

New Hampshire Medicaid Care Management Program Member Handbook

Effective September 1, 2019

[This cover or title page is for explanatory purposes. Plans may modify the cover to include plan name, logo and/or graphics; however, at a minimum, the words “Medicaid Care Management Program Member Handbook” and effective date must remain prominently on the cover page].

[Plans should review additional model handbook instructions available separately.]

[NH Model Handbook_20190611 - Remove prior to publication.]

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Chapter 1. Getting started as a member

Section 1.1 Welcome

You are enrolled in *[Plan name]*

You will get most of your New Hampshire Medicaid health care and prescription drug coverage through our plan, *[Plan name]*, a New Hampshire Medicaid managed care plan. Please refer to Section 4.1 (*About the Benefits Chart (what is covered)*) and 4.2 (*Benefits Chart*) for the list of services the plan covers.

[Plan name] is contracted with the New Hampshire Department of Health and Human Services (NH DHHS) to provide the covered services described in the Benefits Chart in Chapter 4 (*Covered services*). The plan contracts with a network of doctors, hospitals, pharmacies, and other providers to provide covered services for plan members. For more information on using network and out-of-network providers, refer to Chapter 3 (*Using [Plan Name] for covered services*).

[Modify as appropriate and include other language about the plan, as helpful:] As a *[Plan name]* member, you will get your New Hampshire Medicaid health care and prescription drug coverage through our plan. We also offer health programs designed to help you manage your special medical and/or behavioral health needs through education and coaching about your health condition.

[Modify as appropriate:] Your feedback is important to us. Several times each year *[Plan name]* convenes Member Advisory Council meetings to hear from members like you. If you are interested in joining the plan Member Advisory Council, let us know by calling Member Services (phone numbers are printed on the back cover of this handbook).

Section 1.2 What makes you eligible to be a plan member

Medicaid is a joint federal and state program that helps people with limited incomes and resources receive needed health care coverage.

You are eligible for our plan as long as:

- You are eligible and remain eligible for New Hampshire Medicaid*
- *and* you live in New Hampshire (the *[Plan name]*'s service area);
- *and* you are a United States citizen or are lawfully present in the United States.

If you are pregnant and enrolled in *[Plan name]* when you deliver your baby, your baby is automatically covered by *[Plan name]* effective on your baby's date of birth. Contact NH DHHS Customer Service Center toll-free at **1-844-ASK-DHHS** (1-844-275-3447) (TDD Relay Access:

1-800-735-2964), Monday through Friday, 8:00 a.m. to 4:00 p.m. ET when you deliver your baby or to find out more about New Hampshire Medicaid and its programs.

*Your continued eligibility for New Hampshire Medicaid is re-determined every six to twelve months. Six weeks before your eligibility is up for renewal you will receive a letter and a Redetermination Application in the mail from NH DHHS. To ensure there will be no break in your health care coverage, you must fill out and return the Redetermination Application by the due date stated in the letter. If you need help to complete the form, contact the NH DHHS Customer Service Center (Eligibility) toll-free at **1-844-ASK-DHHS** (1-844-275-3447) (TDD Relay Access: 1-800-735-2964), Monday through Friday, 8:00 a.m. to 4:00 p.m. ET.

Section 1.3 What to expect from the plan

Member Handbook

This Member Handbook describes how the plan works and is in effect beginning *[Insert effective date]* through each month you are enrolled with *[Plan name]*. The Member Handbook is also available on our website at *[insert URL]*.

Your *[Plan name]* membership card – Use it to get all covered services and prescription drugs

While you are a member of the plan, you must use your *[Plan name]* membership card whenever you get covered services or prescription drugs. However, even if you don't have your plan membership card, a provider should never deny care to you. If a provider refuses to treat you, call our Member Services Department. We will verify your eligibility for the provider.

Here is a sample membership card, as an example:

[Insert picture of front and back of membership card. Mark it as a sample card (for example, by superimposing the word "sample" on the image of the card.)]

As long as you are a member of the plan, **you must use your *[Plan name]* membership card** to get covered services. Keep your New Hampshire Medicaid card too. Present **both** your plan membership card and New Hampshire Medicaid card whenever you get services.

If your plan membership card is damaged, lost or stolen, call Member Services right away. We will send you a new card. (Phone numbers for Member Services are printed on the back cover of this handbook.) *[Plans may include details about the availability of temporary cards and may provide instructions for requesting new or replacement cards by other methods.]*

Welcome Call

[Plans modify and describe your welcome call process and discussion topics, as appropriate.]

When you first join *[Plan name]*, we will call to welcome you as a plan member. During the call, we will explain plan rules and answer any questions you might have about the plan. As described in the next section, we will explain the importance of completing your Health Needs Assessment (HNA).

Health Needs Assessment (HNA)

[Plans may modify this section as appropriate.]

NH DHHS requires us to ask you to complete your Health Needs Assessment (HNA). The information you provide in the HNA helps us plan and work with you to meet your health care and functional needs.

We will reach out to you to complete the HNA by telephone or mail. *[Plans may modify and/or describe other ways to complete the HNA, as applicable.]* Your completion of the HNA is optional. However, we encourage you to complete the assessment, and return it to *[Plan name]*.

Explanation of Benefits Notice

From time to time, we will send you a report called the *Explanation of Benefits (EOB)*. *[Plans provide an explanation about the EOB, when members receive one, and how they should use them.]*

Section 1.4 Staying up-to-date with your personal information and other insurance information

How to help make sure that we have accurate information about you

Your membership record with the plan has information from NH DHHS, including your address and telephone number. It is important that you keep your information up to date. Network providers and the plan need to have correct information to communicate with you as needed.

Let us know about these changes:

- Changes to your name, your address, or your phone number;
- Changes in any other health insurance coverage you have, including:
 - An employer's group health insurance policy for employees or retirees, either for yourself, or anyone in your household covered under the plan;
 - Workers' Compensation coverage because of a job-related illness or injury;
 - Veteran's benefits or other government health plan coverage;
 - Medicare;
 - COBRA or other health insurance continuation coverage. (COBRA is a law that requires certain employers to let employees and their dependents keep their group

- health coverage for a period of time after leaving employment, changes in employment, and other life events.); or
- If you have any liability claims, such as claims from an automobile accident.
 - Changes in your income or other financial support;
 - If you have been admitted to a nursing home;
 - If you deliver your baby;
 - If you receive care in an out-of-area or out-of-network hospital or emergency room; or
 - If your guardian, conservator, authorized representative, or personal representative changes, or if your Durable Power of Attorney is activated.

If any of this information changes, please call Member Services (phone numbers are printed on the back cover of this handbook) or call the New Hampshire Medicaid Customer Service Center toll-free at **1-844-ASK-DHHS** (1-844-275-3447) (TDD Access Relay: 1-800-735-2964), Monday through Friday, 8:00 a.m. to 4:00 p.m. ET.

Member personal health information is kept private

Federal and state laws require that we keep your medical records and personal health information private. We protect your health information as required by these laws.

Section 1.5 How other insurance works with our plan

Which plan pays first when you have other insurance

[Plans must explain how prior authorizations and requirements for primary care provider selection work when primary insurance is available.]

Medicaid is the payer of last resort. This means when you have other insurance (like employer group health coverage or Medicare), they always pay your health care bills first. This is called “primary insurance”). You must follow all of your primary insurance rules when getting services. Items or services not covered by your primary insurance and your primary insurance copayments or deductibles may be covered by *[Plan name]*. For claims to pay correctly, it is important that you use providers that are in both your primary insurance network and our network.

When you receive services, tell your doctor, hospital or pharmacy if you have other health insurance. Your provider will know how to process claims when you have primary insurance and New Hampshire Medicaid through *[Plan name]*. If you receive a bill for your covered health care services, refer to Chapter 9 (*Asking us to pay*).

If you have questions, or you need to update your insurance information, call Member Services (phone numbers are printed on the back cover of this handbook).

[Plans may include additional information to describe their subrogation process.]

Chapter 2. Important phone numbers and resources

Section 2.1 How to contact *[Plan name]* Member Services

[Plans may add, modify or delete contact headings and information specific to their organization, including for purposes of directing members to contact subcontractors.]

For assistance with coverage questions, finding a provider, claims, membership cards, or other matters, please call or write to *[Plan name]* Member Services. We will be happy to help you.

In case of a medical or behavioral health emergency – Dial 911 or go directly to the nearest hospital emergency room. For a description of emergency services, refer to the Chapter 4 (*Benefits Chart*).

| Method | <i>[Plan name]</i> Member Services – Contact Information |
|----------------|---|
| CALL | <p><i>[Insert phone number(s)]</i> Calls to this number are toll-free. <i>[Insert days and hours of operation, including information on the use of alternative technologies.]</i></p> <p>Member Services also has free language interpreter services available for non-English speakers.</p> |
| TTY/TDD | <p><i>[Insert number]</i> <i>[Insert if plan uses a direct TTY number: This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.]</i></p> <p>Calls to this number are free.</p> |
| FAX | <i>[Optional: insert fax number]</i> |
| WRITE | <p><i>[Insert address]</i> <i>[Note: plans may add email addresses here.]</i></p> |
| WEBSITE | <i>[Insert URL]</i> |

Section 2.2 How to contact the plan about a coverage decision or to file an appeal

A coverage decision is a decision we make about whether a service or drug is covered by the plan. The coverage decision may also include information about the amount of any prescription copayment you may be required to pay. If you disagree with our coverage decision, you have the right to appeal our decision.

An appeal is a formal way of asking us to reconsider and change a coverage decision we have made. For more information on appeals, refer to Chapter 10 (*What to do if you want to appeal a plan decision or ‘action’, or file a grievance*).

| Method | Coverage Decision or Appeals – Contact Information |
|----------------|--|
| CALL | <p><i>[Insert phone number]</i></p> <p>Calls to this number are toll-free. <i>[Insert days and hours of operation]</i> [Note: You may also include reference to 24-hour lines here.] [Note: If you have a different number for accepting expedited appeals, also include that number here.]</p> |
| TTY/TDD | <p><i>[Insert number]</i></p> <p><i>[Insert if plan uses a direct TTY number: This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.]</i></p> <p>Calls to this number are free. [Note: If you have a different TTY number for accepting expedited appeals, also include that number here.]</p> |
| FAX | <p><i>[Optional: insert fax number]</i> [Note: If you have a different fax number for accepting expedited appeals, also include that number here.]</p> |
| WRITE | <p><i>[Insert address]</i> [Note: If you have a different address for accepting expedited appeals, also include that address here.]</p> |
| WEBSITE | <p><i>[Optional: Insert URL]</i></p> |

Section 2.3 How to contact the plan about a grievance

A grievance is the formal name of the process a member uses to make a complaint to the plan about the plan staff, plan providers, coverage and copayments. For more information on filing a grievance, refer to Chapter 10 (*What to do if you want to appeal a plan decision or “action”, or file a grievance*).

| Method | Grievance – Contact Information |
|----------------|---|
| CALL | <i>[Insert phone number]</i> Calls to this number are toll-free. <i>[Insert days and hours of operation]</i> |
| TTY/TDD | <i>[Insert number]</i> <i>[Insert if plan uses a direct TTY number: This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.]</i> Calls to this number are free. |
| FAX | <i>[Optional: insert fax number]</i> |
| WRITE | <i>[Insert address]</i> |

Section 2.4 How to contact the plan about care coordination

Care coordination is the term used to describe the plan’s practice of assisting members with getting needed services and community supports. Care coordinators make sure participants in the member’s health care team have information about all services and supports provided to the member, including which services are provided by each team member or provider. For more information, refer to Section 5.2 (*Care coordination support*).

| Method | Care Coordination – Contact Information |
|----------------|---|
| CALL | <p><i>[Insert phone number(s)]</i></p> <p>Calls to this number are toll-free. <i>[Insert days and hours of operation, including information on the use of alternative technologies.]</i></p> <p>Member Services also has free language interpreter services available for non-English speakers.</p> |
| TTY/TDD | <p><i>[Insert number]</i></p> <p><i>[Insert if plan uses a direct TTY number: This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.]</i></p> <p>Calls to this number are free.</p> |
| FAX | <i>[Optional: insert fax number]</i> |
| WRITE | <p><i>[Insert address]</i></p> <p><i>[Note: plans may add email addresses here.]</i></p> |
| WEBSITE | <i>[Insert URL]</i> |

Section 2.5 How to contact the plan's Nurse Advice Line

[Modify as appropriate:] The Nurse Advice Line is a free 24-hour medical information phone service provided by *[Plan Name]*. Registered nurses are ready to answer your questions 24 hours a day, 365 days of the year. Contact the Nurse Advice Line when you have questions about *[Plans briefly explain]*.

In case of a medical or behavioral health emergency – Dial 911 or go directly to the nearest hospital emergency room. For a description of emergency services, refer to the Chapter 4 (*Benefits Chart*).

| Method | Nurse Advice Line – Contact Information |
|----------------|---|
| CALL | <p><i>[Insert phone number(s)]</i></p> <p>Calls to this number are toll-free. <i>[Insert days and hours of operation, including information on the use of alternative technologies.]</i></p> <p>Member Services also has free language interpreter services available for non-English speakers.</p> |
| TTY/TDD | <p><i>[Insert number]</i></p> <p><i>[Insert if plan uses a direct TTY number: This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.]</i></p> <p>Calls to this number are free.</p> |
| FAX | <i>[Optional: insert fax number]</i> |
| WRITE | <p><i>[Insert address]</i></p> <p><i>[Note: plans may add email addresses here.]</i></p> |
| WEBSITE | <i>[Insert URL]</i> |

Section 2.6 How to request behavioral health services (mental health or substance use disorder services)

[Modify as appropriate:] Behavioral health services is another term used to describe mental health and/or substance use disorder services. Contact *[plan or subcontractor name]* when you have questions about *[Plans briefly explain]*.

In case of a behavioral health emergency – Dial 911 or go directly to the nearest hospital emergency room. For a description of emergency services, refer to the Chapter 4 (*Benefits Chart*).

| Method | Behavioral Health Services (Mental Health or Substance Use Disorder Services) – Contact Information |
|----------------|---|
| CALL | <p><i>[Insert phone number(s)]</i></p> <p>Calls to this number are toll-free. <i>[Insert days and hours of operation, including information on the use of alternative technologies.]</i></p> <p>Member Services also has free language interpreter services available for non-English speakers.</p> |
| TTY/TDD | <p><i>[Insert number]</i></p> <p><i>[Insert if plan uses a direct TTY number: This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.]</i></p> <p>Calls to this number are free.</p> |
| FAX | <i>[Optional: insert fax number]</i> |
| WRITE | <p><i>[Insert address]</i></p> <p><i>[Note: plans may add email addresses here.]</i></p> |
| WEBSITE | <i>[Insert URL]</i> |

If you or someone you know is struggling with addiction and in need of immediate care, contact the NH Statewide Addiction Crisis Line at **1-844-711-HELP** (4357). This 24-hour toll-free crisis line is available for you or for someone you know who struggles with addiction or substance use.

Section 2.7 **How to request non-emergency medical transportation assistance**

The plan covers non-emergency medical transportation assistance, including mileage reimbursement, if you are unable to pay for the cost of transportation to provider offices and facilities for medically necessary New Hampshire Medicaid-covered services listed in the Benefits Chart in Section 4.2 (see *Transportation services – Non-emergency medical transportation (NEMT)*).

| Method | Non-Emergency Medical Transportation – Contact Information |
|----------------|---|
| CALL | <p><i>[Insert phone number(s)]</i></p> <p>Calls to this number are toll-free. <i>[Insert days and hours of operation, including information on the use of alternative technologies.]</i></p> <p>Member Services also has free language interpreter services available for non-English speakers.</p> |
| TTY/TDD | <p><i>[Insert number]</i></p> <p><i>[Insert if plan uses a direct TTY number: This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.]</i></p> <p>Calls to this number are free.</p> |
| FAX | <i>[Optional: insert fax number]</i> |
| WRITE | <p><i>[Insert address]</i></p> <p><i>[Note: plans may add email addresses here.]</i></p> |
| WEBSITE | <i>[Insert URL]</i> |

Section 2.8 How to contact the NH DHHS Customer Service Center

The New Hampshire Department of Health and Human Services (NH DHHS) Customer Service Center provides help when you have questions about New Hampshire Medicaid eligibility or Granite Advantage eligibility or plan enrollment, Granite Advantage work and community engagement requirements, information or instructions to the NH DHHS website and benefits managed plan enrollment, the other benefits managed directly by NH DHHS as described in Section 4.4 (*New Hampshire Medicaid benefits covered outside the plan*), and when you need a new or replacement New Hampshire Medicaid card. While the plan can help you with your appeal or grievance, the NH DHHS Customer Service Center can also provide guidance.

| Method | NH DHHS Customer Service Center – Contact Information |
|----------------|---|
| CALL | <p>1-888-901-4999 (For plan information) 1-844-ASK-DHHS (1-844-275-3447) (For all other calls)</p> <p>Calls to this number are toll-free. Office hours are Monday through Friday, 8:00 a.m. to 4:00 p.m. ET.</p> <p>Free language interpreter services are available for non-English speakers.</p> |
| TTY/TDD | <p>1-800-735-2964</p> <p>Calls to this number are free. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> |

Section 2.9 How to contact the NH Long-Term Care Ombudsman

The New Hampshire Long-Term Care Ombudsman assists with complaints or problems related to coverage of long-term health care facility (also referred to as nursing facility) services covered directly by NH DHHS. Before contacting the Long-term Care Ombudsman when you have a problem related to plan covered services, seek resolution through the NH DHHS Customer Service Center.

| Method | NH Long-Term Care Ombudsman – Contact Information |
|----------------|--|
| CALL | 1-800-442-5640 Calls to this number are toll-free. Office hours are Monday through Friday, 8:30 a.m. – 4:30 p.m. ET. |
| TTY/TDD | TDD Access Relay (NH): 1-800-735-2964 Calls to this number are free. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. |
| FAX | 603-271-5574 |
| WRITE | Office of the Long-Term Care Ombudsman Office of the Commissioner NH Department of Health and Human Services 129 Pleasant Street Concord, NH 03301 |
| WEBSITE | https://www.dhhs.nh.gov/oltco/contact.htm |

Section 2.10 How to contact the NH DHHS Ombudsman

The New Hampshire Department of Health and Human Services (NH DHHS) Ombudsman assists plan members, clients, Department employees, and members of the public to resolve disagreements, including complaints or problems involving Medicaid eligibility or coverage. Before contacting the NH DHHS Ombudsman when you have a problem related to your plan, seek resolution through the plan’s appeal and grievance processes described in Chapter 10 (*What to do if you want to appeal a plan decision or “action”, or file a grievance*).

| Method | NH DHHS Ombudsman – Contact Information |
|----------------|--|
| CALL | 1-800-852-3345 , ext. 6941 Calls to this number are toll-free. Office hours are Monday through Friday, 8:30 a.m. – 4:30 p.m. ET. |
| TTY/TDD | TDD Access Relay (NH): 1-800-735-2964 Calls to this number are free. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. |
| FAX | 603-271-4632 |
| WRITE | Office of the Ombudsman Office of the Commissioner NH Department of Health and Human Services 129 Pleasant Street Concord, NH 03301 |
| WEBSITE | https://www.dhhs.nh.gov/oos/contact.htm |

Section 2.11 How to contact ServiceLink Aging & Disability Resource Center

ServiceLink is a NH DHHS program that helps individuals identify and access long-term services and supports, access family caregiver information and supports, and learn about Medicare and Medicaid benefits. ServiceLink is a program supported by NH DHHS.

| Method | ServiceLink Aging & Disability Resource Center – Contact Information |
|----------------|--|
| CALL | <p>1-866-634-9412</p> <p>Calls to this national number are toll-free. Calls made to the number from some cell phones and outside of New Hampshire will be directed to the NH DHHS Customer Service Center. When you reach that office, you will be transferred to the number of the appropriate ServiceLink location for your area</p> <p>Office hours are Monday through Friday, 8:30 a.m. - 4:30 p.m. ET.</p> <p>Free language interpreter services are available for non-English speakers.</p> |
| TTY/TDD | Call the number above or visit the website below for TTY/TDD services for your local office. |
| FAX | Call the number above or visit the website below for the fax number of your local office. |
| WRITE | Call the number above or visit the website below for the address of your local office |
| WEBSITE | http://www.servicelink.nh.gov/ |

Section 2.12 How to report suspected cases of fraud, waste or abuse

You play a vital role in protecting the integrity of the New Hampshire Medicaid program. To prevent and detect fraud, waste and abuse, *[Plan name]* works with NH DHHS, members, providers, health plans, and law enforcement agencies. (For definitions of fraud, waste and abuse, refer to Section 13.2 (*Definitions of important words*)).

Examples of fraud, waste and abuse include:

- When you get a bill for health care services you never received.
- Lack of information in member health record to support services billed.
- Loaning your health insurance membership card to others for the purpose of receiving health care services, supplies or prescription drugs.
- Providing false or misleading health care information that affect payment for services.

