State of New Hampshire
Health Related Insurance Mandates
Updated January 2011

The following list of mandates is a summary of benefits required for inclusion in fully insured insurance policies and certificates issued in New Hampshire. See the applicable RSAs, N.H. Insurance Department Bulletins and insurance regulations for specific details and guidance.

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ALTERNATIVE SERVICES - Services Performed By Chiropractic, Osteopathy, Podiatry, Optometry, or Advanced Registered Nurse Practitioner

Any policy that provides for reimbursement for any service which may be alternatively performed by a N.H. licensed chiropractor, osteopath, podiatrist, optometrist, or advanced registered nurse practitioner, reimbursement shall not be denied coverage when such service is rendered by a person so licensed.

RSA 415:5 (8); RSA 415:18 VI
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BONE MARROW Testing For Donation

New Hampshire law requires insurance coverage for the cost of testing for bone marrow donation. The testing shall be performed in a facility that is accredited by the American Association of Blood Banks or the College of American Pathologists, or any other national accrediting body. The person tested shall complete and sign an informed consent form that also authorizes the results of the test to be used for participation in the National Marrow Donor Program.

Effective: July 25, 2006
RSA 415:6-m; 415:18-r; 420-A: 2; 420-B: 20 III
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CHILDREN

CHILDREN - Coverage of Children During Adoption Proceedings

All individual and group policies that provide coverage for family members shall provide health insurance benefits for any minor from the date the minor is placed in the custody of the insured pursuant to an adoption proceeding under the provisions of RSA 170-B. Such health insurance benefits shall terminate upon dismissal or withdrawal of the petition for adoption.

RSA 415:22-a, RSA 420-A: 15, RSA 420-B: 8-g
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CHILDREN - Certain Dental Procedures Performed At Dental Office (Effective January 1, 2004):

Each dental insurer or other similar entity, including Delta Dental under RSA 420-F, that issues or renews any policy of group insurance providing benefits for oral surgical procedures, shall provide benefits for children who are residents of New Hampshire and under the age of 6 who have a dental condition of significant dental complexity, an exceptional medical circumstance or developmental disability, coverage for the administration of general anesthesia for procedures performed in a dentist's office.

Effective January 1, 2004
RSA 415:18-h
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CHILDREN - Coverage for Dental Procedures: Medical or Hospital Group: Effective January 1, 2004

Each insurer that issues or renews any group or blanket accident or health insurance policy or certificate providing benefits for medical or hospital expenses, shall provide benefits for children who are residents of N.H., under the age of 6 who have a dental condition of significant dental complexity, exceptional medical circumstances or a developmental disability, coverage for medically necessary hospital or surgical day care facility charges and administration of general anesthesia.

Effective January 1, 2004
RSA 415:18-g, RSA 420-A: 17-b, RSA 420-B: 8-ee
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CHILDREN - Newborn Children Covered from Birth

All policies providing coverage on a provision of service or an expense shall provide health insurance benefits to newborn children of the insured from the moment of birth. Coverage for the newborn child shall consist of coverage for injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and abnormalities.

If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy may require that notification of the birth and payment of the required premium or fee must be furnished to the insurer within 31 days after the date of birth in order to have coverage continue after the 31-day period.

Unless the policy or contract specifically provides that grandchildren of the insured or subscriber are eligible for coverage, coverage for newly born children of a dependent child of the insured will not continue beyond the initial 31-day period following birth.

RSA 415:22, RSA 420-B: 8-j
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CHILDREN - Nonprescription Enteral Formulas

Any policy of accident or health insurance providing benefits for medical or hospital expenses, shall provide to insureds who are residents of this state, coverage for:

1. Nonprescription enteral formulas for the treatment of impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, or motility of the gastrointestinal tract.

2. Nonprescription enteral formulas and food products required for persons with inherited diseases of amino acids and organic acids. Such coverage for inherited diseases of amino acids and organic acids shall, in addition to the enteral formula, include food products modified to be low protein, the amount shall not be less than $1,800 annually for any insured individual.

