

UNIVERSITY OF NEW HAMPSHIRE

STUDENT HEALTH BENEFITS PLAN (SHBP) PLAN DOCUMENT

Revised Effective: September 1, 2024

Originally Effective August 1, 2007

For the most current information regarding the SHBP, refer to the SHBP website at:

<https://www.unh.edu/health/shbp>

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NOTE: Abbreviations and terms both capitalized and italicized are defined in [Section XVIII: Definitions](#) (e.g., *Urgent Care*). Capitalized terms without italics are either major or Subsection headings in The SHBP Document or are terms used to identify organizations or individuals in [Section III: General Information](#) (e.g., Claims Administrator, Plan Administrator). For capitalized terms without italics and with no specific Section reference, see the Table of Contents and/or [Section III: General Information](#).

THIS INSTRUMENT, established by the University of New Hampshire (hereinafter UNH or Plan Sponsor), sets forth the University of New Hampshire Student Health Benefits Plan (hereinafter the SHBP).

- A. Establishment of the SHBP.** UNH hereby sets forth its student group health plan under the following terms and conditions.
- (1) UNH provides the SHBP for the sole purpose of providing health care benefits to the *Students* covered by the program. SHBP reserve funds are encumbered for the sole purpose of operating the SHBP.
 - (2) In the event there are surplus reserve funds upon termination of the SHBP, these funds will be used exclusively to provide health care services and/or health education services for the UNH *Student* population.
 - (3) SHBP claims/operating funds and SHBP reserve funds earn interest income and are not commingled with other UNH accounts.
 - (4) Benefits are administered exclusively based on the provisions of the SHBP Document. There are no unpublished Plan provisions. Refer to www.unh.edu/shbp for all documents pertaining to the program and/or links to other applicable UNH policies.
 - (5) Extra-contractual benefits may be provided only to the extent that the Plan Administrator determines that such benefits are *Medically Necessary* and result in either (1) improved quality of care for the *Covered Person* with no substantive difference in the amount of benefit payments that would otherwise be provided by the SHBP, or (2) cost savings for the SHBP. Upon recommendation of the Claims Administrator, any extra-contractual benefits must be reviewed and approved by the Plan Administrator.
- B. Effective.** The SHBP for the 2024-2025 *Plan Year*, as described herein, is revised effective **September 1, 2024**, originally effective August 1, 2007.
- C. General Provisions.** The SHBP is subject to all of the conditions and provisions set forth in this document and subsequent amendments, which are made a part of the SHBP Document.

IN WITNESS WHEREOF, the University of New Hampshire has caused the SHBP to be executed by its duly-authorized representative.

University of New Hampshire

_____ By:
Date

Authorized Signature

Title

Printed Name

The University of New Hampshire (UNH) has prepared this document to help you understand your medical and prescription drug benefits as a *Covered Person* in the Student Health Benefits Plan (SHBP). Please read it carefully. The Schedule of Benefits provides an overview of your coverage.

Abbreviations and terms both capitalized and italicized are defined in [Section XVIII: Definitions](#) (e.g., *Urgent Care*). Capitalized terms without italics are either major or Subsection headings in the SHBP Document or are terms used to identify organizations or individuals in [Section III: General Information](#) (e.g., Claims Administrator, Plan Administrator). For capitalized terms without italics with no specific Section reference, see the Table of Contents and/or [Section III: General Information](#).

For United States citizens and permanent residents, treatment or services rendered outside the United States of America or its territories are covered on the same basis as treatment or services rendered within the United States. For international *Students* and their covered dependents, such SHBP benefits are provided only to the extent that they are not covered by any other insurance plan, insurance program, or system of socialized medicine.

Benefits are not provided for certain kinds of treatments or services, even if your health care *Provider* recommends them.

You can minimize your out-of-pocket expenses by using *In-Network Providers*. We also encourage you to use Psychological and Counseling Services and Health & Wellness at UNH whenever possible. More information about the Psychological and Counseling Services may be obtained from its website at www.unh.edu/pacs. The Health & Wellness website is www.unh.edu/health.

If you have questions about any of your coverage, please contact the SHBP's Claims Administrator: Wellfleet at 877-657-5041. By working together, we can help contain medical expenses. Please make note of the following provisions.

(A) Preferred Provider Networks

The chosen Preferred Provider Network is a group of *Providers/Practitioners* and *Hospitals* who have agreed to accept a negotiated fee for their services. Preferred Provider Networks may be used by *Covered Persons* to provide most of the Covered Medical Services described in [Section VII](#) of the SHBP Document. As a *Covered Person* in the SHBP, you maintain the freedom to choose participating or non-participating *Providers/Practitioners*.

When you choose a participating *Provider/Practitioner* or *Hospital*, the SHBP contains many advantages because:

- (1) you usually pay less out-of-pocket for health care services;
- (2) you may change your *Provider(s)/Practitioner(s)* and/or *Hospital* at any time, because you are not required to designate a primary care *Provider/ Practitioner*;

- (3) your participating *Provider(s)/Practitioner(s)* and/or *Hospital* will file claims directly, so you do not have to wait for claim reimbursement; and
- (4) you are not responsible for charges over the negotiated fees allowed by the applicable network for the Covered Medical Services described under [Section VII](#) of the SHBP Document, but you are responsible for the applicable deductible, co-payment, and/or coinsurance amounts.

Please also refer to the important Preadmission/Precertification of care requirements, explained in [Section VIII](#).

(B) Outpatient surgery

If appropriate, consider having surgery performed in the outpatient department of the *Hospital*, a surgical care center, or a *Provider's/Practitioner's* office. This will eliminate the *Hospital* room and board charges as well as overnight stays.

(C) Generic Medications

A generic drug is a prescription drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. Whenever possible, request that your *Provider(s)/Practitioner(s)* prescribe a generic drug if it is the lowest cost option.

(D) Patient and Protection Affordable Care Act (PPACA) and State of New Hampshire Essential Benefits Benchmark Plan

The SHBP fully complies with the benefit requirements, Appeals procedures, and other provisions of the regulations issued by the U.S. Department of Health and Human Services for fully insured student health insurance programs under the Patient Protection and Affordable Care Act (PPACA). The SHBP also fully complies with mandates for covered medical services that are required under the Essential Health Benefits Benchmark Plan adopted by the State of New Hampshire.

You are encouraged to review the preventive care benefits included in the program and the new Appeals procedure. Refer respectively to [Sections VI: Required Benefits](#), and [Section XIX-B: Inquiry, Grievance, and Appeals Process](#).

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For United States citizens and permanent residents, treatment or services rendered outside the United States of America or its territories are covered on the same basis as treatment or services rendered within the United States. For international *Students* and their covered dependents, such SHBP benefits are provided only to the extent that they are not covered by any other insurance plan, insurance program, or system of socialized medicine for health care services and supplies that are received outside of the United States or its territories.

Your benefits under the SHBP are affected by certain limitations and conditions designed to encourage you to be a wise consumer of health services and to use only those services you need. Also, benefits are not provided for certain kinds of treatments or services, even if your health care *Provider* recommends them.

You can minimize your out-of-pocket expenses by using *In-Network Providers*. We also encourage you to use Psychological and Counseling Services and Health & Wellness at UNH whenever possible. More information about Psychological and Counseling Services may be obtained from its website at www.unh.edu/pacs/. The Health & Wellness website is www.unh.edu/health/.

If you have questions about any of your coverage, please contact the SHBP's Claims Administrator: Wellfleet, 877-657-5041. By working together, we can help contain medical expenses. Please make note of the following provisions.

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When you choose a participating *Provider/Practitioner* or *Hospital*, the SHBP contains many advantages because:

- (1) you usually pay less out-of-pocket for health care services;
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The SHBP fully complies with the benefit requirements, Appeals procedures, and other provisions of the regulations issued by the U.S. Department of Health and Human Services for fully insured student health insurance programs under the Patient Protection and Affordable Care Act (PPACA). The SHBP also fully complies with mandates for covered medical services that are required under the Essential Health Benefits Benchmark Plan adopted by the State of New Hampshire.

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Plan Name	University of New Hampshire Student Health Benefits Plan (SHBP).
Type of Plan	Non-ERISA governed student health benefits plan providing medical and prescription drug benefits on a self-funded basis.
Effective	Revised effective September 1, 2024; Originally effective August 1, 2007.
Plan Sponsor	University of New Hampshire Health & Wellness 4 Pettee Brook Lane Durham, NH 03824 (603) 862-2853
Group Number	ST1283SH
Plan Administrator	Business Director Health & Wellness University of New Hampshire 4 Pettee Brook Lane Durham, NH 03824 (603) 862-2853 https://www.unh.edu/health/shbp Email: health&wellness@unh.edu
SHBP Privacy Officer	Business Director Health & Wellness (see Plan Administrator contact information)
Claims Administrator (refer to Section XIX, Procedures/Statement of Rights , for claims submission instructions)	Wellfleet PO Box 15369 Springfield, MA 01115-5369 877-657-5041
Secure Messaging	www.studentinsurance.com/unh
In-Network Providers	CIGNA OAP (www.cigna.com)
Pharmacy Benefits Solution	Wellfleet Rx (http://www.wellfleetrx.com) Customer Service: 800-922-1557

Medical Evacuation and Repatriation Provider

Travel Guard (www.travelguard.com)
3300 Business Park Drive
Stevens Point, WI 54482
U.S toll free: 1-800-826-5248
U.S. and international collect: 1-715-345-0505

Agent for Service of Legal Process

General Counsel
University System of New Hampshire
5 Chenell Drive, Suite 301
Concord, NH 03301
(603) 862-1800
FAX: (603) 862-0909

Termination and/or Modification of SHBP

The Plan Sponsor may terminate the SHBP at the end of any *Plan Year* or change the provisions of the SHBP at any time by a written Plan Document amendment signed by a duly-authorized officer of the Plan Sponsor. The consent of any *Covered Person* is not required to terminate or change the SHBP.

NOTE: The SHBP is not an employer-sponsored health plan. Accordingly, the rules and regulations of the Employee Retirement Income Security Act of 1974 (ERISA), the Consolidated Omnibus Budget Reconciliation Act of 1996 (COBRA), and other federal laws that apply exclusively to employer-sponsored health plans are not applicable to the SHBP. To the extent that the SHBP voluntarily adopts certain practices as described under ERISA, such adoption shall not be deemed to subject the SHBP to ERISA regulation.

The SHBP is licensed as a self-funded health plan and regulated by the State of New Hampshire's Department of Insurance.

The federal laws and regulations that are applicable to the SHBP include, but are not limited to, the following.

- Patient Protection and Affordable Care Act (refer to CMS-9981-F).
- Title IX of the Education Amendments of 1972. The SHBP provides pregnancy benefits on the same basis as any other temporary disability.
- Section 504 of the Rehabilitation Act of 1973.
- Age Discrimination Act of 1975.
- Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- Regulations of the United States Information Agency applicable to visa recipients.

The SHBP fully complies with the benefit requirements mandated in regulations for fully insured student health insurance plans issued by the U.S. Department of Health and Human Services (refer to [Federal Register 77 FR 16453](#)) and covered medical services specified under the Essential Health Benefits Benchmark plan adopted by the State of New Hampshire (refer to [Section VI, Required Benefits](#)).

It is the policy of UNH to uphold the constitutional rights of all members of the University community and to abide by all United States and New Hampshire State laws and University System of New Hampshire and UNH policies applicable to discrimination and harassment. In accordance with those laws and policies, all members of the UNH community will be responsible for maintaining a university environment that is free of discrimination and harassment based on race, color, religion, sex, age, national origin, sexual orientation, gender identity or expression, disability, veteran status, or marital status. Therefore, no member of UNH may engage in discriminatory or harassing behavior within the jurisdiction of the university that unjustly interferes with any individual's required tasks, career opportunities, learning, or participation in university life.

Full disclosure of UNH's Affirmative Action and Equity Policy may be found online at <http://www.unh.edu/vpsas/handbook/administrative-policies-and-regulations>.

General Notice about Nondiscrimination and Accessibility

The SHBP complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The SHBP does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Refer to [Section XIX, Claims and Appeals Procedures](#).

A. Eligible Students

Students eligible for the SHBP are defined as:

- (1) any full-time domestic undergraduate degree candidate *Student* (12 or more credits per semester);
- (2) full-time exchange students enrolled at UNH (12 or more credit hours per semester);
- (3) any full-time domestic graduate degree candidate *Student* (9 credits or more per semester);
- (4) any *Student* enrolled in a post-baccalaureate certificate program (9 or more credits per semester);
- (5) any *Student* enrolled in Doctoral Research 999 or GRAD 900;
- (6) any undergraduate or graduate *Student* holding an F-1 or J-1 visa (regardless of the number of credit hours or degree candidate status);
- (7) any Graduate Assistant or Fellow;
- (8) any part-time undergraduate or graduate *Student* (fewer than 9 credits per semester), but eligibility is limited to their final semester and only if the *Student* had been enrolled in the SHBP in the previous semester and is in the last semester of his/her educational program;
- (9) *Students* (a) who otherwise meet the eligibility requirements specified in this Section, (b) were covered by the SHBP in the *Coverage Period* immediately preceding the period for which this eligibility provision applies, and (c) who are enrolled in a UNH program that has a *Coverage Period* that differs from the semester or summer session *Coverage Periods* specified in the SHBP brochure (coverage will be provided on a pro-rated monthly basis for this class of eligible *Students*); or
- (10) other classes of *Students* determined by UNH to be eligible for the SHBP, and officially published by amendment to the SHBP Document, as being eligible for the SHBP.

Any *Student* who does not meet one of the classifications listed above is not eligible to enroll in the SHBP. [Refer to Section XIII, When Coverage Ends](#), for provisions relating to the termination of coverage under the SHBP, including loss of SHBP Eligibility. Refunds for the cost of coverage under the SHBP are provided only to *Students* who enter into the *Uniformed Services*.

Eligible *Students* may choose to participate in the SHBP during the *Annual Open Enrollment Period* with coverage commencing on the first day of the *Plan Year* or the first day of the *Coverage Period* (the *Effective Date*). The *Effective Date* will be earlier than the first day of the *Plan Year* if the *Student* is required by UNH to be on campus or participate in a UNH-sponsored activity or program. In no event will the *Effective Date* be more than twenty (20) days earlier than the first day of the *Plan Year*.

The requirements for *Students* to have health insurance are established by UNH under policies published separately from the SHBP Document.

Eligible *Students* must enroll each *Plan Year* by the enrollment deadlines established by the Plan Administrator. *Students* who have other health insurance will be able to waive coverage under the SHBP if their insurance meets or exceeds the waiver criteria established and published by the Plan Administrator. All waivers must be received by the Plan Administrator by the due dates established and published by the Plan Administrator each *Plan Year*. Otherwise, eligible *Students* will be automatically enrolled in and charged for the SHBP.

Each *Student* who meets the eligibility requirements of the SHBP and who submits an enrollment application that has been approved by the Plan Administrator (or who is automatically enrolled per the terms of the SHBP) shall become a *Covered Student*.

B. Qualified Late Enrollees

Students may be approved to enroll in the SHBP after the *Plan Year's* enrollment deadline under the provision established in this Section. Eligible *Students* may include those who enroll at UNH in the spring semester, or those who *Involuntarily Lose* eligibility under a group health insurance plan either due to a loss of employment or to attainment of a maximum age to be covered under their parent's plan. Such *Students* will be Qualified Late Enrollees for the SHBP if they request enrollment from the Plan Administrator within thirty (30) days of the *Involuntary Loss* of their group health insurance plan, or within the enrollment deadlines for spring semester *Students* as established by the Plan Administrator. Qualified Late Enrollees may also enroll their *Eligible Dependents* in the SHBP. Documentation of *Involuntary Loss* of coverage must be provided to the Plan Administrator. The cost of the SHBP is pro-rated for Qualified Late Enrollees on a monthly basis. The *Effective Date* will be the first of the month in which the *Student Involuntarily Loses* his or her health insurance.

Qualified Late Enrollees also includes any eligible student who is discovered to be without health insurance and who has not yet attained age 19.

C. Unqualified Late Enrollees

Any eligible *Student* who is subject to the University of New Hampshire's insurance requirement and is found to be uninsured during the *Plan Year* (and is not a Qualified Late Enrollee) will be required to enroll in the SHBP and charged for the full year cost regardless of the effective date of coverage under the SHBP. Unqualified Late Enrollees

cannot purchase dependent coverage under the SHBP until the next *Annual Open Enrollment Period*.

D. Eligible Dependents

An *Eligible Dependent* is one of the following:

- (1) A person who is the husband or wife of the *Covered Student*. Such person may also be referred to as a spouse under the terms of the SHBP.
- (2) A child of the *Covered Student* who has not attained the age of 26 and who meets the following requirements is an *Eligible Dependent*:
 - a natural child;
 - a stepchild by legal marriage;
 - a child who has been legally adopted by the *Covered Student* or placed with the *Covered Student* for adoption by a court of competent jurisdiction; or
 - a child for whom legal guardianship has been awarded, provided that the child legally resides with the *Covered Student* in a parent-child relationship for more than one-half of the taxable year, must not have provided more than one-half of his or her own support in that year, or be the subject of a Qualified Medical Child Support Order (as described later in this Section).
- (3) A child who meets any of the requirements in (a) through (d) above and who is permanently and *Totally Disabled* at any time during the calendar year in which the *Covered Student* begins coverage is an *Eligible Dependent*. The Plan Administrator may require, at reasonable intervals during the two years following the child's 26th birthday, subsequent proof of the child's incapacity and dependency. After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator has the right to have such child examined by a *Provider/Practitioner* of the Plan Administrator's choice to determine the existence of such incapacity. The cost for any examination of the child to determine continued eligibility will be borne by the UNH SHBP.

Except as provided under Subsection B: Qualified Late Enrollees and Subsection C: Unqualified Late Enrollees of this Section IV, each *Eligible Dependent* will be eligible to participate in the SHBP beginning with the latest of the following dates, provided the Plan Administrator is notified in writing within thirty-one (31) days of such event and the *Covered Student* has agreed to pay any required contribution for such coverage:

- the date the *Covered Student's* coverage begins, provided the *Covered Student* enrolled all *Eligible Dependents* on or before the date on which such *Covered Student's* participation commenced hereunder;

- the date of enrollment, if the *Covered Student* enrolls all *Eligible Dependents* within thirty-one (31) days of the *Covered Student*'s own eligibility date;
- the date the *Covered Student* enrolls the *Eligible Dependent*, if the enrollment is within thirty-one (31) days of the date any new *Eligible Dependent* is acquired, and proof of *Eligible Dependent* status is furnished (A newborn *Eligible Dependent*, born to either a male or female *Covered Student*, is not considered to be acquired until the *Eligible Dependent*'s birth.); or
- in the case of an adopted child, the date the child is placed with the *Covered Student* for adoption by a court of competent jurisdiction, as defined in Subsection E of this Section IV.

E. Adopted Child Provision

Eligible Dependent children placed for adoption with a *Covered Student* shall be eligible for coverage under the same terms and conditions as *Eligible Dependent* children who are natural children of *Covered Students*, whether or not the adoption has become final. Coverage under the SHBP shall not be restricted for any *Eligible Dependent* child adopted by the *Covered Student* or placed with a *Covered Student* for adoption if the adoption or placement for adoption occurs while the *Covered Student* is enrolled in the SHBP.

