Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder:	Tw Ventures Inc.
Group Policy No.:	GP-861495
Rider:	New Hampshire ET Medical
Issue Date:	March 12, 2021
Effective Date:	January 1, 2021

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of New Hampshire. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of New Hampshire, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Understanding Precertification *(GR-9N 08-060 01-NH)*

Precertification

If this plan is determined to be the primary plan for purposes of the Coordination of Benefits provision of this Booklet-Certificate, **precertification** may be required as herein described. If this plan is determined to be the secondary plan for purposes of the Coordination of Benefits provision of this Booklet-Certificate, **precertification** shall not be required for benefits under this plan, however if the services do not meet **Aetna's** criteria for **medical necessity**, payment of secondary benefits may be denied.

Certain services, such as inpatient **stays**, certain tests, procedures and **outpatient surgery** require **precertification** by **Aetna**. **Precertification** is a process that helps you and your **physician** determine whether the services being recommended are **covered expenses** under the plan. It also allows **Aetna** to help your provider coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning), and to register you for specialized programs or case management when appropriate.

You do not need to **precertify** services provided by a **network provider**. **Network providers** will be responsible for obtaining necessary **precertification** for you. Since **precertification** is the provider's responsibility, there is no additional out-of-pocket cost to you as a result of a **network provider's** failure to **precertify** services.

When you go to an **out-of-network provider**, it is your responsibility to obtain **precertification** from **Aetna** for any services or supplies on the **precertification** list below. If you do not **precertify**, your benefits may be reduced. The list of services requiring **precertification** follows on the next page.

Important Note

Please read the following sections in their entirety for important information on the **precertification** process, and any impact it may have on your coverage.

The Precertification Process

Prior to being **hospitalized** or receiving certain other medical services or supplies there are certain **precertification** procedures that must be followed.

You are responsible for obtaining **precertification**. You or a member of your family, a **hospital** staff member, or the attending **physician**, must notify **Aetna** to **precertify** the admission or medical services and expenses prior to receiving any of the services or supplies that require **precertification** pursuant to this Booklet-Certificate in accordance with the following timelines:

Precertification should be secured within the timeframes specified below. To obtain **precertification**, call **Aetna** at the telephone number listed on your ID card. This call must be made:

For non-emergency admissions:	You, your **physician** or the facility will need to call and request **precertification** at least 14 days before the date you are scheduled to be admitted.
For an **emergency** outpatient **medical condition**:	You or your **physician** should call prior to the outpatient care, treatment or procedure if possible; or as soon as reasonably possible.
For an **emergency admission**:	You, your **physician** or the facility must call within 48 hours after you have been admitted.
For an **urgent admission**:	You, your **physician** or the facility will need to call before you are scheduled to be admitted. An urgent admission is a **hospital** admission by a **physician** due to the onset of or change in an **illness**; the diagnosis of an **illness**; or an **injury**.
For outpatient non-emergency medical services requiring **precertification**:	You or your **physician** must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.

Aetna will provide a written notification to you and your **physician** of the **precertification** decision. If your **precertified** expenses are approved the approval is good for 60 days as long as you remain enrolled in the plan.

When you have an inpatient admission to a facility, **Aetna** will notify you, your **physician** and the facility about your **precertified** length of **stay**. If your **physician** recommends that your **stay** be extended, additional days will need to be certified. You, your **physician**, or the facility will need to call **Aetna** at the number on your ID card as soon as reasonably possible, but no later than the final authorized day. **Aetna** will review and process the request for an extended **stay**. You and your **physician** will receive a notification of an approval or denial.

If **precertification** determines that the **stay** or services and supplies are not **covered expenses**, the notification will explain why and how **Aetna's** decision can be appealed. You or your provider may request a review of the **precertification** decision pursuant to the Appeals Amendment included with this Booklet-Certificate.

- Certain types of medical care require **precertification**. It is your responsibility to obtain the necessary **precertification** from **Aetna**. If your medical expenses are not **precertified** by **Aetna**, the benefit payable will be reduced by $1,000 or 50% of the cost of the expense whichever is less, or the expense may not be covered if the service or supply is not medically necessary. This means you will be responsible to pay the unpaid balance of the bill. If **precertification** is denied, **Aetna** will notify you how the decision may be appealed. You must call the **precertification** toll-free number on your ID card to **precertify** services. Refer to the *Understanding Precertification* section for more information on the precertification process and what to do if your request for precertification is denied.

Important Note
If this plan is determined to be the primary plan for purposes of the Coordination of Benefits provision, failure to **precertify** will result in a reduction of benefits under this Booklet-Certificate. Please refer to the *Understanding Precertification* section for information on how to request precertification.

Routine Mammogram

Even though not incurred in connection with an **illness** or **injury**, **covered expenses** include charges incurred by a female age 35 or over for a routine mammogram as follows:

- One baseline mammogram for a person 35 to 39 years of age.
- One mammogram every 1 to 2 years, even if no symptoms are present, for women 40 to 49 years of age.
- An annual mammogram for a person 50 years of age or older.

Diabetic Equipment And Outpatient Self-Management Training And Education Expenses *(GR-9N 11-135 01-NH)*

Covered expenses include charges for the following services, supplies, equipment and training for the treatment of insulin and non-insulin dependent diabetes and for elevated blood glucose levels during pregnancy:

- Insulin preparations;
- External insulin pumps;
- Syringes;
- Injection aids for the blind;
- Test strips and tablets;
- Blood glucose monitors without special features unless required due to blindness;
- Lancets;
- Prescribed oral medications whose primary purpose is to influence blood sugar;
- Alcohol swabs;
- Injectable glucagons;
- Glucagon emergency kits;
- Self-management training provided by a licensed health care provider certified in diabetes self-management training; and
- Foot care to minimize the risk of infection.

Certain expenses incurred in connection with the treatment of diabetes are **covered expenses**. Benefits for these expenses are provided to the same extent as benefits for any other illness.

Charges incurred in a **hospital**, convalescent or skilled nursing facility, or home health care will be paid at the applicable payment percentage.

If a **physician**, nurse practitioner, or clinical nurse specialist:

- diagnoses diabetes; or
- diagnoses a significant change in the person's diabetic symptoms or condition that requires a change in the person's self-management of the disease; or
- determines that a person who is a diabetic needs reeducation or refresher education;

charges for the following for the treatment of diabetes will be included as Other Medical Expenses; to the extent they are not already covered under any part of this Plan:

- insulin;
- oral agents;
- and medically appropriate or necessary equipment;

Also included as Other Medical Expenses are charges incurred for Diabetic Self-Management Education. "Diabetic self-management education" is training designed to instruct a person in self-management of diabetes, including medical nutrition therapy. It may include training in self care or diet. Such charges must be made by:

- a **physician**, nurse practitioner, clinical nurse specialist; or
- a pharmacist or dietitian who is legally qualified to provide diabetic management education.

Charges incurred for the following are not included as **covered expenses**:

- a diabetic education program whose only purpose is weight control; or which is available to the public at no cost; or
- a general program not just for diabetics; or
- a program made up of services not generally accepted as necessary for the management of diabetes.

Infertility services

Basic infertility

Covered services include seeing a **provider**:

- To diagnose and evaluate the underlying medical cause of **infertility**.
- To do **surgery** to treat the underlying medical cause of **infertility**. Examples are endometriosis **surgery** or, for men, varicocele **surgery**.

