

Member Handbook

Effective January 1, 2025

New Hampshire Medicaid Care Management Program



Multilanguage Interpreter Services

Important! This is about your WellSense Health Plan benefits. We can translate it for you free of charge. Please call **877-957-1300 (TTY: 711)** for translation help.

¡Importante! Esta información es sobre sus beneficios de WellSense Health Plan. Podemos traducirlo para usted de forma gratuita. Llame al **877-957-1300 (TTY: 711)** para obtener ayuda de traducción. (ESA)

Important! Cela concerne vos prestations WellSense Health Plan. Nous pouvons traduire ce contenu gratuitement pour vous. Veuillez appeler le **877-957-1300 (TTY: 711)** pour obtenir de l'aide concernant la traduction. (FRC)

重要提示！此信息与您的 WellSense Health Plan 福利有关，我们可免费提供翻译。如需获得翻译服务，请拨打 **877-957-1300 (TTY: 711)**。(CHS)

هامة! هذا حول مزايا WellSense Health Plan الخاصة بك. يمكننا ترجمتها لك مجاناً. يرجى الاتصال
بـ **877-957-1300 (TTY: 711)** للمساعدة في الترجمة. (ARA)

Wichtig! In diesem Dokument geht es um Ihre WellSense Health Plan-Vorteile. Wir können es kostenlos für Sie übersetzen. Bitte rufen Sie uns unter **877-957-1300 (TTY: 711)** an, um Übersetzungshilfe zu erhalten. (DEU)

Importante! Esta comunicação é sobre os benefícios da WellSense Health Plan. Podemos traduzir para você gratuitamente. Ligue para **877-957-1300 (TTY: 711)** para obter ajuda com a tradução. (PTB)

Σημαντικό! Πρόκειται για τις παροχές του WellSense Health Plan. Μπορούμε να σας το μεταφράσουμε δωρεάν. Καλέστε στο **877-957-1300 (TTY: 711)** για βοήθεια σχετικά με τη μετάφραση. (ELG)

Важно! Здесь содержится информация о преимуществах вашего медицинского страхового плана WellSense Health Plan. Мы можем перевести для вас этот документ бесплатно. За помощью в переводе позвоните по телефону **877-957-1300 (TTY: 711)**. (RUS)

Quan trọng! Đây là thông tin về quyền lợi trong WellSense Health Plan của quý vị. Chúng tôi có thể dịch thông tin này miễn phí cho quý vị. Vui lòng gọi số **877-957-1300 (TTY: 711)** để được trợ giúp dịch thuật. (VIT)

ముఖ్యమైనది! ఇది మీ WellSense Health Plan ప్రయోజనాల గురించి.
మేము దానిని మీ కోసం ఉచితంగా అనువదించగలము. అనువాద సహాయం
కోసం దయచేసి **877-957-1300 (TTY: 711)** కు కాల్ చేయండి. (TELG)

중요! 이것은 WellSense Health Plan 혜택에 대한 내용입니다. 무료로 번역해 드릴 수 있습니다. 번역 도움이 필요하면 **877-957-1300 (TTY: 711)**번으로 문의하십시오. (KOR)

Enpotan! Sa a se sou avantaj WellSense Health Plan ou an. Nou ka tradui li pou ou gratis. Tanpri relel **877-957-1300 (TTY: 711)** pou jwenn èd ak tradiksyon. (HRV)

Ważne! To dotyczy Twoich świadczeń w ramach planu zdrowotnego WellSense Health Plan. Możemy nieodpłatnie przetłumaczyć dla Ciebie te informacje. Zadzwoń pod numer **877-957-1300 (TTY: 711)**, aby uzyskać pomoc w tłumaczeniu. (POL)

Important! This material can be requested in an accessible format by calling 877-957-1300 (TTY: 711).

Notice About Nondiscrimination and Accessibility

WellSense Health Plan complies with applicable federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, sex, gender identity, sexual orientation, limited English proficiency, primary language, or moral or religious grounds (including limiting or not providing coverage for counseling or referral services). WellSense Health Plan provides:

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

Please contact WellSense if you need any of the services listed above and we will provide them in a timely manner. You can also find this information at the bottom of wellsense.org in the Nondiscrimination Section.

Civil Rights Coordinator
100 City Square, Suite 200
Charlestown, MA 02129
Phone: 877-957-1300 (TTY: 711)
Fax: 617-897-0805

You can also file a civil rights complaint with the U.S. DHHS, Office for Civil Rights by mail, by phone or online at:

U.S. Dept. of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019 (TDD: 800-537-7697)

Complaint Portal:
hhs.gov/ocr/office/file/index.html

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Chapter 1: Getting started as a member

Section 1.1 Welcome

You are enrolled in WellSense Health Plan.

You will get most of your New Hampshire Medicaid health care and prescription drug coverage through our plan, WellSense Health Plan, 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.

WellSense Health Plan 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 WellSense Health Plan for covered services*).

As a WellSense Health Plan 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.

Your feedback is important to us. Several times each year WellSense Health 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 Service (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 WellSense Health Plan's service area);
- *and* you are a United States citizen or are lawfully present in the United States.

If you are pregnant and enrolled in WellSense Health Plan when you deliver your baby, your baby is automatically covered by WellSense Health Plan 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. Several weeks before your eligibility is up for renewal you will receive a letter in the mail or a NH Easy email with a Redetermination Application 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 notice. 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

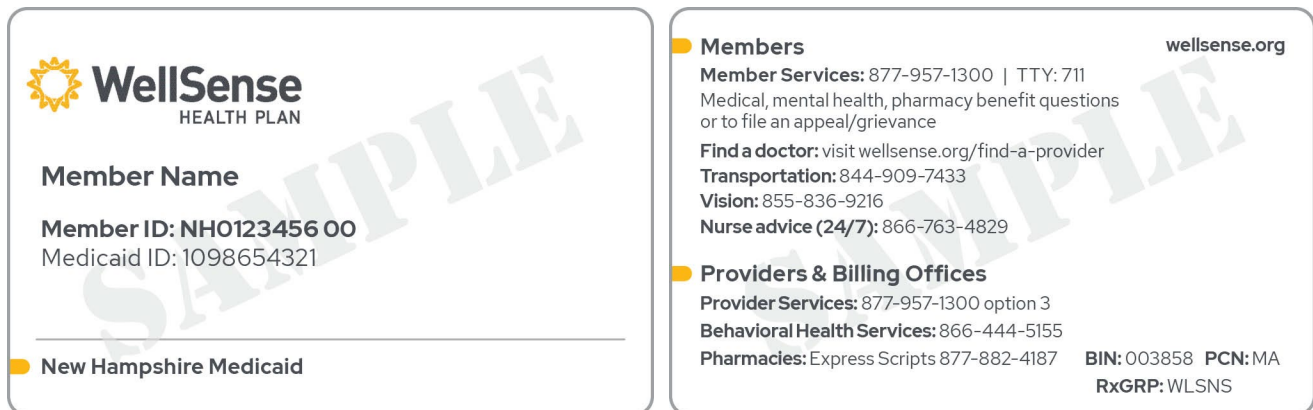
Member Handbook

This *Member Handbook* describes how the plan works and is in effect beginning September 2024 through each month you are enrolled with WellSense Health Plan. The *Member Handbook* is also available on our website at wellsense.org.

Your WellSense Health Plan membership card – Use it to get all covered services and prescription drugs

While you are a member of the plan, you must use your WellSense Health Plan membership card whenever you get covered services or prescription drugs. However, even if you don't have your plan membership card, a provider should never deny care to you. If a provider refuses to treat you, call our Member Service 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 WellSense Health Plan 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 Service right away. We will send you a new card. Or, you may order a new one from our website at wellsense.org. (Phone numbers for Member Service are printed on the back cover of this handbook.)

Welcome Call

When you first join WellSense Health Plan, we will call to welcome you as a plan member. You will also receive a packet of member materials including this *Member Handbook* and other important materials. During the call, we will explain plan rules, your benefits, and translation services, and answer any questions you might have about the plan or its materials. We will also ask you if you have any special healthcare needs for which you require assistance. As described in the next section, we will explain the importance of completing a Health Risk Assessment (HRA) with your Primary Care Physician (PCP). If we can't reach you, please call our Member Service department and a representative will be happy to speak with you. (Phone numbers are printed in the back of this handbook.)

Health Risk Assessment (HRA)

NH DHHS requires us to ask you to complete a Health Risk Assessment (HRA) for review with your PCP. The HRA collects information about your health (including medical, behavioral health, and other health needs) that we use to give you better care. The information you provide in the HRA helps your PCP plan and work with you to meet your health care and functional needs. The HRA will be completed once annually or when your needs change significantly. Based on the answers, your PCP may refer you to programs to help improve your health.

Your PCP has access to HRA forms and WellSense HRA forms are available online in the member self-service section at wellsense.org or by contacting Member Service. Completing the HRA with your PCP and reviewing the results together will help them create a custom **Care Plan** that includes your goals to help you stay healthy.

Filling out the HRA does not affect your eligibility or your health benefits in any way. So, please complete your HRA. Please know that WellSense and your PCP we will keep your health information (Protected Health Information, or "PHI") confidential as required by law.

Explanation of Benefits Notice

From time to time, we will send you a report called the Explanation of Benefits (EOB). This is a statement after you receive medical services that explains what was covered and what you might owe.

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

Member personal health information is kept private

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

Section 1.5 How other insurance works with our plan

Which plan pays first when you have other insurance

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 WellSense Health Plan. 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 WellSense Health Plan. If you receive a bill for your covered health care services, refer to Chapter 9 (*Asking us to pay*).

If the service is not covered or is denied by your other insurance and the service is covered by Medicaid, prior authorization may be needed for WellSense Health Plan to cover the service. For a description of services that require prior authorization, refer to Chapter 4 (Benefits Chart).

Who pays if another person or party is or may be responsible for your injury (Subrogation)

If another person or party injures you, WellSense Health Plan will go through a process called "subrogation." This means that we may use your assignment of legal rights as a condition of your Medicaid application, to recover money expended by us for your medical services from:

- The person(s) who caused your injury; or
- An insurance company or other responsible party.

If another person or party is or may be responsible to pay for services related to your injury, we will use your assignment of legal rights to recover the full amount of money we have paid or will pay for the health care services for your injury. Under no circumstance will you be required to pay for your medical services directly.

To carry out these rights, we may take legal action, with or without your consent, against any responsible party to pay back the money we paid for your treatment. Our subrogation rights apply even if the injured Member is under 18 years old. If another party pays you directly for any medical expenses that we paid for, we have the right to get back from you the full amount we paid for your treatment.

If you have other coverage available because of an accidental injury (such as an auto accident), call Member Service as soon as possible (Phone numbers are printed on the back cover of this handbook).

If an attorney represents you for your injury, it is your responsibility to inform your attorney that you have Medicaid coverage through WellSense Health Plan. You should also inform any insurance company (whether your insurance or another person's insurance) related to the accidental injury that you have Medicaid coverage through our plan and provide related contact information. In addition, if we receive information from another source that you may have other coverage as the result of an accident, we will mail you an accident questionnaire form. This form will ask for details about your accident and other coverage. You must fill out and return the completed form to us. We may also contact you for details about your accident and other coverage.

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

Member cooperation

As our member, you agree to cooperate with us and New Hampshire Medicaid in exercising our rights under Coordination of Benefits and Subrogation. This means you must complete and sign all necessary forms to help us exercise these rights. This includes any accident questionnaire you may receive from us. We require that you:

- Give us all information and documents we request
- Sign any documents we think are necessary to protect our rights
- Promptly assign us any money that you got for services we paid for when other coverage is available through Coordination of Benefits or Workers' Compensation
- Promptly notify us of any possible Subrogation or benefit coordination potential.

You also agree to do nothing to prejudice or interfere with our rights to benefit coordination. If you are not willing to help us, you may be responsible for paying us for any of our expenses relating to the Coordination of Benefits and Subrogation processes. These expenses may include reasonable attorneys' fees that we pay to enforce our rights. Nothing in this Member Handbook may be interpreted to limit our right to use any legal means to enforce our rights, as listed in this section.

Chapter 2: Important phone numbers and resources

Section 2.1 How to contact WellSense Health Plan Member Service

For assistance during normal business hours with coverage questions, finding a provider, claims, membership cards, or other matters, please call or write to WellSense Health Plan Member Service. We will be happy to help you. If you need assistance after hours please call our Member Service line listed below, this number is also listed on the back of your Plan ID card. When you call this number you will be prompted to select an option to bring you to the topic you are calling about.

In case of a medical emergency – Dial 911 or go directly to the nearest hospital emergency room.

In case of a mental health and/or substance use emergency or crisis – If you or someone you know is in need of emotional or mental health supports/services (or there is a risk of suicide), call, text or chat **988** – the Suicide and Crisis Lifeline 24 hours a day, 7 days a week to connect with a trained crisis counselor. The Lifeline is a national service that provides free and confidential emotional support to people in suicidal crisis or emotional distress.

Or, call or text the toll-free NH Rapid Response Access Point (**1-833-710-6477**) anytime day or night. Crisis response services are available over the phone, by text, or face-to-face through Mobile Crisis Teams who can meet you when and where you need them when needed.

Or, call 211 to connect to your local Doorway for substance misuse supports and services in NH.

For a description of emergency mental health and substance use services, refer to Chapter 4 (*Benefits Chart: Emergency medical care; Outpatient mental health services; Substance use disorder (SUD) treatment services*).

Method	WellSense Health Plan Member Service - Contact Information
Call	<p>877-957-1300</p> <p>Calls to this number are toll-free. Representatives are available Monday through Wednesday, 8:00 a.m. to 8:00 p.m. ET; Thursday through Friday, 8:00 a.m. to 6:00 p.m. ET.</p> <p>Member Service also has free language interpreter services available for non-English speakers. Alternate format materials are also available upon request.</p>

Method		WellSense Health Plan Member Service - Contact Information
TTY/TDD	711	<p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free. Representatives are available Monday through Wednesday, 8:00 a.m. to 8:00 p.m. ET; Thursday through Friday, 8:00 a.m. to 6:00 p.m. ET.</p>
Fax	617-897-0884	
Write		<p><i>Corporate Headquarters:</i> 100 City Square, Suite 200 Charlestown, MA 02129</p> <p><i>Local Office:</i> WellSense Health Plan 1155 Elm Street, 5th floor Manchester, NH 03101</p>
Website		wellsense.org

Section 2.2 How to contact the plan or Carelon Behavioral Health (Carelon) about a coverage decision or to file an appeal

A coverage decision is a decision we or Carelon 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 or Carelon 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	Medical Coverage Decision or Appeals – Contact Information
Call	<p>877-957-1300</p> <p>Calls to this number are toll-free. Representatives are available Monday through Wednesday, 8:00 a.m. to 8:00 p.m. ET; Thursday through Friday, 8:00 a.m. to 6:00 p.m. ET.</p> <p>Member Service also has free language interpreter services available for non-English speakers. Alternate format materials are also available upon request.</p>
TTY/TDD	<p>711</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free. Representatives are available Monday through Wednesday, 8:00 a.m. to 8:00 p.m. ET; Thursday through Friday, 8:00 a.m. to 6:00 p.m. ET.</p>
Fax	<p>1-617-897-0805</p>
Write	<p><i>Corporate Headquarters:</i> 100 City Square, Suite 200 Charlestown, MA 02129</p> <p><i>Local Office:</i> WellSense Health Plan 1155 Elm Street, 5th floor Manchester, NH 03101</p>
Website	<p>wellsense.org</p>

Method	Behavioral Health (Mental Health or Substance Use Disorder Services)–Coverage Decisions or Appeals Contact Information for Carelon
Call	<p>877-957-1300, 24-hour telephone line</p> <p>Calls to this number are toll-free and are available 24 hours a day, seven days a week.</p> <p>Member Service also has free language interpreter services available for non-English speakers. Alternate format materials are also available upon request.</p>
TTY/TDD	<p>711</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p>
Fax	1-617-897-0805
Write	<p>Carelon Behavioral Health ATTN: Appeals Coordinator PO Box 1856 Hicksville, NH 11802-1856</p>
Website	<p>www.carelonbehavioralhealth.com</p> <p>www.carelonbehavioralhealth.com/members/dashboard</p>

Section 2.3 How to contact the plan about a grievance

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

Method	Grievance – Contact Information
Call	<p data-bbox="527 285 748 317">877-957-1300</p> <p data-bbox="527 401 1422 512">Calls to this number are toll-free. Representatives are available Monday through Wednesday, 8:00 a.m. to 8:00 p.m. ET; Thursday through Friday, 8:00 a.m. to 6:00 p.m. ET.</p> <p data-bbox="527 573 1479 684">Member Service also has free language interpreter services available for non-English speakers. Alternate format materials are also available upon request.</p>
TTY/TDD	<p data-bbox="527 722 574 753">711</p> <p data-bbox="527 783 1414 852">This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p data-bbox="527 879 1446 991">Calls to this number are free. Representatives are available Monday through Wednesday, 8:00 a.m. to 8:00 p.m. ET; Thursday through Friday, 8:00 a.m. to 6:00 p.m. ET.</p>
Fax	<p data-bbox="527 1045 773 1077">1-617-897-0805</p>
Write	<p data-bbox="527 1119 902 1230">Corporate Headquarters 100 City Square, Suite 200 Charlestown, MA 02129</p> <p data-bbox="527 1283 867 1436">Local Office WellSense Health Plan 1155 Elm Street, 5th floor Manchester, NH 03101</p>

Section 2.4 How to contact the plan about care management

Care management is the term used to describe the practice of assisting members with getting needed services and community supports. Care managers or 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 and care management support*).

Method	Care Coordination – Contact Information
Call	<p>Contact your PCP to help you with care coordination support. If you need assistance identifying or contacting your PCP call WellSense Member Service.</p> <p>Phone: 877-957-1300</p> <p>Website: wellsense.org (member self-service section or the <i>Provider Directory</i>)</p> <p>Calls to this number are toll-free.</p> <p>Representatives are available</p> <ul style="list-style-type: none"> • Monday–Wednesday, 8:00 a.m.–8:00 p.m. ET • Thursday–Friday, 8:00 a.m.–6:00 p.m. ET <p>Member Service also has free language interpreter services available for non-English speakers. Alternate format materials are also available upon request.</p>

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 WellSense Health Plan. 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 feeling sick, dizziness, back pain, coughing, or baby is crying and feels hot, as examples.

In case of a medical emergency – Dial **911** or go directly to the nearest hospital emergency room.

In case of a mental health and/or substance use emergency or crisis – If you or someone you know is in need of emotional or mental health supports/services (or there is a risk of suicide), including concerns about substance use, call, text or chat **988** – the Suicide and Crisis Lifeline is a national service that 24 hours a day, 7 days a week to connect with a trained crisis counselor. The Lifeline provides free and confidential emotional support to people in suicidal crisis or emotional distress.

Or, call or text the toll-free NH Rapid Response Access Point (**1-833-710-6477**) anytime day or night. Crisis response services are available over the phone, by text, or face-to-face through Mobile Crisis Teams who can meet you when and where you need them when needed.

Or, call 211 to connect to your local Doorway for substance misuse supports and services in NH.

For a description of emergency mental health and substance use services, refer to the Chapter 4 (*Benefits Chart*).

Method	Nurse Advice Line – Contact Information
CALL	<p>1-866-763-4829, 24-hour access</p> <p>Calls to this number are toll-free.</p> <p>Member Service also has free language interpreter services available for non-English speakers. Alternate format materials are also available upon request.</p>
TTY/TDD	<p>711</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p>

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. We contract with Carelon Behavioral Health to manage these services. Contact Carelon Behavioral Health (Carelon) when you have questions about behavioral health (mental health or substance use disorder services).

In case of a behavioral health (mental health and substance use) emergency or crisis – Call, text or chat **988** – the Suicide and Crisis Lifeline 24 hours a day, 7 days a week to connect with a trained crisis counselor. The Lifeline is a national service that provides free and confidential emotional support to people in suicidal crisis or emotional distress.

Or, call or text the toll-free NH Rapid Response Access Point (1-833-710-6477) anytime day or night. Crisis response services are available over the phone, by text, or face-to-face through Mobile Crisis Teams who can meet you when and where you need them when needed.

Or, call 211 to connect to your local Doorway for substance misuse supports and services in NH.

For a description of emergency mental health and substance use services, refer to the Chapter 4 (*Benefits Chart*).

Method	Behavioral Health Services (Mental Health or Substance Use Disorder Services) – Contact Information
Call	<p>855-834-5655 (TTY: 866-727-9441), 24-hour telephone line, seven days a week.</p> <p>Calls to this number are toll-free.</p> <p>Member Service also has free language interpreter services available for non-English speakers. Alternate format materials are also available upon request.</p>
TTY/TDD	<p>711</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p>
Fax	1-617-897-0805
Write	<p>Carelon Behavioral Health P.O. Box 1856 Hicksville, NY 11802-1856</p>
Website	<p>www.carelonbehavioralhealth.com www.carelonbehavioralhealth.com/members/dashboard/</p>

Section 2.7 How to request non-emergency medical transportation assistance

The plan covers non-emergency medical transportation assistance, including mileage reimbursement, if you are unable to pay for the cost of transportation to provider offices and facilities for medically necessary New Hampshire Medicaid-covered services listed in the Benefits Chart in Section 4.2 (*Benefits Chart*) (See *Transportation services – Non-emergency medical transportation (NEMT)*). We contract with a non-emergent medical transportation management vendor to manage these services. Contact the WellSense Health Plan transportation line listed below when you have questions about NEMT services. For authorized non-emergency medical transportation, you must follow plan rules for transportation coordination and reimbursement. See table below the contact information for more instructions for how your non-emergency medical transportation services benefit works and how to book a ride.