In connection with any adoption, or placement for adoption of a child, the term "child" as used in this Section only means a person who has not attained age 26 as of the date of such adoption or placement for adoption. The terms "placement" or "being placed for adoption" with any person means: the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

The child's placement for adoption terminates upon the termination of such legal obligations. In such an event, the child's coverage shall cease after the last day of the month the placement is terminated unless coverage must be continued pursuant to a Qualified Medical Child Support Order.

F. Coverage Pursuant to a Qualified Medical Child Support Order

Certain *Eligible Dependents* shall be provided benefits in accordance with applicable requirements of any Qualified Medical Child Support Order, provided that such order does not require the SHBP to provide any type or form of benefit, or any option under the SHBP, not otherwise provided under the SHBP, except to the extent necessary to meet the requirements of law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 4301 of the Omnibus Budget Reconciliation Act of 1993). A *Covered Student* may obtain a copy of the Qualified Medical Child Support Order procedures from the Plan Administrator.

An Alternate Recipient shall mean: any child of a *Covered Student* who is recognized under a Medical Child Support Order as having a right to enroll under the SHBP with respect to such *Covered Person*.

Any payment of benefits made by the SHBP pursuant to a Medical Child Support Order in reimbursement for expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian. The terms "Qualified Medical Child Support Order" and "Medical Child Support Order" are defined in Section 609 of ERISA.

PRESCRIPTION DRUG BENEFIT	
<p>Prescription Drugs</p> <p>Benefit applies only to covered medications as defined in the Plan Document. Dispensing limits may apply in accordance with federal and/or state regulations.</p>	<p>Tier One Prescriptions copayments: (applies to prescriptions filled at Rite Aid #10295; 5 Mill Road #G Durham NH 03824)</p> <p>Generic: \$5 (up to a 30-day supply) Preferred Brand: \$25 (up to a 30-day supply) Non-Preferred Brand: \$40 (up to a 30-day supply)</p> <p>Tier Two Prescriptions copayments: (applies to prescriptions filled through Wellfleet Rx)</p> <p>Generic: \$15 (up to a 30-day supply) Preferred Brand: \$35 (up to a 30-day supply) Non-Preferred Brand: \$50 (up to a 30-day supply)</p> <p>Specialty drugs: Purchased from retail pharmacy: Payable as shown for retail drugs Provided in physician’s office or in a hospital: In-Network: \$50 copay then 15% coinsurance; Out-of-Network: 80% Allowed Amount (after Deductible)</p> <p>\$0 Copayment for FDA approved contraceptive medications.</p> <p>A 90-day supply of maintenance drugs is provided for retail purchase.</p> <p><u>Note:</u> Covered Persons pay prescription drug copayments which accumulate toward the prescription drug Out-of-Pocket Maximums. Once the prescription drug Out-of-Pocket Maximums have been met, prescription drugs are covered at 100% the remainder of the Plan Year.</p>
<p>Annual Out-Of-Pocket Expense Limit</p>	<p>Individual: \$1,250 Family: \$3,500</p> <p>Separate from the Annual Out-of-Pocket Maximum Expense Limit for Medical Benefits. Outpatient prescription drug copayments/coinsurance do not count toward satisfaction of the Annual Out-of-Pocket Maximum Expense Limit for Medical Benefits.</p>

MEDICAL BENEFITS	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Lifetime Maximum	Unlimited	Unlimited
Annual Plan Year Deductible	Not Applicable – In-network benefits are generally subject to a copayment for each service provided.	Per <i>Covered Person</i> : \$350 Family: \$1,500
Coinsurance	Following satisfaction of any required copayment, the SHBP reimburses <i>Covered Expenses</i> at 85% of the <i>Contracted Rate</i> amount (unless otherwise stated) up to the Annual Out-of-Pocket Maximum Expense Limit. The SHBP provides 100% coverage for <i>Covered Expenses</i> once your annual out-of-pocket expense maximum is reached.	Following satisfaction of the annual <i>Plan Year</i> deductible, the SHBP reimburses <i>Covered Expenses</i> up to 65% of <i>Allowed Amounts</i> . The SHBP provides 100% coverage for <i>Reasonable and Customary Charges</i> for <i>Covered Expenses</i> once your annual out-of-pocket expense maximum is reached.
Annual Medical Out-of-Pocket Maximums (Including the <i>Plan Year</i> deductible, copayments, and, coinsurance) Note: Eligible charges incurred for either <i>In-Network</i> or <i>Out-of-Network Providers/Practitioners</i> will be used to satisfy the Out-of-Pocket Maximums simultaneously.	Individual: \$3,250 per <i>Covered Person</i> , per <i>Plan Year</i> (\$4,500 including prescription drugs). Family: \$8,100 (\$11,600 including prescription drugs).	Individual: \$8,750 per <i>Covered Person</i> , per <i>Plan Year</i> (including prescription drugs). Family: \$17,500 (including prescription drugs). Out-of-Network deductibles, copayments, and coinsurance count toward satisfaction of the Annual Out-of-Pocket Maximum.
Annual Prescription Drug Out-of-Pocket Maximums	\$1,250 individual \$3,500 family Refer to the Schedule of Benefits for Prescription Drugs.	Out-of-Pocket costs for Prescription Drugs (see requirements in Prescription Drugs Schedule of Benefits) count toward the Out-of-Network Annual Medical Out-of-Pocket Maximum.

MEDICAL BENEFITS	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
<p>Preventive Care Preventive care services, as specified in Section VI, Required Benefits, are covered in compliance with the Patient Protection and Affordable Care Act (PPACA) for (1) any covered services that are not available at UNH Health & Wellness or (2) for services provided when the SHBP-Covered <i>Person</i> is away from the <i>Durham Area</i> outside of the <i>Academic Year</i>. These limitations do not apply to SHBP-Covered <i>Persons</i> enrolled on the Manchester or Concord campuses of UNH or children enrolled in the SHBP.</p> <p>Certain other preventive care services are provided in addition to the mandated coverage under the PPACA. Refer to other Sections of the Schedule of Benefits for copayment and coinsurance requirements.</p>	<p>\$0 Copayment/\$0 Coinsurance.</p> <p>For SHBP-Covered <i>Persons</i>, students and spouses in the Durham campus, benefits are covered only at UNH Health & Wellness if care is received during the academic year, except as specifically provided.</p>	<p>Not Covered</p>
<p>Pediatric Dental Benefits and Pediatric Vision Benefits</p>	<p>Refer to Section VI, Required Benefits</p>	
<p>State of New Hampshire Required Benefits Under Essential Health Benefits Benchmark Plan</p>	<p>Refer to Section VI, Required Benefits</p>	
<p>Routine Newborn Care – In Hospital (Including <i>Provider/Practitioner</i> visits and circumcision)</p>	<p>85% (150 copayment per admission is waived).</p>	<p>65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).</p>
<p>Allergy Injections (If not billed with an office visit)</p>	<p>85%.</p>	<p>65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).</p>

MEDICAL BENEFITS	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Anesthesia (Inpatient/Outpatient)	85%.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).
Maternity Care for Provider/Practitioner Services (Includes prenatal care, delivery, and postpartum care)	\$0 copayment per visit. 100% coverage.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).
Second and Third Surgical Opinion	85%.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).
Surgery (Inpatient and outpatient <i>Providers</i>)	\$100 copayment per surgery, then 85% coverage thereafter.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).
Provider/Practitioner Home and Office Visits Charges Including diagnostic Lab, X-ray, and Clinic Tests that are billed by the <i>Provider/Practitioner</i> .	\$30 copayment per visit, then 100% coverage thereafter.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).
Provider/Practitioner Hospital Visits	85%.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).
Urgent Care Services	\$40 copayment per visit, then 85% coverage thereafter.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).
<p>Preadmission/Precertification for Inpatient Hospitalizations Recommended: All inpatient hospitalizations are encouraged to be precertified. There is no reduction in benefits for hospitalizations that are not precertified. Refer to Section VIII entitled Preadmission/Precertification for a more complete explanation.</p>		
Birth Center	\$150 copayment per admission, then 85% coverage thereafter.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).
Hospital Room and Board	\$250 copayment per admission, then 85% coverage thereafter of the <i>Hospital's</i> semi-private room rate and special care unit.	65% of <i>Allowed Amounts</i> of the <i>Hospital's</i> semi-private room rate and special care unit (after annual <i>Plan Year</i> deductible).
Hospital Miscellaneous Expenses	85%.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).

MEDICAL BENEFITS	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Intensive Care Unit	\$150 copayment per admission, then 85% coverage thereafter.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).
Maternity Services	\$150 copayment per admission, then 85% coverage thereafter.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).
Newborn Care – In Hospital (Including <i>Provider/Practitioner</i> visits and circumcision)	85% (\$150 copayment is waived).	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).
Organ Transplants (Limitations Apply. Refer to Section VII: Covered Medical Services , Subsection EE: Organ Transplant Benefits)	\$150 copayment per admission, then 85% coverage thereafter.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).
Surgical Facilities and Supplies	85%.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).
Clinic Services (At a <i>Hospital</i>)	\$30 copayment per visit, then 100% coverage thereafter.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).
Emergency Room Expenses – Medically Necessary (Facility, Lab, X-ray, and <i>Provider/Practitioner</i> services). Copayment/Deductible is waived if admitted.	\$100-copayment per visit, then 85% coverage thereafter.	\$100 copayment per visit, then 85% coverage thereafter.
Outpatient Hospital Departments	85%.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).
Outpatient Surgery in Hospital, Ambulatory Surgical Center, etc.	\$100 copayment per surgery, then 85% coverage thereafter.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).
Preadmission Testing	85%.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).

MENTAL HEALTH/ SUBSTANCE USE DISORDER CARE*	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Inpatient Mental Health and Substance Use Disorder (Includes <i>Provider/Practitioner</i> visits).	\$150 copayment per admission, then 85% coverage thereafter.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).
Partial Day/Intensive Outpatient Care.	100%.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).
Outpatient Mental Health and Substance Use Disorder	\$30 copayment per visit, then 100% coverage thereafter.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).
* The SHBP fully complies with federally mandated mental health benefits coverage.		

SCHEDULE OF BENEFITS

Section V

OTHER SERVICES AND SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Acupuncture	\$30 copayment per visit, then 85% coverage thereafter up to a maximum 10 visits per person, per <i>Plan Year</i> .	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).
Ambulance Services	\$100 copayment per trip, then 85% coverage thereafter.	\$100 copayment per trip, then 85% of <i>Allowed Amounts</i> (deductible waived).
Cardiac Rehabilitation Treatment must be completed within six months of the cardiac diagnosis or procedure.	\$30 copayment per visit, then 85%.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).
Habilitative Services Early Intervention Developmental Delays Autism Spectrum Disorders (include Applied Behavioral Analysis (ABA))	85%. 85%. 85%.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible). 65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible). 65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).
Chemotherapy and Radiation Therapy	85%.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).
Physical Therapy Services (Precertification recommended) Physical Therapy services are subject to a maximum benefit of 20 visits per <i>Plan Year</i> .	\$30 copayment per visit, then 85% coverage thereafter.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).
Chiropractic Services Chiropractic services are subject to a maximum benefit of 12 visits per <i>Plan Year</i> .	\$30 copayment per visit, then 85% coverage thereafter.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).

OTHER SERVICES AND SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
<p>Dental Care (Limited to treatment of <i>Injury</i> to sound natural teeth)</p> <p>Refer also to Section VI, Required Benefits, for Pediatric Dental Benefits.</p>	85%.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).
Diabetes Self-Management Education and Training	\$30 copayment per visit, then 85% thereafter.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).
Diagnostic X-ray, Lab and Other Clinical Tests	85%.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).
Diagnostic Imaging (e.g., PET, CAT, DEXA, MRI scans, and ultrasound)	\$100 copayment per procedure, then 85% coverage thereafter.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible)
<p>Hearing Aids</p> <p>Limited to 1 hearing aid each time prescription changes.</p>	85% (after Deductible waived)	65% Allowed Amount (after annual <i>Plan Year</i> deductible)
Hemodialysis	85%.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).
<p>Home Health Care</p> <p>(Precertification recommended)</p>	85%.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).
<p>Home Hospice Care</p> <p>(Precertification recommended)</p>	85%.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).
<p>Durable Medical Equipment</p> <p>(Precertification recommended for equipment rental in excess of three (3) months, TENS units, and equipment in excess of \$1,000; see Medical Benefits section for other limitations)</p>	85%.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).

SCHEDULE OF BENEFITS

Section V

OTHER SERVICES AND SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Elective Termination of Pregnancy	85%.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).
Metabolic Formula and Special Modified Low Protein Food Products	85%;	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible)
Occupational Therapy (Precertification recommended)	\$30 copayment per visit, then 85% coverage thereafter.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).
Private Duty Nursing	85%.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).
Skilled Nursing/Extended Care/Rehabilitation Facility	85%.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).
Speech Therapy (Precertification recommended)	\$30 copayment per visit, then 85% coverage thereafter.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).
Temporomandibular Joint Disorders (TMJ) –	85%.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).
Wigs (when hair loss is due to cancer, a medical condition, or <i>Injury</i>)	85%.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).
Infertility Treatment	85%.	65% of <i>Allowed Amounts</i> (after annual <i>Plan Year</i> deductible).
Repatriation Return of <i>Covered Person’s</i> mortal remains to home country or permanent home residence.	100% percent coverage of actual charges up to a maximum benefit of \$10,000. Transportation arrangements must be coordinated and approved by Travel Guard.	

OTHER SERVICES AND SUPPLIES	IN-NETWORK PROVIDERS
<p>Emergency Medical Evacuation</p> <p>Return of Covered Person to home country or permanent residence.</p>	<p>100% coverage of <i>Allowed Amounts</i> for <i>Medically Necessary</i> transportation to return student to his or her home country or permanent residence.</p> <p>Transportation arrangements must be coordinated and approved by Travel Guard.</p>

*These are combined maximums for *In-Network Providers* and *Out-of-Network Providers*.

Preventive Care Benefits are provided by the SHBP when care is received at the UNH Health & Wellness facility in full compliance with the terms prescribed by the regulations issued under the Patient Protection and Affordable Care Act (PPACA) of 2010, as may be amended from time to time, if the service or supply is available at UNH Health & Wellness. This limitation does not apply for services received at *In-Network Providers* if:

- the PPACA Preventive Care mandated service or supply is not provided by UNH Health & Wellness; or
- the *Student* receives the service or supply outside of the *Durham Area* outside of the academic year; *or*
- the *SHBP-Covered Person* is not eligible to obtain the service or supply from the UNH Health & Wellness facility.

PPACA Preventive Care Benefits are provided at 100% percent reimbursement as specified in the Schedule of Benefits for services received at UNH Health & Wellness and services received at *In-Network Providers* as specified in this Section.

The SHBP also provides certain preventive care benefits and services that exceed requirements of the PPACA; these benefits and services are provided in the Section entitled Covered Medical Services and are provided pursuant to the Schedule of Benefits.

[PPACA Preventive Care Benefits](#) are subject to change, pursuant to determinations by the U.S. Department of Health and Human Services and the [U.S. Preventive Services Task Force](#). **Specific services may be covered based on the recommended frequency, age and gender. For additional detail about the coverage levels, please go to www.HealthCare.gov or refer to the SHBP website for updates.**

A. Covered Preventive Services for Adults (age 19 or over)

- Abdominal aortic aneurysm one-time screening for men of specified ages who have ever smoked.
- Alcohol misuse screening and counseling.
- Aspirin use for men and women of certain ages.
- Blood pressure screening for all adults.
- Cholesterol screening for adults of certain ages or at higher risk.
- Colorectal cancer screening for adults over age 50.
- Depression screening for adults.
- Type 2 diabetes screening for adults with high blood pressure.
- Falls prevention in older adults
- Diet counseling for adults at higher risk for chronic disease.
- HIV screening for all adults at higher risk.
- Immunization vaccines for adults (doses, recommended ages, and recommended populations vary):
 - covid
 - hepatitis a

- hepatitis b
 - herpes zoster
 - human papillomavirus
 - influenza (flu shot)
 - measles, mumps, rubella
 - meningococcal
 - pneumococcal
 - tetanus, diphtheria, pertussis
 - varicella
- Lung cancer screening
 - Obesity screening and counseling for all adults
 - Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
 - Statin preventive medication for adults 40 to 75 at high risk
 - Syphilis screening for all adults at higher risk
 - Tobacco use screening for all adults and cessation interventions for tobacco users
 - Tuberculosis screening for certain adults without symptoms at high risk

B. Covered Preventive Services for Women, Including Pregnant Women

- Anemia screening on a routine basis for pregnant women.
- Bacteriuria urinary tract or other infection screening for pregnant women.
- BRCA risk assessment and genetic counseling/testing for women at higher risk.
- Breast cancer preventive medications.
- Breast cancer mammography screenings every 1 to 2 years for women over 40 years.
- Breast cancer chemoprevention counseling for women at higher risk.
- Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women.
- Cervical cancer screening for sexually active women.
- Chlamydia infection screening for younger women and other women at higher risk.
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs.
- Domestic and interpersonal violence screening and counseling for all women.
- Folic acid supplements for women who may become pregnant.
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes.
- Gonorrhea screening for all women at higher risk.
- Hepatitis B screening for pregnant women at their first prenatal visit.
- Preeclampsia prevention and screening for pregnant women with high blood pressure.
- Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women.
- Human papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are age 30 or older.

- Osteoporosis screening for women over age 60 depending on risk factors.
- Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk.
- Tobacco screening and interventions for all women and expanded counseling for pregnant tobacco users.
- Sexually transmitted infections (STI) counseling for sexually active women.
- Syphilis screening for all pregnant women or other women at increased risk.
- Well-woman visits to obtain recommended preventive services for women under age 65.

C. Covered Preventive Services for Children

- Alcohol and Drug Claims Administrator assessments for adolescents.
- Autism screening for children at 18 and 24 months.
- Behavioral assessments for children of all ages (up to age 18).
- Bilirubin concentration screening for newborns.
- Blood Pressure screening for children (up to age 18).
- Cervical Dysplasia screening for sexually active females.
- Congenital screening for newborns.
- Depression screening for adolescents.
- Developmental screening for children under age 3, and surveillance throughout childhood.
- Dyslipidemia screening for children at higher risk of lipid disorders (up to age 18).
- Fluoride chemoprevention supplements for children without fluoride in their water source.
- Fluoride varnish for all infants and children as soon as teeth are present.
- Gonorrhea preventive medication for the eyes of all newborns.
- Hearing screening for all newborns.
- Height, weight and body mass index measurements for children.
(ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years)
- Hematocrit or hemoglobin screening for children.
- Hemoglobinopathies or sickle cell screening for newborns.
- HIV screening for adolescents at higher risk.
- Immunization vaccines for children from birth to age 18 (doses, recommended ages, and recommended populations vary) including:
 - covid
 - diphtheria, tetanus, pertussis
 - haemophilus influenzae type b
 - hepatitis a
 - hepatitis b
 - human papillomavirus
 - inactivated poliovirus
 - influenza (flu shot)
 - measles, mumps, rubella

- meningococcal
 - pneumococcal
 - rotavirus
 - varicella
- Iron supplements for children ages 6 to 12 months at risk for anemia.
 - Lead screening for children at risk of exposure.
 - Medical history for all children throughout development. (ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years)
 - Obesity screening and counseling.
 - Oral health risk assessment for young children (ages: 0 to 11 months, 1 to 4 years, 5 to 10 years).
 - Phenylketonuria (PKU) screening for this genetic disorder in newborns.
 - Sexually transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk.
 - Skin cancer behavioral counseling.
 - Tobacco use counseling and interventions for those who use tobacco products and to prevent use of tobacco products.
 - Tuberculin testing for children at higher risk of tuberculosis (ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, and 15 to 17 years).
 - Vision screening for all children.