Comprehensive infertility services

Covered services include the following **infertility** services provided by a **network infertility specialist**:

- Ovulation induction cycle(s) while on injectable medication to stimulate the ovaries
- Artificial insemination, which includes intrauterine (IUI)/intracervical (ICI) insemination
- Oral and injectable **prescription** drugs used:
  - To stimulate the ovaries
  - Primarily for treating the underlying cause of **infertility**

A "cycle" is defined as:

- An attempt at ovulation induction while on injectable medication to stimulate the ovaries with or without artificial insemination
- An artificial insemination cycle with or without injectable medication to stimulate the ovaries

You are eligible for these **covered services** if:

- You or your partner have been diagnosed with **infertility**
- You have met the requirement for the number of months trying to conceive through egg and sperm contact

Aetna's National Infertility Unit

The first step to using your comprehensive **infertility covered services** is enrolling with our National Infertility Unit (NIU). Our NIU is here to help you. It is staffed by a dedicated team of registered nurses and **infertility** coordinators. They can help you with determining eligibility for benefits. They can also help your **provider** with **precertification.** You can call the NIU at 1-800-575-5999.

Your **network provider** will request approval from us in advance for your **infertility** services. If your **provider** is not a **network provider**, you are responsible to request approval from us in advance.

Advanced reproductive technology (ART)
Advanced reproductive technology (ART)**,** also called "assisted reproductive technology", is a more advanced type of **infertility** treatment. **Covered services** include the following services provided by a **network** ART **specialist**:

- In vitro fertilization (IVF)
- Zygote intrafallopian transfer (ZIFT)
- Gamete intrafallopian transfer (GIFT)
- Intracytoplasmic sperm injection (ICSI)
- Sperm, egg and/or inseminated egg procurement and processing, or banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor's insurer, if any.
- Cryopreservation (freezing) of eggs, sperm, and embryos when being done for medically necessary fertility preservation
- Assisted hatching
- Storage of eggs, sperm and embryos when done for medically necessary fertility preservation
- Cryopreserved (frozen) embryo transfers (FET).
- Charges associated with your care when you receive a donor egg or embryo in a donor IVF cycle. These services include culture and fertilization of the egg from the donor and transfer of the embryo into you.
- Charges associated with your care when using a gestational carrier including egg retrieval and culture and fertilization of your eggs that will be transferred into a gestational carrier. Services for the gestational carrier, including transfer of the embryo into the carrier, are not covered. (See exclusions, below.)
- Oral and injectable **prescription** drugs used:
  - To stimulate the ovaries
  - Primarily for treating the underlying cause of **infertility**

An ART "cycle" is defined as:

Procedure	**Cycle count**
One complete fresh IVF cycle with transfer (egg retrieval, fertilization, and transfer of embryo)	One full cycle
One fresh IVF cycle with attempted egg aspiration (with or without egg retrieval) but without transfer of embryo	One-half cycle
Fertilization of egg and transfer of embryo	One-half cycle
One cryopreserved (frozen) embryo transfer	One-half cycle
One complete GIFT cycle	One full cycle
One complete ZIFT cycle	One full cycle

You are eligible for ART services if:

- You or your partner have been diagnosed with **infertility**
- You have exhausted comprehensive **infertility** services benefits or have a clinical need to move on to ART procedures

Aetna's National Infertility Unit

The first step to using your ART **covered services** is enrolling with our National Infertility Unit (NIU). Our NIU is here to help you. It is staffed by a dedicated team of registered nurses and **infertility** coordinators. They can help you with determining eligibility for benefits and can give you information about our **infertility** Institutes of Excellence™ facilities. They can also help your **provider** with **precertification**. You can call the NIU at 1-800-575-5999.

Your **network provider** will request approval from us in advance for your **infertility** services. If your **provider** is not a **network provider**, you are responsible to request approval from us in advance.

Fertility preservation

Fertility preservation involves the retrieval of mature eggs/sperm with or without the creation of embryos that are frozen for future use.

Covered services for fertility preservation are provided when:

- You are believed to be fertile
- You have planned services that are proven to result in **infertility** such as:
  - Chemotherapy or radiation therapy that is established in medical literature to result in **infertility**
  - Other gonadotoxic therapies
  - Removing the uterus
  - Removing both ovaries or testicles

Premature ovarian insufficiency

If your **infertility** has been diagnosed as premature ovarian insufficiency (POI), as described in our clinical policy bulletin, you are eligible for ART services using donor eggs/embryos through age 45 regardless of FSH level.

The following are not **covered services**:

- All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father.
- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor eggs or donor sperm.
- The donor's care in a donor egg cycle. This includes, but is not limited to, screening fees, lab test fees and charges associated with donor care as part of donor egg retrievals or transfers.
- A gestational carrier's care, including transfer of the embryo to the carrier. A gestational carrier is a woman who has a fertilized egg from another woman placed in her uterus and who carries the resulting pregnancy on behalf of another person.
- Obtaining sperm from a person not covered under this plan.
- **Infertility** treatment when a successful pregnancy could have been obtained through less costly treatment.
- **Infertility** treatment when either partner has had voluntary sterilization **surgery**, with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- **Infertility** treatment when **infertility** is due to a natural physiologic process such as age related ovarian insufficiency (e.g. perimenopause, menopause) as measured by an unmedicated FSH level at or above 19 on cycle day two or three of your menstrual period or other abnormal testing results as outlined in Aetna's **infertility** clinical policy.
- Treatment for dependent children, except for fertility preservation as described above.
- Injectable **infertility** medication, including but not limited to menotropins, hCG, and GnRH agonists.

Prosthetic Devices *(GR-9N 11-110 01-NH)*

Covered expenses include charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by **illness**, **injury** or congenital defect. **Covered expenses** also include instruction and incidental supplies needed to use a covered prosthetic device.

The plan covers the first prosthesis you need that temporarily or permanently replaces all or part of a body part lost or impaired as a result of disease or injury or congenital defects as described in the list of covered devices below for an

- Internal body part or organ; or
- External body part.

Covered expenses also include replacement of a prosthetic device if:

- The replacement is needed because of a change in your physical condition; or normal growth or wear and tear; or
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

The list of covered devices includes but is not limited to:

- An artificial arm, leg, hip, knee or eye;
- Eye lens;
- An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
- A breast implant after a mastectomy;
- Ostomy supplies, urinary catheters and external urinary collection devices;
- Scalp hair prosthesis worn for hair loss suffered as a result of alopecia areata, alopecia medicamentosa, alopecia totalis resulting from the treatment from any form of cancer or leukemia, or permanent hair loss of scalp hair due to injury. The treating physician must certify that the prosthesis is medically necessary. A benefit of no more than $350 per calendar year will be covered for scalp hair prosthesis worn suffered as a result of alopecia medicamentosa.
- Speech generating device;
- A cardiac pacemaker and pacemaker defibrillators; and
- A durable brace that is custom made for and fitted for you.

The plan will not cover expenses and charges for, or expenses related to:

- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes; or if the orthopedic shoe is an integral part of a covered leg brace; or
- Trusses, corsets, and other support items or
- any item listed in the *Exclusions* section.

Nutritional support

For purposes of this benefit, "low protein modified food product" means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a **physician** for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.

Covered services include non-prescription enteral formulas for home use, as ordered by a **physician** stating the enteral formula is needed to sustain life and is **medically necessary**. Coverage is provided for the treatment of impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, or motility of the gastrointestinal tract. **Covered services** also include formula and low protein modified food products ordered by a **physician** for the treatment of phenylketonuria or an inherited disease of amino and organic acids.

The following are not **covered services**:

- Any food item, including:
  - Infant formulas
  - Nutritional supplements
  - Vitamins
  - Medical foods
  - Other nutritional items

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)

Covered expenses include charges made by a **physician**, a **dentist** and **hospital** for:

- Non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues.

Services and supplies for treatment of, or related conditions of, the teeth, mouth, jaws, jaw joints or supporting tissues, (this includes bones, muscles, and nerves), for surgery needed to:

- Treat a fracture, dislocation, or wound.
- Cut out cysts, tumors, or other diseased tissues.
- Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

Hospital services and supplies received for a **stay** required because of your condition.