Method	Non-Emergency Medical Transportation – Contact Information
Call	<p>844-909-7433</p> <p>Calls to this number are toll-free. Monday – Friday 8 am to 8 pm.</p> <p>Member Service also has free language interpreter services available for non-English speakers. Alternate format materials are also available upon request.</p>
TTY/TDD	<p>711</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p>

How does Non-Emergency Medical Transportation (NEMT) work?

WellSense works with our contracted non-emergent medical transportation management vendor to help get you to your scheduled healthcare services and back home.

The plan only 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 services, you must follow plan rules described under Transportation services – Non-emergency medical transportation (NEMT) section of the benefit grid located in Chapter 4.

If you satisfy the requirements/plan rules for transportation services we can:

- Pay you, your friends, or a family member for mileage if you have circumstances that prevent you from paying the cost of transportation
- **Note:** Reimbursement will only be allowed from the address that the plan has on file for you. You must submit completed reimbursement forms to us within 30 calendar days after the month that the appointment took place. You can find the reimbursement forms on the plan website at wellsense.org. You may also call the WellSense Health Plan transportation line toll-free at 1-844-909-7433 or 1-844-909-RIDE to request a reimbursement form.
- Pay you to use public transportation
- Arrange for a taxi, when other options are not available
- Arrange for a specialty vehicle when needed, such as a wheelchair van or ambulance

Book your trip

- Call Coordinated Transportation Solutions at 1-877-909-7433 to reserve.
- You must call at least 48 hours before your visit to be paid back for your mileage.
- Have your WellSense ID card and appointment information available when you call.
- If you cancel or change your appointment, call the WellSense Health Plan transportation line right away to let them know.

When booking let our transportation line staff know if:

- You need help getting to or from the vehicle.
- You use a new mobility aid such as a wheelchair, scooter, crutches, or cane. Inform us if your wheelchair is extra-wide, extra-long, or (when occupied) weighs over 600 lbs.
- You need assistance to or from the building entrance.
- You need to bring your children with you, and if they need car seats. We may not be able to arrange your trip so that you can bring your children. Be sure to ask when you call.
- Your child is between 12 and 16 years old and needs to travel alone to a doctor's visit.
- You need to bring one person to help you during your visit so we can make sure there is space in the vehicle.

If there is more than one member of your household travelling to the same location, please note that only one member reimbursement will be approved.

Process for Member Reimbursement for approved Family and Friends transportation

We will reimburse you for approved mileage reimbursement requests, if you, your friend, or family member provide transportation. You must submit a completed reimbursement form to us within 30 calendar days from the last day of the month that the appointment occurred. You can either fax it to (203) 375-0516, email it to FF@ctstransit.com or mail it to the following address:

Coordinated Transportation Solutions, Inc.

35 Nutmeg Drive Suite 120
Trumbull, CT 06611

Section 2.8 How to request Pharmacy Services

The plan covers medically necessary covered pharmacy (prescription) services listed in the Benefits Chart in Chapter 4 (Covered services) (See Prescription Drugs) and Chapter 7 (Getting covered prescription drugs). We contract with Express Scripts to manage your prescription drug benefit. The plan also contracts with Cornerstone Health Solutions for mail order drug services.

Method	Pharmacy Services – Contact Information
<p>Call</p>	<p>For general pharmacy questions, call Express Scripts: 877-957-1300, available 24 hours a day, seven days a week.</p> <p>WellSense Health Plan Representatives are available Monday through Wednesday, 8:00 a.m. to 8:00 p.m. ET; Thursday through Friday, 8:00 a.m. to 6:00 p.m. ET.</p> <p>Mail Order:</p> <p>To Request a new Mail Order Prescription</p> <ul style="list-style-type: none"> • Call Cornerstone Health Solution (Cornerstone) at 844-319-7588, available Monday through Friday 7 a.m. to 6 p.m.ET • Complete the mail order pharmacy enrollment form and mail it in with your prescription(s) to us, or • Have your doctor submit your prescription electronically to us via fax. <p>To Request a Refill of your Mail Order Prescription</p> <ul style="list-style-type: none"> • Call Cornerstone Health Solutions mail order pharmacy at 781-805-8220 Monday through Friday 7 a.m. to 6 p.m.ET to request your refill • Email www.CornerstoneMailOrderPharmacy@bmc.org 24 hours a day, 7 days a week to request your refill • Start an online refill request from the Cornerstone Health Solutions webpage, or • Start a mobile refill using the Cornerstone Health Solutions mobile app. <p>Specialty Pharmacy:</p> <p>Call Cornerstone Health Solutions at 844-319-7588, available Monday through Friday 7 a.m. to 6 p.m. ET, with on-call services available 24 hours a day, 7 days a week.</p> <p>Calls to these numbers are toll-free.</p> <p>Member Service also has free language interpreter services available for non-English speakers. Alternate format materials are also available upon request.</p>

Method	Pharmacy Services – Contact Information
TTY/TDD	<p>711</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p>
Fax	<p>Express Scripts: 877-251-5896</p> <p>Cornerstone Mail Order: 781-805-8221</p> <p>Cornerstone Specialty: 781-805-8221</p>
Write	<p>Express Scripts Attn: Medicaid Reviews P.O. Box 66588 St. Louis, MO 63166-6588</p> <p>Cornerstone Health Solutions Mail Order and Specialty Pharmacy 40 Teed Drive Randolph, MA 02368</p>
Website	<p>Express Scripts https://express-scripts.com/</p> <p>Cornerstone Health Solutions Mail Order and Specialty Pharmacy www.cornerstonehealthsolutions.org</p>

Section 2.9 How to request Vision Services

The plan covers medically necessary covered vision services listed in the Benefits Chart in Chapter 4 (*Covered services*) (See *Vision services*). We contract with Vision Services Plan (VSP). If you need help with your vision services benefits or need help finding VSP-Participating Eye Care providers, contact VSP.

Method		Vision Services – Contact Information	
Call	800-877-7195	<p>Calls to this number are toll-free. Representatives are available Monday through Friday, 8:00 a.m. to 8:00 p.m. ET; Saturday and Sunday 10:00 a.m. to 8:00 p.m. ET. Closed Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day.</p> <p>Member Service also has free language interpreter services available for non-English speakers. Alternate format materials are also available upon request.</p>	
TTY/TDD	800-428-4833	<p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p>	
Write	Vision Service Plan	<p>Attn: Customer Care 3333 Quality Drive Rancho Cordova, CA 95670-7985</p>	
Website	www.VSP.com		

Section 2.10 How to request Durable Medical Equipment, Prosthetics, Orthotics, or Supplies

The plan covers medically necessary covered Durable Medical Equipment, Prosthetics, Orthotics, or Medical Supplies (DMEPOS). These services include medical formulas and low protein food and other services listed in the Benefits Chart in Chapter 4 (*Covered services*). We contract with Northwood, Inc. to manage these services. Contact Northwood Inc. when you have questions about coverage for DMEPOS services.

Method	DMEPOS – Contact Information
CALL	<p>877-957-1300, 24 hours a day, seven days a week</p> <p>Calls to this number are toll-free. Representatives are available Monday through Wednesday, 8:00 a.m. to 8:00 p.m. ET; Thursday through Friday, 8:00 a.m. to 6:00 p.m. ET.</p> <p>Member Service also has free language interpreter services available for non-English speakers. Alternate format materials are also available upon request.</p>
TTY/TDD	<p>711</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p>

Section 2.11 How to contact the NH DHHS Customer Service Center

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

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

Method		NH DHHS Customer Service Center – Contact Information
Website		https://nheasy.nh.gov/ www.dhhs.nh.gov

Section 2.12 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/about-dhhs/long-term-care-ombudsman

Section 2.13 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. 16941 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/about-dhhs/office-ombudsman

Section 2.14 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 Info
Call	<p>1-866-634-9412</p> <p>Calls to this national number are toll-free. Calls made to the number from some cell phones and outside of New Hampshire will be directed to the NH DHHS Customer Service Center. When you reach that office, you will be transferred to the number of the appropriate ServiceLink location for your area</p> <p>Office hours are Monday through Friday, 8:30 a.m. - 4:30 p.m. ET.</p> <p>Free language interpreter services are available for non-English speakers.</p>
TTY/TDD	Call the number above or visit the website below for TTY/TDD services for your local office.
Fax	Call the number above or visit the website below for the fax number of your local office.
Write	Call the number above or visit the website below for the address of your local office
Website	http://www.servicelink.nh.gov/

Section 2.15 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, WellSense Health Plan 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	WellSense Health Plan to report fraud, waste or abuse – Contact Information
Call	<p>888-411-4959 (Our confidential compliance hotline)</p> <p>Calls to this number are toll-free. The hotline is available 24 hours a day, 365 days a year.</p> <p>Member Service also has free language interpreter services available for non-English speakers.</p>
TTY/TDD	<p>711</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p>
Fax	866-750-0947

Method	WellSense Health Plan to report fraud, waste or abuse – Contact Information
Write	WellSense Health Plan Attention Special Investigations Unit 1155 Elm Street, Suite 600 Bank of America Building Manchester, NH 03101 or e-mail FraudandAbuse@bmchp-wellsense.org

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 2.16 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. An Authorized Representative may act on your behalf with respect to an appeal, a state fair hearing, or a complaint (grievance). Your authorized representative or personal

representative designation is valid until you revoke or amend it in writing. For more information, contact Member Service (Phone numbers are printed on the back cover of this handbook.)

- **Alternative formats and interpretation services** - To get information from us in a way that works for you, please call Member Service (Phone numbers are printed in the back of this handbook.)

WellSense Health Plan:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- TTY services
- 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 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. Additionally, any information received electronically can be printed and mailed to you upon request.

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 Service. (Phone numbers are printed in the back 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**

- WellSense Health Plan is operated by Boston Medical Center Health Plan, Inc. We are a Massachusetts non-profit tax-exempt 501(c)(3) corporation.
- We are a Medicaid managed care organization.
- Our corporate office is located in Charlestown, Massachusetts.
- We are part of a family of companies that includes Boston Medical Center.
- We have a Board of Trustees that oversees our operations.
- WellSense Health Plan contracts with health care providers—such as doctors, nurse practitioners, and hospitals—that form our state-wide provider network.
- We contract with other organizations to help administer our Medicaid plan. For example, we contract with Carelon Behavioral Health for behavioral health services and Express Scripts for pharmacy services.

- We contract with the New Hampshire Department of Health and Human Services to offer the benefits described in this handbook.
- We also offer other health coverage programs in addition to the New Hampshire Medicaid managed care plan. In New Hampshire, we offer New Hampshire Medicare Advantage Plans. Also in Massachusetts, we offer MassHealth(Medicaid) plans, a Senior Care Options plan, and Qualified Health Plans.

For more information about our structure and operations, please contact our Member Service Department. (Phone numbers are printed in the back of this handbook.)

- **Information about plan provider incentives and compensation arrangements** - Provider incentives describe how network providers are paid for covered services, including any payment bonuses they may be eligible to receive based on patient outcomes or other performance measures.

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

- Whether the plan uses a Physician Incentive Plan that affects the use of referral services;
- The type of incentive arrangements in place with providers; and
- Whether stop-loss protection arrangements afford providers financial relief for high-cost members, when appropriate.

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

- **Member material requests** - Contact WellSense Health Plan Member Service to request a copy of our *Member Handbook*, *Drug List*, or *Provider Directory*. Document(s) will be sent within 5 business days of your request. Any information received electronically can be printed and mailed to you upon request and free of charge. (Phone numbers for Member Service are printed on the back cover of this Handbook.)
- **Quality Improvement Program** - The Quality Improvement Committee annually reviews and approves the WellSense Health Plan's Quality Improvement Program plan. This Quality Improvement Program plan is our guide to improving the quality of care and services for our members. For example, we have focused on improving care for:
 - Members with diabetes, asthma, and other chronic health conditions
 - Women, pregnant members, new mothers, and children
 - Members with substance use or mental health concerns
 - Members with special needs

To ensure the success of our Quality Improvement Program we develop goals to track provider/clinician performance, overall coordination of care, and member satisfaction with the care experience. At the end of each year we check our progress compared to established goals, identify how we can do better, and set the next year's Quality Improvement Program goals.

- **Clinical Practice Guidelines** - To help improve clinical outcomes, the plan adopts Clinical Practice Guidelines (CPGs) from national health organizations that tell us how to provide the best care for specific medical conditions. These CPGs are posted on our website and can be used by our clinicians to make sure they are providing appropriate and effective care to our members. You may request a copy of our current CPGs by contacting the Member Service department. (Phone numbers for Member Service are printed in the back of this handbook.)
- **Process to review new technology** - We review new medical technologies and new uses for existing medical technologies for safety and efficacy before we decide if we will cover those technologies. (Efficacy means that the technology works.) These technologies include medical and behavioral health therapies, devices, surgical and testing procedures, and medications. Our review process includes talking with medical experts. It also includes reviewing published medical research, reports from appropriate government agencies (such as the federal Food and Drug Administration), and standards of national medical associations and specialty societies. The information is then presented to our internal committees. These committees make final decisions about whether we will cover new technologies.
- **Utilization Management** - Utilization Management (UM) is the process we use to make sure the care you are getting is "Medically Necessary." This is appropriate care when and where you need it. Our processes include pre-service review, urgent/ongoing review, and post-service review. UM looks at the clinical necessity, appropriateness, efficiency of services, supplies, equipment, drugs, procedures, and/or settings. We make decisions based on criteria developed from scientific and medical research. The criteria are also developed with input from providers. This process and the criteria support the correct use of services to give our members the best health outcomes. We do not reward any decision-maker for denying coverage of a service or offer them money to discourage them from authorizing services. UM decisions are based on the appropriateness of care and service and the existence of coverage.

For more information about the UM process, the criteria we use, or the coverage decisions we make, call Member Service at 1-877-957-1300. For hearing impaired members, call 711. After hours, leave a message or send a fax. All messages left after hours will be read the next business day. Member Service can also connect you to our clinical staff to discuss the UM process.

Chapter 3: Using WellSense Health Plan 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 Chapter 13 (*Acronyms and definitions of important words*).

WellSense Health Plan 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 https://www.gencourt.state.nh.us/rules/about_rules/listagencies.aspx

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

WellSense Health Plan covers all services required in our contract with NH DHHS.

WellSense Health Plan 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, even if we are your secondary insurance.
- **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 authorization for 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 Service (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 routine care and most health problems. He or she makes sure you get the care you need to keep you healthy. A provider who is not a network provider is not permitted to act as a PCP. 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 Service (Phone numbers are printed on the back cover of this handbook).

There are select circumstances in which we will allow a specialist to serve as the member’s PCP. The plan may authorize a specialist physician to serve as a member’s PCP if the member has a life-threatening, degenerative, or disabling condition or disease that requires prolonged specialized care, e.g., HIV, end stage renal disease, or an oncology diagnosis, and the plan believes it will be in the best interests of the member to make this exception. The plan’s Medical Director must review and approve the request before a specialist can act as your PCP. Specialists acting in the capacity of a PCP must be, or must become a Plan-participating physician, and are required to adhere to all plan standards applicable to PCPs.

Each family member enrolled with us must have a PCP. If every enrolled member in your family wants the same PCP, you may be able to choose a family practice or general practice doctor to be the PCP for all enrolled family members.

Your PCP will do many things for you, such as:

- Provide, oversee, and coordinate all your care
- Complete and review an annual health risk assessment
- Conduct or arrange preventive health care screenings
- Treat you for your basic health needs and problems
- Direct you to specialists and other providers within your plan provider network
- Direct you to supports for health care related social needs
- Direct you to inpatient hospital care
- Write prescriptions and assist with medication management
- Keep your medical records
- Request prior authorizations from us, when needed
- Respond to your phone calls about your medical needs or problems, even after business hours

- Care coordination and provide direction on WellSense care management programs

There are times that you need to see a doctor that is not a PCP, such as a specialist. Referrals are not required from your PCP to see a specialist. Your PCP, specialist, or other provider you are seeing will obtain prior authorization for services that require prior authorization. The authorization decision may be made either by the plan or one of its designated vendors. The plan has vendors for select services such as pharmacy; durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS); and behavioral health. The Benefits Chart in Chapter 4 (*Covered services*) specifies the vendor responsible for the prior authorization process.

Call your PCP for an appointment

When you join the plan you should make an appointment to see your PCP for a checkup. Call your PCP's office. Tell the office staff this will be your first visit with this PCP, or that this is your first visit with the PCP using your plan coverage. If you have any problems making an appointment, call our Member Service department. (Phone numbers are printed in the back of this handbook.) If it is your first visit with your PCP, most likely you will get a physical exam and behavioral health screening. Your PCP will ask you questions about your health and your family's health. The more your PCP knows about you and your family's health history, the better he or she can manage your care. Adults should visit their PCPs at least once a year for a comprehensive annual exam. Infants, children, and pregnant women should see their PCPs more often.

Call your PCP first when you are sick – unless you think it's an Emergency

Your PCP will provide and coordinate all your care, except in an emergency. You should call your PCP's office if you feel sick. Your PCP, or a covering provider, is on-call to help, 24 hours a day, seven days a week.

If you think you are having a medical emergency, call **911** or go to the nearest hospital emergency room.

What to do if you have health questions after hours

First, you should call your PCP's office and follow the instructions from the PCP office. Your PCP's office has after-hour coverage that is available 24 hours a day / 7 days a week. You can also call our Nurse Advice Line as they can answer questions and possibly save you a trip to the emergency department or urgent care. See Section 2.5 (*How to contact the plan's Nurse Advice Line*) for contact information.

If you are unable to see your PCP, you can go to an Urgent Care Center. These are also called "Walk-In Care" or "Convenience Care" providers. They are able to provide care for injuries or illness that requires immediate attention, but are not serious enough to require an emergency department visit.

If you have behavioral health questions after hours please call Carelon 24/7 at 855-834-5655. TTY: 866-727-9441.

How do you choose your PCP?

If you need help picking a PCP, or if you have already picked a new PCP, call us. We want to make sure we have the correct information for our records. If you haven't picked a PCP yet, we can help you pick one. You can pick a PCP from anywhere in our network. It makes sense that you pick one who is near you. Check our online *Provider Directory* at wellsense.org. You can also have a free printed *Provider Directory* sent to you by calling our Member Service department (Phone numbers are printed in the back of this handbook). We will assign a PCP to you if you do not pick one within 15 days of your Effective Date of Enrollment in the plan.

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*).

If you feel the need to change your PCP, you can find a new PCP in our online *Provider Directory* or you may contact Member Service to help you find a new PCP. Once you've chosen a new PCP, you can update your PCP with us in a few different ways:

- You may call our Member Service department to let us know your new PCP's name. (Phone numbers are printed in the back of this handbook).
- You may complete a PCP Selection Form at your new PCP's office.
- You may register with us at wellsense.org to change your PCP online.

Once you have updated your PCP, the change will be effective the same 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 WellSense Health Plan.

- Routine women's health care, including breast exams, screening mammograms (X-rays of the breast), pap tests, pelvic exams, and maternity care.
- Flu shots, Hepatitis B vaccinations, and pneumonia vaccinations as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed services from network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible (e.g., when you are temporarily outside of the plan's service area).
- Family planning services when you go to any participating New Hampshire Medicaid family planning provider.
- Kidney dialysis services that you get at a certified dialysis facility when you are temporarily outside the plan's service area. (If possible, please call Member Service before you leave

the service area so we can help arrange for you to have maintenance dialysis while you are away. (Phone numbers for Member Service are printed in the back of this handbook.)

- Office visits with network specialists, including second and third opinions.

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 Service. (Phone numbers are printed on the back cover of this handbook). The *Provider Directory* lists network providers. Also, you may ask Member Service for more information about our network providers, including their qualifications. You can also see the *Provider Directory* at wellsense.org, or download it from this website. Both Member Service and the website can give you the most up-to-date information about changes in our network providers.

There may be times when you may need to see a specialist. A specialist is a health care provider who is trained to provide specific treatment as described above. If you think you need to see a specialist or other type of provider, you should first call your PCP. Your PCP can help identify your needs. If your PCP thinks you need to see a specialist or other type of provider, your PCP will direct you to a specialist or other provider who works with your PCP within the plan's provider network, unless you need to see an out-of-network provider for one of the exceptions permitted in Section 3.5 (*Getting care from out-of-network providers*).

If you choose to go to an out-of-network provider for your healthcare services and your care does not fall into one of the exceptions listed below, you will be responsible for payment for the care you receive. Mental Health and Substance Use Disorder services do not require a referral from your PCP.