D. Additional Preventive Care Services/Benefits

- Hepatitis B screening: nonpregnant adolescents and adults, which is required by the USPSTF;
- Hepatitis B screening: pregnant women, which is required by the USPSTF;
- Hepatitis C virus infection screening: adults, which is required by the USPSTF;
- Preeclampsia prevention: aspirin, which is required by the USPSTF;
- Haemophilus influenza type b
- Critical Congenital Heart Defect Screening for newborn, which is required by HRSA.

E. Pediatric Dental Benefits

The dental benefits described in this dental plan are limited to *Covered Persons* who are under age 19 (from birth through age 18). No benefits are provided for a *Covered Person* who is age 19 or older.

Dental services for children under the age of six who have a dental condition of significant complexity for which *Medically Necessary Hospital* or surgical day care facility services, including administration of general anesthesia are covered by the SHBP. Refer also to Dental Injury and Dental Care Services.

Annual Deductible: \$0

REQUIRED BENEFITS

Section VI

Your deductible each plan year: \$0

Your out-of-pocket maximum each *Plan Year*: \$1,000

Group 1— Preventive Services and Diagnostic Services		Schedule of Benefits
Oral Exams	<ul style="list-style-type: none"> • One complete initial oral exam per provider or location (includes initial history and charting of teeth and supporting structures). • Periodic or routine oral exams; twice in 12 months. • Oral exams for a member under age three; twice in 12 months. • Limited oral exams; twice in 12 months. 	100% (no <i>Deductibles, Copayments, or Coinsurance</i>)
X-rays	<ul style="list-style-type: none"> • Single tooth x-rays; no more than one per visit. • Bitewing x-rays; twice in 12 months. • Full mouth x-rays; once in 36 months per provider or location. • Panoramic x-rays; once in 36 months per provider or location. 	
Routine Dental Care	<ul style="list-style-type: none"> • Routine cleaning, minor scaling, and polishing of the teeth; twice in 12 months. • Fluoride treatments; once per calendar quarter. • Sealants; once per tooth in three years per provider or location (sealants over restored tooth surfaces not covered). • Space maintainers. 	
Group 2—Basic Restorative Services		Schedule of Benefits
Fillings	<ul style="list-style-type: none"> • Amalgam (silver) fillings; one filling per tooth surface in 12 months. • Composite resin (white) fillings; one filling per tooth surface in 12 months (for primary, back teeth, payment for a composite filling will not be more than the amount 	80% <i>Coinsurance</i> .

	allowed for an amalgam filling).
Root Canal Treatment	<ul style="list-style-type: none"> • Root canals on permanent teeth; once per tooth. • Vital pulpotomy. • Retreatment of prior root canal on permanent teeth; • Root end surgery on permanent teeth; once per tooth.
Crowns (see also Group 3)	<ul style="list-style-type: none"> • Prefabricated stainless steel crowns; once per tooth (primary and permanent)
Gum treatment	<ul style="list-style-type: none"> • Periodontal scaling and root planing; once per quadrant in 36 months • Periodontal surgery; once per quadrant in 36 months
Prosthetic maintenance	<ul style="list-style-type: none"> • Repair of partial or complete dentures and bridges; once in 12 months • Reline or rebase partial or complete dentures; once in 24 months • Recementing of crowns, inlays, onlays, and fixed bridgework; once per tooth
Oral surgery	<ul style="list-style-type: none"> • Simple tooth extractions; once per tooth • Erupted or exposed root removal; once per tooth • Surgical extractions; once per tooth (approval required for complete, boney impactions) • Other necessary oral surgery

Pediatric dental benefits include:

CLASS A – BASIC

Diagnostic and Treatment Services

- D0220 Intraoral – periapical first film;
- D0230 Intraoral – periapical – each additional film;
- D0240 Intraoral – occlusal film;
- D0340 Cephalometric x-ray;
- D0350 Oral / Facial Photographic Images;
- D0470 Diagnostic Models;

Preventative Services

D1352 Preventative resin restorations in a moderate to high caries risk patient – permanent tooth – 1 sealant per tooth every 36 months;

D1550 Re-cementation of space maintainer – Limited to children under age 19; Additional Procedures covered as Basic Services;

D9110 Palliative treatment of dental pain – minor procedure;

CLASS B INTERMEDIATEMinor Restorative Services

D2940 Protective Restoration;

D2951 Pin retention – per tooth, in addition to restoration; Periodontal Services;

D4910 Periodontal maintenance – 4 in 12 months combined with adult prophylaxis after the completion of active periodontal therapy;

Prosthodontic Services

D5410 Adjust complete denture – maxillary;

D5411 Adjust complete denture – mandibular;

D5421 Adjust partial denture – maxillary;

D5422 Adjust partial denture – mandibular;

D5520 Replace missing or broken teeth – complete denture (each tooth);

D5620 Repair cast framework;

D5630 Repair or replace broken clasp;

D5640 Replace broken teeth – per tooth;

D5650 Add tooth to existing partial denture;

D5660 Add clasp to existing partial denture;

D5850 Tissue conditioning (maxillary);

D5851 Tissue conditioning (mandibular);

Oral Surgery

D7251 Coronectomy – intentional partial tooth removal;

D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth;

D7280 Surgical access of an unerupted tooth;

D7310 Alveoloplasty in conjunction with extractions – per quadrant;

D7311 Alveoloplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant;

D7320 Alveoloplasty not in conjunction with extractions – per quadrant;

D7321 Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant;

D7471 Removal of exostosis;

D7510 Incision and drainage of abscess – intraoral soft tissue;

D7910 Suture of recent small wounds up to 5 cm;

D7971 Excision of pericoronal gingiva;

CLASS C MAJORMajor Restorative Services

D2510 Inlay – metallic – one surface – An alternate benefit will be provided;
D2520 Inlay – metallic – two surfaces – An alternate benefit will be provided;
D2530 Inlay – metallic – three surfaces – An alternate benefit will be provided;
D2542 Onlay – metallic – two surfaces – Limited to 1 per tooth every 60 months;
D2543 Onlay – metallic – three surfaces – Limited to 1 per tooth every 60 months;
D2544 Onlay – metallic – four or more surfaces – Limited to 1 per tooth every 60 months;
D2780 Crown – 3/4 cast high noble metal – Limited to 1 per tooth every 60 months;
D2781 Crown – 3/4 cast predominately base metal – Limited to 1 per tooth every 60 months;
D2790 Crown – full cast high noble metal– Limited to 1 per tooth every 60 months;
D2791 Crown – full cast predominately base metal – Limited to 1 per tooth every 60 months;
D2792 Crown – full cast noble metal– Limited to 1 per tooth every 60 months;
D2794 Crown – titanium– Limited to 1 per tooth every 60 months;
D2950 Core buildup, including any pins– Limited to 1 per tooth every 60 months;
D2954 Prefabricated post and core, in addition to crown– Limited to 1 per tooth every 60 months;
D2980 Crown repair, by report;

Endodontic Services

D3346 Retreatment of previous root canal therapy-anterior,
D3347 Retreatment of previous root canal therapy-bicuspid,
D3348 Retreatment of previous root canal therapy-molar
D3351 Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.);
D3352 Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.);
D3353 Apexification/recalcification – final visit (includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption, etc.);
D3354 Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration;
D3410 Apicoectomy/periradicular surgery – anterior;
D3421 Apicoectomy/periradicular surgery – bicuspid (first root);
D3425 Apicoectomy/periradicular surgery – molar (first root);
D3426 Apicoectomy/periradicular surgery (each additional root);
D3450 Root amputation – per root;
D3920 Hemisection (including any root removal) – not including root canal therapy;

Periodontal Services

D4210 Gingivectomy or gingivoplasty – four or more teeth – Limited to 1 every 36 months;
D4211 Gingivectomy or gingivoplasty – one to three teeth;
D4240 Gingival flap procedure, four or more teeth – Limited to 1 every 36 months; D4249
Clinical crown lengthening-hard tissue;
D4260 Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant – Limited to 1 every 36 months;

D4270 Pedicle soft tissue graft procedure;
D4271 Free soft tissue graft procedure (including donor site surgery);
D4273 Subepithelial connective tissue graft procedures (including donor site surgery);
D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis – Limited to 1 per lifetime;

Prosthodontic Services

D5110 Complete denture – maxillary – Limited to 1 every 60 months;
D5120 Complete denture – mandibular – Limited to 1 every 60 months;
D5130 Immediate denture – maxillary – Limited to 1 every 60 months;
D5140 Immediate denture – mandibular – Limited to 1 every 60 months;
D5211 Maxillary partial denture – resin base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months;
D5212 Mandibular partial denture – resin base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months;
D5213 Maxillary partial denture – cast metal framework with resin denture base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months;
D5214 Mandibular partial denture – cast metal framework with resin denture base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months;
D5281 Removable unilateral partial denture-one-piece cast metal (including clasps and teeth) – Limited to 1 every 60 months; age 8 to 19
D6010 Endosteal Implant – 1 every 60 months;
D6012 Surgical Placement of Interim Implant Body – 1 every 60 months;
D6040 Eposteal Implant – 1 every 60 months;
D6050 Transosteal Implant, Including Hardware – 1 every 60 months;
D6053 Implant supported complete denture;
D6054 Implant supported partial denture;
D6055 Connecting Bar – implant or abutment supported – 1 every 60 months;
D6056 Prefabricated Abutment – 1 every 60 months;
D6062 Abutment supported cast high noble metal crown – 1 every 60 months;
D6063 Abutment supported cast predominately base metal crown – 1 every 60 months;
D6064 Abutment supported cast noble metal crown – 1 every 60 months;
D6067 Implant supported metal crown – 1 every 60 months;
D6080 Implant Maintenance Procedures -1 every 60 months;
D6090 Repair Implant Prosthesis -1 every 60 months;
D6091 Replacement of Semi-Precision or Precision Attachment -1 every 60 months;
D6095 Repair Implant Abutment -1 every 60 months;
D6100 Implant Removal -1 every 60 months;
D6190 Implant Index -1 every 60 months;
D6210 Pontic – cast high noble metal – Limited to 1 every 60 months;
D6211 Pontic – cast predominately base metal – Limited to 1 every 60 months;
D6212 Pontic – cast noble metal– Limited to 1 every 60 months;
D6214 Pontic – titanium – Limited to 1 every 60 months;
D6240 Pontic – porcelain fused to high noble metal – Limited to 1 every 60 months;
D6241 Pontic – porcelain fused to predominately base metal – Limited to 1 every 60 months;
D6242 Pontic – porcelain fused to noble metal – Limited to 1 every 60 months;

D6245 Pontic – porcelain/ceramic – Limited to 1 every 60 months;
D6519 Inlay/onlay – porcelain/ceramic – Limited to 1 every 60 months;
D6520 Inlay – metallic – two surfaces – Limited to 1 every 60 months;
D6530 Inlay – metallic – three or more surfaces – Limited to 1 every 60 months;
D6543 Onlay – metallic – three surfaces – 1 every 60 months;
D6544 Onlay – metallic – four or more surfaces -1 every 60 months;
D6780 Crown – 3/4 cast high noble metal – 1 every 60 months;
D6781 Crown – 3/4 cast predominately base metal – 1 every 60 months;
D6782 Crown – 3/4 cast noble metal – 1 every 60 months;
D6790 Crown – full cast high noble metal – 1 every 60 months;
D6791 Crown – full cast predominately base metal – 1 every 60 months;
D6792 Crown – full cast noble metal – 1 every 60 months; and,
D6973 Core buildup for retainer, including any pins – 1 every 60 months

Group 3—Major Restorative Services		Schedule of Benefits
Crowns	<ul style="list-style-type: none"> • Resin crowns; once per tooth in 60 months • Porcelain/ceramic crowns; once per tooth in 60 months • Porcelain fused to metal/high noble crowns; once per tooth in 60 months 	80% <i>Coinsurance</i>
Tooth replacement	<ul style="list-style-type: none"> • Removable complete or partial dentures, including services to fabricate, measure, fit, and adjust them; once every 60 months • Fixed prosthetics, only if there is no other less expensive adequate dental service; once in 60 months 	
Other necessary services	<ul style="list-style-type: none"> • Occlusal guards when necessary; once in calendar year • Fabrication of an athletic mouth guard 	
Orthodontic Services		Schedule of Benefits
Medically necessary orthodontic care that has been preauthorized for a qualified <i>member</i>	Braces for a <i>member</i> who has a severe and handicapping malocclusion Related orthodontic services for a <i>member</i> who qualifies	80% <i>Coinsurance</i>

F. Pediatric Vision Benefits

One visit per plan year for routine vision exam, including refraction and glaucoma testing, covered at 100%. 100% coverage for either prescription lenses and frames or contact lenses, but not both. This coverage is limited one (1) benefit per *Plan Year*.

This benefit includes a choice of plastic or glass lenses, single, bifocal, trifocal, lenticular, fashion and gradient tinting, oversized glass-grey #3 prescription sunglass lenses, polycarbonate prescription lenses with scratch resistance coating, low vision items and *Medically Necessary* contact lenses for the conditions of keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, and irregular astigmatism.

G. State of New Hampshire Benefits/Mandates

The SHBP provides benefits that are specified by either specific mandates that are applicable to individual health insurance or required under the State of New Hampshire’s Essential Health Benefits Benchmark Plan (including prescription drug formulary).

The following are specific mandates for coverage that apply to the SHBP (Note: some mandates are duplicative of coverage required by the Patient Protection and Affordable Care Act or other federal statutes and regulations).

Benefit	Coverage Requirements or Stipulations
Bariatric Surgery	Obesity & <i>Morbid Obesity</i> / Bariatric Surgery
Prenatal and Postnatal Care	Newborn Children Covered from Birth
Delivery and All Inpatient Services for Maternity Care	Pregnancy, Delivery and Postpartum Coverage
Mental/Behavioral Health Outpatient Services	Coverage for Mental or Nervous Conditions and Treatment for Chemical Dependency Required
Mental/Behavioral Health Outpatient Services	Coverage for Mental Illnesses
Mental/Behavioral Health Inpatient Services	Coverage for Mental Illnesses
Substance Use Disorder Outpatient Services	Coverage for Mental or Nervous Conditions and Treatment for Chemical Dependency Required
Substance Use Disorder Inpatient Services	Coverage for Mental or Nervous Conditions and Treatment for Chemical Dependency Required
<i>Habilitation Services</i>	Coverage for Treatment of Pervasive Developmental Disorder or Autism
Durable Medical Equipment	Artificial Limb Coverage
Durable Medical Equipment	Scalp Hair Protheses
Preventive Care/Screening/Immunization	Mammography, BRCA Testing & for Testing for Occult Breast Cancer
Bone Marrow Transplant	Bone marrow testing
Reconstructive Surgery	Reconstruction Surgery as a Result of Mastectomy
Clinical Trials	Coverage for Preventive Care Services received as part of Qualified Clinical Trials
Dental Anesthesia	Coverage for Dental Procedures: Medical or Hospital Group
Diabetes Care Management	DIABETES - Diabetes Services and Supplies
Early Intervention Services	CHILDREN - Early Intervention Therapy Services for Children
Inherited Metabolic Disorder - PKU	CHILDREN - Nonprescription Enteral Formulas
Off Label Prescription Drugs	Off-Label Prescription Drugs

A. Hospital Charges

Room and board and other professional services on an inpatient or outpatient basis are covered, including:

- (1) *Preadmission Tests* on an outpatient basis for a scheduled *Hospital* admission or surgery provided the tests are done within seven (7) days of the planned admission, and the surgery and the tests are accepted by the *Hospital* in place of the same post-admission tests;
- (2) *Hospital* charges for room and board in a semiprivate room, *Intensive Care Unit*, cardiac care unit, or burn care unit, but excluding charges for a private room (unless *Medically Necessary*) which are in excess of the *Hospital's* semiprivate room rate (charges made by a *Hospital* having only private rooms will be considered at 80% of the private room rate [i.e., 20% of the charge for private room will be excluded before benefits are determined]);
- (3) *Routine Nursery Care* (including circumcision and *Provider/Practitioner* visits) while confined, even though no sickness or *Injury* exists;
- (4) *Hospital* charges for necessary medical supplies and services, including X-rays, laboratory, and anesthetics and the administration thereof;
- (5) *Hospital* charges for drugs and medicines obtained through written prescription by a *Provider/Practitioner*;
- (6) outpatient surgical services performed at a *Provider's/Practitioner's* office, *Ambulatory Surgical Center*, the outpatient department of a *Hospital*, *Birthing Center* or *Freestanding Health Clinic*;
- (7) *Birthing Center* or *Freestanding Health Clinic* (Payment will be limited to the amount that would have been paid if that person were in a *Hospital*.);
- (8) radiation, chemotherapy, or hemodialysis (renal therapy) at a *Medicare*-approved dialysis center;
- (9) administration of infusions and transfusions (this includes the cost of unreplaced blood and blood plasma or autologous blood and blood plasma: expenses for storage of autologous blood or blood plasma will not be covered);
 1. inpatient respiratory, physical, occupational, inhalation, speech, and cardiac rehabilitation therapy;
 2. emergency room; and
 3. outpatient department.

Day treatment/inpatient confinement in a licensed general Hospital, in a mental Hospital under the direction and supervision of the Department of Mental Health, or in a private mental Hospital licensed by the Department of Mental Health, or confinement in a public or private Alcoholism/Substance Addiction/Substance Use Disorder facility, for the treatment of a Mental or Nervous Disorder or Substance Use Disorder.

B. Skilled Nursing/Extended Care Facilities

Inpatient confinement in a *Skilled Nursing/extended care facility* and/or in a *rehabilitation facility/Hospital* is covered if:

- (1) charges are incurred within fourteen (14) days following a *Hospital* confinement; and
- (2) the attending Provider/Practitioner certifies that 24-hour nursing care is Medically Necessary for recuperation from the Illness or Injury which required the *Hospital* confinement.

C. Ambulance Services

Ambulance services are covered provided the conveyance is:

- (1) to the nearest *Hospital* or medical facility which is equipped to provide the service required;
- (2) from a *Hospital* when Medically Necessary, or
- (3) an air ambulance or rail transportation when it is:
- (4) required because the life of the patient would be endangered through the use of any other form of transportation; and
- (5) used to transport the patient to the nearest medical facility equipped to provide care.

D. Diagnostic X-ray and Laboratory Services

Charges incurred for X-rays, microscopic tests, laboratory tests, allergy testing, allergy injections, electrocardiograms, electroencephalograms, pneumoencephalograms, and basal metabolism tests, or similar well-established diagnostic tests generally approved and performed by *Providers/Practitioners* throughout the United States.

E. Diagnostic Imaging and Scans

Charges incurred for diagnostic imaging and general imaging, including but not limited to, ultrasounds, MRI/MRA, CT/CAT and PET scans, and nuclear medicine.

F. Emergency Facilities

Charges incurred for *Medically Necessary* care for *Emergency Medical Services* at an emergency treatment center, walk-in medical clinic, or ambulatory clinic (including clinics located at a *Hospital*).

G. Provider/Practitioner Services

Charges made by *Providers/Practitioners* for medical care and/or treatment including office visits, home visits, diagnostic eye exam, *Hospital* inpatient care, *Hospital* outpatient visits/exams, and clinic care.