Dental work, surgery and **orthodontic treatment** needed to remove, repair, restore or reposition:

(a) Natural teeth damaged, lost, or removed; or
(b) Other body tissues of the mouth fractured or cut due to **injury**.

Any such teeth must have been free from decay or in good repair, and are firmly attached to the jaw bone at the time of the **injury**.

The treatment must be completed in the [calendar year] of the **accident** or in the next calendar year.

If crowns, dentures, bridges, or in-mouth appliances are installed due to **injury**, **covered expenses** only include charges for:

- The first denture or fixed bridgework to replace lost teeth;
- The first crown needed to repair each damaged tooth; and
- An in-mouth appliance used in the first course of **orthodontic treatment** after the **injury**.

Covered expenses include charges made for limited services and supplies related to the treatment of teeth, gums, and jaws and their supporting structures, muscles and nerves as follows:

- Impacted teeth. This Plan covers oral surgery to remove:
  - Teeth partly or completely impacted in the jaw bone;
  - Teeth that will not erupt through the gum; and
  - Other teeth that cannot be removed without removing bone.
- Accidental **injuries** and other trauma. This Plan covers oral surgery and **medically necessary** dental services resulting from an accidental **injury** to return sound natural teeth and gums to their pre-trauma functional state, but only when the course of treatment for the accidental **injury** is received or authorized within 3 months of the date of the **injury**. Treatment made necessary due to **injury** to the jaw and oral structures other than teeth shall be covered without time limit. Coverage will be subject to such other terms and conditions of the Booklet-Certificate that may apply.

Sound natural teeth are teeth that were stable, functional, and free from decay and advanced periodontal disease at the time of the trauma.

If a child needs oral surgery as the result of accidental **injury** or trauma, surgery may be postponed until a certain level of growth has been achieved.

Important Note

Trauma which occurs as a result of biting or chewing is ***not*** considered accidental **injury**, even if it is unplanned or unexpected.

Pathology

- This Plan covers removal of tumors and cysts requiring pathological examination.

Radiation treatment

- This Plan covers fluoride treatment, removal of teeth and hyperbaric oxygen therapy in connection with covered radiation therapy.

Anatomical defects

- This Plan covers oral surgery and related dental services to correct a gross anatomical defect present at birth that result in significant functional impairment of a body part, if the services or supplies will improve function.

Related dental services are limited to:

- The first placement of a permanent crown or cap to repair a broken tooth;
- The first placement of dentures or bridgework to replace lost teeth; and
- Orthodontic therapy to preposition teeth; and

Dental implants are ***not*** covered.

Treatment of Obesity and Morbid Obesity *(GR-9N 11-165-01)*

If you are at least 18 years of age, covered expenses include charges for the diseases and ailments caused by obesity and morbid obesity and treatment for such, including bariatric surgery, when the prescribing physician has issued a written order stating that treatment is medically necessary and in accordance with the patient qualifications and treatment standards set forth by the American Society for Metabolic and Bariatric Surgery or the American College of Surgeons. Such treatment standards may include, but not be limited to, pre-operative psychological screening and counseling, behavior modification, weight loss, exercise regimens, nutritional counseling, and post-operative follow-up, overview, and counseling of dietary, exercise, and lifestyle changes. Covered expenses will be payable the same as any other illness.

Maternity Expenses *(GR-9N-011-100-01NH)*

Covered expenses include charges made by a **physician** for pregnancy and childbirth services and supplies at the same level as any **illness** or **injury**. This includes prenatal visits, delivery and postnatal visits.

For inpatient care of the mother and newborn child, **covered expenses** include charges made by a **Hospital** for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a cesarean section.
- A shorter stay, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier.

If the mother is discharged earlier, this Plan will pay for 2 post-delivery home visit by a health care provider.

Covered Expenses also include services rendered by a certified midwife acting within the scope of their license for services provided in a licensed health care facility or at home. Benefits are payable on the same basis as any other illness. Please refer to the Birthing Center provision for more information regarding birthing centers.

Covered expenses also include charges made by a **birthing center** as described under Alternatives to **Hospital** Care.

[Important Note:

Covered expenses also include services and supplies provided for circumcision.]

Child Early Intervention Services *(GR-9N 11-005 02-NH)*

Covered expenses also include coverage for Child Early Intervention Services. Child Early Intervention Services include services rendered to your covered dependent child from birth to 3 years of age, who has an identified developmental disability. Such service will be covered when provided by:

- A speech-language pathologist;
- an occupational or physical therapist; and
- a clinical social worker.

Child Early Intervention Services *(GR-9N-S-11-010-01 NH)*		
Calendar Year Maximum	$3,200	$3,200
Aggregate Maximum over total 3 year period	$9,600	$9,600

Autism Spectrum Disorders *(GR-9N 11-171 04 NH)*
Autism Spectrum Disorder is defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Covered expenses include charges made by a **physician** or **behavioral health provider** for services and supplies for the diagnosis and treatment of Autism Spectrum Disorder. The services and supplies must be ordered by a **physician** or a **behavioral health provider.**

Coverage also includes early intensive behavioral interventions such as Applied Behavioral Analysis (ABA). Applied Behavioral Analysis is an educational service that is the process of applying interventions that:
- Systematically change behavior; and
- Are responsible for the observable improvement in behavior.

Coverage for behavioral therapy and Applied Behavioral Analysis for Autism Spectrum Disorders is subject to the maximum benefit amount, if any, shown on the Schedule of Benefits.

Limitations:
Unless specified above, not covered under this benefit are charges for:
- Educational services for behavioral disorders are listed as not covered in the Medical Plan Exclusions and Limitations section of the Policy.

Treatment of a Biologically Based Mental Disorder *(GR-9N 11-170 01-NH)*
Covered medical expenses for the effective treatment of **biologically based mental disorder** include those incurred:

- During a **stay** in a **hospital** or **residential treatment facility**;
- For **partial confinement treatment**; and
- For outpatient treatment.

Benefits are payable in the same way as those for any other disease.

Emergency Prescriptions
When you need a **prescription** filled in an emergency or urgent care situation, or when you are traveling, you can obtain **network pharmacy** benefits by filling your **prescription** at any **network pharmacy**. A pharmacist may dispense a one-time emergency prescription, up to a 72-hour supply, of covered prescription drug that is listed on your plan's formulary list. Coverage will be provided even if the prescription requires prior authorization and the prior authorization has neither been approved or denied and a pharmacist has determined that:

- The medication is essential to the maintenance of life or to the continuation of therapy in a chronic condition, or
- The interruption of therapy might reasonably produce undesirable health consequences or may cause physical or mental discomfort

Exceptions to the above:

- The following drugs or classes of drugs or their medical uses, may be excluded from coverage or otherwise restricted when used:
  - For anorexia, weight loss, or weight gain
  - To promote fertility
  - For cosmetic purposes or hair growth
  - For the symptomatic relief of cough and colds
  - To promote smoking cessation

  Or when the drugs or class of drugs is:
  - Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
  - Nonprescription drugs, except, in the case of pregnant women when recommended by or under the supervision of a physician, agents approved by the FDA for tobacco cessation

- Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer
- Barbiturates
- Benzodiazepines
- Agents when used for the treatment of sexual or erectile dysfunction, unless the agents have been approved by the FDA to treat a condition other than sexual or erectile dysfunction

Coverage for **prescription drugs** obtained from an **out-of-network pharmacy** is limited to those obtained in connection with emergency and out-of-area urgent care services.

- You will be responsible for the **copayment** for each **prescription** or refill as specified in the *Schedule of Benefits*. The copayment will be the lesser of the copayment and the pharmacy's usual and customary price of filling the prescription. The copayment is payable directly to the network pharmacy at the time the prescription is dispensed.