Your PCP may also help if you need hospital services or any follow-up care that is important for your health and recovery, both while being treated by a specialist and after. Therefore, it is important that you talk with your PCP about your specialty care needs.

If the visit to the specialist requires Prior Authorization, your PCP will reach out to the plan to obtain that Prior Authorization. If the services that the specialist will be providing you require Prior Authorization, it is the specialist's responsibility to obtain that Prior Authorization. If you are pregnant, either you or your physician should notify WellSense Health Plan of your pregnancy, anticipated due date, and remember to notify DHHS and WellSense Health Plan once your baby is born in order to enroll them in WellSense Health Plan.

Getting behavioral health and substance use disorder services

We partner with another organization called Carelon Behavioral Health (Carelon) to manage and coordinate covered behavioral health (mental health and substance use disorder) services for our members. Carelon also manages the behavioral health providers in your plan's provider network, including telehealth providers. You can find a list of behavioral health network providers in our online *Provider Directory* wellsense.org. You can also call Carelon 24/7 at 855-834-5655 (TTY: 866-727-9441), assistance finding a provider.

If you need a free printed *Provider Directory* of behavioral health network providers in your area, call our Member Service department. (Phone numbers for Member Service are printed in the back of this handbook.) You can also ask family members, guardians, a community agency, your PCP, or another provider to recommend a behavioral health network provider.

Behavioral health services (mental health and substance use disorder services) are available by "self-referral." This means that you can go to a behavioral health network provider when you think you need one. You do not have to first ask your PCP or other provider. No prior authorization is needed to visit an in-network behavioral health provider. All out-of-network mental health and substance use disorder services must be authorized in advance for them to be covered.

You can always call the Carelon Member Service line at 855-834-5655 (TTY: 866-727-9441) if you have any questions about coverage for behavioral health covered services. Remember, in a behavioral health emergency you should call 911, go to the nearest hospital emergency room, or contact the Rapid Response Access Line provider in your area. A statewide list of Rapid Response Access Line providers is in the WellSense online member directory under Community Resources.

Getting dental care and services

As described in Section 4.4 (*New Hampshire Medicaid benefits covered outside the plan*), your dental benefits are not managed by WellSense Health Plan. They are managed through New Hampshire Medicaid. For questions about your dental benefits, please contact NH Medicaid Customer Service. See Section 2.11 (*How to contact the NH DHHS Customer Service Center*) for contact information.

Getting vision care

Please refer to your Benefits Chart in Section 4.2 for information about your vision care benefit and Section 2.9 (*How to request Vision Services*) for information on how to contact Vision Services Plan (our vendor who is contracted to manage your vision services) for information about how to locate network providers or when to obtain an authorization.

How to access the *Provider Directory* (list of network providers)

Your WellSense Health Plan *Provider Directory* is on our website at wellsense.org. Just click on “Find a Provider” tab at the top of the home page. You can see or download the *Provider Directory* from this website. The *Provider Directory* includes important information about network providers, such as: phone number and addresses, languages spoken, handicap access, hours of operation, hospital affiliation, applicable specialty, and board certification status.

The online *Provider Directory* is always the most current version. You may also request a copy of the *Provider Directory* from Member Service. (Phone numbers are printed in the back of this handbook.) The *Provider Directory* lists network providers.

If you need help finding a network provider, or for more information about our network providers (including their qualifications), call Member Service. Both Member Service and the website can give you the most up-to-date information about changes in our network providers.

To find a Mental Health or Substance Use Disorder provider visit [https://wellsense.org/members/NH/Medicaid/find a provider](https://wellsense.org/members/NH/Medicaid/find-a-provider)

You can also call Carelon 24/7 at 855-834-5655 (TTY: 866-727-9441), for assistance finding a provider.

For more provider information about professional qualifications (including but not limited to medical school attended and residencies completed) contact the New Hampshire State Board of Medicine at 603-271-1203, Monday through Friday from 8:00 a.m. to 4 p.m. (the office is close for state holidays) or go to www.nh.gov/medicine and click on “Physician Finder”.

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, specialist, or other provider you routinely receive treatment from leaves our plan, you have certain rights and protections described below:

- When possible we will notify you when your PCP or other provider who you receive routine treatment from leaves the plan’s network. We will notify you the earlier of 15 calendar days after the plan receives notice of your provider leaving the network, or 30 calendar days prior to the effective date of the provider termination so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted. For more information, refer to Section 5.3 (*Continuity of care, including transitions of care*).

- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file a grievance or an appeal of our decision.
- If you find out your doctor or specialist is leaving our plan, please contact us so we can assist you in finding a new provider to manage your care.
- You may choose your preferred network health providers to the extent possible and appropriate.
- If you are receiving a prior authorized ongoing course of treatment with a participating provider who becomes unavailable to continue to provide services, the plan shall notify you in writing within 7 calendar days from the date the plan becomes aware of such unavailability and will develop a transition plan to help you with your continued ongoing care.

Section 3.5 Getting care from out-of-network providers

You are not covered for services provided by an out-of-network provider—except in any of the following cases:

- Emergency services.
- Urgent care.
- If WellSense Health Plan gives an authorization in advance for you to get care from an out-of-network provider.
- If Carelon gives an authorization in advance for you to get care from an out-of-network mental health or substance use disorder provider.
- Second opinions, provided you receive a prior authorization from us.
- For family planning services and supplies, you may choose any NH Medicaid participating doctor, clinic, community health center, hospital, pharmacy, or family planning office.
- If you need care that is a covered service and is medically necessary and our network providers cannot provide this care, you may be able to get this care from an out-of-network provider. We must approve this in advance through our prior authorization process.
- You have been authorized to see an out-of-network provider under our Continuity of Care policy described in Section 5.3 (Continuity of care, including transitions of care).

You can obtain covered services from any provider in our provider network. There are no restrictions on which network providers you can use.

Note: You are not covered for any medical care, including emergency or urgent care, outside of the United States or its territories. You should still seek emergency care or urgent care when you are outside the country, but the services you receive will not be covered by us.

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 Service 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 Service (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. The back of your plan membership card has important phone numbers for contacting us, getting behavioral health care, and what to do when you need emergency care.

If you have a mental health or substance use emergency:

- **Get help as quickly as possible.** Call, text or chat **988** – the Suicide and Crisis Lifeline 24 hours a day, 7 days a week to connect with a trained crisis counselor. The Lifeline is a national service that provides free and confidential emotional support to people in suicidal crisis or emotional distress.
- Or, call or text the toll-free NH Rapid Response Access Point (**1-833-710-6477**) anytime day or night. Crisis response services are available over the phone, by text, or face-to-face through Mobile Crisis Teams who can meet you when and where you need them when needed.
- Call 211 to connect to your local Doorway for substance misuse supports and services in NH.

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
- Overdose

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” or “behavioral health crisis”?

What is a “behavioral health emergency” or “behavioral health crisis”?

A “behavioral health emergency” is an emergent situation in which someone is in need of behavioral health (mental health and/or substance use) assessment and treatment, is a danger to themselves or others, or exhibits significant behavioral deterioration rendering the member unmanageable and unable to cooperate in treatment.

A “behavioral 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 behavioral 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 behavioral health illness or disorder.

People have better health outcomes when they connect to care EARLY. These resources are for anyone, at any time to call, text or chat for any reason. A crisis is defined by the individual and we may each experience different levels of stress. Please encourage people to call and not to wait.

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

- **Get help as quickly as possible.** Call, text or chat **988** – the Suicide and Crisis Lifeline 24 hours a day, 7 days a week to connect with a trained crisis counselor. The Lifeline is a national service that provides free and confidential emotional support to people in suicidal crisis or emotional distress.
- Or, call or text the toll-free NH Rapid Response Access Point (**1-833-710-6477**) anytime day or night. Crisis response services are available over the phone, by text, or face-to-face through Mobile Crisis Teams who can meet you when and where you need them when needed.
- Call 211 to connect to your local Doorway for substance misuse supports and services in NH.
- **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. The back of your plan membership

card has important phone numbers for contacting us, getting behavioral health care, and what to do when you need emergency care.

- You do not need to get approval or a referral first from your PCP.

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

WellSense Health Plan understands that substance use disorder, like other chronic health conditions, require access to immediate help and this care is critical to recovery.

- If you are a WellSense Health Plan member struggling with substance misuse and are in need of urgent care, contact Carelon 24/7 at 855-834-5655 (TTY: 866-727-9441). Calls to this number are toll-free and available 24 hours a day, 7 days a week; or
- If you are experiencing a substance use crisis or emergency, **get help as quickly as possible**. Call 211 to connect to your local Doorway for substance misuse supports and services in NH.
- Or call, text or chat **988** – the national Suicide and Crisis Lifeline 24 hours a day, 7 days a week to connect with a trained crisis counselor. The Lifeline is a national service that provides free and confidential emotional support to people in suicidal crisis or emotional distress.
- Or, call or text the toll-free NH Rapid Response Access Point (**1-833-710-6477**) anytime day or night. Crisis response services are available over the phone, by text, or face-to-face through Mobile Crisis Teams who can meet you when and where you need them when needed.

You do not need to get approval or a referral first from your PCP.

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.

First you should call your PCP's office and follow the instructions from the PCP office. You can also call our Nurse Advice Line as they can answer questions and possibly save you a trip to the emergency department or urgent care. See Section 2.5 (*How to contact the plan's Nurse Advice Line*) for contact information.

If you are unable to see your PCP, you can go to an Urgent Care Center. These are also called "Walk-In Care" or "Convenience Care" providers. They are able to provide care for injuries or illness that requires immediate attention, but are not serious enough to require an emergency department visit.

If you have behavioral health questions after hours please call Carelon 24/7 at 855-834-5655. TTY: 866-727-9441.

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 WellSense Health Plan 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.aspx.

About covered services:

- The Benefits Chart lists the services WellSense Health Plan covers. The chart is for your general information and may not include all the benefits available to you. Please call WellSense Health Plan Member Service 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 WellSense Health Plan 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 from the plan in advance (called "prior authorization"). Prior authorization requirements for covered services are in italics in Section 4.2 (*Benefits Chart*).
- You pay nothing, except for any applicable copayments, for the covered services described in the Benefits Chart as long as you follow the plan's rules described in this handbook. Currently you are only responsible for the copayment for your covered prescription drugs.
- New Hampshire Medicaid benefits may change over time. You will be notified of those changes.

If you have questions about covered services, call Member Service (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 Service.

Abortion services

The plan covers abortion services only as follows:

Prior to 24 weeks of gestation:

- 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.

At or after 24 weeks of gestation:

- In the case of a medical emergency (“medical emergency” means to encompass significant health risks namely those circumstances in which a pregnant women’s life or a major bodily function is threatened).

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

For more information, please call Member Service.

Adult community reentry services

The plan covers services to help adults ages 18 and older who are getting ready to leave certain New Hampshire correctional facilities. This program offers health care services for **45 days before release** and continues to help after release if you qualify.

Services covered by the plan

Covered services include:

Before Release

The program works with your health plan to provide:

- Virtual health care visits and health screenings
- Virtual and in-person peer support services
- Treatment for substance use withdrawal
- Scheduling health appointments for after release

Upon Release

The program continues to help by providing:

- A 30-day supply of medications at the time of release

Extended Services for Those Who Qualify

- **Ongoing health care coverage** – If you still qualify for Medicaid, you can keep receiving care.
- **Extra support** – You can get 12 more months of health plan support after the month you are released.
- **Additional reentry services** – If you were in foster care, you may also qualify for both adult and youth and young adult reentry services until age 26. (*Youth and young adult reentry services are explained separately.*)

For more information, please call Member Service.

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
-

Services covered by the plan

- Medical supplies
- Health and safety services

Prior authorization from the plan is required.

For more information, please call Member Service.

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 Service.

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.

Services covered by the plan

For more information, please call Member Service.

Ambulance services – Non-emergency

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

Covered ambulance services include:

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

Services are managed through our WellSense Health Plan Transportation line. You can reach us at **1-844-909-7433** or **1-844-909-RIDE**, for hearing impaired members, 711. Please see the introduction for more information about how this non-emergency transportation benefit works.

Prior authorization from the WellSense Health Plan transportation line is required, by you or the requesting provider, for non-emergency ambulance services.

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

For more information, please call Member Service.

Anesthesia

Refer to *Physician, physician assistant, and advanced practice registered nurse 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 Service.

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 Service.

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 Service.

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.

For more information, please call Member Service.

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 Service.

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 Service.

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 Service.

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.

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

For more information, please call Member Service.

Chemotherapy

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

Covered chemotherapy services include:

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

Prior authorization from the plan may be required.

Services covered by the plan

For more information, please call Member Service.

Colorectal cancer screening

The plan covers the following preventive screening services for members ages 45-75.

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

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

For more information, please call Member Service.

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/Nicotine-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 Service.

Counseling/coaching to stop smoking, tobacco or other nicotine use

The plan covers counseling or coaching to help with quitting smoking, tobacco or other nicotine use. (Refer also to "Tobacco and nicotine use treatment services" in the Benefits Chart.)

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

Services covered by the plan

For more information, please call Member Service.

Dental and oral health services

The plan does not cover dental and oral health services. However, certain dental services are coordinated through New Hampshire Medicaid or its dental managed care plan, as follows:

- For members under age 21 years, comprehensive dental services are coordinated through New Hampshire Medicaid as long as the provider is enrolled with New Hampshire Medicaid.
For more information about dental benefits for members under age 21 years, please contact the New Hampshire Medicaid Customer Service Center. Refer to Section 2.11 (How to contact the NH DHHS Customer Service Center).
- Fluoride varnish services are covered by the plan for some members. Refer to Fluoride varnish in the Benefits Chart.
- For members age 21 years and over, covered dental and oral health services, and related transportation are coordinated through the State's dental managed care plan, Delta Dental of New Hampshire in partnership with DentaQuest.

For more information about the adult dental benefit, please call DentaQuest Member Service toll-free at **1-844-583-6151** (TDD Relay Access: 1-800-466-7566), Monday through Wednesday, 8:00 a.m. to 8:00 p.m. and Thursday and Friday 8:00 a.m. to 5:00 p.m. ET.

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 Service.

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
-

Services covered by the plan

- Fittings for and provision of therapeutic, custom-molded or depth shoes if you have severe diabetic foot disease.
- Diabetes preventive education is a health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.

Diabetic Supply services provided or dispensed by a Durable Medical Equipment/Supply provider are managed by Northwood, Inc. for the plan. Contact Northwood Inc. at 1-877-957-1300, 24 hours a day, seven days a week. For hearing impaired, dial 711. Calls to this number are toll-free. Representatives are available Monday through Wednesday, 8:00 a.m. to 8:00 p.m. ET; Thursday through Friday, 8:00 a.m. to 6:00 p.m. ET.

Prior authorization from Northwood, Inc., by the requesting DMEPOS provider or supplier, is required for all diabetic supplies, blood glucose meters, and supplies that are brand-name products over \$500.

For more information, please call Member Service.

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 Service.

Services covered by the plan

Durable medical equipment (DME) including replacement parts, modification, repairs, and training.

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

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

Repair, adjustment or replacement of parts and accessories are covered for the normal and effective functioning of the equipment

Benefits are available for necessary repairs and maintenance of purchased equipment, unless a manufacturer's warranty or a purchase agreement covers such repairs and maintenance.

Benefits are available for replacement of equipment when the replacement is more cost effective than repair.

For equipment which had been in use prior to the user enrolling in the plan, these repair policies will apply if the health plan considers the equipment medically necessary.

Benefits for repair, maintenance, or replacement on rental equipment are ineligible for coverage. The rental price includes expenses incurred by the provider in maintaining equipment in working order.

Repair or replacement of equipment damaged due to patient neglect, theft, abuse, or when another available coverage source is an option (e.g., homeowners, rental, auto, liability insurance, etc.) is ineligible for coverage. Requests for replacement or modified devices will be

Services covered by the plan

reviewed on a case-by-case basis.

Training on equipment is not separately covered as it is included in the cost of the device.

All durable medical equipment services provided by DMEPOS providers are managed by Northwood, Inc. for the plan.

Contact Northwood Inc. at 1-877-957-1300, 24-hours, seven days a week. For hearing impaired, dial 711. Calls to this number are toll-free. Representatives are available Monday through Wednesday, 8:00 a.m. to 8:00 p.m. ET; Thursday through Friday, 8:00 a.m. to 6:00 p.m. ET.

Prior authorization from Northwood, Inc., by the requesting DMEPOS provider or supplier, is required for all durable medical equipment over \$500.

For more information, please call Member Service.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services

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

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

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

For more information or information on specialty treatment services, contact the plan Member Service department for more information. (Phone numbers are printed in the back of this handbook.)

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:

Services covered by the plan

- 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 Service.

Family planning services

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

The following services are covered:

- Family planning exam and medical treatment
 - Family planning lab and diagnostic tests
 - Family planning methods (birth control pills, patch, ring, IUD, injections or implants)
 - Family planning supplies with prescription (condom, sponge, foam, film, diaphragm or cap)
 - Counseling and testing for sexually transmitted infections (STIs), AIDS and other HIV-related conditions when done as part of an initial, regular, or follow-up family planning visit
 - Treatment for sexually transmitted infections (STIs), including AIDS and other HIV-related conditions is subject to the requirements described under *Physician services* in this Benefits Chart
-

Services covered by the plan

- 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 Service.

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 Service.

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 Service.

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.

Services covered by the plan

Examples include therapy for a child who is not walking or talking at the expected age, and therapy for an adult for purpose of maintaining muscle tone.

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

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

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

For more information, please call Member Service.

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, may be required for hearing aids, repairs and replacements but is required for surgically implanted hearing aids.

For more information, please call Member Service.

Hepatitis B screening

Services covered by the plan

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 Service.

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 Service.

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 Service.

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 Service.

Services covered by the plan

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 information, please call Member Service.

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
-

Services covered by the plan

Prior authorization from the plan is required.

For more information, please call Member Service.

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 Service.

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 Service.

Infertility services

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

Services covered by the plan

Prior authorization from the plan is required for certain services such as surgery or some diagnostic procedures provided by a network provider.

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 Service.

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 Service 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.

Services covered by the plan

Services are managed by Carelon for the plan. For more information or to request a Prior Authorization, please call Member Service Line 24 hour/7 days a week at: 855-834-5655 (TTY: 866-727-9441)

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

For more information, please call Member Service.

Laboratory services

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

Prior authorization is only required for genetic testing.

For more information, please call Member Service.

Maternity and lactation consultation 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.

Lactation consultation and supportive services are covered by the plan when furnished in a provider's office, your home, a hospital, nursing facility, or elsewhere for eligible breastfeeding (or lactating) members, including:

- Breastfeeding education
- Individual and group lactation consultation

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. 14501 (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 Service.

Medical supplies

Services covered by the plan

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 is required for medical supply services.

For more information, please call Member Service.

Medical nutrition therapy

This benefit is covered for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor or when the member is not able to meet daily nutritional requirements using traditional foods alone due to injury or illness. This benefit also includes coverage for children with special health care needs or medical conditions, such as low birth weight, premature birth, malabsorption, or other medical condition having a nutritional impact. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.

Prior authorization from the plan is not required.

For more information, please call Member Service.

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.

Services covered by the plan

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 Service.

Occupational therapy services

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

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 Service.

Orthotic devices

Services covered by the plan

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 orthotics
- Foot and shoe orthotics are covered for members with diabetes, peripheral vascular disease or metabolic, neurological conditions, or pathological conditions of the foot due to localized illness, injury or symptoms involving the foot

Services are managed by Northwood, Inc. for the plan.

Contact Northwood Inc. at 1-877-957-1300, 24-hours, seven days a week. For hearing impaired, dial 711. Calls to this number are toll-free. Representatives are available Monday through Wednesday, 8:00 a.m. to 8:00 p.m. ET; Thursday through Friday, 8:00 a.m. to 6:00 p.m. ET.

Prior authorization from Northwood, Inc., by the requesting DMEPOS provider or supplier, is required for all durable medical equipment over \$500.

For more information, please call Member Service.

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)
-

Services covered by the plan

- Emergency psychiatric and psychotherapy services*
- Electroconvulsive therapy (ECT)
- Transcranial magnetic stimulation
- Crisis intervention and related post-stabilization services*
- Individualized Resiliency and Recovery Oriented Services (IROS)
- Case Management services, including Assertive Community Treatment (ACT)
- Psychological testing

*Some crisis intervention mental health services, related post-intervention stabilization services, and emergency psychiatric and psychotherapy services are covered outside our plan when delivered by Community Mental Health Center Rapid Response Teams. For more information, refer to Section 4.4 (*New Hampshire Medicaid benefits covered outside the plan*).

If you are experiencing a mental health or substance use crisis—

Call 211 to connect to your local Doorway for substance misuse supports and services in NH.

Or, call, text or chat **988**—the Suicide and Crisis Lifeline 24 hours a day, 7 days a week to connect with a trained crisis counselor. The Lifeline is a national service that provides free and confidential emotional support to people in suicidal crisis or emotional distress.

Or, call or text the toll-free NH Rapid Response Access Point (**1-833-710-6477**) anytime day or night. Crisis response services are available over the phone, by text, or face-to-face. You do not need to get approval or a referral first from your PCP.

