Member Handbook

NEW HAMPSHIRE MEDICAID CARE MANAGEMENT PROGRAM

Effective September 1, 2024

CARE IS THE HEART OF OUR WORK®

www.amerihealthcaritasnh.com

AmeriHealth Caritas™
New Hampshire

AmeriHealth Caritas
New Hampshire

Discrimination is against the law

AmeriHealth Caritas New Hampshire complies with applicable federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of age, race, ethnicity, national origin or ancestry, mental or physical disability, sexual or affection orientation or preference, gender identity, marital status, genetic information, source of payment, sex, creed, religion, health or mental health status or history, need for health care services, amount payable to AmeriHealth Caritas New Hampshire on the basis of an eligible person's or member's actuarial class or pre-existing medical/health conditions, whether or not the member has executed an advance directive, or any other status protected by federal or state law.

AmeriHealth Caritas New Hampshire provides free aids and services to people with disabilities. Examples of these aids and services include qualified sign language interpreters and written information in other formats (large print, braille, audio, accessible electronic formats, other formats). We provide free language services, such as qualified interpreters and information written in other languages, to people with limited English proficiency or whose primary language is not English.

If you need these services, contact AmeriHealth Caritas New Hampshire 24 hours a day, seven days a week, at **1-833-704-1177 (TTY 1-855-534-6730)**.

If you believe that AmeriHealth Caritas New Hampshire has failed to provide these services or has discriminated against you in another way, you or your authorized representative (if we have your written authorization on file) can file a grievance with:

- AmeriHealth Caritas New Hampshire Grievances
  P.O. Box 7389
  London, KY 40742-7389
  1-833-704-1177 (TTY 1-855-534-6730)
- You can also file a grievance by phone at **1-833-704-1177 (TTY 1-855-534-6730)**. If you need help filing a grievance, AmeriHealth Caritas New Hampshire Member Services is available to help you. You can contact Member Services 24 hours a day, seven days a week, at **1-833-704-1177 (TTY 1-855-534-6730)**.

You may also file a discrimination complaint through the Department of Health and Human Services (DHHS) Office of the Ombudsman who has been designated to coordinate the efforts of NH DHHS's civil rights compliance for the Department:

State of New Hampshire, Department of Health and Human Services, Office of the Ombudsman
129 Pleasant Street
Concord, NH 03301-3857
1-603-271-6941 or **1-800-852-3345** ext. **16941**
Fax: **1-603-271-4632**, **(TTY 1-800-735-2964)**
E-mail: **ombudsman@dhhs.nh.gov**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, 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, DC 20201
1-800-368-1019 (TTY 1-800-537-7697)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html.**

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Multi-language interpreter services

English — Attention: If you do not speak English, language assistance services, free of charge, are available to you. Call **1-833-704-1177 (TTY 1-855-534-6730)**.

Spanish — Atención: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-833-704-1177 (TTY 1-855-534-6730)**.

French — Attention : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-833-704-1177 (TTY 1-855-534-6730)**.

Chinese — 注意：如果您使用中文，我们可为您提供免费语言援助服务。请致电 **1-833-704-1177 (TTY 1-855-534-6730)**。

Nepali — ध्यान दिनुहोस्: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू नि:शुल्क रूपमा उपलब्ध छन्। फोन गर्नुहोस्: **1-833-704-1177 (TTY 1-855-534-6730)**।

Vietnamese — Chú ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-833-704-1177 (TTY 1-855-534-6730)**.

Portuguese — Atenção: Se você fala português, serviços de assistência linguística estão disponíveis gratuitamente. Ligue para **1-833-704-1177 (TTY 1-855-534-6730)**.

Greek — Προσοχη: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε **1-833-704-1177 (TTY 1-855-534-6730)**.

Arabic — ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-833-704-1177 (TTY 1-855-534-6730)**.

Serbo-Croatian — Pažnja: Ako govorite srpskohrvatski, besplatno su vam dostupne usluge jezičke pomoći. Nazovite **1-833-704-1177 (TTY 1-855-534-6730)**.

Indonesian — Perhatian: Jika Anda berbicara dalam Bahasa Indonesia, layanan bantuan bahasa akan tersedia secara gratis. Hubungi **1-833-704-1177 (TTY 1-855-534-6730)**.

Korean — 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-833-704-1177 (TTY 1-855-534-6730)**번으로 전화해 주십시오.

Russian — Внимание: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-833-704-1177 (TTY 1-855-534-6730)**.

French Creole — Atansyon: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-833-704-1177 (TTY 1-855-534-6730)**.

Kirundi — Uragaba: Nimba uvuga Ikirundi, uzohabwa serivisi zigufasha mu ndimi ku buntu ata kiguzi. Terefona **1-833-704-1177 (TTY 1-855-534-6730)**.

Polish — Uwaga: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-833-704-1177 (TTY 1-855-534-6730)**.

Please visit **www.amerihealthcaritasnh.com**
for the most current version of the Member Handbook.

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Chapter 1. Getting started as a member

Section 1.1 Welcome

You are enrolled in AmeriHealth Caritas New Hampshire.

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

AmeriHealth Caritas New Hampshire 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 AmeriHealth Caritas New Hampshire for covered services*).

As an AmeriHealth Caritas New Hampshire 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 AmeriHealth Caritas New Hampshire convenes Member Advisory Board meetings to hear from members like you. If you are interested in joining the plan Member Advisory Board, let us know by calling Member Services (phone numbers are printed on the back cover of this handbook).

Section 1.2 What makes you eligible to be a plan member?

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

You are eligible for our plan as long as:

- You are eligible and remain eligible for New Hampshire Medicaid.*
- You live in New Hampshire (the AmeriHealth Caritas New Hampshire service area).
- You are a United States citizen or are lawfully present in the United States.

If you are pregnant and enrolled in AmeriHealth Caritas New Hampshire when you deliver your baby, your baby is automatically covered by AmeriHealth Caritas New Hampshire 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) (TTY 1-800-735-2964)**, Monday through Friday, 8 a.m. to 4 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 redetermined every six to twelve months. Several weeks before your eligibility is up for renewal you will receive a letter in the mail or an 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 letter. If you need help to complete the form, contact the NH DHHS Customer Service Center (Eligibility) toll-free at **1-844-ASK-DHHS (1-844-275-3447) (TTY 1-800-735-2964)**, Monday through Friday, 8 a.m. to 4 p.m. ET.

Section 1.3 What to expect from the plan

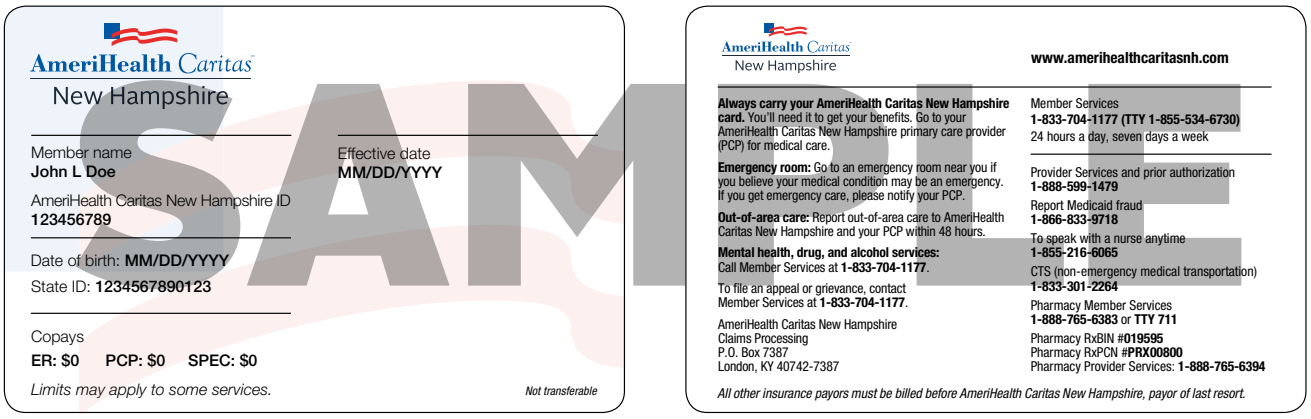
Member Handbook

This Member Handbook describes how the plan works and is in effect beginning September 1, 2024, through each month you are enrolled with AmeriHealth Caritas New Hampshire. The Member Handbook is also available free of charge, upon request, and on our website at **www.amerihealthcaritasnh.com**.

Your AmeriHealth Caritas New Hampshire membership card – Use it to get all covered services and prescription drugs.

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

Here is a sample membership card, as an example:



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

If your plan membership card is damaged, lost or stolen, call Member Services right away. We will send you a new card. (Phone numbers for Member Services are printed on the back cover of this handbook.) If you lose your card and need a replacement, we can help — call Member Services at **1-833-704-1177 (TTY 1-855-534-6730)**.

Welcome Call

When you first join AmeriHealth Caritas New Hampshire, we will call to welcome you as a plan member. During the call, we will explain plan rules and answer any questions you might have about the plan. As described in the next section, we will explain the importance of completing a Health Risk Assessment (HRA) with your Primary Care Provider (PCP).

Health Risk Assessment (HRA)

NH DHHS requires us to ask you to complete a Health Risk Assessment (HRA) for review with your PCP. The information you provide in the HRA helps your PCP plan and work with you to meet your health care and functional needs. When you complete this assessment and discussion with your doctor you can earn $30 on your CARE Card.

There is a form that you can print and complete from **www.amerihealthcaritasnh.com**, and bring with you to your annual wellness visit.

Explanation of Benefits Notice

From time to time, we will send you a report called the Explanation of Benefits (EOB). Each month, we reach out to members like you who have gotten services that AmeriHealth Caritas New Hampshire was asked to pay for. This report is not a bill. We just want to make sure that you got all of the services that we were asked to pay for. If you get one of these reports from us, please review the list on the back of the report. This list shows some of the medical services that AmeriHealth Caritas New Hampshire was asked to pay for within a certain time. Please call us if you did not get some of these services or have questions about these services. You can call Member Services at **1-833-704-1177 (TTY 1-855-534-6730)**. You can also write to us at:

AmeriHealth Caritas New Hampshire
ATTN: Member Services Department
200 Stevens Drive
Philadelphia, PA 19113-1570

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 phone 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 any of 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.).
  - 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.
- 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:

If any of this information changes, please call:

Member Services at **1-833-704-1177 (TYY 1-855-534-6730)**

AND

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 a.m. to 4 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. Upon member enrollment and annually thereafter, the plan distributes a notice of privacy practices to members that includes:

- The organization's routine use and disclosure of PHI.
- Use of authorizations.
- Access to PHI.
- Internal protection of oral, written, and electronic PHI across the organization.

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 AmeriHealth Caritas New Hampshire. **For claims to be paid 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 AmeriHealth Caritas New Hampshire. If you receive a bill for your covered health care services, refer to Chapter 9 (*Asking us to pay*).

