New Hampshire Medicaid Care Management Program Member Handbook

Effective January 1, 2019

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Chapter 1. Getting started as a member

Section 1.1 Welcome

You are enrolled in NH Healthy Families Medicaid Care Management program.

You will get most of your New Hampshire Medicaid health care and prescription drug coverage through our plan, NH Healthy Families, 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.

NH Healthy Families 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* NH Healthy Families *for covered services*).

As a NH Healthy Families 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.

This Member Handbook tells you about your healthcare benefits. It is designed to make it easy for you to make the most of your benefits and services.

Your feedback is important to us. Several times each year, the plan 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 NH Healthy Families service area);
- *and* you are a United States citizen or are lawfully present in the United States.

If you are pregnant and enrolled in NH Healthy Families when you deliver your baby, your baby is automatically covered by NH Healthy Families 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

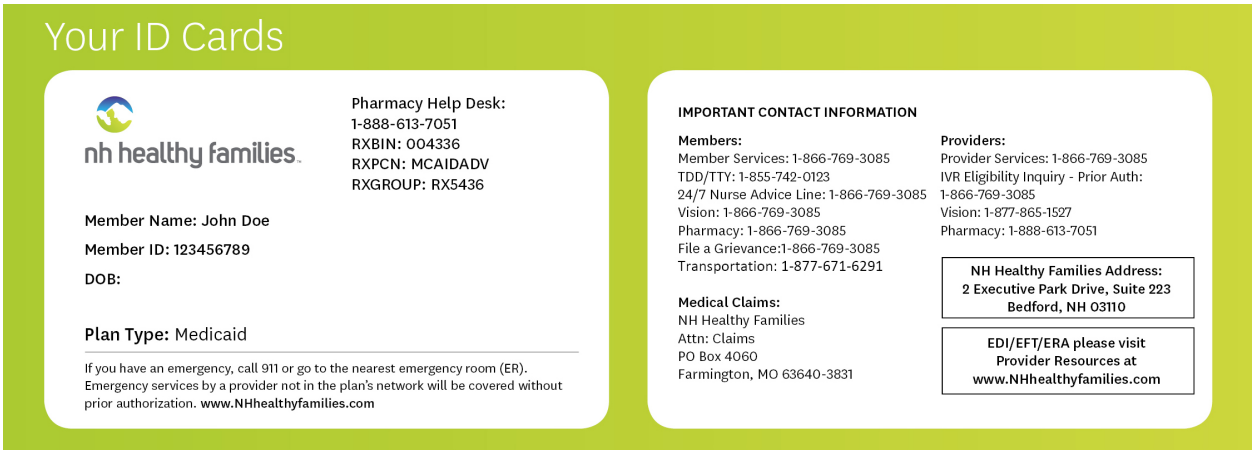
Member Handbook

This Member Handbook describes how the plan works and is in effect beginning January 1, 2019 through each month you are enrolled with NH Healthy Families. The Member Handbook is also available on our website at www.NHhealthyfamilies.com.

Your NH Healthy Families membership card – Use it to get all covered services and prescription drugs

While you are a member of the plan, you must use your NH Healthy Families membership card whenever you get covered services or prescription drugs. However, even if you do not 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:



As long as you are a member of the plan, **you must use your NH Healthy Families 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.)

Welcome Call

Understanding your health and other special needs is important to us.

When you first join NH Healthy Families, 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)

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.

The HNA will include questions to identify your medical, behavioral health, functional and other needs. We will reach out to you to complete the HNA. It can be completed by telephone, or mail, or via the member secure portal on the NH Healthy Families website. This form is in your Welcome Packet with a postage-paid envelope. Your completion of the HNA is optional. However, we encourage you to complete the assessment, and return it to NH Healthy Families.

Explanation of Benefits Notice

From time to time, we will send you a report called the *Explanation of Benefits* (*EOB*).

The Explanation of Benefits tells you the total amount you, or others on your behalf, have spent on a particular service. An Explanation of Benefits is also available when you ask for one. To get a copy, please contact Member Services. You can also print a copy of your EOB from our secure member portal at www.NHhealthyfamilies.com.

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 NH Medicaid 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

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 NH Healthy Families**.** 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 NH Healthy Families**.** 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).

Chapter 2. Important phone numbers and resources

Section 2.1 How to contact NH Healthy Families Member Services

For assistance with coverage questions, finding a provider, claims, membership cards, or other matters, please call or write to NH Healthy Families 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	NH Healthy Families Member Services – Contact Information
CALL	1-866-769-3085 Calls to this number are toll-free. Normal business hours of operation are Monday-Wednesday 8:00 a.m. to 8:00 p.m. and Thursday - Friday 8:00 a.m. to 5:00 p.m. Member Services also has free language interpreter services available for non-English speakers.
TTY/TDD	1-855-742-0123 Relay 711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.] Calls to this number are free.
FAX	1-877-502-7255
WRITE	NH Healthy Families 2 Executive Park Drive Bedford, NH 03110
WEBSITE	www.NHhealthyfamilies.com

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	1-866-769-3085 Calls to this number are toll-free. Normal business hours of operation are Monday-Wednesday 8:00 a.m. to 8:00 p.m. and Thursday - Friday 8:00 a.m. to 5:00 p.m. Member Services also has free language interpreter services available for non-English speakers.
TTY/TDD	1-855-742-0123 Relay 711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	1-866-270-9943
WRITE	NH Healthy Families 2 Executive Park Drive Bedford, NH 03110
WEBSITE	www.NHhealthyfamilies.com

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	1-866-769-3085 Calls to this number are toll-free. Normal business hours of operation are Monday-Wednesday 8:00 a.m. to 8:00 p.m. and Thursday - Friday 8:00 a.m. to 5:00 p.m. Member Services also has free language interpreter services available for non-English speakers.
TTY/TDD	1-855-742-0123 Relay 711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	1-866-270-9943
WRITE	NH Healthy Families Complaint, Grievance and Appeal Department 2 Executive Park Drive Bedford, NH 03110
WEBSITE	www.NHhealthyfamilies.com

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	1-866-769-3085 Calls to this number are toll-free. Normal business hours of operation are Monday-Wednesday 8:00 a.m. to 8:00 p.m. and Thursday - Friday 8:00 a.m. to 5:00 p.m. Member Services also has free language interpreter services available for non-English speakers..
TTY/TDD	1-855-742-0123 Relay 711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	1-877-502-7255
WRITE	NH Healthy Families 2 Executive Park Drive Bedford, NH 03110
WEBSITE	www.NHhealthyfamilies.com

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

The Nurse Advice Line is a free 24-hour medical information phone service provided by NH Healthy Families. 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 the following:

- Medical advice
- Health information library
- Answers to questions about your health
- Advice about an injury or illness
- Help with scheduling PCP appointments

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	1-866-769-3085 Calls to this number are toll-free. *The nurse advice line is available 24 hours a day, 7 days a week* Member Services also has free language interpreter services available for non-English speakers.
TTY/TDD	1-855-742-0123 Relay 711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.

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

Behavioral health services is another term used to describe mental health and/or substance use disorder services. Contact NH Healthy Families when you have questions about covered services and/or network Providers related to behavioral health and substance use disorder services available under your plan.

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	1-866-769-3085 Calls to this number are toll-free. Normal business hours of operation are Monday-Wednesday 8am to 8pm and Thursday and Friday 8am to 5pm Member Services also has free language interpreter services available for non-English speakers.
TTY/TDD	1-855-742-0123 Relay 711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WRITE	NH Healthy Families 2 Executive Park Drive Bedford, NH 03110
WEBSITE	www.NHhealthyfamilies.com

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

Non-emergency medical transportation services are covered for a member who has no other means of transportation and needs to be transported to and from a New Hampshire Medicaid covered service as listed in the Benefits Chart in Chapter 4 (*Covered services: Transportation services – Non-emergency medical transportation (NEMT)*). (*Transportation services – Non-emergency medical transportation (NEMT)*).

Method	Non-Emergency Medical Transportation – Contact Information
CALL	1-877-671-6291, Coordinated Transportation Solutions
TTY/TDD	1-855-742-0123 Relay 711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	**Reimbursement Forms only 1-203-375-0516**
WRITE	**Reimbursement Forms only** Coordinated Transportation Solutions 35 Nutmeg Drive, Suite 120 Trumbull, CT 06611
WEBSITE	www.NHhealthyFamilies.com

Need help getting to an appointment?

If you do not have a car or anyone available to give you a ride, we can help you get to your medical appointments as well as your state-covered dental appointments. Transportation is covered for all medically necessary services. Covered transportation services include but are not limited to:

- Scheduled routine medical appointments
- Transportation from the Emergency Room (non-emergent transportation to the ER is not covered)
- Transportation from a hospital or other medical facility
- Scheduled state-covered dental appointments
- Pharmacy stops to pick up medications
- Pharmacy stops after being discharged from a hospital

- Pharmacy stops immediately following a medical appointment

Requests for transportation must be made within two (2) business days but no more than thirty (30) calendar days in advance of your scheduled appointment(s).

The only exceptions to this rule are for requests such as:

- Urgent trip requests (transport to an Urgent Care Clinic or the appointment has been evaluated and requested by the Provider to being urgent in nature).
- Hospital discharge requests (discharge nurse at hospital can help with this).
- Regular routine requests considered "indefinite" or "reoccurring" such as: dialysis, chemotherapy or weekly methadone clinic visits.

What information do I need to know when I call?