RSA 415:6-c, RSA 415:18-e, RSA 420-A: 17, RSA 420-B: 8-ff
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CHILDREN - Early Intervention Therapy Services For Children

This law requires insurance coverage for the cost of early intervention services for children with a developmental disability or delay, from birth to 36 months of age. Coverage must be provided for expenses of licensed and credentialed occupational therapists, physical therapists, speech-language pathologists, and clinical social workers if referred by a primary physician. The benefits may be subject to deductibles, co-payments, coinsurance, or other terms and conditions of the policy, and may have a cap of $3,200 per child per year with coverage maximums not less than $9,600 by the child's third birthday.

Effective September 14, 2007
RSA 415:6- n, 415:18-s, 420-A:17-g, 420-B:8-r
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CHIROPRACTIC CARE - 12 Self-Referred Visits

Managed care health care plans offering chiropractic benefits shall provide benefits to a covered person who utilizes services of a chiropractic provider (doctor of chiropractic) by self-referral for 12 visits. After 12 self-referral visits, a covered person who is continuing chiropractic care may be subject to utilization review from the health plan for the purpose continued care.

RSA 420-J: 6-b
BULLETIN: 00-010-AB - THE IMPLEMENTATION OF SB 147 (C 14, LAWS OF 2000) RELATIVE TO SELF-REFERRALS FOR CHIROPRACTIC CARE UNDER MANAGED CARE ORGANIZATIONS
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CLINICAL TRIALS - Coverage for Qualified Clinical Trials

All group hospital and medical expense policies, shall provide coverage for medically necessary routine patient care costs incurred as a result of a treatment being provided in accordance with a clinical trial [to the extent such costs would be covered by non-investigative treatments if the treatment is being provided or the studies are being conducted in a phase I, phase II, phase III or phase IV clinical trial for cancer or the treatment is being provided for any other life-threatening condition]. Coverage for phase I or phase II clinical trials shall be decided on a case by case basis.

Coverage shall be required if:

1. Treatment is being provided by an approved clinical trial
2. Standard treatment has been or would be ineffective, does not exist, or there is no superior non-investigational treatment alternative
3. Facility and personnel providing the treatment are capable of doing so by virtue of their experience
4. Available clinical data provide a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative

The provisions of this section shall not apply to policies paid under the federal Medicare program nor the state children's health insurance program.
RSA 415:18-l Return to Table of Contents

DEPENDENTS

DEPENDENTS - Coverage for a Dependent Who is Mentally or Physically Incapable of Earning Their Own Living

Every policy that includes coverage for family members shall continue coverage for an insured family member who is mentally or physically incapable of earning his own living on the date such dependent's status as a covered family member would otherwise expire because of age. While the policy remains in force, or is replaced by another policy, it shall continue to cover the dependent as long as the incapacity continues and as long as said dependent remains chiefly financially dependent on the policyholder for support.

RSA 415:5 (3-a); RSA 415:18 V
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DEPENDENTS - Dependent Health and Dental Insurance Coverage until age 26

A policy may, at the election of the carrier, insure(d), originally or by subsequent amendment, upon application of an adult member of a family who shall be deemed the policyholder, any 2 or more eligible members of that family, including husband, wife, dependent children, or any other person dependent upon the policyholder. In the event a carrier elects to provide coverage for dependent children, the term "dependent child" shall include a subscriber's child by blood or by law, who is under age 26.

Nothing in this section shall be construed to require:

a) Coverage for services provided to a dependent before the effective date of this section; or

b) That an employer pays all or part of the cost of family coverage that includes a dependent as provided pursuant to this section.

A subscriber that elects family coverage during any applicable open enrollment period may enroll any dependent child eligible pursuant to this section.

Coverage for a dependent provided pursuant to this section shall be provided until the earlier of the following:

- The dependent is disqualified for dependent status as set forth in paragraph I of this section; or
- The date upon which the employer under whose contract coverage is provided to a dependent ceases to provide coverage to the subscriber.

