any *physician*. However, if a *listed transplant* is performed in a *Center of Excellence:*

1. *Covered service expenses* for the *listed transplant* will include the acquisition cost of the organ or bone marrow; and
2. *We* will pay a maximum of $10,000 per lifetime for the following services:
    a. Transportation for the *member,* any live donor, and the *immediate family* to accompany the *member* to and from the *Center of Excellence.*
    b. Lodging at or near the *Center of Excellence* for any live donor and the *immediate family* accompanying the *member* while the *member* is confined in the *Center of Excellence. We* will pay the costs directly for transportation and lodging, however, *you* must make the arrangements.

Exclusions:
No benefits will be paid under these Transplant Expense Benefits for charges:

1. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no *listed transplant* occurs;
2. For animal to human transplants;
3. For artificial or mechanical devices designed to replace a human organ temporarily or permanently;
4. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision;
5. To keep a donor alive for the transplant operation;
6. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ;
7. Related to transplants not included under this provision as a *listed transplant; and*
8. For a *listed transplant* under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (*USFDA*) regulation, regardless of whether the trial is subject to *USFDA* oversight.

Limitations on Transplant Expenses Benefits:
In addition to the exclusions and limitations specified elsewhere in this section:

1. *Covered service expenses* for *listed transplants* will be limited to two transplants during any 10- year period for each *member*;
2. If a designated *Center of Excellence* is not used, *covered service expenses* for a *listed transplant* will be limited to a maximum for all expenses associated with the transplant; and
3. If a designated *Center of Excellence* is not used, the acquisition cost for the organ or bone marrow is not covered.

**Second Medical Opinion**
*Members* are entitled to a second medical opinion under the following conditions:

1. Whenever a minor surgical procedure is recommended to confirm the need for the procedure;
2. Whenever a serious injury or illness exists; or
3. Whenever *you* find that *you* are not responding to the current treatment plan in a satisfactory manner.

If requested, the second opinion consultation is to be provided by a *physician* of the *member's* choice. The *member* may select a *network provider* listed in the Healthcare Provider Directory. If a *member* chooses a *network provider*, he or she will only be responsible for the applicable co-payment for the consultation. Any lab tests and/or diagnostic and therapeutic services are subject to the additional co-payment.

# PRIOR AUTHORIZATION

**Prior Authorization Required**
Some *covered service expenses* require prior authorization. In general, *network providers* must obtain authorization from *us* prior to providing a service or supply to a *member.* However, there are some *network eligible expenses* for which *you* must obtain the prior authorization.

For services or supplies that require prior authorization *you* must obtain authorization from *us* before the *member:*

1. Receives a service or supply from a *non-network provider;*
2. Is admitted into a *network* facility by a *non-network provider;* or
3. Receives a service or supply from a *network provider* to which the *member* was referred by a *non-network provider.*

The following services or supplies require prior authorization:

1. *Hospital confinement*s;
2. *Hospital confinement* as the result of a *medical emergency;*
3. *Hospital confinement* for *psychiatric care;*
4. *Outpatient surgeries* and *major diagnostic tests*;
5. *All inpatient services;*
6. *Extended care facility* confinements;
7. *Rehabilitation facility* confinements;
8. *Skilled nursing facility* confinements;
9. *Transplants;* and
10. Chemotherapy, *specialty drugs* and biotech medications.

Prior Authorization requests must be received by phone/efax/ Provider portal as follows:

1. At least 5 days prior to an elective admission as an inpatient in a Hospital, extended care or Rehabilitation facility, or Hospice facility.
2. At least 30 days prior to the initial evaluation for organ transplant services.
3. At least 30 days prior to receiving clinical trial services.
4. At least 5 days prior to a scheduled inpatient behavioral health or Substance Abuse treatment admission.
5. At least 5 days prior to the start of Home Healthcare.

After prior authorization has been requested and all required or applicable documentation has been submitted, we will notify you and your Provider if the request has been approved as follows:

1. For immediate request situations, within 1 business day, when the lack of treatment may result in an emergency room visit or emergency admission.
2. For urgent concurrent review within 24 hours of receipt of the request.
3. For urgent pre-service, within 72 hours from date of receipt of request.
4. For non-urgent pre-service requests within 5 days but no longer than 15 days of receipt of the request.
5. For post-service requests, with in 30 calendar days of receipt of the request.

Except for *medical emergencies*, prior authorization must be obtained before services are rendered or expenses are *incurred*.

**How to Obtain Prior Authorization**
To obtain prior authorization or to confirm that a *network provider* has obtained prior authorization, contact *us* by telephone at the telephone number listed on *your* health insurance identification card before the service or supply is provided to the *member.*

**Failure to Obtain Prior Authorization**
Failure to comply with the prior authorization requirements will result in benefits being reduced. There is a penalty if treatment is not authorized prior to service. The penalty is a 20% reduction of the *eligible expenses* for all charges related to the treatment, not to exceed $1,000. The penalty applies to all otherwise *eligible expenses* that are:

- Incurred for treatment without prior authorization;
- Incurred during additional *hospital* days without prior authorization; or
- Determined to be inappropriately authorized due to misrepresentation of facts or false statements.

*Network providers* cannot bill *you* for services for which they fail to obtain prior authorization as required.

Benefits will not be reduced for failure to comply with prior authorization requirements prior to an *emergency.* However, *you* must contact *us* as soon as reasonably possible after the *emergency* occurs.

**Prior Authorization Does Not Guarantee Benefits**
*Our* authorization does not guarantee either payment of benefits or the amount of benefits. Eligibility for, and payment of, benefits are subject to all terms and conditions of the *contract.*

**Requests for Predeterminations**
*You* may request a predetermination of coverage. *We* will provide one if circumstances allow *us* to do so. However, *we* are not required to make a predetermination of either coverage or benefits for any particular treatment or medical expense. Any predetermination *we* may make will be reviewed after the medical expense is incurred and a claim is filed. A review that shows one or more of the following may cause *us* to reverse the predetermination:

1. The predetermination was based on incomplete or inaccurate information initially received by *us;*
2. The medical expense has already been paid by someone else; and
3. Another party is responsible for payment of the medical expense.

*We* will make all benefit determinations after a *loss* in good faith. All benefit determinations are subject to *our* receipt of proper *proof of loss.*

**Services from Non- Network Providers**
Except for emergency medical services, unless Covered Services are not available from Network Providers within a reasonable proximity such services will not be covered. If required Medically Necessary services are not available from Network Providers **you or the Network Provider must request Prior Authorization from us before you may receive services from Non-Network Providers.** Otherwise you will be responsible for all charges incurred.