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

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

If another person or party injures you, AmeriHealth Caritas New Hampshire 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 younger than 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 Services 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 AmeriHealth Caritas New Hampshire. 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 may contact you for details about your accident and other coverage.

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

Chapter 2. Important phone numbers and resources

Section 2.1 How to contact AmeriHealth Caritas New Hampshire Member Services

For assistance with coverage questions, finding a provider, claims, membership cards, or other matters, please call or write to AmeriHealth Caritas New Hampshire Member Services. We will be happy to help you.

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

In case of a mental health and/or substance use emergency — 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 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.

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

Method	AmeriHealth Caritas New Hampshire Member Services – Contact
CALL	**1-833-704-1177** Calls to this number are toll-free, 24 hours a day, seven days a week. Member Services also has free language interpreter services available for non-English speakers.
TTY	**1-855-534-6730** Calls to this number are free.
FAX	**1-833-243-2264**
WRITE	AmeriHealth Caritas New Hampshire P.O. Box 7386 London, KY 40742-7386
WEBSITE	**www.amerihealthcaritasnh.com**

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

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

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

Method	Coverage Decision or Appeals – Contact Information
CALL	**1-833-704-1177** Calls to this number are toll-free, 24 hours a day, seven days a week. Member Services also has free language interpreter services available for non-English speakers.
TTY	**1-855-534-6730** Calls to this number are free.
FAX	**1-833-243-2264**
WRITE	AmeriHealth Caritas New Hampshire P.O. Box 7386 London, KY 40742-7386
WEBSITE	**www.amerihealthcaritasnh.com**

Section 2.3 How to contact the plan about a grievance

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

Method	Grievance – Contact Information
CALL	**1-833-704-1177** Calls to this number are toll-free, 24 hours a day, seven days a week.
TTY	**1-855-534-6730** Calls to this number are free.
FAX	**1-833-243-2264**
WEBSITE	**www.amerihealthcaritasnh.com**

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 Management makes 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)*. Contact your PCP to help you with care coordination support.

Method	To find your Primary Care Provider (PCP) and their contact information
CALL	**1-833-704-1177** Calls to this number are toll-free, 24 hours a day, seven days a week.
Member Portal	Register or log in to the member portal at: **www.amerihealthcaritasnh.com/memberportal**
Letter	Your assigned PCP 's contact information is in the letter we mailed to you as a new member or if you requested to change your doctor.

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

The Nurse Call Line is a free 24-hour medical information phone service provided by AmeriHealth Caritas New Hampshire. Registered nurses are ready to answer your questions 24 hours a day, 365 days of the year. Contact the Nurse Call Line when you have questions or concerns about your health, need advice on when to go to your PCP or ask questions about symptoms or medications.

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

In case of a mental health and/or substance use emergency — 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 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.

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

Method	Nurse Call Line – Contact Information
CALL	**1-855-216-6065** Calls to this number are toll-free, 24 hours a day, seven days a week. Member Services also has free language interpreter services available for non-English speakers.
TTY	**1-855-534-6730** Calls to this number are free.
FAX	**1-833-243-2264**
WEBSITE	**www.amerihealthcaritasnh.com**

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

A behavioral health service is another term used to describe services for mental health and/ or substance use concerns. This includes, but is not limited to, mood problems like depression, problems with anger and aggression at school, or problems with using alcohol or other drugs. Contact AmeriHealth Caritas New Hampshire when you have questions about what kinds of services are covered for mental health and substance use concerns. You do not need a referral from us or your PCP to receive covered behavioral health services. Just go to one of our behavioral health providers and they can help you get the needed services.

In case of a behavioral health (mental health and substance use) emergency or crisis — 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. Or, call **211** to connect to your local Doorway for substance misuse supports and services in New Hampshire. For a description of emergency services, refer to Chapter 4 (*Benefits Chart*).

Method	Behavioral Health Services (Mental Health or Substance Use Disorder Services) – Contact Information
CALL	**1-833-704-1177** Crisis Hotline: **1-833-234-2264** Calls to this number are toll-free, 24 hours a day, seven days a week. Member Services also has free language interpreter services available for non-English speakers.
TTY	**1-855-534-6730** Calls to this number are free.
WEBSITE	**www.amerihealthcaritasnh.com**

Section 2.7 How to request non-emergency medical transportation

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 service listed in the Benefits Chart in Section 4 (*see Transportation services – Non-emergency medical transportation (NEMT)).*

Method	Non-emergency Medical Transportation - (NEMT) – Contact Information
CALL	**1-833-301-2264** Calls to this number are toll-free. 8 a.m. – 8 p.m. M/T/W 8 a.m. – 5 p.m. Th/F Coordinated Transportation Services (CTS) also has free language interpreter services available for non-English speakers.

Section 2.8 How to contact the NH DHHS Customer Service Center

The New Hampshire Department of Health and Human Services (NH DHHS) Customer Service Center provides help when you have questions about:

- New Hampshire Medicaid eligibility.
- Granite Advantage eligibility.
- 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	**1-844-ASK-DHHS (1-844-275-3447)** Calls to this number are toll-free. Office hours are Monday through Friday, 8 a.m. to 4 p.m. ET. Free language interpreter services are available for non-English speakers.
TTY	**1-800-735-2964** Calls to this number are free. This number requires special phone equipment and is only for people who have difficulties with hearing or speaking.
WEBSITE	**https://nheasy.nh.gov/** **www.dhhs.nh.gov**

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

The New Hampshire Long-Term Care Ombudsman assists with complaints or problems **related to coverage of long-term health care facility (also referred to as nursing facility) services** covered directly by NH DHHS.

When you have a problem related to plan-covered services, first seek to resolve the problem through the NH DHHS Customer Service Center. If the NH DHHS Customer Service Center is unable resolve the problem, then contact the Long-term Care Ombudsman.

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 Access Relay (NH): **1-800-735-2964** Calls to this number are free. This number requires special phone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**1-603-271-5574**
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 2.10 How to contact the NH DHHS Ombudsman

The New Hampshire Department of Health and Human Services (NH DHHS) Ombudsman assists in resolving disagreements, including complaints or problems involving Medicaid eligibility or coverage, for the following:

- Plan members.
- Clients.
- Department employees.
- Members of the public.

Before contacting the NH DHHS Ombudsman when you have a problem related to your plan, first 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	**1-800-735-2964** Calls to this number are free. This number requires special phone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**1-603-271-4632**
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 2.11 How to contact ServiceLink Aging & Disability Resource Center

ServiceLink is an NH DHHS program that helps individuals:

- Identify and access long-term services and supports.
- Access family caregiver information and supports.
- Learn about Medicare and Medicaid benefits.

ServiceLink is a program supported by NH DHHS.

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

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

You play a vital role in protecting the integrity of the New Hampshire Medicaid program. To prevent and detect fraud, waste, and abuse, AmeriHealth Caritas New Hampshire 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	AmeriHealth Caritas New Hampshire to report fraud, waste, or abuse
CALL	**1-866-833-9718** Calls to this number are toll-free, 24 hours a day, seven days a week. Member Services also has free language interpreter services available for non-English speakers.
WRITE	AmeriHealth Caritas New Hampshire Special Investigations Unit 200 Stevens Drive Philadelphia, PA 19113 OR Email: fraudtip@amerihealthcaritas.com
WEBSITE	**www.amerihealthcaritasnh.com**

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

Section 2.13 Other important information and resources

- **You may designate an authorized representative or personal representative** – You may designate a person to whom you give authority to act on your behalf. Your representative will be able to provide the plan with information or receive information about you in the same manner that the plan would discuss or disclose information directly to you.

  To have someone represent you, you must authorize your representative in writing and tell us how they may represent you. Your authorized representative or personal representative designation is valid until you revoke or amend it in writing. For more information, contact Member Services (phone numbers are printed on the back cover of this handbook.)

- **Alternative formats and interpretation services.**
  If you have a hearing, vision, or speech disability, you have the right to receive information about your health plan, care, and services in a format that you can understand and access. That's why AmeriHealth Caritas New Hampshire offers language assistance services. These services are available at no cost to members. Aids and services that AmeriHealth Caritas New Hampshire provides to help people communicate with us include:
  - A TTY machine. Our TTY phone number is **1-855-534-6730**.
  - Qualified American Sign Language interpreters.
  - Closed captioning.
  - Written information in other formats (like large print, audio, accessible electronic format, and other formats).

These services are available to members with disabilities at no cost. To ask for aids or services, please call Member Services at **1-833-704-1177 (TTY 1-855-534-6730**).

- If you are eligible for Medicaid, we are required to give you information about the plan's benefits that is accessible and appropriate for you at no cost. Information is available in Braille, in large print, and other formats.

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

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

- **Information about the structure and operation of the plan** – AmeriHealth Caritas New Hampshire has a contract with the New Hampshire Department of Health and Human Services to meet the health care needs of people with New Hampshire Medicaid. We partner with a group of health care providers to help us meet your needs. These providers (doctors, therapists, specialists, hospitals, home care providers, and other health care facilities) make up our provider network.

- **Information about plan provider incentives and compensation arrangements** – To request information about our provider incentives or payment arrangements, contact Member Services (phone numbers are printed on the back cover of this handbook). Provider incentives and payment arrangements describe how network providers are paid for covered services, including any payment bonuses they may be eligible to receive based on patient outcomes or other performance measures.

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

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

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

- **Member material requests** — Contact AmeriHealth Caritas New Hampshire Member Services to request a copy of our Member Handbook, Drug List, or Provider Directory. Document(s) will be sent within five business days of your request. (Phone numbers for Member Services are printed on the back cover of this Handbook.)
- **Clinical Practice Guidelines** — AmeriHealth Caritas New Hampshire adopts Clinical Practice Guidelines (CPGs) from national health experts to help with your care needs. Health care providers can use these as a guide for care. As a member or future member you can request these CPGs by calling Member Services at **1-833-704-1177 (TTY 1-855-534-6730**) or you can view them on our website at **www.amerihealthcaritasnh.com/assets/pdf/provider/resources/clinical/CPG-ACNH-1121.pdf**.

Chapter 3. Using AmeriHealth Caritas New Hampshire for covered services

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

AmeriHealth Caritas New Hampshire will work with you and your primary care provider (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

AmeriHealth Caritas New Hampshire covers all services required in our contract with NH DHHS.

AmeriHealth Caritas New Hampshire 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. No referral from your PCP is required if you choose to see another provider that is in the AmeriHealth Caritas New Hampshire provider network.
- **If you believe you have an emergency, call 911 or go to the nearest emergency room.** You do not need approval from your plan or your PCP before getting emergency care, and you are not required to use our hospitals or doctors.
- **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)*. When you receive care from an out-of-network provider (a provider who is not part of our plan's network) most services will not be covered, except with prior approval from the plan or for emergency services. For more information about when out-of-network services may be covered, refer to Section 3.5 (*Getting care from out-of-network providers*).