- Your Medicaid ID number
- Pick-up/destination address and phone number
- Name of provider/facility you are travelling to
- Appointment date and time, including length of appointment
- Contact phone number where you can be reached by CTS, driver, etc.
- If you use any mobility aids (wheelchair, cane, etc.) or any other equipment in order to get to appointments.

If you are travelling alone, you must be 16 years of age or older. If you are a minor under the age of 15, an adult over the age of 18 must accompany you. Additional passengers are allowed for medical, interpretive, or other relevant support and assistive needs.

<u>Mileage Reimbursement</u>

If you get a ride from someone else (loved one, friend, neighbor etc.), they can be reimbursed for mileage when transporting you to and from covered medical appointments. Requests for mileage reimbursement must be made at least two (2) business days prior to your appointment.

What information do I need to know when I call?

- Your Medicaid ID number
- Pick-up/destination address and phone number
- Name of provider/facility they are travelling to
- Appointment date and time
- Who is transporting you to the appointment

A mileage reimbursement form must be filled out by you, signed by the provider's office staff at the time of your appointment, and submitted to Coordinated Transportation Solutions (CTS), our transportation vendor. The mileage reimbursement forms can be requested by calling Member Services at NH Healthy Families or when speaking to a CTS representative to schedule your trip.

The form is also on our website at www.NHhealthyfamilies.com. Choose "Medicaid Plan", then "Member Resources", then "Member Handbooks and Forms", and then you will find the "Transportation Reimbursement Form" link.

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 plan enrollment, the other benefits managed directly by NH DHHS as described in Section 4.4 *(NH 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	**1-888-901-4999** (For plan information) **1-844-ASK-DHHS** (1-844-275-3447) (For all other calls) Calls to this number are toll-free. Office hours are Monday through Friday, 8:00 a.m. to 4:00 p.m. ET. Free language interpreter services are available for non-English speakers.
TTY/TDD	**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.

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	**1-866-634-9412** 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 Office hours are Monday through Friday, 8:30 a.m. - 4:30 p.m. ET. Free language interpreter services are available for non-English speakers.
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, NH Healthy Families 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	NH Healthy Families to report fraud, waste or abuse – Contact Information
CALL	1-866-769-3085 Calls to this number are toll-free. Normal business hours of operation are Monday-Wednesday 8 am to8 pm and Thursday and Friday 8 am to 5 pm Member Services also has free language interpreter services available for non-English speakers.
TTY/TDD	1-855-742-0123 Relay 711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WRITE	NH Healthy Families 2 Executive Park Drive Bedford, NH 03110
WEBSITE	www.NHhealthyfamilies.com

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. 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** – Plan information is available in alternative formats for those members with limited reading abilities or who require interpretation services. If you need materials in an alternative format or require free interpretation services for covered services listed in the Benefits Chart in Chapter 4, contact Member Services (phone numbers are printed on the back cover of this handbook).
    - 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** – Physician Incentive Plan NH Healthy Families encourages our providers to offer you the best care. You have the right to request and receive the plan we use to offer incentives to the providers in our network.
- **Information about plan provider incentives and payment arrangements** – To request information about our provider incentives or payment arrangements, contact Member Services (phone numbers are printed on the back cover of this handbook). Provider incentives and payment arrangements 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.

- **Member material requests** – Contact NH Healthy Families Member Services to request a copy of our Member Handbook, Drug List, or Provider Directory. Document(s) will be sent within five (5) business days of your request. (Phone numbers for Member Services are printed on the back cover of this Handbook.)

Chapter 3. Using NH Healthy Families 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*).

NH Healthy Families 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

NH Healthy Families covers all services required in our contract with NH DHHS.

NH Healthy Families 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*).
- **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 (for more information about this, see Section 3.1 (*Your Primary Care Provider (PCP) provides and oversees your medical care)*
  - In some situations, your network PCP may give you a recommendation in advance before you use other providers in the plan's network, such as specialists, behavioral health providers, hospitals, skilled nursing facilities or home health care agencies. A written referral is not required to see participating providers. Your provider may submit a "prior authorization" to the plan to request approval of specific services. For more information, refer to Chapter 6 (Rules for accessing covered services). Please refer to your provider directory to find in-network specialty care and behavioral health care providers as well as in hospitals.
  - Authorizations 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 Section 4.2 (Benefits Chart).
- **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. 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?

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).

- What is a PCP? A PCP is a doctor who oversees all of your care.

- What types of providers may act as a PCP? Can a specialist be a PCP? Pediatricians, Family/General Practitioners, Internal Medicine, Obstetricians/Gynecologists, Registered Nurse Practitioners, Physician Assistant (under the supervision of a physician), and Advanced Registered Nurse Practitioners (ARNP) can all serve as your PCP. Specialists can be your PCP for special needs upon request, contact Member Services for more information.

- What is the role of a PCP in your plan? A Primary Care Provider (PCP) is your point person for your health care needs. These doctors or nurse practitioners help take care of the basics of health care, focusing on wellness and prevention. The PCP is your primary partner for your health.

- What is the role of a PCP in coordinating covered services? Your PCP will refer you to specialists who can assist with coordinating your care that is medically necessary. It is your responsibility to make sure that the providers you receive services from are in network with NH Healthy Families. Contact Member Services for assistance.

- What is the role of the PCP in making decisions about or obtaining prior authorization? Your PCP is responsible for obtaining any prior authorizations that may be needed for specialty care and other services based on your medical need.

- Can you have a PCP that is not in the NH Healthy Families' network? The PCP you select must be within our network.

- Can you choose to go to another doctor who is not your PCP? You may visit any provider that is within our network for medical needs.

- What are NH Healthy Families referral requirements? NH Healthy Families does not require any written referrals from your PCP as long as the service(s) recommended by your PCP or Specialist is medically necessary.

How do you choose your PCP?

The Provider Directory is a list of all the providers in our network. Our network includes, doctors, pharmacies and hospitals. The Provider Directory also provides information about specialist providers and behavioral health providers.

When picking a PCP, look for one of the following kinds of providers:

- Pediatricians
- Family /General Practitioners
- Internal Medicine
- Obstetricians/Gynecologists
- Registered Nurse Practitioners
- Physician Assistants (under the supervision of a physician)
- Advanced Registered Nurse Practitioners (ARNP)

*Specialists can be your PCP for special needs upon request.

We are always working for our members to build the best provider network. You can check our online Provider Directory at www.NHhealthyfamilies.com to see if new providers have been added. Upon request, a specialist can be your PCP for special needs.

If you do not choose a PCP, we will automatically assign one to you based on your address on file and the PCP availability in your area.

Want to learn more about a provider before you choose? Call Member Services at 1-866-769-3085.

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*).

You must notify us when you change your PCP. You can do this by:

- Calling member services at 1-866-769-3085
- Going online. Visit the Member Secure Portal at www.NHhealthyfamilies.com

Your PCP change will be effective the next day.

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 NH Healthy Families.

- Routine women's health care, including breast exams, screening mammograms (X-rays of the breast), pap tests, pelvic exams, and maternity care.
- Flu shots.
- 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.
- Any preventative care service

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 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.

You can also see the Provider Directory at https://providersearch.nhhealthyfamilies.com 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.

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.

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 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.

Your PCP will refer you to specialists who can assist with coordinating your care that is medically necessary. It is your responsibility to make sure that the providers you receive services from are in network with NH Healthy Families. Contact Member Services for assistance. If there are no local in- network providers to assist with your care, your PCP can work with our plan to obtain a prior authorization to receive the services outside of the plan network.

A Prior Authorization Request is submitted by your PCP, specialist or facility to request certain medically necessary services/procedures. This request is processed by a Referral Specialist (RS) who reviews the information submitted and builds an authorization. The RS may reach out to the requesting provider for additional information that is required. The request is then sent to a nurse for review.

- The nurse reviews the clinical information and compares it to the current state policy, corporate clinical policy and InterQual Medical necessity criteria. If the information is complete and criteria is met, the request will be approved. The nurse will then issue an approval letter to the requesting provider, you the member, and the facility/office/servicing provider. This approval recognizes that the request is medically necessary.
- If the nurse reviews the clinical information and it does not meet the criteria, the request is sent to a Medical Director (MD) to review. The MD will review all information provided and this review may result in an approval or denial.

- If denied, the MD's denial reason will be shared in the denial letter as well as any medical policy utilized to make the decision. NH Healthy Families notifies the requesting provider of the denial within 24 hours by phone. During this call, the nurse will provide a verbal notification of the denial and how the provider can request a Peer-to-Peer review, as well as your appeal rights.
- A denial letter is issued after verbal notification is given and is sent to both the requesting provider and you the member.
- A Peer-to-Peer review is a conversation between the requesting provider and our Health Plan Medical Director. This allows for further discussion about your individual case and additional clinical information may be provided to the MD. This may or may not result in an approval.

Family Planning

NH Healthy Families covers family planning services. You can get these services and supplies from providers that are not in our network. You do not need a prior authorization. These services are free to our members. These services are voluntary and confidential. Some examples of family planning services are:

- Education and advice from a trained personnel to help you make choices
- Information about birth control
- Physical exams
- Follow-up visits
- Immunization services
- Pregnancy tests
- Birth control supplies
- Tests and treatment of STDs

Vision

NH Healthy Families allows members to choose from a standard selection of frames and lenses. Members can choose to opt out of the standard benefit and select frames outside of the standard selection. An amount will be given to you as a credit. You can use this to buy glasses with single vision lenses, or glasses with bifocal or trifocal lenses. You will have to pay for any charges that go over the allowed amount. Contact member services to find out the amount you have as credit.