**HOSPITAL BASED PROVIDERS**

When receiving care at an Ambetter participating hospital it is possible that some hospital-based providers (for example, anesthesiologists, radiologists, pathologists) may not be under contract with Ambetter as participating providers. These providers may bill you for the difference between Ambetter's allowed amount and the providers billed charge – this is known as "balance billing". We encourage you to inquire about the providers who will be treating you before you begin your treatment, so you can understand their participation status with Ambetter.

ALTHOUGH HEALTHCARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO YOU AT A HEALTHCARE FACILITY THAT IS A MEMBER OF THE PROVIDER NETWORK USED BY YOUR HEALTH BENEFIT PLAN, OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY PHYSICIANS AND OTHER HEALTHCARE PRACTITIONERS WHO ARE NOT MEMBERS OF THAT NETWORK. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE PROFESSIONAL SERVICES THAT ARE NOT PAID OR COVERED BY YOUR HEALTH BENEFIT PLAN.

# GENERAL LIMITATIONS AND EXCLUSIONS

No benefits will be paid for:

1. Any service or supply that would be provided without cost to *you* or *your* covered *dependent* in the absence of insurance covering the charge;
2. Expenses/surcharges imposed on *you* or *your* covered *dependent* by a provider, including a *hospital*, but that are actually the responsibility of the provider to pay;
3. Any services performed by a member of a *member's immediate family; and*
4. Any services not identified and included as *covered service expenses* under the *contract*. *You* will be fully responsible for payment for any services that are not *covered service expenses.*

Even if not specifically excluded by this *contract,* no benefit will be paid for a service or supply unless it is:

1. Administered or ordered by a *physician;* and
2. *Medically necessary* to the diagnosis or treatment of an *injury* or *illness,* or covered under the Preventive Care Expense Benefits provision.

*Covered service expenses* will not include, and no benefits will be paid for any charges that are incurred:

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *contract*, except as expressly provided for under the Benefits After Coverage Terminates clause in this *contract's* Termination section;
2. For any portion of the charges that are in excess of the *eligible expense;*
3. For weight modification, , or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass surgery and weight loss programs, except as specifically covered in this *contract*;
4. For breast reduction or augmentation;
5. For modification of the physical body in order to improve the psychological, mental, or emotional well-being of the *member,* such as sex-change *surgery*;
6. For the reversal of sterilization and the reversal of vasectomies;
7. For abortion unless *medically necessary* or the life of the mother would be endangered if the fetus were carried to term;
8. For artificial insemination (AI), assisted reproductive technology(ART) procedures or the diagnostic tests and drugs to support AI or ART procedures;
9. For expenses for television, telephone, or expenses for other persons;
10. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions;
11. For failure to keep a scheduled appointment;
12. For *hospital* room and board and nursing services for the first Friday or Saturday of an *inpatient* stay that begins on one of those days, unless it is an *emergency*, or *medically necessary inpatient surgery* is scheduled for the day after the date of admission;
13. For stand-by availability of a *medical practitioner* when no treatment is rendered;
14. For *dental expenses,* including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under Medical Benefits;
15. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child that has resulted in a functional defect;
16. For diagnosis or treatment of learning disabilities, attitudinal disorders, or disciplinary problems*;*

17. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Expense Benefits;
18. For high dose chemotherapy prior to, in conjunction with, or supported by *ABMT/BMT*, except as specifically provided under the Transplant Expense Benefits;
19. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism;
20. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services unless expressly provided for by the *contract*;
21. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *contract*;
22. For alternative or complementary medicine using non-orthodox therapeutic practices that do not follow conventional medicine. These include, but are not limited to, wilderness therapy, outdoor therapy, boot camp, equine therapy, and similar programs;
23. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as specifically provided under the *contract*;
24. For *experimental or investigational treatment(s)* or *unproven services.* The fact that an *experimental or investigational treatment* or *unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational treatment* or *unproven service* for the treatment of that particular condition;
25. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of 180 consecutive days. If travel extends beyond 180 consecutive days, no coverage is provided for medical *emergencies* for the entire period of travel including the first 180 days;
26. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *member* is insured by workers' compensation insurance pursuant to applicable state or federal law. If *you* enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's w*orkers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency**.** Coverage is provided under the contract when a member waives worker's compensation coverage in accordance with New Hampshire law;
27. As a result of:
    a. Intentionally self-inflicted bodily harm whether the *member* is sane or insane;
    b. An *injury* or *illness* caused by any act of declared or undeclared war; or
    c. The *member* taking part in a riot;
28. For or related to surrogate parenting;
29. For or related to treatment of hyperhidrosis (excessive sweating);
30. For fetal reduction surgery;
31. Except as specifically identified as a *covered service expense* under the *contract*, expenses for alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health;
32. For the following miscellaneous items, unless specifically described in this *contract*: artificial Insemination except where required by federal or state law; care or complications resulting from non-*covered service expenses*; chelating agents; domiciliary care; food and food supplements; routine foot care, foot orthotics or corrective shoes; health club memberships, unless otherwise

covered; home test kits; care or services provided to a non-*member* biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; private duty nursing; rehabilitation services for the enhancement of job, athletic or recreational performance; routine or elective care outside the service area; sclerotherapy for varicose veins; treatment of spider veins; transportation expenses; and

33. Services or supplies eligible for payment under either federal or state programs (except Medicaid). This exclusion applies whether or not *you* assert *your* rights to obtain this coverage or payment of these services.

# TERMINATION

**Termination of Contract**
All insurance will cease on termination of this *contract.* This *contract* will terminate on the earliest of:

1. Nonpayment of premiums when due, subject to the Grace Period provision in this *contract*.
2. The date *we* receive a request from you to terminate this *contract,* or any later date stated in *your* request, or if you are enrolled through the Exchange, the date of termination that the Exchange provides us upon your request of cancellation to the Exchange.
3. The date *we* decline to renew this *contract,* as stated in the Discontinuance provision.
4. The date of *your* death, if you are the only *member* on this *contract*.
5. The date that *you* accept any direct or indirect contribution or reimbursement through wage adjustment or otherwise, by or on behalf of an employer for any portion of the premium for coverage under this *contract,* or the date *your* employer and *you* treat this *contract* as part of an employer-provided health plan for any purpose, including tax purposes.
6. The date *your* eligibility for insurance under this *contract* ceases due to losing network access as the result of a permanent move.
7. The date *your* eligibility for insurance under this *contract* ceases due to any of the reasons stated in the Ongoing Eligibility section in this *contract*.
8. The date *your* eligibility for coverage under this Contract ceases as determined by the Exchange.