  Here are four exceptions:

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

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

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

A PCP is the network provider you choose (or is assigned to you by the plan until you select one) and who you should see first for routine care and most health problems. They make sure you get the care you need to keep you healthy. They 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. They initiate referrals for specialist care, and maintains the continuity of your care. Make sure to let your PCP know if you are seeing any other providers such as a specialist or acupuncturist. This will help your PCP better coordinate your care.

Your PCP may include a network:

- Pediatrician,
- Family practitioner,
- General practitioner,
- Internist,
- Obstetrician/gynecologist,
- Physician assistant (under the supervision of a physician),
- Nurse practitioner, or
- Advanced practice registered nurse (APRN).

If you need help selecting or changing your PCP, call Member Services (phone numbers are printed on the back cover of this handbook). Your PCP is a doctor, nurse practitioner, physician assistant, or other type of provider who will care for your health, coordinate your care needs, and help you get referrals for specialized services if you need them. Your PCP will complete your annual wellness exam, to include completing the Health Risk Assessment (HRA), reviewing the results with you, and discussing any medications and/or questions you may have.

Women can choose an in-network OB/GYN to serve as their PCP. Women do not need a PCP referral to see an in-network OB/GYN or another provider who offers women's health care services. Women can get routine checkups, follow-up care if needed, and regular care during pregnancy.

If you have a complex health condition or a special health care need, you may be able to choose a specialist to act as your PCP. For more information or to request to choose a specialist as your PCP, call Member Services at **1-833-704-1177 (TTY 1-855-534-6730**). We will work with you to help coordinate the care that you need.

How do you choose your PCP?

When you enroll in AmeriHealth Caritas New Hampshire, you will have an opportunity to choose your own PCP. To choose your PCP, call Member Services at **1-833-704-1177 (TTY 1-855-534-6730**).

If you do not select a PCP, we will choose one for you. We take into consideration the following:

- Member claims history.
- Family member's provider assignment.
- Location.
- Special medical needs.
- Language/cultural preferences.

You can find your PCP's name and contact information on the letter that came with your ID card, on the Member Portal, or by calling Member Services.

When deciding on a PCP, you may want to find a PCP who:

- You have seen before.
- Understands your health problems.
- Is taking new patients.
- Can serve you in your language.
- Is easy to get to.

Changing your PCP

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

You can find your PCP's name and contact information on your ID card. You can change your assigned PCP within 30 days from the date you receive your AmeriHealth Caritas New Hampshire ID card. Just call Member Services at **1-833-704-1177 (TTY 1-855-534-6730**). You do not have to give us a reason for the change. If you want to change your PCP more than one time a year, you can change at any time if you have a good reason (good cause). For example, you may have good cause if:

- You do not agree with your treatment plan.
- Your PCP moves to a different location that is not easy to get to.
- You have trouble communicating with your PCP because of a language barrier or another communication issue.
- Your PCP is not able to accommodate your special needs.

Call Member Services at **1-833-704-1177 (TTY 1-855-534-6730)** to learn more about how you can change your PCP.

Section 3.2 Services you can get without getting approval in advance

You can get some services without getting an approval in advance, such as:

- Routine women's health care, including breast exams, screening mammograms (X-rays of the breast), pap tests, pelvic exams, and maternity care.
- Flu shots.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed services from network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible (e.g., when you are temporarily outside of the plan's service area).
- Family planning services when you go to any participating New Hampshire Medicaid family planning provider.

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 so that your services will be paid for by the health plan. The plan will only pay for your services if you use in-network providers required by the plan to get your covered services.

The only exceptions to this rule are:

- Emergencies.
- Urgently needed services when the network is not available.
- When you receive authorization in advance from the plan to see an out-of-network provider.

How to know which providers are in our network

There are three easy ways to check which providers are in our network:

- Look through our Provider Directory either online or in print. The Provider Directory lists network providers.
- Use our Find a Provider link: **amerihealthcaritasnh.com/find-provider**.
- Call Member Services at **1-833-704-1177 (TTY 1-855-534-6730**). You may request a copy of the Provider Directory from Member Services. This can be provided by email or mail. Also, you may ask Member Services for more information about our network providers, including their qualifications.

You can also see the Provider Directory at **www.amerihealthcaritasnh.com**, or download it from the website. Both Member Services and the website can give you the most up-to-date information about changes in our network providers.

The Provider Directory is available in regular or large print, alternative formats, including auxiliary aids and services, and is available upon request at no cost to the member or potential member.

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: (bullets)

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

Sometimes you, or your child with special health needs, may need care from a specialist. Specialists treat special types of conditions, including physical, intellectual, and development disabilities, as well as behavioral health or substance use concerns. Your primary care provider (PCP) can help you find a specialist or behavioral health care provider. You don't need a formal referral from your PCP as long as the specialist is in our provider network.

When your PCP thinks that you need specialized treatment, he or she could give you a referral (approval in advance) to see a network specialist or certain other providers. For some types of referrals, your PCP may need to get approval in advance from our plan. (This is called getting "prior authorization." Prior authorization requirements for covered services are in italics in Section 4.2 (*Benefits chart*).

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

Here are some things you should know about getting care from providers who are not your PCP.

For a specialist

Your PCP will refer you to a specialist if you need specialized care that your PCP cannot give. A specialist is a doctor who is trained and practices in a specific area of medicine (like a cardiologist or a surgeon). If your PCP refers you to another provider, we will pay for your care. Most of the specialists your PCP might refer you to are AmeriHealth Caritas New Hampshire providers. Talk with your PCP to be sure you know how referrals work.

- If you think a specialist does not meet your needs, talk with your PCP. Your PCP can help you if you need to see a different specialist.
- There are some treatments and services that your PCP must ask AmeriHealth Caritas New Hampshire to approve before you can get them. Your PCP will be able to tell you what they are.
- If you have trouble getting a referral you need, contact Member Services at **1-833-704-1177 (TTY 1-855-534-6730)**.

If AmeriHealth Caritas New Hampshire does not have a specialist in our provider network who can give you the care you need, we will refer you to a specialist outside our plan. This is called an **out-of-network** referral. Your PCP or another network provider must ask AmeriHealth Caritas New Hampshire for approval before you can get an out-of-network referral. This is called prior authorization.

Your provider will send the prior authorization request with medical information to AmeriHealth Caritas New Hampshire to help us make a decision about your care. Our Utilization Management team will review this information and make a decision.

Sometimes we may not approve an out-of-network referral because we have a provider in our network who can treat you. If you do not agree with our decision, you can appeal our decision. See page 83 to find out how.

You can talk to your PCP about this or call AmeriHealth Caritas New Hampshire Member Services at **1-833-704-1177 (TTY 1-855-534-6730)** to talk about your needs and get more details.

If you have a complex health condition or a special health care need, you may be able to choose a specialist to act as your PCP. For more information or to request to choose a specialist as your PCP, call Member Services at **1-833-704-1177 (TTY 1-855-534-6730**). We will work with you to help coordinate the care you need.

For an OB/GYN provider

You can choose any OB/GYN provider that is in the AmeriHealth Caritas New Hampshire provider network. You do not need a referral to get treatment from family planning providers either in or out of our network. Obstetric services such as prenatal care and postpartum support are covered. **You will need to notify AmeriHealth Caritas New Hampshire of your baby's birth within 30 days.**

For other providers and services

Please call Member Services at **1-833-704-1177 (TTY 1-855-534-6730**) for more information about getting vision or mental health and/or substance use disorder services. Also see Chapter 4. *Covered services*.

Vision
See Section 4.2 (*Benefits chart*) under "Vision services and eyewear". In addition to the benefits listed in section 4.2, vision covers $100 yearly allowance for contact lenses.

Dental
See Section 4.2 (*Benefits chart*) for information on how to access dental benefits and providers through your state Medicaid benefits.

Mental Health/Substance Use Disorder
Member Services can also help you find a mental health and/or substance use disorder provider and get services you may need. You may also ask your PCP for help finding a mental health or substance use disorder provider. You do not need a referral to access mental health or substance use disorder services.

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 either 15 calendar days after the plan receives notice of your provider leaving the network, or 30 calendar days before the effective date of the provider termination, whichever is first, 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 seven calendar days** from the date the plan becomes aware of such unavailability and will develop a transition plan to help you with your continued ongoing care.

Section 3.5 Getting care from out-of-network providers

If AmeriHealth Caritas New Hampshire does not have a specialist in our provider network who can give you the care you need, we will refer you to a specialist outside our plan. This is called an out-of-network referral. Your PCP or another network provider must ask AmeriHealth Caritas New Hampshire for approval before you can get an out-of-network referral. You can talk to your PCP about this or call AmeriHealth Caritas New Hampshire Member Services at **1-833-704-1177 (TTY 1-855-534-6730)** to discuss your needs and to get more details. We will review and make a decision about your request.

Sometimes we may not approve an out-of-network referral because we have a provider in AmeriHealth Caritas New Hampshire who can treat you. If you do not agree with our decision, you can appeal our decision. See Chapter 10 (*What to do if you want to appeal a plan decision or "action", or file a grievance*) to find out how.

Sometimes, we may not approve an out-of-network referral for a specific treatment because you asked for care that is not very different from what you can get from an AmeriHealth Caritas New Hampshire provider. If you do not agree with our decision, you can appeal our decision. See Chapter 10 (*What to do if you want to appeal a plan decision or "action", or file a grievance*) to find out how.

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

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

Section 3.6 Emergency, urgent, and after-hours care

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

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

If you have a medical emergency:

- **Get help as quickly as possible.** Call **911** for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do not need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours of the onset of the emergency. Please contact Member Services at **1-833-704-1177 (TTY 1-855-534-6730)**, 24 hours a day, seven days a week.

If you have a mental health or substance use emergency:

- **Get help as quickly as possible.** Call the NH Rapid Response Access Point (**1-833-710-6477**) anytime day or night. You **do not** need to get approval or a referral first from your PCP.

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.
- The additional care you get is considered "urgently needed services" and you follow the rules for getting these services. For more information, see the subsections 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"?

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 behavior 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 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.
- Or, call **211** to connect to your local Doorway for substance misuse supports and services in New Hampshire.

As soon as possible, make sure that our plan has been told about your behavioral health emergency or crisis. We need to follow up on your emergency or crisis care. You or someone else should call to tell us about your emergency or crisis care, usually within 48 hours at **1-833-704-1177** (**TTY 1-855-534-6730**) available 24 hours a day, seven days a week.

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?

AmeriHealth Caritas New Hampshire understands that substance use disorder, like other chronic health conditions, requires access to immediate help and this care is critical to recovery.