Dental services

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

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

Behavioral health services

The plan covers inpatient and outpatient mental health services. For specific details refer to Section 4.2 (Benefits chart). Inpatient services include:

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

Outpatient mental health services are covered when 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*

**Indicates a service that requires a Prior Authorization*

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

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 or specialist 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 fifteen (15) calendar days after the plan receives notice of your provider leaving the network, or fifteen (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. NH Healthy Families may approve visits with your doctor for up to 90 days after he/she leaves the network. During this time, we will help you find a new doctor. If your provider has been terminated because of a quality of care issue, this option is not available. Your doctor must agree to:
    - Treat your healthcare needs
    - Accept the same payment rate from NH Healthy Families
    - Follow NH Healthy Families' quality assurance standards
    - Follow NH Healthy Families' policies about prior authorization and use a treatment plan
    - Provide necessary medical information to you
- 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. We will assign you to another PCP if you do not select one prior to the effective date of the PCP termination.
- You can change your PCP by calling Member Services at 1-866-769-3085 or going online via the member secure portal at www.NHhealthyfamilies.com
- 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 seven (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

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.
- **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. This helps your PCP to provide or arrange for any follow-up care that you may need. We can also help you get follow-up care. Call Member Services at 1-866-769-3085 (TDD/TYY 1-855-742-0123, Relay 711).

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.

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 Member Services at 1-866-769-3085 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.
- **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. Call Member Services 24 hours a day, 365 days a year (the phone number is located on our Member ID Card and on the back cover of this handbook.)

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

NH Healthy Families understands that addiction is a disease and that access to immediate help is critical to recovery.

- If you are a NH Healthy Families member struggling with addiction and are in need of urgent care, contact the phone number on your Member ID Card or call Member Services; 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.

Here are some examples of when to go to the ER and when NOT to go to the ER:

Go to the ER	Do NOT go to the ER
• Broken bones. • Gun or knife wounds. • Bleeding that will not stop. • You are pregnant, in labor and/or bleeding. • Severe chest pain or heart attack. • Drug overdose. • Poisoning. • Bad burns. • Shock (you may sweat, feel thirsty or dizzy or have pale skin). • Convulsions or seizures. • Trouble breathing. • Suddenly unable to see, move or speak.	• Flu, colds, sore throats, and earaches. • A sprain or strain. • A cut or scrape not requiring stitches. • To get more medicine or have a prescription refilled. • Diaper rash.

When you need **urgent care,** follow these steps:

- Call your PCP. Your PCP may give you care and directions over the phone. If it is after hours and you cannot reach your PCP, call NH Healthy Families at 1-866-769-3085 (TDD/TTY 1-855-742-0123, Relay 711) and say "Nurse". You will be connected to a nurse. Have your NH Healthy Families ID card number handy. The nurse may help you over the phone or direct you to other care. You may have to give the nurse your phone number. During normal office hours, the nurse will assist you in contacting your PCP.
- If you are told to see another doctor or go to the nearest hospital emergency room, bring your NH Healthy Families ID card. Ask the doctor to call your PCP or NH Healthy Families.

If you are not sure what to do, remember these tips:

- If you can, **call your doctor first**.
- If your condition is severe, **call 911 or go to the nearest hospital**. You do not need a doctor's approval. Also, you can use any hospital in an emergency, even if it is not in our network.
- Not sure if it is an emergency? Call your PCP. Your PCP will tell you what to do. If your PCP is not available, a doctor taking calls can help. There may be a message telling you what to do.

- **Call Our 24-hour nurse advice line** 1-866-769-3085 (TDD/TTY 1-855-742-0123, Relay 711) and say "Nurse" if you have questions.
- **Urgent Care is not Emergency Care.**
- **Emergency rooms are for emergencies.**

It is important that, you or someone acting on your behalf MUST call your PCP and NH Healthy Families within 48 hours of admission. This helps your PCP to provide or arrange for any follow-up care that you may need. We can also help you get follow-up care. Call us 1-866-769-3085 (TDD/TTY 1-855-742-0123, Relay 711).

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 NH Healthy Families 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 NH Healthy Families covers. The chart is for your general information and may not include all the benefits available to you. Please call NH Healthy Families 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* NH Healthy Families *for covered services*).
  - You have a primary care provider (a PCP) who is providing and overseeing your care. Some of the services listed in the Benefits Chart in this chapter are covered only if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. Covered services that need authorization in advance are marked in italics in the 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).

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.
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. Voluntary termination of pregnancy is not covered. *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
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 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.
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.

Services covered by the plan

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: o You cannot safely be transported in a timely basis via ground transportation; and o You are at imminent risk of losing life or limb, if the fastest means of transport is not utilized Services are managed by CTS (Coordinated Transportation Solutions) for the plan. You can arrange for transportation by calling CTS at 1-877-671-6291. *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. *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, 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. Pap tests are recommended every 3 years however, plan will cover based on medical necessity if needed more frequently. Pelvic exams are recommended annually. *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 can 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 Members aged 50 years and over are covered for one routine, preventative screening service per benefit year for the following 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 counseling on quitting smoking or tobacco use. (Refer also to "Smoking cessation" in the Benefits Chart.) The Tobacco Cessation program provides telephonic education and support services to reduce the risk of tobacco related health conditions such as high blood pressure, heart disease and certain cancers by promoting cessation of all tobacco products. *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
Dental services The plan <u>does not</u> cover dental services. The services are managed through New Hampshire Medicaid. For questions about your dental benefits, please contact the NH 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 (*NH 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.
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.

Services covered by the plan

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.
- The Diabetes education program provides telephonic outreach, education, and support services to optimize blood glucose, blood pressure and lipid control to minimize the development and/or progression of diabetic complications.

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:
  o Wheelchairs
  o Crutches
  o Hospital beds
  o Monitoring equipment
  o Special beds
  o Canes
  o Commodes
  o Nebulizers
  o Oxygen equipment
  o IV infusion pumps
  o Walkers
  o Speech generating devices (augmentative alternative communication (AAC) devices
  o Any other medically necessary DME
• Replacement parts, necessary modifications, and training
 	
Prior authorization may be *required for certain equipment.*
 	
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.

For specialty treatment services, contact the Special Needs Coordinator at the plan. Call Member Services and ask for the Special Needs Coordinator during normal business hours as listed at the bottom of this page.

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

For more information, please contact the Special Needs Coordinator at the plan.

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. Also, 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 the 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, 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. *Prior authorization from the plan may be required..*

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. *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 and provided by a network laboratory. *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 *Prior authorization from the plan may be required.* For more information, please call Member Services.

Services covered by the plan
Medical nutrition therapy Coverage is provided for medically necessary Medical Nutrition Therapy when provided as a part of EPSDT services for Members who are age 21 and under when furnished by a registered dietician and prescribed by a physician. Coverage for Medical Nutrition Services includes (but is not limited to): • Scientific evaluation of your diet; • Suggestions for diet modification; • Nutritional screening; • Preventive or therapeutic dietary therapy Services must be rendered by a registered dietician and prescribed by a physician that is participating with NH Healthy Families, unless authorized in advance. *Prior authorization is not required for Medical Nutritional Services when provided as part of EPSDT services for Members age 21 and under. Prior authorization is not required for Nutritional Services when provided as part of extended services offered to pregnant women, regardless of age.* For more information, please call Member Services
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

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* **Prior Authorization from the plan is not required except for those services indicated with an asterisk.* Refer also to *Inpatient mental health services* in this Benefits Chart. Refer also to *Substance use disorder (SUD) treatment services* in this Benefits Chart. 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 and services in network hospital outpatient facilities and network ambulatory surgical centers. *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.* *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.

Services covered by the plan
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 Service limits for routine and non-routine services do not apply. For more information, please call Member Services.
Prescription drugs Prescription Drugs (and over the counter drugs with a prescription) Retail Pharmacy Copayment • $1 copayment – up to a 30-day supply • $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) Mail Order Copayment (only certain drugs available through mail order) • $1 copayment for a 90-day supply • $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*).

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 *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 The Tobacco Cessation program provides telephonic education and support services to reduce the risk of tobacco related health conditions such as high blood pressure, heart disease and certain cancers by promoting cessation of all tobacco products. The plan covers medications to aid the cessation of smoking including nicotine patches, gums, lozenges and Chantrix (for which specific limits apply). 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. Special coverage rules apply for some inpatient stays. If you are age 21 – 64 years, contact Member Services to see if you meet inpatient coverage requirements. *Prior authorization 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)
Transportation services – Ambulance transportation Refer to *Ambulance services – Emergency* in this Benefits Chart. Refer to *Ambulance services – Non-emergency* in this Benefits Chart.

Services covered by the plan

Transportation services – Non-emergency medical transportation (NEMT)

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 for transportation coordination and reimbursement.

- Enroll in the Friends and Family Mileage Reimbursement Program: Get reimbursement for mileage from your home to your Medicaid-covered healthcare service, then back to your home. Drive yourself or have a friend or family member drive you to the appointment. A Medicaid Transportation Reimbursement Form must be completed for each approved trip.
- Request a ride: Members who do not have a vehicle or a friend or family member who can drive them can request a ride by calling the plan's transportation broker who will arrange the ride using public transportation, a transportation service, a wheelchair van service, or non-emergency ambulance service. Please call at least 48 hours in advance to request a ride.

Services are managed by Coordinated Transportation Solutions (CTS). They can be reached by calling 1-877-671-6291.

Prior authorization may be required.

For more information, please call Member Services.

Services covered by the plan

Urgently needed care

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*).