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

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

Services are managed by Carelon for the plan. For more information or to request a Prior Authorization, please call Member Service Line 24 hour/7 days a week at: 855-834-5655 (TTY: 866-727-9441)

Prior authorization from Carelon is needed when you exceed 18 outpatient visits for members ages 18 and older; or when you exceed the 24 outpatient visits for members under 18 years old with an in-network behavioral health provider.

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

For more information, please call Member Service.

Outpatient hospital services

Services covered by the plan

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 Service.

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 Service.

Outpatient surgery

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

Services covered by the plan

Prior authorization may be required for certain procedures. You may refer to the [Prior Authorization Matrix](#) to see the list of services that require prior authorization by going to wellsense.org/providers.

For more information, please call Member Service.

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 is required for respiratory therapy equipment.

For more information, please call Member Service.

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, require use of a wheelchair, 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 Service.

Services covered by the plan

Physical therapy services

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

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 Service.

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 directs you to a podiatrist
 - Prevention and reduction of corns, calluses, and warts by cutting or surgical means
-

Services covered by the plan

- Casting, strapping, and taping when performed by a podiatrist for the treatment of fractures, dislocations, sprains, strains, and open wounds of the ankle, foot, and toes

For more information, please call Member Service.

Prescription drugs

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

Retail Pharmacy Copayment

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

Mail Order Copayment (only certain drugs available through mail order)

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

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

Services are managed by Express Scripts for prescription drugs and Cornerstone Health Solutions for mail order services for the plan.

See Section 2.8 (*How to request Pharmacy Services*) for contact information or you may contact Express Scripts at 877-957-1300 or 711 for hearing impaired, available 24 hours a day, seven days a week.

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

Services covered by the plan

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 Service.

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 Service.

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 by the requesting DMEPOS provider or supplier is required for all prosthetic devices and related supplies over \$500.

For more information, please call Member Service.

Services covered by the plan

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 Service.

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 Service.

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 Service.

Speech and language pathology services)

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

Substance use disorder (SUD) treatment services

Services covered by the plan

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
- Alcohol withdrawal treatment
- Opioid treatment services
- Medication assisted treatment
- Medically monitored residential withdrawal management
- Residential treatment services, including specialty services for pregnant and postpartum women

*Some crisis intervention substance use services, related post-intervention stabilization services, and emergency psychiatric and psychotherapy services are covered outside our plan when delivered by Community Mental Health Center Rapid Response Teams. For more information, refer to Section 4.4 (*New Hampshire Medicaid benefits covered outside the plan*).

If you are experiencing a mental health or substance use crisis—

Call 211 to connect to your local Doorway for substance misuse supports and services in NH.

Or call, text or chat **988**—the Suicide and Crisis Lifeline 24 hours a day, 7 days a week to connect with a trained crisis counselor. The Lifeline is a national service that provides free and confidential emotional support to people in suicidal crisis or emotional distress.

Or, call or text the toll-free NH Rapid Response Access Point (**1-833-710-6477**) anytime day or night. Crisis response services are available over the phone, by text, or face-to-face. You do not need to get approval or a referral first from your PCP.

Services covered by the plan

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

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

Services are managed by Carelon for the Plan. For more information or to request prior authorization, please call Member Service Line 24 hours/7 days a week at: 855-834-5655 (TTY: 866-727-9441)

Prior authorization from Carelon may be required.

For more information, please call Member Service.

Sunny Start

WellSense has a program called "Sunny Start" available to all pregnant members. To enroll in "Sunny Start" please call **855-833-8119**.

Services provided include:

- Help with scheduling your doctor visits and transportation to your appointments
- Access to a registered nurse skilled in caring for pregnant women and new babies
- Breastfeeding and other postpartum support
- Free car seats, reimbursed childbirth training classes, a free box of diapers and more

For more information, please call Member Service.

Telemedicine services

The plan covers all modes of telemedicine, including audio and video interactive services, audio-only or other electronic media for Medicaid-covered services when services are delivered by the following providers as a method of medical care service delivery:

- Physician or Physician Assistant
 - Advance Practice Registered Nurse (APRN) or Clinical Nurse Specialist
 - Nurse Midwife
 - Registered Nurses employed by home health care agency
 - Psychologist
 - Allied health professional (e.g., technician, assistant, therapist, technologist)
 - Dentist
 - Mental health practitioner including clinical social worker
 - Community mental health provider
 - Alcohol and other drug use professional
 - Dietitian
 - Behavior analyst with national board certification
-

Services covered by the plan

Eligible sites where video interactive telemedicine services may originate and/or be delivered include, but are not limited to the following sites:

- Medical practitioner's office
- Allied health professional's office
- Home health office
- Hospital
- Skilled nursing facility
- Community Mental Health Center
- Federally Qualified Health Center (FQHC)
- Rural Health Center (RHC)
- Member's home
- Rapid Response Team services delivery site*

*Some crisis intervention substance use services, related post-intervention stabilization services, and emergency psychiatric and psychotherapy services are covered outside our plan when delivered by Community Mental Health Center Rapid Response Teams. For more information, refer to Section 4.4 (*New Hampshire Medicaid benefits covered outside the plan*).

For more information, please call Member Service.

Tobacco and nicotine use treatment services

The plan covers counseling services, tobacco and nicotine cessation products, and drugs.

The plan supports *QuitNowNH* tobacco and nicotine use treatment services whether you smoke, chew, snuff, or vape. Call toll-free **1-800-QUIT-NOW** (1-800-784-8669) (TDD Relay Access **1-800-833-1477**), 24 hours a day, 7 days a week; or log on to www.QuitNowNH.org for adults, and MYLIFEMYQUIT (nh.mylifemyquit.org and Text 36072) for children 13-17 years old.

Tobacco and nicotine use treatment services covered by the plan are eight (8) counseling sessions per quit attempt with two (2) quit attempts per member each year when provided by your PCP or other qualified provider.

For more information, please call Member Service.

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 network provider offices and facilities (and out-of-network providers with prior authorization) for medically necessary New Hampshire Medicaid covered services listed in the Benefits Chart in Chapter 4.

The following services are covered through this benefit:

- Non-emergency ambulance when medically necessary.
- Wheelchair van when certified by your provider (limited to 24 trips per Benefit Year)
- Public transportation—including bus and train.
- Private transportation—mileage reimbursement when driver is pre-qualified. See the information in the box below for more details.
- Transportation services to a medical appointment originating from and returning to your residence, to include nursing facilities or other residential treatment facilities.

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

Plan rules include:

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

Exceptions to the Family and Friends Mileage Reimbursement Program

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

Services covered by the plan

Exceptions to the public transportation requirement are:

- If you have two (2) or more children under age six (6) who shall travel with the you;
- If you have one (1) or more children over age six (6) who has limited mobility and shall accompany you to the appointment; or
- If you have at least one (1) of the following conditions:
 - Pregnant or up to six (6) weeks post-partum;
 - Moderate to severe respiratory condition with or without an oxygen dependency;
 - Limited mobility (walker, cane, wheelchair, amputee, etc.);
 - Visually impaired;
 - Developmentally delayed;
 - Significant and incapacitating degree of mental illness; or
 - Other exception by provider approval only

NEMT services are managed by the Coordinated Transportation Solutions, Inc. (CTS) Call this line directly toll-free at **1-844-909-7433** or 711 for hearing impaired members, for information on non-emergent medical transportation services.

Prior authorization from Coordinated Transportation Solutions is required. See the information in the box below for more information about booking your transportation.

The following is a list of services that require prior authorization from Coordinated Transportation Solutions (CTS):

- Wheelchair transports if no Level of Need Form is on file
- Upgrades on Modes of Transportation
- Out of state transportation
- Long distance transportation over 100 miles 1 way
- High cost transportation
- Basic Life (BLS) and Advanced Life Service (ALS)
- Ambulance request form

To schedule transportation to provider offices or facilities for services provided directly by NH DHHS, call CTS toll-free at **1-844-909-7433**, Monday through Wednesday, 8:00 a.m. to 8:00 p.m. ET and Thursday through Friday, 8:00 a.m. to 6:00 p.m. ET. For a list of these services, refer to Section 4.4 (*New Hampshire Medicaid benefits covered outside the plan*).

For more information, please call Member Service.

Urgently needed care

Services covered by the plan

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
- A sudden change in mental health
- Substance use
- 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 1-866-763-4829 or refer to Section 2.5 (*How to contact the plan's Nurse Advice Line*). You should inform your PCP whenever possible if you have received such care.

If you require urgently needed care for a mental health or substance use crisis –call, text or chat **988** – the Suicide and Crisis Lifeline 24 hours a day, 7 days a week to connect with a trained crisis counselor. The Lifeline is a national service that provides free and confidential emotional support to people in suicidal crisis or emotional distress.

Or, call or text the toll-free NH Rapid Response Access Point (**1-833-710-6477**) anytime day or night. Crisis response services are available over the phone, by text, or face-to-face through Mobile Crisis Teams who can meet you when and where you need them when needed.

Or, call 211 to connect to your local Doorway for substance misuse supports and services in NH.

You do not need to get approval or a referral first from your PCP.

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 Service.

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

Prior authorization from the plan is not required for covered services provided by network providers. For more information, please call Member Service.

Services covered by the plan

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 Service.

Youth community reentry services

The plan covers services to help youth and young adults under age 21 who are getting ready to leave certain New Hampshire detention and correctional facilities. This program offers health care services for **30 days before release** and continues to help after release if you qualify.

Covered services include:

Before Release

The program works with your health plan to provide:

- A physical check-up with screenings to find out what care you may need after release
- Virtual and/or in-person health care visits and screenings
- Scheduling health appointments for after release

Upon and After Release

The program continues to help by providing:

- A 30-day supply of medications at the time of release
- Additional tests and treatments based on screenings done before release
- Help with health care needs for 30 more days after release

Extended Services for Those Who Qualify

- **Ongoing health care coverage** – If you still qualify for Medicaid, you can keep receiving care.
- **Extra support** – You can get 12 more months of health plan support after the month you are released.
 - **Additional reentry services** – Former foster youth and young adults up to age 26 may be able to get both youth and adult reentry services. (*Adult reentry services are explained separately.*)

Services covered by the plan

More Information and Resources

- **Want to know more?** Check the Member Handbook under **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services** for more details.

For more information, please call Member Service.

Section 4.3 Extra benefits provided by the plan

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

The full list of these extra benefits is available on our website at wellsense.org and may be subject to change. To get your Member Extras, call our Member Service department. (Phone numbers are printed in the back of this handbook or visit wellsense.org to print and complete the correct member form to request your extra benefit. You may need to supply additional information such as child height and weight information or gym membership receipts for faster processing of your extra benefits.

You may now get rewarded for completing healthy activities. To learn more about the Over-the-counter Rewards Program go to wellsense.org.

Extra benefits include but are not limited to:

- Dental kits*
- Car and booster seats*
- No-cost bicycle helmets*
- Up to \$200 back on a health club membership*
- Up to \$200 back on fitness and wellness tools*
- Up to \$100 back on Weight Watchers subscription fees*

Additional extras may be available to individuals who meet specific requirements please see wellsense.org member extras for more information.

* Some restrictions and limitations apply. Each member can earn up to \$250 in cash and non-cash goods and services each year, with the year running from July 1st to June 30th.

Section 4.4 New Hampshire Medicaid benefits covered outside the plan

New Hampshire Medicaid directly covers some Medicaid benefits that the plan does not cover even though the plan may help coordinate them. That is why you should always carry both your

WellSense Health Plan and New Hampshire Medicaid membership cards. Always show your WellSense Health Plan membership card to receive services covered by the plan. If you need help getting any covered services, please call Member Service (Phone numbers are printed on the back cover of this handbook).

ALWAYS CARRY BOTH YOUR WELLSENSE HEALTH PLAN AND NEW HAMPSHIRE MEDICAID MEMBERSHIP CARDS.

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

- Dental and oral health services are not covered by our plan. However, some dental and oral health services are available, as follows:
 - For members under age 21 years, comprehensive dental services are coordinated through New Hampshire Medicaid as long as the provider is enrolled with New Hampshire Medicaid.
For more information about the dental benefit for members under age 21 years, please contact the New Hampshire Medicaid Customer Service Center. Refer to Section 2.11 (*How to contact the NH DHHS Customer Service Center*).
 - For members age 21 years and over, covered dental and oral health services, and related transportation are coordinated through the State's dental managed care plan, Delta Dental of New Hampshire in partnership with DentaQuest.
For more information about the adult dental benefit, please call DentaQuest Member Service toll-free at **1-844-583-6151** (TDD Relay Access: 1-800-466-7566), Monday through Wednesday, 8:00 a.m. to 8:00 p.m. and Thursday and Friday 8:00 a.m. to 5:00 p.m. ET.
- Early supports and services for infants and children aged birth to 3 years
- Medicaid-to-school services
- Nursing home or nursing facility services (sometimes called long-term care nursing facility services), including: skilled nursing facility services, long-term care nursing facility services, and intermediate care facility services (nursing homes and acute care swing beds)
- Intermediate care facility services (nursing home and acute care swing beds)
- Glenclyff Home services
- Pediatric Residential Treatment Program Services
- Qualified Residential Treatment Program Services
- Division of Child, Youth, and Family Program services for Medicaid eligible children and youth referred by the courts or juvenile parole board, including:
 - Home based therapy
 - Child support services (also known as Child Health Support Services)
 - Intensive Home and Community Services
 - Placement services
 - Private Non-medical Institutional Care for Children
 - Crisis intervention

- Home and Community-Based Care waiver services for:
 - Members with acquired brain disorders;
 - Members with developmental disabilities;
 - Members up to age 21 years with developmental disabilities under the In-Home Supports waiver program; and
 - Members with age-related disabilities, chronic illnesses, or physical disabilities under the Choices for Independence waiver.

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

- Crisis intervention mental health services, including mobile crisis response services, related post-intervention stabilization services, and emergency psychiatric and psychotherapy services when delivered by a Community Mental Health Center Rapid Response Team.

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

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

Benefits excluded by the plan and NH DHHS

Alternative Treatments

- Acupuncture
 - Ayurveda
 - Biofeedback (except for the treatment of urinary incontinence)
 - Chelation therapy (except for lead poisoning treatment)
 - Craniosacral therapy, unless performed as part of the physical therapy benefit
 - Holistic treatments and related supplies
 - Homeopathic and naturopathic treatments
 - Hypnotherapy or hypnosis except when performed by a psychiatrist as part of an established treatment plan
 - Meditation, prayer, mental healing
 - Myotherapy
-

Benefits excluded by the plan and NH DHHS

- Pet therapy
- Pulsed or magnetic fields; electromagnetic or alternating current or direct-current fields (except for services listed in the Section 4.2 above)
- Reflexology, relaxation therapies, therapeutic touch
- Reiki
- Therapies that use creative outlets such as art, music, dance, or yoga

Behavioral health services

- Psychoanalysis
- Pastoral counseling when provided by a non licensed counselor
- Interactive individual psychotherapy
- Multiple-family group therapy
- Psychiatric evaluation of records and reports
- Neurobehavioral status exams administered/interpreted by physicians and computer
- Neuropsychological rehabilitation
- Behavioral Health hotline service
- Mental health clubhouse services
- Halfway house services
- Mental health or substance use disorder services provided to members who are in jail, prison, a house of correction or custodial facility, except as required by state law
- Alcohol or drug testing for legal or other purposes unrelated to Medical Necessity
- Mental health or substance use disorder services provided by the New Hampshire Bureau of Behavioral Health
- Custodial care
- Programs in which the member has a pre-defined duration of care without the plan's ability to conduct concurrent determinations of continued medical necessity
- Programs that only provide meetings or activities that are not based on individualized treatment plans
- Programs that focus solely on improvement in interpersonal or other skills rather than treatment directed toward symptom reduction and functional recovery related to lessening of specific psychiatric symptoms or syndromes
- Tuition-based programs that offer educational, vocational, recreational or personal development activities, such as a therapeutic school, camp or wilderness program
- For admissions beginning on or after July 1, 2022, inpatient psychiatric services for mental health diagnoses coverage for admissions exceeding 60 days for members ages 21-64

Benefit Limits

Any service that is more than the benefit limit noted (if any) on that service, unless WellSense Health Plan provides an authorization in advance for additional benefits. Benefit limits can be found in the Benefits Chart in Chapter 4 (*Covered services*).

Benefits excluded by the plan and NH DHHS

Child/Family Health Care Support Services

The following services shall be non-covered as child/family health care support services:

- Any covered service listed which duplicates a service already being provided, such as, but not limited to:
 - Services which are free to the public
 - Travel
 - Phone calls or video conferences, other than those in place of a visit, as described in the regulations

Drugs

- The following are excluded from coverage even if your provider gives you a written prescription:
 - Drugs listed on our formulary (drug list as approved by New Hampshire DHHS) as excluded
 - Prescriptions not written by a licensed practitioner
 - Prescriptions written by an out-of-network provider, except in an emergency, for urgent care when you are traveling outside the service area, for family planning services or when your visit to the provider was authorized by us
 - All over-the-counter drugs that are not listed in our formulary as covered
 - All over-the-counter drugs listed as covered in our formulary—but for which you do not have a written prescription. The written prescription must meet all legal requirements for a prescription.
 - Prescriptions filled at out-of-network pharmacies, except in cases of emergency care or urgent care when you are traveling outside the service area
 - Drugs that WellSense Health Plan specifically excludes:
 - Experimental or investigational drugs
 - Drugs that have not been approved by the FDA, including herbal and/or alternative drugs and medical foods that require a prescription
 - Drugs listed by the FDA as being deemed less-than effective (DESI) and identical, related or similar (IRS) drugs
 - Drugs that are not part of a medical treatment for a specific illness, injury, or disease
 - Drugs used to relieve cough and cold symptoms
 - Drugs used for cosmetic purposes or hair growth
 - Drugs used to enhance or promote fertility or procreation, or for which the labeled use is ovulation stimulation
 - Drugs used for the treatment of sexual or erectile dysfunction
 - Convenience packaged drugs that contain non-prescription topical products and/or medical supplies
 - Dietary and nutritional supplements when not needed to sustain life
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Benefits excluded by the plan and NH DHHS

- Bulk chemicals
- Compounded drugs, if no active ingredients by law require a prescription
- Medication flavoring
- Delivery, shipping and handling costs related to delivering drugs to you

Durable Medical Equipment, including Prosthetics, Medical Supplies, Orthotics, Formulas & Low Protein Foods, Oxygen & Respiratory Equipment

- Equipment that does not meet the definition of “durable medical equipment” in the plan’s Medical Policies. For example, equipment that is used primarily and customarily for a nonmedical purpose is not considered durable medical equipment, even if such equipment has a medically related use.
 - Services which are more costly than other services which could be expected to provide the member with the same outcome.
 - Personal Comfort Items: Items that are primarily for your personal comfort or convenience or environmental comfort. All comfort or convenience items considered to be so by the Centers for Medicare and Medicaid Services (CMS) are excluded. Examples of excluded items include, without limitation: telephones, radios, televisions, handheld showers, and personal care items.
 - Equipment that is a duplicate or back-up item.
 - Customized items such as: customized beds (except for members who are under 21) and customized car seats (except for those used for members who have a neuromotor diagnosis)
 - Devices such as: air purifiers, humidifiers, vaporizers, air conditioners, foot pads, furniture for non-mobility purposes, heaters, fans, heating pads, hot water bottles.
 - Helmets (except for members with drop seizures or severe head-banging disorders), molding helmets (except for members 3 months to 18 months old and meeting certain criteria in the plan’s Medical Policies)
 - Items typically used by the general public for preventing injury or ensuring safety that are free to the public such as massage and therapy tables and equipment, medical bracelets, recreational, therapy and exercise equipment, including bicycles and tricycles, tables, and swings
 - Nursery supplies
 - Thermometers
 - Disposable supplies such as: Band-Aids, corn plasters, sheets, linens, odor barrier product (except as needed for ostomies)
 - Nutritional supplements when not needed to sustain life, except for members under the age of 21 who have a failure to thrive diagnosis or when specialty formulas are prescribed for metabolic diseases or when enteral formulas are prescribed when oral feeds are contraindicated
 - Non-rigid appliances and supplies, such as: elastic stockings, garter belts, corsets, and sports-related braces.
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Benefits excluded by the plan and NH DHHS