Nothing in this section shall be construed to permit a health insurance carrier to refuse an election for coverage by a dependent pursuant to paragraph III, based upon the dependent's prior disqualification pursuant to subparagraph IV(a).

Notice regarding coverage for a dependent as provided pursuant to this section shall be provided to a subscriber:

On the certificate of coverage prepared for subscribers on or about the date of commencement of coverage; and

- Within 30 days following the effective date of this section.
- Such notice shall include information regarding the required special open enrollment period.

Effective: 9/23/10 – RSA 415:5, I (3), 420-A:10-a, 420-B:8-aa, 420-C:4-a, 420-F:5-a, 420-J:8-d

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DEPENDENTS - Michelle's Law

Extends health insurance coverage to full-time students on medical leaves of absence

Health coverage for dependent children who are full-time students, as defined by the educational institution and beyond the age of 18, will be allowed to continue their health insurance for a medically necessary leave of absence from school for a period not to exceed 12 months or the date on which coverage would otherwise end pursuant to the terms and conditions of the policy, whichever comes first. Any breaks in the school semester shall not disqualify the dependent child from coverage.

Documentation and certification of the medical necessity leave of absence shall be submitted to the insurer by the student's attending physician and shall be considered adequate evidence of entitlement to coverage. The date of the documentation shall be the date the insurance coverage begins.

Effective June 22, 2006
RSA 415:5, RSA 415:18
Effective January 1, 2008, this law was expanded to include RSA 420-A:15-b, 420-B: 8-q, 420-C:4-a, 420-F:5, 420-J:6-d
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DIABETES

DIABETES - Diabetes Services and Supplies

Any individual, group, blanket policy or HMO contract that provides benefits for medical or hospital expenses shall provide to insureds who are residents of this state, coverage for medically appropriate and necessary outpatient self-management training and educational services, pursuant to a written order of a primary care physician or practitioner. Required coverage includes, but is not limited to medical nutrition therapy for the treatment of diabetes provided by a certified, registered or licensed health care professional with expertise in diabetes.

RSA 415:6-e, RSA 415:18-f, RSA 420-A: 17-a, RSA 420-B: 8-k
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DIABETES - Diabetes Treatments

Any individual or group policy or contract that provides benefits for medical or hospital expenses and coverage for durable medical equipment coverage shall provide for medically appropriate or necessary equipment used to treat diabetes, coverage is subject to the terms and conditions of the policy.

RSA 415:6-e, RSA 415:18-f, RSA 420-A: 17-a, RSA 420-B: 8-k (also listed under Prescription Drugs)
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DIVORCE/LEGAL SEPARATION - Continuation of Group Health and Dental Insurance Coverage In The Event Of Divorce or Legal Separation

This law expands continuation of group health and dental insurance in the event of divorce or legal separation. The law allows a former spouse or eligible dependent to stay on the ex-spouse's group policy for a period of 3 years and then obtain New Hampshire continuation coverage at the end of the 3 year period. The law applies to any group policy that covers a resident of New Hampshire regardless of where the policy was issued or delivered. The department has issued a bulletin (dated 7/7/07) that provides further guidance on the application of this law.

Effective January 1, 2008
RSA 415:18, 458:18
BULLETIN - 07-064-AB- IMPLEMENTATION OF SB 197 - DIVORCED SPOUSE BILL
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HEARING AIDS: Coverage for Hearing Aids (Does not apply to Medicare and Medicare Supplement plans)

Each insurer that issues or renews any individual policy, group policy, HMO, Health Service Corporation, or certificate for delivery in this state, or contract of accident or health insurance providing benefits for medical or hospital expenses, shall provide coverage for the professional services associated with the practice of fitting, dispensing, servicing, or sale of hearing instruments or hearing aids. The benefits included in this section shall not be subject to any greater deductible or coinsurance or co-pay than any other benefits provided by the insurer. Insurers are required to cover the cost of a hearing aid for each ear, as needed, as well as related services necessary to assess, select, and fit the hearing aid with a maximum for the hearing aid and related services of no less than $1,500 per hearing aid every 60 months. The insured may choose a higher price hearing aid and pay the difference in cost. The hearing aid shall be prescribed and dispensed by a licensed audiologist or hearing instrument specialist. Notwithstanding any provision of law or rule to the contrary, the coverage under this section shall not apply to the medical assistance program, pursuant to RSA 161 and RSA 167. In this section:

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

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

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

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

This act shall apply to all group policies, contracts, and certificates issued or renewed on or after January 1, 2011.