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 1-866-769-3085. 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:
  o Is employed and the trifocal lenses are required for the work involved in the member's employment; or
  o Is a full time student and the trifocal lenses are required for the work involved in the member's education; or
  o 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
 	
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

Our plan offers some extra benefits. NH Healthy Families has programs and services that add value to your covered services. We are always looking for ways to help you stay healthy or improve your health. Check our website at www.NHhealthyfamilies.com for the most up-to-date list of value added benefits or call Member Services for more information.

Extra benefits include:

Programs and Services	Details
CentAccount Rewards for completing healthy behaviors.	• $30 incentive payment for each: o Annual Flu Shot or Flu Mist Vaccine - ages 6 months and up o Annual Breast Cancer Screening (mammogram) - women ages 40-74 o Annual Prostate Exam/Prostate Cancer Screening– men ages 50 and up o Completion of Tobacco Cessation Program – complete 6 health coaching sessions – ages 18 and up o Complete Annual Health Needs Assessment o 6 Infant Well Care visits by 15 months old o Annual Well Care Visit (one per calendar year/ ages 2+) • $20 incentive payment o Annual Comprehensive diabetes care • $10 incentive payment: o Every 3rd prenatal doctor visit.* ($30 maximum.) o Postpartum doctor visit between 21 – 56 days after delivery. * You must notify NH Healthy Families of your pregnancy by calling us or submitting a completed Notification of Pregnancy (NOP) form. The form can be found on the website at www.NHhealthyfamilies.com. Note, the prenatal visit count begins after you notify us you are pregnant.
Start Smart for Your Baby – A program designed to support pregnant members.	• Aims to reduce pregnancy complications, premature deliveries, low birth weight, and other poor birth outcomes in babies. • Start Smart for Baby Packet and Thermometer • Start Smart Baby Shower Program • Start Smart for Your Baby Texting Program • Electric Breast Pumps available

Programs and Services	Details
24-Hour Nurse Advice Line Free health information staffed by nurses available 24/7.	• Medical advice • Answers to questions about your health • Advice about an injury or illness • Answers questions about going to ER or Urgent Care
Disease Management – Services geared toward helping you improve your health through a personal health coach.	Your one-on-one coaching sessions support you as you manage your health conditions such as: o Asthma (adult and pediatric) o Back Pain o COPD o Diabetes (adult and pediatric) o Heart Disease (heart failure and CAD) o Hypertension/Hyperlipidemia o Depression
MemberConnections® – Program to promote preventive health and connect high-risk members to healthcare and community social services.	MemberConnections representatives help you to: Find a doctor in your area Assist with access to care concerns Navigate health plan benefits And even check on you at home, if necessary

VALUE ADDED BENEFITS CONTINUED.

Programs and Services	Details
ConnectionsPLUS® – Program that provides free cell phone to members who do not have safe and reliable access to a phone.	Gives 24/7 access to: • Our staff • Your providers • Telehealth services • 911
Fluvention	Free flu shots every year for members 6 months and older.
Interpreter Services	Telephonic or face-to-face services covered free of charge.
Puff-Free Pregnancy	Special tobacco-cessation program for pregnant women.
Vision Enhancement- Choose to get a credit and select frames outside of the standard selection.	Use the credit to buy glasses with: • Single vision lenses • Bifocal or trifocal lenses
Smoking Cessation –Health Coaches available to help members quit smoking.	Health coaches offer telephonic educationand support to help you quit smoking. A special program is available to assist pregnant members to quit smoking (Puff Free Pregnancy).
Secure Member Portal	All health plan Members have free access to their account information and helpful tools 24 hours per day / 7 days per week through the Secure Member Portal. Once the Member enrolls and becomes active with NHHF, they can create an account online where they are able to update their PCP, send a secure e-mail to a health plan representative, complete their annual Health Needs Assessment, view their benefit summary, etc.

Section 4.4 NH 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 NH Healthy Families and New Hampshire Medicaid membership cards. Always show your NH Healthy Families 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 NH HEALTHY FAMILIES 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 certain prescription drugs related to Hepatitis C and Hemophilia, and prescription drugs Carbaglu® and Ravicti®.
- 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 (early intervention services) for infants and children aged birth to 3 years
- Medicaid-to-school services
- Nursing home or 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)Nursing home or nursing facility services (sometimes called long-term care nursing facility services)
- 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 long-term services and supports 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 program.

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

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

This section tells you what benefits are excluded by the plan. "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*).

The following services and supplies are not covered. This may not be an all-inclusive list. If a service is on the "List of Non-Covered Services" that means both NH Healthy Families and NH Medicaid do not pay for these services. Remember, if you seek care for any "Non-Covered" service, you will be responsible for payment of any changes.

List of Non-Covered Services

List of Non- Covered Services
Abortions (Voluntary) - Some abortions are covered in limited circumstances.
Alternative Medicine - Acupuncture and Biofeedback, etc.
Cosmetic or Plastic Surgery
Treatment of Infertility, Impotence and Sexual Dysfunction
Experimental Procedures, Drugs and Equipment
Personal Comfort Items
Non-Medical Equipment
Physical Exams Required for Employment, Insurance or Licensing
Radial Keratotomy
Services Not Allowed by Federal or State Law.
Weight Reduction and Control Services - This includes, weight loss drugs or products, gym memberships or equipment for the purpose of weight reduction.
Service and Therapy Animals
Services Provided Outside the US and its Territories including Vaccinations for Out of Country Travel

Chapter 5. Using NH Healthy Families to help manage your health

Section 5.1 Staying healthy

NH Healthy Families has many options to help you get and stay healthy. We believe in treating the whole person and throughout this handbook you will find programs that reinforce this practice. Some of the programs listed in Section 4.3 (*Extra benefits)* can help improve your quality of life as well.

NH Healthy Families also wants to make sure you get supportive services to ensure that your care is effective. Habilitative and Rehabilitative services are part of your covered benefits (see Chapter 4) along with support for your children's and your own preventive care needs.

Quality Improvement Program
NH Healthy Families' Quality Improvement program is committed to providing quality healthcare for you and your family. We want to help you improve and maintain your health. Our program follows the National Committee on Quality Assurance (NCQA) standards and helps promote safe, reliable, and quality healthcare. NH Healthy Families adopts and uses evidence-based preventive and clinical practice guidelines for medical and Behavioral Health care which are reviewed and approved on an annual basis or when changes are needed by our Quality Improvement Committee.

To help promote safe, reliable, and quality healthcare, we:

- Conduct a detailed check on providers when they join our provider network.
- Monitor our network to make sure you have access to all types of healthcare services.
- Offer education and programs about your general healthcare and specific diseases.
- Remind you to see your doctor for well visits and get preventive tests.
- Investigate your concerns about healthcare services you received.

NH Healthy Families believes your input can help improve our services. We send out a member survey each year asking you questions about your experience with health care and the services you are receiving. If you receive a survey, we hope you will take the time to send us your answers. For more information on the QI Program, please visit our website at www.NHhealthyfamilies.com.

If you have a concern about your care or any service we provided, please contact us at 1-866-769-3085.

NH Healthy Families provides primary and secondary preventive care services, rated A or B, in accordance with the recommendations of the U.S. Preventive Services Task Force. For children, we also provide preventive services recommended by the American Academy of Pediatrics Bright Futures Program.

Section 5.2 Care coordination support

NH Healthy Families understands you may need assistance navigating the healthcare system. We offer care management services to assist with scheduling appointments, arranging for transportation, housing and connecting you with community resources such as food stamps, utilities and support groups.

These services are available if you:

- have social and care coordination needs
- have complex medical health needs
- have behavioral health needs
- are pregnant
- have a disability

Our care managers are registered nurses, behavioral health clinicians or social workers. They help our members understand major health problems and assist in arranging members' health care needs. Care Managers work with members and their doctors to help identify barriers and support the provider's plan of care.

Members enrolled in care management often see several doctors. They may need medical supplies or help at home. NH Healthy Families' care managers can assist members in coordinating aspects of their care. Members enrolled in care management often have complex conditions such as Sickle, Cell, Multiple Sclerosis, Kidney or Renal Disease, Organ Transplants, Cancer, Hemophilia and/or Depression.

In addition to Care Managers, NH Healthy Families has a Special Needs Coordinator who can help you enroll in the care management program and connect you with healthcare and community based resources. If you have one or more of the following conditions, we invite you to contact our Special Needs Coordinator or any member of our Care Management team:

- Chronic illness such as asthma, diabetes, heart failure, chronic obstructive pulmonary disease(COPD)
- Mental illness
- HIV/AIDS
- Foster care needs or receiving services the Department of Child, Youth and Families (DCYF)
- Homeless

If you have special healthcare needs, NH Healthy Families is here for you. To enroll in our Care Management Program please call 1-866-769-3085 (TDD/TTY 1-855-742-0123 Relay 711) and request care management services.

Section 5.3 Continuity of care

"Continuity of care" refers to continuing your care coverage through your transitions between plans, health care settings, or other treatment settings.

For example, transitions occur when:

- You change from the New Hampshire Medicaid Fee-for-Service program which contracts directly with providers to a New Hampshire Medicaid managed care plan, such as NH Healthy Families.
- You change from treatment provided by a New Hampshire Medicaid Fee-for-Service provider to a Medicaid managed care plan network provider.
- You change from one New Hampshire Medicaid managed care plan to another.
- You move from a nursing facility to home and you continue to need some or all of the care you received in the nursing facility.

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).