If you suspect Medicaid fraud, waste, or abuse, report it immediately. Anyone suspecting a New Hampshire Medicaid member, provider, or plan of fraud, waste, or abuse may also report it to the plan and/or the New Hampshire Office of the Attorney General. You do not have to give your name. You may remain anonymous.

| Method | <i>[Plan name]</i> to report fraud, waste or abuse – Contact Information |
|----------------|---|
| CALL | <p><i>[Insert phone number(s)]</i></p> <p>Calls to this number are toll-free. <i>[Insert days and hours of operation, including information on the use of alternative technologies.]</i></p> <p>Member Services also has free language interpreter services available for non-English speakers.</p> |
| TTY/TDD | <p><i>[Insert number]</i></p> <p><i>[Insert if plan uses a direct TTY number: This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.]</i></p> <p>Calls to this number are free.</p> |
| FAX | <i>[Optional: insert fax number]</i> |
| WRITE | <p><i>[Insert address]</i></p> <p><i>[Note: plans may add email addresses here.]</i></p> |
| WEBSITE | <i>[Insert URL]</i> |

| Method | New Hampshire Office of the Attorney General to report fraud waste or abuse – Contact Information |
|----------------|--|
| CALL | 603-271-3658 Office hours are Monday through Friday, 8:00 a.m. - 5:00 p.m. ET. |
| TTY/TDD | TDD Access Relay (NH): 1-800-735-2964 Calls to this number are free. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. |
| FAX | 603-271-2110 |
| WRITE | Office of the Attorney General 33 Capitol Street Concord, NH 03301 |
| WEBSITE | http://www.doj.nh.gov/consumer/complaints/index.htm |

Section 2.13 Other important information and resources

- **You may designate an authorized representative or personal representative** – You may designate a person to whom you give authority to act on your behalf. Your representative will be able to provide the plan with information or receive information about you in the same manner that the plan would discuss or disclose information directly to you. To have someone represent you, you must authorize your representative in writing and tell us how they may represent you. *[Plans may include or modify instructions for authorization and release forms, include them in the handbook, and/or reference a URL to access the form(s): An authorization form is available from the plan.]* Your authorized representative or personal representative designation is valid until you revoke or amend it in writing. For more information, contact Member Services (phone numbers are printed on the back cover of this handbook.)
- **Alternative formats and interpretation services** – *[Plans may modify information about the availability of written materials in languages other than English. Explain how members secure interpretation services, including how far in advance of needed interpretation services, whether a family or friend can interpret for the member at the provider's office in person or by phone.]*
- If you are eligible for Medicaid, we are required to give you information about the plan's benefits that is accessible and appropriate for you at no cost. Information is available in Braille, in large print, and other formats.

Interpretation services are also available. To arrange interpretation services or get information from the plan in a way that works for you, please call Member Services (phone numbers are printed on the back cover of this handbook).

If you have any trouble getting information from our plan because of problems related to language or a disability, please report the problem to the NH DHHS Customer Service Center at **1-844-ASK-DHHS** (1-844-275-3447) (TDD Access Relay: 1-800-735-2964), Monday through Friday, 8:00 a.m. to 4:00 p.m. ET.

- **Information about the structure and operation of the plan** – *[Plans must include a basic description of their organization, and a brief description of their relationship to providers.]*
- **Information about plan provider incentives and compensation arrangements** – Provider incentives describe how network providers are paid for covered services, including any payment bonuses they may be eligible to receive based on patient outcomes or other performance measures.

Members may request the following provider incentive and compensation arrangement information from the plan:

- Whether the plan uses a Physician Incentive Plan that affects the use of referral services;

- The type of incentive arrangements in place with providers; and
- Whether stop-loss protection arrangements afford providers financial relief for high-cost members, when appropriate.

To request this information, contact Member Services (phone numbers are printed on the back cover of this handbook).

- **Member material requests** – Contact *[Plan name]* Member Services to request a copy of our Member Handbook, Drug List, or Provider Directory. Document(s) will be sent within 5 business days of your request. (Phone numbers for Member Services are printed on the back cover of this Handbook.)
- *[Plans may describe other information, as helpful.]*

Chapter 3. Using *[Plan name]* for covered services

This chapter explains what you need to know about accessing covered services under the plan. It gives definitions of select terms and explains the rules you will need to follow to get health care services covered by the plan. For more definitions, refer to Section 13 (*Acronyms and definitions of important words*).

[Plan name] will work with you and your primary care physician (PCP) to ensure you receive medical services from specialists trained and skilled in your unique needs, including information about and access to specialists within and outside the plan’s provider network, as appropriate.

For information on what services are covered by our plan, refer to the Benefits Chart in Chapter 4. The Medicaid covered services in the Benefits Chart are supported by New Hampshire Department of Health and Human Services rules (Chapters He-W, He-E, He-C, He-M, and He-P). The rules are available online at http://www.gencourt.state.nh.us/rules/about_rules/listagencies.htm.

What are “network providers” and “covered services”?

Here are some definitions that can help you understand how you get the care and services covered for you as a member of our plan:

- **“Providers”** are doctors and other health care professionals licensed by the state to provide medical services and care. The term “providers” also includes hospitals and other health care facilities, as well as pharmacies.
- **“Network providers”** are the doctors, pharmacies and other health care professionals, medical groups, hospitals, durable medical equipment suppliers, and other health care facilities that have an agreement with the plan to accept our payment and your prescription copayment, if any, as payment in full. The providers in our network bill us directly for care they give you.
- **“Covered services”** include all health care services, prescription drugs, supplies, and equipment covered by our plan. Refer to the Benefits Chart in Chapter 4 for a list of covered services.

Rules for getting your health care services and prescriptions covered by the plan

[Plan name] covers all services required in our contract with NH DHHS.

[Plan name] will generally cover your health care as long as:

- **The care you receive is included in the plan’s Benefits Chart** (this chart is in Chapter 4 of this handbook).
- **The care you receive is considered medically necessary.** “Medically necessary” means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice. For more information about medically necessary services, refer to Section 6.1 (*Medically necessary services*).

- **You receive approval in advance from the plan before receiving the covered service, if required.** Prior authorization requirements for covered services are in italics in Section 4.2 (*Benefits Chart*).
- *[Plans may omit or edit the PCP-related bullets as necessary; and must explain PCP requirements if Medicaid is secondary payer].* **You have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP. *[In most situations, insert as applicable: your network PCP OR our plan must give you approval in advance before you can use other providers in the plan’s network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a “referral” or providing “prior authorization”. For more information, refer to Chapter 6 (Rules for accessing covered services).]*
- *[Insert or modify as applicable: Referrals from your PCP are not required for emergency care or urgently needed services. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information, refer to Chapter 4 (Covered services).]*
- **The care you receive is from a network provider** (for more information, refer to Section 3.3 (*How to get care from specialists and other network providers*)). Most care you receive from an out-of-network provider (a provider who is not part of our plan’s network) will not be covered, except with prior approval from the plan or for emergency services. For more information about when out-of-network services may be covered, refer to Section 3.5 (*Getting care from out-of-network providers*)).

Here are four exceptions:

- The plan covers emergency care or urgently needed services that you get from an out-of-network provider. For more information about emergency or urgently needed services, refer to Section 3.6 (*Emergency, urgent and after-hours care*).
- If you need medical care that New Hampshire Medicaid requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. *[Plans may specify if authorization is required from the plan prior to seeking care.]* For information about getting approval to see an out-of-network doctor, refer to Section 6.3 (*Getting out-of-network services*).
- The plan covers kidney dialysis services that you get at a New Hampshire Medicaid participating, Medicare-certified dialysis facility when you are temporarily outside the plan’s service area. For more information, contact Member Services (phone numbers are printed on the back cover of this handbook).
- For covered family planning services, you may see any New Hampshire Medicaid participating doctor, clinic, community health center, hospital, pharmacy or family-planning office. For more information, refer to “Family planning services” in the Benefits Chart in Chapter 4 (*Covered services*).

Section 3.1 Your Primary Care Provider (PCP) provides and oversees your medical care

What is a “PCP” and what does the PCP do for you?

[Plans may modify this section, as applicable:] A PCP is the network provider you choose (or is assigned to you by the plan until you select one) and who you should see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and providers about your care. Your PCP has the responsibility for supervising, coordinating, and providing your primary health care. He or she initiates referrals for specialist care, and maintains the continuity of your care.

Your PCP may include a network Pediatrician, Family Practitioner, General Practitioner, Internist, Obstetrician/Gynecologist, Physician Assistant (under the supervision of a physician), or Advance Practice Registered Nurse (APRN). If you need help selecting or changing your PCP, call Member Services (phone numbers are printed on the back cover of this handbook).

[Plans must describe the following in the context of their plan(s):

- *What is a PCP?*
- *What types of providers may act as a PCP? Can a specialist be a PCP?*
- *Explain the role of a PCP in coordinating covered services and making decisions about or obtaining prior authorization.]*
- *When a member can have a PCP out-of-network and how prior authorizations are managed in this case.*
- *When a member can choose to go to another doctor who is not his or her PCP.*
- *Explain any referral requirements.]*

How do you choose your PCP?

[Plans should describe how to choose a PCP, auto-assignment of a PCP, and any requirements for network PCP selection when New Hampshire Medicaid is not the primary payer.]

Changing your PCP

You may change your network PCP for any reason, at any time. Also, if your PCP leaves the plan’s provider network, you may have to find a new PCP. For more information about what happens when your provider leaves the network, refer to Section 3.4 (*What happens when a PCP, specialist or another network provider leaves our plan’s network*).

[Plans should describe how to change a PCP and indicate when that change will take effect (e.g., on the first day of the month following the date of the request, immediately upon receipt of request, etc.).]

Section 3.2 Services you can get without getting approval in advance

You can get the services listed below without getting approval in advance from your PCP or *[Plan name]*.

- Routine women’s health care, including breast exams, screening mammograms (X-rays of the breast), pap tests, pelvic exams, and maternity care.
- Flu shots *[insert if applicable: Hepatitis B vaccinations, and pneumonia vaccinations]* *[insert if appropriate: as long as you get them from a network provider]*.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed services from network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible (e.g., when you are temporarily outside of the plan’s service area).
- Family planning services when you go to any participating New Hampshire Medicaid family planning provider.
- *[Plans should add additional bullets as appropriate.]*

Section 3.3 How to get care from specialists and other network providers

It is important to know which providers are included in our network. With some exceptions, the plan will only pay for your services if you use *[insert as appropriate: must use OR may be required to use]* network providers required by the plan to get your covered services. The only exceptions are emergencies and for urgently needed services when the network is not available or when you receive authorization in advance from the plan to see an out of network provider.

A specialist is a doctor who provides health care services for a specific disease or a specific part of the body. When your PCP thinks that you need a specialist, he or she will refer you (or hand-off your care) to a network specialist. There are many kinds of specialists. Here are a few examples:

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart conditions.
- Orthopedists care for patients with certain bone, joint or muscle conditions.

You may request a copy of the *Provider Directory* from Member Services. (Phone numbers are printed on the back cover of this handbook). The *Provider Directory* lists network providers. Also, you may ask Member Services for more information about our network providers, including their qualifications. *[Plans may add additional information describing the information available in the provider directory, on the plan’s website, or from Member Services. For*

example, you can also see the [Provider Directory](#) at [\[insert URL\]](#), or download it from this website. Both Member Services and the website can give you the most up-to-date information about changes in our network providers.]

[Insert as applicable: When your PCP thinks that you need specialized treatment, he or she will give you a referral (approval in advance) to see a network specialist or certain other providers. For some types of referrals, your PCP may need to get approval in advance from our plan. (This is called getting “prior authorization.” Prior authorization requirements for covered services are in italics in Section 4.2 (Benefits Chart).]

[It is very important to get a referral (approval in advance) from your PCP before you see a network specialist or certain other providers.]

[Plans should describe how members access in-network specialists and other providers, including:

- What is the role (if any) of the PCP in referring members to specialists and other providers?*
- Include an explanation of the process for obtaining Prior Authorization (PA), including who makes the PA decision (e.g., the plan, PCP, another entity) and who is responsible for obtaining the prior authorization (e.g., PCP, member).*
- Explain if the selection of a PCP results in being limited to specific specialists or hospitals to which that PCP refers, i.e. sub-network, referral circles.]*
- Explain how to get behavioral health or SUD services.*
- Explain how to get dental and vision services.*
- Do the members have the right to choose an OB/GYN? How does she choose?*
- Explain how to get family planning services. Member does not need a referral before seeking treatment from family planning in or out of network providers.*
- Explain obstetric services and any requirements to notify the plan when a member is pregnant, including plan enrollment requirements for her newborn.]*

Section 3.4 What happens when a PCP, specialist or another network provider leaves our plan

[Plans must describe that notice will be provided to the member when their PCP or other providers they routinely see leaves the network. Plans should describe how to change a PCP and indicate when that change will take effect (e.g., on the first day of the month following the date of the request, immediately upon receipt of request, etc.).]

We may make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the year. Also, sometimes your provider might leave the network. If your doctor, specialist, or other provider you routinely receive treatment from leaves our plan, you have certain rights and protections described below:

- When possible we will notify you when your PCP or other provider who you receive routine treatment from leaves the plan's network. We will notify you the earlier of 15 calendar days after the plan receives notice of your provider leaving the network, or 15 calendar days prior to the effective date of the provider termination so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted. For more information, refer to Section 5.3 (*Continuity of care, including transitions of care*).

If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file a grievance or an appeal of our decision.

- If you find out your doctor or specialist is leaving our plan, please contact us so we can assist you in finding a new provider to manage your care.
- You may choose your preferred network health providers to the extent possible and appropriate.
- If you are receiving a prior authorized ongoing course of treatment with a participating provider who becomes unavailable to continue to provide services, the plan shall notify you in writing within 7 calendar days from the date the plan becomes aware of such unavailability and will develop a transition plan to help you with your continued ongoing care.

Section 3.5 Getting care from out-of-network providers

[Plans must explain under what circumstances members may obtain services from out-of-network providers (e.g., when providers of specialized services are not available in network). Describe the process for obtaining authorization, including who is responsible for obtaining authorization.]

If you are an American Indian or Alaska Native (AI/AN) of a federally recognized tribe or another individual determined eligible for Indian health care services, special coverage rules apply. You may get out-of-network services at an Indian health facility without prior authorization. Contact Member Services for more information (phone numbers are printed on the back cover of this handbook).

When you receive prior authorization from the plan for treatment from an out-of-network provider, you should never be charged more than a prescription drug copayment, if any, for covered services. If you are charged for covered services, please contact Member Services (phone numbers are printed on the back cover of this handbook).

Section 3.6 Emergency, urgent, and after-hours care

What is a “medical emergency” and what should you do if you have one?

A “**medical emergency**” is when you, or any other reasonable person with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a body organ or part. Or in the case of a pregnant women in active labor, meaning labor at a time when there is not enough time to safely transfer you to another hospital before delivery, or the transfer may pose a threat to your health or safety or to that of your unborn child.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP.
- *[Plans add, if applicable: **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours of the onset of the emergency. *[Plans must provide either the phone number and days and hours of operation or explain where to find the number (e.g., on the back the plan membership card).]**

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories. Emergency care is not covered outside of the United States or its territories. The plan covers ambulance services in situations where you, or any other reasonable person with an average knowledge of health and medicine, believe getting to the emergency room in any other way could endanger your health.

If you have an emergency, the Plan or your PCP will talk with the doctors who are giving you emergency care to help manage and follow-up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

[Plans may modify this paragraph as needed to address the post-stabilization care specific to your plan.] After the emergency is over, you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan. If an out-of-network provider provides your emergency care, the plan or your PCP will work with you as needed to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

For more information, refer to the Benefits Chart (*Emergency medical care*) in Chapter 4 of this handbook.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it was not a medical emergency after all.

Examples of medical emergencies include:

- Broken bones
- Convulsions or seizures
- Severe chest pain or heart attack
- Serious accidents
- Stroke (symptoms often include facial droop, speech difficulty)
- Loss of consciousness
- Heavy bleeding
- Severe headaches or other pain
- Vomiting blood or continuous vomiting
- Fainting or dizzy spells
- Poisoning
- Shock (symptoms often include sweating, feeling thirsty, dizzy, pale skin)
- Severe burns
- Trouble breathing
- Sudden inability to see, move, or speak
- Suicidal thoughts, plans and/or actions
- First experience of auditory or visual hallucinations

If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care. However, after the doctor has said that it was *not* an emergency, we will cover additional care *only* if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care;
- – *or* – The additional care you get is considered “urgently needed services” and you follow the rules for getting these services. For more information see the information below titled, “*What if you are in the plan’s service area when you have an urgent need for care after normal business hours*” and “*What if you are outside the plan’s service area when you have an urgent need for care?*”.

What is a “behavioral health emergency”

A “**behavioral health emergency**” is an emergent situation in which someone is in need of behavioral health assessment and treatment in a safe and therapeutic setting, is a danger to themselves or others, or exhibits significant behavioral deterioration rendering the member unmanageable and unable to cooperate in treatment.

If you have a behavioral health emergency or mental health crisis:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP.
- **If you are experiencing a mental health crisis,** call *[Plans insert behavioral health crisis phone number, TTY/TDD number, and/or modify this bullet as applicable]* 24 hours a day, 365 days a year.

A mental health crisis is any situation in which a person’s behaviors puts them at risk of hurting themselves or others, and/or when they are not able to resolve the situation with the skills and resources available. Many things can lead to a mental health crisis including, increased stress, physical illness, problems at work or at school, changes in family situations, trauma/violence in the community or substance use. These issues are difficult for everyone, but they can be especially hard for someone living with a mental illness.

- *[Plans add, if applicable: As soon as possible, make sure that our plan has been told about your emergency. We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. [Plans must provide either the phone number and days and hours of operation or explain where to find the number (e.g., on the back the plan membership card).]*

What if you or someone you know struggles with addiction or substance use?

[Plan name] understands that addiction is a disease and that access to immediate help is critical to recovery.

- If you are a *[Plan name]* member struggling with addiction and are in need of urgent care, contact *[insert plan contact information]*; or
- If someone you know struggles with addiction or substance use, call the 24-hour toll-free NH Statewide Addiction Crisis Line at **1-844-711-HELP** (4357).

What if you are in the plan’s service area when you have an urgent need for care after normal business hours?

Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or a condition that requires immediate medical care to prevent a worsening of health due to symptoms that a reasonable person would believe are not an emergency but do require medical attention. You should always try to obtain urgently needed services from network

providers. However, if providers are temporarily unavailable and it is not reasonable to wait to obtain care from a network provider, we will pay for the covered service(s) provided to you.

[Plans must insert instructions for how to access medical and behavioral health urgently needed services during regular business hours, after-hours and on weekends (e.g., using urgent care centers, a provider hotline, etc.).]

What if you are outside the plan's service area when you have an urgent need for care?

When you are outside the service area and cannot get care from a network provider, our plan will pay for urgently needed covered services that you get from any provider. However, our plan does not cover urgently needed services or any other services if you receive the care outside of the United States or its territories.

Chapter 4. Covered services

Section 4.1 About the Benefits Chart (what is covered)

This chapter describes what services *[Plan name]* covers. You can obtain covered services from the plan's provider network, unless otherwise allowed as described in this handbook. Some covered services require prior authorization from the plan. Prior authorization requirements for covered services are in italics in Section 4.2 (*Benefits Chart*).

The Benefits Chart in this chapter explains when there are limits or prior authorization requirements for services. The Medicaid covered services in the Benefits Chart are supported by New Hampshire Department of Health and Human Services rules (Chapters He-W, He-E, He-C, He-M, and He-P). The rules are available online at http://www.gencourt.state.nh.us/rules/about_rules/listagencies.htm.

About covered services:

- The Benefits Chart lists the services *[Plan name]* covers. The chart is for your general information and may not include all the benefits available to you. Please call *[Plan name]* Member Services with questions about your services (phone numbers are printed on the back cover of this handbook).
- The services listed in the Benefits Chart are covered **only when the following requirements are met:**
 - The services meet the coverage guidelines established by New Hampshire Medicaid.
 - The services are medically necessary. For more information about medically necessary services, refer to Section 6.1 (*Medically necessary services*).
 - The services are provided by network providers, unless otherwise allowed as described in this handbook. In most cases, care you receive from an out-of-network provider will not be covered unless you have received prior authorization from the plan. For more information about using in-network and out-of-network providers, refer to Chapter 3 (*Using [Plan name] for covered services*).
 - *[Insert if applicable: You have a primary care provider (a PCP) who is providing and overseeing your care. [Plans that do not require referrals may omit the rest of this bullet] In most situations, your PCP must give you approval in advance before you can see other providers in the plan's network. This is called giving you a "referral." Chapter 3 provides more information about getting a referral and the situations when you do not need a referral.]*
 - *[Insert if applicable: Some of the services listed in the Benefits Chart in this chapter are covered only if your doctor or other network provider gets approval from the plan in advance (called "prior authorization"). Prior authorization requirements for covered services are in italics in Section 4.2 (Benefits Chart).]*
- You pay nothing, except for any applicable copayments, for the covered services described in the Benefits Chart as long as you follow the plan's rules described in this

handbook. Currently you are only responsible for the copayment for your covered prescription drugs.

- New Hampshire Medicaid benefits may change over time. You will be notified of those changes.

If you have questions about covered services, call Member Services (phone numbers are printed on the back cover of this handbook).

[Plan instructions for completing the benefits chart:

- *[Plans should clearly indicate which benefits are subject to prior authorization.]*
- *[Plans may insert any additional benefits information that is not captured in the benefits chart or in the exclusions section. Additional benefits should be placed alphabetically in the chart.]*
- *[Plans must describe any restrictive policies, limitations, or monetary limits that might impact a member's access to services within the chart.]*
- *[Plans may add references to the list of exclusions as appropriate.]*
- *[In the case of a counseling or referral service the plan does not cover because of moral or religious objections, describe the service that is not covered and how members can obtain information to access this service in the benefit chart.]]*

Section 4.2 Benefits Chart

Services covered by the plan

Abdominal aortic aneurysm screening

The plan covers a one-time ultrasound screening for men aged 65-75 year who have never smoked.

Prior authorization is not required for services provided by a network provider.

For more information, please call Member Services.