H. Second and Third Surgical Opinions

Charges incurred for a second surgical opinion, and, in some instances, a third opinion, provided:

- (1) fees of a *Provider/Practitioner* for a second surgical consultation when non-Emergency or elective surgery is recommended by the Covered Person's attending *Provider/Practitioner* (the *Provider/Practitioner* rendering the second opinion regarding the Medical Necessity of such surgery must be qualified to render such a service, either through experience, specialization training, education, or similar criteria, and must not be affiliated in any way with the *Provider/Practitioner* who will be performing the actual surgery); and
- (2) fees of a legally-qualified *Provider/Practitioner* for a third consultation, if the second opinion obtained does not concur with the first *Provider's/Practitioner's* recommendation (this third *Provider/Practitioner* must be qualified to render such a service and must not be affiliated in any way with the consulting *Provider/Practitioner* or with the *Provider/Practitioner* who will be performing the actual surgery).

I. Anesthesia Services

Charges by a *Provider/Practitioner* incurred for a surgical operation and for the administration of anesthesia.

J. Multiple Surgical Procedures

If two or more surgical procedures are performed at one time through the same incision in the same operative field, the maximum allowable amount for the surgery will be either the *Contracted Rate* amount for the primary procedure and 50% *Contracted Rate* of the amount for the or lesser procedure(s), or if not in the network, the *Allowed Amount* for the major procedure and 50% of the *Allowed Amount* for the secondary or lesser procedure(s). No additional benefit will be paid under the SHBP for incidental surgery done at the same time and under the same anesthetic as another surgery.

K. Assistant Surgeons

Surgical assistant charges when the nature of the procedure is such that the services of an assistant, who is a *Provider/Practitioner*, are *Medically Necessary*.

L. Dental Injury and Dental Care Services

The following dental procedures, including related *Hospital* expenses (when deemed to be *Medically Necessary*), will be covered the same as any other *Illness*:

- (1) treatment of an *Injury* to a sound natural tooth, other than from eating or chewing, including replacement of teeth and any related X-rays.
- (2) dental services for children under the age of six who have a dental condition of significant complexity, or for *Covered Persons* who have exceptional medical circumstances or developmental disabilities for which *Medically Necessary Hospital* or surgical day care facility services, including administration of general anesthesia, are required, except as defined under Medical Benefit Exclusions.
- (3) treatment made necessary due to injury to the jaw and oral structures other than teeth shall be covered without time limit. Coverage shall be subject to other terms and conditions of the policy.

Dental services for children under the age of six who have a dental condition of significant complexity, or for *Covered Persons* who have exceptional medical circumstances or developmental disabilities, for which *Medically Necessary Hospital* or surgical day care facility services, including administration of general anesthesia are covered by the SHBP.

M. Cosmetic Surgery

Charges for cosmetic purposes or for cosmetic surgery if required due solely as the result of:

- (1) an *Accidental* bodily *Injury*, providing that coverage is in effect at the time that the *Injury* and treatment occur;
- (2) a birth defect of a covered person;
- (3) need for restoration of a functional body part, surgery to restore or improve a bodily function, as well as coverage for mastectomy for gynecomastia, port wine stain removal, as well as mandibular/maxillary orthognathic surgery; or
- (4) surgical removal of diseased tissue as a result of an *Illness*. *Covered Persons* electing breast reconstruction, following a mastectomy, are also covered for reconstruction of the other breast to produce symmetrical appearance, and coverage for prostheses and physical complications of all stages of a mastectomy

(the reconstruction procedure will be performed in a manner determined between the *Providers/Practitioners* and the patient).

N. Miscellaneous Surgical Procedures

Charges for surgical procedures including circumcision and termination of pregnancy. Amniocentesis is included if deemed *Medically Necessary*. No benefits will be payable if amniocentesis is performed only to determine the sex of an infant before birth and for women under age thirty-five (35) unless certified as *Medically Necessary* by a *Provider/Practitioner*.

O. Mental or Nervous Disorders or Substance Use Disorders

The SHBP fully complies with federally mandated mental health benefits coverage.

Charges for the treatment of *Mental or Nervous Disorders* and charges for the treatment of *Substance Use Disorder* are covered on the same basis as any other medical condition. Services must be furnished by:

- (1) a comprehensive health service organization;
- (2) a licensed or accredited *Hospital*;
- (3) a community mental health center, or other mental health clinic or day care center which furnishes mental health services, subject to the approval of the Department of Mental Health;
- (4) a licensed detoxification facility;
- (5) a licensed social worker; or
- (6) a psychiatrist.

P. Chiropractic Care

Charges made by a licensed chiropractor.

Q. Podiatry Services

Charges incurred for *Medically Necessary* treatment of the feet, including treatment of metabolic or peripheral vascular disease.

R. Nursing Services

Services by a private duty nurse are eligible expenses (24-hour private duty nursing care is not a *Covered Expense*) when furnished by a Registered Nurse (R.N.), or Licensed Practical Nurse (L.P.N.), for necessary nursing care as evidenced by a written statement

from the attending *Provider/Practitioner*, providing that the nurse is not an immediate member of the *Covered Person's* family and does not reside in the *Covered Person's* home. Charges billed by a Visiting Nurse Association for such services are included.

S. Diabetic Care

Charges incurred for ambulatory diabetic self-management training and education, including:

- (1) medical nutrition therapy, used to diagnose or treat insulin dependent diabetes, non-insulin dependent diabetes, or gestational diabetes; and
- (2) approved self-management education training as well as professional instructions, excluding printed material.

T. Home Health Care Services

Charges made by a *Home Health Care Agency* for care in accordance with a *Home Health Plan*. Such expenses include charges for:

- (1) part-time or intermittent nursing care rendered by a Registered Nurse (R.N.);
- (2) a Licensed Practical Nurse (L.P.N.), a vocational nurse, or a public health nurse who is under the direct supervision of a Registered Nurse;
- (3) *Home Health* aides; and
- (4) medical supplies, drugs, and medications prescribed by a *Provider/Practitioner* and laboratory services by, or on behalf of, a *Hospital* to the extent that such items would have been covered by the SHBP had the *Covered Person* remained in the *Hospital*.

Home Health care means a visit by a member of a *Home Health* care team. Each such visit that lasts for a period of 4 hours or less is treated as one (1) visit. No benefits will be provided for services and supplies not included in the *Home Health Plan*, such as transportation services, *Custodial Care* and housekeeping, or for services of a person who ordinarily resides in the home of the *Covered Person* or is a close relative of the *Covered Person*.

U. Outpatient Rehabilitation Services

Charges incurred for outpatient rehabilitative therapy services include the following expenses.

- (1) Charges incurred for the treatment or services rendered by a physical therapist under direct supervision of a *Provider/Practitioner* in a home setting, at a facility

or institution whose primary purpose is to provide medical care for an *Illness* or *Injury*, at a *Freestanding Health Clinic*, or at a duly-licensed outpatient therapy.

- (2) Charges incurred for inhalation therapy under the direct supervision of a *Provider/Practitioner* in a home setting, at a facility or institution whose primary purpose is to provide medical care for an *Illness* or *Injury*, or at a freestanding duly-licensed outpatient therapy facility.
- (3) Charges incurred for the treatment and services rendered by a registered occupational therapist to restore physical function and provided under the direct supervision of a physician in a home setting, at a facility or institution whose primary purpose is to provide medical care for an *Illness* or *Injury*, or at a freestanding duly-licensed outpatient therapy facility.
- (4) Charges incurred for the services of a speech therapist under the direct supervision of a physician for restorative or rehabilitative speech therapy due to speech loss or impairment or due to surgery performed on account of an *Illness* or *Injury*. If speech loss is due to a *Congenital* anomaly, surgery to correct the anomaly must have been performed prior to therapy.
- (5) Charges incurred for cardiac rehabilitation program, provided such treatment is recommended by the attending *Provider/Practitioner*. Phase I consists of acute inpatient hospitalization, whether for heart attack or heart surgery, which is highly supervised and with a tailored exercise program with continuous monitoring during exercise. Phase II consists of outpatient supervised treatment for *Covered Persons* who have left the *Hospital* but still need a certain degree of supervised physical therapy and monitoring during exercise. Phase II services are usually tailored to meet the *Covered Person's* individual needs. Benefits are payable for Phase III, which consists of outpatient services without supervision. The Phase III program is developed for patients who are well enough to continue exercising on their own while monitoring their own progress. Benefits are payable for Phase IV cardiac rehabilitation.

V. Pregnancy Care

Expenses relating to pregnancy and birthing are covered according to the following schedule.

- (1) Prenatal care of the mother and/or fetus is treated as any other *Illness* or *Injury* covered under the SHBP.
- (2) Inpatient care for the mother and/or newborn child will be provided for a minimum of 48 hours following a vaginal delivery, or a minimum of 96 hours following a cesarean section. However, the mother's or newborn's attending health care *Provider/Practitioner*, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

- (3) No authorization from the SHBP need be sought by the attending *Provider/Practitioner* for prescribing a length of inpatient stay for the mother or newborn not in excess of 48 hours (or 96 hours, as applicable). In any case, the 48- or 96-hour limit may be exceeded with authorization of the Claim Administrator in cases of *Medical Necessity*.

W. Mastectomy Care

For individuals receiving mastectomy-related benefits, coverage will be provided in a manner to be determined in consultation with the attending *Provider/Practitioner* and the patient, for:

- (1) all stages of reconstruction of the breast on which the mastectomy was or is to be performed;
- (2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
- (3) prostheses; and
- (4) treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductible, coinsurance, and/or copayments applicable to other medical and surgical benefits provided under the SHBP.

X. Miscellaneous Medical Services and Supplies

- (1) Charges for expendable supplies including, but not limited to, prescription drugs, medicines, oral contraceptives, contraceptive devices and Depo Provera[®] injections, insulin, surgical bandages, syringes, dressings, surgical supports, head halters, colostomy bags, catheters, crutches, splints, casts, trusses, traction apparatus, and cervical collars.
- (2) Charges for oxygen and other gasses and their administration.
- (3) Charges for prosthetics, which are artificial substitutes for body parts for functional or therapeutic purposes, when they are *Medically Necessary* for activities of daily living.

Benefits include the purchase, fitting, adjustments, repairs and replacements.

Covered Services may include, but are not limited to:

- (a) Artificial limbs and accessories. Artificial limbs are prosthetic devices that replace, in whole or in part, an arm or leg;
- (b) One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes);
- (c) Breast prosthesis (whether internal or external) after a mastectomy, as required by the Women's Health and Cancer Rights Act.

- (d) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- (e) Restoration prosthesis (composite facial prosthesis).
- (f) A scalp hair prosthesis. A scalp hair prosthesis is an artificial substitute for scalp hair that is made specifically for you. Benefits are available for scalp hair prostheses for *Covered Persons* who have hair loss as a result of alopecia areata, alopecia totalis, or alopecia medicamentosa resulting from treatment of any form of cancer or leukemia and/or who have permanent hair loss as a result of injury.

Except as described above, no benefits are available for scalp hair prostheses or wigs. For example, except as stated above, no benefits are available for temporary hair loss. No benefits are available for male pattern baldness

- (4) Charges for compression therapy garments (e.g., Jobst[®] garments) when *Medically Necessary* due to an *Injury* or *Illness*.
- (5) Charges for chemotherapy (antineoplastic) when drugs are taken by infusion, perfusion, intracavity, or parenteral means and administered by a provider. Includes related charges for prescription drugs ordered and administered by a medical provider as part of a doctor's visit, home care visit, or at an outpatient facility. Benefits for drugs that are self-administered are not covered under this section. Benefits for self-administered drugs are provided in [Section IX, Prescription Benefits and Exclusions](#).
- (6) Charges for Clinical Trials - Routine costs for items and services furnished in connection with participation in *Qualified Clinical Trials* are covered at the same level as the same services provided outside *Qualified Clinical Trials*, including Hospital visits, imaging and laboratory tests if:
 - (a) the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate, or
 - (b) the participant or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate, and
 - (c) these services are Covered Services under the SHBP.
- (7) Charges for growth hormones when prescribed by a board-certified pediatric endocrinologist and a written treatment plan is submitted for approval of the Claims Administrator. Benefits include self-administered human growth hormones to treat children with short stature who have an absolute deficiency in natural growth hormone and children with short stature who have chronic renal insufficiency and do not have a functioning renal transplant. The *Covered Person* must be seen by the attending *Provider/Practitioner* every six (6) months and a written response to the treatment must be verified by the *Provider/Practitioner*. The medication will be covered for a thirty (30) day supply at a time.

- (8) Charges for allergy testing and treatment, including preparation of serum and injections.
- (9) Charges for Bariatric surgery for the treatment of Morbid Obesity
- (10) Charges for titer when Medically Necessary and not for routine testing.
- (11) Charges, to the extent defined herein, for services provided to children in addition to or in lieu of the services which may be available, provided, and/or used under a federal or state mandated program such as the Individual with Disabilities Educational Act, Public Law 105-17.
- (12) Charges for other *Medically Necessary* services and supplies as prescribed by the attending *Provider/Practitioner* and determined to be *Medically Necessary* by the Claims Administrator.

Y. Hospice Care Benefits

Hospice care benefits are provided to a terminally-ill *Covered Person* with a life expectancy of less than six (6) months; or to members of his or her immediate family. Benefits are limited to:

- (1) room and board for a confinement in an *Inpatient Hospice Facility*;
- (2) ancillary charges furnished by the *Inpatient Hospice Facility* while the patient is confined therein, including rental of durable medical equipment which is used solely for treating an *Injury* or *Illness*;
- (3) medical supplies, drugs, and medicines prescribed by the attending *Provider/Practitioner*, but only to the extent that such items are necessary for pain control and management of the terminal condition;
- (4) *Provider/Practitioner* services and/or nursing care by a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or a Licensed Vocational Nurse (L.V.N.);
- (5) *Home Health* aide services;
- (6) charges for home care furnished by a *Hospital* or *Home Health Care Agency*, under the direction of a *Hospice*, including *Custodial Care* if it is provided during a regular visit by a Registered Nurse, a Licensed Practical Nurse, or a *Home Health* aide;
- (7) medical social services by licensed or trained social workers, psychologists, or counselors;
- (8) nutrition services provided by a licensed dietitian;
- (9) respite care; and

(10) bereavement counseling.

Bereavement counseling is a support service provided by the *Inpatient Hospice Facility* team to *Covered Persons* in the deceased's immediate family after the death of such terminally-ill person. Such visits are to assist the *Covered Persons* in adjusting to the death. Benefits will be payable provided:

- (a) on the date immediately before his or her death, the terminally-ill person was in a *Hospice Plan of Care* program and was a *Covered Person* under the SHBP; and
- (b) charges for such services are incurred by the *Covered Person(s)* within six (6) months of the terminally-ill person's death.

The term immediate family means: parents, spouse, and children of the terminally-ill *Covered Person*.

Z. Organ Transplant Benefits

Expenses for an organ and/or tissue transplant will be subject to the following requirements.

(1) Covered Organ Transplants

Any Medically Necessary human organ, tissue, and stem cell/bone marrow transplants and infusions including necessary acquisition procedures, mobilization, harvest and storage.

Any Medically Necessary myeloablative or reduced intensity preparative chemotherapy, radiation therapy, or a combination of these therapies.

(2) Preauthorization Requirement for Organ Transplants

Inpatient Hospital Expenses Incurred in connection with any organ or tissue transplant will be subject to Preadmission/Precertification Requirement for Hospitalization as described in [Section VIII](#) of the SHBP Document entitled Preadmission/Precertification. All potential transplant cases will be assessed for their appropriateness for Large Case Management.

(3) Transplant Benefit Period

Covered transplant expenses will accumulate during a Transplant Benefit Period and will be charged toward the Transplant Benefit Period maximums, if any, shown in the Schedule of Benefits. The term Transplant Benefit Period means the period which begins on the date of the initial evaluation and ends on the date which is twelve (12) consecutive months following the date of the transplant. If

the transplant is a bone marrow transplant, the date the marrow is reinfused is considered the date of the transplant.

(4) Covered Transplant Expenses

Covered Expenses, with respect to transplants, refers to the *Contract Rate for In-Network Providers*, or if not in the network, the *Allowed Amounts* for services and supplies which are covered under the SHBP (or which are specifically identified as covered only under this provision) and which are *Medically Necessary* and appropriate to the transplant. Such *Covered Expenses* include:

- (a) charges incurred in the evaluation, screening, and candidacy determination process;
- (b) charges incurred for organ transplantation; and
- (c) charges for organ procurement, including donor expenses which are not covered under the donor's plan of benefits, subject to the following:
 - Coverage for organ procurement from a non-living donor will be provided for costs involved in removing, preserving, and transporting the organ.
 - Coverage for organ procurement from a living donor will be provided for the costs involved in screening the potential donor, as well as for medical expenses employed with removal of the donated organ and the related medical services provided to the donor in the interim and for follow-up care.
 - If the transplant procedure is a bone marrow transplant, coverage will be provided for the cost involved in the removal of the *Covered Person's* bone marrow (autologous) or donated marrow (allogenic). Coverage will also be provided for search charges to identify an unrelated match, treatment and storage costs of the marrow, up to the time of reinfusion. The harvesting of the marrow need not be performed within the Transplant Benefit Period.
 - Coverage will be provided for follow-up care, including immuno-suppressant therapy.
 - Coverage will be provided for transportation to and from the site of the covered organ transplant procedure for the recipient and one other individual or in the event that the recipient or the donor is a minor, two other individuals. In addition, all reasonable and necessary lodging and meal *Expenses Incurred* during the Transplant Benefit Period will be covered.

(5) Re-Transplantation

Up to two re-transplants, for a total of three transplants, will be covered per person, per lifetime. Each transplant and re-transplant will have a new Transplant Benefit Period and a new maximum benefit.

(6) Donor Expenses

If the recipient is not covered under the SHBP, but the donor is, neither the donor nor the recipient is eligible for coverage; however,

- (a) if both the donor and recipient are covered under the SHBP, eligible charges incurred by both patients will be covered; or
- (b) if the recipient is covered under the SHBP, but the donor is not, the SHBP will provide coverage for eligible charges to both the recipient and donor as long as similar benefits are not available to the donor from other coverage sources.

AA. Repatriation Benefits

In the event of the death of a *Covered Person*, the SHBP will pay the actual charges incurred for preparing and transporting that person's remains to his or her home country or permanent residence. Benefits are provided in accordance with legal requirements in effect at the time the bodily remains are to be returned. The death must occur while the person is covered by the SHBP. Return of Mortal Remains must be approved in advance by Travel Guard.

BB. Emergency Medical Evacuation Benefits.

The SHBP will pay benefits up to the Allowed Amount incurred if an Injury or Illness results in the Emergency Evacuation of the Covered Person. *Covered Expenses* are expenses for transportation, medical services and medical supplies necessarily incurred in connection with an *Emergency Evacuation* of the *Covered Person*. All transportation arrangements made for evacuating the Insured Person must be: a) by the most direct and economical conveyance; and b) approved in advance by Travel Guard.

Transportation means any land, water or air conveyance required to transport the Insured Person during an *Emergency Evacuation*. Expenses for special transportation must be: a) recommended by the attending physician; or b) required by the standard regulations of the conveyance transporting the *Covered Person*. Special transportation includes, but is not limited to; Air Ambulance, land Ambulance, and private motor vehicle. Expenses for medical supplies and services must be recommended by the attending Physician and approved by Travel Guard.