RSA 415:6-p, RSA 415:18-u, 420-B:20, 420-A:2 – effective January 1, 2011
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MENTAL HEALTH

MENTAL HEALTH - Court Ordered Psychiatric and Psychological Services

No policy or certificate issued shall contain a provision denying insurance benefits for psychiatric and psychological services solely because they have been ordered by the court. Benefits for services shall be subject to the same dollar limits, deductibles and co-pays, policy conditions and managed care provisions as for other services.

RSA 415:6-b; RSA 415:18-a VII; RSA 420-B: 8 II
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MENTAL HEALTH - Coverage For Certain Biologically Based Mental Illnesses: 417-E:1

I. For the purposes of this chapter ""mental illness'' means a clinically significant or psychological syndrome or pattern that occurs in a person and that is associated with present distress, a painful symptom or disability, impairment in one or more important areas of functioning, or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.

II. Notwithstanding any other provision of law, each insurer that issues or renews any policy of group or blanket accident or health insurance and each nonprofit health service corporation under RSA 420-A and health maintenance organization under RSA 420-B providing benefits for disease or sickness in the state of New Hampshire shall provide benefits for treatment and diagnosis of certain biologically-based mental illnesses under the same terms and conditions and which are no less extensive than coverage provided for any other type of health care for physical illness.

III. The following mental illnesses, as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association, shall be covered under this section:

(a) Schizophrenia and other psychotic disorders.
(b) Schizoaffective disorder.
(c) Major depressive disorder.
(d) Bipolar disorder.

(e) Anorexia nervosa and bulimia nervosa.
(f) Obsessive-compulsive disorder.
(g) Panic disorder.
(h) Pervasive developmental disorder or autism.
(i) Chronic post-traumatic stress disorder.

IV. The benefits required under this section shall begin when benefits provided under RSA 415:18-a and RSA 420-B:8-b, as applicable are exhausted.

V. The commissioner may adopt rules, under RSA 541-A, as may be necessary to effectuate any provisions of the Mental Health Parity Act of 2008 that relate to the business of insurance.

VI. Nothing in this section shall be construed to affect any obligation to provide services to an individual under an individualized family service plan or an individualized education program, as required under the federal Individuals With Disabilities Education Act, or the provision of services to an individual under any other federal or state law.

417-E:1
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MENTAL HEALTH - Coverage For Treatment Of Pervasive Developmental Disorder Or Autism: 417-E:2

I. For the purposes of this chapter, treatment of pervasive developmental disorder or autism as required under RSA 417-E:1, III(h) shall include the following:

(a) Professional services and treatment programs, including applied behavioral analysis, necessary to produce socially significant improvements in human behavior or to prevent loss of attained skill or function. To be eligible for coverage, applied behavior analysis must be provided by a person professionally certified by the national Behavior Analyst Certification Board or performed under the supervision of a person professionally certified by the national Behavior Analyst Certification Board.

(b) Prescribed pharmaceuticals subject to the same terms and conditions of the policy as other prescribed pharmaceuticals.

(c) Direct or consultative services provided by a licensed professional including a licensed psychiatrist, licensed advanced practice registered nurse, licensed psychologist, or licensed clinical social worker; and

(d) Services provided by a licensed speech therapist, licensed occupational therapist, or licensed physical therapist.