If there are other *members* covered under this *contract*, it may be continued after *your* death:

1. By *your spouse*, if a *member;* otherwise
2. By the youngest child who is a *member.*

This *contract* will be changed and *your spouse* or youngest child will replace *you* as the primary *member*. A proper adjustment will be made in the premium required for this *contract* to be continued. *We* will also refund any premium paid and not earned due to *your* death. The refund will be based on a pro-rata basis.

**Refund Upon Cancellation**
*We* will refund any premium paid and not earned due to *contract* termination. After the *contract* has been continued beyond its original term, *you* may cancel the *contract* at any time by written notice, delivered or mailed to the Marketplace, or if an off-exchange *member* by written notice, delivered or mailed to *us*. Such cancellation shall become effective upon receipt, or on such later date specified in the notice. If *you* cancel, *we* shall promptly return any unearned portion of the premium paid, but in any event shall return the unearned portion of the premium within 30 days. The earned premium shall be computed on a pro-rata basis. Cancellation shall be without prejudice to any claim originating prior to the effective date of the cancellation.

**Discontinuance**
90-Day Notice:
If *we* discontinue offering and refuse to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where *you* reside, *we* will provide a written notice to *you* at least 90 days prior to the date that *we* discontinue coverage. *You* will be offered an option to purchase any other coverage in the individual market *we* offer in *your* state at the time of discontinuance of this *contract*. This option to purchase other coverage will be on a guaranteed issue basis without regard to health status.

180-Day Notice:
If *we* discontinue offering and refuse to renew all individual policies/certificates in the individual market in the state where *you* reside, *we* will provide a written notice to *you* and the Commissioner of Insurance at least 180 days prior to the date that *we* stop offering and terminate all existing individual policies in the individual market in the state where *you* reside.

**Notification Requirements**
It is the responsibility of *you* or *your* former *spouse* to notify the Exchange or *us* within 31 days of *your* legal divorce.

**Benefits After Coverage Terminates**
Benefits for *covered service expenses* incurred after *you* cease to be insured are provided for certain *illnesses* and *injuries.* However, no benefits are provided if this *contract* is terminated because of:

1. A request by *you*;
2. Fraud or material misrepresentation on *your* part; or
3. *Your* failure to pay premiums.

The *illness* or *injury* must cause a *period of extended loss*. The *period of extended loss* must begin before insurance ceases under this *contract*. No benefits are provided for *covered service expenses* incurred after the *period of extended loss* ends.

In addition to the above, if this *contract* is terminated because *we* refuse to renew all policies issued in this form, with the same type and level of benefits, to residents of the state where *you* live, termination of this *contract* will not prejudice a claim for a *continuous loss* that begins before *your* ceases under this *contract.* In this event, benefits will be extended for that *illness* or *injury* causing the *continuous loss,* but not beyond the earlier of:

1. The date the *continuous loss* ends; or
2. 12 months after the date renewal is declined.

# REIMBURSEMENT

If a *member's illness* or *injury* is caused by the acts or omissions of a *third party*, *we* will not cover a *loss* to the extent that it is paid as part of a settlement or judgment by any *third party*.

However, if payment by or for the *third party* has not been made by the time *we* receive acceptable *proof of loss, we* will pay regular *contract* benefits for the *member's loss*. *We* will have the right to be reimbursed to the extent of benefits *we* paid for the *illness* or *injury* if the *member* subsequently receives any payment from any *third party*. The *member* or the guardian, legal representatives, estate, or heirs of the *member* shall promptly reimburse *us* from the settlement, judgment, or any payment received from any *third party*.

As a condition for *our* payment, the *member* or anyone acting on his or her behalf including, but not limited to, the guardian, legal representatives, estate, or heirs agrees:

1. To fully cooperate with *us* in order to obtain information about the *loss* and its cause;
2. To immediately inform *us* in writing of any claim made or lawsuit filed on behalf of a *member* in connection with the *loss*;
3. To include the amount of benefits paid by *us* on behalf of a *member* in any claim made against any *third party*;
4. That *we*:
    a. Will have a lien on all money received by a *member* in connection with the *loss* equal to the amount *we* have paid;
    b. May give notice of that lien to any *third party* or *third party's* agent or representative;
    c. Will have the right to intervene in any suit or legal action to protect *our* rights;
    d. Are subrogated to all of the rights of the *member* against any *third party* to the extent of the benefits paid on the *member's* behalf; and
    e. May assert that subrogation right independently of the *member*;
5. To take no action that prejudices *our* reimbursement and subrogation rights;
6. To sign, date, and deliver to *us* any documents *we* request that protect *our* reimbursement and subrogation rights;
7. To not settle any claim or lawsuit against a *third party* without providing *us* with written notice of the intent to do so; and
8. To reimburse *us* from any money received from any *third party*, to the extent of benefits *we* paid for the *illness* or *injury*, whether obtained by settlement, judgment, or otherwise, and whether or not the *third party's* payment is expressly designated as a payment for medical expenses.

Furthermore, as a condition of *our* payment, *we* may require the *member* or the *member's* guardian, if the *member* is a minor or legally incompetent, to execute a written reimbursement agreement. However, the terms of this provision remain in effect regardless of whether or not an agreement is actually signed.

*We* have a right to be reimbursed in full regardless of whether or not the *member* is fully compensated by any recovery received from any *third party* by settlement, judgment, or otherwise.

*We* will not pay attorney fees or costs associated with the *member's* claim or lawsuit unless *we* previously agreed in writing to do so.

If a dispute arises as to the amount a *member* must reimburse *us*, the *member* or the guardian, legal representatives, estate, or heirs of the *member* agrees to place sufficient funds in an escrow or trust account to satisfy the maximum lien amount asserted by *us* until the dispute is resolved.

# CLAIMS

**Notice of Claim**
Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any *loss* covered by the contract, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary should be sent to the insurer at Ambetter from NH Healthy Families, P.O. Box 26110 Little Rock, AR 72221, or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

**Claim Forms**
Upon receipt of a notice of claim, *we* will furnish to the claimant such forms as are usually furnished by *us* for filing *proofs of loss*. If such forms are not furnished within 15 days after the giving of such notice *you* shall be deemed to have complied with the requirements of this contract as to *proof of loss* upon submitting, within the time fixed in the contract for filing *proofs of loss*, written proof covering the occurrence, the character and the extent of the *loss* for which claim is made.