- Other excluded items include: Adjust-a-beds, bathtub lifts, bed boards, hot tubs, over-bed tables, telephone arms, and water beds, personal emergency response systems
 - Pneumatic vests and lumbar supports.
 - Safety equipment, such as: bath/shower grab bars, chest harness/seat belts, safe beds, and crib enclosures
 - Safety items used in the absence of a disease or medical condition, such as: door alarms, wanderer/locator devices, protective beds or bedding (except for dust mite covers for members with asthma)
 - Self-help devices that are not primarily medical items, such as: elevators, ramps, sauna baths, special telephone or communication devices (not including speech-generating devices), stair lifts, and chair lifts.
 - Clothing items, except for clothing needed to wear a covered device (for example, mastectomy bras and stump socks) and gradient pressure support aids for lymphedema or venous disease.
 - Wheelchair or mobility aids such as:
 - Air suspension systems (wheelchair accessories)
 - Attendant control switches (wheelchair accessories)
 - Back cushions
 - Back-up wheelchairs for members who already have a manual wheelchair
 - Baskets and horns (wheelchair accessories)
 - Grade aids and antiroll devices for manual wheelchairs (wheelchair accessories)
 - Light packages (wheelchair accessories)
 - Power assist devices or equipment to modify a manual wheelchair into a power wheelchair (wheelchair accessories)
 - Power seat lift mechanisms (wheelchair accessories), over age 21.
 - Customized Strollers (unless member is non-ambulatory, meets wheelchair medical policy criteria, does not already have a wheelchair, and has mobility needs that cannot be met with a commercial stroller)
 - Titanium-framed and sport-type wheelchairs
 - Wheelchair accessory or option for purposes of allowing the member to perform leisure, social, or recreational activities (wheelchair accessories)
 - Wheelchair remote controls
 - Wheelchairs with power stander, seat lift, or stair climbing options
 - Replacement or repair of durable medical equipment or prosthetic devices due to loss, intentional damage, negligence, theft, or due to making improper repairs to the item which would void any manufacturer's warranty; failure to maintain the item through proper routine maintenance by an authorized dealer; or taking any action that would otherwise void the manufacturer's warranty
 - Repairs and adjustments to rented DME and repairs and adjustments to purchased DME within the provider's or manufacturer's warranty
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Benefits excluded by the plan and NH DHHS

- Upgrades to or replacement of any functioning DME that still meets the member's needs, including external insulin infusion pumps, ventilators, and glucose meters
- Hospital-grade breast pumps
- Exercise or hygienic equipment such as: bidet toilet seats, enuresis alarms, exercise mats, exercycles, treadmills
- Physician's equipment, such as manual blood pressure cuffs and stethoscopes
- Assistive technology and adaptive equipment, such as: adaptive or computer switch toys and other such equipment not intended for use in the home
- Computers and computer software (unless required as an augmentative and alternative communication aid)
- Gait trainers (except with an authorization for members who have a reasonable degree of medical certainty of gaining functional ambulation as documented in the member's goal-oriented care plan)
- Supine boards
- Cryotherapy (i.e., Game Ready)
- Hot/cold compression therapy
- Polar packs

Education-Related Services

- Educational-related services: examinations, evaluations, or services for educational or developmental purposes, including physical therapy, speech therapy, and occupational therapy

Also excluded are:

- Academic performance testing not related to a medical condition
 - Services for behavior problems and developmental delays
 - Services to treat learning disabilities
 - Services related to school-based sports
 - School-based services, including, but not limited to speech, hearing, and language disorders. (School-based services may be covered by NH Medicaid)
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Benefits excluded by the plan and NH DHHS

Environmental modifications and controls (unless they are covered items under the member's home and community-based services (HCBC) waived program), including:

- Wheelchair ramps
- Tub rails
- Air conditioners
- Air purifiers
- Humidifiers
- Vaporizers
- Power generators
- Aromatherapy
- Stairway elevators/stair lift
- Heaters
- Fans
- Ceiling tract lifting device

EPSDT-Specific Excluded Services

The following services are excluded from coverage when provided in relation to EPSDT:

- Any service that is not medically necessary or for which the medical necessity has not been established
 - Services that have not been proven to be safe or effective, as documented in medical peer review literature
 - Experimental or investigational treatment
 - Services which are more costly than other services which could be expected to provide the member with the same outcome
 - Services which are not medical in nature, except that transportation shall be covered as described in this handbook, including listed in the Benefits Chart in Chapter 4 (*Covered services*).
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Benefits excluded by the plan and NH DHHS

Experimental and Investigational Treatments

- Experimental or investigational treatments, as determined by the plan's Medical Policies; or
 - Experimental or investigational treatments (or related services or drugs that are provided for the purpose of furnishing these treatments) as described in the current edition of the "Medicare National Coverage Determination Manual" found at [cms.hhs.gov](https://www.cms.gov/medicare/coverage/determination-manual); or
- The following services:
- Actigraphy
 - Lumbar Artificial Disc Replacement
 - Computer Assisted Navigation for Orthopedic Procedures
 - Electromagnetic therapy for skin ulcers
 - Electrosleep therapy
 - Mechanized Spinal Distraction Therapy
 - Prolotherapy
 - Subtalar arthroereisis
 - Thermogenic therapy
 - Transoral Incisionless Fundoplication for GERD
 - Whole Body Integumentary Photography

If a treatment is experimental or investigational, we will not pay for that treatment or any related services or drugs that are provided to the member for the purpose of furnishing the experimental or investigational treatment.

Clinical Trials Exception: In accordance with our Medical Policy, we will cover the cost of otherwise covered patient care services for members diagnosed with cancer and enrolled in a qualified clinical trial. Patient care services do not, under any circumstances, include the costs of the experimental or investigational treatment (such as a drug or device) being tested in the trial.

Foot Care

- Foot and shoe orthotics; arch supports, shoe inserts; or fittings, casting and other services related to devices for the feet (except for members with diabetes, peripheral vascular disease or metabolic, neurological conditions, or pathological conditions of the foot due to localized illness, injury or symptoms involving the foot)
- Orthopedic or corrective shoes that are not part of a covered leg brace
- Routine foot care (trimming of corns, nails, or other hygienic care) except as described in the Benefits Chart in Chapter 4 (*Covered services*)

Homecare Services

- Social worker, physician, and nutritionist services, and home-delivered meals
 - Homemaker services, except when provided as part of an authorized waived program such as HCBC-elderly and chronically ill (ECI) support plan to HCBC-ECI members
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Benefits excluded by the plan and NH DHHS

- Respite care, except when provided as part of a licensed hospice program; or as a service under a home and community-based care waiver in accordance with federal regulations
- Visits provided solely for the purpose of supervising the home health aide
- Homecare services without a physician's signed order
- Any service whose primary purpose is providing emotional support
- Services which are not medically related and constitute routine household activities, day care, or recreational services
- Homecare services that are provided through other state-funded department programs

Infertility Services

The plan does not cover any infertility services. These are services to enhance fertility or procreation. These include the following:

- Costs associated with donor recruitment, testing, and compensation
- Cryopreservation of eggs, sperm, or embryos
- Donor sperm and associated laboratory
- Drugs for anonymous or designated egg donors that are directly related to a stimulated Assisted Reproductive Technology (ART) cycle
- Experimental or investigational infertility procedures
- Infertility services necessary for conception as a result of voluntary sterilization or following an unsuccessful reversal of a voluntary sterilization
- Operations for impotency
- Operations, devices, and procedures for the purpose of contributing to or enhancing fertility or procreation
- Reversal of voluntary sterilization
- Surrogacy/gestational carrier related costs: this means all procedures and costs incurred by a fertile woman to achieve a pregnancy as a surrogate or gestational carrier for an infertile member
- Pre-implantation genetic diagnosis (PGD)

Inpatient Hospital Services

Inpatient hospital visits for non-acute inpatient stays shall be non-covered, including but not limited to:

- Member stays in an inpatient hospital setting while awaiting placement to a long-term care facility
- Visits for days that have not been approved by a Quality Improvement Organization (QIO) in accordance with NH requirements

Maternity and OB/GYN Care

- When the member is traveling outside the service area, we will not cover:
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Benefits excluded by the plan and NH DHHS

- Routine maternity services for prenatal or postpartum care; or
- Maternity services (including postpartum care and care provided to the newborn) or problems with pregnancy beyond the 37th week of pregnancy or any time after the member has been told by her provider that she is at risk for early delivery
- Services by a NH Medicaid certified midwife (NHCM) for which a NHCM is not legally recognized to perform, as it is not within the scope of his/her license, including any of the following:
 - Operative obstetrics
 - Cesarean sections
 - General and conductive anesthesia
 - Contraction stress tests
 - Treatment to enhance fertility or procreation
 - Any artificial, forcible, or mechanical means to assist the delivery
 - Induced abortions

Personal Care Attendant Services

Personal care attendant services that are not medically oriented, including any of the following:

- Chore services, which are tasks that exceed light housekeeping
- Services provided outside the member's home for the convenience of the personal care attendant, such as care provided at the personal care attendant's home, or any other location where the recipient would not normally go within the community
- Services performed for the convenience of the member, or the member's family member(s), or intended to otherwise replace assistance available through the member's natural supports system, time spent with the member when no actual hands-on care or other covered services are being provided, including, but not limited to supervision, companion care, baby-sitting the recipient's dependents, or social visits.
- Services provided to a member while the member is:
 - An inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease, in accordance with federal regulations
 - An inmate of a public institution in accordance with 1905(a)(27)(A) of the Social Security Act
 - Attending a program for which personal care services are already provided, such as adult medical day care

Physical Appearance

- Services to promote a desired lifestyle
 - Cosmetic Services/Cosmetic Surgery: These are services given solely for the purpose of changing or improving a member's appearance whether or not these services are meant to
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Benefits excluded by the plan and NH DHHS

make a member feel better about himself/herself or treat a member's mental condition.

Examples of excluded services are:

- Injection of collagen or other bulking agents to enhance appearance; or thigh, leg, hip, or buttock lift procedures
- Blepharoplasty unless medically necessary to prevent vision occlusion
- Facelift surgery or rhytidectomy
- Abdominoplasty, abdominal liposuction, or suction-assisted lipectomy of the abdomen, mini abdominoplasty, repair of diastasis recti, panniculectomy for back or neck pain and as an adjunct to other procedures
- Dermabrasion or other procedures to plane the skin
- Acne-related services, such as the removal of acne cysts or injections to raise acne scars
- Hair removal, hair transplants, or hair restoration
- Electrolysis
- Rhinoplasty (except as part of a medically necessary reconstructive surgery)
- Liposuction
- Brachioplasty
- Treatment of spider veins
- Treatment of melasma
- Tattooing or reversal of tattooing except when needed as a result of breast cancer
- Reversal of inverted nipples
- Body piercing
- Removal or destruction of skin tags

Private Duty Nursing (PDN)

- Private duty nursing shall not be a covered service when the member resides in any one of the following:
 - A licensed nursing facility
 - A licensed hospital
 - A licensed assisted living residence (ALR)-supported residential health care (SRHC) facility
 - A licensed private non-medical institution as defined in the federal requirements (42 CFR 434.2)
 - An intermediate care facility for the mentally retarded (ICF/MR)
 - An institution for mental diseases (IMD) as defined in the federal requirements (42 CFR 435.1010)
 - Private duty nursing shall not be covered when the services consist only of assistance with activities of daily living or other non-skilled services needed to live at home that do not require a nurse, including but not limited to assistance with grooming, toileting, eating, dressing, getting into or out of a bed or chair, and walking
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Benefits excluded by the plan and NH DHHS

Procedures and Treatment

- Dental services to treat TMJ (temporomandibular joint) syndrome; all TMJ-related appliances, other than a mandibular orthopedic repositioning appliance (MORA); services, procedures or supplies to adjust the height of teeth or in any other way restore occlusion, such as crowns, bridges, or braces; and medical and dental treatment of TMJ disorders that are not proven to be caused by or to result in a specific medical condition
- Harvesting of a human organ transplant donor's organ or stem cells when the recipient is not a member
- Massage therapies
- Service to enhance sexual activity
- Thermogenic therapy, which treats certain types of resistant infectious diseases through the production of artificial fever
- Pre-implantation genetic diagnosis testing
- Snoring: services to treat or reduce snoring. Examples include: laser assisted uvulopalatoplasty, somnoplasty, snore guards, and any other snoring-related appliances
- Weight-related services equipment:
 - Commercial diet plans
 - Services in connection with such plans or programs
 - Weight loss or weight control programs and clinics (except those related to covered bariatric surgery or programs)
 - Exercise regimens
- Treatment at sports medicine clinics; services by a personal trainer; or any diagnostic services related to any of these programs, services, or procedures

Provider Fees

- Claim Fees: A provider's charges to file a claim.
 - Concierge Services: Any fees charged by a provider for so called "concierge services." These are fees charged as a condition of selecting or using the services of the provider or fees for amenities offered by the provider.
 - Medical Record Fees: Fees charged by providers for copies of medical records.
 - Missed appointment charges
 - Physician Care in a non-medical government or public institution
 - Physician services for the surgery, inpatient hospital services for the surgical admission(s), and organ procurement services related to any of the following types of transplants are non-covered services:
 - Any type of organ transplant or tissue transplant not specified in NH regulations
 - Organ transplants requiring prior authorization but which are not prior authorized
 - More than 2 transplants of the same type of organ per member per lifetime
 - Private Room Charges: Charges greater than the rate for a semi-private room (except when a private room is medically necessary)
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Benefits excluded by the plan and NH DHHS

- Services provided by out-of-network providers, except as follows:
 - Emergency care
 - Urgent care when you are traveling outside our service area
- Family planning services
- If we (or an organization with which we contract) gives prior authorization (in advance) for you to get care from an out-of-network provider
- Taxes: A provider's charge for taxes or sales tax related to any product delivered or given to a member.
- Audit fees

Services Provided Under Another Health Plan

- Government Program Benefits: Services for which a member has the right to benefits under government programs. These include:
 - Medicare
 - The Veterans Administration for illness or injury related to military service
 - Schools
 - Other programs set up by local, state, federal or foreign laws or regulations that provide or pay for healthcare services or that require care or treatment to be provided in a public facility
 - No coverage is provided if the member could have received governmental benefits by applying for them on time
- Workers' Compensation: Care for conditions for which benefits are available under a workers' compensation plan or an employer under state or federal law

Transportation, Non-Emergency

General Transportation services are not covered in the following situations:

- If you or another family member/friend are able to drive and have access to a car that can be used to drive you to and from your covered service
 - If you (or your provider) did not obtain a reservation number in advance from the WellSense Transportation Line
 - A member reimbursement is submitted for more than one family member when multiple members of the same household are being transported to the same location
 - A member reimbursement when a member has failed to comply with the member reimbursement guidelines (example: if the member filed for reimbursement outside of the required 30 calendar day timeframe requirements)
 - When you go to a pharmacy to pick up medication and the pharmacy provides free delivery services to your home
 - If you need transportation to anything other than healthcare services that are plan covered services or healthcare services covered directly by New Hampshire Medicaid. For example, you are not eligible for transportation coverage when the purpose of the transport is to take
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Benefits excluded by the plan and NH DHHS

you grocery or other shopping, banking, picking up children, getting to work, or doing laundry.

- When you are able to obtain free transportation
- When the transportation is payable by another agency
- When transportation by ambulance is only for the member's or his or her family's convenience
- The following services shall not be covered as wheelchair van services:
 - Transportation for purposes of member or provider convenience
- Transportation that is otherwise available free of charge or payable by another agency, or transportation to obtain an item when the item can be obtained using a free delivery service
- Transportation for any purpose other than to receive plan covered services or NH Medicaid covered services from a network Medicaid provider

Types of Care

- Outpatient cardiac rehabilitation without continuous ECG monitoring
- Chiropractor services of any form—regardless of who provides the service
- Child care
- Cognitive rehabilitation programs, cognitive retraining programs, and diagnostic services related to these programs
- Custodial care, long-term care, or care in a rest home
- Dental Services: The plan does not pay for any dental services, including emergency dental services. Dental services are any service provided by a licensed dentist involving the diagnosis or treatment of any disease, pain, injury, deformity, or other condition of the human teeth, alveolar process, gums, jaw, or associated structures of the mouth. The plan also does not pay for splints, dentures, and oral appliances. Dental services and appliances may be covered by NH Medicaid.
- Services requested for the sole purpose of accommodating a member's religious preference and not for medically necessary reasons
- Services to improve athletic performance
- Services for which there is a less intensive level of service or more cost-effective alternative that can be safely and effectively provided, or if the service can be safely and effectively provided to the member in a less intensive setting, and would provide the member with the same expected outcome

Vision & Hearing

- Auditory training (except for auditory trainer devices, which are covered)
 - Replacement of hearing aids due to loss, misuse, or abuse, except for recipients under age 21 year if covered in accordance with EPSDT medical necessity criteria and replacement is due to loss FM (frequency modulation) systems, if the systems are for the sole purpose of
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Benefits excluded by the plan and NH DHHS

- member use in an educational setting and are coverable under Medicaid in the Schools program
- Repair of hearing aids which are covered under a warranty
 - Pocket talker repairs, batteries, accessories, except replacement of a headset, earbuds, or neckloop for a pocket talker once every year if an audiologist determines that such accessories are malfunctioning; and optional telelinks
 - A pocket talker if a hearing aid is already covered by Medicaid
 - A hearing aid if a pocket talker is already covered by Medicaid, unless authorization criteria have been met
 - Binaural hearing aids for members 21 years of age or over when authorization criteria have not been met
 - The following vision-related items and services:
 - Refractive eye surgery including laser surgery
 - Radial keratotomy and orthokeratology
 - Orthoptics and vision therapy
 - Glasses, frames and contact lenses, unless specifically listed as a covered service in this handbook
 - Replacement of lost glasses for members 21 or older, and more than one pair of glasses for lifetime of members under age 21
 - Progressive lenses
 - Photochromatic lenses, including transition lenses, except for members with ocular albinism
 - Low vision aids such as magnifying glasses sunglass and eyeglass tinting and polarized lenses and anti-reflective coatings
 - Titanium frames high index lenses

General Excluded Services

- Services provided outside of the United States and its territories
 - Services for non-members
 - Services and/or equipment that lack effectiveness or have not been proven to be safe as outlined in reputable medical peer review literature
 - Services for which a member is not legally obligated to pay, or services which are free to the public and for which no charge would be made in the absence of health insurance
 - Services provided by individuals who are not licensed, certified, or otherwise recognized by NH regulations to provide such services
 - Services given or furnished to a member by his/her immediate family (by blood or marriage) or anyone who ordinarily lives with the member, except as allowed for transportation services. "Immediate family" means: spouse or spouse equivalent, parent, child, brother, sister; stepparent, stepchild, stepbrother or stepsister, father-in-law, mother-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, or grandchild.
 - Services not described as a covered service in this handbook
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Benefits excluded by the plan and NH DHHS

- Services related to or furnished along with a non-covered service, except as otherwise expressly stated in this handbook, including the Benefits Chart in Chapter 4 (*Covered services*). This includes costs for professional fees, medical equipment, drugs, and facility charges.
 - Services that are not medically necessary. The only exceptions are: voluntary sterilization, prescription birth control drugs used for contraceptive purposes and preventive health services described in this handbook.
 - Services that do not meet the plan's Medical Policies
 - Duplicative services. These are services that deliver the same functionality to the same member during the same period of time, regardless of whether those services are provided solely under Medicaid or by Medicaid in combination with another program or entity.
 - Services that the member received when not enrolled as a member under this plan. This means before the member's effective date and after his/her plan membership ends.
 - Charges for services that the member received after he/she chose to stay in a hospital or facility beyond the discharge date determined and communicated by us unless the member avails himself/herself of the appeals option described in this handbook
 - Third-Party Required Treatment: services required by a third party that are not otherwise Medically Necessary. Examples of third parties include: an employer, insurance company, licensing organization/agency, school, or court (unless requested services are otherwise used to determine medical necessity for covered Medicaid health care services). Examples of services include: exams and tests required for recreational activities or employment, court-ordered exams, vocational evaluations on job adaptability, vocational rehabilitation, job placement, or therapy to restore function for a specific occupation. Also excluded are: tests to establish paternity, tests for forensic purposes, services related to occupational ailments or injury, and post-mortem autopsies, exams, and tests.
 - Transportation and Lodging: transportation (other than as described in this handbook, including the services listed in the Benefits Chart in Chapter 4 (*Covered services*)), or lodging related to receiving any medical service
 - Service animals and related expenses
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Chapter 5: Using WellSense Health Plan to help manage your health

Section 5.1 Staying healthy

WellSense Health Plan offers several programs and services to help you stay healthy. For example, the plan offers annual flu shots, regular eye exams, breast cancer and colorectal screenings, and blood pressure monitoring to keep you healthy and to assist you and your provider in identifying potential health issues. Our family planning services can help you plan when to have children and regular prenatal care will help you stay healthy when pregnant. In addition, our Care Management program is available to assist you in managing complex, chronic, or long-term conditions such as asthma, cancer, depression, or diabetes.

Getting regular routine health care visits (sometimes called a “wellness visit”) with your PCP are important to your health and well-being. Your PCP can help you keep up to date with gender and age specific preventive care screenings like mammograms, PAP smears, and other health screenings. Your PCP can also help identify and refer you to other services you may need to stay healthy.

Regular visits with your PCP help build a strong, trusting relationship with your provider which is shown to have positive effects on health outcomes.

Your OB/GYN

You need to see a doctor as soon as you know you are pregnant. Please also notify WellSense as soon as you know you are pregnant.

An obstetrician (OB) is a doctor who is trained to care for pregnant women and deliver babies. This type of doctor may also be a gynecologist (GYN). Family practice providers and midwives may provide care when you are pregnant. They are trained to know all about conditions of the female reproductive system.