II. An insurer may require submission of a treatment plan, including the frequency and duration of treatment, signed by the primary care provider, an appropriately credentialed treating specialist, a child psychiatrist, a pediatrician with a specialty in behavioral-developmental pediatrics, a neurologist with a specialty in child neurology, or a licensed psychologist with training in child psychology, that the treatment is medically necessary for the patient and is consistent with nationally recognized treatment standards for the condition such as those set forth by the American Academy of Pediatrics. An insurer may require an updated treatment

plan no more frequently than on a semi-annual basis. Coverage shall not be denied on the basis that services are habilitative in nature.

III. **The policy, contract, or certificate may limit coverage for applied behavior analysis to $36,000 per year for children 0 to 12 years of age, and $27,000 from ages 13 to 21.** An insurer may not apply payments for coverage unrelated to autism spectrum disorders to any maximum benefit established under this paragraph.

IV. Nothing in this section shall be construed to affect any obligation by a school district or the state of New Hampshire to provide services to an individual under an individualized family service plan or an individualized education program, as required under the federal Individuals With Disabilities Education Act, or the provision of services to an individual under any other federal or state law.

V. The commissioner shall adopt rules, pursuant to RSA 541-A, relative to the insurance coverage requirements established under this section.

This act shall apply to all group policies, contracts, and certificates issued or renewed on or after January 1, 2011.

RSA 417-E:2
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MENTAL HEALTH - Coverage for Dependents who are Mentally or Physically Incapable of Earning their own Living

Every policy that includes coverage for family members shall continue coverage for an insured family member who is mentally or physically incapable of earning his own living on the date such dependent's status as a covered family member would otherwise expire because of age. While the policy remains in force, or is replaced by another policy, it shall continue to cover the dependent as long as the incapacity continues and as long as said dependent remains chiefly financially dependent on the policyholder.

RSA 415:5 (3-a); RSA 415:18 V
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MENTAL HEALTH - Coverage for Mental or Nervous Conditions and Treatment for Chemical Dependency Required

Any group, blanket accident or health insurance policy providing benefits for medical or hospital expenses, shall provide to insureds who are residents of New Hampshire, and whose principle place of employment is in this state, coverage for expenses arising from the treatment of mental illness and emotional disorders which are subject to significant improvement through short-term therapy, and benefits for expenses arising from diagnosis and evaluation of all other mental illnesses and emotion disorders.

In the case of policies providing benefits for hospital and medical expenses on a major medical basis, benefits arising from the treatment, diagnosis and evaluation of mental illnesses and disorders shall be subject to deductibles and coinsurance at least as favorable as those which apply to the benefits for any other illness. Benefits payable for expenses incurred in any consecutive 12-month period may be limited to an amount not less than $3,000 per covered individual, and to a lifetime maximum of not less than $10,000 per covered individual.

RSA 415:18-a IV (a)

Any group, blanket accident or health insurance policy providing benefits for medical or hospital expenses, shall include coverage for expenses arising from the treatment for chemical dependency including alcoholism and shall include both an inpatient and outpatient benefit for detoxification and rehabilitation.

RSA 415:18-a I(c)
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MENTAL HEALTH - Health Maintenance Organization Benefits for Mental and Nervous Conditions and Treatment for Chemical Dependency

Benefits for mental or nervous conditions shall conform to the requirements of (RSA 415:18-a) or alternatively with the basic health services requirements of the Health Maintenance Organization Act of 1973. If the HMO provides these alternative benefits, such benefits will not be subject to any deductible and any coinsurance cannot exceed 20%.

A HMO must allow its subscribers 2 visits to a psychiatrist or other mental health care providers, within the organization's network, for diagnosis followed by up to 3 visits in each contract year without utilization review. Subsequent visits within the contract year may be subject to utilization review.