Services covered by the plan**Abortion services**

The plan covers abortion services only as follows:

- If the pregnancy is the result of rape or incest; or
- In the case of a woman who has a physical disorder, physical injury or physical illness (including a life-endangering physical condition caused by or arising from the pregnancy itself) that would, as certified by a physician, endanger the life of the woman unless an abortion is performed.

Prior authorization from the plan is not required for services provided by a network provider.

For more information, please call Member Services.

Adult medical day care services

The plan covers services provided by licensed adult medical day care providers. Services are provided to adults aged 18 years and older who otherwise live in an independent living situation.

Participants must require adult medical day care services for a minimum of four (4) hours per day on a regularly occurring basis, but services are not covered for more than 12 hours per day on a regularly occurring basis.

Covered services include:

- Nursing services and health supervision
- Maintenance level therapies
- Nutritional and dietary services
- Recreational, social, and cognitive activities
- Assistance with activities of daily living
- Medical supplies
- Health and safety services

Prior authorization from the plan is required.

For more information, please call Member Services.

Alcohol misuse screening and counseling

Refer to *Substance use disorder (SUD) treatment services* in this Benefits Chart.

Services covered by the plan**Allergy testing and treatment**

The plan covers allergy testing when significant symptoms exist and conventional therapy has not worked. Allergy testing focuses on determining what allergens cause a particular reaction, the degree of the reaction and informs treatment options.

Covered testing services include the professional service to prepare and to administer an allergenic extract.

If an allergen is identified, covered allergy treatment includes medication and immunotherapy

Prior authorization from the plan is not required for services provided by a network provider.

For more information, please call Member Services.

Ambulance services – Emergency

The plan covers ambulance services when you have an emergency medical condition and when other modes of transportation could risk your health or your life.

Covered ambulance services include:

- Ground ambulance services; and
- Air ambulance services if:
 - You cannot safely be transported in a timely basis via ground transportation; and
 - You are at imminent risk of losing life or limb, if the fastest means of transport is not utilized.

Emergency ambulance services will take you to the nearest facility that can provide you appropriate care.

Prior authorization is not required for emergency ambulance services.

Ambulance services are not covered outside the United States and its territories.

For more information, please call Member Services.

Services covered by the plan**Ambulance services – Non-emergency**

The plan covers non-emergency ambulance services to appointments for Medicaid-covered services covered by the plan when other modes of transportation would likely endanger your health and safety.

Covered ambulance services include:

- Ground ambulance services
- Air ambulance services if:
 - You cannot safely be transported in a timely basis via ground transportation; and
 - You are at imminent risk of losing life or limb, if the fastest means of transport is not utilized

[Include, as applicable:] Services are managed by [Subcontractor Name] for the plan. [Plans provide contact information.]

Prior authorization from the plan is required for non-emergency ambulance services.

Ambulance services are not covered outside the United States and its territories.

For more information, please call Member Services.

Anesthesia

Refer to *Physician services* in this Benefits Chart.

Audiologist services

The plan covers hearing tests and hearing aid evaluations to determine if a hearing aid is needed. Hearing aid evaluations or hearing aid consultations performed by an audiologist are limited to one every 24 months for members over 21 years old, and as needed for members under age 21 years. *[Plans please describe limits/frequency of covered services.]*

Prior authorization from the plan is not required for services provided by a network provider.

Refer to “Hearing services” for more information on related services and hearing aids.

For more information, please call Member Services.

Services covered by the plan**Bariatric surgery (weight loss surgery)**

The plan covers a variety of bariatric surgical procedures to treat obesity.

To be eligible a person must have a body mass index (BMI) of more than 35 and a severe obesity related health condition, such as diabetes, sleep apnea, high blood pressure, or heart disease.

Prior authorization from the plan is required.

For more information, please call Member Services.

Behavioral health services

Refer to *Inpatient mental health services* in this Benefits Chart.

Refer to *Outpatient mental health services* in this Benefits Chart.

Refer to *Substance use disorder (SUD) treatment services* in this Benefits Chart.

Bone mass measurement

The plan covers certain bone mass measurement procedures.

Prior authorization from the plan is not required for services provided by a network provider.

For more information, please call Member Services.

Breast cancer screening (mammogram)

The plan covers mammograms and clinical breast exams for women aged 40 years and older every one to two years. More frequent mammograms and breast exams may be provided when ordered by your PCP.

Prior authorization from the plan is not required for screenings provided by a network provider, [\[Plans include, as applicable: but may be\]](#) required for screenings that are ordered at a higher than recommended frequency.

For more information, please call Member Services.

Cardiac (heart) rehabilitation services

The plan covers cardiac rehabilitation services, such as exercise, education, and counseling. The plan also covers more *intensive* cardiac rehabilitation programs.

Prior authorization from the plan is required.

For more information, please call Member Services.

Services covered by the plan**Cardiovascular (heart) disease risk-reduction visit (therapy for heart disease)**

The plan covers visits with your PCP as part of an effort to help lower your risk for heart disease.

During this visit, your doctor may:

- Discuss aspirin use
- Check your blood pressure
- Give you tips to make sure you are eating right

Prior authorization from the plan is not required for services provided by a network provider.

For more information, please call Member Services.

Cardiovascular (heart and blood vessel) disease testing

The plan covers blood tests to check for cardiovascular (heart and blood vessel) and related disease.

Prior authorization from the plan is not required for services provided by a network provider.

For more information, please call Member Services.

Cervical and vaginal cancer screening

The plan covers pap tests and pelvic exams for women as ordered by a physician or other licensed health care professional. [\[Plans please describe limits/frequency of services.\]](#)

Prior authorization from the plan is not required for services provided by a network provider.

For more information, please call Member Services.

Services covered by the plan**Chemotherapy**

The plan covers chemotherapy for cancer treatment. Chemotherapy may be administered in your home, a doctor's office, or at a hospital inpatient or outpatient facility.

Covered chemotherapy services include:

- Drugs
- Professional services needed to administer the drugs
- Facility fees
- X-ray and lab tests needed for follow-up

Prior authorization from the plan may be required.

For more information, please call Member Services.

Colorectal cancer screening

The plan covers the following services *[Plans please describe and limits and/or frequency of covered services.]*

- Guaiac-based fecal occult blood test
- Fecal immunochemical test
- Screening barium enema
- Flexible sigmoidoscopy
- Screening colonoscopy

Prior authorization from the plan is not required for services provided by a network provider.

For more information, please call Member Services.

Services covered by the plan**Community health center services**

The plan covers services provided by a community health center.

Services include the following:

- Office visits for primary care and behavioral health services
- Obstetric or gynecology (OB/GYN) visits
- Health education
- Medical social services
- Nutrition services, including diabetes self-management training and medical nutrition therapy
- Tobacco-cessation services
- Vaccines, except for vaccines for travel out of the country

Prior authorization from the plan is not required for services provided by a network provider.

For more information, please call Member Services.

Counseling to stop smoking or tobacco use

The plan covers *[Plans explain limits, if any: up to x]* counseling on quitting smoking or tobacco use. (Refer also to “Smoking cessation” in the Benefits Chart.)

[Plans describe counseling to stop smoking or tobacco use benefit, including any benefit limits.]

Prior authorization from the plan is not required for services provided by a network provider.

For more information, please call Member Services.

Dental services

The plan does not cover dental services. Dental services are managed through New Hampshire Medicaid. For questions about your dental benefits, please contact the New Hampshire Medicaid Customer Service Center. Refer Section 2.8 (*How to contact the NH DHHS Customer Service Center*) for contact information and refer to Section 4.4 (*New Hampshire Medicaid benefits covered outside the plan*).

Fluoride varnish services are covered by the plan for some members. Refer to *Fluoride varnish* in the Benefits Chart.

For more information, please call Member Services.

Services covered by the plan**Depression screening**

The plan covers depression screening for children and adults.

Prior authorization from the plan is not required for services provided by a network provider.

For more information, please call Member Services.

Diabetic supplies and training

The plan covers the following items and services if you have diabetes or pre-diabetes (even if you do not use insulin):

- Supplies to monitor your blood glucose levels include:
 - Blood glucose monitoring device
 - Blood glucose test strips
 - Lancet devices and lancets
 - Glucose-control solutions for checking the accuracy of test strips and monitors
- Fittings for and provision of therapeutic, custom-molded or depth shoes if you have severe diabetic foot disease.
- *[Plans describe diabetic education coverage.]*

[Include, as applicable:] Services are managed by [Subcontractor Name] for the plan. [Plans provide contact information, including hours of operation.]

[Plans explain which services require a PRIOR AUTHORIZATION.] Prior authorization from the [Subcontractor Name] may be required.

Prior authorization from the plan may be required if using blood glucose meters and supplies that are non-preferred products.

For more information, please call Member Services.

Services covered by the plan**Dialysis and other renal (kidney) disease services and supplies**

The plan covers the following services:

- Kidney disease education services to teach kidney care and help you make good decisions about your care
- Outpatient dialysis treatment, including dialysis treatments when you are temporarily out of the network area, such as when traveling;
- Inpatient dialysis treatments if you are admitted as an inpatient to a hospital or special care unit
- Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments
- Home dialysis equipment and supplies
- Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply

Prior authorization from the plan is not required for services provided by a network provider. However, prior authorization is required for out-of-network dialysis services.

For more information, please call Member Services.

Services covered by the plan**Durable medical equipment (DME) including replacement parts, modification, repairs, and training.**

The plan covers durable medical equipment (DME) which include items that are:

- Non-disposable and able to withstand repeated use;
- Primarily used to serve a medical purpose for the treatment of an acute or chronic medically diagnosed health condition, illness, or injury; and
- Not useful to an individual in the absence of an acute or chronic medically diagnosed health condition, illness, or injury.
- Examples of covered DME include:
 - Wheelchairs
 - Crutches
 - Hospital beds
 - Monitoring equipment
 - Special beds
 - Canes
 - Commodes
 - Nebulizers
 - Oxygen equipment
 - IV infusion pumps
 - Walkers
 - Speech generating devices (augmentative alternative communication (AAC) devices
 - Any other medically necessary DME
- *[Plans explain coverage for replacement parts, modifications, and training.]*

[Include, as applicable:] Services are managed by [Subcontractor Name] for the plan. [Plans provide contact information, including hours of operation.]

[Plans explain which services require a PRIOR AUTHORIZATION.] Prior authorization from the [Subcontractor Name] may be required.

For more information, please call Member Services.

Services covered by the plan**Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services**

The plan covers EPSDT services for members under the age of 21 years, including applied behavioral analysis (ABA) for members with a diagnosis of autism.

The EPSDT benefit is a comprehensive health benefit that helps meet children's health and developmental needs. Covered benefits include age-appropriate medical, dental, vision, and hearing screening services at specified times, commonly referred to as well-child check-ups, and when health problems arise or are suspected. In addition to screening, EPSDT services include all medically necessary diagnostic and treatment services to correct or improve a child's physical or mental illness-or condition. This is particularly important for children with special health care needs and disabilities.

Prior authorization from the plan is not required for EPSDT screenings. However, some treatment services do require a prior authorization.

For specialty treatment services, contact [\[Plans specify plan contact information and hours of operation\]](#).

For more information, please contact [\[Plans specify plan contact information and hours of operation\]](#).

Services covered by the plan**Emergency medical care**

The plan covers emergency medical care. A “medical emergency” occurs when you have a medical condition that anyone with an average knowledge of health and medicine could expect is so serious that without immediate medical attention, the result may be:

- Serious risk to your health or the health of your unborn child;
- Serious harm to bodily functions;
- Serious dysfunction of any bodily organ or part; or
- In the case of a pregnant woman having contractions:
 - There is not enough time to safely transfer you to another hospital before delivery; or
 - The transfer may pose a threat to your health or safety or to that of your unborn child.

Emergency medical care is covered wherever and whenever you need it, anywhere in the United States or its territories. Emergency medical care is not covered outside of the United States and its territories.

If you get emergency medical care at an out-of-network hospital and need inpatient care after your condition is stabilized you must return to a network hospital for your care to continue to be covered by the plan. Out-of-network hospital inpatient care is covered if the plan approves your inpatient stay.

Prior authorization from the plan is not required for in-network and out-of-network emergency medical care; however, prior authorization is required from the plan for out-of-network hospital inpatient care after your care is stabilized.

For more information, please call Member Services.

Services covered by the plan**Family planning services**

You may choose any New Hampshire Medicaid participating doctor, clinic, community health center, hospital, pharmacy, or family-planning office in-network or out-of-network. Family planning services do not need a referral.

The following services are covered:

- Family planning exam and medical treatment
- Family planning lab and diagnostic tests
- Family planning methods (birth control pills, patch, ring, IUD, injections or implants)
- Family planning supplies with prescription (condom, sponge, foam, film, diaphragm or cap)
- Counseling and testing for sexually transmitted infections (STIs), AIDS and other HIV-related conditions when done as part of an initial, regular, or follow-up family planning visit
- Treatment for sexually transmitted infections (STIs), including AIDS and other HIV-related conditions is subject to the requirements described under *Physician services* in this Benefits Chart
- Voluntary sterilization. You must be aged 21 years or older, mentally competent and you must sign a sterilization-consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the consent form and the date of the sterilization procedure.

Prior authorization from the plan is not required.

For more information, please call Member Services.

Fluoride varnish

The plan covers fluoride varnish applied during a doctor/pediatrician visit for a member age 6 months up to age 5 years. Coverage is limited to application of fluoride varnish twice a year.

Prior authorization from the plan is not required for services provided by a network provider.

For more information, please call Member Services.

Services covered by the plan**Gender reassignment surgery**

The plan covers gender reassignment services.

Covered services include:

- Mastectomy
- Breast augmentation
- Hysterectomy
- Salpingectomy
- Oophorectomy
- Genital reconstructive surgery

The plan does not cover cosmetic procedures.

Prior authorization from the plan is required.

For more information, please call Member Services.

Habilitation services

The plan covers healthcare services that help children and adults keep, learn or improve skills and functioning for daily living. These services include occupational, physical and speech therapies and other services for members with disabilities in a variety of outpatient settings. Examples include therapy for a child who is not walking or talking at the expected age, and therapy for an adult for purpose of maintaining muscle tone.

The plan covers outpatient physical therapy (PT), occupational therapy (OT) and speech therapy (ST) services limited to 20 visits per benefit year for each type of therapy. Benefit limits are shared between habilitation services and outpatient rehabilitation services.

Services may be provided in your home, in the therapy provider's office, in a hospital outpatient department, or in a rehabilitation facility.

Prior authorization from the plan is required for services exceeding the 20 visit limit.

For more information, please call Member Services.

Services covered by the plan**Hearing services, including hearing aids**

The plan covers hearing tests when you get them from a network physician, audiologist, or other qualified provider.

The plan also covers the following:

- Hearing exams, balance tests, and related consultations
- Evaluations for fitting hearing aids, including ear molds and ear impressions
- Hearing aids, including binaural
- Providing and dispensing hearing aids, batteries, and accessories
- Instruction in the use, care, and management of hearing aids
- Follow-up visit to ensure hearing aid performance
- Loan of a hearing aid when necessary

The hearing aid evaluation exam or a hearing aid consultation is limited to one exam or consultation every 2 years since the last date of service for members aged 21 years or over, and as needed for members under age 21 years.

Prior authorization from the plan is not required for hearing exams provided by a network provider, [\[Plans explain which services require a prior authorization: but may be\]](#) required for hearing aids, repairs and replacements.

For more information, please call Member Services.

Hepatitis B screening

The plan covers Hepatitis B screening for adolescents and adults when ordered and delivered by the PCP in an office setting.

Prior authorization from the plan is not required for services provided by a network provider.

For more information, please call Member Services.

Services covered by the plan**Hepatitis C virus (HCV) screening**

The plan covers HCV screening for adults who present with one of the following conditions when ordered and delivered by the PCP in an office setting:

- High risk for Hepatitis C Virus infection, including having had a blood transfusion before 1992; or
- One-time screening for adults born from 1945 through 1965

Prior authorization from the plan is not required for services provided by a network provider.

For more information, please call Member Services.

HIV screening

The plan covers HIV screening exams and related tests for adults and adolescents when ordered and delivered by the PCP in an office setting.

Prior authorization from the plan is not required for services provided by a network provider.

For more information, please call Member Services.

Home health care services

The plan covers services provided by a home health agency including:

- Part-time or intermittent skilled nursing and home health aide services
- Physical therapy, occupational therapy and speech therapy
- Durable medical equipment and supplies

Prior authorization from the plan is required.

For more information, please call Member Services.

Home infusion therapy services

The plan covers home infusion therapy services that include administering nutrients, antibiotics, and other drugs and fluids by an intravenous (IV) route. Covered services include medically necessary professional services, medical supplies, and equipment.

Prior authorization from the plan is required.

For more information, please call Member Services.

Services covered by the plan**Hospice care**

The plan covers hospice care services that are reasonable and necessary to relieve or lessen the symptoms of the terminal illness, including related conditions or complications. You have the right to elect hospice if your provider and hospice medical director determine that you are terminally ill. This means you have a medical condition resulting in a life expectancy of 6 months or less, if the illness runs its normal course.

Covered services include:

- Nursing care
- Medical social services
- Physician services provided by the hospice physician or the member's PCP
- Counseling services, including dietary counseling
- General inpatient care for pain control or symptom management which cannot be provided in an outpatient setting
- Inpatient respite care for members not residing in a nursing facility
- Durable medical equipment and supplies for self-help and personal comfort related to relieving, lessening, or managing the symptoms and effects of the member's terminal illness or conditions related to the terminal illness
- Drugs to relieve, lessen, or manage the symptoms or effects of the member's terminal illness or conditions related to the terminal illness
- Home health aide and homemaker services
- Physical therapy, occupational therapy, and speech language pathology services for the purpose of symptom control or to enable the member to maintain the ability to perform activities of daily living and basic functional skills
- Ambulance and wheelchair van transportation
- Any other service that is specified in the member's plan of care as reasonable and necessary to relieve, lessen, or manage the member's terminal illness and related conditions

Prior authorization from the plan is required.

For more information, please call Member Services.

Services covered by the plan**Hysterectomy**

The plan covers a hysterectomy, which is the surgical removal of the uterus (womb). The plan does not cover hysterectomy procedures when performed solely for the purpose of sterilization.

In accordance with federal regulations, a hysterectomy consent form must be signed and must include written acknowledgment that you were informed both orally and in writing that the hysterectomy would make you permanently incapable of reproducing.

Prior authorization from the plan is required.

For more information, please call Member Services.

Immunizations

The plan covers certain vaccines (age restrictions may apply), including:

- Pneumonia (pneumococcal) vaccine
- Flu (influenza) shots
- Hepatitis B vaccine, if you are at high or intermediate risk of getting Hepatitis B
- Childhood/adolescent immunizations
- Shingles (Herpes zoster) vaccine
- Human papilloma virus (HPV)

Immunization coverage does not include vaccines required or recommended for out of country travel.

Prior authorization from the plan is not required for services provided by a network provider.

For more information, please call Member Services.

Infertility services

The plan covers infertility services limited to determining the cause and treatment of medical condition(s) causing infertility.

[Plans describe prior authorization requirements: Prior authorization from the plan is required or Prior authorization from the plan is not required for services provided by a network provider.]

Services covered by the plan**Inpatient hospital services, including acute rehabilitation services**

The plan covers inpatient hospital services, including:

- Semi-private room (or a private room if it is medically necessary)
- Meals, including special diets
- Nursing services
- Costs of special care units, such as intensive care or coronary care units
- Drug and medications
- Lab tests
- X-ray and other radiology services
- Surgical and medical supplies
- Durable medical equipment, such as wheelchairs
- Operating and recovery room services
- Physical, occupational, and speech therapy
- Administration of blood products
- Physicians services, including anesthesia

Prior authorization from the plan is required except for emergency admissions.

For more information, please call Member Services.

Services covered by the plan**Inpatient mental health services**

The plan covers inpatient mental health services that include:

- Inpatient mental health services to evaluate and treat an acute psychiatric condition*
- Psychiatric consultation on an inpatient medical unit*

*Special coverage rules apply for some inpatient stays. If you are age 21-64 years, contact Member Services to see if you meet coverage requirements.

There is no lifetime limit on the number of days a member can have in an inpatient mental health care facility.

Refer also to *Outpatient mental health services* in this Benefits Chart.

Refer also to *Substance use disorder (SUD) treatment services* in this Benefits Chart.

[Include, as applicable:] Services are managed by [Subcontractor Name] for the plan. [Plans provide contact information, including hours of operation.]

[Plans explain which services require prior authorization.] Prior authorization from the [Subcontractor Name] may be required.

Prior authorization from the plan is required except for residential substance use disorder and emergency admissions.

For more information, please call Member Services.

Laboratory services

The plan covers laboratory services when ordered by a physician or other health care practitioner licensed to do so.

[Plans explain which services require a prior authorization.] Prior authorization may be required.

For more information, please call Member Services.

Services covered by the plan**Maternity services**

The plan covers pre-natal, delivery, nursery, and postpartum maternity services. Delivery is covered in a hospital and birthing center (whether in the birthing center or as a home birth when attended by birthing center staff), and in your home. Any required laboratory and ultrasound services are also covered.

Additional maternity related services are also available through the Home Visiting NH and Comprehensive Family Support Services programs. For information about these programs, please call the NH Division of Public Health Services toll-free at **1-800-852-3345**, ext. 4501 (TDD Access Relay: 1-800-735-2964), Monday through Friday, 8:00 a.m. to 4:30 p.m. ET.

Prior authorization from the plan is not required for services provided by network providers.

For more information, please call Member Services.