Services under this Benefit include:

- Medical Consultation, Evaluation and Referrals.
- Foreign Hospital Admission Guarantee.
- Emergency Medical Evacuation.
- Critical Care Monitoring.
- Medically Supervised Repatriation.
- Prescription Assistance.
- Transportation costs for one (1) family member to Join Patient.
- Return of Mortal Remains.
- Emergency Counseling Services.
- Lost Luggage or Document Assistance.
- Interpreter and Legal Referrals.

CC. Habilitative Services

Services that help you keep, learn, or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

A. Hospital Confinement and Emergency Admissions

Precertification is a process through which a SHBP *Covered-Person* receives confirmation that benefits are payable based on the *Medical Necessity* of the treatment recommended by or received from a health care *Provider*. Services which precertification is encouraged, regardless of whether the service is rendered inpatient, outpatient, or in an office setting, are identified in [Section V](#), Schedule of Benefits.

Call Wellfleet Insurance at (877) 657-5041 prior to receiving services shown as requiring precertification to confirm the *Medical Necessity* of the proposed services.

The SHBP does not cover services that precertification determines in advance are not *Medically Necessary*. If services rendered in an inpatient *Hospital* setting exceed the number of days precertified and the *Hospital's* reimbursement arrangement for those services is based on the diagnostic related group (DRG) pricing, the inpatient services will be paid according to the DRG priced amount. If precertification is required but is not obtained, the SHBP may not cover services that are determined not to have been *Medically Necessary* after they have been provided. The SHBP may also deny coverage prospectively for any service that may not require precertification if it is determined not to be *Medically Necessary*.

Except as specified above, there is no benefit reduction for failure to obtain a precertification for a *Hospital* confinement.

In the event of an *Emergency* or if the *Covered Person* is confined to the *Hospital's* observation area for more than 24 hours, it is recommended that the *Covered Person* contact the Case Management Service within 48 hours after an admission.

The Preadmission/Precertification recommendation applies to maternity admissions as well.

B. Case Management Provision for Alternate Treatment

In cases where a *Covered Person's* condition is, or is expected to be, of a serious nature, the Plan Administrator may arrange for review and/or case management services from a professional qualified agency. This service involves the cost-effective voluntary management of a potentially high-cost claim for a high-risk or long-term medical condition. The intention of the service is to plan necessary, quality care in the most cost-effective manner with the approval of the *Covered Person*, family, and attending *Provider(s)/Practitioner(s)*.

In the event a *Covered Person* is identified as a candidate for case management, then upon approval of the attending *Provider(s)/Practitioner(s)*, the *Covered Person*, and the case management agency, a treatment plan is developed and implemented. If the attending *Provider(s)/Practitioner(s)* and/or the *Covered Person* do not wish to follow the treatment plan as developed, then treatment and coverage of the patient's medical condition will continue uninterrupted and benefits will be paid as stated in the SHBP.

While large case management treatment usually contains treatment options covered under the terms of the SHBP, in some cases, the most appropriate and cost-effective care will be rendered in a setting or manner not normally covered under the terms of the SHBP. In such cases, all *Medically Necessary* aspects of the approved treatment will be covered under the terms of the SHBP. Any alternative care or treatment provided will not be considered as setting any precedent or creating any future liability with respect to that *Covered Person* or any other *Covered Persons*. Benefits provided under this Section are subject to all other SHBP provisions.

Refer also to the provision for extra-contractual benefits provided in [Section I, Establishment of SHBP](#)

A. Covered Drugs

When all of the provisions of the SHBP are satisfied, the SHBP will provide benefits as specified in the Schedule of Benefits for the following *Medically Necessary* covered drugs, devices, and supplies:

- (1) Federal Legend Drugs and State-Restricted Drugs;
- (2) compounded medications of which at least one ingredient is a Legend Drug;
- (3) insulin;
- (4) diabetic testing supplies, including continuous glucometers (CGM), transmitters and sensors, test strips, lancets, and insulin syringes;
- (5) oral, transdermal, intervaginal contraceptives (including devices and implants), or contraceptive injections;
- (6) blood factors up to a maximum of three treatments per *Plan Year*;
- (7) smoking deterrents that help you stop smoking or reduce your dependence on tobacco products when prescribed by a medical provider and furnished by an In-Network Pharmacy;
- (8) Legend Vitamin B12 (all dosage forms);
- (9) prenatal vitamins;
- (10) anti-malarial drugs; and
- (11) prescription oral fluoride products; no cost-sharing for children under the age of 5.

B. Dispensing Limits

Up to a 90-day supply of covered maintenance prescription drugs is provided using the plan formulary at a pharmacy of the *Covered Person's* choice within the Wellfleet Rx network, provided that the *Covered Person* can demonstrate that such drug has been taken for a continuous period of one year and provided that such drug is not subject to utilization management, prior authorization, or pre-certification requirements. Controlled substances as identified by the United States Drug Enforcement Administration are exempt from this provision. Refer to <http://www.gencourt.state.nh.us/rsa/html/XXXVII/420-J/420-J-7-b.htm>

C. Excluded Drugs

Some items which are excluded under the Prescription Benefits and Exclusions may be Covered Medical Services as provided in [Section VII](#) of the SHBP Document. Expenses

for the following are not covered by the SHBP unless specifically listed as a covered benefit:

- (1) drugs not classified as Federal Legend Drugs (i.e., over-the-counter drugs and products) unless preventative medication prescribed by a medical provider and coverage is required under federal law with a Prescription;
- (2) non-prescription contraceptives such as contraceptive creams and foams, condoms, spermicidal jelly or contraceptive sponges;
- (3) Sexual dysfunction drugs, except when *Medically Necessary* for treatment of conditions other than sexual dysfunction;
- (4) Legend vitamins;
- (5) cosmetic drugs and drugs used to promote or stimulate hair growth;
- (6) biologicals, immunization agents, or vaccines, except as specifically provided; unless we are required to cover them under federal law. Oral Immunizations and biologicals, even if they are legend Drugs, are covered as medical supplies based on where you get the service or item;
- (7) drugs labeled “Caution – limited by federal law to *Investigational* use,” or “*Experimental* drugs,” even though a charge is made to the individual;
- (8) any prescription refilled in excess of the number of refills specified by the ordering *Provider/Practitioner*, or any refill dispensed one year after the original order (as determined by the Plan Administrator, this provision may not apply, in whole or in part, to prescription benefits at UNH Health & Wellness);
- (9) medication dispensed in excess of the dispensing limits;
- (10) medication for which the cost is recoverable under any workers’ compensation or occupational disease law or any state or governmental agency, or medication furnished by any other drug or medical service for which no charge is made by the pharmacy or *Provider/Practitioner*;
- (11) services or products that are determined by the SHBP as not being *Medically Necessary, including pre-exposure rabies vaccine*;
- (12) medications provided to an international *Student* in his or her home country; and
- (13) any medication that would be excluded under Medical Benefit Exclusions, except as otherwise provided, stated in [Section X](#).

D. Review of Prescription Drugs for Medical Necessity

All prescription drug charges are subject to review for *Medically Necessity* and for eligibility under the Prescription Benefits and Exclusions of the SHBP. This review process may require the SHBP-Covered Person to complete a claim form and submit it to the Claims Administrator, or your Physician to submit clinical information. A determination of Medical Necessity will be responded to within 24 hours of receipt of the required documentation. Refer also the definition of *Expedited Exception Process* in [Section XVIII, Definitions](#).

If Clinical information is required, your Prescription may not be immediately filled. The Pharmacy Benefit Facilitator will contact the prescribing Physician and respond to your Physician within 24 hours of receipt of the supporting clinical rationale.

- (1) Any treatment not resulting from an *Accident, Illness, Mental or Nervous Disorder, or Substance Use Disorder*, except covered Preventive Care as specified, or for any service or supply that is not specifically listed as a *Covered Expense* under Covered Medical Services in the SHBP Document.
- (2) Treatment not prescribed or recommended by a *Provider/Practitioner*; services, supplies, or treatments which are not *Medically Necessary*; except covered Preventive Care as specified; and expenses for supplies that do not require a *Provider's/Practitioner's* prescription.
- (3) Charges for which there is no legal obligation to pay, such as that portion of any charge which would not have been made if the patient did not have this coverage, or any charge for services or supplies which are normally furnished without charge.
- (4) *Experimental/Investigational* equipment, services, or supplies.
- (5) Charges for services, supplies, or treatment not recognized by the American Medical Association as generally accepted and *Medically Necessary* for the diagnosis and/or treatment of an active *Illness or Injury*; or charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value.
- (6) Charges for services rendered by a provider who is not a *Provider/Practitioner*.
- (7) Any condition, disability, or expense sustained as a result of being engaged in: participation in a civil revolution or a riot or a war, or act of war which is declared or undeclared.
- (8) Any condition or disability sustained as a result of being engaged in an activity primarily for wage, profit, or gain and that could entitle the *Covered Person* to a benefit under the Worker's Compensation Act or similar legislation.
- (9) Educational, vocational, or training services and supplies. This exclusion does not apply to treatment of diabetes, specifically provided Preventive Care benefits, or other specifically provided benefits for services or supplies that would be educational, vocational, or for training purposes.
- (10) Expenses for preparing medical reports, itemized bills, or claim forms; and mailing and/or shipping and handling expenses; and sales tax.
- (11) Expenses for broken appointments.
- (12) Services furnished by or for the United States government or any other government, unless payment is legally required; and Services or supplies furnished, paid for, or for which benefits are provided or required by reason of past or present service of any covered family member in the armed forces of a government.
- (13) Travel expenses of a *Physician/Practitioner*; and travel expenses of a *Covered Person* other than local ambulance services to the nearest medical facility equipped to treat the *Illness or Injury*, except as specified.
- (14) Charges incurred outside of the United States, if the *Covered Person* traveled to such location for the purpose of obtaining non- Emergency Medical Care, drugs, or supplies.

- (15) *Custodial Care* (except as specifically provided under *Hospice Plan of Care*).
- (16) Expenses for treatment, services, or supplies provided by a *Provider/Practitioner* who ordinarily resides with the *Covered Person*, or is the *Covered Person*, including but not limited to, his or her spouse, child, brother, sister, or parent.
- (17) *Expenses Incurred* for services rendered prior to the *Effective Date* of coverage under the SHBP or after coverage terminates, even though *Illness* or *Injury* started while coverage was in force and claims originally submitted to the Claims Administrator for the SHBP more than one year after the date on which the service or supply was incurred.
- (18) Personal comfort or service items while confined in a *Hospital*, such as, but not limited to, radio, television, telephone, and guest meals.
- (19) Charges incurred at a residential treatment facility that is not a *Hospital*, regardless of whether the service or supply is a *Covered Expense*.
- (20) Any refractive eye surgery or procedure designed to improve nearsightedness, farsightedness, and/or astigmatism by changing the shape of the cornea, including, but not limited to, LASIK, radial keratotomy, and keratomileusis surgery; and other services such as fitting of eyeglasses or lenses, orthoptics, vision therapy, or supplies.
- (21) Services related to Dental or oral surgery, except as specifically provided.
- (22) Expenses for treatment of behavioral problems, learning disabilities, or developmental delays when furnished by an individual who is NOT professionally certified by a national board of behavior analysts. This exclusion includes, , but not limited to, Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD). This exclusion applies to the treatment of a condition; it does not apply to *Expenses Incurred* for the diagnosis of the condition.
- (23) Charges for services for, or related to, reconstructive surgery or cosmetic health services except as specifically provided. This exclusion applies to liposuction or other weight loss procedures for cosmetic purposes. This exclusion does not apply to: reconstructive surgery for newborn children; reconstructive surgery related to an *Injury* or *Accident*; or reconstructive surgery of the breasts following a mastectomy, including: reconstructive surgery of the breast(s) on which the surgery was performed, reconstructive surgery of an unaffected breast to produce a symmetrical appearance, and expenses related to prostheses and physical complications at all stages of a mastectomy.
- (24) Except as specifically provided, hearing examinations, hearing aids, or related supplies (Refer to [Section VI, Required Benefits](#)).
- (25) Adoption expenses; and Surrogate expenses.
- (26) Biofeedback, unless approved by the UNH Counseling Center.
- (27) Hypnosis.
- (28) Except as specifically provided, genetic counseling and testing (Refer to [Section VI, Required Benefits](#)).

- (29) Expenses for pastoral counseling, marriage therapy, music or art therapy (unless part of an inpatient program), assertiveness training, dream therapy, recreational therapy, stress management, or other supportive therapies; sex counseling; and massage therapy or Rolfing.
- (30) *Expenses Incurred* for non-surgical treatment of the feet, including treatment of corns, calluses, and toenails, or other routine foot care, except as specifically provided.
- (31) Services or supplies that are primarily and customarily used for a non-medical purpose, or used for environmental control or enhancement (whether or not prescribed by a physician), including, but not limited to, equipment such as air conditioners, air purifiers, dehumidifiers, heating pads, hot water bottles, water beds, swimming pools, hot tubs, and any other clothing or equipment which could be used in the absence of an *Illness* or *Injury*.
- (32) Expenses exceeding the *Allowed Amount* for the geographic area in which services are rendered; and expenses for services and supplies in excess of SHBP limits or benefit maximums.

A. Maximum Benefits under All Plans

If any *Covered Person* covered under the SHBP is also covered under one or more Other Plan(s), and the sum of the benefits payable under all the plans exceeds the *Covered Person's* eligible charges during any claim determination period, then the benefits payable under all the plans involved will not exceed the eligible charges for such period as determined under the SHBP. Benefits payable under another plan are included, whether or not a claim has been made. For these purposes,

- (1) claim determination period means a *Plan Year*; and
- (2) eligible charge means any necessary *Allowed Amount* item of which at least a portion is covered under the SHBP but does not include charges specifically excluded from benefits under the SHBP that may also be eligible under any Other Plans covering the *Covered Person* for whom the claim is made.

B. Other Plans

Other Plan means the following plans providing benefits or services for medical and dental care or treatment and include:

- (1) group insurance or any other arrangement for coverage for *Covered Persons* in a group, whether on an insured or uninsured basis;
- (2) Blue Cross, Blue Shield, or any other prepayment coverage, including health maintenance organizations (HMOs), *Medicare*, or Medicaid; or
- (3) no-fault automobile insurance (for purposes of the SHBP, in states with compulsory no-fault automobile insurance laws, each *Covered Person* will be deemed to have full no-fault coverage to the maximum available in that state. The SHBP will coordinate benefits with no-fault coverage as defined in the state of residence, whether or not the *Covered Person* is in compliance with the law, or whether or not the maximum coverage is carried).

C. Determining Order of Payment

If a *Covered Person* is covered under two or more plans, the order in which benefits will be determined is as follows.

- (1) The plan covering the covered person other than as an eligible dependent, for example as an employee, member, subscriber, policyholder or retiree, pays benefits first. The plan covering the covered person as an eligible dependent pays benefits second.
- (2) If no plan is determined to have primary benefit payment responsibility under (1) above, then the plan that covered the *Covered Person* for the longest period has the primary responsibility.

- (3) A plan that has no Coordination of Benefits provision will be deemed to have primary benefit payment responsibility.
- (4) The plan covering the parent of the *Eligible Dependent* child pays first if the parent's birthday (month and day of birth, not year) falls earlier in the calendar year. The plan covering the parent of an *Eligible Dependent* child pays second if the parent's birthday falls later in the calendar year.
- (5) In the event that the parents of the *Eligible Dependent* child are divorced or separated, the following order of benefit determination applies:
 - (a) the plan covering the parent with custody pays benefits first;
 - (b) if the parent with custody has not remarried, then the plan covering the parent without custody pays benefits second;
 - (c) if the parent with custody has remarried, then the plan covering the step-parent pays benefits second, and the plan covering the parent without custody pays benefits third; and
 - (d) if a divorce decree or other order of a court of competent jurisdiction places the financial responsibility for the child's health care expenses on one of the parents, then the plan covering that parent pays benefits first.

D. Facilitation of Coordination

For the purpose of Coordination of Benefits, the Claims Administrator:

- (1) may release to, or obtain from, any other insurance company or other organization or individual any claim information, and any *Covered Person* claiming benefits under the SHBP must furnish any information that the Plan Administrator may require;
- (2) may recover on behalf of the SHBP any benefit overpayment from any other individual, insurance company, or organization; and
- (3) has the right to pay to any other organization an amount it will determine to be warranted, if payments that should have been made by the SHBP have been made by such organization.

E. Persons Covered by Medicare

An SHBP-*Covered Person* who becomes entitled to medical benefit coverage under Medicare shall remain eligible for benefits under the SHBP on the same terms and conditions as any other SHBP-*Covered Person*. The SHBP will coordinate benefits with Medicare in accordance with the rules of the Medicare Secondary Payor (MSP) Program as promulgated by the Centers for Medicare & Medicaid Services (CMS) as may be amended from time to time. The Medicare secondary payor rules under Social Security

Act Section 1862(b) (42 U.S.C. Section 1395y(b)(5)), as may be amended from time to time, and applicable federal regulations are hereby incorporated by reference and shall supersede any inconsistent provision(s) of the SHBP. These rules will determine when the SHBP will be the primary payer of covered Medical benefit expenses and when Medicare will be the primary payer.

F. Discrimination Against Older Participants Prohibited

The SHBP will provide benefits for anyone age 65 or older under the same terms and conditions that apply to an SHBP-*Covered Person* who is under age 65.

G. Enrollment and Provision of Benefits without Regard to Medicaid Eligibility

As an SHBP-*Covered Person*, the fact that the student is eligible for or is provided medical assistance under a state plan for medical assistance approved under Title XIX of the Social Security Act will not be taken into account.

H. Plan Charges Covered by Medicaid or CHIP (Children's Health Insurance Plan)

The SHBP will not reduce or deny benefits for any SHBP-*Covered Person* to reflect the fact that such an SHBP-*Covered Person* is eligible to receive medical assistance through Medicaid or CHIP.

I. Medicare and Medicaid Reimbursements

The SHBP will reimburse the Centers for Medicare and Medicaid Services or any successor government agency for the cost of any items and services provided by Medicare for any SHBP-*Covered Person* that should have been borne by the SHBP. Similarly, the SHBP will reimburse any state Medicaid program for the cost of items and services provided under the state plan that should have been paid for by the SHBP-*Covered Person* he SHBP.

J. Right to Receive and Release Necessary Information

For the purposes of determining the applicability of and implementing the terms of this Section or any provision of similar purpose of any other plan, the SHBP, through its authorized administrator, may, without the consent of or notice to any person to the extent permitted by law, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which is deemed to be necessary for such purposes. Any person claiming benefits under the SHBP will furnish such information as may be necessary to implement this provision.

K. Facility of Payment

Whenever payments which should have been made under the SHBP in accordance with this provision, have been made under any other plans, the SHBP will have the sole right and discretion to pay over to any organizations making such other payments any

amounts it will determine to be warranted in order to satisfy the intent of this provision, and amounts so paid will be deemed to be benefits paid under the SHBP.

L. Right of Recovery

Whenever payments have been made by the SHBP with respect to allowable expenses in a total amount which is, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the SHBP will have the right to recover such payments to the extent of such excess from any persons to or for or with respect to whom such payments were made and any other insurance companies and any other organizations.

M. Special Provision for NCAA-Sanctioned Intercollegiate Sports

The SHBP provides coverage on a primary basis, in Coordination of Benefits with any other health plan or health insurance policy for injury resulting from the practice or play of UNH's NCAA-Sanctioned Intercollegiate Sports.