- After you pay the applicable **copayment**, you will be responsible for any applicable **coinsurance** for **covered expenses** that you incur. Your **coinsurance** is based on the lesser of the **negotiated charge** and the pharmacy's usual and customary price of filling the prescription. You will not have to pay any balance bills above the **negotiated charge** for the **covered expense**.

Off-Label Use *(GR-9N 13-005 01 NH)*

FDA-approved **prescription drugs** may be covered when the off-label use of the drug has not been approved by the FDA for your symptom(s) subject to the following:

- The drug must be accepted as safe and effective to treat your symptom(s) in one of the following standard compendia:
  - American Society of Health-System Pharmacists Drug Information (AHFS Drug Information);
  - Thomson Micromedex DrugDex System (DrugDex);
  - Clinical Pharmacology (Gold Standard, Inc.); or
  - The National Comprehensive Cancer Network (NCCN) Drug and Biologics Compendium; or

- Use for your symptom(s) has been proven as safe and effective by at least one well-designed controlled clinical trial. Such a trial must be published in a peer reviewed medical journal known throughout the U.S. and either:
  - The dosage of a drug for your symptom(s) is equal to the dosage for the same symptom(s) as suggested in the FDA-approved labeling or by one of the standard compendia noted above; or
  - The dosage has been proven to be safe and effective for your symptom(s) by one or more well-designed controlled clinical trials. Such a trial must be published in a peer reviewed medical journal.

Coverage of off-label use of these drugs may, in **Aetna's** sole discretion, be subject to **precertification**, **step therapy** or other requirements or limitations.

Medical Exceptions:

You or your **prescriber** may seek a medical exception to obtain coverage for drugs for which coverage is denied through **Precertification** or **Step Therapy**. **Aetna** maintains an expeditious exceptions process, not to exceed 48 hours, by which covered persons may obtain coverage for a **medically necessary** non-formulary **prescription drug**. You or your **prescriber** must submit such exception requests to **Aetna**. The exception process shall begin when the **prescriber** has provided **Aetna** with the clinical rationale for the medical exception. Coverage granted as a result of a medical exception shall be based on an individual, case by case **medical necessity** determination and coverage will not apply or extend to other covered persons. A **prescription drug** that requires an exception for coverage shall be considered approved if the exception process exceeds 48 hours.

Continuing Health Care Benefits

Part I
When an individual loses Health Expense Coverage under this plan for any reason, except gross misconduct; coverage may be continued for you and your eligible dependents.

You must request continuation within 45 days of the later of the date Aetna notifies you of the right to continue and the date coverage would otherwise terminate. The request must include an agreement to pay up to 102% of the cost to this Plan. Premium payments must be continued.

Coverage will not be continued beyond the first to occur of:

- The end of an 18 month period which starts on the date coverage would otherwise terminate; However, if you or your dependent provide notice to your Employer that you or your dependent has been determined to be disabled under Title II or XVI of the Social Security Act within the first 60 days your coverage would have otherwise terminated, except for this section, coverage for you and your dependents will be continued, unless terminated for another reason, until the end of a 29 month period which starts on the date coverage would have otherwise terminated.
- The date you become eligible for like group benefits.
- The end of the period for which any required contributions have been made.

Coverage for a dependent will not be continued beyond the date it would otherwise terminate.

Part II
If Health Expense Coverage would terminate because of discontinuance of the coverage involved as to employees of the Eligible Class of which you were a member, coverage, except Comprehensive Dental Expense Coverage, may be continued for you and your eligible dependents. You must request continuation within 45 days of the later of the date Aetna notifies you of the right to continue and the date coverage would otherwise terminate. The request must include an agreement to pay up to 102% of the cost to this Plan. Premium payments must be continued.

Coverage will cease on the first to occur of:

- The date you are eligible for like group benefits.
- The end of the period for which any contributions have been made.
- The end of a period equal to 39 weeks, less the number of weeks your coverage was continued under this Plan during a strike, lockout or labor dispute. However, if coverage is being continued in accordance with Part I at the time coverage terminates as to your Eligible Class, coverage will be continued for up to the remainder of the 18 or 29 month period specified in Part I.

Part III
If any coverage being continued under Part I or Part II ceases because coverage has been continued for the maximum period, a personal policy issued by the New Hampshire High Risk Pool may be applied for. This must be done within 31 days of the date coverage ceases.

Continuation of Coverage For Your Spouse/Former Spouse

Part I
If Health Expense Coverage for your **dependent** spouse would terminate due to divorce (or legal separation), the former spouse may continue to be covered. The former spouse is eligible for coverage while policy remains in force or is replaced by another policy covering the member. Premium payments must be continued. Coverage will not continue beyond the first to occur:

- 3-year (36 month) anniversary of final decree of the divorce or legal separation;
- Remarriage of former spouse;
- Remarriage of member;
- Death of member; or
- Such earlier time provided in final divorce or legal separation.

Part II
If Health Expense Coverage for your former spouse would terminate because of one of the reasons listed under Part I, the former spouse may continue coverage, except in the case where former spouse remarries. The former spouse must make written request for coverage within 30 days from the first occurring event as listed above, except in the case where former spouse remarries. The former spouse is eligible for coverage for an additional 36 months. If former spouse is 55 years or older, coverage must continue until spouse is eligible under another employer-based group plan or becomes eligible for Medicare.

Except for when former spouse is age 55 or older, coverage will not be continued beyond the first to occur:

- The end of the 36-month period; or
- The end of the period for which required contributions have been made.

Part III
If any coverage continued under Part I or Part II ceases because coverage has been continued for the maximum period, the former spouse may be eligible for a personal policy issued by the New Hampshire high risk pool. This must be done within 31 days of the date coverage ceases.

Continuation of Coverage For Your Dependents After Your Death

If you should die while covered under any part of this Plan, any Health Expense Coverage then in force for your dependents may be continued.

Written request for such continuation must be made within 45 days of the later of the date Aetna notifies your dependents of the right to continue and the date coverage would otherwise terminate. The request must include an agreement to pay up to 102% of the cost to this Plan. Premium payments must be continued.

Any dependent's coverage will not continue beyond the first to occur of:

- The end of a 36 month period which starts on the date of your death; except that if the coverage involved discontinues during such 36 month period as to employees of the Eligible Class of which you were a member, coverage will be continued, unless terminated for another reason, until the later of:
  - 39 weeks from the date of such discontinuance; and
  - the remainder of the 36 month period on the date of such discontinuance.
- The date the dependent becomes eligible for like group benefits.
- The end of the period for which any required contributions have been made.

Coverage may also be provided under this Plan for your child, born after your death, as long as coverage for your other dependents is being continued.

If any coverage being continued ceases because coverage has been continued for the maximum period, a personal policy issued by the New Hampshire High Risk Pool may be applied for. This must be done within 31 days of the date coverage ceases.

Continuation of Coverage For Your Child

If Health Expense Coverage for your child would terminate because the child ceases to meet this Plan's definition of dependent, such child may continue the coverage then in force.

Written request for such continuation must be made within 45 days of the later of the date Aetna notifies the child of the right to continue and the date coverage would otherwise terminate. The request must include an agreement to pay up to 102% of the cost to this Plan. Premium payments must be continued.

Coverage will not continue beyond the first to occur of:

- The end of a 36 month period which starts on the date the child ceases to meet this Plan's definition of dependent; except that if the coverage involved discontinues during such 36 month period as to employees of the Eligible Class of which you are a member, coverage will be continued, unless terminated for another reason, until the later of:
  - 39 weeks from the date of such discontinuance; and
  - the remainder of the 36 month period on the date of such discontinuance.
- The date the child becomes eligible for like group benefits.
- The end of the period for which any required contributions have been made.