Medical supplies

The plan covers medical supplies. Medical supplies are consumable or disposable items that are appropriate for relief or treatment of a specific medically diagnosed health condition, illness, or injury.

Medical supplies include the following:

- Ostomy supplies
- Catheters
- Incontinence products
- Splints
- Tracheotomy supplies

[Plans explain which services require prior authorization.] Prior authorization from the plan may be required.

For more information, please call Member Services.

Medical nutrition therapy

[Plans describe the benefit.]

For more information, please call Member Services.

Services covered by the plan**Mental health services**

Refer to *Inpatient mental health services* in this Benefits Chart.

Refer to *Outpatient mental health services* in this Benefits Chart.

Refer to *Substance use disorder (SUD) treatment services* in this Benefits Chart.

Obesity screening and therapy for weight loss

The plan covers obesity screening and counseling therapy to help you lose weight. Talk to your doctor to find out more.

Prior authorization from the plan is not required for services provided by a network provider.

For more information, please call Member Services.

Occupational therapy services

Refer to *Outpatient rehabilitation services (physical therapy, occupational therapy, speech and language therapy services)* in this Benefits Chart.

Services covered by the plan**Organ and tissue transplants**

The plan covers the following organ and tissue transplants:

- Kidney transplants
- Heart transplants
- Heart and lung transplants
- Lung transplants
- Bone marrow
- Stem cell
- Liver transplants
- Pancreas transplants
- Pancreas and kidney transplants
- Cornea transplants
- Skin transplants except for hair transplants
- Bone grafts

If you need a transplant, a plan approved transplant center will review your case to determine your status as a candidate for a transplant.

Prior authorization from the plan is required.

For more information, please call Member Services.

Services covered by the plan**Orthotic devices**

The plan covers orthotic devices, which are orthopedic items applied externally to a limb or body to:

- Protect against injury
- Support a weak or deformed portion of the body; or
- Prevent or correct a physical deformity or malfunction.

Orthotic devices include:

- Scoliosis spinal braces
- Leg braces
- Hand and foot orthotics

[Include, as applicable:] Services are managed by [Subcontractor Name] for the plan. [Plans provide contact information.]

[Plans explain which services require prior authorization.] Prior authorization from the [Subcontractor Name] may be required.

Prior authorization from the plan is required.

For more information, please call Member Services.

Services covered by the plan**Outpatient mental health services**

The plan covers outpatient mental health services provided by a community mental health center, psychiatrist, psychiatric advance practice registered nurse (APRN), mental health therapy provider, psychologist, licensed psychotherapy provider, community health center, federally qualified health center (FQHC), rural health center (RHC), and outpatient mental health facilities.

Covered services include:

- Medication visits
- Individual, group and family therapy
- Diagnostic evaluations
- Partial hospitalization program (PHP)
- Intensive outpatient program (IOP)
- Emergency psychiatric services
- Electroconvulsive therapy (ECT)
- Transcranial magnetic stimulation
- Crisis intervention
- Individualized Resiliency and Recovery Oriented Services (IROS)
- Case Management services, including Assertive Community Treatment (ACT)
- Psychological testing

Refer also to *Inpatient mental health services* in this Benefits Chart.

Refer also to *Substance use disorder (SUD) treatment services* in this Benefits Chart.

[Include, as applicable:] Services are managed by [Subcontractor Name] for the plan. [Plans provide contact information.]

[Plans explain which services require prior authorization.] Prior authorization from the [Subcontractor Name] may be required.

Prior authorization from the plan is not required except for neuropsychological testing, electroconvulsive therapy, transcranial magnetic stimulation and mental health services provided in a day program.

For more information, please call Member Services.

Services covered by the plan**Outpatient hospital services**

The plan covers outpatient hospital services for the diagnosis or treatment of an illness or injury.

Covered services include:

- Services in an emergency department or outpatient clinic, including observation stays or outpatient surgery
- Labs and diagnostic tests provided by the hospital
- X-rays and other radiology services provided by the hospital
- Radiation therapy, including technician services, materials, and supplies
- Some screening and preventive services
- Some drugs that you cannot administer yourself
- Surgical supplies, such as dressings
- Casting materials
- Administration of blood products
- Intravenous (IV) infusions

Prior authorization from the plan is required for some services, including outpatient surgery and some diagnostic tests.

See the specific service in this Benefits Chart for more information or please call Member Services.

Outpatient rehabilitation services (physical therapy, occupational therapy, speech and language therapy services)

The plan covers rehabilitation services to help you recover from an illness, accident, or surgery. Rehabilitation services include physical therapy, occupational therapy, and speech language therapy.

Coverage is limited to 20 visits per benefit year for each type of therapy. Benefit limits are shared between outpatient rehabilitation and habilitation services. Services may be provided in your home, in the therapy provider's office, in a hospital outpatient department, or in a rehabilitation facility.

Prior authorization from the plan is required for services exceeding the 20 visit limit.

For more information, please call Member Services.

Services covered by the plan**Outpatient surgery**

The plan covers outpatient surgery performed in hospital outpatient facilities and ambulatory surgical centers.

[Plans explain which services require prior authorization.] Prior authorization may be required for certain procedures.

For more information, please call Member Services.

Oxygen and respiratory therapy equipment

The plan covers oxygen equipment, including oxygen systems, oxygen refills, and oxygen therapy equipment rentals.

The plan also covers respiratory equipment, including CPAP machines, BiPAP machines, and ventilators.

Prior authorization from the plan is not required for oxygen provided by a network provider. [Plans explain which services require prior authorization.] Prior authorization from the plan may be required for respiratory therapy equipment.

For more information, please call Member Services.

Services covered by the plan**Personal care attendant services**

The plan covers personal care attendant services to assist with activities of daily living and instrumental activities of daily living. To be eligible for this service, you must be age 18 years or older, wheelchair bound, and able to self-direct your care.

Services include assistance with:

- Bathing and other personal hygiene activities
- Dressing and grooming
- Medication administration and management
- Mobility and transfers
- Toileting and related tasks
- Meal preparation and eating
- Laundry
- Light housekeeping

Prior authorization from the plan is required.

For more information, please call Member Services.

Physical therapy services

Refer to *Outpatient rehabilitation services (physical therapy, occupational therapy, speech and language therapy services)* in this Benefits Chart.

Services covered by the plan**Physician, physician assistant, and advance practice registered nurse services**

The plan covers physician, physician assistant, and advance practice registered nurse services, including

- Diagnosis and treatment services, preventive services and surgical services, (including anesthesia), which are provided in an office or other outpatient setting, nursing facility, or your home:
- Consultation, diagnosis, and treatment by a specialist, including an obstetrician or gynecologist (OB/GYN), either face-to-face, or via telemedicine services
- Second opinion by an in-network provider or an out-of-network provider (with prior authorization), for example, before medical or surgical procedure is performed
- Inpatient hospital visits for acute care days of stay
- Laboratory and radiology services
- Temporomandibular joint (TMJ) evaluation and treatment
- Pain management
- Anesthesia as part of a child's dental treatment plan

See also specific services for additional coverage by the plan.

Prior authorization from the plan is not required for services provided by a network provider, except for certified ambulatory surgical centers, outpatient surgery and some pain management centers.

For more information, please call Member Services.

Podiatry services

The plan covers routine and specialty foot care for pathological conditions of the foot due to localized illness, injury or symptoms involving the foot.

Services include:

- Routine foot care burring and trimming of nails when your PCP determines your need for the service and provides you with a referral to a podiatrist
- Prevention and reduction of corns, calluses, and warts by cutting or surgical means
- Casting, strapping, and taping when performed by a podiatrist for the treatment of fractures, dislocations, sprains, strains, and open wounds of the ankle, foot, and toes

For more information, please call Member Services.

Services covered by the plan**Prescription drugs**

The plan covers prescription drugs (and over the counter drugs with a prescription) included on the plan's list of covered drugs approved by NH DHHS. Drug coverage rules and restrictions may apply.

Retail Pharmacy Copayment

- \$1 copayment – up to a 30-day supply
- \$1 copayment for a prescription drug that is not identified as either a preferred or non-preferred prescription drug
- \$2 copayment for each non-preferred prescription drug (if the prescribing provider determines that a preferred drug will be less effective and/or will have adverse effects for the member, the non-preferred drug will be \$1.00)

[Plans modify as applicable:] Mail Order Copayment (only certain drugs available through mail order)

- \$1 copayment for a 90-day supply
- \$1 copayment for a prescription drug that is not identified as either a preferred or non-preferred prescription drug
- \$0 copayment for family planning products or for Clozaril® (Clozapine) prescriptions or tobacco cessation products.

For information on prescription drug coverage, refer to Chapter 7 (*Getting covered prescription drugs*).

[Include, as applicable:] Services are managed by [Subcontractor Name] for the plan. [Plans provide contact information.]

Services covered by the plan**Private duty nursing services**

The plan covers private duty nursing services provided by a registered nurse (RN) or licensed practical nurse (LPN). Members eligible for these services require continual skilled nursing observation, judgment, assessment, or interventions for more than a 2-hour duration to maintain or improve the member's health status.

The first step in the approval process is a written order from a physician or advanced practice registered nurse, including a written plan of care, that describes why private duty nursing services are medically necessary for the member. Supporting documentation demonstrating the care skill level and continuous needs of the member must be provided by the agency delivering private duty nursing services.

Prior authorization from the plan is required.

For more information, please call Member Services.

Prostate cancer screening

The plan covers the following prostate cancer screening as part of a medical exam or as needed:

- A digital rectal exam
- A prostate specific antigen (PSA) test

Prior authorization from the plan is not required for services provided by a network provider.

For more information, please call Member Services.

Services covered by the plan**Prosthetic devices and related supplies**

The plan covers the purchase and repair of prosthetic devices and related supplies. Prosthetic devices are non-dental, artificial types of replacement, corrective or supportive devices or parts of a device that are used to replace a missing portion of the body, or to replace a missing function of the body.

Covered prosthetic devices and related supplies include:

- Prosthetic shoes
- Artificial arms and legs
- Breast prostheses (including a surgical brassiere) after a mastectomy
- Artificial larynxes

[Plans explain which services require prior authorization.] Prior authorization from the plan may be required.

For more information, please call Member Services.

Pulmonary rehabilitation services

The plan covers pulmonary rehabilitation services for members who have moderate-to-severe chronic obstructive pulmonary disease (COPD). Covered services include training on breathing techniques, medications, nutrition, relaxation, oxygen, travel, and how to do everyday tasks with less shortness of breath, as well as how to stay healthy and prevent worsening of COPD symptoms.

Prior authorization from the plan is not required.

For more information, please call Member Services.

Screening for lung cancer with low dose computed tomography (LDCT)

The plan covers LDCT services once every 12 months for people aged 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.

Prior authorization from the plan is not required for services provided by a network provider.

For more information, please call Member Services.

Services covered by the plan**Sexually transmitted infection (STI) screening and counseling**

In addition to screening for HIV and Hepatitis B (discussed separately in this Benefits Chart), the plan covers screenings for chlamydia, gonorrhea, and syphilis. The plan also covers related intensive behavioral counseling sessions.

Prior authorization from the plan is not required for services provided by a network provider.

For more information, please call Member Services.

Smoking cessation

[Plans describe smoking cessation benefits, including available prescriptions.]

For more information, please call Member Services.

Speech and language pathology services)

Refer to *Outpatient rehabilitation services (physical therapy, occupational therapy, speech and language therapy services)* in this Benefits Chart.

Services covered by the plan**Substance use disorder (SUD) treatment services**

The plan covers substance use disorder treatment services provided by a community mental health center, community health center, federally qualified health center (FQHC), rural health center (RHC), mental health provider, acute care hospital, psychiatric hospital, masters licensed alcohol and drug counselor (MLDAC), licensed alcohol drug counselor (LADC), psychiatrist, psychiatric advance practice registered nurse (APRN), physician, certified recovery support worker, residential treatment and rehabilitation facilities, methadone clinics/opioid treatment programs, and peer recovery programs.

Covered services may include:

- Screening, brief intervention, and referral to treatment (SBIRT)
- Substance use screenings
- Individual, group, and family therapy
- Intensive outpatient substance use disorder services
- Partial hospitalization program (PHP)
- Medically monitored outpatient withdrawal management
- Crisis intervention
- Peer recovery support
- Non-peer recovery support
- Continuous recovery monitoring
- Opioid treatment services
- Medication assisted treatment
- Medically monitored residential withdrawal management
- Residential treatment services, including specialty services for pregnant and postpartum women

Refer also to *Inpatient mental health services* in this Benefits Chart.

Refer also to *Outpatient mental health services* in this Benefits Chart.

[Include, as applicable:] Services are managed by [Subcontractor Name] for the plan. [Plans provide contact information.]

[Plans explain which services require prior authorization.] Prior authorization from the [Subcontractor Name] may be required.

For more information, please call Member Services.

Services covered by the plan**Telemedicine services**

The plan covers audio and video interactive telemedicine services for Medicaid-covered services (excluding primary care services) when services are delivered by the following providers as a method of delivery of medical care:

- Physician or Physician Assistant
- Advance Practice Registered Nurse (APRN) or Clinical Nurse Specialist
- Nurse Midwife
- Clinical Psychologist
- Clinical Social Worker
- *[Insert as applicable: Registered Dietitian]*

Eligible sites where video interactive telemedicine services may be delivered are:

- Medical practitioner's offices
- Hospitals
- Skilled nursing facilities
- Community Mental Health Centers
- Federally Qualified Health Centers (FQHC)
- Rural Health Centers (RHC)

For more information, please call Member Services.

Transportation services – Ambulance transportation

Refer to *Ambulance services – Emergency* in this Benefits Chart.

Refer to *Ambulance services – Non-emergency* in this Benefits Chart.

Transportation services – Non-emergency medical transportation (NEMT)

[Plans modify and describe how members may access non-emergency medical transportation services, including future and same-day services.]

The plan covers non-emergency medical transportation services if you are unable to pay for the cost of transportation to provider offices and facilities for medically necessary New Hampshire Medicaid covered services listed in the Benefits Chart in Chapter 4.

For authorized non-emergency medical transportation, you must follow plan rules to get reimbursement or transportation services.

Plan rules include:

- You must use either the Family and Friends Mileage Reimbursement Program or public transportation. If these options are unavailable to you, network transportation services shall be provided when plan rules are met

Exceptions to the Family and Friends Mileage Reimbursement Program

- You must use the Family and Friends Mileage Reimbursement Program if you have a car, or when a friend or family member with a car can drive you to your medically necessary service
- If you have a car and do not want to enroll in the Family and Friends Program you must meet one (1) of the following criteria to qualify for transportation services:
 - Do not have a valid driver's license;
 - Do not have a working vehicle available in the household;
 - Are unable to travel or wait for services alone; or
 - Have a physical, cognitive, mental or developmental limitation
- If no car is owned or available, you must use public transportation if you meet one (1) of the following criteria:
 - You live less than one half mile from a bus route;
 - Your provider is less than one half mile from the bus route;
 - You are an adult under the age of sixty-five (65)

Exceptions to the public transportation requirement are:

- If you have two (2) or more children under age six (6) who shall travel with the you;
- If you have one (1) or more children over age six (6) who has limited mobility and shall accompany you to the appointment; or

Services covered by the plan

Continued on the next page

Transportation services – Non-emergency medical transportation (NEMT) – Continued from the previous page

- If you have at least one (1) of the following conditions:
 - Pregnant or up to six (6) weeks post-partum;
 - Moderate to severe respiratory condition with or without an oxygen dependency;
 - Limited mobility (walker, cane, wheelchair, amputee, etc.);
 - Visually impaired;
 - Developmentally delayed;
 - Significant and incapacitating degree of mental illness; or
 - Other exception by provider approval only

[Include, as applicable:] Services are managed by [Subcontractor Name] for the plan. [Plans provide contact information, including hours of operation.]

[Plans explain which services require prior authorization.] Prior authorization from the [Subcontractor Name] may be required.

To schedule transportation to provider offices or facilities for services provided directly by NH DHHS, call CTS toll-free at **1-844-259-4780**, Monday through Wednesday, 8:00 a.m. to 8:00 p.m. ET and Thursday through Friday, 8:00 a.m. to 6:00 p.m. ET. For a list of these services, refer to Section 4.4 (*New Hampshire Medicaid Services provided outside the plan*).

For more information, please call Member Services.

Services covered by the plan**Urgently needed care**

[Plans modify and/or describe any restrictions.] The plan covers urgently needed care whether from an in-network or out-of-network provider when network providers are unavailable.

Urgently needed care is care given to treat the following:

- A non-emergency (does not include routine primary care services)
- A sudden medical illness
- An injury
- A condition that needs care right away

For more information, refer to Section 3.6 (*Emergency, urgent, and after-hours care*).

[Plans modify as appropriate:] If you require urgently needed care, you should first try to get it from a network urgent care center or call the plan's 24/7 Nurse Advice Call Line at *[Insert phone number]*. You should inform your PCP whenever possible if you have received such care.

Prior authorization from the plan is not required for urgently needed services.

Urgently needed care is not covered outside of the United States and its territories.

For more information, please call Member Services.

Services covered by the plan**Vision services and eyewear**

The plan covers the following services:

- Eye care services by an ophthalmologist, optometrist or optician
- One (1) refraction eye exam to determine the need for eyeglasses no more frequently than every 12 months.
- Eye exams to diagnose and monitor medical conditions of the eye
- One pair of single vision lenses with frames, as follows:
 - For members 21 years of age and older, if the refractive error is at least plus or minus .50 diopter, according to the refractive error which may be calculated as a combined total of the spherical and cylindrical errors, in both eyes
 - For members under 21 years of age, if the refractive error is at least plus or minus .50 diopter, according to the refractive error which may be calculated as a combined total of the spherical and cylindrical errors, in at least one eye
- One pair of eyeglasses with bifocal corrective lenses (or one pair of eyeglasses with corrective lenses for close vision and one pair of eyeglasses with corrective lenses for distant vision) if there is a refractive error of at least .50 diopter for both close and distant vision
- Transition lenses for members with ocular albinism
- Contact lenses for ocular pathology in cases where the visual acuity is not correctable to 20/70 or better without contact lenses, or when required to correct aphakia or to treat corneal disease
- Replacement of the component eyeglasses parts due to breakage or damage, subject to all of the following:
 - Replacements may be in the form of a single lens, both lenses, frame only, or a complete pair of corrective lenses
 - Each component part or complete pair of corrective lenses may only be replaced one time within a 12-month period
 - When the member has two (2) pairs of eyeglasses in lieu of bifocals, each pair of eyeglasses is eligible for replacement
- Only one replacement of lost eyeglasses per lifetime for members under age 21 years

Continued on the next page

Services covered by the plan

Vision services and eyewear – Continued from the previous page

The plan covers the following services:

- Trifocal lenses if the member:
 - Is employed and the trifocal lenses are required for the work involved in the member's employment; or
 - Is a full time student and the trifocal lenses are required for the work involved in the member's education; or
 - Currently has trifocals.
- Replacement of nickel frames after 12 months, if the member has a documented allergy to nickel demonstrated by skin irritation and wearing down of the frame in the affected area
- Ocular prostheses, including artificial eyes and lenses

[Plan must explain any other special eyewear selection requirements or limitations, including standard eyeglass selection or dollar allowance.]

Prior authorization from the plan is not required for covered services provided by network providers.

For more information, please call Member Services.

X-rays and radiology services

The plan covers radiation therapy and diagnostic X-rays.

Prior authorization from the plan is required for high-tech diagnostic imaging, including CT scans, MRIs, MRAs, PET scans, and nuclear cardiac imaging, unless part of an emergency room visit, an inpatient hospitalization, or provided at the same time with, or on the same day as, an urgent care facility visit.

For more information, please call Member Services.

Section 4.3 Extra benefits provided by the plan

[Plans must include information in this section if they offer plan supplemental or value-added services or items. For value-added services or items, describe how the member accesses the service or item. If by referral or prior authorization, explain requirements for receiving benefits.]

The plan offers some extra benefits that are available to you in addition to the covered services required by New Hampshire Medicaid.

Extra benefits include:

[Insert plan-specific benefits.]

Section 4.4 New Hampshire Medicaid benefits covered outside the plan

New Hampshire Medicaid directly covers some Medicaid benefits that the plan does not cover even though the plan may help coordinate them. That is why you should always carry both your *[Plan name]* and New Hampshire Medicaid membership cards. Always show your *[Plan name]* membership card to receive services covered by the plan. If you need help getting any covered services, please call Member Services (phone numbers are printed on the back cover of this handbook).

ALWAYS CARRY BOTH YOUR *[PLAN]* AND NEW HAMPSHIRE MEDICAID MEMBERSHIP CARDS.

The following services are not covered by our plan. However, these services are available through New Hampshire Medicaid as long as the provider is enrolled with New Hampshire Medicaid:

- Some prescription drugs are covered by New Hampshire Medicaid when billed through a pharmacy. They include, but are not limited to, certain prescription drugs used to treat Hemophilia, and the drugs Carbaglu® and Ravicti®. The pharmacy will bill New Hampshire Medicaid for these medications.
- Comprehensive dental services, including orthodontia, for members under age 21 years
- Dental services limited to the treatment of acute pain or infections for members aged 21 years and over
- Early supports and services for infants and children aged birth to 3 years
- Medicaid-to-school services
- Nursing home or nursing facility services (sometimes called long-term care nursing facility services), including: skilled nursing facility services, long-term care nursing facility services, and intermediate care facility services (nursing homes and acute care swing beds)
- Intermediate care facility services (nursing home and acute care swing beds)
- Glencliff Home services

- Division of Child, Youth, and Family Program services for Medicaid eligible children and youth referred by the courts or juvenile parole board, including:
 - Home based therapy
 - Child support services (also known as Child Health Support Services)
 - Intensive Home and Community Services
 - Placement services
 - Private Non-medical Institutional Care for Children
 - Crisis intervention
- Home and Community-Based Care waiver services for:
 - Members with acquired brain disorders;
 - Members with developmental disabilities;
 - Members up to age 21 years with developmental disabilities under the In-Home Supports waiver program; and
 - Members with age-related disabilities, chronic illnesses, or physical disabilities under the Choices for Independence waiver.