**Proof of Loss**
*You* or *your* covered *dependent* must give *us* written *proof of loss* within 90 days of the *loss* or as soon as is reasonably possible. *Proof of loss* furnished more than one year late will not be accepted, unless *you* or *your* covered *dependent* had no legal capacity in that year.

**Cooperation Provision**
Each *member*, or other person acting on his or her behalf, must cooperate fully with *us* to assist *us* in determining *our* rights and obligations under the *contract* and, as often as may be reasonably necessary:

1. Sign, date and deliver to *us* authorizations to obtain any medical or other information, records or documents *we* deem relevant from any person or entity;
2. Obtain and furnish to *us*, or *our* representatives, any medical or other information, records or documents *we* deem relevant;
3. Answer, under oath or otherwise, any questions *we* deem relevant, which *we* or *our* representatives may ask; and
4. Furnish any other information, aid or assistance that *we* may require, including without limitation, assistance in communicating with any person or entity including requesting any person or entity to promptly provide to *us*, or *our* representative, any information, records or documents requested by *us*.

If any *member*, or other person acting on his or her behalf, fails to provide any of the items or information requested or to take any action requested, the claim(s) will be closed and no further action will be taken by *us* unless and until the item or information requested is received or the requested action is taken, subject to the terms and conditions of the *contract*.

In addition, failure on the part of any *member*, or other person acting on his or her behalf, to provide any of the items or information requested or to take any action requested may result in the denial of claims of that *member*.

**Time for Payment of Claims**
Benefits will be paid within 15 days for clean claims filed electronically, or 30 days for clean claims filed on paper. "Clean claims" means a claim submitted by you or a provider that has no defect, impropriety, or

particular circumstance requiring special treatment preventing payment. If *we* have not received the information *we* need to process a claim, *we* will ask for the additional information necessary to complete the claim. You will receive a copy of that request for additional information, for your information. In those cases, *we* cannot complete the processing of the claim until the additional information requested has been received. We will make *our* request for additional information within 30 days of *our* initial receipt of the claim and will complete *our* processing of the claim within 15 days after *our* receipt of all requested information.

**Payment of Claims**
Benefits are paid to the *member* within 30 days after receipt of a clean non-electronic claim or 15 calendar days upon receipt of a clean electronic claim.

If NH Healthy Families is denying or pending the claim, NH Healthy Families shall have 15 calendar days upon receipt of an electronic claim or 30 days upon receipt of a non-electronic claim to notify the healthcare provider or *member* of the reason for denying or pending the claim and what, if any, additional information is required to adjudicate the claim. Upon NH Healthy Families receipt of the requested additional information, NH Healthy Families shall adjudicate the claim within 45 calendar days. If the required notice is not provided, the claim shall be treated as a clean claim and shall be adjudicated.

Any claim not paid within the time periods specified shall be deemed overdue. When a claim is overdue, the healthcare provider may notify NH Healthy Families in writing of NH Healthy Families noncompliance. If *we* fail to pay the claim within the allotted time, then:

- The amount of the overdue claim shall include an interest payment of 1.5 percent per month beginning from the date the payment was due; and
- The healthcare provider may recover from NH Healthy Families, upon a judicial finding of bad faith, reasonable attorney's fees for advising and representing a healthcare provider in a successful action against *us* for payment of the claim.

**Foreign Claims Incurred For Emergency Care**
Claims incurred outside of the United States for *emergency* care and treatment of a *member* must be submitted in English or with an English translation. Foreign claims must include the applicable medical records in English to show proper *proof of loss*.

**Assignment**
*We* will reimburse a *hospital* or healthcare provider if:
1. *Your* health insurance benefits are assigned by *you* in writing; and
2. *We* approve the assignment.

Any assignment to a *hospital* or person providing the treatment, whether with or without *our* approval, shall not confer upon such *hospital* or person, any right or privilege granted to *you* under the *contract* except for the right to receive benefits, if any, that *we* have determined to be due and payable.

**Medicaid Reimbursement**
The amount payable under this *contract* will not be changed or limited for reason of a *member* being eligible for coverage under the Medicaid program of the state in which he or she lives.

*We* will pay the benefits of this *contract* to the state if:

1. A *member* is eligible for coverage under his or her state's Medicaid program; and
2. *We* receive proper *proof of loss* and notice that payment has been made for *covered service expenses* under that program.

*Our* payment to the state will be limited to the amount payable under this *contract* for the *covered service expenses* for which reimbursement is due. Payment under this provision will be made in good faith. It will satisfy *our* responsibility to the extent of that payment.

**Insurance with Other Insurers**

If there is other valid coverage, not with *us*, providing benefits for the same *loss* on a provision of service basis or an expense incurred basis, payment shall not be prorated or reduced. If such is the case, the *member* shall be entitled to payment from both insurers. Provided, however, that the provisions of this subparagraph shall not prohibit the issuance of a *benefits deductible*. *Benefits deductible*, as used herein, means the value of any benefits provided on an expense incurred basis which are provided with respect to covered medical expenses by any other *hospital*, surgical or medical insurance *contract* or *hospital* or medical service subscriber contract or medical practice or other prepayment plan, or any other plan or program whether on an insured or uninsured basis. Provided, however, that the term *benefits deductible* shall not mean the value of benefits provided with respect to medical or liability insurance offered under either a general liability insurance contract or an auto insurance contract.

**Custodial Parent**

This provision applies if the parents of a covered *eligible child* are divorced or legally separated and both the custodial parent and the non-custodial parent are subject to the same court or administrative order establishing custody. The custodial parent, who is not a *member*, will have the rights stated below if *we* receive a copy of the order establishing custody.

Upon request by the custodial parent, *we* will:

1. Provide the custodial parent with information regarding the terms, conditions, benefits, exclusions and limitations of the *contract*;
2. Accept claim forms and requests for claim payment from the custodial parent; and
3. Make claim payments directly to the custodial parent for claims submitted by the custodial parent. Payment of claims to the custodial parent, which are made under this provision, will fully discharge *our* obligations.

A custodial parent may, with *our* approval, assign claim payments to the *hospital* or *medical practitioner* providing treatment to an *eligible child*.

**Physical Examination**

*We* shall have the right and opportunity to examine a *member* while a claim is pending or while a dispute over the claim is pending. These examinations are made at *our* expense and as often as *we* may reasonably require.

**Legal Actions**

No suit may be brought by *you* on a claim sooner than 60 days after the required *proof of loss* is given. No suit may be brought more than three years after the date *proof of loss* is required.