- If you are a AmeriHealth Caritas New Hampshire member struggling with substance misuse and are in need of urgent care, contact AmeriHealth Caritas New Hampshire; 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 New Hampshire.
- 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.

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.

You can visit an urgent care clinic to get care the same day or make an appointment for the next day. Whether you are at home or away, call your PCP any time, day or night, if you have questions about your health. If you cannot reach your PCP, call Member Services at **1-833-704-1177 (TTY 1-855-534-6730**). Tell the person who answers what is happening. They will help you decide what to do.

If you are in danger or need immediate medical attention, call **911**.

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 AmeriHealth Caritas New Hampshire 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 **www.gencourt.state.nh.us/rules/about_rules/listagencies.aspx**.

About covered services:

- The Benefits Chart lists the services AmeriHealth Caritas New Hampshire covers. The chart is for your general information and may not include all the benefits available to you. Please call AmeriHealth Caritas New Hampshire Member Services with questions about your services (phone numbers are printed on the back cover of this handbook).
- The services listed in the Benefits Chart are covered **only when the following requirements are met:**
    - The services meet the coverage guidelines established by New Hampshire Medicaid.
    - The services are medically necessary. For more information about medically necessary services, refer to Section 6.1 (*Medically necessary services)*.
    - The services are provided by network providers, unless otherwise allowed as described in this handbook. In most cases, care you receive from an out-of-network provider will not be covered unless you have received prior authorization from the plan. For more information about using in-network and out-of-network providers, refer to Chapter 3 (*Using AmeriHealth Caritas New Hampshire for covered services*).
    - You have a primary care provider (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.
- Your provider may suggest medical services that the plan does not cover. If you get those services, you may have to pay for them. The plan does not use religious or moral objections as a basis to deny coverage of a covered service.

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

Section 4.2 Benefits Chart

Services covered by the plan

Abdominal aortic aneurysm screening

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

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

For more information, please call Member Services.

Abortion services

The plan covers abortion services only as follows:

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 Services.

Adult medical day care services

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

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

Covered services include:

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

Prior authorization from the plan is required.

For more information, please call Member Services.

Services covered by the plan
Alcohol misuse screening and counseling Refer to Substance use disorder (SUD) treatment services in this Benefits Chart.
Allergy testing and treatment The plan covers allergy testing when significant symptoms exist and conventional therapy has not worked. Allergy testing focuses on determining what allergens cause a particular reaction, the degree of the reaction and informs treatment options. Covered testing services include the professional service to prepare and to administer an allergenic extract. If an allergen is identified, covered allergy treatment includes medication and immunotherapy. *Prior authorization from the plan is not required for services provided by a network provider.* For more information, please call Member Services.
Alternative Pain Therapies: acupuncture and chiropractic services Acupuncture and chiropractic services, not to exceed 12 visits of each per member per year benefit, as alternatives to opioid prescriptions through our Living Beyond Pain Program.
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. • Air ambulance services if: ○ You cannot safely be transported in a timely manner 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.* *Prior authorization is required for air ambulance.* Ambulance services are not covered outside the United States and its territories. For more information, please call Member Services.

Services covered by the plan

Ambulance services – Non-emergency

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

Covered ambulance services include:

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

Services are managed by CTS for the plan. Please call CTS at **1-833-301-2264**.

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

Ambulance services are not covered outside the United States and its territories.
For more information, please call Member Services.

Anesthesia

Refer to *Physician services* in this Benefits Chart.

Audiologist services

The plan covers hearing tests and hearing aid evaluations to determine if a hearing aid is needed. Hearing aid evaluations or hearing aid consultations performed by an audiologist are limited to one every 24 months for members older than 21 years, and as needed for members younger than 21 years.

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

Refer to "Hearing services" for more information on related services and hearing aids.
For more information, please call Member Services.

Bariatric surgery (weight loss surgery)

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

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

Prior authorization from the plan is required.

For more information, please call Member Services.

Behavioral health services

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

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

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

Services covered by the plan

Bone mass measurement

The plan covers certain bone mass measurement procedures.

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

For more information, please call Member Services.

Breast cancer screening (mammogram)

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

Prior authorization from the plan is not required for screenings provided by a network provider, but may be required for screenings that are ordered at a higher than recommended frequency.

For more information, please call Member Services.

Cardiac (heart) rehabilitation services

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

Prior authorization from the plan is required.

For more information, please call Member Services.

Cardiovascular (heart) disease risk-reduction visit (therapy for heart disease)

The plan covers visits with your PCP as part of an effort to help lower your risk for heart disease. During this visit, your doctor may:

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

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

For more information, please call Member Services.

Cardiovascular (heart and blood vessel) disease testing

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

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

For more information, please call Member Services.

Cervical and vaginal cancer screening

The plan covers pap tests and pelvic exams for women as ordered by a physician or other licensed health care professional.

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

For more information, please call Member Services.

Services covered by the plan

Chemotherapy

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

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

Prior authorization from the plan may be required.

For more information, please call Member Services.

Colorectal cancer screening

The plan covers the following services:

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

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 Services.

Counseling/Coaching to stop smoking, tobacco, or nicotine use

The plan covers up to 8 counseling or coaching sessions per quit attempt to help with quitting smoking, tobacco, or other nicotine use. Up to 2 quit attempts per year when provided by your PCP or other qualified provider.
(Refer also to "Smoking, tobacco, and nicotine cessation" in the Benefits Chart.)

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

For more information, please call Member Services.

Services covered by the plan

Dental 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 younger than 21 years of age, 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 younger than 21 years of age, please contact the New Hampshire Medicaid Customer Service Center. Refer to Section 2.8 (*How to contact the NH DHHS Customer Service Center*).
- Flouride varnish services are covered by the plan for some members. Refer to *Fluoride varnish* in the Benefits Chart.
- For members 21 years of age and older, 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 Services toll-free at **1-844-583-6151 (TDD Relay Access: 1-800-466-7566)**, Monday through Wednesday, 8 a.m. to 8 p.m., and Thursday and Friday, 8 a.m. to 5 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 Services.

Diabetic supplies and training

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

- Supplies to monitor your blood glucose levels include:
  - Blood glucose monitoring device.
  - Blood glucose test strips.
  - Lancet devices and lancets.
  - Glucose-control solutions for checking the accuracy of test strips and monitors.
- Fittings for and provision of therapeutic, custom-molded or depth shoes if you have severe diabetic foot disease.
- Education to help you understand your diabetes is a covered benefit.

Prior authorization from the AmeriHealth Caritas New Hampshire may be required.

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

For more information, please call Member Services.

Services covered by the plan

Dialysis and other renal (kidney) disease services and supplies

The plan covers the following services:

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

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

For more information, please call Member Services.

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.

Prior authorization from AmeriHealth Caritas New Hampshire may be required.

For more information, please call Member Services.

Services covered by the plan

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

The plan covers EPSDT services for members younger than 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, vision, and hearing screening services at specified times, commonly referred to as well-child checkups, and when health problems arise or are suspected. In addition to screening, EPSDT services include all medically necessary diagnostic and treatment services to correct or improve a child's physical or mental illness or condition. This is particularly important for children with special health care needs and disabilities.

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

For specialty treatment services or for more information, please contact Member Services at **1-833-704-1177 (TTY 1-855-534-6730)**, 24 hours a day, seven days a week.

Emergency medical care

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

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

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

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

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

For more information, please call Member Services.

Services covered by the plan

Family planning services

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

The following services are covered:

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

Prior authorization from the plan is not required.

For more information, please call Member Services.

Fluoride varnish

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

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

For more information, please call Member Services.

Gender reassignment surgery

The plan covers gender reassignment services. Covered services include:

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

The plan does not cover cosmetic procedures.

Prior authorization from the plan is required.

For more information, please call Member Services.

Services covered by the plan

Habilitation services

The plan covers health care services that help children and adults keep, learn, or improve skills and functioning for daily living.

These services include occupational, physical, and speech therapies and other services for members with disabilities in a variety of outpatient settings.

Examples:

- Therapy for a child who is not walking or talking at the expected age.
- Therapy for an adult for purpose of maintaining muscle tone.

The plan covers:

- Outpatient physical therapy (PT).
- Occupational therapy (OT).
- Speech therapy (ST).

Limit of 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 is required for members younger than age 21.
For members 21 and older, prior authorization is required for services exceeding the 20 visit limit per modality.

For more information, please call Member Services.

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.

Hearing aid evaluation exam/hearing aid consultation:

Age 21 years or older — one exam or consultation every two years since the last date of service.

Younger than 21 years — as needed.

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

For more information, please call Member Services.

Services covered by the plan

Hepatitis B screening

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

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

For more information, please call Member Services.

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.
- One-time screening for adults born from 1945 through 1965.

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

For more information, please call Member Services.

HIV screening

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

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

For more information, please call Member Services.

Home health care services

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

- Parttime 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 not required for the first 18 visits (combined modalities, not each).

For more information, please call Member Services.

Home infusion therapy services

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

Prior authorization from the plan is required.

For more information, please call Member Services.

Services covered by the plan

Hospice care

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

Covered services include:

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

Prior authorization from the plan is required.

For more information, please call Member Services.

Hysterectomy

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

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

Prior authorization from the plan is required.

For more information, please call Member Services.

Services covered by the plan

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) vaccine.

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

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

For more information, please call Member Services.

Infertility services

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

Prior authorization from the plan is required.

Inpatient hospital services, including acute rehabilitation services

The plan covers inpatient hospital services, including:

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

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

For more information, please call Member Services.

Services covered by the plan

Inpatient mental health services

The plan covers inpatient mental health services that include:

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

*Special coverage rules apply for some inpatient stays. If you are age 21 – 64 years, contact Member Services to see if you meet coverage requirements. Inpatient stays may not exceed 60 days per admission for members age 21 – 64 years.

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

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

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

Prior authorization from AmeriHealth Caritas New Hampshire may be required.

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

For more information, please call Member Services.

Laboratory services

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

Prior authorization may be required.

For more information, please call Member Services.

Maternity and lactation consultation services

The plan covers prenatal, 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 a.m. to 4:30 p.m. ET.

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

For more information, please call Member Services.

Services covered by the plan

Medical supplies

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

Medical supplies include the following:

- Ostomy supplies.
- Catheters.
- Incontinence products.
- Splints.
- Tracheotomy supplies.
- Items with billed charges equal to or greater than $750.
- DME leases or rentals and custom equipment.
- Diapers/pull-ups (age 3 and older) for amounts over the state published quantity limits.
- Enteral nutritional supplements.
- Prosthetics and custom orthotics.
- All unlisted or miscellaneous items, regardless of cost.
- Negative Pressure Wound Therapy.

Prior authorization from the plan may be required.

For more information, please call Member Services.

Medical nutrition therapy

Nutritional counseling group or individual, dietitian visit, and weight management program.

For more information, please call Member Services.