If, at the time you enroll in NH Healthy Families, you are transferring from:

- New Hampshire Medicaid's Fee-For-Service program—You can continue to get services, including prescription drugs, for which you received written prior authorization for up to 60 calendar days. This occurs only after your initial enrollment effective date with NH Healthy Families, or until completion of a medical necessity review by the plan, whichever comes first.
- Another New Hampshire Medicaid managed care plan—You can continue to get services for which you received written prior authorization for up to 15 calendar days or until the expiration of the issued prior authorization(s), whichever comes first.

  Note: If you have a prescription that was authorized prior to your enrollment with the plan and you have one or more refills remaining, your pharmacist may be able to transfer your prescription refill(s) to our plan if the drug does not require prior authorization. For more information, contact Member Services (phone numbers are printed on the back cover of this handbook).

If you transfer from NH Healthy Families to another New Hampshire Medicaid managed care plan:

- Your NH Healthy Families benefits end on the effective date of enrollment in your new plan.

- The plan or other payer responsible for your coverage at the time of your inpatient admission is fully responsible for your inpatient care and all related services authorized while you were an inpatient until the day of your discharge from the hospital.

- Your *new* New Hampshire Medicaid managed care plan must honor a prior authorization in place by NH Healthy Families for 15 calendar days, or until the prior authorization expires, whichever comes first. If you need to continue the service or drug beyond the prior authorization expiration date, contact your new health plan to request continuation of benefits.

Continuity of care after discharge

When you are discharged from inpatient, nursing facility, or institutional care for physical or behavioral health disorders, or discharged from a substance use disorder treatment program, transitional care shall be:

- Readily available and delivered in accordance with your discharge plan, or as order by your primary care or specialty care provider.

- Clinical assessment and care planning from a primary or specialty provider shall be available within seven (7) calendar days of discharge.

- Home care shall be available with a home care nurse or a licensed counselor within two (2) calendar days of discharge, if ordered by your primary care or specialty care provider or as part of your discharge plan.

When discharged from NH Hospital, NH Healthy Families will ensure:

- An appointment with a community mental health program or other appropriate mental health clinician is scheduled for you within seven (7) calendar days after discharge;

- If you are a new Community Mental Health Center client, an intake appointment is scheduled for you within seven (7) calendar days; and

- Homeless members shall be discharged to an appropriate living situation.

Continuity of care for pregnancy

If, at the time of enrollment into NH Healthy Families, you are transferring from the New Hampshire Medicaid Fee-for-Service program or another Medicaid managed care health plan, and are currently receiving services from provider who is not in the NH Healthy Families network:

- If in your first trimester of your pregnancy at the time of your enrollment in NH Healthy Families, you may continue your covered prenatal services with your out-of-network provider, as applicable, until NH Healthy Families can transfer you to a network provider. The transfer will only occur when it will not be harmful to your health; or

- If in your second or third trimester of pregnancy at the time of your enrollment in NH Healthy Families, you may continue your covered prenatal care services with your out-of-network provider, as applicable, through the postpartum period. (Postpartum or after delivery care includes the first postpartum visit, any additional visits necessary to manage any complications related to delivery, and medical record documentation.)

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:

- NH Healthy Families 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;

- NH Healthy Families must have similar prior authorization requirements and treatment limitations for mental health and substance use disorder benefits as it does for other medical benefits;

- NH Healthy Families must provide you or your provider with the medical necessity criteria used by NH Healthy Families for prior authorization upon either your request or your provider's request;

- NH Healthy Families must not impose aggregate lifetime or annual dollar limits on mental health or substance use disorder benefits;

- Within a reasonable time frame, NH Healthy Families must provide you the reason for any denial of authorization for mental health and/or substance use disorder services; and

- If NH Healthy Families 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 NH Healthy Families 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 NH Healthy Families did not provide 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 NH Healthy Families in order for you to get coverage for the service. If you do not get this authorization, NH Healthy Families 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, *NH Healthy Families* will consider whether the service is medically necessary

NH Healthy Families 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.)

In some cases, NH Healthy Families will review medical necessity after covered services are delivered.

Covered Services that you get must be Medically Necessary. This means getting the right care, at the right place, at the right time. NH Healthy Families uses standard guidelines to check Medical Necessity. NH Healthy Families has policies in place to ensure:

- Decisions are made based on the appropriateness of the care and service, and that health insurance coverage is in place.
- The organization does not reward its Network Providers or their staff to deny coverage, service, or care.
- Financial incentives for decision makers do not encourage decisions that result in denying needed treatment.

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 21years 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.

New Technology

NH Healthy Families evaluates new technology, including medical procedures, drugs and devices, and the new application of existing technology, for coverage determination. The NH Healthy Families medical director and/or medical management staff may periodically identify relevant technological advances for review pertinent to the NH Healthy Families population. The Clinical Policy Committee (CPC) reviews all requests for coverage and makes a determination regarding any benefit changes that are indicated. When a request is received for coverage of new technology that has not been reviewed by the CPC, the NH Healthy Families medical director will review the request and make a one-time determination. This new technology request will then be reviewed at the next regularly scheduled CPC meeting.

Section 6.2 Getting plan authorization for certain services

For certain covered services, you or your provider will need to get approval from the plan before we will agree to cover the service for you. This is called "**prior authorization**." Sometimes the requirement for getting approval in advance helps guide appropriate use of certain services. If you do not get this approval, your service might not be covered by the plan.

When you need care, start with a call to your PCP. Some covered services may require prior authorization. Prior authorization is a review by NH Healthy Families before you get certain services. Prior authorization is needed for services or visits to an out of network provider and some specialists. Home health services and some surgeries also need to be reviewed. Your doctor can tell you if a service needs prior authorization. To find a list of services that need prior authorization visit our website at www.NHhealthyfamilies.com. You can also call Member Services at 1-866-769-3085 to see if something needs to be reviewed by NH Healthy Families.

Your doctor will give us information about why you need the service. NH Healthy Families will look to see if the service is covered and that it is appropriate. NH Healthy Families clinical staff will make the decision as soon as possible, based on your medical condition. Standard decisions are made within 14 calendar days. If the service is urgent, the decision will be made within three (3) business days. We will let you and your doctor know if the service is approved or denied. If you or your doctor are not happy with the decision you can ask us for a second review. This is called an appeal. See Chapter 10 for more information about appeals.

If there are any major changes to the prior authorization process, we will let you and your doctors know right away.

Self – Referral

You may self-refer for certain covered services. This means, you do not need your PCP to recommend you go see a specific provider. You can choose to see certain providers without checking with your PCP first. It is always a good idea to inform your PCP of any other providers you see so they can have a complete picture of your overall health. Always be sure to see a NH Healthy Families network provider.

If you aren't sure if you need a referral, contact your PCP or Member Services for assistance. Your PCP can also tell you if a service requires a prior authorization.

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

You may choose any doctor, clinic, community health center, hospital, pharmacy or family-planning office in- 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
- Treatment for sexually transmitted infections (STIs)
- Voluntary sterilization, you must be 21 older, mentally competent and you must sign a federal sterilization-consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign and the date of surgery.
- Voluntary hysterectomies are not covered for the sole purpose of sterilization. Services must be deemed medically necessary and a signed Acknowledgement of Sterilization due to Hysterectomy Form (910) is required to be reviewed and signed by both the Member and rendering provider prior to the services being rendered.

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

Section 6.6 Getting a second medical opinion

Members may receive a second opinion from a qualified health care professional within the network, or one may be arranged by NH Healthy Families outside the plan's network at no cost to you.

This means you can talk to a different doctor to get their point of view. Another opinion may help you decide what treatment or service is best for you. Tell your primary care provider (PCP) or call Member Services, if you want a second opinion.

A second opinion:

- Is covered by NH Healthy Families at no cost to you.
- Is available from an in-network provider.
- Is available from an out-of-network provider with prior authorization.
- May lead to additional tests that require prior authorization.
- Will be reviewed by your PCP or specialist, who will help you decide on the best treatment plan.

Chapter 7. Getting covered prescription drugs

Section 7.1 Drug coverage rules and restrictions

The plan's Preferred Drug List (PDL) 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 www.NHhealthyfamilies.com

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.)

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

- A NH Healthy Families 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 NH Healthy Families.
- You fill your prescription at a network pharmacy, unless otherwise allowed, as described in section 7.4, "*Fill your prescriptions at a network pharmacy.*
- Your drug is on the plan's Preferred 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.

To fill your prescription, show your plan membership card at the network pharmacy you choose. 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 when you pick up your prescription, if required. If you don't have your plan membership card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

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

Generally, a "generic" drug works the same as a brand name drug and usually costs less. **In most cases, 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 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

Some drugs have limits or require NH Healthy Families to grant permission before your prescription is covered. This is called a prior authorization. The pharmacist will inform the doctor if a prior authorization is needed. Your doctor can ask NH Healthy Families to cover the prescription if there is a medical reason. We will let you know if we do not grant the request for prior authorization. We will also tell you how you can file an appeal of that decision.

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

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 Preferred 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

If your drug is not on the Preferred 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.
    - In these situations please contact Member Services (phone numbers are printed on the back cover of this handbook) for an override or have your pharmacist contact the pharmacy help desk phone number (located on the back of you Member ID Card) to get the override.
- 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. If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact Member Services to learn what you or your provider would need to do to get coverage for the drug.
- 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

The plan has a Preferred Drug List (PDL) 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 by the plan with help from a team of doctors and pharmacists. The NH Healthy Families List of Covered Drugs is called the Preferred Drug List (PDL).

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.

What is *not* on the Preferred Drug List

The plan does not cover all prescription drugs. NH Healthy Families chooses which drugs to cover and Medicaid law prohibits coverage of some drugs.