A. Allocation of Authority

The Plan Administrator will control and manage the operation and administration of the SHBP. The Plan Administrator shall have the sole and exclusive right and discretion:

- (1) to interpret the SHBP, the Plan Document, and any other writings affecting the establishment or operation of the SHBP, both as to legal import and as to the application of the provisions of any such documents to the facts of a particular claim for benefits, and to decide all matters arising under the SHBP, including the right to remedy possible ambiguities, inconsistencies, or omissions; and
- (2) to make factual findings and decide conclusively all questions regarding any claim for benefits made under the SHBP.

All determinations of the Plan Administrator with respect to any matter relating to the administration of the SHBP will be conclusive and binding on all persons. You have the right to appeal our determination. Please refer to the Appeals section of this Plan Document.

B. Powers and Duties of Plan Administrator

The Plan Administrator will have the following powers and duties:

- (1) to require any person to furnish such reasonable information as the Plan Administrator may request for the proper administration of the SHBP as a condition to receiving any benefits under the SHBP;
- (2) to make and enforce such rules and regulations and prescribe the use of such forms as the Plan Administrator will deem necessary for the efficient administration of the SHBP;
- (3) to decide on questions concerning the SHBP, or the eligibility of any person to participate in the SHBP, in accordance with the provisions of the SHBP;
- (4) to determine the amount of benefits that will be payable to any person in accordance with the provisions of the SHBP;
- (5) to inform *Covered Person(s)*, as appropriate, of the amount of such benefits payable in accordance with the provisions of the SHBP;
- (6) to designate other persons to carry out any duty or power that would otherwise be a fiduciary or clerical responsibility of the Plan Administrator under the terms of the SHBP;
- (7) to retain such actuaries, accountants, consultants, third-party administration services, legal counsel, or other specialists, as the Plan Administrator may deem appropriate and necessary for the SHBP's effective administration; and

- (8) to perform any other functions or actions that would commonly be within the purview of a similarly situated administrator for a student health insurance/benefits plan.

C. Delegation by the Plan Administrator

The Plan Administrator may employ the services of such persons (including an insurance company or third-party administrator) as it may deem necessary or desirable in connection with the administration of claims or other operations of the SHBP.

The Plan Administrator will also have the power and duty to retain the services of one or more health care professionals, for the purpose of reviewing benefit claims that are under Appeal for reasons based on medical judgment, such as *Medical Necessity* or *Experimental* treatments.

The Plan Administrator (and any person to whom any duty or power in connection with the operation of the SHBP is delegated) may rely upon all tables, valuations, certificates, reports, and opinions furnished by any duly-appointed actuary, accountant, consultant, third-party administration service, legal counsel, or other specialist, and the Plan Administrator or such delegate will be fully protected in respect to any action taken or permitted in good faith in reliance upon such table, valuations, certificates, etc.

D. Payment of Administrative Expenses

All reasonable costs incurred in the administration of the SHBP including, but not limited to, administrative fees and expenses owed to any third-party administrative service, actuary, consultant, accountant, specialist, or other person or organization that may be employed by the Plan Administrator in connection with the administration thereof, will be paid by the Plan Sponsor unless the Plan Administrator directs the SHBP to pay such expenses and such payment by the SHBP is permitted by law.

A. Termination Events

The coverage of any *Covered Person* shall automatically cease immediately upon the earliest day indicated below:

- (1) on the last day of the month in which a *Covered Person* ceases to be in a class of eligible *Students*, except as specifically provided for coverage to continue through the end of the summer coverage period for SHBP-Covered Persons enrolled in the Spring Semester or for a Medical Leave of Absence as specified in Section B;
 - (2) on the last day of the month in which the child attains age 26, except as specified below for a child is determined to be Totally Disabled;
 - (3) on the day the SHBP terminates;
 - (4) on the day in which the *Covered Person* dies;
 - (5) on the day in which the *Covered Person* enters service in the *Uniformed Services* on an active-duty basis;
 - (6) on the day an international *Student* withdraws from UNH or the day an international *Student* receives an approved medical withdrawal from UNH and leaves the United States; or
 - (7) at the end of the *Plan Year* for a spouse who is divorced from a *Covered Student* during the *Plan Year*.
- (8) Intentional fraudulent misuse of insurance card; for example allowing another individual to utilize your insurance card for care.

The coverage of an *Eligible Dependent* who has attained the maximum age limit shall not terminate if such *Eligible Dependent* is permanently and *Totally Disabled* (as defined in Internal Revenue Code section 22(e) (B) and in [Section XVIII](#) of the SHBP Document, entitled Definitions), at any time during the calendar year in which the taxable year of the *Covered Student* begins. Written proof of such *Eligible Dependent's* permanent and *Total Disability* must be submitted on an annual basis to the Plan Administrator, and the Plan Administrator reserves the right to require, at its expense, an independent medical, psychiatric, or psychological evaluation or examination in connection with any such annual review of such *Eligible Dependent's* disability status.

B. Medical Leave of Absence

Any full-time *Student* enrolled in the SHBP, who, as a result of an *Injury* or *Illness*, is *Totally Disabled*, will be eligible to continue coverage under the SHBP for himself/herself for a period not to exceed 90 days following the date the Medical Leave

of Absence is communicated by UNH to the Plan Administrator, except as specifically provided in this Section. Coverage under the SHBP will continue during the maximum 90-day period until the date coverage becomes effective under other health insurance purchased by the *Student*. The 90-day coverage period resulting from a Medical Leave of Absence is subject to the approval of the Plan Administrator, including a determination by the Plan Administrator that the *Student* (or his or her representatives) made a good faith effort to obtain health insurance under a state or federal insurance exchange. If a Covered Dependent, enrolled in the SHBP, becomes Totally Disabled as a result of an Injury or Illness, he/she will be eligible to continue coverage for himself/herself for a period of up to 12 months following the date the Medical Leave is communicated by UNH to the Plan administrator, or the date coverage would otherwise end pursuant to the terms and conditions of this Plan, whichever comes first.

The *Student*, or his or representative, may submit a request to the Plan Administrator to have eligibility for the SHBP continued until the end of the *Plan Year*, or the date the student is no longer *Totally Disabled* and/or returns to UNH, whichever is earlier. The request for extension of eligibility beyond the maximum 90 day period under the Medical Leave of Absence must be based on the *Student* either (1) not having eligibility to enroll in a health insurance plan provided by a state or federal insurance exchange following withdrawal from UNH and loss of SHBP eligibility; or (2) the insurance exchange coverage that would replace the SHBP does not provide either *Essential Benefits/Services* or coverage, either in-network or out-of-network, for a health care provider that is *rendering Essential Services* to the *Student*. In no event will coverage for the SHBP extend beyond the end of the Plan Year in which the *Student* has a Medical Leave of Absence from UNH.

Certification of the Medical Leave of Absence must be made by the *Student's Provider/Practitioner* and such certification must be presented to and approved by the Plan Administrator. The Medical Leave of Absence cannot extend beyond end of the Plan Year in which the Medical Leave of Absence is granted. Refer also to Termination Events for international *Students* who leave the United States.

For the purpose of this Medical Leave of Absence provision, full-time *Student* status is defined by the Registrar for UNH for each class of *Students*.

C. Continuation of Coverage

Except as provided in Section C, Medical Leave of Absence, the SHBP does not offer Continuation of Coverage in the event a *Covered Person* loses coverage under the SHBP. The SHBP is not subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) affords protection to patients from unwarranted disclosure of private medical information by specifying those situations in which, and those persons to whom, personal information may be disclosed.

A. Permitted Disclosures

There are three circumstances under which the SHBP may disclose an individual's protected health information to the Plan Sponsor.

- (1) The SHBP may inform the Plan Sponsor whether an individual is enrolled in the SHBP.
- (2) The SHBP may disclose summary health information to the Plan Sponsor. The Plan Sponsor must limit its use of that information to obtaining quotes from insurers or modifying, amending, or terminating the SHBP. Summary health information is information that summarizes claims history, claims expenses, and/or types of claims without identifying the individual.
- (3) The SHBP may disclose an individual's protected health information to the Plan Sponsor for SHBP administrative purposes. This is because the Plan Sponsor performs many of the administrative functions necessary for the management and operation of the SHBP. The Plan Sponsor has certified to the SHBP that the SHBP's terms have been amended to incorporate the terms of this summary. The Plan Sponsor has agreed to abide by the terms of this summary. The SHBP's privacy notice also permits the SHBP to disclose an individual's protected health information to the Plan Sponsor as described in this summary.

B. Restrictions on Plan Administrator and Disclosure

The restrictions that apply to the Plan Sponsor's use and disclosure of an individual's protected health information are as follows:

- (1) The Plan Sponsor will only use or disclose an individual's protected health information for SHBP administrative purposes, as required by law, or as permitted under HIPAA regulations. (Refer to SHBP's privacy notice for more information about permitted uses and disclosures of protected health information under HIPAA.)
- (2) If the Plan Sponsor discloses any of an individual's protected health information to any of its agents or subcontractors, the Plan Sponsor will require the agent or subcontractor to keep an individual's protected health information confidential as required by the HIPAA regulations.
- (3) The Plan Sponsor will not use or disclose an individual's protected health information for UNH admissions-related or employment-related actions or

decisions or in connection with any other benefit or benefit plan of the Plan Sponsor unless permitted under HIPAA.

- (4) The Plan Sponsor will promptly report to the SHBP any use or disclosure of an individual's protected health information that is inconsistent with the uses or disclosures allowed in this summary.
- (5) The Plan Sponsor will allow an individual or the SHBP to inspect and copy any protected health information about that individual who is in the Plan Sponsor's custody and control. The HIPAA Regulations set forth the rules that an individual and the SHBP must follow in this regard. There are some exceptions to this provision allowed under federal regulations.
- (6) The Plan Sponsor will amend, or allow the SHBP to amend, any portion of an individual's protected health information to the extent permitted or required under the HIPAA Regulations.
- (7) With respect to some types of disclosures, the Plan Sponsor will keep a disclosure log for a period of not less than six (6) years (but not before April 14, 2004). An individual has a right to see the disclosure log. The Plan Sponsor does not have to maintain the log if disclosures are for certain SHBP-related purposes, such as payment of benefits or health care operations.
- (8) The Plan Sponsor will make its internal practices, books, and records relating to its use and disclosure of an individual's protected health information available to the SHBP and to the U.S. Department of Health and Human Services.
- (9) The Plan Sponsor will, if feasible, return or destroy all of an individual's protected health information in the Plan Sponsor's custody or control that the Plan Sponsor has received from the SHBP or from any business partner, agent, or subcontractor when the Plan Sponsor no longer needs an individual's protected health information to administer the SHBP. If it is not feasible for the Plan Sponsor to return or destroy an individual's protected health information, the Plan Sponsor will limit the use or disclosure of such protected health information.

C. Authorized Recipients of Protected Health Information

In addition to the Privacy Officer, the following classes of individuals or other workforce members under the control of the Plan Sponsor may be given access to an individual's protected health information on a need-to-know basis, solely for the purposes set forth above:

- (1) Director of Finance and Administration, Health & Wellness, UNH;
- (2) Chair of the Student Health Insurance Advisory Committee;

- (3) Executive Director for Health & Wellness, UNH;
- (4) Professional staff and/or clinicians or counselors of UNH Health & Wellness and Counseling Center, and
- (5) Consultants or other third parties retained by the Plan Sponsor to perform duties necessary for the function of the SHBP.

This list includes every class of individuals or other workforce members under the control of the Plan Sponsor who may receive an individual's protected health information. If any of these individuals or workforce members use or disclose an individual's protected health information in violation of the rules that are set out in this summary, the responsible individual(s) or workforce member(s) will be subject to disciplinary action and sanctions. If the Plan Sponsor becomes aware of any such violations, the Plan Sponsor will promptly report the violation to the SHBP and will cooperate with the SHBP to correct the violation, to impose appropriate sanctions, and to mitigate any harmful effects to the individual. Any violations will also be reported to the Centers for Medicare and Medicaid Services.

D. Security Provisions

The Plan Sponsor will receive or generate electronic protected health information. The information may be identified to the individual in some cases. In relation to such electronic protected health information, the Plan Sponsor certifies to the SHBP that it agrees to:

- (1) take appropriate and reasonable safeguards (administrative, physical, and technical) to protect the confidentiality, integrity, and availability of the information it creates, receives, maintains, or transmits;
- (2) require that any agent or subcontractor of the Plan Sponsor agrees to the same requirements that apply to the Plan Sponsor under this provision;
- (3) report to the SHBP any security incident of which the Plan Sponsor becomes aware; and
- (4) apply reasonable and appropriate security measures to maintain adequate separation between the SHBP and Plan Sponsor.

A. Payment Condition

- (1) In the event a SHBP Beneficiary initiates litigation against, negotiates a settlement with, or otherwise recovers from any third party or Coverage, the SHBP Beneficiary agrees to promptly notify SHBP of the litigation, settlement or other recovery. The SHBP Beneficiary agrees to reimburse SHBP for its proportional share of any judgment, settlement or other recovery, and acknowledges that SHBP, except as otherwise ordered or directed by a court of competent jurisdiction, has the priority lien against any judgment, settlement or other recovery against any third party or Coverage.
- (2) If there is more than one party responsible for charges paid by the Plan or may be responsible for charges paid by the Plan, SHBP will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the SHBP Beneficiary is only one or a few, that unallocated settlement fund is considered designated as an “identifiable” fund from which the Plan may see reimbursement. The SHBP may assert its right of subrogation against any and all parties that may be responsible for an SHBP Beneficiary’s medical expenses paid by the SHBP.

B. Subrogation

- (1) As a condition to participating in and receiving benefits under this SHBP, the SHBP Beneficiary agrees to assign to SHBP to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation, and/or entity, and to any Coverage for which the SHBP Beneficiary claims an entitlement, regardless of how classified or characterized. In the event the SHBP Beneficiary is successful in obtaining a judgement or settlement with any third party or Coverage, the SHBP Beneficiary agrees to reimburse the SHBP for its proportional share of the judgment or settlement.
- (2) If an SHBP Beneficiary receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the SHBP to any claims, which any SHBP Beneficiary may have against any Coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the SHBP plus reasonable costs of collection.
- (3) The SHBP may, in its own name or in the name of the SHBP Beneficiary or their personal representative, commence a proceeding or pursue a claim against such other third party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the SHBP.
- (4) The SHBP Beneficiary then authorizes the SHBP to pursue, sue, compromise, or settle any such claims in their name and agrees to cooperate fully with the SHBP

in the prosecution of any such claims. * This includes the failure of the SHBP Beneficiary to file a claim or pursue damages against:

- (a) the responsible party, their insurer, or any other source on behalf of that party;
- (b) any first party insurance through personal injury protection, no-fault coverage, or uninsured or underinsured motorist coverage;
- (c) any policy of insurance from any insurance company or guarantor of a third party;
- (d) any worker's compensation or other liability insurance company; or
- (e) any other source, including but not limited to, crime victim restitution funds, any medical, disability, or other benefit payments, and school insurance coverage.

* The SHBP Beneficiary, his or her guardian, or the estate of a SHBP Beneficiary, assigns all rights to the SHBP or its assignee to pursue a claim and the recovery of all expenses from any sources listed above.

C. Right of Reimbursement

- (1) The SHBP shall be entitled to recover its proportional share of the value of the benefits paid, as provided for in N.H. Rev. Sta. Ann. 507-j.
- (2) The SHBP will not be responsible for any expenses, attorney fees, costs, or other monies incurred by the attorney for the SHBP Beneficiary or his/her beneficiaries, commonly known as the common fund doctrine. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of a litigious nature may be deducted from the SHBP's recovery without the prior expressed written consent of the SHBP.
- (3) Furthermore, it is prohibited for the SHBP Beneficiary to settle a claim against a third party or any available coverage for certain elements of damages, but eliminating damages relating to medical *Expenses Incurred*.
- (5) These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the SHBP and signed by the SHBP Beneficiary.
- (6) This provision shall not limit any other remedies of the SHBP provided by law. These rights of subrogation and reimbursement shall apply without regard to the

location of the event that led to or caused the applicable *Illness, Injury*, disease, or disability.

D. Separation of Funds

Benefits paid by the SHBP, funds recovered by the SHBP Beneficiary, and funds held in trust over which the SHBP has an equitable lien exist separately from the property and estate of the SHBP Beneficiary, such that the death of the SHBP Beneficiary, or filing of bankruptcy by the SHBP Beneficiary, will not affect the SHBP's equitable lien, the funds over which the SHBP has a lien, or the SHBP's right to subrogation and reimbursement.

E. Wrongful Death Claims

In the event that the SHBP Beneficiary dies as a result of his or her *Injuries* and a wrongful death or survivor claim is asserted against a third party or any Coverage under the laws of any state, the SHBP's subrogation and reimbursement rights still apply.

F. Obligations

It is the SHBP Beneficiary's obligation at all times, both prior to and after payment of medical benefits by the SHBP, to:

- (1) cooperate with the SHBP, or any representatives of the SHBP, in protecting its rights of subrogation and reimbursement, including completing discovery, attending depositions, and/or attending or cooperating in a trial in order to preserve the SHBP's subrogation rights;
- (2) provide the SHBP with pertinent information regarding the *Injury*, including accident reports, settlement information, and any other requested additional information;
- (3) take such action and execute such documents as the SHBP may require to facilitate enforcement of its subrogation and reimbursement rights;
- (4) do nothing to prejudice the SHBP's rights of subrogation and reimbursement;
- (5) promptly reimburse the SHBP when a recovery through settlement, judgment, award, or other payment is received;
- (6) not settle, without the prior consent of the SHBP, any claim that the SHBP Beneficiary may have against any legally-responsible party or insurance carrier; and
- (7) refrain from releasing any party, person, corporation, entity, insurance company, or insurance policies or funds that may be responsible for or obligated to the

SHBP Beneficiary for the *Injury* or condition without obtaining the SHBP's written approval.

If the SHBP Beneficiary fails to reimburse the SHBP for all benefits paid or to be paid, as a result of said *Injury* or condition, out of any judgment or settlement received, the SHBP Beneficiary will be responsible for any and all expenses (whether fees or costs) incurred with the SHBP's attempt to recover such money from the SHBP Beneficiary.

The SHBP's rights to reimbursement and/or subrogation are in no way dependent upon the SHBP Beneficiary's cooperation or adherence to these terms.

G. Minor Status

In the event the SHBP Beneficiary is a minor, as that term is defined by applicable law, the minor's parent(s) or court-appointed guardian shall cooperate in any and all actions requested by the SHBP to seek and obtain any requisite court approval in order to bind the minor and his or her estate insofar as the subrogation and reimbursement provisions are concerned.

H. Severability

In the event that any part of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining Sections of this provision and the SHBP. The affected section shall be fully severable. The SHBP shall be construed and enforced as if such invalid or illegal Sections had never been inserted in the SHBP.

A. Amendment

The Plan Administrator has the right to amend this SHBP in any and all respects at any time, and from time to time. For modifications that affect the Summary of Benefits and Coverage (SBC), the Plan Administrator will provide notification of such change 60 days prior to the *Effective Date*. Any such amendment will be by a written instrument signed by a duly-authorized Officer of the Plan Sponsor. For all other Plan changes, the Plan Administrator will notify all *Covered Persons* of any amendment modifying the material terms of the SHBP as soon as is administratively feasible after its adoption.