If any coverage being continued ceases because coverage has been continued for the maximum period, a personal policy issued by the New Hampshire High Risk Pool may be applied for. This must be done within 31 days of the date the coverage ceases.

Continuation of Coverage Due to a Labor Dispute

If your coverage under this Plan would cease because you cease work due to a strike, lockout or a labor dispute, and if the New Hampshire Insurance Code applies, you can arrange to continue your coverage (except Accidental Death and Dismemberment, Short Term Disability, Long Term Disability and Comprehensive Dental Expense Coverages) during your absence from work. Coverage may continue for up to 6 months after the date your compensation is suspended or terminated because of a strike, lockout or labor dispute.

Continuation will cease when the first of these events occurs:

- You fail to make the required contributions to your Employer.
- Your Employer fails to make the required contributions to Aetna.
- You go to work full time for another employer.
- The strike, lockout or labor dispute ends.
- The 6 month continuation period ends. However, after this 6-month period, you shall have the right to continue the benefits being continued under this paragraph for an additional 12 months as if you originally had elected the extension period provided under the Continuing Health Care Benefit section subject to the same conditions. At the end of the additional 12 months, you shall have the right, if the group insurance is no longer available, to coverage from the high risk pool. Please see the section, *Converting to an Individual Health Insurance Policy* for more information.
- The monthly premium required by Aetna for each person's coverage will be the applicable rate in effect on the date you cease work. Aetna has the right to change premium rates under the terms of this Plan subject to 60 day notice.

Handicapped Dependent Children *(GR-9N 31-015 02-NH)*

Health Expense Coverage for your fully handicapped dependent child may be continued past the maximum age for a dependent child. However, such coverage may not be continued if the child has been issued an individual medical conversion policy.

Your child is fully handicapped if:

- he or she is not able to earn his or her own living because of a mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children under your plan; and
- he or she depends chiefly on you for support and maintenance; or you or your estate is chargeable for the child's care.

Proof that your child is fully handicapped must be submitted to **Aetna** no later than 31 days after the date your child reaches the maximum age under your plan.

Coverage will cease on the first to occur of:

- Cessation of the handicap.
- Your child ceases to be financially dependent on you; or you or your estate is no longer chargeable for your dependent's care.
- Premiums cease to be paid for your child's coverage.Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age under your plan.

If:

- any health coverage for dependents under this plan replaces health coverage under any group or blanket plan; and
- the prior plan contained a handicapped dependent children provision;

then any child to whom that provision applied who was covered under the prior plan on the day before the effective date of this Plan will be entitled to coverage under this Plan subject to terms of this provision.

Any child whose coverage is continued under this section will be entitled to any Medical Conversion Privilege contained in this Plan if the incapacity ceases.

Continuation of Coverage on a Loss of Coverage Due to a Bankruptcy Proceeding

If your health coverage as a retired employee would terminate or be substantially eliminated due to your former Employer commencing a bankruptcy proceeding under Title 11, United States Code, or within the 12 month period prior to or following such a proceeding, you may be eligible to elect to continue coverage for yourself and your dependents or your dependents may each be eligible to elect to continue his or her own coverage.

Written request for such continuation must be made within 45 days of the later of the date Aetna notifies you or your dependents of the right to continue and the date bankruptcy proceedings begin. The request must include an agreement to pay up to 102% of the cost to this Plan. Premium payments must be continued.

Coverage will not be continued beyond the first to occur of:

- The end of a 36 month period which starts on the date coverage would otherwise terminate.
- The date you or your dependent becomes eligible for like coverage under this Plan.
- The end of the period for which any required contribution was made.
- The date of the first Medicare open enrollment period following the date you or your dependent became ineligible for the group plan.

Continuation of Coverage For Your Dependents After You Become Eligible For Medicare

If coverage for your dependents would terminate because you become eligible for Medicare, any Health Expense Coverage, then in force for your dependents may be continued.

Written request for such continuation must be made within 45 days of the later of the date Aetna notifies your dependents of the right to continue and the date coverage would otherwise terminate. The request must include an agreement to pay up to 102% of the cost to this Plan. Premium payments must be continued.

Coverage for a dependent will not continue beyond the first to occur of:

- The end of a 36 month period which starts on the date you become eligible for Medicare; except that if the coverage involved discontinues during such 36 month period as to employees of the Eligible Class of which you were a member, coverage will be continued, unless terminated for another reason, until the later of:
  - 39 weeks from the date of such discontinuance; and
  - the remainder of the 36 month period on the date of such discontinuance.
- The date the dependent becomes eligible for like group benefits.
- The end of the period for which any required contributions have been made.

If any coverage being continued ceases because coverage has been continued for the maximum period, a personal policy issued by the New Hampshire High Risk Pool may be applied for. This must be done within 31 days of the date coverage ceases.

Converting to an Individual Medical Insurance Policy *(GR-9N 31-040 01-NH)*

Eligibility

You and your covered dependents may apply for an individual Medical insurance policy if you lose coverage under the group medical plan because:

- You terminate your employment;
- You are no longer in an eligible class;
- Your dependent no longer qualifies as an eligible dependent;
- Any continuation coverage required under federal or state law has ended; or
- You retire and there is no medical coverage available.

You can only use the conversion option once. If your group plan allows retirees to continue medical coverage, and you wish to continue your plan, then the conversion privilege will not be available to you again.

The individual conversion policy may cover:

- You only; or
- You and all dependents who are covered under the group plan at the time your coverage ended; or
- Your covered dependents, if you should die before you retire.

Features of the Conversion Policy

The individual policy and its terms will be the type:

- Required by law or regulation for group conversion purposes in your or your dependent's states of residence; and
- Offered by **Aetna** when you or your dependents apply under your employer's conversion plan.

However, coverage will not be the same as your group plan coverage. Generally, the coverage level may be less, and there is an applicable overall lifetime maximum benefit.

The individual policy may also:

- Reduce its benefits by any like benefits payable under your group plan after coverage ends (for example: if benefits are paid after coverage ends because of a disability extension of benefits);
- Not guarantee renewal under selected conditions described in the policy.

Limitations

You or your dependents do not have a right to convert if:

- Medical coverage under the group contract has been discontinued.
- You or your dependents are eligible for Medicare (Title XVIII of the Social Security Act, as amended). Covered dependents not eligible for Medicare may apply for individual coverage even if you are eligible for Medicare.
- Coverage under the plan has been in effect for less than 60 days.
- A lifetime maximum benefit under this plan has been reached. For example:
  - If a covered dependent reaches the group plan's lifetime maximum benefit, the covered dependent will not have the right to convert. If you or your dependents have remaining benefits, you are eligible to convert.
  - If you have reached your lifetime maximum, you will not be able to convert. However, if a dependent has a remaining benefit, he or she is eligible to convert.
- You or your covered dependents become eligible for any other medical coverage under this plan.
- You apply for individual coverage in a jurisdiction where **Aetna** cannot issue or deliver an individual conversion policy.
- You or your covered dependents are eligible for, or have benefits available under, another plan that, in addition to the converted policy, would either match benefits or result in over insurance. Examples include:
  - Any other hospital or surgical expense insurance policy;
  - Any hospital service or medical expense indemnity corporation subscriber contract;
  - Any other group contract; or
  - Any statute, welfare plan or program.

Electing an Individual Conversion Policy

You or your covered dependents have to apply for the individual policy within 31 days after your coverage ends. You do not need to provide proof of good health if you apply within the 31 day period.

If coverage ends because of retirement, the 31 day application period begins on the date coverage under the group plan actually ends. This applies even if you or your dependents are eligible for benefits based on a disability continuation provision because you or they are totally disabled.