Mental health services

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

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

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

Obesity screening and therapy for weight loss

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

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

For more information, please call Member Services.

Occupational therapy services

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

Services covered by the plan

Organ and tissue transplants

The plan covers the following organ and tissue transplants:

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

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

Prior authorization from the plan is required.

For more information, please call Member Services.

Orthotic devices

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

- Protect against injury.
- Support a weak or deformed portion of the body.
- 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, or pathological conditions of the foot due to localized illness, injury, or symptoms involving the foot.

Prior authorization from the plan is required.

For more information, please call Member Services.

Services covered by the plan

Outpatient mental health services

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

Covered services include:

- Medication visits.
- Individual, group, and family therapy.
- Diagnostic evaluations.
- Partial hospitalization program (PHP).
- Intensive outpatient program (IOP).
- Emergency psychiatric 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 New Hampshire.

Or, call, text, or chat **988** — the Suicide and Crisis Lifeline — 24 hours a day, seven 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.

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

For more information, please call Member Services.

Services covered by the plan
Outpatient hospital services The plan covers outpatient hospital services for the diagnosis or treatment of an illness or injury. Covered services include: • Services in an emergency department or outpatient clinic, including observation stays or outpatient surgery. • Labs and diagnostic tests provided by the hospital. • X-rays and other radiology services provided by the hospital. • Radiation therapy, including technician services, materials, and supplies. • Some screening and preventive services. • Some drugs that you cannot administer yourself. • Surgical supplies, such as dressings. • Casting materials. • Administration of blood products. • Intravenous (IV) infusions. *Prior authorization from the plan is required for some services, including outpatient surgery and some diagnostic tests.* See the specific service in this Benefits Chart for more information or please call Member Services.
Outpatient rehabilitation services (physical therapy, occupational therapy, speech and language therapy services) The plan covers rehabilitation services to help you recover from an illness, accident, or surgery. Rehabilitation services include physical therapy, occupational therapy, and speech language therapy. **Coverage is limited to 20 visits per benefit year for each type of therapy.** Benefit limits are shared between outpatient rehabilitation and habilitation services. Services may be provided in your home, in the therapy provider's office, in a hospital outpatient department, or in a rehabilitation facility. *Prior authorization is required for members younger than age 21.* *For members age 21 and older, prior authorization is required for services exceeding the 20-visit limit per modality.* For more information, please call Member Services.
Outpatient surgery The plan covers outpatient surgery performed in hospital outpatient facilities and ambulatory surgical centers. *Prior authorization may be required for certain procedures.* For more information, please call Member Services.

Services covered by the plan

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 continuous positive airway pressure (CPAP) machines, bilevel positive airway pressure (BiPAP) machines, and ventilators.

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

Prior authorization is required for hyperbaric oxygen. Prior authorization from the plan may be required for respiratory therapy equipment.

For more information, please call Member Services.

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, a wheelchair user, and able to self-direct your care.

Services include assistance with:

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

Prior authorization from the plan is required.

For more information, please call Member Services.

Physical therapy services

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

Services covered by the plan

Physician, physician assistant, and advance practice registered nurse services

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

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

See also specific services for additional coverage by the plan.

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

For more information, please call Member Services.

Podiatry services

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

Services include:

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

For more information, please call Member Services.

Services covered by the plan

Prescription drugs

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

Retail pharmacy copayment:

- $1 copayment for each preferred or approved non-preferred prescription drug — up to a 34-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 copayment for the non-preferred drug will be $1.00)

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

Private duty nursing services

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

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

Prior authorization from the plan is required.

For more information, please call Member Services.

Prostate cancer screening

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

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

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

For more information, please call Member Services.

Services covered by the plan

Prosthetic devices and related supplies

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

Covered prosthetic devices and related supplies include:

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

Prior authorization from the plan may be required.

For more information, please call Member Services.

Pulmonary rehabilitation services

The plan covers pulmonary rehabilitation services for members who have moderate-to-severe chronic obstructive pulmonary disease (COPD). Covered services include:

- Training on breathing techniques.
- Nutrition.
- Oxygen.
- Medications.
- Relaxation.
- Travel.
- How to do everyday tasks with less shortness of breath.
- How to stay healthy and prevent worsening of COPD symptoms.

Prior authorization from the plan is not required.

For more information, please call Member Services.

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

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

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

For more information, please call Member Services.

Sexually transmitted infection (STI) screening and counseling

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

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

For more information, please call Member Services.

Services covered by the plan

Smoking, tobacco, and nicotine cessation services

AmeriHealth Caritas New Hampshire supports the New Hampshire State tobacco treatment quitline QuitNowNH for tobacco and nicotine use treatment services. AmeriHealth Caritas New Hampshire offers incentives to quit smoking and supports prescription medications and couching/counseling. This program is available for use 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, seven days a week, or log on to **www.quitnownh.org**. 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 a list of covered nicotine replacement therapy prescriptions and generic over-the-counter products available through network pharmacies, refer to the plan's Prescription Drug List.

Prior authorization from the plan may be required for certain services, prescriptions, and products.

*The Food and Drug Administration defines tobacco products to include cigarettes, cigars, dissolvables, hookah tobacco, nicotine gels, pipe tobacco, roll-your-own tobacco, smokeless tobacco products, including dip, snuff, snus, and chewing tobacco, vapes, e-cigarettes, hookah pens, and other electronic nicotine delivery systems.

For more information, please call Member Services.

Speech and language pathology services

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

Services covered by the plan

Substance use disorder (SUD) treatment services

The plan covers substance use disorder treatment services provided by a community mental health center, community health center, federally qualified health center (FQHC), rural health center (RHC), mental health provider, acute care hospital, psychiatric hospital, masters licensed drug and alcohol 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 New Hampshire.

Or, call, text or chat **988** — the Suicide and Crisis Lifeline — 24 hours a day, seven 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 *Smoking and tobacco, and nicotine cessation services* in this Benefits Chart.

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

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

Prior authorization from AmeriHealth Caritas New Hampshire may be required.

For more information, please call Member Services.

Services covered by the plan

Telemedicine services

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

- Physician or Physician Assistant.
- Advance Practice Registered Nurse (APRN) or Clinical Nurse Specialist.
- Nurse Midwife.
- Clinical Psychologist.
- Clinical Social Worker.

Eligible sites where video interactive telemedicine services may originate and/or be delivered are:

- Medical practitioner's office.
- Allied health professionals 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 Services.

Transportation services – Ambulance transportation

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

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

Transportation services – Non-emergency medical transportation (NEMT)

The plan covers non-emergency medical transportation services.

For authorized non-emergency medical transportation, you must follow plan rules to get reimbursement or transportation services. Mileage reimbursement, public transportation, and rides are available as appropriate.

- Members are required to use Family and Friends Mileage Reimbursement program whenever possible.
- Reimbursement rate is $.67 per mile.

Continued on the next page

Services covered by the plan

Transportation services– Continued from the previous page

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 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.
  - Have a physical, cognitive, mental or developmental limitation.
- Public transportation is available when all of the following conditions apply:
  - 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 younger than age 65.

Exceptions to the public transportation requirement are:

- If you have two or more children younger than age 6 who shall travel with the you.
- If you have one or more children older than age 6 who have limited mobility and shall accompany you to the appointment.
- If you have at least one of the following conditions:
  - Pregnant or up to six weeks postpartum.
  - 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.
  - Other exception, by provider approval only.

Non-emergency medical transportation services are provided by Coordinated Transportation Solutions (CTS). They can be reached at **1-833-301-2264**.

To schedule a trip for a routine medical appointment covered by the health plan, call CTS

Mondays, Tuesdays, and Wednesdays	from 8 a.m. to 8 p.m. and
Thursdays and Fridays	from 8 a.m. to 5 p.m.

You should also call this number for pickup following an appointment or for any other non-emergency medical transportation question.

For more information, please call Member Services.

To schedule transportation to provider offices or facilities for services provided directly by NHDHHS, call CTS toll-free at **1-844-259-4780**, Monday through Wednesday, 8 a.m. to 8 p.m. ET and Thursday through Friday, 8 a.m. to 6 p.m. ET.

Services covered by the plan

Urgently needed care

The plan covers urgently needed care whether from an in-network or out-of-network provider when network providers are unavailable.

Urgently needed care is care given to treat the following:

- A non-emergency (does not include routine primary care services).
- A sudden medical illness.
- A sudden change in mental health.
- Substance use.
- An injury.
- A condition that needs care right away.

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 Call Line at **1-855-216-6065**. 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 national Suicide and Crisis Lifeline — 24 hours a day, seven 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.

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

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

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 Call Line at **1-855-216-6065**. You should inform your PCP whenever possible if you have received such care.

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

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

For more information, please call Member Services.

Services covered by the plan

Vision services and eyewear

The plan covers the following services:

- Eye care services by an ophthalmologist, optometrist, or optician.
- One 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 younger than 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 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 younger than age 21 years.

The plan covers the following services:

- Trifocal lenses if the member:
  - Is employed and the trifocal lenses are required for the work involved in the member's employment; or

Continued on the next page

Services covered by the plan
Vision services and eyewear – Continued from the previous page ○ 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 Services.
X-rays and radiology services The plan covers radiation therapy and diagnostic X-rays. *Prior authorization from the plan is required for high-tech diagnostic imaging, including CT scans, MRIs, MRAs, PET scans, and nuclear cardiac imaging, unless part of an emergency room visit, an inpatient hospitalization, or provided at the same time with, or on the same day as, an urgent care facility visit.* For more information, please call Member Services.

Section 4.3 Extra benefits provided by the plan

The plan offers some extra benefits that are available to you in addition to the covered services required by New Hampshire Medicaid. Additional details are available on our website or by calling Member Services at **1-833-704-1177 (TTY 1-855-534-6730**).

Value-added benefits include:

- **Vision** — Adult members age 21 and older get $100 per year for contact lenses.
- **Home education visits for children** — We provide home visits to address home-based asthma triggers to qualifying members with asthma. In Manchester and Nashua, we work with the Department of Public Health.
- **SafeLink Lifeline Wireless** — This is a federal program that provides free phone service and minutes each month to income-eligible customers who apply and qualify for the program.
- **Living Beyond Pain** — Members living with chronic pain can enroll in care coordination to access alternative pain management strategies as part of a person-centered plan. Members can get referrals to and coverage for appropriate pain management alternatives, such as acupuncture and chiropractic therapy, not to exceed 12 visits each of acupuncture and chiropractic therapy per member per benefit year. Referral and coverage of services is facilitated through a Care Coordinator as part of a member-centered plan of care statewide.

AmeriHealth Caritas New Hampshire also offers member rewards and incentives.*

- **CARE Card** — With our CARE Card program, you can receive rewards for completing health-related activities (up to a $250 value per member per year*). Note: Child members will earn rewards on their own CARE Card up to $250 per card.