B. Termination of SHBP

Regardless of any other provision of the SHBP, the Plan Sponsor reserves the right to terminate the SHBP at any time. Such termination will be evidenced by a written resolution of the Plan Sponsor. The Plan Administrator will provide notice of the SHBP's termination as soon at least 60 days prior to termination date.

A. Plan Funding

All benefits paid under the SHBP shall be paid in cash from the designated SHBP fund established and maintained by the Plan Sponsor. No person shall have any right or title to, or interest in, any investment reserves, accounts, or funds that UNH may purchase, establish, or accumulate to aid in providing benefits under the SHBP. No person shall acquire any interest greater than that of an unsecured creditor.

B. In General

Any and all rights provided to any person under the SHBP shall be subject to the terms and conditions of the SHBP. This Plan Document shall not constitute a contract between the Plan Sponsor and any SHBP-Covered Person or other person(s) nor shall it be consideration or an inducement for the initial or continued enrollment of any *Student* in the University of New Hampshire. Likewise, maintenance of this SHBP shall not be construed to give any SHBP-Covered Person the right to be retained as a *Covered Person* by the Plan Sponsor or the right to any benefits not specifically provided by the SHBP.

C. Waiver and Estoppel

No term, condition, or provision of the SHBP shall be deemed to be waived, and there shall be no estoppel against enforcing any provision of the SHBP, except through a writing of the party to be charged by the waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless explicitly made so, and it shall operate only with regard to the specific term or condition waived, and it shall not be deemed to waive such term or condition in the future, or as to any act other than as specifically waived. No *Covered Person* or eligible beneficiary other than as named or described by class in the waiver shall be entitled to rely on the waiver for any purpose.

D. Non-Vested Benefits

Nothing in the SHBP shall be construed as creating any vested rights to benefits in favor of any *Covered Person*.

E. Interests Not Transferable

The interests of the *Covered Student* and their *Eligible Dependents* under the SHBP are not subject to the claim of their creditors and may not be voluntarily or involuntarily transferred, alienated, or encumbered without the written consent of the Plan Administrator.

F. Severability

If any provision of the SHBP shall be held invalid or illegal for any reason, any invalidity or illegality shall not affect the remaining parts of the SHBP, but the SHBP

shall be construed and enforced as if the invalid or illegal provision had never been inserted. The Plan Sponsor shall have the privilege and opportunity to correct and remedy those questions of invalidity or illegality by amendment as provided in the SHBP.

G. Confidentiality and Release of Information

The SHBP will use reasonable efforts to preserve the confidentiality of your medical information. The SHBP may use data collected in the course of providing services hereunder for statistical evaluation and research. If such data is ever released to a third party, it shall be released only in aggregate statistical form without identifying you. Medical Information may only be released with your written consent or as required by law. It must be signed, dated, and must specify the nature of the information and to which persons and/or organizations it may be disclosed. You may access your own records.

H. Right of Recovery

Whenever payment has been made in error, the SHBP or its Claims Administrator, will have the right to recover such payment from you or, if applicable, the Provider. You will not receive notice of an adjusted cost share amount as a result of such recovery activity

I. Unauthorized Use of Identification Card

If you permit your identification card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expense incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of coverage.

J. Headings

All Section headings in the SHBP Document have been inserted for convenience only and shall not determine the meaning of the content thereof.

The following words and phrases will have the following meanings when used in the within the SHBP Document, unless a different meaning is plainly required by the context.

Academic Year – refer to the University of New Hampshire’s calendar for the Academic Year at <http://www.unh.edu/main/unh-calendar>.

Accident/Accidental – means a sudden or unforeseen event resulting in an *Injury*.

- (1) An *Accident* does not include harm resulting from a disease or sickness and will be determined by the Claims Administrator.
- (2) An *Accident* does not include *Injuries* for which benefits are provided under workers’ compensation, employers’ liability or similar law or injuries occurring while the Covered Person is engaged in any activity pertaining to a trade, business, employment or occupation for wage or profit.

Adverse Benefit Determination – means:

- (1) the requested benefit is denied, reduced, or terminated, or payment is not made, in whole or in part, for the benefit because a determination was made by the Claims Administrator that, based upon the information provided, the request for benefit under the SHBP does not meet the requirements for *Medical Necessity*, appropriateness, health care setting, level of care or effectiveness, or is determined to be experimental or investigational;
- (2) the denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by the Claims Administrator of your ineligibility to participate in the SHBP;
- (3) any prospective review or retrospective review determination that denies, reduces or terminates or fails to provide or make payment in whole or in part for a benefit; or
- (4) a rescission of coverage determination.

Alcoholism – means an alcohol-induced disorder which produces a state of psychological and/or physical dependence.

Allowed Amount – the maximum amount the SHBP will pay an *Out-of-Network Provider* for *Covered Expenses* minus any applicable Coinsurance, Co-payment or Deductible a Covered Person may be responsible for under the Plan. The *Allowed Amount* for services received from an *Out-of-Network Provider* depends upon where the services are provided. *SHBP-Covered Persons* may be responsible for paying the balance of these claims after the SHBP pays its portion, if any.

Services in New England (NH, MA, ME, CT, RI)

If Covered *Expenses* are received from an *Out-of-Network Provider* in New England, the *Allowed Amount* is defined as an amount that is consistent with the normal range of charges by health care *Providers* for the same or similar, products or services in a given geographic area provided to an *SHBP-Covered Person*. *Allowed Amounts* are based on data from a national database of medical and dental charges which is periodically updated.

Services Outside New England

If Covered *Expenses* are received from an *Out-of-Network Provider* located outside of New England, the *Allowed Amount* is defined as the lower of one of the following:

- fee(s) that are negotiated with the *Provider*; or
- 50% of the billed charges

The specific reimbursement formula used for services provided by an *Out-of-Network Provider* located outside of New England will vary depending upon the type of *Provider(s)* and the type of *Covered Expense(s)*.

Ambulatory Surgical Center – means a specialized facility:

- (1) where coverage of services performed at such a facility is mandated by law, and such facility has been licensed by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located; or
- (2) where coverage of services performed at such a facility is not mandated by law and meets all of the following requirements.
 - (a) It is established, equipped, and operated in accordance with the applicable laws in the jurisdiction in which it is located primarily for the purpose of performing surgical procedures.
 - (b) It is operated under the supervision of a licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is devoting full-time to such supervision and permits a surgical procedure to be performed only by a duly-qualified *Provider/Practitioner* who, at the time the procedure is performed, is privileged to perform such procedure in at least one *Hospital* (as defined) in the area.
 - (c) It requires in all cases (other than those requiring only local infiltration anesthetics) that a licensed anesthesiologist or licensed *Practitioner/Provider* qualified to administer anesthesia, administers the anesthetics and remains present throughout the surgical procedure.
 - (d) It provides at least two operating rooms and at least one post-anesthesia recovery room; is equipped to perform diagnostic X-ray and laboratory examinations; has trained personnel and necessary equipment and supplies

available to handle foreseeable emergencies; and has such equipment and supplies including but not limited to, a defibrillator, a tracheotomy set, and a blood bank or other blood supply.

- (e) It provides the full-time services of one or more Registered Nurses (R.N.) for patient care in the operating rooms and in the post-anesthesia recovery room.
- (f) It maintains a written agreement with at least one *Hospital* in the area for immediate acceptance of patients who develop complications or require post-operative or post-treatment confinement.
- (g) It maintains an adequate medical record for each patient, and such record shall contain an admitting diagnosis, and, for all patients except those undergoing a procedure under local anesthesia, a pre-operative examination report, medical history, laboratory tests and/or X-rays, an operative report, and a discharge summary.

Annual Open Enrollment Period – means the period of time at the beginning of each *Plan Year* under policies determined and published by the Plan Administrator, during which *Students* may elect to enroll in the SHBP. *Students* first enrolling at UNH at periods other than the beginning of a *Plan Year* may also enroll in the SHBP under policies determined and published by the Plan Administrator. *Students* who waive enrollment in the SHBP cannot change their election until the next *Annual Open Enrollment Period*. *Students* who attain other health insurance that would qualify for waiving SHBP coverage may apply to withdraw from the SHBP at the end of any semester *Coverage Period*.

Approved Clinical Trial – See Qualified Clinical Trial

Birthing Center – means a facility operated primarily for the purpose of providing treatment for obstetrical care for which it was duly incorporated as a *Birthing Center* and registered as a *Birthing Center* with the existing state. The *Birthing Center* must also be licensed, if required by law.

Claimant – means SHBP-Covered Person to whom the claim relates or, as applicable, to the SHBP Covered Person's authorized representative.

Contracted Rate – the negotiated amount the SHBP has agreed to pay an In-Network Provider for *Covered Expenses* minus any applicable Coinsurance, Copayment or Deductible an SHBP-Covered Person may be responsible as specified in [Section V](#) of the SHBP Document entitled Schedule of Benefits.

Coverage Period – means the various periods during which benefits provided under the SHBP are available to a *Covered Person*.

Covered Expense(s) – means the services or supplies that an SHBP-*Covered Person* is eligible to receive, or obtain payment for, as specified in this Plan Document [in Section V, Schedule of Benefits](#), [Sections VI, Required Benefits](#), [Section VII, Covered Medical Expenses](#), and [Section IX, Prescription Benefits and Exclusions](#). All provisions contained in this Plan Document, including exclusions, limitations, preadmission/precertification requirements, and special provisions such as Coordination of Benefits and Subrogation apply to *Covered Expenses*.

Covered Person/SHBP-Covered Person – means a *Student* or *Eligible Dependent* enrolled in this SHBP.

Covered Student – means any *Student* who enrolls in the SHBP and signs the enrollment application form on behalf of himself or herself, and on behalf of any *Eligible Dependents*, and pays the necessary contributions under the SHBP. *Covered Student* also means those *Students* who are automatically enrolled in the SHBP and pay the necessary contributions under the SHBP.

Custodial Care – means care which is designed essentially to assist the *Covered Person*, whether disabled or not, in meeting the activities of daily living, including services which constitute personal care such as help in walking and getting in or out of bed, assistance in bathing, dressing, feeding, using the toilet, preparation of special diets, and supervision over medication which can normally be self-administered. Such services and supplies are deemed to be *Custodial Care* whenever and wherever furnished, without respect to the *Provider/Practitioner* by whom or by which they are prescribed, recommended, or performed.

Day Treatment – means mental health or *Substance Use Disorders* care on an individual or group basis for more than 2 hours but less than 24 hours per day in either a licensed *Hospital*, rural health center, community mental health center or *Substance Abuse Disorder* treatment facility. This type of care is also referred to as partial hospitalization.

Durham Area – means geographic areas that have “038” in the first three digits of their U.S. Postal zip code.

Effective Date – means either the first day of the *Plan Year* or the first date of any *Coverage Period*. The *Effective Date* may be earlier than the first day of the *Plan Year* under certain circumstances established by UNH and published in the SHBP Document or subsequent amendment. For Qualified Late Enrollees and newly acquired dependents, the *Effective Date* will be the first date of the month for SHBP coverage, unless otherwise specified in the SHBP Document.

Effective Treatment of Substance Use Disorders – is a program of *Alcoholism/ Substance Use Disorders* therapy that relies upon ASAM criteria.

Treatment for maintenance care is not considered *Effective Treatment*. Maintenance care consists of providing an environment without access to alcohol or drugs.

Eligible Dependent(s) – means person(s) eligible for coverage under the SHBP as a dependent of a *Covered Student* as defined in [Section IV](#) of the SHBP Document, entitled SHBP Eligibility.

Emergency/Emergency Care/Emergency Medical Condition – means the sudden onset of a medical condition of sufficient severity that an individual possessing an average knowledge of health and medicine could reasonably expect that failure to obtain medical treatment would seriously jeopardize the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child); or cause serious harm to bodily functions or any bodily organ or part.

Examples of medical emergencies include symptoms of heart attack and stroke; poisoning; loss of consciousness; severe difficulty breathing or shortness of breath; shock; convulsions; uncontrolled or severe bleeding; sudden and/or severe pain; coughing or vomiting blood; sudden dizziness or severe weakness; profound change in vision; severe or persistent vomiting or diarrhea; and profound change in mental status

Emergency Care does not include ambulance service to the facility where treatment is received (see Ambulance Services in [Section V: Schedule of Benefits](#), and [Section VIII: Preadmission/ Precertification](#)).

Emergency Evacuation – means after being treated at a local *Hospital*; the *Covered Person's* medical condition warrants transportation to his/her home country or permanent residence to obtain further medical treatment to recover from an *Illness* or *Injury* sustained while covered under the SHBP.

Emergency Medical Services – means care administered in a *Hospital*, clinic, or *Provider's/Practitioner's* office for an *Emergency Medical Condition*; but does not include ambulance service to the facility where treatment is received

Essential Benefits/Services – means, for the purposes of considering a request for extension of the maximum 90 day period under the provision for extension of SHBP eligibility due to a Medical Leave of Absence (refer to [Section VIII, When Coverage Ends](#)), a *Medically Necessary* service or supply that could not be reasonably be provided by a health care provider that is covered by a health insurance that replaces the SHBP with similarly expected medical outcomes, convenience for access to care for the patient, continuity of care, or other factor for care, that, in the sole judgment of the Plan Administrator, appropriately necessitates the continuation of SHBP eligibility under the provisions for a Medical Leave of Absence.

ERISA – means the Employee Retirement Income Security Act of 1974, as amended from time to time.

Expedited Exception Process – means an exigent circumstance when a *Covered Person* is suffering from a health condition that may seriously jeopardize the *Covered Person's* life, health or ability to regain maximum function, or when a *Covered Person* is undergoing a current course of treatment using a non-formulary drug. The notification of the decision by the Claims Administrator will be made to the *Covered Person* and the prescriber *Provider* no later than 24 hours after the receiving the request.

Expenses Incurred – means an *Expense Incurred* at the time the service or supply is provided.

Experimental/Investigational – means any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply that is Experimental or Investigational and is used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition.

A drug, biologic, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational if one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought:

- (1) cannot be lawfully marketed in the United States without the final approval of the U.S. Food and Drug Administration (FDA) or any other state or federal regulatory agency and such final approval has not been granted at the time the drug, biologic, device, treatment, new technology, procedure, or supply is furnished; or
- (2) the service has been determined by the FDA to be contraindicated for the specific use; or
- (3) the service is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- (4) The service is subject to review and approval of an *Institutional Review Board (IRB)* or other body serving a similar function; or
- (5) the service is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental or Investigational or otherwise indicate that the safety, toxicity, or efficacy is under evaluation.

A service that is not Experimental or Investigational based on the above criteria may still be Experimental or Investigational if:

- (1) the scientific evidence is not conclusory concerning the effect of the service on health outcomes;

- (2) the evidence does not demonstrate the service improves the net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- (3) the evidence does not demonstrate the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- (4) the evidence does not demonstrate the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

The SHBP may include one or more items from the following list, which is not all inclusive, when applying the above provisions

- (1) published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- (2) evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- (3) Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- (4) documents of an IRB or other similar body performing substantially the same function; or,
- (5) consent document(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professional or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- (6) medical records; or
- (7) the opinions of consulting Providers and other experts in the field.

No benefits are available for the cost of care related to, resulting from, arising from, or provided in connection with Experimental or Investigational Services. No benefits are available for care furnished for complications arising from Experimental or Investigational Services.

You have the right to appeal benefit determinations including *Adverse Determinations* regarding Experimental or Investigational Services. For complete information about the appeal process, please see the “Appeal and External Review” sections.

Freestanding Health Clinic – means a private facility other than a private office of a *Provider/Practitioner*, which is operated primarily for the purpose of providing the treatment of *Illness* or minor *Injuries* of patients who are treated with or without an appointment for which it is duly licensed.

Grievance – means a written or oral complaint submitted by you, or on your behalf, regarding:

- (1) availability, delivery or quality of health care services, including a complaint regarding an *Adverse Benefit Determination*; or
- (2) claims payment, handling or reimbursement for health care services; or
- (3) matters pertaining to the relationship between you and the Claims Administrator.

Habilitative/Habilitation Services – means health care services that help a *Covered Person* or their *Eligible Dependent* keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include, but are not limited to, physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Home Health/Hospice – means care provided by a *Home Health Care/Hospice Care Agency* under an approved *Home Health Plan/Hospice Plan of Care*. *Home Health/Hospice* also means a licensed *Home Health Care/Hospice Care Agency* or *Inpatient Hospice Facility* that meets all of the requirements specified in the SHBP Document.

Home Health Care Agency/Hospice Care Agency – means an agency or organization which fully meets each of the following requirements.

- (1) It is primarily engaged in and is duly licensed, if such licensing is required, by the appropriate licensing authority to provide *Skilled Nursing* services and other therapeutic services.
- (2) It has policies established by a professional group employed with the agency or organization. The professional group must include at least one *Provider/Practitioner* and at least one Registered Nurse (R.N.) to govern the services provided and it must provide for full-time supervision of such services by a *Provider/Practitioner* or Registered Nurse.
- (3) It maintains a complete medical record on each patient.
- (4) It has an administrator.

Home Health Plan/Hospice Plan of Care – means a prearranged, written outline of care that will be provided for the palliation and management of a person's terminal *Illness* or *Home Health* care services.

Hospital – means a facility licensed and operated as required by law, which has:

- (1) Room, board, and nursing care;
- (2) A staff with one or more Doctors on hand at all times;
- (3) 24-hour nursing service;
- (4) All the facilities on site are needed to diagnose, care, and treat an illness or injury; and
- (5) Is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

The term Hospital does not include a facility, or that part of a facility, used mainly for:

- (1) Nursing care
- (2) Rest care
- (3) Convalescent care
- (4) Care of the aged
- (5) Custodial Care
- (6) Educational care
- (7) Subacute care

Illness(es) – means a sickness, bodily disorder, disease, or *Mental or Nervous Disorder or Substance Use Disorder*. An *Illness* due to causes which are the same as or related to causes of a prior *Illness*, from which there has not been complete recovery will be considered a continuation of such prior *Illness*. The term *Illness* as used in this SHBP will include pregnancy, childbirth, miscarriage, termination of pregnancy, and any complications of pregnancy and related medical conditions.

Incurred Date – means the date the service was performed or the supply was provided.

Infertility – means the condition of a presumably healthy individual who is unable to conceive or produce conception during a one-year period.

Injury(ies) – means an event from an external agent resulting in damage to the physical structure of the body independent of *Illness*, and all complications arising from such external agent. Injury includes medical expenses incurred while engaged in the practice or play of NCAA-sanctioned intercollegiate sports.

Inquiry – means any communication to the Claims Administrator, Plan Administrator, or Case Management Service, or utilization review organization by you, or on your behalf, that has not been the subject of an *Adverse Benefit Determination* and that requests redress of an action, omission, or policy of the SHBP.

In-Network Provider(s)/Practitioner(s) – means an individual *Provider/Practitioner*, an organization of *Provider(s)/Practitioner(s)*, *Hospitals* and other health care *Provider(s)/Practitioner(s)* that have agreed to participate in the Preferred Provider Networks offered under the SHBP. The level of coverage for benefits within the network is generally greater than the level of coverage for benefits outside the network.

Inpatient Hospice Facility – means an establishment which may or may not be part of a *Hospital* and which meets all of the following requirements.

- (1) It complies with licensing and other legal requirements in the jurisdiction where it is located.
- (2) It is mainly engaged in providing inpatient palliative care for the terminally-ill on a 24-hour basis under the supervision of a *Provider/Practitioner* or by a Registered Nurse (R.N.) if the care is not supervised by a *Provider/Practitioner* available on a prearranged basis.
- (3) It provides pre-death and bereavement counseling.
- (4) It maintains clinical records on all terminally-ill persons.
- (5) It is not mainly a place for the aged or a nursing or convalescent home.