These programs provide long-term services and supports in your home, as well as in assisted living facilities, community residences, and residential care homes.

- *[Plans include any services not covered for moral or religious reasons. If services and items are not covered for moral or religious reasons, provide instructions on how the member may seek care covered by New Hampshire Medicaid.]*

For more information, please call NH DHHS Customer Service Center at **1-844-ASK-DHHS** (1-844-275-3447) (TDD Relay Access: 1-800-735-2964), Monday through Friday, 8:00 a.m. to 4:00 p.m. ET.

Section 4.5 Benefits not covered by our plan or New Hampshire Medicaid

[Plans must include information on where and how members may access benefits not available from or not covered by the plan or New Hampshire Medicaid.]

[The services listed below are excluded from NH DHHS, New Hampshire Medicaid, and [Plan name] benefit packages. If any services below are supplemental benefits offered by the plan, delete them from this list. Plans may add parenthetical references to the Benefits Chart for descriptions of covered services/items as appropriate. Plans may also add exclusions as needed.]

This section tells you what benefits are excluded by the plan and New Hampshire Medicaid. “Excluded” means that the plan does not pay for these benefits. The list below describes some services and items that are not covered by the plan.

The plan will not cover the services and items listed in this section (or anywhere else in this Member Handbook) except under the specific conditions listed. If you think that we should pay for a service or item that is not covered, you may file an appeal or grievance. For information about filing an appeal or grievance, refer to Section 10 (*What to do if you want to appeal a plan decision or “action”, or file a grievance*).

[Plans must include a list of benefits not covered by the plan.]

Chapter 5. Using *[Plan name]* to help manage your health

Section 5.1 Staying healthy

[Plans should describe any additional special programs offered that have not been discussed previously, including but not limited to preventive care, special needs, disease management, well child programs, pregnancy program, value-added services, wellness programs, including how to access Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) services for members under age 21 years entitled to the benefit.]

Section 5.2 Care coordination support

[Plans must explain how the member may access care coordination services, how it works with their PCP, other providers, and case manager, duration of support, including who is eligible for support, and who to call for information and services.]

Section 5.3 Continuity of care, including transitions of care

[Plans should include information about modified practices or other continuity of care practices, as applicable. At a minimum, practices must be compliant with the NH DHHS contract.]

“Continuity of Care” means the provision of continuous care for chronic or acute medical conditions through member transitions between:

- Health care facilities
- Member or community residence
- Providers
- Service areas
- Managed care health plans
- Medicaid fee-for-service (FFS)
- Foster care and independent living (including return from foster care placement to community; or change in legal status from foster care to adoption)
- Private insurance and managed care coverage

[Plans explain what the plan does or what the member must do to ensure each of these arrangements are available to them.]

When you transition to our plan from New Hampshire Medicaid, another Medicaid managed care plan, or another type of health insurance coverage you may be able to continue your treatment. When you meet at least one (1) of the conditions below you may continue to get care from your current providers for a limited time, even if your provider is outside the *[Plan name]* network. In addition to meeting at least one (1) of the conditions below, your current network

provider must be in good standing with the plan and New Hampshire Medicaid to continue to provide your treatment.

| <p>When one of these clinical circumstances apply to you, you may continue to get care from your treating provider(s) for a limited time</p> | <p>You may continue to get care from your treating provider(s) during this time period</p> | <p>You may continue to get currently prescribed prescription drugs during this time period</p> |
|---|---|---|
| <p>You are receiving a prior authorized ongoing course of treatment your current provider at the time of transition</p> | <p>Up to 90 calendar days from your enrollment date or until the completion of a medical necessity review by the plan, whichever occurs first</p> | <p>For up to 90 calendar days from your enrollment date or until the completion of a medical necessity review by the plan, whichever occurs first</p> |
| <p>You are receiving services with your current provider and you have an acute illness, a condition that is serious enough to require medical care for which a break in treatment could likely result in a reasonable possibility of death or permanent harm</p> | | |
| <p>You are receiving services that need to continue because you have a chronic illness or condition, a disease or condition that is life threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time</p> | | |
| <p>You are a child with Special Health Care Needs meaning those who have or are at increased risk of having a serious chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that usually expected for the child’s age and you are in a course of ongoing treatment at the time of transition*</p> | | |
| <p>You are in your second or third trimester of pregnancy and prefer to</p> | | |

| | | |
|--|---|---|
| <p>When one of these clinical circumstances apply to you, you may continue to get care from your treating provider(s) for a limited time</p> | <p>You may continue to get care from your treating provider(s) during this time period</p> | <p>You may continue to get currently prescribed prescription drugs during this time period</p> |
| <p>continue to receive care through your current provider</p> | | |
| <p>You desire or require continued services with your current providers because you have a terminal illness, you have a medical prognosis that life expectancy is six (6) months or less</p> | <p>For the remainder of your life with respect to care directly related to the treatment of the terminal illness or its medical effects</p> | |

*Including children or infants in foster care; requiring care in a neonatal intensive care unit; diagnosed with neonatal abstinence syndrome (NAS); in high stress social environments/caregiver stress; receiving family centered early supports and services, or participating in Special Medical Services or Partners in Health Services with a serious emotional disturbance, intellectual developmental disability or substance use disorder diagnosis.

When you transfer to another provider or plan, you or your authorized provider may request transfer of your medical records to your new provider(s).

For more information, contact Member Services (phone numbers are printed on the back cover of this handbook).

Section 5.4 Mental health parity assurance

Federal and state laws require the plan to provide coverage for mental health and substance use disorder treatments as favorably as it provides coverage for other medical health services. This is referred to as parity. Parity laws require coverage for mental health and/or substance use disorders be no more restrictive than coverage for other medical conditions, such as diabetes or heart disease. For example, if the plan provides unlimited coverage for physician visits for diabetes, it must do the same for depression or schizophrenia.

Parity means that:

- *[Plan name]* must provide the same level of benefits for any mental health and/or substance use disorder as it would for other medical conditions you may have;

- *[Plan name]* must have similar prior authorization requirements and treatment limitations for mental health and substance use disorder benefits as it does for other medical benefits;
- *[Plan name]* must provide you or your provider with the medical necessity criteria used by *[Plan name]* for prior authorization upon either your request or your provider's request;
- *[Plan name]* must not impose aggregate lifetime or annual dollar limits on mental health or substance use disorder benefits;
- **Within a reasonable time frame**, *[Plan name]* must provide you the reason for any denial of authorization for mental health and/or substance use disorder services; and
- If *[Plan name]* provides out-of-network coverage for other medical benefits, it must provide comparable out-of-network coverage for mental health and/or substance use disorder benefits.

The parity requirement applies to:

- Drug copayments;
- Limitations on service coverage (such as limits on the number of covered outpatient visits);
- Use of care management tools (such as prescription drug rules and restrictions);
- Criteria for determining medical necessity and prior authorizations; and
- Prescription drug list structure, including copayments.

If you think that *[Plan name]* is not providing parity as explained above, you have the right to file an appeal or file a grievance. For more information, refer to Chapter 10 (*What to do if you want to appeal a plan decision or "action", or file a grievance*).

If you think *[Plan name]* did not cover behavioral health services (mental health and/or substance use disorder services) in the same way as medical services, you may also file a grievance or complaint with the New Hampshire Department of Insurance Consumer Services Hotline at **1-800-852-3416** (TDD Access Relay: 1-800-735-2964), Monday through Friday, 8:00 a.m. to 4:30 p.m. ET, or online at <https://www.nh.gov/insurance/consumers/complaints.htm>.

Chapter 6. Rules on prior authorization of services

Prior authorization requirements for covered services are in italics in Section 4.2 (*Benefits Chart*). For all services requiring prior authorization, your provider must request and receive prior authorization from the *[Plan name]* in order for you to get coverage for the service. If you do not get this authorization, *[Plan name] may not cover the service.*

For more information on how to get prior authorization for services, refer to Section 6.2 (*Getting plan authorization for certain services*).

For information about how to get prior authorization for prescription drugs, refer to Section 7.1 (*Drug coverage rules and restrictions: Getting plan authorization in advance*).

Section 6.1 Medically necessary services

When making its coverage decision, *[Plan name]* will consider whether the service is medically necessary

[Plan name] determines whether a service is "medically necessary" in a manner that is no more restrictive than the New Hampshire Medicaid criteria. For information about criteria used to support a medical necessity decision, call Member Services and request a copy of written rules specific to your situation. (Phone numbers for Member Services are printed on the back cover of this handbook.)

[Plans delete or modify as appropriate: In some cases, [Plan name] will review medical necessity after covered services are delivered. [Plans must explain this process, including what happens when medical necessity is not found.]

For members up to age 21 years “medically necessary” means the course of treatment:

- Is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that:
 - Endanger life,
 - Cause pain,
 - Result in illness or infirmity;
 - Threaten to cause or aggravate a handicap;
 - Cause physical deformity or malfunction; and
- No other equally effective course of treatment is available or suitable for the member.

For additional information about medically necessary services for members up to age 21, refer to *EPSDT services* in Section 4.2 (*Benefits Chart*).

For members aged 21 years and older, “medically necessary” means health care services that a licensed health care provider, exercising prudent clinical judgment, would provide, in accordance with generally accepted standards of medical practice to a member for the purpose of evaluating, diagnosing, preventing, or treating an acute or chronic illness, injury, disease, or its symptoms.

Medically necessary health care services for members ages 21 years and older must be:

- Clinically appropriate in extent, site, and duration;
- Consistent with the established diagnosis or treatment of the recipient’s illness, injury, disease, or its symptoms;
- Not primarily for the convenience of the member or the member’s family, caregiver, or health care provider;
- No more costly than other items or services which would produce equivalent diagnostic, therapeutic, or treatment results as related to the member’s illness, injury, disease, or its symptoms; and
- Not experimental, investigative, cosmetic or duplicative in nature.

Section 6.2 Getting plan authorization for certain services

[Plan name]’s prior authorization decisions comply with state and federal law, and in accordance with evidence-based clinical practice standards and guidelines. The plan’s decision guidelines consider your needs and are based valid and reasonable clinical evidence or as agreed upon by practicing specialty care providers. To request a copy of practice guidelines, contact Member Services for more information (phone numbers are printed on the back cover of this handbook).

When the plan denies a service authorization request, or authorizes a service in an amount, duration, or scope that is less than request, the plan issues a written notice of coverage decision to you and your provider. For help with filing an appeal, refer to Section 10.1 (*About the appeals process*).

The following conditions apply to requests for urgent prior authorization decisions:

- Plan decisions involving urgent care shall be made as expeditiously as your health condition requires, but no later than 72 hours after receipt of the request for service, unless you or your authorized representative fails to provide sufficient information to determine whether, or to what extent your benefits are covered.
- In the case of such failure, *[Plan name]* shall notify you or your authorized representative within 24 hours of receipt of the request and advise of specific information needed for the plan to make a decision.
- You or your representative shall be afforded a reasonable amount of time, taking into account any special circumstances, but not less than 48 hours to provide specified information.

- Thereafter the plan's decision shall be made as soon as possible, but not later than 48 hours after the earlier of the plan's receipt of the specified additional information, or the end of the period afforded to you or your authorized representative to provide the additional information.
- In the case of authorization requests to continue or extend your service(s) involving urgent care of an ongoing course of treatment and a question of medical necessity, the plan's decision shall be made with 24 hours of receipt of the request provided the request is made at least 24 hours prior to the expiration of the prescribed period of time or course of treatment.
- If you disagree with the plan's adverse prior authorization decision, refer to Section 10.1 (*About the appeals process*).

For all other prior authorization decisions by *[Plan name]*, the following conditions apply:

- The plan's prior authorization decision shall be made within a reasonable time period appropriate to your medical circumstances, but shall not exceed 14 calendar days of receipt of an authorization request.
- An extension of up to 14 calendar days is available for non-diagnostic radiology decisions if you or your authorized representative request an extension, or the plan justifies a need for additional information. If the extension is necessary due to failure of you or your authorized representative to provide sufficient information for the plan's decision, you or your authorized representative have at least 45 calendar days from receipt of the notice to provide the specified information to the plan.
 - When *[Plan name]* extends the timeframe, the plan will provide written notice of the reasons for the extension decision, and advise of your right to file a grievance if you disagree with our decision. For help with filing a grievance, refer to Section 10.7 (*How to file a grievance and what to expect after you file*).
- Thereafter the plan's decision shall be made as soon as possible, but not later than 14 calendar days after the earlier of:
 - The plan's receipt of specific additional information; or
 - The end of the period afforded you or your authorized representative to provide the additional specified information.
- If you disagree with the plan's adverse prior authorization decision, refer to Section 10.1 (*About the appeals process*).

For coverage decisions after the service or item has been delivered to you, the following conditions apply:

- The plan's decision shall be made within 30 calendar days of receipt of you or your authorized representative's coverage request.

- In the event you or your authorized representative fail to provide sufficient information for *[Plan name]* to make its decision, the plan will notify you or your authorized representative within 15 calendar days of the date of the request as to what additional information is required for the plan to make its decision. You or your authorized representative have 45 calendar days to provide the required information. If the plan requests specified additional information, the timeframe for decision resumes upon receipt of the specified additional information.
- For an adverse decision, the plan will notify you or your authorized representative in writing within 3 calendar days of the decision.
- If you disagree with the plan's adverse prior authorization decision, refer to Section 10.1 (*About the appeals process*).

**For help with your service request, contact Member Services (phone numbers are printed on the back cover of this handbook).Section 6.3
Getting authorization for out-of-network services**

For information on how to get care from out-of-network providers, refer to Section 3.5 (*Getting care from out-of-network providers*).

If you are an American Indian or Alaska Native (AI/AN) of a federally recognized tribe or another individual determined eligible for Indian health care services, special coverage rules apply. You may get out-of-network services at an Indian health facility without prior authorization. Contact Member Services for more information (phone numbers are printed on the back cover of this handbook).

Section 6.4 Out-of-network hospital admissions in an emergency

The general rules for coverage of out-of-network care are different for emergency care. For information on how to get care from out-of-network hospitals in an emergency and for post stabilization services, refer to Section 3.6 (*Emergency, urgent, and after-hours care*).

Section 6.5 Getting family planning services and supplies in- or out-of-network

[Plans must explain how members may get in- or out-network family planning services and supplies without prior authorization from the plan.]

Section 6.6 Getting a second medical opinion

[Plans must fully explain how members may request a second opinion.]

Members may receive a second opinion from a qualified health care professional within the network, or one may be arranged by *[Plan name]* outside the plan's network at no cost to you.

Chapter 7. Getting covered prescription drugs

Section 7.1 Drug coverage rules and restrictions

The plan's *[Drug List]* includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the *[Drug List]*. For the most up-to-date information, call Member Services (phone numbers are printed on the back cover of this handbook) or check our website (*[insert URL]*).

If there is a restriction on your drug, it usually means that you or your provider will have to take extra steps in order for the plan to cover the drug. If there is a restriction on the drug you want to take, ask your doctor to request prior authorization from the plan. For more information, contact Member Services (phone numbers are printed on the back cover of this handbook.)

[Plans must explain rules for drug coverage.]

[Plans may include information about other rules or restrictions for drug coverage.]

The plan will generally cover your drugs as long as you follow these basic rules:

- A *[Plan name]* network provider (a doctor or other qualified prescriber) writes your prescription.
- The prescribing doctor (or other qualified prescriber) is enrolled with both New Hampshire Medicaid and *[Plan name]*.
- You fill your prescription at a network pharmacy, unless otherwise allowed, as described in section 7.4, “*Fill your prescriptions at a network pharmacy [Insert if applicable: or through the plan’s mail-order service]*”.
- Your drug is on the plan’s *[Drug List]*.
- Your drug is to be used for a medically accepted reason, one that is either approved by the Food and Drug Administration or supported by recognized publications.
- If a copayment is required, you pay the copayment for the prescription. However, remember, that an inability to pay your copayment does not prevent you from getting your prescription filled. (For more information on copayments, refer to Section 7.7, *Prescription drug copayments*.)

You or your provider may request an exception to drug coverage restrictions when you ask the plan to allow you to get a drug that is not on the plan formulary. You may also request an exception when the plan requires you to try another drug first or limits the quantity or dosage of the drug you request, for example.

Drug coverage restrictions

For some prescription drugs, more detailed rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most safe and effective ways. These rules also help control overall drug costs, requiring a lower cost drug if it works as well as a higher cost drug.

Drug list rule restrictions described in this section include:

- Restricting access to brand name drugs when a generic version of the drug is available
- Requiring prior authorization from the plan
- Requiring you try a different but similar drug first (“step therapy”)
- Imposing quantity limits on prescription drugs

Restricting access to brand name drugs when a generic version is available

[Plans may modify language to address their generic substitution program, as applicable.]

Generally, a “generic” drug works the same as a brand name drug and usually costs less. *[Insert as applicable: In most cases, when OR When]* a generic version of a brand name drug is available and has been proven effective for most people with your condition, network pharmacies will provide you the generic version. We usually will not cover the brand name drug when a generic version is available. However, if your provider *[insert as applicable: has told us the medical reason that the generic drug will not work for you OR has written “Brand Medically Necessary” on your prescription for a brand name drug OR has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you]*, then the plan will cover the brand name drug.

Requiring prior authorization from the plan

[Plans must describe how drugs requiring prior authorization are identified in the drug list and/or elsewhere.]

For these drugs, you or your provider will need to get authorization from the plan in order to get coverage for the drugs.. This is called “**prior authorization.**”

Requiring you try a different but similar drug first (“step therapy”)

[Plans explain how step therapy would work if a member moves between managed care plans.]

This requirement requires you try a less costly and equally effective drug before the plan covers the more costly drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try lower cost Drug A first. If Drug A does not work for you, the plan will then cover the higher cost Drug B. This requirement to try a particular drug first is called “step therapy.”

Imposing quantity limits on a prescription drug

For some drugs in the plan's *[Drug List]* the plan limits the amount of the drug that you can get each time you fill or refill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than 30 pills per refill and no more than one refill every 30 days. If you try to refill your prescription too early, you may be asked by the pharmacist to refill your prescription later.

What to do if your drug has restrictions or is not on the plan formulary or drug list

[Plans explain the conditions under which members may get a temporary supply, change drugs, or request an exception.] If your drug is not on the *[Drug List]* or has restrictions, here are things you can do:

- Start by talking with your provider about your options.
- Sometimes you may be able to get a temporary supply of the drug. This will give you and your provider time to change to another drug or to file a request to have the drug covered. *[Plans explain when a temporary fill is allowed and how to request one.]*
- You can change to another drug. You or your provider can request a list of covered drugs that treat your condition from Member Services (phone numbers are printed on the back cover of this handbook).
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug. *[Plans explain how to request an exception.]*
- You can file an appeal or a grievance. Chapter 10 (*What to do if you want to appeal a plan decision or "action", or file a grievance*).

For more information, contact Member Services (phone numbers are printed on the back cover of this handbook).

Section 7.2 Plan formulary or drug list

[Plan must explain any difference between formulary and preferred drug list, as well as preferred and non-preferred drugs, as applicable.]

The plan has a *[Drug List]* which is approved by the New Hampshire Department of Health and Human Services (NH DHHS). The drugs on this list include both generic and brand name drugs carefully selected with help from a team of doctors and pharmacists. The *[Plan name]* List of Covered Drugs is called *[Drug List]*.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Generally, it works as well as the brand name drug and usually costs less. There are generic drug substitutes available for many brand name drugs.

[Plans may omit or modify, as needed: Sometimes a drug may appear more than once in our drug list. This is because different restrictions or copayments may apply based on factors such as the strength, amount, or form of the drug prescribed by your health care provider (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).]

What is *not* on the *[Drug List]*

The plan does not cover all prescription drugs. *[Plan name]* chooses which drugs to cover and Medicaid law prohibits coverage of some drugs.

How to find out if a specific drug is on the *[Drug List]*

You may find out if a particular drug is on the *[Drug List]* by:

- Visiting the plan's *[Plan name]* website (*[insert URL]*). The *[Drug List]* on the website is always the most current.
- Calling and asking Member Services to find out if the drug is on the plan's *[Plan name] [Drug List]*. (Phone numbers for Member Services are printed on the back cover of this handbook.)
- Calling and asking Member Services for a copy of the *[Drug List]*. (Phone numbers for Member Services are printed on the back cover of this handbook.)
- *[Plans may insert additional ways to find out if a drug is on the Drug List.]*

Over-the-Counter Drugs

[Plans explain whether OTC drugs are in the Drug List, or how members find out what OTC drugs are covered by the plan and explain how to fill the OTC prescription and whether a copayment or reimbursement is required.] The plan also covers certain over-the-counter drugs **when you have a prescription** from your provider. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. For more information on coverage of over-the-counter drugs, call Member Services (phone numbers are printed on the back cover of this handbook).

The formulary or *[Drug List]* can change during the enrollment year

During the enrollment year, the plan may make changes to the Drug List. *[Plans should describe how often the drug list changes and how affected members are notified of changes.]* For example, the plan might:

- **Add or remove drugs from the *[Drug List]*.** For example, *[Plan name]* may add new generic or brand name drugs as they become available. *[Plan name]* may remove a drug from the *[Drug List]* if it is recalled or it is found to be ineffective.
- **Add or remove a restriction on coverage for a drug.** For more information about drug coverage restrictions, refer to Section 7.3 (*Drug coverage rules and restrictions*) in this chapter.