$15	Get Care Management help for unmet social needs.
$20	Annual flu shot
	Annual breast cancer screening (mammogram) for women ages 40 – 74
	Stop smoking (eight weeks of nicotine replacement use).
	Get RSV vaccine — between 32 to 36 weeks of pregnancy; ages 60 and older.
$25	Your child will get $25 on their CARE Card after their first lead screening (between 11 and 23 months) another $25 on their CARE Card after their second lead screening (between 23 and 35 months).
	Attend at least one Member Advisory Board meeting.
	When members ages 12 – 18 download the NextStep Goodlife mobile app and have a parent or guardian notify us through the secure contact form at www.amerihealthcaritasnh.com
$30	Annual blood sugar screening (HbA1c) for members with diabetes
	Complete HRA once each year with your provider.
	Child/teen annual checkup (per child) for ages 2 – 21
$40	Have a postpartum visit 7 – 84 days after delivery.
$50	Blood pressure management (one reading under 140/90 taken at provider's office for members with hypertension or diabetes)
	Antipsychotic medicine adherence (keep using the same medicine for 90 days) and annual metabolic screening (HbA1c or glucose)
	Get recommended preteen shots (Tdap, meningitis, and HPV) by child's 13th birthday.
	Notify us of your pregnancy in the second or third trimester or after the first 30 days of plan enrollment.
	By second birthday, baby has had at least six well visits, all 10 required shots, and a lead screening.
	When members continue to take their prescription of buprenorphine/naloxone for 60 days in a row
$70	Notify us of your pregnancy in the first trimester or within 30 days of plan enrollment.

- **Car seats and booster seats** — We provide a car seat or booster seat at no cost to you for each child member (up to a $210 value*).
- **Well-child visit raffles** — Members ages 2 –16 are automatically entered into a raffle for a chance to win a bike helmet ($35 value*) when they attend their yearly well visit. Members ages 12 – 17 are automatically entered into a raffle for a chance to win a $120 Adidas gift card* when they attend their yearly well visit.
- **WW® (formerly Weight Watchers®) membership** — Eligible members can get a three-month online membership (up to a $133 value*).
- **Mission GED®** — Qualifying adult members can receive support to earn their high school equivalency exam (HiSET® in NH) (up to a $125 value*).
- **Home-delivered meals*** — Members being discharged after a qualifying inpatient hospital stay can receive home-delivered meals (14 meals/seven days) post discharge. Qualifying stays include those for:

- New moms in recovery from substance use disorder.
- Members with substance use disorder who successfully complete an inpatient substance use disorder treatment program as part of the Flexible Recovery Benefit.
- Adult members (ages 21 to 64) with heart disease or diabetes.

Meals for members with dietary restrictions are prepared according to dietary guidelines (up to a $98 value*).

- **Community transportation** — Six rides to and from community destinations such as events at our Wellness and Opportunity Center or to job interviews, exams, food banks, and more (30-mile limit each way).
- **Peer respite transportation** — Transportation to state-covered respite services to remove access barrier for members in need of peer respite (up to a $175 value*).
- **Flexible benefit to support recovery** — Members may receive up to a $500 credit to access alternative peer recovery support services available after completing a nonhospital substance use disorder residential treatment program. Services available are subject to a $500 lifetime limit, and some are also subject to the $250 annual incentive limit. Services include chiropractic care, acupuncture, and transportation. For more information, please contact Member Services at **1-833-704-1177 (TTY 1-855-534-6730**) or refer to the website.

(*Some restrictions and limitations may apply. Earn up to $250 in cash and non-cash goods and services each state fiscal year ending June 30.)

- **Wellness and Opportunity Center** — Located at 25 Sundial Avenue, Suite 130, 1st Floor, Manchester, NH 03103. Visit **www.amerihealthcaritasnh.com/wellness-center** to learn hours for walk-ins, a calendar of events and services available.
- **New technology** — AmeriHealth Caritas New Hampshire evaluates new technology, including medical procedures, drugs and devices, and the new application of existing technology, for coverage determination. The AmeriHealth Caritas New Hampshire medical director and/or medical management staff may periodically identify relevant technological advances for review pertinent to the AmeriHealth Caritas New Hampshire population. The Clinical Policy Committee (CPC) reviews all requests for coverage and makes a determination regarding any benefit changes that are indicated. AmeriHealth Caritas New Hampshire uses nationally recognized technology guidelines from scientific journals and the Centers for Medicaid & Medicare Services (CMS). When a request is received for coverage of new technology that has not been reviewed by the CPC, the AmeriHealth Caritas New Hampshire medical director will review the request and make a one-time determination. This new technology request will then be reviewed at the next regularly scheduled CPC meeting.

Section 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 AmeriHealth Caritas New Hampshire and New Hampshire Medicaid membership cards. Always show your AmeriHealth Caritas New Hampshire membership card to receive services covered by the plan. If you need help getting any covered services, please call Member Services (phone numbers are printed on the back cover of this handbook).

ALWAYS CARRY BOTH YOUR AMERIHEALTH CARITAS NEW HAMPSHIRE 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 younger than 21 years of age, 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 younger than 21 years of age, please contact the New Hampshire Medicaid Customer Service Center. Refer to Section 2.8 (*How to contact the NH DHHS Customer Service Center*).
  - For members age 21 years and older, 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 Services toll-free at **1-844-583-6151 (TDD Relay Access: 1-800-466-7566)**, Monday through Wednesday, 8 a.m. to 8 p.m., and Thursday and Friday, 8 a.m. to 5 p.m. ET.
- Early supports and services for infants and children ages birth to 3 years.
- Medicaid-to-school services.
- Nursing home or nursing facility services – sometimes called long-term care nursing facilities), including: skilled nursing facility services, long-term care nursing facility services, and intermediate care facility services (nursing homes and acute care swing beds) .
- Intermediate care facility services (nursing home and acute care swing beds).
- Glencliff Home services.
- Division of Child, Youth, and Family Program services for Medicaid-eligible children and youth referred by the courts or juvenile parole board, including:
  - Home-based therapy.
  - Child support services (also known as Child Health Support Services).
  - Intensive Home and Community Services.
  - Placement services.
  - Private Non-medical Institutional Care for Children.
  - Crisis intervention.
- Home and Community-Based Services waiver 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 Community Mental Health Center Rapid Response Teams.

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

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

AmeriHealth Caritas New Hampshire can connect you to resources and referrals in your community to help you manage issues beyond your medical care.

If you:

- Need help with child care or meeting your or your family's basic needs.
- Worry about your housing or living conditions.
- Have trouble getting enough food to feed you or your family.
- Find it hard to get to appointments, work, or school because of transportation issues.
- Feel unsafe or are experiencing domestic violence (if you are in immediate danger, call **911**).

For help and more information, you can call:

- Member Services at **1-833-704-1177 (TTY 1-855-534-6730**), 24 hours a day, seven days a week.
- **211** or **1-866-444-4211 (TTY 1-603-634-3388**). You can also visit **www.211nh.org**.

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 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*).

Chapter 5. Using AmeriHealth Caritas New Hampshire to help manage your health

Section 5.1 Staying healthy

AmeriHealth Caritas is committed to helping you stay healthy. When you choose a PCP, you will receive preventive care and services. Regular visits with your PCP will help:

- Keep your health records up to date.
- Answer questions about your health.
- Give you information about healthy eating.
- Keep you up to date on any shots and health screenings.
- Find problems before they become serious.
- Help you get care from other providers if needed. Getting regular routine health care visits (sometimes called "wellness visits") with your PCP is 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.

  On an annual basis, your PCP will complete your wellness exam, to include completing a Health Risk Assessment (HRA), reviewing the results with you, and discussing any medications and/or questions you may have.

If you or your child have any special needs, AmeriHealth Caritas New Hampshire Member Services and Care Management staff will communicate with you to identify any existing conditions and determine any special services you or your child require when completing a care needs screening. This screening identifies your needs and whether you may need complex care management. Members from birth to age 21 get health care services through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. To keep your children healthy, you need to make regular appointments with your child's PCP. These are called well-child visits and they are important at every age. They are different from visits to the PCP when your child is sick. At a well-child visit, the PCP will examine your child. What the PCP does during the exam depends on the age of your child. The PCP will ask questions, order tests, and check your child's growth and development based on your child's age.

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

AmeriHealth Caritas New Hampshire will inform EPSDT-eligible members (or their family or caregivers) about the EPSDT program within sixty calendar days of becoming eligible and then yearly for members who have not accessed the benefit. Information about EPSDT will include mailed information, Member Handbook material, text messages, and phone outreach.

Care Management

Care Managers can also assist you in staying healthy. Care management is available and free to all participants. If participating in care management, you will be assigned a primary care manager. Our care management team is an integrated team of:

- Registered nurses (RNs).
- Substance use disorder coordinator.
- Housing coordinator.
- Nonclinical care connectors.
- Community health navigators. The team works collaboratively to assist you in managing your health needs, connecting you with the health care and services you need to get well and stay well.

Our whole-person approach includes educating and empowering you to actively participate in improving your health. We'll provide you with the information you need, when you need it, to help you manage complex, chronic, or long-term conditions.

You can get help managing your chronic conditions, such as:

- Diabetes.
- Asthma.
- Heart disease.
- High blood pressure.
- Depression.
- Substance use issues.
- Attention-deficit/hyperactivity disorder (ADHD).

We'll also help you when you are leaving the hospital or other medical setting to make sure you have the services you need in place and coordinate any follow-up appointments for you.

Our care managers can assist with a variety of special health conditions:

- Adults and children with special health care needs.
- HIV/AIDs.
- Serious Mental Illness (SMI).
- Serious Emotional Disturbance (SED).
- Intellectual/development disability (I/DD).
- Substance use disorder.
- Chronic pain.
- Members receiving services under Home and Community-Based Services (HCBS) waivers.
- Members identified as rising risk.
- Individuals with high unmet resource needs.
- Mothers of babies born with neonatal abstinence syndrome (NAS).
- Infants with neonatal abstinence syndrome (NAS).
- Pregnant women with substance use disorder.
- 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 ER for an overdose event in the last twelve (12) months.
- Recently incarcerated individuals.
- Individuals who have a suicide attempt in the last 12 months.

If you are pregnant, AmeriHealth Caritas New Hampshire offers our Bright Start® program to help you have a healthy pregnancy and baby. The Bright Start program gives you information about:

- The importance of eating right.
- Taking your prenatal vitamins.
- Receiving care in a timely manner.
- Staying away from drugs, alcohol, and smoking.
- Visiting your dentist.

AmeriHealth Caritas New Hampshire will work with your providers to make sure you get the care you need.

Call AmeriHealth Caritas New Hampshire's Member Services for more information at **1-833-704-1177 (TTY 1-855-534-6730)**.