How to find out if a specific drug is on the Preferred Drug List

You may find out if a particular drug is on the Preferred Drug List by:

- Visiting the plan's website (www.NHhealthyfamilies.com). The Preferred 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 NH Healthy Families Preferred 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 Preferred Drug List. (Phone numbers for Member Services are printed on the back cover of this handbook.)

Over-the-Counter Drugs

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 Preferred Drug List can change during the enrollment year

During the enrollment year, the plan may make changes to the Drug List. For example, the plan might:

- **Add or remove drugs from the Preferred Drug List**. For example, NH Healthy Families may add new generic or brand name drugs as they become available. NH Healthy Families may remove a drug from the Preferred 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 Preferred 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.

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**, 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 www.NHhealthyfamilies.com 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

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.

NH Healthy Families will not cover drugs in the following situations:

- You are *eligible* for Medicare and Medicare Part D, whether you are enrolled or not. NH Healthy Families will not cover drugs covered by Medicare Parts A, B, or D if you are eligible for Medicare coverage.
- 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

You may go to any of our network pharmacies. To find a network pharmacy, you can look in your Provider Directory, visit our website (*www.NHhealthyfamilies.com)*, or call Member Services (phone numbers are printed on the back cover of this handbook).

If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask 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).

What if you need a specialized pharmacy

Sometimes prescriptions must be filled at a specialized network pharmacy. Specialized pharmacies include pharmacies that supply drugs for home infusion therapy. Other specialty pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. If you are in a LTC facility, we must ensure that you are able to routinely receive your benefits through our network of LTC pharmacies, which is typically the pharmacy that the LTC facility uses. If you have any difficulty accessing your benefits in a LTC facility, please contact Member Services.

To locate a specialized network pharmacy, look in your Provider Directory on our website www.NHhealthyfamilies.com or call Member Services (phone numbers are printed on the back cover of this handbook).

When you may use an out-of-network pharmacy

In emergencies when no in-network pharmacy is available, you may contact Member Services (phone numbers are printed on the back cover of this handbook) for an override to fill your prescription at an out-of-network pharmacy. The pharmacy may have to contact the pharmacy help desk phone number (located on the back of your membership card) in order to obtain this override.

How you can get an emergency supply of your medication

In emergencies when you are unable to receive your medication due to the need for prior authorization, your pharmacy may contact the Pharmacy Help Desk at 888-613-7051 for an override to fill up to a 72-hour emergency supply of your medication in most circumstances. The pharmacy help desk phone number is located on the back of your membership card.

How to get a temporary supply of your medication

In certain circumstances, you can get a temporary supply of your medication, such as when you go on vacation or your medication is lost. Limitations may apply. In these situations please contact Member Services (phone numbers are printed on the back cover of this handbook) for an override or have your pharmacy contact the pharmacy help desk phone number (located on the back of your membership card) to get the override.

For lost medication overrides please contact Member Services (phone numbers are printed on the back cover of this handbook) for an override or have the pharmacy contact the pharmacy help desk phone number (located on the back of your membership card) in order to obtain this override. NH Healthy Families may require proof of loss in certain circumstances such as stolen medication in the form of a police report.

Using the plan's mail-order services

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.

To get information about filling your prescriptions by mail please contact Member Services (phone numbers are printed on the back cover of this handbook).

Usually a mail-order pharmacy order will get to you in no more than two business days. If your medication delivery will not arrive in time for your treatment, please call Member Services (phone numbers are printed on the back cover of this handbook). Member Services will assist you by helping to get your medication from a different pharmacy.

The pharmacy will contact you each time it refills your medication or 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 it is billed and 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 ensure the pharmacy can reach you to confirm your order before shipping, make sure to let the pharmacy know the best ways to contact you by calling Member Services (phone numbers are printed on the back cover of this handbook).

To opt out of automatic deliveries of new prescriptions received directly from your health care provider's office, please contact the plan by calling Member Services.

It is important that you tell the pharmacy the best ways to contact you.

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 *Provider Directory* by viewing it online or calling member services 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

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.

In 2018, prescription drug copayments are:

- $1 copayment for each preferred prescription drug, 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 by the plan with help from a team of doctors and pharmacists. The NH Healthy Families List of Covered Drugs is called "Preferred Drug List (PDL)."
- $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). NH Healthy Families Incorporates a Preferred Drug List. A notation of 'Non-Formulary' corresponds to drugs identified on the NH Healthy Families PDL indicating the trial and failure of preferred alternatives. The number of preferred drugs that must be tried prior to approval of non-formulary drugs varies by therapeutic drug class. To request approval of a non-formulary drug please submit rational via prior authorization request form to Envolve Pharmacy Solutions (fax 1-866-399-0929.)
- $1 copayment for a prescription drug that is not identified as either a preferred or non-preferred prescription drug.
- Copayments are not required for family planning products or for Clozaril® (Clozapine) prescriptions.

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.

You may be eligible for copayment reimbursement

NH DHHS offers eligible members copayment reimbursement. The information in this section applies to you only if:

- You are required to pay prescription drug copayments; and
- You want to seek reimbursement for copayments your household may have overpaid.

To learn whether you are required to pay prescription drug copayments in our plan, refer to Section 7.7 (*Prescription drug copayments: Members who are exempt from copayments).*

What you need to know if you are responsible for copayments and want to seek reimbursement from NH DHHS for any overpayments you may have made:

- You are only responsible for copayments up to a maximum household dollar amount per calendar quarter based on household income as reported during your New Hampshire Medicaid eligibility process.
- For the 12-month period beginning January 1, 2018, the maximum dollar amount for a household size of one (1) person is the lesser of $150.75 or 5 percent (5%) of household income per calendar quarter. The maximum dollar amount varies by household size. Copayments you and your family members pay under and NH Healthy Families apply to your household maximum dollar amount.
- Once you and other members of your household pay the maximum dollar amount in a calendar quarter, you are not responsible for any more copayments for the remainder of that quarter.
- You and other members of your household will be required to pay copayments at the start of each new quarter until the maximum dollar amount is met for the quarter.
- If you want to collect reimbursement for any overpayments you and other members of your household have made, you must provide proof of all your paid copayments for each quarter and submit detailed information regarding each copayment transaction to NH DHHS.

If you want more information, including what you need to submit for reimbursement purposes, 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.

  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.

How and where to send us your request for payment

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 (www.NHhealthyfamilies.com) 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 us your request for payment, along with your bill and documentation of any payment you have made. It is a good idea to make a copy of your bill and receipts for your records.

Send payment requests to:

NH Healthy Families
Attn: Member Services
2 Executive Park Drive
Bedford, NH 03110

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

NH Healthy Families 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

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 receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
- You have the right to make complaints or appeals about the organization or the care provided, and to ask us to reconsider decisions that have been made.
- You have the right to make recommendations regarding the organization's member rights and responsibilities policy.
- 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.

- 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 thirty (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*).
- You have a right to a candid discussion about treatment options, regardless of cost or benefit coverage.
- In the case of a counseling or referral service that we do not cover because of moral or religious objections, we must inform you that the service is not covered and how you can obtain information on how to access this service.
- You are free to exercise your rights, and the plan shall assure that the exercise of those rights shall not adversely affect the way plan and its providers or DHHS treat you.
- Information provided by us will reflect changes in State law as soon as possible, but no later than ninety (90) calendar days after the effective date of the change;

Section 9.2 Your responsibilities

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).

- You have the responsibility to give NH Healthy Families practitioners and providers complete and accurate information.
- You have the responsibility to follow plans and instructions that for treatment that were agreed upon.
- You have the responsibility to understand your health problems and to participate in developing mutually agreed upon treatment goals with your provider to the highest degree possible.

- **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 NH Healthy Families, 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 NH Healthy Families 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.

- 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 are 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 NH Healthy Families 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:

- 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 NH Healthy Families, 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 NH Healthy Families 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 NH Healthy Families 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 NH Healthy Families makes a coverage decision or takes an action that you disagree with, you may file an appeal. If NH Healthy Families 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 a verbal denial, you should request a written denial notice from the plan and appeal after receiving the verbal 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 NH Healthy Families 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 NH Healthy Families.

  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 NH Healthy Families 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:

  NH Healthy Families
  Attn: Grievances and Appeals
  2 Executive Park Drive
  Bedford, NH 03110
  Fax Number: 1-866-270-9943

- **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 NH Healthy Families 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.
- NH Healthy Families 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, NH Healthy Families 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. 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 NH Healthy Families reverses its decision to deny, reduce, limit, suspend, or end services that were not provided while the appeal was pending, NH Healthy Families 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 NH Healthy Families, 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 NH Healthy Families. 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 NH Healthy Families 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.**
- In your signed, 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:

  NH Healthy Families
  Attn: Grievances and Appeals
  2 Executive Park Drive
  Bedford, NH 03110
  Fax Number: 1-866-270-9943

- **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 NH Healthy Families 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 NH Healthy Families 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, NH Healthy Families 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 verbal 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 NH Healthy Families **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 NH Healthy Families **denies** your request for an expedited appeal, the plan must make reasonable efforts to give you prompt verbal 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 NH Healthy Families if the plan denies your request for an expedited appeal.** If the plan denies your request for an expedited appeal, NH Healthy Families will treat your appeal as part of the standard appeal process.
- **If NH Healthy Families reverses its decision to deny, reduce, limit, suspend, or end services that were not provided while the appeal was pending, NH Healthy Families 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 NH Healthy Families, 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 NH Healthy Families, 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 NH Healthy Families 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 NH Healthy Families 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 <u>in writing</u> 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 NH Healthy Families 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 verbal 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 NH Healthy Families 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)
o **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** o The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; and o The service was ordered by an authorized provider; and o The original authorization period for the service has not expired.	o **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** If you did not request continuation of benefits during your first level appeal with the plan, the following conditions also apply: o The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; and o The service was ordered by an authorized provider; and o The original authorization period for the

	service has not expired.

