NH Healthy Families
Addendum to the Member Handbook
Effective October 2025

This is important information on how your coverage has changed from that described in your NH Healthy Families Member Handbook effective October 2025. You are not required to take any action in response to this document, but we recommend you keep this information for future reference.

We previously sent you the Member Handbook, which provides information about your coverage as an enrollee in our plan. This notice is to let you know there are changes to your benefit coverage. Below you will find information describing these changes. Please keep this information for your reference.

If you have any questions please call Member Services at 1-866-769-3085 (TDD/TTY: 1-855-742-0123) Monday - Wednesday, 8:00 a.m. to 8:00 p.m., Thursday - Friday, 8:00 a.m. to 5:00 p.m.

Changes to your NH Healthy Families Member Handbook include:

Where you can find the change in your 2025 Member Handbook	Original Information	Corrected Information	What does this mean for you?
On page 56, under Section 4.2 (*Benefits Chart*)	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	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	Added clarifying language that cost-sharing and copays do not apply to EPSDT services. EPSDT services are available to members at no cost.

25-1032

Where you can find the change in your 2025 Member Handbook	Original Information	Corrected Information	What does this mean for you?
	health care needs and disabilities.	health care needs and disabilities. Cost-sharing, such as copays, do not apply to EPSDT services, these are provided at no cost to the member. Upon request, NH Healthy Families can assist in scheduling appointments and arrange for transportation for EPSDT services.	
On page 77, under Section 4.2 (*Benefits Chart*)	**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	**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 • $4 copayment – up to a 30-day supply Mail Order Copayment (only certain drugs available through mail order) • $4 copayment for a 90-day supply • $0 copayment for family planning products, Clozaril® (Clozapine) prescriptions, Pre-Exposure Prophylaxis (PrEP) drugs, or nicotine cessation products.	Beginning October 20, 2025, you will be charged a $4 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. For information on who is exempt from copayments, refer to Section 7.7 (*Prescription drug copayments: Members who are exempt from copayments*) below.

Where you can find the change in your 2025 Member Handbook	Original Information	Corrected Information	What does this mean for you?
	will be less effective and/or will have adverse effects for the member, the non-preferred drug will be $1.00) 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 or other nicotine cessation products. For information on prescription drug coverage, refer to Chapter 7 (*Getting covered prescription drugs*). For more information, please call Member Services.	For information on prescription drug coverage, refer to Chapter 7 (*Getting covered prescription drugs*). For more information, please call Member Services.	

Where you can find the change in your 2025 Member Handbook	Original Information	Corrected Information	What does this mean for you?
On page 89, under Section 4.3 (*Extra benefits provided by the plan*)	**Extra Benefits Provided by the Plan** with chart showing My Health Pays® dollar reward amounts for healthy behaviors followed by the Value Added Benefits chart.	**Extra Benefits Provided by the Plan** with a reformatted chart showing My Health Pays® dollar reward amounts for healthy behaviors which also identify the preventive screening and services rewards that are exempt from the $250 limit. The **Value Added Benefits** chart remains and followed by a new An **In Lieu of Services** chart.	To help you identify the My Health Pays® dollar rewards for preventive screenings and services that do not apply to the $250 limit per state fiscal year (ending on June 30th annually). Also, we want you to know about the other kinds of care available to you at no cost beyond seeing your doctor or hospitalization that helps you stay healthy. Referred to as **In Lieu of Services**.
On page 119, under Section 7.1 (*Drug coverage rules and restrictions*)	**Drug coverage restrictions** 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	**Drug coverage restrictions** Drug list rule restrictions described in this section include: • Restricting access to non-preferred generic drugs when the brand name version of the drug is preferred • Requiring prior authorization from the plan • Requiring you try a different but similar drug first ("step therapy") • Imposing quantity limits on prescription drugs	Beginning October 1, 2025, for new and renewed covered prescriptions, dispensing of a preferred brand name drug may be required instead of dispensing a non-preferred generic drug.

Where you can find the change in your 2025 Member Handbook	Original Information	Corrected Information	What does this mean for you?
On page 119, under Section 7.1 (*Drug coverage rules and restrictions*)	**Restricting access to brand name drugs when a generic version is available** Generally, a "generic" drug works the same as a brand name drug and usually costs less. **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 has told us the medical reason that the generic drug will not work for you *AND* 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.	**Restricting access to non-preferred brand name drugs when a preferred generic version is available** Generally, a "generic" drug works the same as a brand name drug and usually costs less. **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 sometimes will not cover the brand name drug when a generic version is available. For coverage information, refer to the plan's Preferred Drug List. However, if your provider has told us the medical reason that the generic drug will not work for you *AND* 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.	Beginning October 1, 2025, for new and renewed covered prescriptions, dispensing of a preferred brand name drug may be required instead of dispensing a non-preferred generic drug.

Where you can find the change in your 2025 Member Handbook	Original Information	Corrected Information	What does this mean for you?
On page 129, under 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).	**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). **When subject to Medicaid copayments and other out-of-pocket costs for covered services including prescription drugs**, you pay no more than five percent (5%) of your household income every quarter (January-March, April-June, etc.). For example: If your	Beginning October 20, 2025, you will be charged a $4 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. **If you are required to pay a Medicaid copayment or other out-of-pocket costs for covered services, keep track of your receipts.** When you have met your 5% household income limit for the quarter, 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. For information on who is exempt from copayments, refer to Section 7.7 (Prescription drug copayments: Members who are exempt from copayments) below.

Where you can find the change in your 2025 Member Handbook	Original Information	Corrected Information	What does this mean for you?
		household earns $6,000 each quarter: • 5% of that is $300. • Once you have paid $300 out-of-pocket in that quarter, you pay nothing for prescriptions until the next quarter. **Keep track of your receipts.** If you find you have met your household income limit for the quarter, 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.	
On page 129, under Section 7.7 (*Prescription drug copayments*)	**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;	**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;	Clarifies for conditions related to pregnancy, members are exempt from a prescription copayment up to 12 months after the month the pregnancy ended.

Where you can find the change in your 2025 Member Handbook	Original Information	Corrected Information	What does this mean for you?
	• 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.	• 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 12 months 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.	

You are not required to take any action in response to this document, but we recommend you keep this information for future reference. If you have any questions please call us at 1-866-769-3085 (TTY/TDD 1- 855-742-0123) with any questions. Hours of operation are Monday – Wednesday 8:00 a.m. to 8:00 p.m., Thursday - Friday 8:00 a.m. to 5:00 p.m.

Statement of Non-Discrimination

NH Healthy Families complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

NH Healthy Families cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

NH Healthy Families respecte toutes les lois fédérales en vigueur en matière de droits civils et ne se livre à aucune discrimination fondée sur la race, la couleur, l'origine nationale, l'âge, la situation de handicap ou le sexe.

ATTENTION: If you do not speak English, language assistance services are available to you at no cost. Call 1-866-769-3085 (TTY 1-855-742-0123).

ATENCIÓN: si no habla inglés, hay servicios de asistencia en diferentes idiomas disponibles para usted sin costo. Llame al 1-866-769-3085 (TTY 1-855-742-0123).

ATTENTION : si vous ne parlez pas anglais, des services d'aide linguistique sont mis à votre disposition sans paiement de votre part. Composez le 1-866-769-3085 (TTY 1-855-742-0123).