To apply for an individual medical insurance policy:

- Get a copy of the "Notice of Conversion Privilege and Request" form from your employer.
- Complete and send the form to **Aetna** at the specified address.

Your Premiums and Payments

Your first premium payment will be due at the time you submit the conversion application to **Aetna**.

The amount of the premium will be **Aetna's** normal rate for the policy that is approved for issuance in your or your dependent's state of residence.

When an Individual Policy Becomes Effective

The individual policy will begin on the day after coverage ends under your group plan. Your policy will be issued once **Aetna** receives and processes your completed application and premium payment.

Payment of Benefits *(GR-9N 32-025 02-NH)*

All covered health benefits are payable to you. However, **Aetna** has the right to pay any health benefits to the service provider. This will be done unless you have told **Aetna** otherwise by the time you file the claim.

Medical or hospital benefits will be paid within 30 calendar days upon receipt of a clean non-electronic claim or 15 calendar days upon receipt of a clean electronic claim. A "clean claim" means a claim for payment of covered health care expenses that is submitted to an insurer on the insurer's standard claim form using the most current published procedural codes, with all the required fields completed with correct and complete information in accordance with the insurer's published filing requirements. An "electronic claim" means the transmission of data for purposes of payment of covered health care services in an electronic data format specified by the insurer and, if covered by the Health Insurance Portability and Accountability Act (HIPAA), is in such form and substance to be in compliance with such act.

Aetna will notify you in writing, at the time it receives a claim, when an assignment of benefits to a health care provider or facility will not be accepted.

When You Have Medicare Coverage *(GR-9N 33-020-02 NH)*

This section explains how the benefits under **This Plan** interact with benefits available under **Medicare**.

Medicare, when used in this Booklet-Certificate, means the health insurance provided by Title XVIII of the Social Security Act, as amended. It includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of **Medicare**

A person is "eligible for **Medicare**" if he or she is covered under it by reason of:

- Age;
- Disability; or
- End Stage Renal Disease.

If you are eligible for **Medicare**, the plan coordinates the benefits it pays with the benefits that **Medicare** pays. Sometimes, the **plan** is the primary payor, which means that the **plan** pays benefits before **Medicare** pays benefits. Under other circumstances, the **plan** is the secondary payor, and pays benefits after **Medicare**.

Which Plan Pays First

The plan is the primary payor when your coverage for the **plan's** benefits is based on current employment with your employer. The **plan** will act as the primary payor for the **Medicare** beneficiary who is eligible for **Medicare**:

- Solely due to age if the **plan** is subject to the Social Security Act requirements for **Medicare** with respect to working aged (i.e., generally a plan of an employer with 20 or more employees);
- Due to diagnosis of end stage renal disease, but only during the first 30 months of such eligibility for **Medicare** benefits. This provision does not apply if, at the start of eligibility, you were already eligible for **Medicare** benefits, and the **plan's** benefits were payable on a secondary basis;
- Solely due to any disability other than end stage renal disease; but only if the **plan** meets the definition of a large group health plan as outlined in the Internal Revenue Code i.e., generally a plan of an employer with 100 or more employees.

The plan is the secondary payor in all other circumstances.

How Coordination With Medicare Works

When the Plan is Primary
The **plan** pays benefits first when it is the primary payor. You may then submit your claim to **Medicare** for consideration.

When Medicare is Primary
Your health care expense must be considered for payment by **Medicare** first. You may then submit the expense to **Aetna** for consideration.

Aetna will calculate the benefits the **plan** would pay in the absence of **Medicare**:

The amount will be reduced so that when combined with the amount paid by **Medicare**, the total benefits paid or provided by all plans for the claim do not exceed 100 %of the total **allowable expense**.

This review is done on a claim-by-claim basis.

Charges used to satisfy your Part B deductible under **Medicare** will be applied under the **plan** in the order received by **Aetna**. **Aetna** will apply the largest charge first when two or more charges are received at the same time.

Aetna will apply any rule for coordinating health care benefits after determining the benefits payable.

Right to Receive and Release Required Information *(GR-9N-S-33-025-01)*
Certain facts about health care coverage and services are required to apply coordination of benefits (COB) rules to determine benefits under **This Plan** and other **plans**. **Aetna** has the right to obtain or release any information, and make or recover any payments it considers necessary, in order to administer this provision.

Mental Disorder *(GR-9N-34-065-03 NH)*
An **illness** commonly understood to be a **mental disorder**, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a **behavioral health provider** such as a **psychiatric physician**, a psychologist or a psychiatric social worker. A **mental disorder** includes; but is not limited to:

- Schizophrenia;
- Schizoaffective Disorder;
- Major Depressive Disorder;
- Bipolar Disorder;
- Paranoia and other Psychotic Disorders;
- Anorexia Nervosa and Bulimia Nervosa;
- Obsessive-Compulsive Disorder;
- Panic Disorder;
- Pervasive Developmental Disorder or Autism;
- Chronic Post-Traumatic Stress Disorder.

For the purposes of benefits under this plan, **mental disorder** will include alcoholism and drug abuse only if any separate benefit for a particular type of treatment does not apply to alcoholism and drug abuse.

Physician *(GR-9N 34-080 04-NH)*
A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of his or her license or certificate.

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;
- Under applicable insurance law is considered a "physician" for purposes of this coverage; this includes a midwife certified under New Hampshire law, contingent upon services being provided in a licensed health care facility or at home and within the scope of practice of a certified midwife.
- Has the medical training and clinical expertise suitable to treat your condition;
- Specializes in psychiatry, if your **illness** or **injury** is caused, to any extent, by alcohol abuse, substance abuse or a mental disorder; and
- A physician is not you or related to you.

Dan Finke
President
Aetna Life Insurance Company
(A Stock Company)

Amendment: New Hampshire Medical ET
Issue Date: March 12, 2021

The State of New Hampshire
Insurance Department
21 South Fruit Street, Suite 14; Concord, NH 03301
Tel.: (603) 271-2261 Fax: (603) 271-1406 TDD Access Relay NH: 1-800-735-2964

CONSUMER GUIDE TO EXTERNAL APPEAL

What is an External Appeal?

New Hampshire law gives individuals who are covered by fully-insured, health or dental insurance plans the right to have a nationally-accredited, independent, medical review organization (IRO), which is not affiliated with his/her insurance company, review and assess whether the company's denial of a specific claim or requested service or treatment is justified. This type of review is available when a recommended service or treatment is denied on the basis that it does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, and level of care or effectiveness. This review is often called Independent External Appeal, **External Appeal**, External Health Review or simply External Review.

What are the eligibility requirements for External Appeal?

To be eligible for External Appeal the following conditions must be met:

- The patient must have a fully-insured health or dental insurance plan.
- The service that is the subject of the appeal request must be either a) a covered benefit under the terms of the insurance policy or b) a treatment that may be a covered benefit.
- Unless the patient meets the requirements for Expedited External Review (see below), the patient must have completed the Internal Appeal process provided by the insurer and
  have received a final, written decision from the insurer relative to its review.
  - Exception #1: The patient does not need to meet this requirement, if the insurer agrees in writing to allow the patient to skip its Internal Appeal process.
  - Exception #2: If the patient requested an internal appeal from the insurer, but has not received a decision from the insurer within the required time frame, the patient may apply for External Appeal without having received the insurer's final, written decision.
- The patient must submit the request for External Appeal to the Department within 180 days from the date appearing on the insurance company's letter, denying the requested treatment or service at the final level of the company's Internal Appeals process.
- The patient's request for External Appeal may not be submitted for the purpose of pursuing a claim or allegation of healthcare provider malpractice, professional negligence, or other professional fault.

What types of health insurance are excluded from External Appeal?