- **Replace a brand name drug with a generic drug.**

In all cases, we first must get approval from the NH DHHS for changes to the plan's *[Drug List]*.

How you will find out if your drug coverage has changed

If the plan changes coverage of a drug you are taking, the plan will send you a written notice.

[Plans may modify this section as appropriate:] Examples of when your drugs may change include:

- When a drug is **suddenly recalled** by one or both the manufacturer or Food and Drug Administration (FDA) because it has been found to be unsafe or for other reasons. If this happens, the plan will immediately remove the drug from the Drug List. We will notify you and your provider of this change right away. Your provider will work with you to find another drug to treat your condition.
- If a **brand name drug you are taking is replaced by a new generic drug**, *[Plans may modify as appropriate:]* the pharmacy will automatically substitute the generic for the brand name drug. If the brand name drug is medically necessary, the prescriber must issue a new prescription stating “medical necessary” for the brand name drug, and submit a prior authorization request to the plan for review.]

To get the most up-to-date information about which drugs are covered, visit *[insert URL]* or call Member Services (phone numbers are printed on the back cover of this handbook).

Section 7.3 Types of drugs we do not cover

[Plans may modify as appropriate:] This section tells you what types of prescription drugs are not covered.

To get drugs not covered by the plan, you must pay for them yourself. We will not pay for the drugs listed in this section.

[The plan] will not cover drugs in the following situations:

- *[The plan]* will not cover Part D drugs if you are enrolled in Medicare Parts A, B, C (Medicare Advantage), or D.
- The drug is purchased outside of the United States or its territories.
- A drug is for an off-label use and the use is not supported in a recognized publication. (“Off-label use” is any use of the drug other than that indicated on the drug label approved by the FDA. Recognized publications are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology, or their

successors.) **(For members aged 21 years and older, an exception may apply for medically necessary off-label use prescriptions.)**

In addition, the plan does not cover the following categories of drugs:

- Drugs that are experimental or investigational and not approved by the FDA
- Drugs listed by the FDA as being DESI drugs or IRS drugs
- Drugs when used to enhance or promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra, and Caverject
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Items which are free to the general public

Section 7.4 Filling your prescriptions at network pharmacies

In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies. A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs.

To fill your prescription, show your plan membership card at a network pharmacy. When you show your plan membership card, the network pharmacy will automatically bill the plan for *our* share of your covered prescription drug cost. You will need to pay the pharmacy *your* share of the cost (your copayment, if required) when you pick up your prescription. For more information on copayments, refer to Section 7.7 (*Prescription drug copayments*).

If you do not have your plan membership card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

How to find a network pharmacy in your area

[Plans may modify this section, as applicable.] To find a network pharmacy, you can look in your *[Describe: Provider or Pharmacy Directory]*, visit our website (*[insert URL]*), or call Member Services (phone numbers are printed on the back cover of this handbook).

[Plans in which members do not need to take any action to switch their prescriptions may delete the following sentence:] If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask *[insert or modify, as applicable: either to have*

a new prescription written by your provider or ask the pharmacist] to have your prescription transferred to your new network pharmacy.

We will notify you if the pharmacy you have been using leaves the plan's network. If your pharmacy leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy, you can get help from Member Services (phone numbers are printed on the back cover of this handbook) or use the *Pharmacy Directory*. *[Insert if applicable: You can also find information on our website at [insert website address].]*

What if you need a specialized pharmacy

[Plans may modify this section as needed.] Sometimes prescriptions must be filled at a specialized network pharmacy. Specialized pharmacies include pharmacies that supply drugs for home infusion therapy. *[Plans may insert additional information about home infusion services or other specialty pharmacies.]*

[Modify as applicable:] Find a specialized network pharmacy, in your *[Describe: Provider or Pharmacy Directory]* or call Member Services (phone numbers are printed on the back cover of this handbook).

[Plans may add other options such as compounding pharmacies.]

When you may use an out-of-network pharmacy

[Plans explain when members may use an out-of-network pharmacy.]

How you can get an emergency supply of your medication

[Plans explain qualifying situations and how to get an emergency supply.]

How to get a temporary supply of your medication

[Plans explain qualifying situations and how to get a temporary supply.]

Using the plan's mail-order services

[Include the following information only if your mail-order service is limited to a subset of all formulary drugs, adapting terminology as needed:] For certain types of drugs, you may use the plan's network mail-order services. Generally, the drugs provided through mail order are drugs that you take on a regular basis for a chronic or long-term medical condition. *[Insert if plan marks mail-order drugs in formulary:]* The drugs available through the plan's mail-order service are marked as "**mail-order**" drugs in our Drug List. *[Insert if plan marks non-mail-order drugs in formulary:]* The drugs that are *not* available through the plan's mail-order service are marked with an asterisk in our Drug List.]

To get *[insert if applicable: order forms and]* information about filling your prescriptions by mail *[insert instructions]*.

Usually a mail-order pharmacy order will get to you in no more than [XX] days. *[Insert plan's process for members to get a prescription if the mail order is delayed.]*

[Plans for new prescriptions received directly from health care providers, insert one of the following two options.]

[Option: If you used mail order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please contact us by [insert instructions].]

[Option: If you never have never used our mail order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allow you to cancel or delay the order before you are billed and it is shipped. It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.]

To opt out of automatic deliveries of new prescriptions received directly from your health care provider's office, please contact the plan by *[insert instructions].*

It is important that you tell the pharmacy the best ways to contact you *[Insert instructions on how members should provide their communication preferences, and who they should contact with questions or problems with their mail order prescriptions.]*

Section 7.5 Drug coverage in facilities

If you are admitted to a hospital or another facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or another facility, the plan will cover your drugs as long as the drugs meet all of our rules for coverage described in this Chapter.

What if you are a resident in a long-term care (LTC) facility?

Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy, or a network pharmacy that supplies drugs for all of its residents. If you are a resident of a long-term care facility, you may get your prescription drugs through the facility's pharmacy as long as it is part of our network.

Check your *[As applicable:] Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it is not listed in our network, or if you need more information, please contact Member Services (phone numbers are printed on the back cover of this handbook).

Section 7.6 Programs to help members use drugs safely

[Plans may include information about pharmacy lock-in practices and other specialized pharmacy programs.]

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Possible medication errors;
- Drugs that may not be necessary because you are taking another drug to treat the same medical condition;
- Drugs that may not be safe or appropriate because of your age or gender;
- Certain combinations of drugs that could harm you if taken at the same time;
- Prescriptions that have ingredients you are allergic to; and
- Possible errors in the amount (dosage) of a drug you are taking.

If we see a possible problem in your use of medications, we will work with your provider to correct the problem.

Section 7.7 Prescription drug copayments

A copayment may be required for each prescription

You will be charged a copayment at the pharmacy for your covered prescription drugs unless the prescription category is exempted or you are in one of the member exempt categories, as described below (see *Members who are exempt from copayments*).

A “copayment” or “copay” is the fixed amount you may pay each time you fill and refill a prescription. Prescription drug copayment amounts are subject to change.

For prescription drug copayment amounts refer to Section 4.2 (*Benefits Chart*, see *Prescription drugs*).

Members who are exempt from copayments

NH DHHS determines whether you are exempt from prescription copayments.

You do not have to pay a copayment if:

- You fall under the designated income threshold (100% or below the federal poverty level);
- You are under age 18 years;
- You are in a nursing facility or in an intermediate care facility for individuals with intellectual disabilities;
- You participate in one of the Home and Community Based Care (HCBC) waiver programs;
- You are pregnant and receiving services related to your pregnancy or any other medical condition that might complicate your pregnancy;
- You are receiving services for conditions related to your pregnancy and your prescription is filled or refilled within 60 days after the month your pregnancy ended;
- You are in the Breast and Cervical Cancer Program;
- You are receiving hospice care; or
- You are a Native American or Alaskan Native.

If you believe you may qualify for any of these exemptions and are charged a copayment, contact NH DHHS Customer Service Center toll-free at **1-844-ASK-DHHS** (1-844-275-3447) (TDD Relay Access: 1-800-735-2964), Monday through Friday, 8:00 a.m. to 4:00 p.m. ET.

Chapter 8. Asking us to pay

Section 8.1 Network providers may not charge you for covered services

With the exception of prescription drug copayments, network providers may not bill you for covered services. You should never get a bill from a network provider for covered services as long as you follow the rules outlined in this handbook.

We do not allow providers to bill members or add additional or separate charges, called “balance billing.” (For a definition of balance billing, refer to Section 13.2 (*Definitions of important words*)). This protection (that you never pay more than your copayment amount, if applicable) applies even if we pay the provider less than the provider charges for a service. It also applies when there is a dispute about the plan’s payment to the provider for a covered service, and when we do not pay certain provider charges.

Sometimes when you get health care or a prescription drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, all you need do is ask the plan to pay you back.

There may also be times when a provider bills you for the full cost of health care you have received. If you think we should have paid for some or all of these services, you should send the bill to us instead of paying it, or notify the provider to bill the plan.

For information on where to send your request for payment, refer to Section 8.2 (*How and where to send us your request for payment*).

Here are examples of situations in which you may need to ask the plan to pay you back, or to pay a bill you have received:

- **You’ve received emergency or urgently needed health care services or prescription drugs from a provider who is not in the plan’s network**

Ask the provider to bill the plan. You are only responsible for paying your share of the cost for any prescription filled at a retail pharmacy.

If you pay all or part of the cost at the time you receive the health care service or prescription drug, ask the plan to pay you back for its share of the cost. Send us the bill, along with any documentation of payments you have made, such as a receipt.

If you get a bill from a provider asking for payment that you think you do not owe, send the bill to the plan, along with documentation of any payments you have already made, such as a receipt. If the provider is due payment, we will pay the provider directly. If you have already paid more than your share of the cost of the bill, we will pay you back for the plan’s share of the cost. If you received and were billed for services not covered by the plan, you may be responsible for those costs.

For information on where to send your request for payment, refer to Section 8.2 (*How and where to send us your request for payment*).

- **When a network provider sends you a bill you think you should not pay**

Network providers should always bill the plan directly. But sometimes they make mistakes and bill you in error.

When this occurs:

- Send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid the bill, but you think that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

For information on where to send your request for payment, refer to Section 8.2 (*How and where to send us your request for payment*).

- **When you pay the full cost for a prescription because you do not have your plan membership card with you**

If you do not have your plan membership card with you, ask the pharmacy to call the plan or to look up your plan enrollment information. If the pharmacy cannot get the needed enrollment information, you may be asked to pay the full cost of the prescription yourself. If you pay for the prescription, save your receipt, send a copy to us, and ask us to pay you back for our share of the cost.

For information on where to send your request for payment, refer to Section 8.2 (*How and where to send us your request for payment*).

- **When you pay the full cost for a prescription in other situations**

You may pay the full cost of the prescription because you find that the drug is not covered for some reason. For example, the drug may not be on the plan's *List of Covered Drugs (Formulary)*; or it could have a requirement or restriction that was not followed. If you decide to get the drug immediately, you may need to pay the full cost for it. Save your receipt, send a copy to us, and ask us to pay you back for our share of the cost.

In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost. If you received and were billed for services not covered by the plan, you may be responsible for those costs.

[Plans should insert additional circumstances under which they will accept a paper claim from a member.]

For information on where to send your request for payment, refer to Section 8.2 (*How and where to send us your request for payment*).

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision or file a grievance. For information on how to make an appeal or file a grievance, refer to Chapter 10 (*What to do if you want to appeal a plan decision or “action”, or file a grievance*).

Section 8.2 How and where to send us your request for payment

Send us your request for payment, along with a copy of your bill and documentation of any payment you have made. It is a good idea to keep a copy of your bills and receipts for your records.

[If the plan has developed a specific form for requesting payment, insert the following language: To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You do not have to use our claim form, but it will help us process the information faster.
- Either download a copy of the claim form from our website (*[insert URL]*) or call Member Services and ask for the claim form. (Phone numbers for Member Services are printed on the back cover of this handbook.)]

Send payment requests to: *[Plans insert mailing instructions.]*

Contact Member Services if you have any questions (phone numbers are printed on the back cover of this handbook). If you do not know what you should have paid, or you receive a bill that you do not understand, contact Member Services (phone numbers are printed on the back cover of this handbook.). We can help. You can also call the plan if you want to give us more information about a request for payment you have already sent to the plan.

Section 8.3 After the plan receives your request for payment

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will review your request and make a coverage decision.

- If we decide that the health care service or prescription drug is covered and you followed all the rules for getting the service or drug, we will pay for our share of the cost.
 - If you have already paid for the service or drug, we will mail a reimbursement of our share of the cost to you. If you do not agree with the amount we are paying you, you may file an appeal.
 - If you have not paid for the service or drug yet, we will mail the payment directly to the provider.
- If we decide that the health care service or prescription drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

If you think we have made a mistake in turning down your request for payment or you do not agree with the amount we are paying, you can file an appeal. If you file an appeal, it means you are asking the plan to change the decision we made when we turned down your request for payment. For information on how to file an appeal, go to Chapter 10 (*What to do if you want to appeal a plan decision or “action”, or file a grievance*).

Section 8.4 Payment rules to remember

[Plan name] covers all health care services that are medically necessary, are listed in the plan’s Benefits Chart in Chapter 4 of this handbook, and are obtained consistent with plan rules. You are responsible for paying the full cost of services that are not covered by the plan. Such payments may be required because the service is not a covered service, or it was obtained out-of-network and not authorized by the plan in advance.

For covered services that have a benefit limit, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. You can call Member Services when you want to know how much of your benefit limit you have already used. (Phone numbers for Member Services are printed on the back cover of this handbook.)

If you have any questions about whether we will pay for any health care service or care that you are considering, you have the right to ask us whether we will cover it before you get it. You also have the right to ask for this in writing. If we say we will not cover your services or prescriptions, you have the right to file a grievance or appeal our decision not to cover your care. For information on how to file an appeal, go to Chapter 10 (*What to do if you want to appeal a plan decision or “action”, or file a grievance*).

Chapter 9. Your rights and responsibilities

Section 9.1 Your rights

[Plans may add other rights in accordance with state/federal law or NCQA requirements, as applicable.]

As a member of our plan, you have certain rights concerning your healthcare.

- You have the right to receive information in an easily understandable and readily accessible format that meets your needs. For more information, refer to Section 2.13 (*Other important information: Alternative formats and interpretation services*).
- You have the right to be treated with respect and with due consideration for your dignity and privacy.
- You have the right to receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand.
- You have the right to participate in decisions regarding your health care, including the right to refuse treatment.
- You have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- You have the right to see, as well as request and receive a copy of your medical records, and the right to request that your medical records be amended or corrected.
- You have the right to covered services and drugs that are available and accessible in a timely manner.
- You have a right to care coordination.
- You have the right to privacy and protection of your personal health information.
- You have the right to receive information about our plan, our network providers, and your covered services.
- You have the right to make decisions about your health care.
- You cannot be retaliated against in any way by the plan or by the New Hampshire Department of Health and Human Services (NH DHHS) for exercising your rights.
- You have the right to a second opinion. For more information, refer to Section 6.6 (*Getting a second medical opinion*).
- You have the right to know what to do if you are being treated unfairly or your rights are not being respected. For more information, refer to Section 10.7 (*How to file a grievance and what to expect after you file*).
- You have the right to be informed of any changes in state law that may affect your coverage. The plan will provide you with any updated information at least 30 calendar days before the effective date of the change whenever practical.

- You have the right to exercise advance care planning for your health care decisions if you so choose. For more information, refer to Section 9.3 (*Advance care planning for your health care decisions*).
- You have the right to make a complaint if a provider does not honor your wishes expressed in your advance directive. For more information, refer to Section 9.3 (*Advance care planning for your health care decisions*).
- You have the right to leave our plan in certain situations. For more information, refer to Section 11 (*Ending your plan membership*).

Section 9.2 Your responsibilities

[Plans may add responsibilities to the list below to comply with NCQA, state and federal law.]

Below are things you need to do as a member of the plan. If you have any questions, please call Member Services (phone numbers are printed on the back cover of this handbook).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this handbook to learn what is covered, and the rules you need to follow to get your covered services.
 - Chapters 3 and 4 give the details about your health care services, including what is covered by the plan, what is not covered, and rules to follow.
 - Chapter 7 provides details about prescription drug coverage, including what you may be required to pay.
 - To be covered by *[Plan name]*, you must receive all of your health care from the plan's network providers except:
 - Emergency care;
 - Urgently needed care when you are traveling outside of the plan's service area;
 - Family planning services; and
 - When we give you authorization in advance to get care from an out-of-network provider.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell *[Plan name]* as soon as possible.** Please call Member Services to let us know (phone numbers are printed on the back cover of this handbook).

We are required to follow rules set by Medicaid to make sure that you are using all of your coverage. This is called "coordination of benefits" because it involves coordinating the health and prescription drug benefits you get from our plan with any other health and prescription drug benefits available to you. We will help you coordinate your benefits. For more information about coordination of benefits, refer to Section 1.5 (*How other insurance works with our plan*).

- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card and your New Hampshire Medicaid card whenever you get your covered services, including medical or other health care services and prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
 - To help your doctors and other health care providers give you the best care, learn as much as you are able to about your health conditions. Give your health care providers the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
 - Make sure your doctors and other health care providers know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
 - Talk to your PCP about seeking services from a specialist before you go to one, except in an emergency.
 - Keep appointments, be on time, and call in advance if you are going to be late or have to cancel your appointment.
 - Authorize your PCP to get necessary copies of all of your health records from other health care providers. *[Plans may include authorization and release forms in the handbook, or reference a URL to access the form.]*
 - If you have any questions, be sure to ask. Your doctors and other health care providers will explain things in a way you can understand. If you ask a question and you do not understand the answer you were given, ask again.
- **Request interpretation services if you need them.** Our plan has staff and free language interpreter services available to answer questions from non-English speaking members. If you are eligible for New Hampshire Medicaid because of a disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you at no cost. For more information, refer to Section 2.13 (*Other important information: Alternative formats and interpretation services*).
- **Respect other members, plan staff and providers.** For information about when members may be involuntarily disenrolled for threatening or abusive behavior, refer to Section 11.2 (*When you may be involuntarily disenrolled from the plan*).
- **Pay what you owe.** As a plan member, you are responsible for these payments, as applicable:
 - For prescription drugs covered by the plan, you must pay a copayment, if required. However, any inability to pay your copayment does not prevent you from getting your prescription filled. Refer to Chapter 7 (*Getting covered prescription drugs*) to learn what you must pay for your prescription drugs.
 - If you get any health care services or prescription drugs that are not covered by our plan or by other insurance you have, you are responsible for the full cost.
 - If you disagree with our decision to deny coverage for a health care service or prescription drug, you can request an appeal. For information about how to

request an appeal, refer to Chapter 10 (*What to do if you want to appeal a plan decision or “action”, or file a grievance*).

- **Tell the plan if you move.** If you are going to move or have moved, it is important to tell us as soon as possible. Call Member Services (phone numbers are printed on the back cover of this handbook).
- **Do not allow anyone else to use your *[Plan name]* or New Hampshire Medicaid membership cards.** Refer to Section 2.12 (*How to report suspected cases of fraud, waste, and abuse*). Notify us when you believe someone has purposely misused your health care benefits.
- **Call Member Services for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan. (Phone numbers for Member Services are printed on the back cover of this handbook).

Section 9.3 Advance care planning for your health care decisions

You have the right to say what you want to happen if you are unable to make health care decisions for yourself

Sometimes people are unable to make their own health care decisions. Before that happens to you, you can:

- Fill out a written form to give someone the right to make health care decisions for you; and
- Give your doctors written instructions about how you want them to handle your health care if you become unable to make decisions for yourself.

The legal documents you can use to give your directions are called “advance directives”. The documents are a way for you to communicate your wishes to family, friends and health care providers. It allows you to express your healthcare wishes in writing in case you cannot do so if you are seriously sick or injured.

There are two types of advance directives in New Hampshire:

- **Living Will** – A document that tells your healthcare provider whether to give life-sustaining treatment if you are near death or are permanently unconscious without hope of recovery.
- **Durable Power of Attorney for Healthcare** – A document in which you name someone to make health care decisions, including decisions about life support, if you can no longer speak for yourself. This person is your healthcare “agent” and may also carry out the wishes you described in your “Living Will.”

If you want to create an advance directive: *[Plans should add or modify information below to explain how to get forms and include information on non-discrimination and any limitations.]*

- Get the form from your doctor, your lawyer, a legal services agency, or a social worker.
- Fill out and sign the form. Remember, this is a legal document. You may want to have a lawyer help you fill out the form.
- Give copies to people who need to know about it, including your doctor and the person you name as your agent. You may also want to give copies to close friends or family members.
- Be sure to keep a copy at home.
- If you are going to be hospitalized, take a copy of it to the hospital. The hospital will ask you whether you have signed an advance directive form and whether you have it with you. If you have not signed an advance directive form, the hospital will have forms available and may ask if you want to sign one.

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the New Hampshire Department of Health and Human Services Ombudsman who can refer you to the appropriate agency or party. For contact information, refer to Section 2.10 (*How to contact the NH DHHS Ombudsman*).

Remember, it is your choice to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an Advance Directive.

Chapter 10. What to do if you want to appeal a plan decision or “action”, or file a grievance

As a member of *[Plan name]*, you have the right to file an appeal or grievance if you are dissatisfied with the plan in any way. Each appeal and grievance process has a set of rules, procedures, and deadlines that you and the plan must follow. This chapter explains the two types of processes for handling problems and concerns.