No action at law or in equity may be brought against *us* under the *contract* for any reason unless the *member* first completes all the steps in the complaint/grievance procedures made available to resolve disputes in *your* state under the *contract*. After completing that complaint/grievance procedures process, if *you* want to bring legal action against *us* on that dispute, *you* must do so within three years of the date *we* notified *you* of the final decision on *your* complaint/grievance.

## INTERNAL GRIEVANCE, INTERNAL APPEALS AND EXTERNAL REVIEW PROCEDURES

**If *you* need help***:*** If you do not understand your rights or if you need assistance understanding your rights or you do not understand some or all of the information in the following provisions, you may contact Ambetter from NH Healthy Families, Member Services Department, 2 Executive Park Drive, Bedford, NH, 03110, by telephone at 1-844-265-1278 (TDD/TTY 1-855-742-0123), or at Ambetter.NHhealthyfamilies.com

You will have up to one hundred and eighty days (180) days of the date your area of dissatisfaction occurred to file a grievance.

### INTERNAL GRIEVANCE

**Internal Grievance Procedures:** When *you* are dissatisfied with the quality of service or the quality of care *you* have received from the Plan or from our contracted providers, *you* or someone *you* have authorized to speak for *you* on *your* behalf (authorized representative) can request a grievance regarding the:

- Availability, delivery, or quality of health care services, systems, and materials
- The interactions or relationship between you and NH Healthy Families
- Failure to respect your rights
- Our denial to process your request for appeal as an expedited internal first level appeal

You or your authorized representative may file the grievance in writing, either by mail or by facsimile (fax). If you require assistance in filing a grievance or if you are unable to submit the grievance in writing, you can call the Plan Member services to ask for help through the process.

Once your grievance is received, the health plan is required to review and investigate your concerns. The Healthplan will notify you or your authorized representative of our resolution, which will include:

- the nature of the Grievance,
- the specific information reviewed/considered,
- the resolution,
- Standard criteria and/or clinical guidelines used in the basis for the decision,
- and your right to request an Internal Appeal, as appropriate.

We will give you an answer in writing as expeditiously as your health requires, not to exceed 72 hours from receipt of your clinically urgent grievance or within thirty (30) calendar days from receipt of your non-urgent grievance.

You, or your authorized representative, have the right to request a free copy of the documentation used in this decision. You can also ask to get copies, at no cost to you, of all the documents used to review your grievance.

There will be no retaliation of any sort against the you, your authorized representative, or your provider for filing a Grievance.

## INTERNAL APPEALS

**Internal Appeals Procedures:** When a health insurance plan denies a claim for a treatment or service (a claim for plan benefits, *you* have already received (post-service denial) or denies *your* request to authorize treatment or service (pre-service denial), *you*, or someone *you* have authorized to speak on *your* behalf (an authorized representative), can request an appeal of the plan's decision. If the plan rescinds *your* coverage or denies *your* application for coverage, *you* may also appeal the plan's decision. When the plan receives *your appeal*, it is required to review its own decision. When the plan makes a claim or authorization request decision, it is required to notify *you* (provide notice of an *adverse benefit determination*):

- The reasons for the plan's decision;
- *Your* right to file an appeal regarding the adverse decision; and
- *Your* right to request an external review.

- If *you* do not speak English, *you* may be entitled to receive appeals' information in *your* native language upon request.

- When *you* request an internal appeal, the plan must give *you* its decision as soon as possible, but no later than:

    - 72 hours after receiving *your* request when *you* are appealing the denial of an authorization for urgent care. (If *your* appeal concerns urgent care, *you* may be able to have the internal expedited appeal and external reviews take place at the same time.)

    - 30 days for appeals of denials of non-urgent care *you* have not yet received.

    - 60 days for appeals of denials of services *you* have already received (post-service denials).

    - No extensions of the maximum time limits are permitted unless *you* consent.

**Continuing Coverage***: The plan cannot terminate your benefits until all of the appeals have been exhausted.* **However, if the plan's decision is ultimately upheld, you may be responsible for paying any outstanding claims for services provided after receiving notification of the adverse Internal Appeal or External Appeal determination.** If an expedited review involves ongoing urgent care services, the service shall be continued without liability to the *member* until the *member* has been notified of the determination.

**Cost and Minimums for Appeals:** There is no cost to *you* to file an appeal and there is no minimum amount required to be in dispute.

**Emergency medical services**: If the plan denies a claim for an emergency medical service, *your* appeal will be handled as an urgent appeal. The plan will advise you at the time it denies the appeal that you can file an expedited internal appeal. If you have filed for an expedited internal appeal, you may also file for an expedited external review (see "Simultaneous urgent claim, expedited internal review and external review").

***Your* rights to file an appeal of denial of health benefits:** You or your authorized representative, such as your health are provider, may file the appeal for you, in writing, either by mail or by facsimile (fax). For an urgent request, you may also file an appeal by telephone:

Please include in *your* written appeal or be prepared to tell us the following:

- Name, address and telephone number of the insured person;
- The insured's health plan identification number;
- Name of healthcare provider, address and telephone number;
- Date the healthcare benefit was provided (if a post-claim denial appeal)
- Name, address and telephone number of an authorized representative (if appeal is filed by a person other than the insured); and
- A copy of the notice of *adverse benefit determination.*

**Rescission of coverage**: If the plan rescinds *your* coverage, *you* may file an appeal according to the following procedures. The plan cannot terminate *your* benefits until all of the appeals have been exhausted. Since a rescission means that no coverage ever existed, if the plan's decision to rescind is upheld, *you* will be responsible for payment of all claims for *your* healthcare services.

**Time Limits for filing internal and external appeal:** Internal Appeals, including Expedited Appeals, must be pursued within 180 days of receipt of the original determination. Failure to file within this time limit may result in the company's declining to consider the appeal.

**Time Limits for notification on an Internal Appeal determination:** The plan will provide notification of the Internal Appeal determination within the following timeframes:

- 72 hours after receiving your request when you are appealing the denial of a request for urgent care. (If your appeal concerns urgent care, you may be able to have the internal appeal and external reviews take place at the same time.)
- 30 days for appeals of denials of non-urgent care you have not yet received.
- 60 days for appeals of denials of services you have already received (post-service denials).
- No extensions of the above maximum time limits are permitted unless we notified you that the appeal request did not contain sufficient information in order to provide a determination. The extended time period will not exceed 45 days from the date we notified you of what information was required.