If you think you are pregnant, you should either:

- Ask your PCP to recommend a doctor in our provider network (no prior authorization is required) OR
- Call a WellSense Health Plan network provider who is an OB/GYN or family practice doctor and make an appointment. (No prior authorization is needed to see a network provider who is an OB/GYN doctor.)

Pregnancy (prenatal) care

The healthcare you get while you are pregnant is called “prenatal care.” This type of care is very important. It is the best way to:

- See how your pregnancy is going
- See if you and your unborn baby are getting good nutrition

- Make sure your baby is developing properly

Your healthcare provider will monitor you throughout your pregnancy. He or she wants to make sure your baby is developing properly. Early and regular prenatal care is very important to help you have a healthy pregnancy, healthy baby, and a safe delivery. You should also see your OB/GYN as often as the OB/GYN wants to see you. You should see your OB/GYN for follow-up care. This is between 21 and 56 days after your baby is born. We cover all these visits.

Also, let your PCP know you are pregnant. Your PCP can help coordinate your care while you are pregnant. He or she can also give important health information about you to the OB/GYN doctor. This will help you and your unborn baby remain in good health.

Family planning services

Family planning is an important part of staying healthy. Your PCP or family planning services provider can help you plan when to have children. As a member, you may go to any New Hampshire Medicaid participating family planning services provider, including:

- Your PCP
- Other network provider
- An out-of-network provider

Your coverage includes services those listed in the Benefits Chart in Chapter 4 (*Family Planning Services*). These services do not require prior authorization. For a listing of network providers, see our online *Provider Directory* at wellsense.org.

Your family planning services provider can give you information about sexually transmitted diseases (STDs). They can also give you tips for staying healthy.

Staying healthy

The best healthcare happens before you get sick. This is called preventive care. To help you stay healthy, we have put together a chart to show you all the tests and shots you and your children should have, depending on age. If you are in need of a copy of the chart you can call Member Service and we can provide it to you. (Phone numbers are printed in the back of this handbook.) You can also find the chart on our website at wellsense.org.

Primary Care and Prevention Focused Care Model shall include:

- Guaranteed access to related services for all members
- Delivery of services in a manner both clinically and developmentally appropriate, patient focused and support the member may rely on
- Provider delivered care coordination and integration with social services and community care
- Selection or assignment of a PCP within 15 calendar days of enrollment
- Completion of the member welcome call and Health Risk Assessment
- Wellness Visit with PCP at least once per year including screenings for obesity, anxiety, depression and suicide risk, unhealthy alcohol use, unhealthy drug use, and falls prevention

- Medically necessary diagnostic and treatment of covered services based on the findings or risk factors identified in the annual wellness visit, completion of a HRA screening, or during routine, urgent, or emergency health care visits
- Comprehensive Medication reviews
- Transition of care management including coordinating appropriate services between settings of care
- Provider delivered care coordination including:
 - PCP oversight of clinical and non- clinical services, including but not limited to behavioral health services and health related social needs
 - PCP adoption and utilization of oversight to promote efficiency and optimal communication between providers
 - PCP education and training

Preventive care for adults

Routine care to prevent illness is an important part of staying healthy. We encourage all members to visit their primary care providers for a health evaluation and preventive care. Some examples are below:

- Physical exams to be done yearly.
- Blood pressure monitoring beginning at age 18 and at least every two years and whenever you have a visit with your PCP.
- Cholesterol screening beginning at age 18 or as recommended by your healthcare provider.
- Pelvic exams and Pap smears every three years starting at age 21 for women at average risk. These exams screen for cervical cancer.
- Breast cancer screening (mammogram) every two years for ages 40-74; earlier or more frequently based on risk factors.
- Members ages 16-25 who are sexually active should have a chlamydia test every year.
- Colorectal cancer screening starting at age 45 to 50 based on risk factors. Frequency is dependent on the type of test used; follow your doctor's recommendation. If there is an immediate family history of colorectal cancer, exams could be more frequent.
- Flu shot every year.
- Eye exams once every 24 months. (More often if certain medical conditions exist).

Preventive and well-child care for all children

All children under age 21 should go to their PCP for an annual checkup after age 3 and more frequently in the first 2 years of life (even when they are well). Your child's PCP will offer screenings to find out if there are any health problems. These screenings are part of a well-child checkup and include: vision, hearing, immunizations, developmental, and behavioral health.

Behavioral Health screenings can help you and your doctor or nurse identify behavioral health concerns early.

New Hampshire Medicaid requires that primary care providers and nurses use standardized screening tools to check a child's behavioral health during their well-child visits. The screening tools are approved by New Hampshire Medicaid. Screening tools are short lists of questions or

checklists that the parent or child (depending on the child's age) fill out and discuss with the doctor or nurse. You can ask your PCP which tool he or she will use when screening your child for behavioral health concerns. Your provider will discuss the completed screening with you. The screening will help you and your doctor or nurse decide if your child needs further assessment by a behavioral health provider or another medical professional. Information and assistance will be available if you or your doctor or nurse thinks that your child needs to see a behavioral health provider. For more information on how to get behavioral health covered services, or to pick a behavioral health provider, talk to your PCP. You can also call the Carelon Member line at the number found in Section 2.6 (*How to request behavioral health services (mental health or substance use disorder services)*).

WellSense Health Plan pays your child's PCP for these checkups. At well-child checkups, the PCP can find and treat small problems before they become big ones. Here are the ages to take a child for full physical exams and screenings:

- at 1 to 2 weeks
- at 4 months
- at 12 months
- at 1 month
- at 6 months
- at 15 months
- at 15 months
- at 9 months
- at 18 months

Children and adolescents should visit their PCP according to the schedule advised by the American Academy of Pediatrics according to Bright Futures Preventive Health Care found at

https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf.

Children should also go to their PCP any time there is a concern about their medical, developmental, or behavioral health needs, even if it is not time for a regular checkup.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services

If you or your child is under age 21, we will pay for EPSDT medically necessary services. We will pay even if the services are not specifically included in your Benefits Chart (Section 4.2) in Chapter 4 (Covered services). This coverage includes:

- Healthcare
- Diagnostic services
- Treatment and other measures needed to correct or improve deficits and physical or behavior health illnesses and conditions
- Applied Behavioral Analysis

When a PCP or any other provider discovers a health condition, we will pay for medically necessary services covered under Medicaid law. The treatment must be delivered by a network provider who is qualified and willing to provide the service. In addition, a physician or nurse practitioner or nurse midwife must support in writing the medical necessity of the service. You and your PCP can seek help from us to find out what network providers may be available to provide these services and, if necessary, how to get authorization for out-of-network providers. Most of the time, these services

are already covered by your child's WellSense Health Plan coverage and are included on your Benefits Chart in Chapter 4 (*Covered services*).

If the service is not already covered or is not on the list, the provider who will deliver the service can ask us for prior authorization. WellSense Health Plan uses this process to determine if the service is medically necessary. The plan will pay for the service if prior authorization is given. If prior authorization is denied, you, or your authorized representative, have a right to appeal. See Chapter 10 (*What to do if you want to appeal a plan decision or "action" or file a grievance*) or more information. Talk to your child's PCP, behavioral health provider, or other specialist for help in getting these services.

Care Management – special help if you have certain health conditions

We offer special health programs to members to fully respond to their needs, integrating physical, social, behavioral health services, pharmacy management, and wellness services. These are called Care Management programs. Our care management program consists of the following components:

- Care Coordination and care navigation for medical, behavioral health, and social needs
- High-cost/high-risk member management programs
- Management of members with Priority Population characteristics:
 - HIV/AIDS (adult and childhood)
 - A Serious mental illness
 - A Serious emotional disorder
 - Intellectual/developmental disability
 - Substance use disorder diagnosis (SUD)
 - Chronic pain
 - Members receiving services under HCBS waivers
 - Members identified as those with rising risk
 - Individuals with high unmet resource needs
 - Mothers of babies born with neonatal abstinence syndrome
 - High risk newborns: under 2500g and Neonatal Opioid withdrawal
 - Pregnant women with (SUD)
 - Intravenous drug users, including members who require long-term IV antibiotics and/or surgical treatment as a result of IV drug use
 - Individuals who have been in the ED for an overdose event in the last twelve (12) months
 - Recently incarcerated individuals
 - Individuals who have a suicide attempt in the last twelve (12) months.
 - Coordination and integration with social services and community care
 - Coordination of long-term services and supports
 - Division for Children, Youth & Families involved youth
 - Members discharged from a behavioral health inpatient admission
 - Maternal and Child Health

- Behavioral Health

See Section 5.2 (Care coordination support) for more on our Care Management programs. If you have a chronic or long-term condition that is not listed, we will work with you and your healthcare provider to help manage your care.

Section 5.2 Care coordination and care management support

Your PCP or any provider can refer you to WellSense Care Management. They will work collaboratively with Care Management in order to coordinate the most efficient and comprehensive care to keep you healthy. You can also call WellSense and enroll in Care Management, Monday – Friday at 855-833-8119. Our Care Management program gives you the information and tools you need to build and maintain a healthy lifestyle.

Our experienced Care Management staff includes:

- Registered nurses
- Licensed social workers and behavioral health clinicians
- Community Wellness Advocates
- Care Management support staff

Our staff works with you to help you understand your health condition. We will teach you how to take care of yourself and what questions to ask your provider. Our staff will also help coordinate care with all of your doctors and community support services. We will get you the right services and information so you can manage your condition and be healthy. Our Care Management program is free for all members.

Our Care Management program is made up of:

- You
- Your healthcare providers
- Our care managers

We all work together for you. Our care managers will schedule a time to check in with you and we will also provide you with your care manager's direct phone line. The care manager will check on your progress and answer questions regarding your health. We will also help you learn what benefits and community resources are available. We want to help you with more than just healthcare. Our experienced staff can link you with services such as:

- Support groups
- Food stamps
- Housing and emergency shelter
- Assistance with utilities
- Community resources/partners
- Transportation to healthcare appointments

These resources are available to all members, not just those enrolled in Care Management.

Medical Care Management (CM)

Medical Care Management (including disease management) has several program programs aimed at supporting your individual needs. Members within the WellSense Care Management program

will receive interventions based on their risk levels and needs. These interventions will include three categories:

- Care Management Education and Wellness
- Low to Moderate Risk Care Management and Chronic Condition Management
- Complex Care Management

Care Management Education and Wellness

This Education and Wellness program offers information and coaching. We educate you and share culturally and linguistically appropriate educational materials, tools, and resources that promote wellness and disease prevention. The goal is to help you learn and follow new and easy ways to manage your health and provide assistance on the following topics:

- Nicotine cessation
- Childbirth and pre-natal care
- Nutrition
- Stress management
- Physical activity and self-care training, including self-examination
- Over-the-counter and prescribed medications

You and your caregivers also receive personalized information regarding signs and symptoms of common diseases and conditions—such as stroke, diabetes, and depression—and their potential complications. The program focuses on teaching you the importance of self-managing your own health, along with working with your healthcare Provider, to accomplish your health-related goals. We emphasize that early intervention and risk reduction strategies can help avoid complications that occur with disability and chronic illness. As a partner in fostering the health of you, we work with Providers to integrate health education, wellness, and disease prevention into your care.

You can find these resources by logging on to wellsense.org and clicking on Care Management under the member pages. Our online Wellness Center also has helpful information for members on how to stay healthy.

Low to Moderate Risk Care Management and Chronic Condition Management

Low to Moderate Risk Care Management and Chronic Condition Management is an intermediate-level care management program that focuses on helping you develop self-management skills, arranging services, and providing health education. This level offers a more involved approach in which care manager's work directly with you and your *care team*, either by telephone or in person. Care managers assess your condition, coordinate your care, and review available benefits with you. The care manager, with assistance from a Community Wellness Advocate, can help set up services such as family support and community resources. Additionally, they develop and implement individualized *care plans* with you, emphasizing psychosocial and socioeconomic support, self-management goals, care coordination, ongoing monitoring, and appropriate follow-up.

Complex Care Management

The Complex Care Management program is aimed at addressing more complex conditions such as multiple chronic conditions, psychosocial and socioeconomic needs, and high emergency department and inpatient utilization. This may also include individuals who may be unable to adhere to treatment plans designed by providers.

Conditions that may be appropriate for a CM referral for care management include:

- Certain functional impairments that impact personal skills and/or clinical needs
- High emergency department, inpatient, or pharmacy usage
- Homelessness
- An illness or event that has caused a change or decline in ability to self-manage
- Multiple hospitalizations or readmissions to the hospital

Participation in Care Management

Our Care Management program is free and voluntary. Your participation in the program does not replace the care and services that you receive from your PCP and other providers. Entry into the program may happen in many ways. For example:

- Through completing your Health Risk Assessment
- Our review of claims information
- A referral from a hospital care manager, discharge planner, one of our care managers or Utilization Management staff or one of your providers or caregivers
- Self-referral
- Through calling the information line

If you think you would benefit from one of our programs, please call medical Care Management at 855-833-8119 to learn more. You can also opt out of any of our programs by calling the same number.

Behavioral Health Care Management

WellSense offers Care Management and care coordination support to our members with certain behavioral health (mental health and substance use disorder) conditions. WellSense's care managers are behavioral health clinicians who are trained to help you with your behavioral health care needs. WellSense can help you find a behavioral health counselor near you. They can also explain available treatment options. Some of the conditions followed by the WellSense care management team are:

- Depression
- Emotional distress greatly affecting your relationships, school, work, job performance, sleep, or eating patterns
- Mental health needs such as bipolar disorder, mood disorders, or psychotic disorders
- Substance Use Disorder conditions such as opioid and alcohol addiction

To learn more: Call 855-833-8119 for Behavioral Health Care Management.

Section 5.3 Continuity of care, including transitions of care

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

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

WellSense collects information in advance of the transition from New Hampshire Fee for Service Medicaid or another Medicaid managed care plan or from your providers when you move from one treatment setting to another. If your provider leaves the WellSense network, we will work with you and your provider to transition you to a new network provider, or in certain circumstances such as those listed below, allow you to remain with your current provider.

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

<p>When one of these clinical circumstances apply to you, you may continue to get care from your treating provider(s) for a limited time</p>	<p>You may continue to get care from your treating provider(s) during this time period</p>	<p>You may continue to get currently prescribed prescription drugs during this time period</p>
<p>You are receiving a prior authorized ongoing course of treatment your current provider at the time of transition</p>	<p>Up to 90 calendar days from your enrollment date or until the completion of a medical necessity review by the plan, whichever occurs first</p>	<p>For up to 90 calendar days from your enrollment date or until the completion of a medical necessity review by the plan, whichever occurs first</p>
<p>You are receiving services with your current provider and you have an acute illness, a condition that is serious enough to require medical care for which a break in treatment could likely result in a reasonable possibility of death or permanent harm</p>		
<p>You are receiving services that need to continue because you have a chronic illness or condition, a disease or condition that is life threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time</p>		
<p>You are a child with Special Health Care Needs meaning those who have or are at increased risk of having a serious chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that usually expected for the child’s age and you are in a course of ongoing treatment at the time of transition*</p>		
<p>You are in your second or third trimester of pregnancy and prefer to continue to receive care through your current provider</p>	<p>Through your pregnancy and up to 60 calendar days after delivery</p>	
<p>You desire or require continued services with your current providers because you have a terminal illness, you have a medical prognosis that life expectancy is six (6) months or less</p>	<p>For the remainder of your life with respect to care directly related to the treatment of the terminal illness or its medical effects</p>	

*Including children or infants in foster care; requiring care in a neonatal intensive care unit; diagnosed with neonatal abstinence syndrome (NAS); in high stress social environments/caregiver stress; receiving family centered early supports and services, or participating in certain specialized state programs that support members with a serious emotional disturbance, intellectual developmental disability or substance use disorder diagnosis.

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

For more information, contact Member Service (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:

- WellSense Health Plan 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;
- WellSense Health Plan must have similar prior authorization requirements and treatment limitations for mental health and substance use disorder benefits as it does for other medical benefits;
- WellSense Health Plan must provide you or your provider with the medical necessity criteria used by WellSense Health Plan for prior authorization upon either your request or your provider's request;
- WellSense Health Plan must not impose aggregate lifetime or annual dollar limits on mental health or substance use disorder benefits;
- Within a reasonable time frame, WellSense Health Plan must provide you the reason for any denial of authorization for mental health and/or substance use disorder services; and
- If WellSense Health Plan 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 WellSense Health Plan 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 WellSense Health Plan did not cover behavioral health services (mental health and/or substance use disorder services) in the same way as medical services, you may also file a grievance or complaint with the New Hampshire Department of Insurance Consumer Services Hotline at **1-800-852-3416** (TDD Access Relay: 1-800-735-2964), Monday through Friday, 8:00 a.m. to 4:30 p.m. ET, or online at <https://www.nh.gov/insurance/consumers/complaints.htm>.

Chapter 6: Rules on prior authorization of services

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

Section 6.1 Medically necessary services

When making its coverage decision, WellSense Health Plan will consider whether the service is medically necessary

WellSense Health Plan 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 Service and request a copy of written rules specific to your situation. (Phone numbers for Member Service are printed on the back cover of this handbook.)

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

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

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

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

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

- Clinically appropriate in extent, site, and duration;
- Consistent with the established diagnosis or treatment of the recipient's illness, injury, disease, or its symptoms;

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

Section 6.2 Getting plan authorization for certain services

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

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

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

- Plan decisions involving urgent care shall be made as expeditiously as your health condition requires, but no later than 72 hours after receipt of the request for service, unless you or your authorized representative fails to provide sufficient information to determine whether, or to what extent your benefits are covered.
- In the case of such failure, WellSense Health Plan shall notify you or your authorized representative within 24 hours of receipt of the request and advise of specific information needed for the plan to make a decision.
- You or your representative shall be afforded a reasonable amount of time, taking into account any special circumstances, but not less than 48 hours to provide specified information.
- Thereafter the plan's decision shall be made as soon as possible, but not later than 48 hours after the earlier of the plan's receipt of the specified additional information, or the end of the period afforded to you or your authorized representative to provide the additional information.
- In the case of authorization requests to continue or extend your service(s) involving urgent care of an ongoing course of treatment and a question of medical necessity, the plan's decision shall be made with 24 hours of receipt of the request provided the request is made at least 24 hours prior to the expiration of the prescribed period of time or course of treatment.
- If you disagree with the plan's adverse prior authorization decision, refer to Section 10.1 (*About the appeals process*).

For all other prior authorization decisions by WellSense Health Plan, the following conditions apply:

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

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

- The plan's decision shall be made within 30 calendar days of receipt of you or your authorized representative's coverage request.
- In the event you or your authorized representative fail to provide sufficient information for WellSense Health Plan to make its decision, the plan will notify you or your authorized representative within 15 calendar days of the date of the request as to what additional information is required for the plan to make its decision. You or your authorized representative have 45 calendar days to provide the required information. If the plan requests specified additional information, the timeframe for decision resumes upon receipt of the specified additional information.
- For an adverse decision, the plan will notify you or your authorized representative in writing within 3 calendar days of the decision.
- If you disagree with the plan's adverse prior authorization decision, refer to Section 10.1 (*About the appeals process*).

For help with your service request, contact Member Service (Phone numbers are printed on the back cover of this handbook).

Section 6.3 Getting authorization for out-of-network services

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

If you are an American Indian or Alaska Native (AI/AN) of a federally recognized tribe or another individual determined eligible for Indian health care services, special coverage rules apply. You may get out-of-network services at an Indian health facility without prior authorization. Contact Member Service 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

We cover family planning services. These include medical services, counseling, birth control advice, pregnancy tests, sterilization services, and follow-up care. (Sterilization services are permanent medical procedures that prevent you from becoming pregnant or getting someone pregnant in the future.) You can get family planning services from your PCP. You can also get these services from any plan network provider or NH Medicaid participating family planning services provider. No prior authorization from us is required. Ask your PCP for a recommendation to a Family planning services provider. You can also call a family planning services provider directly (self-refer).

Section 6.6 Getting a second medical opinion

You may ask for a second opinion about any healthcare services or treatment your provider thinks you should have. Members may receive a second opinion from a qualified health care professional within the network, or one may be arranged by WellSense Health Plan outside the plan's network at no cost to you.

Chapter 7: Getting covered prescription drugs

Section 7.1 Drug coverage rules and restrictions

The plan's Drug List includes information about the restrictions described below. 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 Service (Phone numbers are printed on the back cover of this handbook) or check our website (wellsense.org).

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

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

Drug coverage restrictions

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

Drug list rule restrictions described in this section include:

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

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 review the request for coverage of the brand name drug against the clinical criteria to determine whether the drug should be approved or denied.

Requiring prior authorization from the plan

For these drugs, you or your provider will need to get authorization from the plan in order to get coverage for the drugs. This is called “**prior authorization**”. To find out if prior authorization is required for your drug, check the Drug List at wellsense.org. The Drug List will indicate when authorization is required by stating Prior Authorization Required or PA in the WellSense Medication Guide Book. 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.”

If you are taking a medication that requires step therapy, your Provider may submit a request for us to cover the medication. If the medication is medically necessary, we will cover the medication. If this approval is not given, your drug will not be covered by us. If we don’t approve the request for prior authorization, the drug will not be covered by us.