Section 5.2 Care coordination and care management support

AmeriHealth Caritas New Hampshire offers care coordination services through our Care Management program to help coordinate your care across your health care team. Our Care Management team will ask you questions to assess your health care needs. If needed, we will help you schedule appointments with your PCP. If you have extra needs, such as care from a specialist, your Care Manager will work with you and your PCP to coordinate care. Your Care Manager will schedule follow-up calls with you and will work with you and your PCP to set personal goals and work to improve your health and quality of life. How long you have care coordination depends on your health condition and progress towards your goals.

Examples of what our Care Managers can assist with:

- Scheduling appointments.
- Arranging transportation.
- Connecting with community resources.
- Obtaining food stamp benefits.
- Joining support groups.
- Coordinating care among providers and specialists.
- Offering education on health conditions and/or medications.

To get started and to see if you or your child is eligible, call the AmeriHealth Caritas New Hampshire Rapid Response and Outreach Team at **1-833-212-2264** or Member Services at **1-833-704-1177 (TTY 1-855-534-6730)**.

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.
- Services 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.

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 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 AmeriHealth Caritas New Hampshire network. In addition to meeting at least one 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.

When one of these clinical circumstances apply to you, you may continue to get care from your treating provider(s) for a limited time	You may continue to get care from your treating provider(s) during this time period	You may continue to get currently prescribed prescription drugs during this time period
You are receiving a prior authorized ongoing course of treatment with your current provider at the time of transition.	Up to 90 calendar days from your enrollment date or until the completion of a medical necessity review by the plan, whichever occurs first.	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.
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.		
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.		
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.*		
You are in your second or third trimester of pregnancy and prefer to continue to receive care through your current provider.	Through your pregnancy and up to 60 calendar days after delivery.	
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.	For the remainder of your life with respect to care directly related to the treatment of the terminal illness or its medical effects.	

*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 who have a serious emotional disturbance, intellectual developmental disability, or substance use disorder diagnosis.

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

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

Section 5.4 Mental health parity assurance

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

Parity means that:

- AmeriHealth Caritas New Hampshire 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.
- AmeriHealth Caritas New Hampshire must have similar prior authorization requirements and treatment limitations for mental health and substance use disorder benefits as it does for other medical benefits.
- AmeriHealth Caritas New Hampshire must provide you or your provider with the medical necessity criteria used by AmeriHealth Caritas New Hampshire for prior authorization upon either your request or your provider's request.
- AmeriHealth Caritas New Hampshire must not impose aggregate lifetime or annual dollar limits on mental health or substance use disorder benefits.
- Within a reasonable time frame, AmeriHealth Caritas New Hampshire must provide you the reason for any denial of authorization for mental health and/or substance use disorder services.
- If AmeriHealth Caritas New Hampshire 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.
- Prescription drug list structure, including copayments.

If you think that AmeriHealth Caritas New Hampshire 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 AmeriHealth Caritas New Hampshire 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 (TTY 1-800-735-2964**), Monday through Friday, 8 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 AmeriHealth Caritas New Hampshire in order for you to get coverage for the service. If you do not get this authorization, AmeriHealth Caritas New Hampshire may not cover the service.

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

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

Section 6.1 Medically necessary services

When making its coverage decision, AmeriHealth Caritas New Hampshire will consider whether the service is medically necessary

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

In some cases, AmeriHealth Caritas New Hampshire will review medical necessity after covered services are delivered.

Review of a service you already got is called a post-service review. If you are getting a post-service review, your provider sends us your medical record. Our team of physicians and other licensed clinicians will review your record and make a decision within 30 days of getting your information. If they decide not to cover your service, you and your provider will be notified of the decision and the reason for the decision.

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.
- 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.
- Not experimental, investigative, cosmetic, or duplicative in nature.

Section 6.2 Getting plan authorization for certain services

AmeriHealth Caritas New Hampshire'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 Services for more information (phone numbers are printed on the back cover of this handbook).

When the plan denies a service authorization request, or authorizes a service in an amount, duration, or scope that is less than requested, 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 quickly as your health condition requires, but no more than 72 hours after receipt of the request for service, unless you or your authorized representative fail to provide sufficient information to determine whether, or to what extent, your benefits are covered.
    - In the case of such failure, AmeriHealth Caritas New Hampshire 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.
    - For authorization requests to continue or extend service(s) involving

      (a) urgent care of an ongoing course of treatment, and

      (b) a question of medical necessity,

      the plan's decision shall be made within 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 AmeriHealth Caritas New Hampshire, 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 AmeriHealth Caritas New Hampshire extends the time frame, 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.
  - 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 your or your authorized representative's coverage request.
- In the event you or your authorized representative fail to provide sufficient information for AmeriHealth Caritas New Hampshire 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 time frame 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 three calendar days of the decision.
- If you disagree with the plan's adverse prior authorization decision, refer to Section 10.1 (*About the appeals process).*

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

Section 6.3 Getting authorization for out-of-network services

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

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

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

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

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

You may choose any New Hampshire Medicaid participating doctor, clinic, community health center, hospital, pharmacy, or family-planning office in-network or out-of-network.

Covered services are listed in Services covered by the plan. Family planning services do not need a referral.

Prior authorization from the plan for family planning services is not required.

For more information, please call Member Services.

Section 6.6 Getting a second medical opinion

Members may receive a second opinion from a qualified health care professional within the network, or one may be arranged by AmeriHealth Caritas New Hampshire outside the plan's network at no cost to you. If the provider is in the AmeriHealth Caritas New Hampshire provider network, you will not be charged for the second opinion. If you choose a provider who is not in the AmeriHealth Caritas New Hampshire network for the second opinion, you may have to get prior authorization.

Chapter 7. Getting covered prescription drugs

Section 7.1 Drug coverage rules and restrictions

The plan's Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Pharmacy Member Services at **1-888-765-6383** or visit our website, **www.amerihealthcaritasnh.com/druglist**.

If there is a restriction on your drug, it usually means that you or your provider will have to take extra steps for the plan to cover the drug. If there is a restriction on the drug you want to take, ask your provider to request prior authorization from the plan. For more information, contact Pharmacy Member Services at **1-888-765-6383**.

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

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

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

Drug coverage restrictions

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

Drug list rule restrictions described in this section include:

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

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

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, then the plan will cover the brand name drug.

Requiring prior authorization from the plan

The NH Medicaid Preferred Drug List (PDL) is a list of effective prescription drugs within drug classes. These drugs are the recommended first choice when prescribing for Medicaid patients. NH DHHS Preferred Drug List can be found at:
https://www.dhhs.nh.gov/ombp/pharmacy/documents/preferred.pdf.

The plan's Drug List will tell you if the medicine requires prior approval to receive the medication. The plan's Drug List will also tell you if the plan limits the amount of the drug that you can get each time you fill or refill your prescription or requires that you try a different, but similar drug first. Medicines that are not on the plan's Drug List or are listed as "Non-Preferred" on the plan's Drug List will also require approval before you can get the medication.

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

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

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. If you have already tried Drug A, or your doctor does not believe it is safe for you to take Drug A, your doctor would need to tell us this information on a prior authorization request form. This requirement to try a particular drug first is called "step therapy."

If you have changed health plans, and the medication you have been taking requires prior approval, you will be allowed to get up to a 30-day supply of your medication filled. This fill is allowed for the first 90 days from the date you changed to AmeriHealth Caritas New Hampshire. This will allow you time to talk to your doctor. If your doctor wants you to continue this medicine, your doctor will need to call to request an approval.

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. If the drug requires prior approval, but you need to start it right away, your pharmacy can give you a three-day emergency supply. This will give you and your provider time to change to another drug or to file a request to have the drug covered. Your pharmacist may not give you a three-day supply of some medicines if they feel it is not safe for you to take the medicine.

- You can change to another drug. You or your provider can request a list of covered drugs that treat your condition from Pharmacy Member Services by calling **1-888-765-6383**.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug. To request an exception, your physician will need to send the plan a prior authorization form. The plan will review the request and let you and your doctor know our decision. The plan will cover the medicine if it is medically necessary. If it is not, the plan will send you and your doctor a letter that will tell you why. The plan will also let you know which other medicines or therapies may be used.

  If you need help requesting an exception, contact Pharmacy Member Services at **1-888-765-6383**.
- 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.
- When a covered prescription is not available due to a supply shortage.

For more information about pharmacy benefits, contact Pharmacy Member Services at **1-888-765-6383**.

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 AmeriHealth Caritas New Hampshire List of Covered Drugs is called the 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.

What is *not* on the Drug List

The plan does not cover all prescription drugs. AmeriHealth Caritas New Hampshire 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 AmeriHealth Caritas New Hampshire website at **www.amerihealthcaritasnh.com**. The Drug List on the website is always the most current.

- Calling and asking Pharmacy Member Services to find out if the drug is on the plan's AmeriHealth Caritas New Hampshire Drug List. Contact Pharmacy Member Services at **1-888-765-6383**.
- Calling and asking Pharmacy Member Services for a copy of the Drug List. Contact Pharmacy Member Services by calling **1-888-765-6383**.

Over-the-Counter Drugs

The plan also covers certain over-the-counter drugs **when you have a prescription** from your provider. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. For more information on coverage of over-the-counter drugs, call Pharmacy Member Services at **1-888-765-6383**.

The formulary or Drug List can change during the enrollment year

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

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

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

How you will find out if your drug coverage has changed

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

Examples of when your drugs may change include:

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

To get the most up-to-date information about which drugs are covered, visit **www.amerihealthcaritasnh.com/druglist** or call Pharmacy Member Services at **1-888-765-6383**.

Section 7.3 Types of drugs we do not cover

This section tells you what types of prescription drugs are not covered.

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

AmeriHealth Caritas New Hampshire **will not cover** drugs in the following situations:

- The plan will not cover Part D drugs if you are enrolled in by 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 that use is not supported in a recognized publication. **(For members aged 21 years and older, an exception may apply for medically necessary off-label use prescriptions.)**
    - "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™ and the DrugDex® Information System. For cancer, the recognized publications are the National Comprehensive Cancer Network® and *Clinical Pharmacology*, or their successors.

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 Drug Efficacy Study Implementation (DESI) drugs or insulin-receptor substrate (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 Provider Directory, visit our website (**www.amerihealthcaritasnh.com**), or call Pharmacy Member Services at **1-888-765-6383**.

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 Pharmacy Member Services by calling **1-888-765-6383** or using 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.

Find a specialized network pharmacy in your Provider Directory or call Pharmacy Member Services at **1-888-765-6383**.

Section 7.5 Drug coverage in facilities

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

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

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

Check your Provider Directory 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 Pharmacy Member Services at **1-888-765-6383**.

Section 7.6 Programs to help members use drugs safely

A prescribing provider, pharmacist, or another qualified provider will conduct a Comprehensive Mediation Review (CMR) to help make sure that members are getting safe and appropriate care. These reviews are especially important for members who have multiple medications and 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.
- Possible errors in the amount (dosage) of a drug you are taking.