**Your Rights to a Full and Fair Review**: The plan must allow *you* to review the appeal file and to present evidence and testimony as part of the internal appeals process.

- The plan must provide *you*, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan (or at the direction of the plan) in connection with the appeal; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the

notice of final internal *adverse benefit determination* is required to give *you* a reasonable opportunity to respond prior to that date; and

- Before the plan can issue a *final internal adverse benefit determination* based on a new or additional rationale, *you* must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of *final internal adverse benefit determination* is required to be provided to give *you* a reasonable opportunity to respond prior to that date.

- The adverse determination must be written in a manner understood by *you*, or if applicable, *your* authorized representative and must include all of the following:

    1. The titles and qualifying credentials of the person or persons participating in the first level review process (the reviewers);
    2. Information sufficient to identify the appeal involved, including the date of service, the healthcare provider; and
    3. A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.

- As a general matter, the plan may deny claims at any point in the administrative process on the basis that it does not have sufficient information; such a decision; however, will allow *you* to advance to the next stage of the claims process.

***Your rights to appeal and the instructions for filing an appeal are described in the provisions following this Overview.***

**Non-urgent, pre-service appeal**

For a non-urgent pre-service appeal, the plan will notify *you* of its decision as soon as possible but no later than 30 days after receipt of the appeal.

If the plan needs additional information from *you* before it can make its decision, it will provide a notice to *you*, describing the information needed. *You* will have 45 days from the date of the plan's notice to provide the information. If *you* do not provide the additional information, the plan can deny *your* appeal. In which case, *you* may file an appeal.

The plan will provide notification of the determination within 30 days of receiving your request for appeal, unless the timeframe was extended because additional information was required. In such a scenario, the plan will provide notification of the determination within 45 days of the date we notified you of what information is required.

**Urgent Pre-service (Expedited) Appeal**

**If your appeal is urgent, you or your authorized representative, or your healthcare provider (*physician*) may contact us with the claim, orally or in writing.**

If the appeal is one *involving urgent care*, we will notify *you* of our decision as soon as possible, but no later than 72 hours after we receive *your* appeal provided *you* have given us information sufficient to make a decision.

If *you* have not given us sufficient information, we will contact *you* as soon as possible but no more than 24 hours after we receive *your* appeal to let *you* know the specific information we will need to make a decision.

*You* must give us the specific information requested as soon as *you* can but no later than 48 hours after we have asked *you* for the information.

We will notify *you* of our decision as soon as possible but no later than 48 hours after we have received the needed information or the end of the 48 hours *you* had to provide the additional information.

To assure *you* receive notice of our decision, we will contact *you* by telephone or facsimile (fax) or by another method meant to provide the decision to *you* quickly. We will provide written notification to *you* within two business days of providing notification of the decision, if the initial notification is not in writing.

In determining whether an appeal involves urgent care, the plan must apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. **However, if a *physician* with knowledge of *your* medical condition determines that an appeal involves urgent care, or an emergency, the appeal must be treated as an urgent care appeal.**

**Simultaneous *expedited internal appeal and expedited* external review:**
In the case of an appeal involving urgent care, *you* or *your* authorized representative may also request an expedited internal review. A request for expedited internal review may be submitted orally or in writing by the claimant; and all necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and the claimant by telephone, facsimile, or other expeditious method.

The *physician*, if the *physician* certifies, in writing, that *you* has a medical condition where the time frame for completion of an expedited review of an internal appeal involving an *adverse benefit determination* would seriously jeopardize *your* life or health or jeopardize *your* ability to regain maximum function, *you* may file a request for an expedited external review to be conducted simultaneously with the expedited internal appeal.

*You*, or *your* authorized representative, may request an expedited external review if both the following apply

(1) *You* have filed a request for an expedited internal review; and
(2) After a final *adverse benefit determination*, if either of the following applies:
(a) Y*our* treating *physician* certifies that the *adverse benefit determination* involves a medical condition that could seriously jeopardize the life or health of *you*, or would jeopardize *your* ability to regain maximum function, if treated after the time frame of a standard external review;
(b) The final *adverse benefit determination* concerns an admission, availability of care, continued stay, or healthcare service for which *you* received emergency services, but *you* have not yet been discharged from a facility.

**Concurrent care decisions**
**Reduction or termination of ongoing plan of treatment**: If we have approved an ongoing plan or course of treatment that will continue over a period of time or a certain number of treatments and we notify *you* that we have decided to reduce or terminate the treatment, we will give *you* notice of that

decision allowing sufficient time to appeal the determination and to receive a decision from us before any interruption of care occurs.

**Request to extend ongoing treatment**: If *you* have received approval for an ongoing treatment and wish *to extend the treatment* beyond what has already been approved, we will consider *your* appeal as a request for urgent care. If *you* request an extension of treatment at least 24 hours before the end of the treatment period, we must notify *you* soon as possible but no later than 24 hours after receipt of the request. An appeal of this decision is conducted according to the urgent care appeals procedures.

**Concurrent urgent care and extension of treatment**: Under the concurrent care provisions , any request that involves both urgent care and the extension of a course of treatment beyond the period of time or number of treatments previously approved by the plan must be decided as soon as possible, taking into account the medical urgencies, and notification must be provided to the claimant within 24 hours after receipt of the claim, provided the request is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

**Non-urgent request to extend course of treatment or number of treatments**: If a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the plan does not involve urgent care, the request may be treated as a new service authorization request and decided within the timeframe appropriate to the type of claim, e.g., as a pre-service claim or a post-service claim.

**If the request is not made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments**, the request must be treated as a claim involving urgent care and decided in accordance with the urgent care claim timeframes, e.g., as soon as possible, taking into account the medical emergencies, but not later than 72 hours after receipt.

**Post-service appeal of a claim denial (retrospective)**
If *your* appeal is for a *post-service claim denial*, we will notify *you* of our decision as soon as possible but no later than 60 days after we have received *your* appeal. If the reason we need more time to make a decision is because *you* have not given us necessary information, *you* will have 45 days from the date we notify *you* to give us the information. We will describe the information needed to make our decision in the notice we send *you*. This is also known as a "retrospective review." The plan will notify *you* of its determination as soon as possible but no later than 5 days after the benefit determination is made.

The plan will let *you* know within 5 days of receipt of your request for appeal by requesting any additional information needed, and advising *you* when a final decision is expected. If more information is requested, *you* have at least 45 days to supply it. The appeal then must be decided no later than 15 days after *you* supply the additional information or the period given by the plan to do so ends, whichever comes first. The plan must give *you* notice that *your* claim has been denied in whole or in part (paying less than 100% of the claim, less any applicable cost-share, such as copayments, coinsurance, or deductible) before the end of the time allotted for the decision, which will not exceed 45 days from the date we notified you that we required additional information.