RSA 420-B: 8-b I

Coverage shall be provided for expenses arising from the treatment for chemical dependency, including alcoholism, up to a specified limit which may be defined in terms of a dollar amount or a maximum number of days or visits. Coverage shall include both an inpatient and outpatient benefit for detoxification and rehabilitation. (Effective 1/1/03)

RSA 420-B: 8-b III
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MENTAL HEALTH - Services Rendered at a Community Mental Health Center or Psychiatric Residential Program

Each insurer of group, blanket accident or health insurance policy providing benefits for medical or hospital expenses shall provide to insureds who are residents of New Hampshire and whose principal place of employment is in this state, benefits for services rendered at a community mental health center or psychiatric residential program approved by the department of health and human services. Those benefits shall be subject to the terms and conditions at least as favorable as those which apply to the treatment of other illnesses.

RSA 415:18-a III (b)
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NH STATE CONTINUATION – Continuation of Coverage Option.

N.H. State Continuation is a right of N.H. residents who are covered employees and qualified beneficiaries of a fully insured group health and/or dental benefit plan which allows, under N.H. law, to temporarily continue on their plan after the date their coverage would have otherwise ended due to a change in eligibility (referred to as a *qualifying event)*. For more information on N.H. State Continuation please refer to the N.H. Insurance Department's booklet, "N.H.I.D.'s Guide to NH State Continuation". *This is available on our website or request copy through the NH Insurance Department's LAH Consumer Division at (800)852-3416. Or refer to the laws governing the general requirements for N.H. State Continuation at RSA 415:18, XVI .*
RSA 415:18, XVI)
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OBESITY - Obesity & Morbid Obesity / Bariatric Surgery

This law provides N.H. residents coverage for the diseases and ailments caused by obesity and morbid obesity, including bariatric surgery, when the prescribing physician has issued a written order stating that bariatric surgery is medically necessary and is in accordance with the patient qualifications and treatment standards set forth by the American Society for Metabolic and Bariatric Surgery or the American College of Surgeons. The covered insured shall be at least 18 years of age. The benefits included in this section shall be subject to the terms and conditions of the policy and shall be no less extensive than coverage provided for similar conditions or illnesses.

Insurers are required to include bariatric surgery on policies and certificates issued or renewed on or after September 14, 2008.

Effective: September 14, 2008
RSA 415:6-o, 415:18-t, 420-A:2, 420-B:20
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PRE-CERTIFICATION

In the event that a person is covered by more than one plan that requires pre-certification, the member shall obtain pre-certification from the primary plan. Although the member shall not be required to obtain pre-certification from the secondary plan, the secondary plan shall not be required to treat such services as covered services if the services do not meet its certification criteria. The secondary plan shall not refuse payment for such services solely on the basis that the services were not pre-certified by the secondary plan.

Effective January 1, 2008
RSA 415:18, 415:6, 420-J:3-b
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PRESCRIPTION

PRESCRIPTION - 90-Day Supply of Prescription Drugs

This law requires insurance companies to allow for the purchase of up to a 90-day supply of covered prescription drugs on the health plan formulary under certain circumstances.

Effective August 10, 2007
RSA 415:6-aa, 420-J:7-b
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PRESCRIPTION - Off Label Prescription Drugs

Policies that include coverage for prescription drugs shall not exclude coverage for any drug for a particular indication on the ground that the drug has not been approved by the Food and Drug Administration (FDA) for that indication, if such drug is recognized for treatment in one of the standard reference compendia or in the medical literature as recommended by the current American Medical Association (AMA) policies. Any coverage of a drug required by this section shall also include medically necessary services associated with the administration of the drug.

RSA 415:6-g, RSA 415:18-j
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PROSTHESES

PROSTHESES - Artificial Limb Coverage

Each insurer that issues or renews an individual, group, blanket accident, or health insurance policy or certificate providing benefits for medical or hospital expenses, shall provide to certificate holders who are residents of N.H., coverage for the provision of benefits for prosthetic devices under the same terms and conditions that apply to other durable medical equipment covered under the policy, except as otherwise provided in this section.

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

An insurer shall not apply amounts paid for prosthetic devices to any annual or lifetime dollar maximum applicable to other durable medical equipment covered under the policy other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy.