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

NH Healthy Families
2 Executive Park Drive
Bedford NH, 03110
Attention: Grievance and Appeals
Fax Number: 866-270-9943

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

For standard and expedited plan appeals (first level appeal)	For standard and expedited State Fair Hearing appeals (second level appeal)
o You withdraw your plan appeal, in writing; or o The plan's first level appeal decision results in an unfavorable decision for you; or o 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.	o You withdraw your State Fair Hearing appeal request, in writing; or o 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 o 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 NH Healthy Families 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 NH Healthy Families. 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:

- **NH Healthy Families 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. 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?** This generally happens November 1 through December 31 each year (dates may vary). NH DHHS will mail you information to remind you about the Annual Open Enrollment Period. The notice will provide instructions on how to switch health plans if you choose to do so.
    - **When will your membership end?** If you switch health plans during the Annual Open Enrollment Period, your membership will end on December 31. The effective date for your new plan coverage will be January 1 the following year. For information on care transitions between plans, refer to Section 5.3 (*Continuity 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 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 has established out of state residence;
- When a member is ineligible for enrollment in the plan as established by NH DHHS;
- 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, or 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.

NH Healthy Families 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.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective 07.01.2017

For help to translate or understand this, please call 1-866-769-3085.
Hearing impaired TTY 1-855-742-0123.

Si necesita ayuda para traducir o entender este texto, por favor llame al telefono.
1-866-769-3085. (TTY 1-855-742-0123).

Interpreter services are provided free of charge to you.

Covered Entities Duties:

NH Healthy Families is a Covered Entity as defined and regulated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). NH Healthy Families is required by law to maintain the privacy of your protected health information (PHI), provide you with this Notice of our legal duties and privacy practices related to your PHI, abide by the terms of the Notice that is currently in affect and notify you in the event of a breach of your unsecured PHI.

This Notice describes how we may use and disclose your PHI. It also describes your rights to access, amend and manage your PHI and how to exercise those rights. All other uses and disclosures of your PHI not described in this Notice will be made only with your written authorization.
NH Healthy Families reserves the right to change this Notice. We reserve the right to make the revised or changed Notice effective for your PHI we already have as well as any of your PHI we receive in the future. NH Healthy Families will promptly revise and distribute this Notice whenever there is a material change to the following:

- The Uses or Disclosures
- Your rights
- Our legal duties
- Other privacy practices stated in the notice

We will make any revised notices available on our website and through newsletter notifications.

Protecting Oral, Written and Electronic Personal Health Information (PHI)

NH Healthy Families protects your PHI. We have privacy and security processes to help. These are some of the ways we protect your PHI:

- We train our staff to follow our privacy and security processes.
- We require our business associates to follow privacy and security processes.
- We keep our offices secure.
- We talk about your PHI only for a business reason with people who need to know.
- We keep your PHI secure when we send it or store it electronically.
- We use technology to keep the wrong people from accessing your PHI.

Permissible Uses and Disclosures of Your PHI:

The following is a list of how we may use or disclose your PHI without your permission or authorization:

- ***Treatment*** - We may use or disclose your PHI to a physician or other health care provider providing treatment to you, to coordinate your treatment among providers, or to assist us in making prior authorization decisions related to your benefits.
- ***Payment*** - We may use and disclose your PHI to make benefit payments for the health care services provided to you. We may disclose your PHI to another health plan, to a health care provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include:
    - processing claims
    - determining eligibility or coverage for claims
    - issuing premium billings
    - reviewing services for medical necessity
    - performing utilization review of claims

- ***HealthCare Operations*** - We may use and disclose your PHI to perform our healthcare operations. These activities may include:
    - providing customer services
    - responding to complaints and appeals
    - providing case management and care coordination
    - conducting medical review of claims and other quality assessment
    - improvement activities

In our healthcare operations, we may disclose PHI to business associates. We will have written agreements to protect the privacy of your PHI with these associates. We may disclose your PHI to another entity that is subject to the federal Privacy Rules. The entity must also have a relationship with you for its healthcare operations. This includes the following:

- quality assessment and improvement activities
- reviewing the competence or qualifications of healthcare professionals
- case management and care coordination
- detecting or preventing healthcare fraud and abuse.

- ***Group Health Plan/Plan Sponsor Disclosures*** – We may disclose your protected health information to a sponsor of the group health plan, such as an employer or other entity that is providing a health care program to you, if the sponsor has agreed to certain restrictions on how it will use or disclose the protected health information (such as agreeing not to use the protected health information for employment-related actions or decisions).

Other Permitted or Required Disclosures of Your PHI:

- ***Fundraising Activities*** – We may use or disclose your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance their activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out, or stop, receiving such communications in the future.
- ***Underwriting Purposes*** – We may use or disclosure your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are prohibited from using or disclosing your PHI that is genetic information in the underwriting process.
- ***Appointment Reminders/Treatment Alternatives*** - We may use and disclose your PHI to remind you of an appointment for treatment and medical care with us or to provide you with information regarding treatment alternatives or other health-related benefits and services, such as information on how to stop smoking or lose.
- ***As Required by Law*** - If federal, state, and/or local law requires a use or disclosure of your PHI, we may use or disclose your PHI information to the extent that the use or disclosure complies with such law and is limited to the requirements of such law. If two or more laws or regulations governing the same use or disclosure conflict, we will comply with the more restrictive laws or regulations.
- ***Public Health Activities*** - We may disclose your PHI to a public health authority for the purpose of preventing or controlling disease, injury, or disability. We may disclosure your PHI to the Food and Drug Administration (FDA) to ensure the quality, safety or effectiveness products or services under the jurisdiction of the FDA.
- •***Victims of Abuse and Neglect*** - We may disclose your PHI to a local, state, or federal government authority, including social services or a protective services agency authorized by law authorized by law to receive such reports if we have a reasonable belief of abuse, neglect or domestic violence.
- ***Judicial and Administrative Proceedings*** - We may disclose your PHI in judicial and administrative proceedings. We may also disclose it in response to the following:
    - an order of a court
    - administrative tribunal
    - subpoena
    - summons
    - warrant
    - discovery request
    - similar legal request.

- ***Law Enforcement*** - We may disclose your relevant PHI to law enforcement when required to do so. For example, in response to a:
    - court order
    - court-ordered warrant
    - subpoena
    - summons issued by a judicial officer
    - grand jury subpoena

We may also disclose your relevant PHI to identify or locate a suspect, fugitive, material witness, or missing person.

- ***Coroners, Medical Examiners and Funeral Directors*** - We may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your PHI to funeral directors, as necessary, to carry out their duties.
- ***Organ, Eye and Tissue Donation*** - may disclose your PHI to organ procurement organizations. We may also disclose your PHI to those who work in procurement, banking or transplantation of:
    - cadaveric organs
    - eyes
    - tissues
- ***Threats to Health and Safety*** – We may use or disclose your PHI if we believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.
- ***Specialized Government Functions*** – if you are a member of the U.S. Armed Forces, we may disclose your PHI as required by military command authorities. We may also disclose your PHI:
    - to authorized federal officials for national security
    - to intelligence activities
    - the Department of State for medical suitability determinations
    - for protective services of the President or other authorized persons
- ***Worker's Compensation*** - We may disclose your PHI to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.
- ***Emergency Situations*** – We may disclose your PHI in an emergency situation, or if you are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previous identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interests. If the disclosure is in your best interest, we will only disclose the PHI that is directly relevant to the person's involvement in your care.
- ***Inmates*** - If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official, where such information is necessary for the institution to provide

you with health care; to protect your health or safety; or the health or safety of others; or for the safety and security of the correctional institution.

- ***Research*** - Under certain circumstances, we may disclose your PHI to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection of your PHI

Verbal Agreement to Uses and Disclosure of Your PHI— We can take your verbal agreement to use and disclose your PHI to other people. This includes family members, close, personal friends or any other person you identify. You may object to the use or disclosure of your PHI at the time of the request. You can give us your verbal agreement or objection in advance. You may also give it to us at the time of the use or disclosure. We will limit the use or disclosure of your PHI in these cases. We limit the information to what is directly relevant to that person's involvement in your health care treatment or payment. We can take your verbal agreement or objection to use and disclose your PHI in a disaster situation. We can give it to an authorized disaster relief entity. We will limit the use or disclosure of your PHI in these cases. It will be limited to notifying a family member, personal representative or other person responsible for your care of your location and general condition. You can give us your verbal agreement or objection in advance. You can also give it to us at the time of the use or disclosure of your PHI.

Uses and Disclosures of Your PHI That Require Your Written Authorization

We are required to obtain your written authorization to use or disclose your PHI, with limited exceptions, for the following reasons:

Sale of PHI – We will request your written authorization before we make any disclosure that is deemed a sale of your PHI, meaning that we are receiving compensation for disclosing the PHI in this manner.

Marketing – We will request your written authorization to use or disclose your PHI for marketing purposed with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.

Psychotherapy Notes – We will request your written authorization to use or disclose any of you psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment or healthcare operation functions.