## EXTERNAL REVIEW

An external review decision is binding on *us*. An external review decision is binding on the claimant except to the extent the claimant has other remedies available under applicable federal or state law.
*We* will pay for the costs of the external review performed by the independent reviewer.

Healthcare services provided pursuant to the marketplace premium assistance program will also be governed by this section.

**Applicability/Eligibility**
The External Review procedures apply to:

1. Any *hospital* or medical contract or certificate; excluding accident only or disability income only insurance; or
2. Conversion plans.

After exhausting the internal review process, the claimant has 180 days after the date of receipt of *our* internal response to make a written request to the New Hampshire Insurance Department for external review.

1. The internal appeal process must be exhausted before the claimant may request an external review unless the claimant files a request for an expedited external review at the same time as an internal *expedited grievance* or *we* either provide a waiver of this requirement or fail to follow the appeal process;
2. A health plan must allow a claimant to make a request for an expedited external review with the plan at the time the claimant receives:
    a. An *adverse benefit determination* if the determination involves a medical condition of the claimant for which the timeframe for completion of an internal *expedited grievance* would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an internal *expedited grievance*; and
    b. A final internal *adverse benefit determination*, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal *adverse benefit determination* concerns an admission, availability of care, continued stay, or healthcare item or service for which the claimant received emergency services, but has not been discharged from a facility; and
3. Claimants may request an expedited external review at the same time the internal *expedited grievance* is requested.

External review is available for *appeals* that involve:

1. Medical judgment, including but not limited to those based upon requirements for medical necessity, appropriateness, healthcare setting, level of care or effectiveness of a covered benefit; or the determination that a treatment is experimental or investigational, as determined by an external reviewer; or
2. *Rescissions* of coverage.

**Standard External Review Process**

1. Within 7 business days after the date of receipt of a request for external review, the New Hampshire Insurance Commissioner ("Commissioner" shall complete a preliminary review of the request to determine whether:
    a. *You* are or were a *covered person* under the health benefit plan;
    b. The determination that is the subject of the request for external review meets the conditions of eligibility for external review; and
    c. The covered person has provided all the information and forms required by the commissioner that are necessary to process a request for an external review.
2. Upon completion of the preliminary review, the Commissioner shall immediately notify *you* or *your* authorized representative in writing:
    a. Whether the request is complete; and
    b. Whether the request has been accepted for external review.
3. If the request is not complete, the Commissioner shall inform the *you* or *your* authorized representative what information or documents are needed to make the request complete and to process the request. *You* or *your* authorized representative must submit such information or documentation within 10 days of being notified that the request was incomplete.
4. If the request for external review is accepted, the Commissioner shall:
    a. Include in the notice provided to *you* 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, 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.
    b. Immediately notify *us* in writing of the request for external review and its acceptance.
5. If the request for external review is not accepted, the Commissioner shall inform *you* or *your* authorized representative and *us* in writing of the reason for its non-acceptance.
6. At the time a request for external review is accepted, the Commissioner shall select and retain an independent review organization that is certified to conduct the external review.
7. Within 10 days after the date of issuance of the notice provided, *we* shall provide to the selected independent review organization and to *you* all information in our possession that is relevant to the adjudication of the matter in dispute.
8. The selected independent review organization will review all of the information and documents received from *us* and any other information submitted by *you* or *your* authorized representative or treating provider with the request for external review and any testimony provided .
9. The selected independent review organization shall render a decision upholding or reversing the *adverse determination* and notify *you* or *your* authorized representative in writing within 20 days of the date that any new or additional information from the covered person is due.

**Expedited External Review Process**

1. Expedited external review shall be available when the *your* treating healthcare provider certifies to the Commissioner that adherence to the time frames for Standard External Review would seriously jeopardize the life or health of *you* or would jeopardize *your* ability to regain maximum function.
2. 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. If these conditions are met, the Commissioner shall immediately

notify the *us*. If the request is not complete, the Commissioner shall immediately contact *you* or *your* authorized representative and attempt to obtain the information or documents that are needed to make the request complete.

3. The Commissioner shall select and retain an independent review organization that is certified to conduct the expedited external review.
4. When handling a review on an expedited basis, the selected independent review organization shall make a decision and notify *you* as expeditiously as *your* medical condition requires, but in no event more than 72 hours after the expedited external review is requested.
5. If the notice provided pursuant to paragraph VI was not in writing, within 2 business days after the date of providing that notice, the selected independent review organization shall provide written confirmation of the decision to *you* or *your* authorized representative.
6. All requirements for Standard External Review apply to Expedited External Review.

Upon receipt of a notice of a decision by the IRO reversing the *adverse benefit determination*, we will approve the covered benefit that was the subject of the *adverse benefit determination*. The eligible grievant/claimant may file a request for an external review with the New Hampshire Department of Insurance at 21 South Fruit Street, Suite 14, Concord, NH 03301 or at 603-271-2261.

Assistance can also be received by contacting the New Hampshire Department of Insurance. Additionally, included as an attachment to this contract is the New Hampshire Department of Insurance's "Managed Care Consumer Guide to External Appeal."

# GENERAL PROVISIONS

**Entire Contract**
This *contract,* with the application and any rider-amendments is the entire contract between *you* and *us.* No change in this *contract* will be valid unless it is approved by one of *our* officers and noted on or attached to this *contract.* No agent may:

1. Change this *contract*;
2. Waive any of the provisions of this *contract*;
3. Extend the time for payment of premiums; or
4. Waive any of *our* rights or requirements.

**Non-Waiver**
If *we* or *you* fail to enforce or to insist on strict compliance with any of the terms, conditions, limitations or exclusions of the *contract* that will not be considered a waiver of any rights under the *contract*. A past failure to strictly enforce the *contract* will not be a waiver of any rights in the future, even in the same situation or set of facts.

**Rescissions**
No misrepresentation of fact made regarding a *member* during the application process that relates to insurability will be used to void/rescind the insurance coverage or deny a claim unless:

1. The misrepresented fact is contained in a written application, including amendments, signed by a *member;*
2. A copy of the application, and any amendments, has been furnished to the *member(s),* or to their beneficiary; and
3. The misrepresentation of fact was intentionally made and material to *our* determination to issue coverage to any *member.* A *member's* coverage will be voided/rescinded and claims denied if that person performs an act or practice that constitutes fraud. "Rescind" has a retroactive effect and means the coverage was never in effect.