Effective January 1, 2004
RSA 415:6-j, RSA 415:18-n
BULLETIN: 04-004-AB Prosthetic Device Interpretation RSA 415:18-n (Group) and RSA 415:6-j (Individual)
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PROSTHESES - Scalp Hair Prostheses

Each insurer that issues or renews any group, blanket accident, health service corporation or health insurance policy or certificate providing benefits for medical or hospital expenses, which provides coverage for outpatient services shall provide coverage for other prostheses, to insureds who are residents of this state and whose principal place of employment is in this state, coverage for expenses for scalp hair prostheses. Coverage applies to hair prostheses worn for hair loss suffered as a result of alopecia areta, alopecia totalis, alopecia medicamentosa resulting from the treatment of any form of cancer or leukemia, or permanent loss of scalp hair due to injury. This coverage is subject to a written recommendation by the

treating physician stating that the hair prosthesis is a medical necessity. Such coverage shall be subject to the same limitations and guidelines as other prostheses, provided, that such coverage for alopecia medicamentosa shall not exceed $350 per year.

RSA 415:18-d, RSA 420-A: 14, RSA 420-B: 8-f
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SAME GENDER MARRIAGE / CIVIL UNIONS

HB 436 became effective January 1, 2010. HB 436 amends RSA 457-A to eliminate the exclusion of same-gender couples from marriage and to recognize civil union partnerships as marriages under RSA 457-A. This amends all fully insured insurance policies and other forms to provide the same benefits to civil unions partners and same-gender married couples that are provided to heterosexual married couples. For further information, please refer Implementation of New Hampshire's Law, RSA 457-A.

Effective January 1, 2010
RSA 457-A
Bulletin: Related to Civil Union (same rules apply to Same Gender Marriage) 07-088-AB Implementation of N.H.'s Civil Union Law, RSA 457-A:6
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WOMEN – General

WOMEN - Contraceptive Services

Each insurer that issues or renews any group, blanket accident or health insurance policy or certificate providing benefits for medical or hospital expenses, which provides coverage for outpatient services, shall provide coverage for outpatient contraceptive services under the same terms and conditions as for other outpatient services. "Outpatient contraceptive services" means consultations, examinations, and medical services provided on an outpatient basis and related to the use of contraceptive methods to prevent pregnancy that has been approved by the U.S. Food and Drug Administration.

RSA 415:18-i, RSA 420-A: 17-c, RSA 420-B: 8-gg
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WOMEN - Prescription Contraceptives

Each insurer that issues or renews any group, blanket accident or health insurance policies or certificate that provide prescription coverage shall cover all prescription contraceptive drugs and prescription contraceptive devices approved by the U.S. Food and Drug Administration under the same terms and conditions as other prescription drugs.

RSA 415:18-i, RSA 420-A: 17-c, RSA 420-B: 8-gg (also listed under Prescription Drugs)
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WOMEN - Obstetrical-Gynecological Coverage

Managed care health plans shall not require prior authorization by a person's primary care provider for coverage of the following services by participating providers who specialize in obstetrics and gynecology:

1. Maternity care;
2. An annual gynecological visit and;

3. Follow-up care for obstetrical or gynecological conditions identified during such maternity care or annual gynecological visit.

RSA 420-J: 6-a
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WOMEN - Mammography & for Testing for Occult Breast Cancer

All policies of accident and health insurance providing benefits for hospital expense, medical-surgical expense, or major medical expense shall provide coverage for screening by low-dose mammography for all women 35 years or older for the presence of occult breast cancer within the provisions of the policy, contract or certificate. The coverage shall be as follows:

1. A baseline mammogram for women 35-39 years of age.
2. A mammogram every 1 to 2 years, even if symptoms are not present, for women 40 to 49 years of age.
3. An annual mammogram for women 50 years of age or older.

RSA 417-D: 2

WOMEN – Pregnancy - Coverage for Delivery by a Midwife

This law states N.H. residents are entitled to coverage for midwives who are certified under RSA 326-D, meet an insurer's standards and mechanisms for credentialing and contracting and contingent upon the services being provided in a licensed health care facility and being within the scope of practice of a certified midwife.