Inpatient Hospice Facility also will include a *Hospice* facility approved for a payment of *Medicare Hospice* benefits.

Intensive Care Unit – means an accommodation of part of a *Hospital*, other than a postoperative recovery room, which, in addition to providing room and board:

- (1) is established by the *Hospital* for a formal *Intensive Care Unit* program;
- (2) is exclusively reserved for critically-ill patients requiring constant audio-visual observation prescribed by a *Provider/Practitioner* and performed by a *Provider/Practitioner* or by a specially-trained Registered Nurse; and
- (3) provides all necessary life-saving equipment, drugs, and supplies in the immediate vicinity on a standby basis.

Involuntarily Lose / Involuntary Loss – means, as this term is used for the purposes of administering the provisions for Qualified Late Enrollees, the involuntary loss of a group health insurance program for any reasons other than (a) non-payment of premium or (b) loss of health insurance because of withdrawal from UNH and with

corresponding loss of eligibility status used to qualify for a parent's group health insurance plan. UNH reserves the right to exclude from this definition losses of group health insurance coverage which the *Covered Person* could have reasonably been expected to avoid.

IRB Institutional Review Board – means is an independent organization mandated to provide ethical and regulatory oversight of research that involves human subjects.

Medical Necessity/Medically Necessary – means a service or supply which is a health care service that a *Provider/Practitioner*, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that is:

- (1) legal and is provided in accordance with generally accepted standards of medical practice;
- (2) clinically appropriate, in terms of type, frequency, extent, site and duration;
- (3) not Experimental or Investigational; and
- (4) not primarily for the convenience of the patient or the *Provider/Practitioner*.

For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community

The fact that a provider or other health practitioner orders, prescribes, recommends or furnishes health care services or products will not cause the intervention to be automatically considered Medically Necessary. The SHBP may consult the Medical Director and/or independent medical specialists, peer review committees, or other health care professionals qualified to make a recommendation regarding the Medical Necessity of any service or product prescribed.

Medicare – means Title XVIII of the Social Security Act of 1965, as amended. Part A means *Medicare's* hospital plan and Part B means the supplementary medical plan.

Mental or Nervous Disorder – means manic depression, neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

Morbid Obesity – means a diagnosed condition in which the body weight exceeds the medically recommended weight using standards that are consistent with qualification and treatment criteria set forth by the American Society for Metabolic and Bariatric Surgery or the American College of Surgeons.

Out-Of-Network Provider(s)/Practitioner(s) – means an individual *Provider/Practitioner*, an organization of *Provider(s)/Practitioner(s)*, and other health care

Providers/Practitioners that do not participate in the Preferred Provider Networks offered under the SHBP. The level of coverage for benefits outside of the network is generally less than the level of coverage for benefits within the network.

Plan Year – September 1, 2024, through August 31, 2025.

Preadmission Tests/Testing – means tests performed in a *Hospital* prior to confinement as an inpatient resident, provided:

- (1) such tests are related to the performance of a scheduled surgery or a scheduled admission;
- (2) such tests have been ordered by a duly-qualified *Provider/Practitioner* after a condition requiring such surgery or treatment has been diagnosed and *Hospital* admission for such surgery or treatment has been requested by the *Provider/Practitioner* and confirmed by the *Hospital*; and
- (3) the patient is subsequently admitted to the *Hospital*, or the confinement is canceled or postponed because there is a change in the condition, which precludes the surgery or the treatment.

Provider(s)/Practitioner(s) – means an appropriately-licensed Doctor of Medicine (M.D.), Doctor of Dental Surgery (D.D.S.), Doctor of Dental Medicine (D.M.D.), Licensed Anesthesiologist (M.D. or D.O), Doctor of Podiatry Medicine (D.P.M.), Doctor of Chiropractic (D.C.), Doctor of Optometry (O.D.), Certified Midwife (C.M.), Certified Registered Nurse Anesthetist (C.R.N.A.), Registered Physical Therapist (R.P.T.), Psychologist (Ph. D., Ed. D., Speed., or MA), Registered Nurse (R.N.), Licensed Clinical Social Worker (L.C.S.W.), Master of Social Work (M.S.W.), Speech Therapist, Occupational Therapist (O.T.), *Provider's/Practitioner's* Assistant, Registered Respiratory Therapist (R.R.T.), Nutritionist, Nurse Practitioner (A.P.R.N.), or Naturopath (N.D.).

Qualified Clinical Trial – means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is one of the following:

- (1) federally funded or approved;
- (2) conducted under a Food and Drug Administration (FDA) investigational new drug application; or
- (3) drug trials which are exempt from the requirements of an FDA investigational new drug application

Routine Nursery Care – means routine room and board or nursery charges, *Provider's/Practitioner's* or surgeon's charges, and any other related charges (including charges for circumcision) incurred while a newborn child is an inpatient in a *Hospital*, but coverage under this provision will not be provided beyond the date the newborn child is first discharged from the *Hospital*.

SHBP – means the Student Health Benefits Plan provided by the Plan Sponsor. Refer to the Plan Document that is applicable for each *Plan Year* that the SHBP is operated.

Skilled Nursing/Skilled Nursing Facility – means an institution or part thereof constituted and operated pursuant to law which:

- (1) provides, for compensation, room and board and 24-hour *Skilled Nursing* service under the full-time supervision of a *Provider/Practitioner* or a Registered Nurse. Full-time supervision means a *Provider/Practitioner* or Registered Nurse is regularly on the premises at least 40 hours per week;
- (2) maintains a daily medical record for each patient;
- (3) has a written agreement of arrangement with a *Provider/Practitioner* to provide *Emergency Care* for its patients;
- (4) qualifies as an extended care facility under *Medicare*, as amended; and
- (5) has a written agreement with one or more *Hospitals* providing for the transfer of patients and medical information between the *Hospital* and the skilled or convalescent nursing facility.

In no event, however, will a convalescent or *Skilled Nursing Facility* be deemed to include an institution which is, other than incidentally, a place for rest, for the aged, for treatment of chemical dependency, for the blind or deaf, for the mentally ill, or for the mentally handicapped.

Student(s) – means persons who are students at UNH who are eligible for coverage under the SHBP as defined in [Section IV](#) of the SHBP Document, entitled SHBP Eligibility. Student(s) also means persons who are enrolled in the International University Transfer Program (IUTP) provided by Navitas and taking classes at the Durham campus of the Plan Sponsor regardless of degree seeking status or credit hours enrolled at UNH. For IUTP students, the Plan Sponsor requires payment of applicable fees for access to UNH Health & Wellness as a condition of having student eligibility for the SHBP. The cost of coverage and period of coverage for IUTP students may vary depending upon the periods they are scheduled to be on the Durham campus of the Plan Sponsor.

Substance Use Disorder – means a substance-induced disorder, which produces a state of psychological and/or physical dependence.

Total Disability or Totally Disabled – means the status of a *Covered Student* who is unable to attend class or complete other required school work as a result of *Injury* or *Illness*. For those already enrolled dependents who cannot work to support themselves due to mental or physical handicap: The dependent’s disability must start before the end of the period they would become ineligible for coverage. The Plan Administrator must be informed of the dependent’s eligibility for continuation of coverage within 31 days after the dependent would normally become ineligible. You must then give proof as often as Plan Administrator requires. This will not be more often than once a year after the two-year period following the child reaching the limiting age. Any cost for examination of a child to determine continued eligibility will be borne by the SHBP.

University of New Hampshire (UNH) – means the University of New Hampshire campuses at Durham, Manchester, and UNH Law in Concord.

Uniformed Service – means the Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty; the commissioned corps of the Public Health Service; and any other category of persons designated by the President in the time of war or emergency.

Urgent Care – means care that is provided when an individual’s health is not in serious danger, but that individual needs immediate medical attention for an unforeseen *Illness* or *Injury*. Examples of *Illnesses* or *Injuries* in which *Urgent Care* might be needed are a broken or dislocated toe, a cut that needs stitches but is not actively bleeding, or symptoms of a urinary tract infection.

A. Claims and Appeals Procedures

This Section describes a SHBP-Covered Person's rights and obligations with respect to filing claims, submission of *Grievances*, receiving timely notice about whether and the extent to which benefits are payable, and the option to appeal a claim that has been denied in whole or in part.

B. Overview

The Plan Administrator has delegated the administration of claims processing under the SHBP to the Claim Administrator. As directed by the Plan Administrator, the Claim Administrator makes initial claim and initial appeal determinations based on the specific terms of the Plan Document. The Plan Administrator has authority to interpret the SHBP Document to determine the amount of benefits that will be paid on any particular benefit claim and has discretion and authority to make factual findings regarding a claim and to interpret the terms of the Plan as they apply to the claims.

The steps involved in claims and appeals processing are outlined below. Important details about the required procedures and SHBP-Covered Person's rights are included in Sections C through G.

- (1) All initial claims must be filed within one (1) year of the date the *Incurred Date* for a *Covered Expense*.
- (2) As directed by the Plan Administrator, the Claim Administrator will make an initial determination about benefits payable based on the specific terms of this Plan Document and will notify the SHBP-Covered Person within the period specified for the type of claim filed (refer below to Initial Claim Determination, and Chart A).
- (3) If the claim is denied in whole or in part, and the SHBP-Covered Person disputes the determination, he or she may contact the Claim Administrator to confirm that the claim was properly processed. The SHBP-Covered Person may also immediately file a formal internal appeal (refer below to Internal Appeals and External Review of Denied Claims).
- (4) The Claim Administrator will send the internal appeal filed to the Plan Administrator to make an appeal determination based on the specific terms of the Plan Document within the period specified for the type of claim that is the subject of the appeal (refer below to Internal Appeals and External Review of Denied Claims, Chart B).
- (5) If the internal appeal is denied in whole or in part and the denial is related to a rescission or is based on medical judgment, and the SHBP-Covered Person disputes the determination, the SHBP-Covered Person (or authorized representative) has the right to request an external review through the New Hampshire Insurance Department.

C. Who May File a Claim

A claim may be filed by a *SHBP-Covered Person*, his or her authorized representative, or his or her health care service provider. To designate an authorized representative, a *SHBP-Covered Person* must submit a request in writing to the Claim Administrator. After an authorized representative has been designated, all subsequent notices and decisions concerning claims will be provided to the *SHBP-Covered Person* through his or her authorized representative. The forms required to authorize a representative are available from the Claim Administrator. For the purposes of this Section, a *Claimant* refers to the Covered Person to whom the claim relates or, as applicable, to the Covered Person's authorized representative.

D. Types of Claims

The time limits applicable to claims and appeals depend on the type of claim at issue. The categories of potential claims are defined below.

- (1) **Urgent Care Claim**—A claim for medical care or treatment where using the time periods for making non-urgent care determinations (a) could seriously jeopardize the life or health of the *SHBP-Covered Person* or the ability of the *SHBP-Covered Person* to regain maximum function, or (b) in the opinion of a *Provider/Practitioner* with knowledge of the *SHBP-Covered Person*'s medical condition, would subject the *Claimant* to severe pain that could not be adequately managed without the care or treatment being claimed. Refer also to *Urgent Care* in the Definitions provided in [Section XVIII](#).
- (2) **Concurrent Care Claim**—A claim for an extension of the duration or number of treatments provided through a previously-approved benefit claim
- (3) **Pre-Service Care Claim**—A claim for a benefit that requires approval (usually referred to as precertification or preauthorization) under the SHBP in advance of obtaining medical care
- (4) **Post-Service Care Claim**—A claim for services that have already been provided or that do not fall into any of the categories above

E. When and How to File a Claim

A *SHBP-Covered Person* must submit, or ensure that his or her *Provider/Practitioner* submits a claim within one (1) year after the date that services are provided. Claims received after that date will be denied. This time limit does not apply if the *SHBP-Covered Person* is legally incapacitated.

How a claim may be filed depends on the type of claim (refer to Section D):

- (1) Urgent Care Claims may be submitted verbally by calling the Claim Administrator at (877) 657-5041 or by any method available for non-urgent and post-service claims.
- (2) Non-Urgent Care Claims and Post-Service Care Claims may be filed electronically or using a written form available from the Claim Administrator, and must be submitted to the Claim Administrator using one of the following methods:
 - Electronically
 - U.S. Mail

-EDI Payer ID: 62308	Cigna OAP PO Box 188061 Chattanooga, TN 37422-8061
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General Notice about Nondiscrimination and Accessibility

The SHBP complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The SHBP does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

The SHBP:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters.

If you need these services, contact our Civil Rights Compliance Coordinator at 800-657-5030.

If you believe that the SHBP 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:

Betsy M. Stevens Civil Rights Coordinator 2077 Roosevelt Ave Springfield MA 01104	John Kelley Civil Rights Coordinator 2077 Roosevelt Ave Springfield MA 01104
Ph: (413) 733-4540 or (413) 733-4612 Fax: (413) 747-8418	

You can file a grievance in person, by mail, fax or email. If you need help filing a grievance, the Civil Rights Coordinator 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, D.C. 20201
(800) 368-1019, (800) 537-7697 (TTY)

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

F. Initial Claim Determination

After a claim has been submitted in compliance with Section, the Claims Administrator is obligated to adjudicate the claim within specified time limits, depending on the type of claim. In some cases, the time limits may be extended if there are circumstances beyond the Claim Administrator's control that require a delay, or if the claim was submitted improperly or lacked information necessary to make a determination. In such cases, the *Claimant* will be notified about the need for a delay or for additional information regarding the claim within a specified period of time.

The following table shows the applicable time limits based on type and specific circumstances of the claim.

CHART A – Time Limits Regarding Initial Claims				
Type of Initial Claim (refer to Section D)	Maximum period after receipt of claim for initial benefits determination	Maximum extension of initial benefits determination for delays beyond the control of Claim Administrator	Maximum period to notify <i>Claimant</i> of improperly filed claim or missing information	Period for <i>Claimant</i> to provide missing information
URGENT CARE CLAIMS (not including urgent concurrent care claims)	72 hours	No extension permitted	24 hours	48 hours minimum*
URGENT CONCURRENT CARE CLAIMS**	24 hours	No extension permitted	24 hours	48 hours minimum*
PRE-SERVICE AND NON-URGENT CONCURRENT CLAIMS	15 days	15 days	15 days	45 days maximum
POST-SERVICE CLAIMS	30 days	15 days	30 days	45 days maximum

*A determination will be made within 48 hours of receiving both a properly filed claim and any missing information.

**If the claim is received at least 24 hours before the end of the previously approved course of treatment. Otherwise the time limits are the same as for Urgent Care Claims.

G. How Claims Are Paid

If a claim is approved, in whole or in part, payment will be made directly to the provider.

H. Internal Appeals of Denied Claims

If a claim is denied in whole or in part, a *Claimant* may file an internal appeal of the *Adverse Benefit Determination*.

Before filing an appeal, a *Claimant* may first, but is not required to, contact the Claim Administrator at (877) 657-5041 to verify that the claim was correctly processed under the terms of the SHBP.

Internal appeals must be filed within 180 days of the initial claim denial; requests for external review must be filed within 180 days of the internal appeal denial. Any appeal received after these deadlines will be denied. Chart B below shows details of the deadlines for filing appeals and making determinations upon review.

How appeals may be filed depends on the type of appeal or request for external review:

- (1) Urgent care appeals or requests for external review may be submitted verbally by calling the Claim Administrator at (877) 657-5041 or by any method available for non-urgent and post-service Appeals.
- (2) Non-urgent care Appeals and post-service appeals must be in writing and submitted to the Claim Administrator using one of the following methods:
 - U.S. Mail
 - Hand delivery
 - Facsimile (FAX): (413) 733-4612

Wellfleet Attn.: Appeals Department PO Box 15369 Springfield, MA 01115-5369	
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Grievances, or written appeals must include the following information:

- (1) The patient’s name
- (2) The patient’s Plan identification number
- (3) Sufficient information to identify the claim or claims being appealed, such as the date of service, provider name, procedure (if known) and claim number (if available)
- (4) A statement that the SHBP-Covered Person (or authorized representative on behalf of the SHBP-Covered Person) is filing an appeal.

In making an appeal, the SHBP-Covered Person has the right to:

- Review pertinent documents and submit issues and comments in writing.
- Request the billing and diagnosis codes related to the claim if the SHBP-Covered Person believes a coding error may have caused the denial.
- Automatically receive any new or additional evidence or rationale considered, relied upon or generated by the SHBP in connection with the claim as soon as possible so as to provide the SHBP-Covered Person with reasonable time to respond before the final internal determination is issued.
- Designate an authorized representative to act on the SHBP-Covered Person’s behalf for the purposes of the appeal or request for external review.

- Submit written comments, documents, records, or any other matter relevant to his or her appeal or request for external review, even if the material was not submitted with the initial claim.
- Have reasonable access to, and copies of, all documents, records, and other information relevant to his or her appeal or request for external review, upon request and free of charge.

Any *Grievance* or appeal will take into account all comments, documents, records, and other information submitted by the *Claimant* relating to the appeal, regardless of whether such information was submitted or considered in the initial benefit determination. In addition, the review will not afford deference to the initial *Adverse Benefit Determination*, and the review decision will be made by individuals who were not involved in the initial claim denial and who are not subordinates of those who made the initial determination. If the denial was based on a medical judgment, the appeal or request for external review will be reviewed by a health care professional who did not participate in the initial denial.

If the initial appeal is denied, the *Claimant* will be given the specific reasons for the denial, with reference to the applicable Plan Document provision, rule, guideline, protocol or criteria upon which the denial was based.

In the event that an appeal is denied, and the denial involved a rescission or was based in whole or in part on medical judgment, the *Claimant* will have 180 days to request an external review. [See Section I]

I. External Review of Denied Claims

You may have the right to an independent External Review of an *Adverse Determination*. External Reviews are arranged through and overseen by the New Hampshire Insurance Department. They are conducted by neutral Independent Review Organizations as certified by the Insurance Department. The SHBP pays for the cost of Independent Review Organization services. There is no cost to you for External Review. For Complete information (including instructions on how to submit new information for review and time-frames for completing the External Review), please see the Insurance Department's Consumer Guide to External Appeal at the websites below:

https://www.nh.gov/insurance/consumers/documents/ex_rev_guide.pdf
https://www.nh.gov/insurance/consumers/documents/ex_rev_app.pdf

or at:

New Hampshire Department of Insurance
ATTN: External Review
21 South Fruit Street, Suite #14
Concord, NH 03301
1-800-852-3416 or 603-271-2261
(603) 271-1406 for Expedited External Review Applications

REQUESTS@INS.NH.GOV

The full copy of the Consumer Guide to External Review and Application can be found at the end of this document.

Type of Claim	Maximum period for Claimant to file initial internal appeal after initial denial	Maximum period for issuing determination regarding appeal	Maximum period for Claimant to file request for external review following denial of final appeal*	Maximum period for issuing determination regarding external review
URGENT CARE CLAIMS (including urgent concurrent care claims)	180 days	72 hours	4 months	72 hours
PRE-SERVICE AND NON-URGENT CONCURRENT CLAIMS	180 days	15 days	4 months	45 days
POST-SERVICE CLAIMS	180 days	30 days	4 months	45 days

*available for rescissions and denials based on medical judgment.



**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.**



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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 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: (____) _____
- 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.

Continued on next page

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

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.



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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