These are:

- **Appeals process** – For some types of problems, you need to use the *[Plan name]* appeals process. In most cases, you must appeal to the plan and exhaust its appeal process (first level appeal) before you request a State Fair Hearing with the NH DHHS Administrative Appeals Unit (AAU) (second level appeal).
- **Grievance process** – For other types of problems, you need to use the *[Plan name]* grievance process.

For help with your appeal or grievance, contact Member Services (phone numbers are printed on the back cover of this handbook). You may also contact the NH DHHS Customer Service Center at **1-844-ASK-DHHS** (1-844-275-3447) (TDD Access Relay: 1-800-735-2964), Monday through Friday, 8:00 a.m. – 4:00 p.m. ET.

Section 10.1 About the appeals process

Whenever *[Plan name]* makes a coverage decision or takes an action that you disagree with, you may file an appeal. If *[Plan name]* denies, reduces, suspends, or ends your health care services, the plan must send you a written notice **within at least 10 calendar days before taking the action**. The written notice must explain the reason for the “action,” specify the legal basis that supports it, and include information about the appeal process. If you decide to appeal the plan’s decision, it is very important to review the plan’s written notice carefully and follow the deadlines for the appeal process.

Plan “actions” that may be appealed include:

- A decision to deny or limit a requested health care service or request for prior authorization in whole or in part;
- A decision to reduce, suspend, or end health care service that you are getting;
- A decision to deny a member request to dispute a financial liability, including cost-sharing, copayments, and other enrollee financial liabilities. This includes denial for payment of a service, in whole or in part; and
- When a member is unable to access health care services in a timely manner.

You have the right to file an appeal even if no notice was sent by the plan. If you receive an oral denial, you should request a written denial notice from the plan and appeal after receiving the oral and/or written denial notice if you are dissatisfied with the plan's decision.

There are **two** levels of appeal.

These are:

- **First level standard or expedited appeals through the plan.** At this level of appeal you ask [\[Plan name\]](#) to reconsider its decision to a particular "action". First level appeals include both standard and expedited appeals. The exception to first level appeal requirements is when the plan misses the timeframe to provide you with timely written notice of its decision. When this happens, you have the right to file a State Fair Hearing appeal immediately.

For more information about standard appeals, refer to Section 10.2 (*How to file a standard appeal and what to expect after you file (standard first level appeal)*).

For more information about expedited appeals, refer to Section 10.3 (*How to file an expedited appeal and what to expect after you file (expedited first level appeal)*).

- **Second level standard or expedited State Fair Hearing appeals.** Before you file a State Fair Hearing appeal with NH DHHS AAU, you must exhaust the first level of appeal through [\[Plan name\]](#).

For more information about standard State Fair Hearing appeals, refer to Section 10.4 (*How to file a standard State Fair Hearing appeal and what to expect after you file (standard second level appeal)*).

For more information about expedited State Fair Hearing appeals, refer to Section 10.5 (*How to file an expedited State Fair Hearing appeal and what to expect after you file (expedited second level appeal)*).

For help with your appeal, contact Member Services (phone numbers are printed on the back cover of this handbook).

Section 10.2 How to file a standard appeal and what to expect after you file (standard first level appeal)

To file a standard appeal (first level appeal) with the plan:

- **You must file your standard appeal with [\[Plan name\]](#) over the phone or in writing within 60 calendar days of the date of the plan's written notice to you. Your oral request for a standard appeal must be followed by a written and signed appeal request from you.**
- In your signed, written appeal request:

- Include your name, address, phone number, and email address (if you have one);
 - Describe the date of the action or notice from the plan you want to appeal, and attach a copy of the notice;
 - Explain why you want to appeal the decision; and
 - If the plan's decision was to deny, reduce, limit, suspend or end your previously authorized benefits, indicate whether you want to have previously authorized benefits continued. For more information, refer to Section 10.6 (*How to request continuation of benefits during appeal and what to expect afterward*).
- Send your written plan appeal request to:

[Insert plan contact information, including address, telephone, fax, hours of operation.]

- **You may designate someone to file the appeal for you, including your provider.** However, you must give written permission to name your provider or another person to file an appeal for you. For more information about how to appoint another person to represent you, refer to Section 2.13 (*Other important information: You may designate an authorized representative or personal representative*).
- **If you appeal the plan's decision to deny, reduce, limit, suspend or end services, you may have a right to request continuation of benefits from *[Plan name]* during your appeal. Your provider cannot request continuation of benefits for you.** For more information, refer to Section 10.6 (*How to request continuation of benefits during appeal and what to expect afterward*).

Here is what you can expect after you file your standard appeal with the plan:

- **After you file your standard appeal, you have the right to request and receive a copy of your case file that the plan used to make its decision.** A copy of your case file is free of charge and may be requested in advance of the plan's decision.
- *[Plan name]* must provide you with reasonable opportunity to present evidence in person as well as in writing as part of the appeal.
- **For a standard appeal, *[Plan name]* will issue its written decision within 30 calendar days after receipt of your appeal request.** The plan may take up to an additional 14 calendar days if you request the extension, or if the plan needs additional information and feels the extension is in your best interest. If the plan decides to take extra days to make the decision, the plan will tell you in writing within 2 calendar days. If you disagree with the plan's extension, you may file a grievance with the plan. For more information, refer to Section 10.7 (*How to file a grievance and what to expect after you file*).
- **If *[Plan name]* reverses its decision to deny, reduce, limit, suspend, or end services that were not provided while the appeal was pending, *[Plan name]* will authorize the services promptly. The services will be authorized as expeditiously as your health condition requires, but no later than 72 hours from the date the plan reversed its decision.**

- If you received continued benefits while the appeal was pending:
 - If the decision is in your favor, the plan will pay for those services.
 - If you lose your appeal and received continued benefits you may be responsible for the cost of any continued benefits provided by the plan during the appeal period.

For more information, refer to Section 10.6 (*How to request continuation of benefits during appeal and what to expect afterward*).

- **If you are dissatisfied with the results of your first level appeal from *[Plan name]*, you may file a second level of appeal by requesting a standard or expedited State Fair Hearing.** For more information, refer to Section 10.4 (*How to file a standard State Fair Hearing appeal and what to expect after you file (standard second level of appeal)*) and Section 10.5 (*How to file an expedited State Fair Hearing and what to expect after you file (expedited second level of appeal)*).

For help with your appeal, contact Member Services (phone numbers are printed on the back cover of this handbook).

Section 10.3 How to file an expedited appeal and what to expect after you file (expedited first level appeal)

If taking the time for standard resolution of your appeal would seriously jeopardize your life or health, or ability to attain, maintain, or regain maximum function, you may request **expedited resolution** of your appeal from *[Plan name]*. This is sometimes called “asking for a fast decision”.

To file an expedited appeal (first level appeal) with the plan:

- **You must file your expedited appeal with *[Plan name]* over the phone or in writing within 60 calendar days of the date of the health plan’s written notice to you. When you contact the plan, remember to ask for an expedited appeal.**
- For your oral or written expedited appeal request:
 - Include your name, address, phone number, and email address (if you have one);
 - Describe the date of the action or notice from the plan you want to appeal, and attach a copy of the notice;
 - Explain the reason for your expedited request and why you want to appeal the decision; and
 - If the plan’s decision was to deny, reduce, limit, suspend or end your previously authorized benefits, indicate whether you want to have previously authorized benefits continued. For more information, refer to Section 10.6 (*How to request continuation of benefits during appeal and what to expect afterward*).

- Send your written appeal request to:

[Insert plan contact information, including address, telephone, fax, hours of operation.]

- **You may designate someone to file the appeal for you, including your provider.** However, you must give written permission to name your provider or another person to file an appeal for you. The plan does not need written permission if your provider is requesting the expedited first level appeal on your behalf. For more information about how to appoint another person to represent you, refer to Section 2.13 (*Other important information: You may designate an authorized representative or personal representative*).
- **If you appeal the plan’s decision to deny, reduce, limit, suspend or end services, you may have a right to request continuation of benefits from *[Plan name]* during your appeal. Your provider cannot request continuation of benefits for you.** For more information, refer to Section 10.6 (*How to request continuation of benefits during appeal and what to expect afterward*).

Here is what you can expect after you file your expedited appeal with the plan:

- **After you file your expedited appeal, you have the right to request and receive a copy of your case file that the plan used to make its decision.** A copy of your case file is free of charge and may be requested in advance of the plan’s decision.
- If *[Plan name]* accepts your request for an expedited appeal, it must provide you with reasonable opportunity to present evidence in person as well as in writing as part of the appeal. You must keep in mind that this may be difficult to do with an expedited “fast” appeal decision.
- **For an expedited appeal, *[Plan name]* must resolve your request as expeditiously as your health condition requires, but no later than 72 hours after the date the plan receives your request.** The plan may take up to 14 calendar days if you request an extension, or if the plan needs additional information and feels the extension is in your best interest. If the plan decides to take extra days to make a decision, the plan will attempt to inform you with prompt oral notice of the delay, and tell you in writing within 2 calendar days. If you disagree with the plan’s extension, you may file a grievance with the plan. For more information, refer to Section 10.7 (*How to file a grievance and what to expect after you file*).
- If *[Plan name]* **accepts** your request for an expedited appeal, the plan will issue its written decision as expeditiously as your health condition requires, but no later than 72 hours after the date the plan receives your request.
- If *[Plan name]* **denies** your request for an expedited appeal, the plan must make reasonable efforts to give you prompt oral notice of the denial, and then must provide written notice of the denial within 2 calendar days.
- **You have the right to file a grievance with *[Plan name]* if the plan denies your request for an expedited appeal.** If the plan denies your request for an expedited appeal, *[Plan name]* will treat your appeal as part of the standard appeal process.

- If *[Plan name]* reverses its decision to deny, reduce, limit, suspend, or end services that were not provided while the appeal was pending, *[Plan name]* will authorize the services promptly. The services will be authorized as expeditiously as your health condition requires, but no later than 72 hours from the date the plan reversed its decision.
- If you received continued benefits while the appeal was pending:
 - If the decision is in your favor, the plan will pay for those services.
 - If you lose your appeal and received continued benefits you may be responsible for the cost of any continued benefits provided by the plan during the appeal period.

For more information, refer to Section 10.6 (*How to request continuation of benefits during appeal and what to expect afterward*).

- If you are dissatisfied with the results of your first level appeal from *[Plan name]*, you may file a second level of appeal by requesting a standard or expedited State Fair Hearing. For more information, refer to Section 10.4 (*How to file a standard State Fair Hearing appeal and what to expect after you file (standard second level appeal)*) and Section 10.5 (*How to file an expedited State Fair Hearing and what to expect after you file (expedited second level appeal)*).

For help with your appeal, contact Member Services (phone numbers are printed on the back cover of this handbook).

Section 10.4 How to file a standard State Fair Hearing appeal and what to expect after you file (standard second level appeal)

If you are dissatisfied with the results of your first level appeal from *[Plan name]*, you may file a second level of appeal by requesting a State Fair Hearing with the NH DHHS Administrative Appeals Unit (AAU).

To file a standard State Fair Hearing appeal (second level appeal):

- **You must request a standard State Fair Hearing in writing within 120 calendar days of the date on the plan's written decision.** In most situations, you cannot request a State Fair Hearing without first going through the plan's standard or expedited (first level appeal) processes described above. For exceptions to when you do not have to exhaust the plan's appeal process before requesting a State Fair Hearing appeal, refer to Section 10.1 (*About the appeals process*).
- In your signed, written standard State Fair Hearing request:
 - Include your name, address, phone number, and email address (if you have one);

- Describe the date of the action or notice from the plan you want to appeal, and attach a copy of the notice;
 - Explain why you want to appeal the decision;
 - If the plan's decision was to deny, reduce, limit, suspend or end your previously authorized benefits, indicate whether you want to have previously authorized benefits continued. You must contact the plan to request continuation of benefits. For more information, refer to Section 10.6 (*How to request continuation of benefits during appeal and what to expect afterward*); and
 - Describe any special requirements you will need for the hearing (e.g., handicap accessibility, interpretation services).
- Send your written State Fair Hearing request to:

Administrative Appeals Unit
NH Department of Health and Human Services
105 Pleasant Street, Room 121C
Concord, NH 03301
Fax: 603-271-8422
 - **If you appeal the plan's decision to deny, reduce, limit, suspend or end services, you may have a right to request continuation of benefits from *[Plan name]* during your appeal. Your provider cannot request continuation of benefits for you.** For more information, refer to Section 10.6 (*How to request continuation of benefits during appeal and what to expect afterward*).

Here is what you can expect after you file your standard State Fair Hearing appeal:

- **After you file your standard State Fair Hearing appeal, you have the right to request and receive a copy of your case file that the plan used to make its decision.** A copy of your case file is free of charge and may be requested in advance of the State Fair Hearing decision.
- **For a standard State Fair Hearing appeal, the AAU must resolve your request as expeditiously as your health condition requires, but no later than 90 days after the date you filed your first level appeal with the plan (excluding the number of days it took you to request the State Fair Hearing).**
- The AAU will let you know where the hearing will take place. Hearings are usually held at the AAU in Concord, or at your local NH DHHS District Office.
- A hearing officer from the AAU will conduct the hearing.
- You may bring witnesses, present testimony and evidence in person as well as in writing, and question other witnesses at your State Fair Hearing.
- **If the AAU reverses the plan's decision to deny, reduce, limit, suspend, or end previously authorized benefits that were not provided while the first level appeal and/or State Fair Hearing were pending, the plan will authorize the services as**

expeditiously as your health condition requires, but no later than 72 hours from the date the plan receives notice that the AAU reversed the plan's decision.

- If you received continued benefits while the appeal was pending:
 - If the decision is in your favor, the plan will pay for those services.
 - If you lose your appeal and received continued benefits you may be responsible for the cost of any continued benefits provided by the plan during the appeal period.

For more information, refer to Section 10.6 (*How to request continuation of benefits during appeal and what to expect afterward*).

For more information, contact the AAU at **1-800-852-3345**, extension 4292, Monday through Friday, 8:00 a.m. – 4:00 p.m. ET. You may also contact the NH DHHS Customer Service Center at **1-ASK-DHHS** (1-844-275-3447) (TDD Access Relay: 1-800-735-2964), Monday through Friday, 8:00 a.m. – 4:00 p.m. ET.

Section 10.5 How to file an expedited State Fair Hearing appeal and what to expect after you file (expedited second level appeal)

If you are dissatisfied with the results of your first level appeal from *[Plan name]* AND any delay of services could seriously jeopardize your life, physical or mental health, or ability to attain, maintain, or regain maximum function, you may file an expedited State Fair Hearing with the NH DHHS Administrative Appeals Unit (AAU).

To file an expedited State Fair Hearing appeal (second level appeal):

- **It is important for you to request an expedited State Fair Hearing appeal in writing immediately upon receipt of the plan's written decision. If your appeal is to continue benefits for previously authorized services, you must also request continuation of benefits at the same time you file your expedited State Fair Hearing appeal.** For more information, refer to Section 10.6 (*How to request continuation of benefits during appeal and what to expect afterward*).

In most situations, you cannot request a State Fair Hearing without first going through the plan's standard or expedited (first level appeal) processes described above. For exceptions to when you do not have to exhaust the plan's appeal process before requesting a State Fair Hearing appeal, refer to Section 10.1 (*About the appeals process*).

- In your signed, written expedited State Fair Hearing request:
 - Include your name, address, phone number, and email address (if you have one);
 - Describe the date of the action or notice from the plan you want to appeal, and attach a copy of the notice;

- **Specify that you want an expedited State Fair Hearing;**
 - **Explain how any delay of services could seriously jeopardize your life, physical or mental health, or ability to attain, maintain, or regain maximum function;**
 - If the plan's decision was to deny, reduce, limit, suspend or end your previously authorized benefits, indicate whether you want to have previously authorized benefits continued. You must contact the plan to request continuation of benefits. For more information, refer to Section 10.6 (*How to request continuation of benefits during appeal and what to expect afterward*); and
 - Describe any special requirements you will need for the hearing (e.g., handicap accessibility, interpretation services).
- Send your written State Fair Hearing request to:

Administrative Appeals Unit
NH Department of Health and Human Services
105 Pleasant Street, Room 121C
Concord, NH 03301
Fax: 603-271-8422

- **You may designate someone to file the appeal for you, including your provider.** However, you must give written permission to name your provider or another person to file an appeal for you. For more information about how to appoint another person to represent you, refer to Section 2.13 (*Other important information: You may designate an authorized representative or personal representative*).
- **If you appeal the plan's decision to deny, reduce, limit, suspend or end services, you may have a right to request continuation of benefits from *[Plan name]* during your appeal. Your provider cannot request continuation of benefits for you.** For more information, refer to Section 10.6 (*How to request continuation of benefits during appeal and what to expect afterward*).

Here is what you can expect after you file your expedited State Fair Hearing appeal:

- **After you file your expedited State Fair Hearing appeal, you have the right to request and receive a copy of your case file that the plan used to make its decision.** A copy of your case file is free of charge and may be requested in advance of the State Fair Hearing decision.
- If the AAU **accepts** your request for an expedited State Fair Hearing appeal, the AAU will issue its written decision as expeditiously as your health condition requires, but no later than 3 business days after the AAU receives the plan's case file and any additional information for your appeal.
- If the AAU **denies** your request for an expedited State Fair Hearing appeal, the AAU will make reasonable efforts to give prompt oral notice to you, and provide written notice of the denial. If your expedited request is denied, your appeal will be treated as a standard

State Fair Hearing appeal described in Section 10.4 (*How to file a standard State Fair Hearing appeal and what to expect after you file (second level appeal)*).

- The AAU will let you know where the hearing will take place. Hearings are usually held at the AAU in Concord, or at your local NH DHHS District Office.
- A hearing officer from the AAU will conduct the hearing.
- You may bring witnesses, present testimony and evidence in person as well as in writing, and question other witnesses at your State Fair Hearing.
- **If the AAU reverses the plan’s decision to deny, reduce, limit, suspend, or end previously authorized benefits that were not provided while the first level appeal and/or State Fair Hearing were pending, the plan will authorize the services as expeditiously as your health condition requires, but no later than 72 hours from the date the plan receives notice that the AAU reversed the plan’s decision.**
- If you received continued benefits while the appeal was pending:
 - If the decision is in your favor, the plan will pay for those services.
 - If you lose your appeal and received continued benefits you may be responsible for the cost of any continued benefits provided by the plan during the appeal period.

For more information, refer to Section 10.6 (*How to request continuation of benefits during appeal and what to expect afterward*).

For more information, contact the AAU at **1-800-852-3345**, extension 4292, Monday through Friday, 8:00 a.m. – 4:00 p.m. ET. You may also contact the NH DHHS Customer Service Center at **1-844-ASK-DHHS** (1-844-275-3447) (TDD Access Relay: 1-800-735-2964), Monday through Friday, 8:00 a.m. – 4:00 p.m. ET.

Section 10.6 How to request continuation of benefits during appeal and what to expect afterward

As described in previous sections of this chapter, if you appeal the plan’s decision to deny, reduce, limit, suspend or end previously authorized benefits, you may have a right to request continued benefits from *[Plan name]* pending the outcome of one or both your first and/or second level appeal. **While you may designate someone to file an appeal for you, your provider cannot request continuation of benefits for you.**

- **The plan must continue benefits at your request when the following occur:**

| For standard and expedited plan appeals (first level appeal) | For standard and expedited State Fair Hearing appeals (second level appeal) |
|--|--|
| <ul style="list-style-type: none"> ○ Within 10 calendar days of the date you receive the notice of action from the plan or the intended effective date of the plan’s action, you file your first level appeal orally or in writing (oral appeals must be followed up in writing) AND you request continuation of benefits pending the outcome of your first level appeal, orally or in writing; and ○ The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; and ○ The service was ordered by an authorized provider; and ○ The original authorization period for the service has not expired. | <ul style="list-style-type: none"> ○ Within 10 calendar days of the date you receive the first level appeal notice of action from the plan or the intended effective date of the plan’s action, you file your second level appeal in writing AND you request continuation of benefits pending the outcome of one or both your first and/or second level appeal, orally or in writing <p>If you did not request continuation of benefits during your first level appeal with the plan, the following conditions also apply:</p> <ul style="list-style-type: none"> ○ The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; and ○ The service was ordered by an authorized provider; and ○ The original authorization period for the service has not expired. |

To request continuation of benefits when the above conditions are met, contact:

[Insert plan contact information, including address, telephone, fax, hours of operation.]

- **If at your request the plan continues or reinstates your benefits while your appeal is pending, your benefits must continue until one of the following occurs:**

| For standard and expedited plan appeals (first level appeal) | For standard and expedited State Fair Hearing appeals (second level appeal) |
|--|--|
| <ul style="list-style-type: none"> ○ You withdraw your plan appeal, in writing; or ○ The plan’s first level appeal decision results in an unfavorable decision for you; or ○ You do not request a State Fair Hearing AND continuation of benefits within 10 calendar days of the plan notifying you of its first level appeal decision. | <ul style="list-style-type: none"> ○ You withdraw your State Fair Hearing appeal request, in writing; or ○ You do not request a State Fair Hearing appeal AND continuation of benefits within 10 calendar days of the plan notifying you of its first level appeal decision; or ○ The State Fair Hearing appeal results in an unfavorable decision for you. |

- If you lose your appeal and have received continued benefits, you may be responsible for the cost of any continued benefits provided by the plan during the appeal period.