Individuals Rights

The following are your rights concerning your PHI. If you would like to use any of the following rights, please contact us using the information at the end of this Notice.

- ***Right to Revoke an Authorization*** - You may revoke your authorization at any time; the revocation of your authorization must be in writing. The revocation will be effective immediately, except to the extent that we have already taken actions in reliance of the authorization and before we received your written revocation.

- ***Right to Request Restrictions*** **-** You have the right to request restrictions on the use and disclosure of your PHI for treatment, payment or healthcare operations, as well as disclosures to persons involved in your care or payment of your care, such as family members or close friends. Your request should state the restrictions you are requesting and state to whom the restriction applies. We are not required to agree to this request. If we agree, we will comply with your restriction request unless the information is needed to provide you with emergency treatment. However, we will restrict the use or disclosure of PHI for payment or health care operations to a health plan when you have paid for the service or item out of pocket in full.
- ***Right to Request Confidential Communications*** **-** You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. This right only applies if the information could endanger you if it is not communicated by the alternative means or to the alternative location you want. You do not have to explain the reason is for your request, but you must state that the information could endanger you if the communication means or location is not changed. We must accommodate your request if it is reasonable and specifies the alternative means or location where you PHI should be delivered.
- ***Right to Access and Received Copy of your PHI*** **-** You have the right, with limited exceptions, to look at or get copies of your PHI contained in a designated record set. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so**.** You must make a request in writing to obtain access to your PHI. If we deny your request, we will provide you a written explanation and will tell you if the reasons for the denial can be reviewed and how to ask for such a review or if the denial cannot be reviewed.
- ***Right to Amend your PHI*** **-** You have the right to request that we amend, or change, your PHI if you believe it contains incorrect information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request for certain reasons, for example if we did not create the information you want amended and the creator of the PHI is able to perform the amendment. If we deny your request, we will provide you a written explanation. You may respond with a statement that you disagree with our decision and we will attach your statement to the PHI you request that we amend. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.
- ***Right to Receive an Accounting of Disclosures*** **-** You have the right to receive a list of instances within the last 6 years period in which we or our business associates disclosed your PHI. This does not apply to disclosure for purposes of treatment, payment, health care operations, or disclosures you authorized and certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will provide you with more information on our fees at the time of your request.
- ***Right to File a Complaint*** **-** If you feel your privacy rights have been violated or that we have violated our own privacy practices, you can file a complaint with us in writing or by phone using the contact information at the end of this Notice.

You can also file a complaint with the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201 or calling 1-800-368-1019, (TTY: 1-866-788-4989) or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

WE WILL NOT TAKE ANY ACTION AGAINST YOU FOR FILING A COMPLAINT.

- ***Right to Receive a Copy of this Notice*** - You may request a copy of our Notice at any time by using the contact information list at the end of the Notice. If you receive this Notice on our web site or by electronic mail (e-mail), you are also entitled to request a paper copy of the Notice.

Contact Information

If you have any questions about this Notice, our privacy practices related to your PHI or how to exercise your rights you can contact us in writing or by phone using the contact information listed below.

NH Healthy Families
Attn: Privacy Official
2 Executive Park Drive
Bedford, NH 03110
1-866-769-3085
(TDD/TTY 1-855-742-0123)

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 does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

NH Healthy Families:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters

- Information written in other languages

If you need these services, contact NH Healthy Families at 1-866-769-3085 (TDD/TTY 1-855-742-0123.)
If you believe that NH Healthy Families has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Grievances and Appeals Coordinator, NH Healthy Families, 2 Executive Park Drive, Bedford, NH 03110,1-866-769-3085 (TDD/TTY 1-855-742-0123), Fax 1-866-270-9943

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, NH Healthy Families is available to help you. You may also file a discrimination complaint through the DHHS Office of the Ombudsman who has been designated to coordinate the efforts of NH DHHS's civil rights compliance for the Department: State of New Hampshire, Department of Health and Human Services, Office of the Ombudsman, 129 Pleasant Street, Concord, NH 03301-3857; (603) 271-6941 or (800) 852-3345 ext. 6941, FAX (603) 271-4632, TDD Access: relay NH 1-800-735-2964; E-mail: ombudsman@dhhs.nh.gov.
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, Complaint forms are available at https://www.ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Other Languages Available

Spanish: Si usted, o alguien a quien está ayudando, tiene preguntas acerca de NH Healthy Families, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-866-769-3085 TTD/TTY 1-855-742-0123

French: Si vous-même ou une personne que vous aidez avez des questions à propos NH Healthy Families, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-866-769-3085 TTD/TTY 1-855-742-0123

Chinese: 如果您，或是您正在協助的對象，有關於 NH Healthy Families 方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 1-866-769-3085 TTD/TTY 1-855-742-0123

Nepali: यिद तपार् ं वा तपार् ंले मद्दत गरिरि्हनुभएको कोही व्यक्ततसँग NH Healthy Families सम्बन्धी कुनै पर्शन् हरु भएको ख ड् मा तपार् ंहरुसँग आ ंनै भाषामा न नन शुल्क मद्दत ि जानकाि ंी पर्ाप्त गने अधधकाि छ। ि ंोभाषेसँग कुि ंा गननका लाधग 1-866-769-3085 TTD/TTY 1-855-742-0123 नम्बिमा कल गनुनहोस्।

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về NH Healthy Families, quý vị sẽ có quyền

được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-866-769-3085 TTD/TTY 1-855-742-0123

Portuguese: Se você, ou alguém a quem você está ajudando, tem perguntas sobre o NH Healthy Families, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-866-769-3085 TTD/TTY 1-855-742-0123

Greek: Εάν εσείς ή κάποιος που βοηθάτε, έχετε ερωτήσεις σχετικά με την NH Healthy Families, έχετε το δικαίωμα να ζητήσετε βοήθεια και πληροφορίες στη γλώσσα σας, χωρίς χρέωση. Για να μιλήσετε με διερμηνέα, καλέστε το 1-866-769-3085 TTD/TTY 1-855-742-0123

Arabic: لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية NH Healthy Families إذا كان لديك أو لدى شخص تساعده أسئلة حول 1-866-769-3085 TTD/TTY 1-855-742- تكلفة. لتتحدث مع مترجم اتصل ب 0123

Serbo-Croatian: Ako Vi, ili neko kome pomažete, imate pitanja u vezi NH Healthy Families, imate pravo na besplatnu pomoć i informaciju na sopstvenom jeziku. Ukoliko želite da pričate sa prevodiocem, pozovite broj 1-866-769-3085 TTD/TTY 1-855-742-0123

Indonesian: Jika Anda, atau orang yang Anda bantu, memiliki pertanyaan tentang NH Healthy Families, Anda berhak mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk berbicara

dengan juru bicara, hubungi 1-866-769-3085 TTD/TTY 1-855-742-0123

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 NH Healthy Families 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-866-769-3085 TTD/TTY 1-855-742-0123 로 전화하십시오.

Russian: В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования NH Healthy Families вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-866-769-3085 TTD/TTY 1-855-742-0123

French Creole: Si oumenm, oubyen yon moun w ap ede, gen kesyon nou ta renmen poze sou NH Healthy Families, ou gen tout dwa pou w jwenn èd ak enfòmasyon nan lang manman w san sa pa koute w anyen. Pou w pale avèk yon entèprèt, sonnen nimewo 1-866-769-3085 TTD/TTY 1-855-742-0123

Bantu: Niba wowe cyangwa undi muntu wese uri gufasha yaba afite ikibazo kijyanye na NH Healthy Families, ufite uburenganzira bwo guhabwa amakuru mu rurimi wunva utishyuye. Kugira ngo uvugane n'umusobanuzi, Hamagara 1-866-769-3085 TTD/TTY 1-855-742-0123

Polish: Jeżeli ty lub osoba, której pomagasz, macie pytania na temat planów oferowanych za pośrednictwem NH Healthy Families, macie prawo poprosić o bezpłatną pomoc i informacje w języku ojczystym. Aby skorzystać z pomocy tłumacza, zadzwoń pod numer 1-866-769-3085 TTD/TTY 1-855-742-0123

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

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.

Granite Advantage – Beginning January 1, 2019, Granite Advantage replaces the New Hampshire Health Protection Program (NHHPP) for eligible members. Impacted individuals will

receive health insurance through the New Hampshire Medicaid Care Management program. The State contracts with Medicaid managed care plans to provide health insurance coverage for Granite Advantage members. Granite Advantage requires community engagement for members between the ages of 19-64, unless otherwise exempted, to maintain health insurance coverage. Community engagement requires that a person work, volunteer, or be engaged in other qualifying activities for continued eligibility and health insurance coverage.

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.

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 – A non-preferred drug is a drug which does not appear on the Preferred Drug List (PDL).

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* NH Healthy Families *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 List – The drugs on this list include both generic and brand name drugs carefully selected by the plan with help from a team of doctors and pharmacists. The NH Healthy Families' List of Covered Drugs is called the "Preferred Drug List" (PDL).

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 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. The service area for NH Healthy Families 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*).

NH Healthy Families Member Services

Method	Member Services – Contact Information
CALL	1-866-769-3085 Calls to this number are toll-free. Normal business hours are Monday-Wednesday 8am to 8pm and Thursday and Friday 8am to 5pm Member Services also has free language interpreter services available for non-English speakers.
TTY/TDD	1-855-742-0123 Relay 711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.] Calls to this number are free.
FAX	1-877-502-7255
WRITE	NH Healthy Families 2 Executive park Drive Bedford, NH 03110
WEBSITE	www.NHhealthyfamilies.com