If you transferred from another managed care plan and you have a prescription that was authorized prior to your enrollment with us and you have one or more refills remaining, your pharmacist may be able to transfer your prescription refills to our plan if the drug does not require prior authorization. For more information, contact Member Service. (Phone numbers are printed in the back of this handbook.)

Imposing quantity limits on a prescription drug

For some drugs in the plan’s Drug List the plan limits the amount of the drug that you can get each time you fill or refill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than 30 pills

per refill and no more than one refill every 30 days. If you try to refill your prescription too early, you may be asked by the pharmacist to refill your prescription later.

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

If your drug is not on the Drug List or has restrictions, here are things you can do:

- Start by talking with your provider about your options.
- Sometimes you may be able to get a temporary supply of the drug. This will give you and your provider time to change to another drug or to file a request to have the drug covered. We provide for a temporary supply of a drug in certain cases where you cannot wait to get a prior authorization from us for coverage of a drug because it will result in a risk to your health. Please have your pharmacy contact our Member Service to obtain authorization for this temporary supply.
- You can change to another drug. You or your provider can request a list of covered drugs that treat your condition from Member Service (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 your doctor thinks it is medically necessary for you to take a medication that is not covered by us, or is not covered under one of our Pharmacy programs, he or she can submit a prior authorization request to us. This request will be reviewed by a clinician. If the drug is medically necessary, we will cover the medication.
- 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*).

Limits on when you may be required to change your covered prescription(s)

You will not be required to change covered prescription drugs more than once per calendar year, except:

- When you are new to Medicaid, or switch from one Medicaid managed care plan to another Medicaid managed care plan;
- When a covered prescription drug change is initiated by your provider;
- When a covered biosimilar product becomes available to the market;
- When Federal Drug Administration (FDA) boxed warnings or new clinical guidelines are recognized by the Centers for Medicare & Medicaid Services, the federal regulator that oversees Medicaid Managed Care health plans;
- When a covered prescription drug is withdrawn from the market because it has been found to be unsafe or removed for another reason; and
- When a covered prescription is not available due to a supply shortage.

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

Section 7.2 Plan formulary or drug list

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

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

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

What is *not* on the Drug List

The plan does not cover all prescription drugs. WellSense Health Plan chooses which drugs to cover and Medicaid law prohibits coverage of some drugs.

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

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

- Visiting the plan's WellSense Health Plan website (wellsense.org). The Drug List on the website is always the most current.
- Calling and asking Member Service to find out if the drug is on the plan's WellSense Health Plan Drug List. (Phone numbers for Member Service are printed on the back cover of this handbook.)
- Calling and asking Member Service for a copy of the Drug List. (Phone numbers for Member Service 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. The over-the-counter OTC drugs that we cover are listed on a separate list on our website at wellsense.org. For more information on coverage of over-the-counter drugs, call Member Service (Phone numbers are printed on the back cover of this handbook).

The formulary or Drug List can change during the enrollment year

During the enrollment year, the plan may make changes to the Drug List. We make changes to the Drug List every month or more frequently if necessary. The online Drug List is updated as changes are made. For example, the plan might:

- **Add or remove drugs from the Drug List.** For example, WellSense Health Plan may add new generic or brand name drugs as they become available. WellSense Health Plan may remove a drug from the Drug List if it is recalled or it is found to be ineffective.
- **Add or remove a restriction on coverage for a drug.** For more information about drug coverage restrictions, refer to Section 7.1 (*Drug coverage rules and restrictions*) in this chapter.
- **Replace a brand name drug with a generic drug.**

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

How you will find out if your drug coverage has changed

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

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 "brand 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 wellsense.org or call Member Service (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. Please also see the excluded benefits that relate to drug coverage in Section 4.5 (*Benefits not covered by our plan or NH Medicaid*).

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.

WellSense Health Plan will not cover drugs in the following situations:

- WellSense Health Plan will not cover Part D drugs if you are enrolled in Medicare Parts A, B, C (Medicare Advantage), or D.
- The drug is purchased outside of the United States or its territories.
- A drug is for an off-label use and the use is not supported in a recognized publication. ("Off-label use" is any use of the drug other than that indicated on the drug label approved by the FDA. Recognized publications are the American Hospital Formulary Service Drug

Information, the DRUGDEX Information System, for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology, or their successors.) **(For members aged 21 years and younger, 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

To find a network pharmacy, you can look in your *Pharmacy Directory*, visit our website (wellsense.org), or call Member Service (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 either to have a new prescription written by your provider or ask the pharmacist to have your prescription transferred to your new network pharmacy.

We will notify you if the pharmacy you have been using leaves the plan's network. If your pharmacy leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy, you can get help from Member Service (Phone numbers are printed on the back cover of this handbook) or use the *Pharmacy Directory*.

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. Certain prescription drugs must be filled through our network specialty pharmacy. These drugs include injectable and intravenous medications that are often used to treat chronic (ongoing) conditions that require special drug support services. Specialty pharmacies can provide extra help to members and providers.

Go to our Drug List on the wellsense.org website to see if your drug is a specialty drug and the instructions and contact information for the Plan network specialty pharmacy will be displayed.

You can also go to the Pharmacy Directory ("Find a Pharmacy" section on our website) or call Member Service. (Phone numbers are printed in the back of this handbook.)

When you may use an out-of-network pharmacy

If you are traveling outside the area and need to fill a prescription due to an emergency or urgent care need, you may have to go to an out-of-network pharmacy. In such case, you may need to pay for the drug and then contact us to have us pay you back.

How you can get an emergency supply of your medication

If you need to fill a prescription due to an emergency or urgent care need, such as when you are traveling outside the area, you may speak to your pharmacist who can help you get an emergency supply of medication or you may contact Express Scripts: 877-957-1300 or 711 for hearing impaired. They are available 24 hours a day, seven days a week. In such cases, you may need to pay for the drug and then contact us to have us pay you back.

How to get a temporary supply of your medication

We provide for a temporary supply of a drug in certain cases where you cannot wait to get a prior authorization from us for coverage of a drug because it will result in risk to your health. Please have your pharmacy contact our Member Service department to obtain authorization for this temporary supply. (Phone numbers are printed in the back of this handbook.)

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. The drugs available through the plan's mail-order service are marked as "**mail-order**" drugs in our Drug List.

To get order forms and information about filling your prescriptions by mail go to our website at wellsense.org. You must enroll in the mail order pharmacy program. To enroll in the mail order pharmacy:

- Contact Cornerstone Health Solutions by phone at 844-319-7588, available Monday to Friday 7:00 a.m. to 6:00 p.m. ET or

- Complete the mail order enrollment form that is located on the plan website under the section titled Two Ways to Get Your Maintenance Medications. The enrollment form is also available at www.cornerstonehealthsolutions.org.
- Once you are enrolled, you can refill prescriptions by mail, phone, or online at www.cornerstonehealthsolutions.org. Your prescribing provider may call Cornerstone Health Solutions or fax your prescription to them at 781-805-8221.
- Please make sure to let the mail order pharmacy know the best ways to contact you so they can confirm your order before shipping.
- Usually a mail order pharmacy order will get to you in no more than 5-7 business days. If the mail order prescription is delayed, you should contact us to obtain a temporary supply of medication from a network pharmacy until the mail order can be delivered. If you have never used our mail order delivery to fill prescriptions, the pharmacy will contact you for set up. The pharmacy will also contact you when it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allow you to cancel or delay the order before you are billed and it is shipped. It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.
- To opt out of automatic deliveries of new prescriptions received directly from your health care provider's office, please contact the plan by calling Member Service Department. The phone number is located at the back of this document. It is important that you tell the pharmacy the best ways to contact you when you enroll in mail order services, including specifying your communication preferences and confirming your shipping address. If you have questions or problems with your mail order prescriptions, please contact Cornerstone Health Solutions by phone at 1-844 319-7588.

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

Section 7.6 Programs to help members use drugs safely

Your PCP, pharmacist, or another qualified provider may conduct a comprehensive medication review to help make sure members are getting safe and appropriate care. These reviews are especially important for members who take multiple medications and/or have more than one provider who prescribes their drugs. During these reviews, the provider or pharmacist will 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.

The provider will address and correct any possible problems.

WellSense Health Plan offers a Medication Management Program (Polypharmacy) to eligible members or upon request to any member. Members can opt in to complete a comprehensive medication review (CMR) annually. A CMR is a process where you discuss your medications and treatment plan with your Primary Care Physician (PCP) or community pharmacist. During these reviews, you'll collaborate with your healthcare provider to:

- Discuss how to take your medications as they were prescribed by your doctor
- Reduce or prevent side effects from medications
- Address and resolve any medication-related issues
- Ensure you are getting the most benefit from your treatment plan, helping you feel better and staying healthier

Comprehensive Medication Review (CMR)

The Comprehensive Medication Review (CMR), also known as Medication Therapy Management (MTM), is available annually to members using multiple medications or upon request. Your primary care physician (PCP) or community pharmacist can conduct this review to improve your understanding of your medications. Understanding why and how to take each medication is important for your overall health. WellSense Health Plan is committed to supporting your journey to better health.

Prescription Drug Monitoring Program (PDMP)

This program uses claims data to identify members who are at risk for use of medications that have potential for abuse. These drugs include schedule II controlled substances (such as oxycodone and morphine) and other non-controlled substances that have risk for overuse (such as gabapentin). The goal of the PDMP program is to help providers to be better informed about their patients' medication use patterns, and to reduce the possibility of medication misuse. Members

who are identified are automatically enrolled into the PDMP program. Reviews of a member's medical history and medication use may result in our taking certain actions, such as:

- Pharmacy Lock-In: This is a process that prevents a member from getting controlled medications (such as hydrocodone or tramadol) at more than one pharmacy for one year. It also helps the members, providers, and pharmacists to better understand the member's medications and reduce risks. Any member who is placed in a pharmacy lock-in will be notified in writing in advance, including appeal rights.
- Direct communication with the doctor who prescribed the medication.
- Referrals to fraud and abuse for further evaluation.

Section 7.7 Prescription drug copayments

A copayment may be required for each prescription

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

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

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

Members who are exempt from copayments

NH DHHS determines whether you are exempt from prescription copayments.

You do not have to pay a copayment if:

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

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

Chapter 8: Asking us to pay

Section 8.1 Network providers may not charge you for covered services

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

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

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

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

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

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

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

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

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

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

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

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

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

When this occurs:

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

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

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

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

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

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

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

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

Please submit a reimbursement form. The member reimbursement forms can be found on the website at wellsense.org.

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.

Send payment requests to:

Send payment requests to:

Send payment requests for medical services to:

Member Service Department
WellSense Health Plan
100 City Square, Suite 200
Charlestown, MA 02129

Payment requests are not applicable for behavioral health services.

For refunds on covered drugs:

- Go to the Pharmacy page at wellsense.org and print out the Member Reimbursement Drug Claim Form; or call Express Scripts at 877-957-1300 for a copy.
- Complete this form AND attach the original paid pharmacy receipt(s).
- Mail or fax the form to:

Express Scripts
P.O. Box 14718
Lexington, KY 40512-4718

Fax: 877-251-5896

Contact Member Service if you have any questions (Phone numbers are printed on the back cover of this handbook). If you do not know what you should have paid, or you receive a bill that you do not understand, contact Member Service (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

WellSense Health Plan 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 Service when you want to know how much of your benefit limit you have already used. (Phone numbers for Member Service 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 2.16 (Other important information and resources: Alternative formats and interpretation services).
- You have the right to be treated with respect and with due consideration for your dignity and privacy.
- You have the right to receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand.
- You have the right to participate in decisions regarding your health care, including the right to refuse treatment.
- You have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- You have the right to see, as well as request and receive a copy of your medical records, and the right to request that your medical records be amended or corrected.
- You have the right to covered services and drugs that are available and accessible in a timely manner.
- You have a right to care coordination.
- You have the right to privacy and protection of your personal health information.
- You have the right to receive information about our plan, our network providers, and your covered services.
- You have the right to make decisions about your health care.
- You cannot be retaliated against in any way by the plan or by the New Hampshire Department of Health and Human Services (NH DHHS) for exercising your rights.
- You have the right to a second opinion. For more information, refer to Section 6.6 (Getting a second medical opinion).
- You have the right to know what to do if you are being treated unfairly or your rights are not being respected. For more information, refer to Section 10.7 (How to file a grievance and what to expect after you file).
- You have the right to be informed of any changes in state law that may affect your coverage. The plan will provide you with any updated information at least 30 calendar days before the effective date of the change whenever practical.
- You have the right to exercise advance care planning for your health care decisions if you so choose. For more information, refer to Section 9.3 (Advance care planning for your health care decisions).

- You have the right to make a complaint if a provider does not honor your wishes expressed in your advance directive. For more information, refer to Section 9.3 (Advance care planning for your health care decisions).
- You have the right to leave our plan in certain situations. For more information, refer to Chapter 11 (Ending your plan membership).
- You have the right to obtain benefits, including family planning services and supplies, from non-participating providers.
- You have the right to be aware of when your plan chooses not to provide a service you need due to moral or religious reasons. We do not exclude services due to moral or religious reasons.
- You have the right to file a grievance or appeal. 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 request information about our physician incentive programs.
- You have the right to make recommendations regarding our member rights and responsibilities policy.

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 Service (Phone numbers are printed on the back cover of this handbook).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this handbook to learn what is covered, and the rules you need to follow to get your covered services.
 - Chapters 3 and 4 give the details about your health care services, including what is covered by the plan, what is not covered, and rules to follow.
 - Chapter 7 provides details about prescription drug coverage, including what you may be required to pay.
 - To be covered by WellSense Health Plan, 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 WellSense Health Plan as soon as possible.** Please call Member Service 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 were given, ask again.
- **Request interpretation services if you need them.** Our plan has staff and free language interpreter services available to answer questions from non-English speaking members. If you are eligible for New Hampshire Medicaid because of a disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you at no cost. For more information, refer to Section 2.16 (*Other important information and resources: 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 Service (Phone numbers are printed on the back cover of this handbook).
- **Do not allow anyone else to use your WellSense Health Plan or New Hampshire Medicaid membership cards.** Refer to Section 2.15 (*How to report suspected cases of fraud, waste or abuse*). Notify us when you believe someone has purposely misused your health care benefits.
- **Call Member Service for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan. (Phone numbers for Member Service 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 2.13 (*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 WellSense Health Plan, 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 WellSense Health Plan 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 WellSense Health Plan grievance process.

For help with your appeal or grievance, contact Member Service (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 WellSense Health Plan makes a coverage decision or takes an action that you disagree with, you may file an appeal. If WellSense Health Plan 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 (except when payment for a service is solely because the claim includes defects or lacks required documentation necessary for timely payment of the claim); and
- When a member is unable to access health care services in a timely manner.

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

There are **two** levels of appeal.

These are:

- **First level standard or expedited appeals through the plan.** At this level of appeal you ask WellSense Health Plan 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 WellSense Health Plan.

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 Service (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 WellSense Health Plan or Carelon (for behavioral health services, including mental health and substance use disorder treatment) over the phone or in writing within 60 calendar days of the date of the plan's written notice to 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 WellSense Health Plan or Carelon (for behavioral health services, including mental health and substance use disorder treatment) using the contact information found in Section 2.2 (*How to contact the plan or Carelon Behavioral Health (Carelon) about a coverage decision or to file an appeal*).
- **You may designate someone to file the appeal through the plan or Carelon** (for behavioral health services, including mental health and substance use disorder treatment) **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 2.16 (*Other important information and resources: 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 WellSense Health Plan or Carelon 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 or Carelon (for behavioral health services, including mental health and substance use disorder treatment):

- **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.
- WellSense Health Plan 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, WellSense Health Plan or Carelon will issue its written decision within 30 calendar days after receipt of your appeal request.** The plan may take up to an additional 14 calendar days if you request the extension, or if the plan needs additional information and feels the extension is in your best interest. If the plan decides to take extra days to make the decision, the plan will tell you in writing within 2 calendar days. If you disagree with the plan's extension, you may file a grievance with the plan. For more information, refer to Section 10.7 (*How to file a grievance and what to expect after you file*).
- **If WellSense Health Plan or Carelon reverses its decision to deny, reduce, limit, suspend, or end services that were not provided while the appeal was pending, WellSense Health Plan or Carelon 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 WellSense Health Plan or Carelon, 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 Service (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 WellSense Health Plan or Carelon. 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 WellSense Health Plan or Carelon over the phone or in writing within 60 calendar days of the date of the health plan’s written notice to you. When you contact the plan, remember to ask for an expedited appeal.**
- For your oral or written expedited appeal request:
 - Include your name, address, phone number, and email address (if you have one);
 - Describe the date of the action or notice from the plan you want to appeal, and attach a copy of the notice;
 - Explain the reason for your expedited request and why you want to appeal the decision; and
 - If the plan’s decision was to deny, reduce, limit, suspend or end your previously authorized benefits, indicate whether you want to have previously authorized benefits continued. For more information, refer to Section 10.6 (*How to request continuation of benefits during appeal and what to expect afterward*).

- Send your written appeal request to WellSense Health Plan or Carelon using the contact information found in Section 2.2 (*How to contact the plan or Carelon Behavioral Health (Carelon) about a coverage decision or to file an appeal*).
- **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 2.16 (*Other important information and resources: 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 WellSense Health Plan or Carelon 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 WellSense Health Plan or Carelon 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, WellSense Health Plan or Carelon must resolve your request as expeditiously as your health condition requires, but no later than 72 hours after the date the plan receives your request.** The plan may take up to 14 calendar days if you request an extension, or if the plan needs additional information and feels the extension is in your best interest. If the plan decides to take extra days to make a decision, the plan will attempt to inform you with prompt oral notice of the delay, and tell you in writing within 2 calendar days. If you disagree with the plan's extension, you may file a grievance with the plan. For more information, refer to Section 10.7 (*How to file a grievance and what to expect after you file*).
- If WellSense Health Plan or Carelon **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 WellSense Health Plan or Carelon **denies** your request for an expedited appeal, the plan must make reasonable efforts to give you prompt oral notice of the denial, and then must provide written notice of the denial within 2 calendar days.
- **You have the right to file a grievance with WellSense Health Plan or Carelon if the plan denies your request for an expedited appeal.** If the plan denies your request for an expedited appeal, WellSense Health Plan or Carelon will treat your appeal as part of the standard appeal process.

- **If WellSense Health Plan or Carelon reverses its decision to deny, reduce, limit, suspend, or end services that were not provided while the appeal was pending, WellSense Health Plan or Carelon 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 or Carelon 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 or Carelon 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 WellSense Health Plan or Carelon, 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 Service (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 WellSense Health Plan or Carelon, 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 or Carelon's decision to deny, reduce, limit, suspend or end services, you may have a right to request continuation of benefits from WellSense Health Plan or Carelon 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 14292, 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 WellSense Health Plan or Carelon (for behavioral health services, including mental health and substance use disorder treatment) AND any delay of services could seriously jeopardize your life, physical or mental health, or ability to attain, maintain, or regain maximum function, you may file an expedited State Fair Hearing with the NH DHHS Administrative Appeals Unit (AAU).

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

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

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

- In your signed, written expedited State Fair Hearing request:
 - Include your name, address, phone number, and email address (if you have one);
 - Describe the date of the action or notice from the plan you want to appeal, and attach a copy of the notice;
 - **Specify that you want an expedited State Fair Hearing;**
 - **Explain how any delay of services could seriously jeopardize your life, physical or mental health, or ability to attain, maintain, or regain maximum function;**

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

Administrative Appeals Unit
NH Department of Health and Human Services
105 Pleasant Street, Room 121C
Concord, NH 03301
Fax: 603-271-8422
- **You may designate someone to file the appeal for you, including your provider.** However, you must give written permission to name your provider or another person to file an appeal for you. For more information about how to appoint another person to represent you, refer to Section 2.16 (*Other important information and resources: 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 WellSense Health Plan or Carelon during your appeal. Your provider cannot request continuation of benefits for you.** For more information, refer to Section 10.6 (*How to request continuation of benefits during appeal and what to expect afterward*).

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

- **After you file your expedited State Fair Hearing appeal, you have the right to request and receive a copy of your case file that the plan used to make its decision.** A copy of your case file is free of charge and may be requested in advance of the State Fair Hearing decision.
- If the AAU **accepts** your request for an expedited State Fair Hearing appeal, the AAU will issue its written decision as expeditiously as your health condition requires, but no later than 3 business days after the AAU receives the plan's case file and any additional information for your appeal.
- If the AAU **denies** your request for an expedited State Fair Hearing appeal, the AAU will make reasonable efforts to give prompt oral notice to you, and provide written notice of the denial. If your expedited request is denied, your appeal will be treated as a standard State Fair Hearing appeal described in Section 10.4 (*How to file a standard State Fair Hearing appeal and what to expect after you file (standard 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 14292, 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 WellSense Health Plan or Carelon pending the outcome of one or both your first and/or second level appeal. **While you may designate someone to file an appeal for you, your provider cannot request continuation of benefits for you.**

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

For standard and expedited plan appeals (first level appeal)	For standard and expedited State Fair Hearing appeals (second level appeal)
<ul style="list-style-type: none"> • Within 10 calendar days of the date you receive the notice of action from the plan or the intended effective date of the plan’s action, you file your first level appeal orally or in writing AND you request continuation of benefits pending the outcome of your first level appeal, orally or in writing; and • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; and 	<ul style="list-style-type: none"> • Within 10 calendar days of the date you receive the first level appeal notice of action from the plan or the intended effective date of the plan’s action, you file your second level appeal in writing AND you request continuation of benefits pending the outcome of one or both your first and/or second level appeal, orally or in writing <p>If you did not request continuation of benefits during your first level appeal with the plan, the following conditions also apply:</p>

<ul style="list-style-type: none"> • The service was ordered by an authorized provider; and • The original authorization period for the service has not expired. 	<ul style="list-style-type: none"> • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; and • The service was ordered by an authorized provider; and • The original authorization period for the service has not expired.
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To request continuation of benefits when the above conditions are met, contact WellSense or Carelon using the contact information found in Section 2.2 (*How to contact the plan or Carelon Behavioral Health (Carelon) about a coverage decision or to file an appeal*).