Effective: April 14, 2006,
Effective: August 27, 2008, this law was expanded to include at home services. RSA 415:6-l; 415:18-q, 420-A: 17-f; 420-B: 8-p, 420-C
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WOMEN - Pregnancy, Delivery and Postpartum Coverage

Each health insurance policy that provides maternity benefits for hospital expense, medical surgical expense, or major medical expense shall provide:

1. The length of hospital stay and number of postpartum visits shall be determined by the attending health care provider based on clinical information that demonstrates that the mother and infant are clinically stable based on nationally accepted guidelines. Any length of stay shorter than the current minimum nationally accepted guidelines for perinatal care, shall be at the recommendation of the attending health care provider in consultation with the mother. If the hospital stay is shorter than the current minimum, then the insurer shall pay for at least 2 postpartum visits. During one such visit, the collection of an adequate sample from the newborn for screening for genetic and metabolic diseases shall take place in accordance with RSA 132 and applicable rules.

2. Upon notification of the pregnancy to the insurer, the insured shall inform the pregnant woman in writing regarding the insurer's prenatal, maternity and postpartum benefits, including but not limited to prenatal visits, diagnostic tests, prenatal education, hospital length of stay, postpartum care, homemaker services and contraceptive counseling and referrals.

3. The insurer shall pay for medically necessary prenatal homemaker services when a woman is confined to bed rest or her activities of daily living are otherwise restricted on the recommendation of her attending health care provider who shall consult with the applicable case manager.

4. Postpartum visits shall include the physical assessment of the mother and infant, including but not limited to: infant nutrition and feeding, infant behavior, family interactions, safety and injury prevention, infant and maternal health promotion, and community resources. Providers of postpartum visits shall be licensed health care providers experienced in perinatal care.

5. The insurer shall pay for appropriate medically necessary postpartum homemaker services as determined by the attending health care provider who shall consult with the applicable case manager.

RSA 417-D: 2-a

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WOMEN - Newborn Children Covered from Birth

All policies providing coverage on a provision of service or an expense incurred basis shall also provide that the health insurance benefits applicable for children are payable with respect to newborn children of the insured or subscriber or a newborn child of a dependent child of the insured or subscriber from the moment of birth. Coverage for the newborn child shall consist of coverage for injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and abnormalities.

If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy may require that notification of the birth and payment of the required premium or fee must be furnished to the insurer within 31 days after the date of birth in order to have coverage continue after the 31-day period.

Unless the policy or contract specifically provides that grandchildren of the insured or subscriber are eligible for coverage, coverage for newly born children of a dependent child of the insured will not continue beyond the initial 31-day period following birth.

RSA 415:22, RSA 420-B: 8-j
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WOMEN – CANCER

WOMEN – CANCER - Reconstruction Surgery as a Result of Mastectomy

Every insurer that provides coverage for mastectomy surgery shall provide coverage for reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the patient elects reconstruction and in the manner chosen by the patient and the physician.

RSA 417-D: 2-b
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WOMEN - CANCER - Scalp Hair Prostheses

Each insurer that issues or renews any group, blanket accident, health service corporation or health insurance policy or certificate providing benefits for medical or hospital expenses and which provides coverage for outpatient services shall provide coverage for other prostheses, shall provide to insureds who are residents of this state and whose principal place of employment is in N.H., coverage for expenses for scalp hair prostheses. Coverage applies to hair prostheses worn for hair loss suffered as a result of alopecia areta, alopecia totalis, alopecia medicamentosa resulting from the treatment of any form of cancer or leukemia, or permanent loss of scalp hair due to injury. This coverage is subject to a written recommendation by the treating physician stating that the hair prosthesis is a medical necessity. Such coverage shall be subject to the same limitations and guidelines as other prostheses, provided, that such coverage for alopecia medicamentosa shall not be less than $350 per year.

RSA 415:18-d, RSA 420-A: 14, RSA 420-B: 8-f
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