In general, External Appeal is available for most health insurance coverage. Service denials relating to the following types of insurance coverage or health benefit programs are not reviewable under New Hampshire's External Appeal law:

- Medicaid (except for coverage provided under the NH Premium Assistance Program)
- The New Hampshire Children's Health Insurance Program (CHIP)
- Medicare
- All other government-sponsored health insurance or health services programs.
- Health benefit plans that are self-funded by employers
  - Note: Some self-funded plans provide external appeal rights which are administered by the employer.

Can someone else represent me in my External Appeal?

Yes. A patient may designate an individual, including the treating health care provider, as his/her representative. To designate a representative, the patient must complete Section II of the External Review Application Form entitled "Appointment of Authorized Representative."

Submitting the External Appeal:

To request an External Appeal, the patient or the designated representative must complete and submit the External Review Application Form, available on the Department's website (www.nh.gov/insurance), and all supporting documentation to the New Hampshire Insurance Department. There is no cost to the patient for an External Appeal.

Please submit the following documentation:

☐ The completed External Review Application Form - signed and dated on page 6.
**** The Department cannot process this application without the required signature(s) ****

☐ A photocopy of the front and back of the patient's insurance card or other evidence that the patient is insured by the insurance company named in the appeal.

☐ A copy of the insurance company's letter, denying the requested treatment or service at the final level of the company's internal appeals process.

☐ Any medical records, statements from the treating health care provider(s) or other information that you would like the review organization to consider in its review.

☐ If requesting an Expedited External Appeal, the Provider's Certification Form.

If you have questions about the application process or the documentation listed above, please call the Insurance Department at 1-800-852-3416.

Mailing Address:

New Hampshire Insurance Department
Attn: External Review Unit
21 South Fruit Street, Suite 14
Concord, NH 03301

Expedited External Review Applications

- **May be faxed to (603) 271-1406, or**
- **Sent by overnight carrier to the Department's mailing address.**

What is the Standard External Appeal Process and Time Frame for receiving a Decision?

It may take up to 60 days for the Independent Review Organization (IRO) to issue a decision in a Standard External Appeal.

- Within 7 business days after receiving your application form, the Insurance Department (the Department) will complete a preliminary review of your application to determine whether your request is complete and whether the case is eligible for external review.
  - If the request is not complete, the Department will inform the applicant what information or documents are needed in order to process the application. The applicant will have 10 calendar days to supply the required information or documents.
- If the request for external appeal is accepted, the Department will select and assign an IRO to conduct the external review and will provide a written notice of the acceptance and assignment to the applicant and the insurer.
- Within 10 calendar days after assigning your case to an IRO, the insurer must provide the applicant and the IRO a copy of all information in its possession relevant to the appeal.
- If desired, the applicant may submit additional information to the IRO by the 20th calendar day after the date the case was assigned to the selected IRO. During this period, the applicant may also present oral testimony via telephone conference to the IRO. However, oral testimony will be permitted only in cases where the Insurance Commissioner determines that it would not be feasible or appropriate to present only written information.
  - To request a "teleconference," complete Section VII of the application form entitled "Request for a Telephone Conference" or contact the Department no later than 10 days after receiving notice of the acceptance of the appeal.
- By the 40th calendar day after the date the case was assigned to the selected Independent Review Organization, the IRO shall a) review all of the information and documents received, b) render a decision upholding or reversing the determination of the insurer, and c) notify in writing the applicant and the insurer of the IRO's review decision.

What is an Expedited External Appeal?

Whereas a Standard External Appeal may take 60 days, Expedited External Appeal is available for those persons who would be significantly harmed by having to wait. An applicant may request expedited review by checking the appropriate box on the External Review Application Form and by providing a Provider's Certification Form, in which the treating provider attests that in his/her medical opinion adherence to the time frame for standard review would seriously jeopardize the patient's life or health or would jeopardize the patient's ability to regain maximum function. Expedited reviews must be completed in 72 hours.

If the applicant is pursuing an internal appeal with the insurer and anticipates requesting an Expedited External Appeal, please call the Department at 800-852-3416 to speak with a consumer services officer, so that accommodations may be made to receive and process the expedited request as quickly as possible.

Please note a patient has the right to request an Expedited External Appeal simultaneously with the insurer's Expedited Internal Appeal.

What happens when the Independent Review Organization makes its decision?

- If the appeal was an Expedited External Appeal, in most cases the applicant and insurer will be notified of the IRO's decision immediately by telephone or fax. Written notification will follow.
- If the appeal was a Standard External Appeal, the applicant and insurer will be notified in writing.
- The IRO's decision is binding on the insurer and is enforceable by the Insurance Department. The decision is also binding on the patient except that it does not prevent the patient from pursuing other remedies through the courts under federal or state law.

Have a question or need assistance?
Staff at the Insurance Department is available to help.
Call 800-852-3416 to speak with a consumer services officer.

The State of New Hampshire
Insurance Department
21 South Fruit Street, Suite 14; Concord, NH 03301
Tel.: (603) 271-2261 Fax: (603) 271-1406 TDD Access Relay NH: 1-800-735-2964

INDEPENDENT EXTERNAL REVIEW

Appealing a Denied Medical or Dental Claim

New Hampshire law gives individuals who are covered by fully-insured, health or dental insurance plans the right to have a nationally-accredited, independent, medical review organization (IRO), which is not affiliated with his/her health insurance company, review and assess whether the company's denial of a specific claim or requested service or treatment is justified. These reviews are available when a recommended service or treatment is denied on the basis that it does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness. This review is called Independent External Appeal, External Health Review or simply **External Review**.

There is no cost to the patient for an external review.

To be eligible for **Standard External Review**, the patient must (1) have a fully-insured health or dental insurance plan, (2) have completed the insurer's internal appeal process, and (3) have received a final denial of services from the insurer. A standard external review must be submitted to the Insurance Department within 180 days of the insurance company's final denial and may take up to 60 days for the IRO to make its decision.

To be eligible for **Expedited External Review**, the patient must (1) have a fully-insured health or dental insurance plan, and (2) the treating provider must certify that delaying treatment will seriously jeopardize the life or health of the patient or will jeopardize the patient's ability to regain maximum function. IROs must complete expedited reviews within 72 hours. An expedited external review may be requested and processed at the same time the patient pursues an expedited internal appeal directly with the insurance company.

For more information about external reviews, see the Insurance Department's Consumer Guide to External Review, available at www.nh.gov/insurance, or call 800-852-3416 to speak with a Consumer Services Officer.

Have a question or need assistance?
Staff at the Insurance Department is available to help. Call 800-852-3416 to speak with a consumer services officer.

SUBMITTING A REQUEST FOR EXTERNAL REVIEW

To request an external review, please provide the following documents to the New Hampshire Insurance Department at the address below:

- ☐ The enclosed, completed application form - signed and dated on page 6.
  **** The Department cannot process this application without the required signature(s) ****
- ☐ A photocopy of the front and back of the patient's insurance card or other evidence that the patient is insured by the health or dental insurance company named in the appeal.
- ☐ A copy of the Health Insurance Company's letter, denying the requested treatment or service at the final level of the company's internal appeals process.
- ☐ Any medical records, statements from the treating health care provider(s) or other information that you would like the Independent Review Organization to consider in its review.
- ☐ If requesting an Expedited External Review, the treating Provider's Certification Form.

If you have questions about the application process or the documentation listed above, please call the Insurance Department at 1-800-852-3416.

Mailing Address:

New Hampshire Insurance Department
Attn: External Review Unit
21 South Fruit Street, Suite 14
Concord, NH 03301

Expedited External Review applications may be faxed to (603) 271-1406 or sent by sent by overnight carrier to the address above. If you wish to email the application package, please call the Insurance Department at 1-800-852-3416.