**Repayment for Fraud, Misrepresentation or False Information**
During the first two years a *member* is insured under the *contract*, if a *member* commits fraud, misrepresentation or knowingly provides false information relating to the eligibility of any *member* under this *contract* or in filing a claim for *contract* benefits, *we* have the right to demand that *member* pay back to *us* all benefits that *we* paid during the time the *member* was insured under the *contract*.

**Conformity with State Laws**
Any part of this *contract* in conflict with the laws of the state in which your contract was issued on this *contract's effective date* or on any premium due date is changed to conform to the minimum requirements of that state's laws.

**Conditions Prior to Legal Action**
On occasion, *we* may have a disagreement related to coverage, benefits, premiums, or other provisions under this *contract*. Litigation is an expensive and time-consuming way to resolve these disagreements and should be the last resort in a resolution process. Therefore, with a view to avoiding litigation, *you* must give written notice to *us* of *your* intent to sue *us* as a condition prior to bringing any legal action. *Your* notice must:

1. Identify the coverage, benefit, premium, or other disagreement;

2. Refer to the specific *contract* provision(s) at issue; and
3. Include all relevant facts and information that support *your* position.

**Time Limit on Certain Defenses**:
After 2 years from the date of issue of this *contract* no misstatements, except fraudulent misstatements, made by *you* in the application for such contract shall be used to void the *contract* or to deny a claim for loss incurred commencing after the expiration of such 2-year period. A 30 day advance notice is required.

# PATIENT'S BILL OF RIGHTS

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

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

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

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

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

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

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

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

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

protect the patient or others from injury. The staff member must promptly report such action to the *physician* and document same in the medical records.

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

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

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

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

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

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

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

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

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

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

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

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


| | |
|---|---|
| **Spanish:** | Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de NH Healthy Families, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-265-1278 (TTY/TDD 1-855-742-0123). |
| **French:** | Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from NH Healthy Families, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-844-265-1278 (TTY/TDD 1-855-742-0123). |
| **Chinese:** | 如果您，或是您正在協助的對象，有關於 Ambetter from NH Healthy Families 方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 1-844-265-1278 (TTY/TDD 1-855-742-0123)。 |
| **Nepali:** | यदि तपाई वा तपाईले मद्दत गरिरहनुभएको कोही व्यक्तिसँग Ambetter from NH Healthy Families सम्बन्धी कुनै प्रश्नहरू भएको खण्डमा तपाईहरूसँग आफ्नै भाषामा निःशुल्क मद्दत र जानकारी प्राप्त गर्ने अधिकार छ। दोभाषेसँग कुरा गर्नका लागि 1-844-265-1278 (TTY/TDD 1-855-742-0123) नम्बरमा कल गर्नुहोस्। |
| **Vietnamese:** | Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from NH Healthy Families, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-265-1278 (TTY/TDD 1-855-742-0123). |
| **Portuguese:** | Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Ambetter from NH Healthy Families, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-265-1278 (TTY/TDD 1-855-742-0123). |
| **Greek:** | Εάν εσείς ή κάποιος που βοηθάτε, έχετε ερωτήσεις σχετικά με την Ambetter from NH Healthy Families, έχετε το δικαίωμα να ζητήσετε βοήθεια και πληροφορίες στη γλώσσα σας, χωρίς χρέωση. Για να μιλήσετε με διερμηνέα, καλέστε το 1-844-265-1278 (TTY/TDD 1-855-742-0123). |
| **Arabic:** | إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from NH Healthy Families، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-844-265-1278 (TTY/TDD 1-855-742-0123). |
| **Serbo-Croatian:** | Ako Vi, ili neko kome pomažete, imate pitanja u vezi Ambetter from NH Healthy Families, imate pravo na besplatnu pomoć i informaciju na sopstvenom jeziku. Ukoliko želite da pričate sa prevodiocem, pozovite broj 1-844-265-1278 (TTY/TDD 1-855-742-0123). |
| **Indonesian:** | Jika Anda, atau orang yang Anda bantu, memiliki pertanyaan tentang Ambetter from NH Healthy Families, Anda berhak mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk berbicara dengan juru bicara, hubungi 1-844-265-1278 (TTY/TDD 1-855-742-0123). |
| **Korean:** | 만약 귀하 또는 귀하가 돌고 있는 어떤 사람이 Ambetter from NH Healthy Families 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-844-265-1278 (TTY/TDD 1-855-742-0123) 로 전화하십시오. |
| **Russian:** | В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from NH Healthy Families вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-844-265-1278 (TTY/TDD 1-855-742-0123). |
| **French Creole:** | Si oumenm, oubyen yon moun w ap ede, gen kesyon nou ta renmen poze sou Ambetter from NH Healthy Families, ou gen tout dwa pou w jwenn èd ak enfòmasyon nan lang manman w san sa pa koute w anyen. Pou w pale avèk yon entèprèt, sonnen nimewo 1-844-265-1278 (TTY/TDD 1-855-742-0123). |
| **Bantu:** | Niba wowe cyangwa undi muntu wese uri gufasha yaba afite ikibazo kijyanye na Ambetter from NH Healthy Families, ufite uburenganzira bwo guhabwa amakuru mu rurimi wunva utishyuye. Kugira ngo uvugane n'umusobanuzi, Hamagara 1-844-265-1278 (TTY/TDD 1-855-742-0123). |
| **Polish:** | Jeżeli ty lub osoba, której pomagasz, macie pytania na temat planów oferowanych za pośrednictwem Ambetter from NH Healthy Families, macie prawo poprosić o bezpłatną pomoc i informacje w języku ojczystym. Aby skorzystać z pomocy tłumacza, zadzwoń pod numer 1-844-265-1278 (TTY/TDD 1-855-742-0123). |

## Statement of Non-Discrimination

Ambetter from NH Healthy Families complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Ambetter from NH Healthy Families does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Ambetter from NH Healthy Families:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Ambetter from NH Healthy Families at 1-844-265-1278 (TTY/TDD 1-855-742-0123).

If you believe that Ambetter from NH Healthy Families has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: NH Healthy Families Appeal Department, 2 Executive Park Drive, Bedford, NH 03110, 1-844-265-1278 (TTY/TDD 1-855-742-0123), Fax 1-855-702-7343. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ambetter from NH Healthy Families is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Ambetter from NH Healthy Families is underwritten by Celtic Insurance Company.