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

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

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

For help with your first and/or second level appeal and continuation of benefits, contact Member Service (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 14292, 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 WellSense Health Plan 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 WellSense Health Plan. 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 2.16 (Other important information and resources: You may designate an authorized representative or personal representative).

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

- **WellSense Health Plan will respond to your grievance as fast as your health condition requires, but no later than 45 calendar days from the date the plan receives it.** The plan may take up to an additional 14 calendar days if you request the extension, or if the plan needs additional information and feels the extension is in your best interest. If the plan decides to take extra days to make the decision, the plan will tell you in writing within 2 calendar days. For grievances about clinical matters, the plan will respond in writing. For grievances unrelated to clinical matters, the plan may respond orally or in writing.
- You do not have the right to appeal your grievance. However, you have the right to voice concerns to NH DHHS if you are dissatisfied with the resolution of your grievance. Contact the NH DHHS Customer Service Center at **1-844-ASK-DHHS** (1-844-275-3447) (TDD Access Relay: 1-800-735-2964), Monday through Friday, 8:00 a.m. – 4:00 p.m. ET.

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

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

Chapter 11: Ending your plan membership

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

The times when your plan membership may end are:

- When you no longer qualify for New Hampshire Medicaid.
- If you decide to switch to another plan during the **Annual Open Enrollment Period**:
 - **When is the Annual Open Enrollment Period?** The Annual Open Enrollment Period is described in the open enrollment notice sent to you each year by NH DHHS. The notice will provide instructions on when and how to switch health plans if you choose to do so, including when your membership ends in your current plan.
 - For information on care transitions between plans, refer to Section 5.3 (*Continuity of care, including transitions of care*).
- 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 NH Medicaid covered services, violation of your rights, or lack of access to network providers experienced in dealing with your needs.

When you request disenrollment from the plan for a reason above (except when you move out of state), you must first file a grievance with the plan to seek a decision about your grievance. If you are dissatisfied with the plan's response and still want to request disenrollment, you may call NH DHHS to learn if you are eligible to disenroll from the plan.

Refer to Section 10.7 (*How to file a grievance and what to expect after you file*).

- You may also be eligible at other times of the year to leave the plan without cause, including:
 - Once during the 90 calendar days following the date of your initial Medicaid eligibility.
 - 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 re-enrollment if the temporary loss of Medicaid has caused you to miss the Annual Open Enrollment Period. (This does not apply to new applications for New Hampshire Medicaid.)

- When NH DHHS grants members the right to terminate enrollment without cause and notifies affected members of their right to disenroll from the plan.
- When your plan chooses not to provide a service you need due to moral or religious reasons.
- When members are involuntarily disenrolled from the plan as described in the next section.

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

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

Section 11.2 When you may be involuntarily disenrolled from the plan

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

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

WellSense Health Plan 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.

The following federal laws apply:

- Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80.
- The Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91.
- The Rehabilitation Act of 1973.
- Title IX of the Education Amendments of 1972 (regarding education programs and activities).
- Titles II and III of the Americans with Disabilities Act; and
- Section 1557 of the Patient Protection and Affordable Care Act.

This may affect your benefits, rights, and responsibilities even if the laws are not included or explained in this document. Covered services shall be consistent with State laws and regulations in effect.

Section 12.1 Notice about Nondiscrimination and Accessibility Requirements and Nondiscrimination Statement

WellSense Health Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender, moral or religious grounds, or limited English proficiency. WellSense Health Plan does not exclude people or treat them differently because of race, color national origin, age, disability, sex, gender sexual orientation, gender identity, limited English proficiency, or moral or religious grounds (including limiting or not providing coverage for counseling and referral services).

WellSense Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - TTY services
 - 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 WellSense Health Plan.

If you believe that WellSense Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender, sexual

orientation, gender identity, moral or religious grounds or limited English proficiency, you can file a grievance with:

Civil Rights Coordinator

100 City Square, Suite 200
Charlestown, MA 02129

Phone: 877-957-1300 (TTY/TDD 711)

Fax: 617-897-0805

You can file a grievance in person or by mail, fax, or e-mail. If you need help filing a grievance, WellSense Health Plan is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are also available at www.hhs.gov/ocr/office/file/index.html

Section 12.2 Notice of Privacy Practices

This section describes how health information about you that may be used and disclosed, and how you can get this information. Please review this Notice of Privacy Practices carefully. If you have any questions, or would like a copy of this Notice, please call our Member Service Department at 1-877-957-1300.

Corporate Office

WellSense Health Plan
100 City Square, Suite 200
Charlestown, MA 02129

New Hampshire Office

WellSense Health Plan
1155 Elm Street, 5th Floor
Manchester, NH 03101
Website: wellsense.org

This Notice of Privacy Practices, effective September 23, 2013, describes how we may use and disclose your health information:

- To carry out treatment, payment or healthcare operations; and
- For other purposes that are permitted or required by law.

It also describes your rights to access and control your health information.

“Protected health information” or “PHI” is health information, including individually identifiable information, related to your physical or behavioral health condition used in providing health care to you or for payment for health care services.

By law, we are required to:

- Maintain the privacy and confidentiality of your protected health information
- Give you this Notice of Privacy Practices
- Follow the practices in this Notice

We use physical, electronic, and procedural safeguards to protect your privacy. Even when disclosure of PHI is allowed, we only use and disclose PHI to the minimum amount necessary for the permitted purpose.

Other than the situations mentioned in this Notice, we cannot use or share your protected health information without your written permission, and you may cancel your permission at any time by sending us a written notice.

We reserve the right to change this Notice and to make the revised notice effective for any of your current or future protected health information. You are entitled to a copy of the Notice currently in effect.

Section 12.3 How we may use and disclose your Protected Health Information (PHI)

For Treatment: We may communicate PHI about you to doctors, nurses, technicians, office staff, or other personnel who are involved in taking care of you and need the information to provide you with medical care. For example, if you are being treated for a back injury, we may share information with your primary care physician, the back specialist, and the physical therapist so they can determine the proper care for you. We will also record the actions they took and the medical claims they made. Other examples of when we may disclose your PHI include:

- Quality improvement and cost containment, wellness programs, preventive health initiatives, early detection programs, safety initiatives, and disease management programs.
- To administer quality-based cost effective care models, such as sharing information with medical providers about the services you receive elsewhere to assure effective and high-quality care is coordinated.

For Payment: We may use and disclose your PHI to administer your health benefits, which may include claims payment, utilization review activities, determination of eligibility, medical necessity review, coordination of benefits and appeals. For example, we may pay claims submitted to us by a provider or hospital.

For Health Care Operations: We may use and disclose your PHI to support our normal business activities. For example, we may use your information for care management, customer service, coordination of care, or quality management.

Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services:

We may contact you to provide appointment or refill reminders, or information about possible treatment options or alternatives and other health-related benefits, or services that may be of interest to you.

As Required By Law: We will disclose PHI about you when we are required to do so by international, federal, state, or local law.

Business Associates: We may disclose PHI to our business associates who perform functions on our behalf or provide services if the PHI is necessary for those functions or services. All of our business associates are obligated, under contract with us, to protect the privacy of your PHI.

Coroners, Medical Examiners, and Funeral Directors: We may communicate PHI to coroners, medical examiners, and funeral directors for identification purposes and as needed to help them carry out their duties consistent with applicable law.

Correctional Facilities: If you are or become an inmate in a correctional facility, we may communicate your PHI to the correctional facility or its agents, as necessary, for your health and the health and safety of other individuals.

Disaster Relief: We may communicate PHI to an authorized public or private entity for disaster relief purposes. For example, we might communicate your PHI to help notify family members of your location or general condition.

Family and Friends: We may communicate PHI to a member of your family, a relative, a close friend, or any other person you identify who is directly involved in your health care or payment related to your care.

Food and Drug Administration (FDA): We may communicate to the FDA, or persons under the jurisdiction of the FDA, your PHI as it relates to adverse events with drugs, foods, supplements, and other products and marketing information to support product recalls, repairs, or replacement.

Health Oversight Activities: We may communicate your PHI to state or federal health oversight agencies authorized to oversee the health care system or governmental programs, or to their contractors, for activities authorized by law, audits, investigations, inspections, and licensing purposes.

Law Enforcement: We may release your PHI upon request by a law enforcement official in response to a valid court order, subpoena, or similar process.

Lawsuits and Disputes: If you are involved in a lawsuit or dispute, we may communicate PHI about you in response to a court or administrative order. We may also communicate PHI about you because of a subpoena or other lawful process, subject to all applicable legal requirements.

Military, Veterans, National Security, and Intelligence: If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may be required by other government authorities to release your PHI for national security activities.

Minors: We may disclose PHI of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

Organ and Tissue Donation: If you are an organ or tissue donor, we may use or disclose your PHI to organizations that handle organ procurement or transplantation—such as an organ bank—as necessary to facilitate organ or tissue donation and transplantation.

Personal Representative: If you have a personal representative, such as a legal guardian (or an executor or administrator of your estate after your death), we will treat that person as if that person is you with respect to disclosures of your PHI.

Public Health and Safety: We may communicate your PHI for public health activities. This includes disclosures to: (1) prevent or control disease, injury, or disability; (2) report births and deaths; (3) report child abuse or neglect; (4) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and (5) the appropriate government authority if we believe a person has been the victim of abuse, neglect, or domestic violence and the person agrees or we are required to by law to make that disclosure or (6) when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Research: We may use and disclose your PHI for research purposes, but we will only do that if the research has been specially approved by an institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your PHI. Even without that special approval, we may permit researchers to look at PHI to help them prepare for research, for example, to allow them to identify persons who may be included in their research project, as long as they do not remove, or take a copy of, any PHI. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. But we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the security of the data, and (3) not identify the information or use it to contact any individual.

Workers' Compensation: We may use or disclose PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Section 12.4 Uses and disclosures that require us to give you an opportunity to object and opt out

Fundraising: We may use PHI about you in an effort to raise money. If you do not want us to contact you for fundraising efforts, you may opt out by notifying us, in writing, with a letter addressed to the WellSense Health Plan Privacy Officer.

Section 12.5 Special protections for HIV, substance use disorders, mental health, and genetic information

Special privacy protections apply to HIV-related information, substance use disorders, mental health, and genetic information that require your written permission, and therefore some parts of this general Notice of Privacy Practices may not apply to these more restricted kinds of PHI.

Section 12.6 Your rights regarding protected health information about you

Right to Access and Copy: You have the right to inspect and obtain a copy of your PHI. To do so, you must submit a written request to the WellSense Health Plan Privacy Officer. We will provide you with a copy or a summary of your records, usually within 30 days and we may ask you to pay a fee to cover our costs of providing you with that PHI, and certain information may not be easily available prior to July 1, 2002. We may deny your request to inspect and copy, in certain limited circumstances.

Right to an Electronic Copy of PHI: You have the right to require that an electronic copy of your health information be given to you or transmitted to another individual or entity if it is readily producible. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic record.

Right to Get Notice of a Security Breach: We are required to notify you by first class mail of any breach of your Unsecured PHI as soon as possible, but no later than 60 days after we discover the breach.

“Unsecured PHI” is PHI that has not been made unusable or unreadable. The notice will give you the following information:

- A short description of what happened, the date of the breach, and the date it was discovered;
- The steps you should take to protect yourself from potential harm from the breach;
- The steps we are taking to investigate the breach, mitigate losses, and protect against further breaches; and
- Contact information where you can ask questions and get additional information.

Right to Amend: If you believe the PHI we have about you is incorrect or incomplete, you may ask us to amend the PHI. You must request an amendment, in writing, to the WellSense Health Plan Privacy Officer and include a reason that supports your request. In certain cases, we may deny your request for amendment, but we will advise you of the reason within 60 days. For example, we may deny a request if we did not create the information, or if we believe the current information is correct.

Right to an Accounting of Disclosures: You have the right to request an “accounting of disclosures.” This is a list of the disclosures we made of PHI about you for most purposes other than treatment, payment, and health care operations. The right to receive an accounting is subject

to certain exceptions, restrictions, and limitations. To obtain an accounting, you must submit your request, in writing, to the WellSense Health Plan Privacy Officer. We will provide one accounting a year for free but may charge a reasonable, cost-based fee if you submit a request for another one within 12 months. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003.

Right to Request Restrictions: You have the right to request, in writing, to the WellSense Health Plan Privacy Officer, a restriction or limitation on our use or disclosure of your PHI. We are not, however, required by law to agree to your request. If we do agree, we will comply with your request unless the PHI is needed to provide emergency treatment to you.

Right to Request Confidential Communication: You have the right to request that we communicate with you about medical matters only in writing or at a different residence or post office box. To request confidential communications, you must complete and submit a Request for Confidential Communication Form to the WellSense Health Plan Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to Notice of Privacy Practice: You have the right to receive a paper copy of the Notice of Privacy Practices upon request at any time.

Section 12.7 How to exercise your rights

To exercise your rights as described in this Notice, send your request, in writing, to our Privacy Officer at the address listed in this Notice.

Assistance in Preparing Written Documents: WellSense Health Plan will provide you with assistance in preparing any of the requests explained in this Notice that must be submitted in writing. There will be no cost to you for this.

Section 12.8 Your written authorization is required for other uses and disclosures

Other Uses and Disclosures of PHI: We will obtain your written authorization before using or disclosing your PHI for purposes other than those provided for above (or as otherwise permitted or required by law). You may revoke such an authorization at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

We will never sell your health information or use your health information for marketing purposes or to offer you services or products unrelated to your health care coverage or your health status, without your written authorization.

Compliance with State and Federal Laws: If more than one law applies to this Notice, we will follow the more stringent law. You may be entitled to additional rights under State law, and we protect your health information as required by these State laws.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with our office or with the Department of Health and Human Services. To file a complaint with our office, contact:

Privacy Officer

WellSense Health Plan
100 City Square, Suite 200
Charlestown, MA 02129

Or, you may call this office at 1-617-748-6325.

You may also notify the Secretary of the Department of Health and Human Services (HHS). Send your complaint to:

**Medical Privacy, Complaint Division
Office for Civil Rights (OCR)
United States Department of Health and Human Services**

200 Independence Avenue, SW, Room 509F, HHH Building
Washington D.C., 20201

You may also contact OCR's Voice Hotline Number at (800) 368-1019 or send the information to their Internet address www.hhs.gov/ocr.

WellSense Health Plan will not take retaliatory action against you if you file a complaint about our privacy practices with either OCR or WellSense Health Plan.

Chapter 13: Acronyms and definitions of important words

Section 13.1 Acronyms

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
CMR	Comprehensive Medication Review
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

HRA	Health Risk 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
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.

Access Point – Is the statewide call/text/chat center for New Hampshire (1-833-710-6477) that provides support, referral, and deployment services for those struggling with mental health and substance use crisis. It is available 365 days a year, 7 days a week, 24 hours a day.

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. (dates may vary) Each year you will receive advance notice from New Hampshire Medicaid about your options to change health plans.

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 2.16 (*Other important information and resources: 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*).

Care Manager – A qualified and trained individual who is primarily responsible for providing Member supportive services. For more information, refer to Section 5.2 (*Care coordination support*).

Care Plan – A document prepared and updated by a member's provider and interdisciplinary Care Team with input from the member which summarizes the member's health conditions, specific care needs, and current treatments. The Care Plan outlines what is needed to manage the member's care needs and helps organize and prioritize care and treatment, including referrals relative to health-related social needs. For more information, refer to Section 5.2 (*Care coordination support*).

Care Team – Chosen and/or approved by the Member, or their parent(s) or guardian(s) if a minor, or their guardian(s) if an adult and applicable, whose composition best meets the unique care needs to be addressed and with whom the Member has already established relationships. The care team shall include the PCP. For more information, refer to Section 5.2 (*Care coordination support*).

Carelon Behavioral Health – A partner of WellSense Health Plan. Carelon manages and coordinates behavioral health (mental health and substance use disorder) covered services for members. They also manage the behavioral health provider network.

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

Claim: A bill from a provider for services that have been provided to a member.

Continuation of benefits: The process of continuing to receive certain services from our plan during an appeal.

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, including transitions of care*).

Comprehensive Medication Review (CMR) – A systematic process of collecting patient-specific information, assessing medication therapies to identify medication-related problems, developing a prioritized list of medication-related problems, and creating a plan to resolve them with the patient, caregiver and/or prescriber.

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.aspx. 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.

Enrollment – The process by which we register individuals to be our members.

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

Express Scripts (Express Scripts, Inc.) – The organization with which we contract to manage prescription drug covered services for members.

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

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

Grievance – The process a member uses to express dissatisfaction about any matter other than a plan action. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the plan to make an authorization decision. For more information, refer to Chapter 10 (*What to do if you want to appeal a plan decision or "action", or file a grievance*).

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

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

Health Risk Assessment (HRA) – A questionnaire about a member's current health situation. The HRA helps us arrange for the right care for members.

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*).

Medical Policies – Plan policies used to determine whether certain covered services are medically necessary for you.

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).

Medicare Part D – A Medicare benefit that provides coverage for prescription drugs. Some WellSense Health Plan members with Medicare coverage may have prescription drug coverage under a Medicare Part D plan.

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

Member Service – A department in our plan responsible for answering your questions about plan membership and benefits. (Phone numbers for Member Service 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 – Brand name drugs.

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 WellSense Health Plan 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 – “Generic drugs.” 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.

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.

Provider Directory – An online search tool on our website (“Find a Provider”), or a printed booklet, containing a list of the providers who contract with WellSense Health Plan. These providers are called “network providers.” The *Provider Directory* includes hospitals, pharmacies, doctors, and other professionals.

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.

Rapid Response – Community Mental Health Center teams consisting of peers, mental health clinicians, and/or counselors that provide mental health and substance use crisis services via walk-in, telemedicine, or face to face at the location of the crisis or an individual’s choosing.

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

Routine Care – Care that is not emergency or urgent care. Examples of routine care are: physical exams, preventive care, and well-child care visits.

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 WellSense Health Plan 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.

Standard Appeal – An appeal processed in accordance with the standard timeframes. For more information, refer to Chapter 10 (*What to do if you want to appeal a plan decision or “action,” or file a grievance*).

State Fair Hearing Appeal – An independent review of denied or partially approved services by the New Hampshire Department of Health and Human Services Administrative Appeals Unit

(AAU). For more information, refer to Chapter 10 (*What to do if you want to appeal a plan decision or "action", or file a grievance*).

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*).

Vision Services Plan (VSP) – An organization with which we contract to manage covered services for vision care. See Benefits Chart in Chapter 4 (*Covered services*) for more information.

VSP-Participating Eye Care provider – An optometrist or ophthalmologist (a physician who is a specialist in treating eye conditions) who contracts with VSP.

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 2.15 (*How to report suspected cases of fraud, waste or abuse*).

Wellness Visit – PCP visit that includes health risk and social determinant of health needs assessments, evaluation of the Member's physical and behavioral health, including the initial screening for depression, mood, suicidality, and Substance Use Disorder.

WellSense Health Plan® (also called the "plan," "we" or "us") – A New Hampshire-licensed health maintenance organization. We arrange for care through contracts with network providers, manage that care, and pay for covered services for our members. Members are individuals who are enrolled in New Hampshire Medicaid and select us as their managed care plan. (WellSense Health Plan is a registered trademark of Boston Medical Center Health Plan, Inc.)

Chapter 14: WellSense Health Plan Member Service

Method	Member Service – Contact Information
Call	877-957-1300 Calls to this number are toll-free. Representatives are available <ul style="list-style-type: none">Monday–Wednesday, 8:00 a.m.–8:00 p.m. ETThursday–Friday, 8:00 a.m.–6:00 p.m. ET Member Service also has free language interpreter services available for non-English speakers. Alternate format materials are also available upon request.
TTY/TDD	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. Representatives are available <ul style="list-style-type: none">Monday–Wednesday, 8:00 a.m.–8:00 p.m. ETThursday–Friday, 8:00 a.m.–6:00 p.m. ET
Write	Corporate Headquarters 100 City Square, Suite 200 Charlestown, MA 02129 Local Office 1155 Elm Street, 5 th Floor Manchester, NH 03101
Website	wellsense.org