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EXTERNAL REVIEW APPLICATION FORM
Request for Independent External Appeal of a Denied Medical or Dental Claim

Section I – Applicant Information

Patient's Name: _____ Patient's Date of Birth: _____

Applicant's Name: _____Applicant's Email: _____

Applicant's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Applicant's Phone Number(s): Daytime: (_____)_____ Evening: (_____) _____

Section II – Appointment of Authorized Representative

** Complete this section, only if someone else is representing the patient in this appeal **

You may represent yourself or you may ask another person, including your treating health care provider, to act as your personal representative. You may revoke this authorization at any time.

I hereby authorize _____ to pursue my appeal on my behalf.

_____ _____
Signature of Enrollee (or legal representative – Please specify relationship or title) Date

Representative's Mailing Address: _____

City: _____State: _____ Zip Code: _____

Representative's Phone Number(s): Daytime: (__)_____ Evening: (__)_____

Section III - Insurance Plan Information

Member's Name: _____ Relationship to Patient: _____

Member's Insurance ID#: _____ Claim Reference#: _____

Health Insurance Company's Name: _____

Insurance Company's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Company's Phone Number: (_____) _____

Name of Insurance Company representative handling appeal: _____

Is the member's insurance plan provided by an employer? Yes: _____ No: _____

- Name of Employer: _____
- Employer's Phone Number: (_) _____
- Treating Provider's Phone Number: ( ) _____
- Is the employer's insurance plan self-funded? Yes*: _____ No: _____

* If you are not certain, please check with your employer. Most self-funded plans are not eligible for external review. However, some self-funded plans may provide external review, but may have different procedures.

New Hampshire Premium Assistance Program

Is the patient's health insurance provided through the Medicaid Premium Assistance Program, which is administered by the NH Department of Health and Human Services?

Yes _____ No _____

If yes, please provide the Medicaid ID number & complete the following records release:

Medicaid ID Number: _____

I,_____, hereby authorize the New Hampshire Insurance Department to release my external review file to the New Hampshire Department of Health and Human Services (DHHS), if I request a Medicaid Fair Hearing following my independent external review. I understand that DHHS will use this information to make a Fair Hearing determination and that the information will be held confidential.

Section IV – Information about the Patient's Health Care Providers

Name of Primary Care Provider (PCP): _____

PCP's Mailing Address: _____

City: _____ State: ___ Zip Code: _____

PCP's Phone Number: (____)_____

Name of Treating Health Care Provider: _____

Provider's clinical specialty: _____

Treating Provider's Mailing Address: _____

City: _____ State: ___ Zip Code: _____

Treating Provider's Phone Number: (___) _____

Section V – Health Care Decision in Dispute

Describe the health insurer company's decision in your own words. Include any information you have about the health care services, supplies or drugs being denied, including dates of service or treatment and names of health care providers. Explain why you disagree.

Please attach the following:

- Additional pages, if necessary;
- Pertinent medical records;
- If possible, a statement from the treating health care provider indicating why the disputed service, supply, or drug is medically necessary.

_____

_____

_____

_____

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_____

Continued on next page

Section VI – Expedited Review

**** Complete this section, only if you would like to request expedited review ****

The patient may request that the external review be handled on an expedited basis. To request expedited review, the treating health care provider must complete the attached Provider Certification Form, certifying that a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function.

Do you request an expedited review? Yes _____ No _____

Applications for Expedited External Review may be faxed to (603) 271-1406 or sent by overnight carrier to the address on the top of this form. To email the appeal, please call the Insurance Department at 1-800-852-3416 for additional instructions.

Section VII – Request for a Telephone Conference

**** Complete this section, only if you would like to request a telephone conference ****

If the patient, the authorized representative or the treating health care provider would like to discuss this case with the Independent Review Organization and the insurer in a telephone conference, select "Yes" below and explain why you think it is important to be allowed to speak about the case. If you do not request a telephone conference, the reviewer will base its decision on the written information only. The request for a telephone conference will be granted only if there is a good reason why the written information would not be sufficient.

**** Telephone conferences often cannot be completed within the timeframe for expedited reviews ****

Do you request a telephone conference? Yes _____ No _____

My reason for requesting a phone conference is:

VIII – Authorization and Release of Medical Records

I,_____, hereby request an external review and authorize the patient's insurance company and the patient's health care providers to release all relevant medical or treatment records to the Independent Review Organization (IRO) and the New Hampshire Insurance Department. I understand that the IRO and the Department will use this information to make a determination to either reverse or uphold the insurer's denial. I also understand that the information will be kept confidential. I further understand that neither the Commissioner nor the IRO may authorize services in excess of those covered by the patient's health care plan. This release is valid for one year.

_____ _____

Signature of Enrollee (or legal representative – Please specify relationship or title) Date

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Before submitting this application, please verify that you have

☐ Completed all relevant sections of the External Review Application Form
- If appointing an authorized representative, the patient must complete Section II.
- If requesting an Expedited External Review, Section VI must be completed and the Provider Certification Form must be submitted.
- If requesting a telephone conference, Section VII must be completed.

☐ Signed and dated the External Review Application Form in Section VIII.

☐ Attached the following documents:
- A photocopy of the front and back of the patient's insurance card or other evidence that the patient is insured by the health or dental insurance company named in the appeal.
- A copy of the Health Insurance Company's letter, denying the requested treatment or service at the final level of the company's internal appeals process.
- Any medical records, statements from the treating health care provider(s) or other information that you would like the Independent Review Organization to consider in its review.
- If requesting an Expedited External Review, the treating Provider's Certification Form.

The State of New Hampshire
Insurance Department
21 South Fruit Street, Suite 14; Concord, NH 03301
Tel.: (603) 271-2261 Fax: (603) 271-1406 TDD Access Relay NH: 1-800-735-2964

PROVIDER'S CERTIFICATION FORM

For Expedited Consideration of a Patient's External Review

NOTE TO THE TREATING HEALTH CARE PROVIDER

The New Hampshire Insurance Department administers the external review process for all fully-insured health and dental plans in New Hampshire. A patient may submit an application for External Review, when his/her health or dental insurer has denied a health care service or treatment, including a prescription, on the basis that the requested treatment or service does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.

The time frame for receiving a decision from an Independent Review Organization (IRO) for a Standard External Review is up to 60 days. Expedited External Review is available, ***only if*** the patient's treating health care provider certifies that, in his/her professional judgment, adherence to the time frame for standard review ***would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function.*** The time frame for receiving a decision from an IRO for an Expedited External Review is
within 72 hours. An Expedited External Review may be requested and processed at the same time the patient pursues an Expedited Internal Appeal directly with the insurance company.

**** Expedited External Review is not available, when services have already been rendered ****

GENERAL INFORMATION

Name of Treating Health Care Provider: _____

Mailing Address: _____

City: _____State: _____Zip Code: _____

Phone Number: (____) _____ Fax Number: (____) _____

Email Address: _____

Licensure and Area of Clinical Specialty: _____

Name of Patient: _____

PROVIDER CERTIFICATION

I hereby certify that I am a treating health care provider for _____ (hereafter referred to as "the patient"); that adherence to the time frame for conducting a standard review of the patient's external review would, in my professional judgment, seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function; and that for this reason, the patient's appeal of the denial by the patient's health insurer of requested medical services should be processed on an expedited basis.

I am aware that the Independent Review Organization (IRO) may need to contact me during non-business hours for medical information and that a decision will be made by the IRO within 72 hours of receiving this Expedited External Review request, regardless of whether or not I provide medical information to the IRO.

During non-business hours I may be reached at: (_____) _____

I certify that the above information is true and correct. I understand that I may be subject to professional disciplinary action for making false statements.

_____

Treating Health Care Provider's Name (Please Print)

_____ _____

Signature Date