For help with your first and/or second level appeal and continuation of benefits, contact Member Services (phone numbers are printed on the back cover of this handbook). You may also contact the NH DHHS Customer Service Center at **1-844-ASK-DHHS** (1-844-275-3447) (TDD Access Relay: 1-800-735-2964), Monday through Friday, 8:00 a.m. – 4:00 p.m. ET.

For help with your second level appeal and continuation of benefits, contact the AAU at **1-800-852-3345**, extension 4292, Monday through Friday, 8:00 a.m. – 4:00 p.m. ET. You may also contact the NH DHHS Customer Service Center at **1-844-ASK-DHHS** (1-844-275-3447) (TDD Access Relay: 1-800-735-2964), Monday through Friday, 8:00 a.m. – 4:00 p.m. ET.

Section 10.7 How to file a grievance and what to expect after you file

A grievance is the process a member uses to express dissatisfaction to the plan about any matter other than the plan's action as described in Section 10.1 (*About the appeals process*). You can file a grievance at any time.

Types of grievances include:

- Dissatisfaction with the quality of care or services you receive;
- Dissatisfaction with the way you were treated by the plan or its network providers;
- If you believe your rights are not respected by *[Plan name]* or its network providers; and
- Dispute of an extension of time proposed by the plan to make an authorization decision

To file your grievance:

- Call or write to *[Plan name]*. Writing is preferred (remember to keep a copy for your records).
- You may designate someone to file the grievance for you, including your provider. However, you must give written permission to name your provider or another person to file a grievance for you. For more information about how to appoint another person to represent you, refer to Section 2.13 (*Other important information: You may designate an authorized representative or personal representative*).

Here is what you can expect after you file your grievance:

- ***[Plan name]* will respond to your grievance as fast as your health condition requires, but no later than 45 calendar days from the date the plan receives it.** The plan may take up to an additional 14 calendar days if you request the extension, or if the plan needs additional information and feels the extension is in your best interest. If the plan decides to take extra days to make the decision, the plan will tell you in writing within 2 calendar days. For grievances about clinical matters, the plan will respond in writing. For grievances unrelated to clinical matters, the plan may respond orally or in writing.

- You do not have the right to appeal your grievance. However, you have the right to voice concerns to NH DHHS if you are dissatisfied with the resolution of your grievance. Contact the NH DHHS Customer Service Center at **1-844-ASK-DHHS** (1-844-275-3447) (TDD Access Relay: 1-800-735-2964), Monday through Friday, 8:00 a.m. – 4:00 p.m. ET.

For help with your grievance, contact Member Services (phone numbers are printed on the back cover of this handbook).

This chapter was prepared by NH DHHS with adaptations from Know Your Rights: New Hampshire Medicaid Managed Care Health Plans – Your Right to Appeal or File a Grievance, a Disability Rights Center – NH (www.drcnh.org), version May 10, 2016.

Chapter 11. Ending your plan membership

Section 11.1 There are only certain times when your plan membership may end

The times when your plan membership may end are:

- When you no longer qualify for New Hampshire Medicaid.
- If you decide to switch to another plan during the **Annual Open Enrollment Period**:
 - **When is the Annual Open Enrollment Period?** The Annual Open Enrollment Period is described in the open enrollment notice sent to you each year by NH DHHS. The Annual Open Enrollment is usually, November 1 through December 31 each year (dates may vary). The notice will provide instructions on when and how to switch health plans if you choose to do so, including when your membership ends in your current plan.
 - For information on care transitions between plans, refer to Section 5.3 (*Continuity of care, including transitions of care*).
- If you request to be assigned to the same plan in which another family member is enrolled.
- In certain situations, you may also be eligible to leave the plan at other times of the year for cause. These situations include:
 - When you move out of state.
 - When you need related services to be performed at the same time and not all related services are available within the network; and when receiving services separately would subject you to unnecessary risk.
 - For other reasons, such as poor quality of care, lack of access to services, violation of your rights, or lack of access to network providers experienced in dealing with your needs.
- You may also be eligible at other times of the year to leave the plan without cause, including:
 - During the 90 calendar days following the initial date of your enrollment with the plan, or the date that NH DHHS sends you notice of enrollment, whichever is later.
 - During the first twelve (12) months of enrollment for members who are auto-assigned to a plan, and have an established relationship with a PCP that is only in the network of a non-assigned health plan.

- During open enrollment related to NH DHHS's new contracts for New Hampshire Medicaid managed care plans.
- For 60 calendar days following an automatic reenrollment if the temporary loss of Medicaid has caused you to miss the Annual Open Enrollment Period. (This does not apply to new applications for New Hampshire Medicaid.)
- When NH DHHS grants members the right to terminate enrollment without cause and notifies affected members of their right to disenroll from the plan.
- When your plan chooses not to provide a service you need due to moral or religious reasons.
- When members are involuntarily disenrolled from the plan as described in the next section.

To request disenrollment from your plan, call or write to NH DHHS. Contact the NH DHHS Customer Service Center at **1-844-ASK-DHHS** (1-844-275-3447) (TDD Access Relay: 1-800-735-2964), Monday through Friday, 8:00 a.m. – 4:00 p.m. ET.

Until your new coverage begins you must continue to get your health care and prescription drugs through our plan.

Section 11.2 When you may be involuntarily disenrolled from the plan

There are times when a member may be involuntarily disenrolled from the plan, including:

- When a member no longer qualifies for New Hampshire Medicaid as established by NH DHHS;
- When a member is ineligible for enrollment in the plan as established by NH DHHS;
- When a member has established out of state residence;
- When a member uses their plan membership card fraudulently;
- Upon a member's death; and
- Under the terms of the plan's contract with NH DHHS, the plan may request a member's disenrollment in the event of the member's threatening or abusive behavior that jeopardizes the health or safety of other members, plan staff, or providers. If such a request is made by the plan, NH DHHS will be involved in the review and approval of such a request.

[Plan name] cannot ask you to leave the plan for any reason related to your health.

If you feel that you are being asked to leave the plan because of a health reason, contact the NH DHHS Customer Service Center at **1-844-ASK-DHHS** (1-844-275-3447) (TDD Access Relay: 1-800-735-2964), Monday through Friday, 8:00 a.m. – 4:00 p.m. ET.

Chapter 12. Legal notices

Many laws apply to this handbook and some additional provisions may apply because they are required by law. This may affect your benefits, rights and responsibilities even if the laws are not included or explained in this document.

[Plans must include legal notices that conform to federal and state laws and regulations.]

Chapter 13. Acronyms and definitions of important words

Section 13.1 Acronyms

[Plans include other acronyms as appropriate.]

| Acronym | Description |
|----------------|--|
| AAC | Augmentative Alternative Communication |
| AIDS | Acquired Immune Deficiency Syndrome |
| APRN | Advance Practice Registered Nurse |
| BiPAP | Bilevel Positive Airway Pressure |
| BMI | Body Mass Index |
| CMS | Centers for Medicare and Medicaid Services |
| COBRA | Consolidated Omnibus Budget Reconciliation Act (COBRA) |
| COPD | Chronic Obstructive Pulmonary Disease |
| CPAP | Continuous Positive Airway Pressure |
| DESI | Drug Efficacy Study Implementation |
| DME | Durable Medical Equipment |
| EOB | Explanation of Benefits |
| EPSDT | Early and Periodic Screening, Diagnostic and Treatment |
| ET | Eastern Time |
| FDA | Food and Drug Administration |
| FFS | Fee-for-Service |
| FQHC | Federally Qualified Health Center |
| HIV | Human Immunodeficiency Virus |
| HNA | Health Needs Assessment |
| IUD | Intrauterine Device |
| IV | Intravenous |
| LADC | Licensed Alcohol Drug Counselor |
| LDCT | Low Dose Computed Tomography |
| LPN | Licensed Practical Nurse |
| LTC | Long-term Care |
| MLADC | Masters Licensed Alcohol and Drug Counselor |
| NEMT | Non-emergency Medical Transportation |
| NH | New Hampshire |
| NH DHHS | New Hampshire Department of Health and Human Services |
| | |
| OB/GYN | Obstetrics/Gynecology |
| OT | Occupational Therapy |
| OTC | Over-the-Counter (Drugs) |
| PCP | Primary Care Provider (or Physician) |
| PAP | Premium Assistance Program |
| PSA | Prostate Specific Antigen |

| Acronym | Description |
|----------------|--|
| PT | Physical Therapy |
| RHC | Rural Health Center |
| RN | Registered Nurse |
| SBIRT | Screening, Brief Intervention, and Referral to Treatment |
| ST | Speech Therapy |
| STI | Sexually Transmitted Infection |
| SUD | Substance Use Disorder |
| TMJ | Temporomandibular Joint |

Section 13.2 Definitions of important words

[Plans should insert other definitions as appropriate. You may insert definitions not included in this model.]

[If allowable revisions to terminology (e.g., changing “Member Services” to “Customer Service”) affect glossary terms, plans should re-label the term and alphabetize it within the glossary.]

Abuse – Abuse describes practices that, either directly or indirectly, result in unnecessary costs to the Medicaid Program. Abuse includes any practice not consistent with providing members with services that are medically necessary, meet professionally recognized standards, and are priced fairly, as applicable. Examples of abuse include: billing for unnecessary medical services, charging excessively for services or supplies, and misusing codes on a claim, such as upcoding or unbundling billing codes.

Action – When the plan denies, reduces, suspends, or ends your health care service in whole or in part. For more information about coverage decisions and other actions, refer to Chapter 10 (*What to do if you want to appeal a plan decision or “action”, or file a grievance*).

Advance Directive – Legal document that allows you to give instructions about your future medical care. You can have someone make decisions for you if you are unable to do so for yourself. Refer also to Section 9.3 (*Advance care planning for your health care decisions*).

Annual Enrollment Period – The time each year when you can change your health plan. This generally happens November 1 through December 31 each year (dates may vary).

Appeal – Action taken if you disagree with the plan’s decision to deny a request for coverage or payment. You may also make an appeal if you disagree with the plan’s decision to stop or reduce services you are receiving. For more information, refer to Chapter 10 (*What to do if you want to appeal a plan decision or “action”, or file a grievance*).

Authorization – Refer to the definition for “Prior Authorization”.

Authorized Representative or Personal Representative – A person to whom you give authority to act on your behalf. The representative will be able to provide the plan with

information or receive information about you in the same manner that the plan would discuss or disclose information directly to you. For more information refer to Section 2.13 (*Other important information: You may designate an authorized representative or personal representative*).

Balance Billing – When a provider bills a member more than the plan’s copayment amount, as applicable, or charges a member for the difference between the provider billed amount and the plan’s payment to the provider. As a plan member, you may only have to pay the plan’s copayment amounts when you get covered prescriptions. We do not allow providers to “balance bill” or otherwise charge you more than the amount of copayment your plan says you must pay.

Behavioral Health Emergency – An emergent situation in which the member is in need of assessment and treatment in a safe and therapeutic setting, is a danger to themselves or others, or exhibits significant behavioral deterioration rendering the member unmanageable and unable to cooperate in treatment.

Behavioral Health Services – Another term used to describe mental health services and/or substance use disorder services.

Benefit Year – The 12-month period during which benefit limits apply.

Brand Name Drug – A prescription drug made and sold by the company that developed the drug. Brand name drugs have the same active ingredients as the generic version of the drug.

Care Coordination – The term used to describe the plan’s practice of assisting members with getting needed services and community supports. Care coordinators make sure participants in the member’s health care team have information about all services and supports provided to the member, including which services are provided by each team member or provider. For more information, refer to Section 5.2 (*Care coordination support*).

Centers for Medicare & Medicaid Services (CMS) – The federal agency that administers the Medicare and Medicaid programs.

Continuity of Care – Refers to practices that ensure uninterrupted care for chronic or acute medical conditions during transitions. For more information, refer to Section 5.3 (*Continuity of care*).

Copayment – An amount you may be required to pay as your share of the cost for a medical service or supply, including a doctor’s visit, hospital outpatient visit, or a prescription drug. Under our plan, you may have a prescription drug copayment.

Cost-sharing – Cost-sharing refers to any copayment amount, deductible or out-of-pocket maximum you may have to pay for a health care service or prescription drug. A member’s cost-sharing is also known as the member’s “out-of-pocket” cost.

Coverage Decision – A determination or decision made by the plan about whether a service or drug is covered. The coverage decision may also include information about any prescription copayment you may be required to pay.

Covered Services – Include all health care services, prescription drugs, supplies, and equipment covered by our plan. New Hampshire Department of Health and Human Services rules (Chapters He-W, He-E, He-C, He-M, and He-P) describe covered services under the plan. The rules are available online at http://www.gencourt.state.nh.us/rules/about_rules/listagencies.htm. Refer to the Benefits Chart in Chapter 4 for a list of covered services.

Disenroll or Disenrollment – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your choice).

Durable Medical Equipment (DME) – Certain equipment that is ordered by your doctor for medical reasons. DME can typically withstand repeated use and is primarily and customarily used to serve a medical purpose, and generally is not useful to a person in the absence of an illness or injury, and is appropriate for use in the home.

Emergency Medical Care or Emergency Services – Treatment to address an emergency medical condition. For more information, refer to Section 3.6 (*Emergency, urgent, and after-hours care*).

Emergency Medical Condition – A “medical emergency” is when you, or any other reasonable person with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a body organ or part. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Or in the case of a pregnant women in active labor, meaning labor at a time when there is not enough time to safely transfer you to another hospital before delivery, or the transfer may pose a threat to your health or safety or to that of your unborn child.

Emergency Medical Transportation – Specialized transportation of a member to receive emergency services as quickly as possible, such as in an ambulance.

Emergency Room or Emergency Department – An emergency facility department often located within a hospital to treat medical emergencies.

Excluded Services – Refers to health care services and prescription drugs the plan does not cover.

Fraud – Intentional deception or misrepresentation made by a person or business entity with the knowledge that the deception could result in some unauthorized benefit to himself, some other person, or the business entity.

Generic Drug – A prescription drug that has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs. The Food and Drug Administration (FDA) rates these drugs to be as safe and effective as brand-name drugs.

Grievance – The process a member uses to express dissatisfaction about any matter other than a plan action. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee,

or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the plan to make an authorization decision. For more information, refer to Chapter 10 (*What to do if you want to appeal a plan decision or "action", or file a grievance*).

Habilitation Services and Devices – Services and devices that help a person keep, learn or improve skills and functioning for daily living. These services may include therapies and services for people with disabilities that are delivered in a variety of outpatient settings.

Health Insurance – A type of insurance coverage that pays for medical, surgical, and other health care expenses incurred by the insured (sometimes called a member). Health insurance can reimburse the insured for expenses incurred from illness or injury, or pay the provider directly.

Home Health Aide – A home health aide provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing).

Home Health Care or Home Health Services – Services include part-time skilled nursing and home health aide services, durable equipment and supplies, and therapies. For more information, refer to the Benefits Chart in Chapter 4.

Hospice Services – Care for members at end of life, with a life expectancy of 6 months or less if the illness runs its normal course.

Hospital Inpatient Stay or Hospitalization – A hospital stay when you have been formally admitted to the hospital for skilled medical services. For more information, refer to the Benefits Chart in Chapter 4 (*Outpatient hospital services*).

Hospital Outpatient Care – Medical care that does not require an overnight stay in a hospital or medical facility. Outpatient care may be administered in a provider office or a hospital. For example, most related services are provided in a provider office or outpatient surgery center.

Initial Enrollment Period – The timeframe when you are first eligible for enrollment in a Medicaid managed care plan.

List of Covered Drugs (Formulary or "Drug List") – A list of covered prescription drugs. The list includes both brand name and generic drugs. *[Plans may modify this definition to refer to preferred or non-preferred drugs.]*

Medicaid (or Medical Assistance) – Medicaid is a joint federal and state program that includes health care coverage for eligible children, adults with dependent children, pregnant women, seniors and individuals with disabilities.

Medically Necessary – Services, supplies, or prescription drugs needed for the prevention, diagnosis, or treatment of a medical condition and meet accepted standards of medical practice. For more information about medically necessary services, refer to Section 6.1 (*Medically necessary services*).

Medicare – The federal health insurance program for people who are 65 years of age or older. Others who can receive Medicare include people with disabilities under age 65 years, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Member (Member of our Plan, or “Plan Member”) – A person who is enrolled in our plan.

Member Services – A department in our plan responsible for answering your questions about plan membership and benefits. (Phone numbers for Member Services are printed on the back cover of this handbook).

Mental Health Crisis – Any situation in which a person’s behaviors puts them at risk of hurting themselves or others and/or when they are not able to resolve the situation with the skills and resources available. Many things can lead to a mental health crisis including, increased stress, physical illness, problems at work or at school, changes in family situations, trauma/violence in the community or substance use. These issues are difficult for everyone, but they can be especially hard for someone living with a mental illness.

Network – The collective group of providers and facilities that are under contract with the plan to deliver covered services to plan members.

Network Provider – Doctors, pharmacies and other health care professionals, medical groups, hospitals, durable medical equipment suppliers, and other health care facilities that have an agreement with the plan to accept our payment and your cost-sharing amount, if any, as payment in full. We have arranged for these providers to deliver covered services to members in our plan.

New Hampshire Medicaid – The plan contracts with NH DHHS to provide managed care services to individuals who are enrolled in New Hampshire Medicaid and select or are assigned to our plan.

Non-Emergency Medical Transportation Services (NEMT) – These services are covered by the plan if you are unable to pay for the cost of transportation to provider offices and facilities. The plan covers non-emergency medical transportation to medically necessary New Hampshire Medicaid covered services listed in the Benefits Chart in Chapter 4 (*Transportation services – Non-emergency medical transportation (NEMT)*).

Non-Participating Provider – Refer to the definition for “Out-of-Network Provider, Out-of-Network Pharmacy or Out-of-Network Facility”.

Non-Preferred Drugs – *[Plans include your plan definition.]*

Out-of-Network Provider, Out-of-Network Pharmacy or Out-of-Network Facility – A provider, pharmacy or facility that is not employed, owned, or operated by our plan or is not under contract to deliver covered services to plan members. Refer to Chapter 3 (*Using [Plan name] for covered services*).

Out-of-Pocket Costs – Refer to the definition for “cost-sharing”.

Participating Provider – Refer to the definition for “Network Provider”.

Personal Representative – Refer to the definition for “Authorized Representative or Personal Representative”.

Physician Services – Services provided by a licensed medical physician.

Plan – For purposes of this handbook, the term generally refers to a Medicaid managed care organization contracted with NH DHHS to provide Medicaid managed care services to eligible New Hampshire Medicaid beneficiaries.

Post-stabilization Care – Covered services, related to an emergency medical condition that are provided after a member is stabilized to maintain the stabilized condition to improve or resolve the enrollee’s condition.

Preauthorization – Refer to the definition for “Prior Authorization”.

Preferred Drugs – *[Plans include your plan definition.]*

Premium – The periodic payment paid to an insurance company or a health care plan by a member or other party to provide health care coverage. There is no member premium for your New Hampshire Medicaid managed care plan.

Prescription Drugs – Covered when filled at a network pharmacy.

Prescription Drug Coverage – The term we use to mean all of the drugs that our plan covers.

Primary Care *[insert as appropriate: **Physician OR Provider**]* (**PCP**) – The network doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and providers about your care. Refer to Section 3.1 (*Your Primary Care Provider (PCP) provides and oversees your medical care*).

Prior Authorization – Approval in advance to get services or drugs. Some medical services or drugs are covered only if your doctor gets prior authorization from the plan. Prior authorization requirements for covered services are in italics in the Benefits Chart in Chapter 4.

Provider – Doctor or other health care professional licensed by the state to provide medical services and care. The term “provider” also includes a hospital, other health care facility, and pharmacy.

Quantity Limits – A tool to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover for each prescription or for a defined period.

Rehabilitation Services and Devices – Treatment or equipment you get to help you recover from an illness, accident, or major operation.

Service Area – Health plans commonly accept or enroll members based on where the member lives and the geographic area the plan serves. *[Modify as necessary: The service area for [Plan Name] is statewide.]*

Skilled Nursing Care – A type of intermediate care in which the member or resident of a nursing facility needs more assistance than usual, generally from licensed nursing staff and licensed nursing assistants.

Specialist – A doctor who provides care for a specific disease or part of the body.

Step Therapy – A requirement to try another drug before a health plan will cover the drug your physician prescribed first.

Urgent Care or Urgently Need Care – Urgently needed services or after-hours care are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care to prevent a worsening of health due to symptoms that a reasonable person would believe are not an emergency but do require medical attention. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Urgently needed services are not routine care. For more information, refer to Section 3.6 (*Emergency, urgent and after-hours care*).

Waste – For purposes of this handbook, waste means the extra costs that happen when services are overused or when bills are prepared incorrectly. Waste often occurs by mistake. For more information, refer to Section 2.12 (*How to report suspected cases of fraud, waste, or abuse*).

[This is the back cover for the Member Handbook. Plans may add a logo and/or photographs, as long as these elements do not make it difficult for members to find and read the plan contact information.]

***[Plan name]* Member Services**

| Method | Member Services – Contact Information |
|----------------|---|
| CALL | <p><i>[Insert phone number(s)]</i></p> <p>Calls to this number are toll-free. <i>[Insert days and hours of operation, including information on the use of alternative technologies.]</i> Member Services also has free language interpreter services available for non-English speakers.</p> |
| TTY/TDD | <p><i>[Insert number]</i> <i>[Insert if plan uses a direct TTY number: This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.]</i></p> <p>Calls to this number are free.</p> |
| FAX | <i>[Optional: insert fax number]</i> |
| WRITE | <p><i>[Insert address]</i> <i>[Note: plans may add email addresses here.]</i></p> |
| WEBSITE | <i>[Insert URL]</i> |