The provider will address any possible problems and work to correct them.

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% of the federal poverty level or below).
- You are younger than 18 years of age.
- 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.
- 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) (TTY 1-800-735-2964**), Monday through Friday, 8 a.m. to 4 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. This might be when you visit a provider who is out of network or when you receive a service without the necessary prior authorization. Other times, you may find that you have paid more than you expected under the coverage rules of the plan.

There may 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).*

Below is a bulleted list of situations in which you may need to ask the plan to pay you back, or to pay a bill you have received. Please note: we will only pay back our share — the amount Medicaid normally pays for that service — which may be less than what you paid the provider.

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

  When you receive such services or prescription drugs, ask the provider to bill AmeriHealth Caritas New Hampshire. You are only responsible for paying your share of the cost for any prescription filled at a retail pharmacy. Please note: If possible, **do not** pay out of your pocket. Have the provider or pharmacy bill AmeriHealth Caritas New Hampshire instead.

  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**. Please note: 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)*. Tips to avoid paying out of your pocket when traveling out of state:

- When traveling out of state, always be sure to bring your state Medicaid ID card and AmeriHealth Caritas New Hampshire Member ID card with you in case you need them.
- If you need medical care that cannot wait until you get home, go to an urgent care center or emergency room (ER). Present your state Medicaid ID card and AmeriHealth Caritas New Hampshire Member ID card so they may bill us for services. Urgent care centers and ERs are required to treat you even if you are not able to pay up front.
- If you are traveling out of state and need to get a prescription, a national pharmacy chain such as CVS, Rite Aid, or Walgreens is more likely to bill AmeriHealth Caritas New Hampshire than a non-national or independent pharmacy. Ask them to bill us instead of paying them out of your own pocket.

- **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. 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.

  If you paid the full cost of the medicine, you may not receive reimbursement for any amount that was over 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).*

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 within 60 days of the date you had your service, 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. Please send this information to:

AmeriHealth Caritas New Hampshire
Re: Request for member payment
25 Sundial Ave, Ste 130
Manchester, NH 03103

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

Section 8.3 After the plan receives your request for payment

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

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

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

Section 8.4 Payment rules to remember

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

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

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

Chapter 9. Your rights and responsibilities

Section 9.1 Your rights

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

- You have the right to receive information in an easily understandable and readily accessible format that meets your needs. For more information, refer to Section 2.13 (*Other important information: Alternative formats and interpretation services*).
- You have the right to be treated with respect and with due consideration for your dignity and privacy.
- You have the right to receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand, regardless of cost or benefit coverage.
- You have the right to participate in decisions regarding your health care, including the right to refuse treatment.
- You have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- You have the right to see, as well as request and receive a copy of your medical records, and the right to request that your medical records be amended or corrected.
- You have the right to covered services and drugs that are available and accessible in a timely manner.
- You have a right to care coordination.
- You have the right to privacy and protection of your personal health information.
- You have the right to receive information about our plan, our network providers, and your covered services.
- You have the right to make decisions about your health care.
- You cannot be retaliated against in any way by the plan or by the New Hampshire Department of Health and Human Services (NH DHHS) for exercising your rights.
- You have the right to a second opinion. For more information, refer to Section 6.6 (*Getting a second medical opinion*).
- You have the right to know what to do if you are being treated unfairly or your rights are not being respected. For more information, refer to Section 10.7 (*How to file a grievance and what to expect after you file*).
- You have the right to be informed of any changes in state law that may affect your coverage. The plan will provide you with any updated information at least 30 calendar days before the effective date of the change whenever practical.
- You have the right to exercise advance care planning for your health care decisions if you so choose. For more information, refer to Section 9.3 (*Advance care planning for your health care decisions*).
- You have the right to make a complaint if a provider does not honor your wishes expressed in your advance directive. For more information, refer to Section 9.3 (*Advance care planning for your health care decisions*).
- You have the right to leave our plan in certain situations. For more information, refer to Section 11 (*Ending your plan membership*).
- You have the right to voice complaints or appeals about the plan or the care it provides.
- You have the right to make recommendations regarding the plan's 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 Services (phone numbers are printed on the back cover of this handbook).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this handbook to learn what is covered, and the rules you need to follow to get your covered services.
  - Chapters 3 and 4 give the details about your health care services, including what is covered by the plan, what is not covered, and rules to follow.
  - Chapter 7 provides details about prescription drug coverage, including what you may be required to pay.
  - To be covered by AmeriHealth Caritas New Hampshire, 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.
    - 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 AmeriHealth Caritas New Hampshire as soon as possible.** Please call Member Services to let us know (phone numbers are printed on the back cover of this handbook).

  We are required to follow rules set by Medicaid to make sure that you are using all of your coverage. This is called "coordination of benefits" because it involves coordinating the health and prescription drug benefits you get from our plan with any other health and prescription drug benefits available to you. We will help you coordinate your benefits. For more information about coordination of benefits, refer to Section 1.5 (*How other insurance works with our plan*).
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card and your New Hampshire Medicaid card whenever you get your covered services, including medical or other health care services and prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help your doctors and other health care providers give you the best care, learn as much as you are able to about your health conditions. Give your health care providers the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors and other health care providers know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - Talk to your PCP about seeking services from a specialist before you go to one, except in an emergency.
  - Keep appointments, be on time, and call in advance if you are going to be late or have to cancel your appointment.
  - Authorize your PCP to get necessary copies of all of your health records from other health care providers.

  - If you have any questions, be sure to ask. Your doctors and other health care providers will explain things in a way you can understand. If you ask a question and you do not understand the answer you were given, ask again.
- **Request interpretation services if you need them.** Our plan has staff and free language interpreter services available to answer questions from non-English speaking members. If you are eligible for New Hampshire Medicaid because of a disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you at no cost. For more information, refer to Section 2.13 *(Other important information: Alternative formats and interpretation services).*
- **Respect other members, plan staff and providers.** For information about when members may be involuntarily disenrolled for threatening or abusive behavior, refer to Section 11.2 *(When you may be involuntarily disenrolled from the plan).*
- **Pay what you owe.** As a plan member, you are responsible for these payments, as applicable:
  - For prescription drugs covered by the plan, you must pay a copayment, if required. However, any inability to pay your copayment does not prevent you from getting your prescription filled. Refer to Chapter 7 (*Getting covered prescription drugs*) to learn what you must pay for your prescription drugs.
  - If you get any health care services or prescription drugs that are not covered by our plan or by other insurance you have, you are responsible for the full cost.
  - If you disagree with our decision to deny coverage for a health care service or prescription drug, you can request an appeal. For information about how to request an appeal, refer to Chapter 10 (*What to do if you want to appeal a plan decision or "action", or file a grievance*).
- **Tell the plan if you move.** If you are going to move or have moved, it is important to tell us as soon as possible. Call Member Services (phone numbers are printed on the back cover of this handbook).
- **Do not allow anyone else to use your AmeriHealth Caritas New Hampshire or New Hampshire Medicaid membership cards.** Refer to Section 2.12 (*How to report suspected cases of fraud, waste, and abuse*). Notify us when you believe someone has purposely misused your health care benefits.
- **Call Member Services for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan. (Phone numbers for Member Services are printed on the back cover of this handbook).

Section 9.3 Advance care planning for your health care decisions

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

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

- Fill out a written form to give someone the right to make health care decisions for you.
- 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. They allow you to express your health care wishes in writing in case you cannot do so if you are seriously sick or injured.

There are two types of advance directives in New Hampshire:

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

If you want to create an advance directive:

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

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

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

For more information contact Member Services or visit **www.amerihealthcaritasnh.com**.

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

As a member of AmeriHealth Caritas New Hampshire, 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 AmeriHealth Caritas New Hampshire 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 AmeriHealth Caritas New Hampshire grievance process.

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

Section 10.1 About the appeals process

Whenever AmeriHealth Caritas New Hampshire makes a coverage decision or takes an action that you disagree with, you may file an appeal. If AmeriHealth Caritas New Hampshire denies, reduces, limits, 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, limit, 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).
- A decision that delays a service authorization beyond the required time limit.
- 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 AmeriHealth Caritas New Hampshire 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 time frame 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 AmeriHealth Caritas New Hampshire.

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

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

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

- **You must file your standard appeal with AmeriHealth Caritas New Hampshire 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.
  - 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:

  AmeriHealth Caritas New Hampshire
  P.O. Box 7389
  London, KY 40742-7389

  To file an appeal by phone, call Member Services at **1-833-704-1177 (TTY 1-855-534-6730)**. You can call 24 hours a day, seven days a week.

  By fax: **1-833-810-2264**.

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

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

- **After you file your standard appeal, you have the right to request and receive a copy of your case file that the plan used to make its decision.** A copy of your case file is free of charge and may be requested in advance of the plan's decision.
- AmeriHealth Caritas New Hampshire 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, AmeriHealth Caritas New Hampshire 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, the plan will tell you in writing **within two calendar days** of making the extension decision. If the plan decides to take extra days to make the decision, the plan will tell you in writing. If you disagree with the plan's extension, you may file a grievance with the plan. For more information, refer to Section 10.7 (*How to file a grievance and what to expect after you file).*
- **If AmeriHealth Caritas New Hampshire reverses its decision to deny, reduce, limit, suspend, or end services that were not provided while the appeal was pending, AmeriHealth Caritas New Hampshire 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 AmeriHealth Caritas New Hampshire, you may file a second level of appeal by requesting a standard or expedited State Fair Hearing.** For more information, refer to Section 10.4 (*How to file a standard State Fair Hearing appeal and what to expect after you file* (*standard second level of appeal*)) and Section 10.5 (*How to file an expedited State Fair Hearing and what to expect after you file* (*expedited second level of appeal*)).

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

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

If taking the time for standard resolution of your appeal would seriously jeopardize your life or health, or ability to attain, maintain, or regain maximum function, you may request **expedited resolution** of your appeal from AmeriHealth Caritas New Hampshire. 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 AmeriHealth Caritas New Hampshire 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.
  - 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:

  AmeriHealth Caritas New Hampshire
  P.O. Box 7389
  London, KY 40742-7389

  To file an appeal by phone, call Member Services at **1-833-704-1177 (TTY 1-855-534-6730)**. You can call 24 hours a day, seven days a week.

  By fax: **1-833-810-2264**.
- **You may designate someone to file the appeal for you, including your provider.** However, you must give written permission to name your provider or another person to file an appeal for you. The plan does not need written permission if your provider is requesting the expedited first level appeal on your behalf. For more information about how to appoint another person to represent you, refer to Section 2.13 (*Other important information: You may designate an authorized representative or personal representative).*
- **If you appeal the plan's decision to deny, reduce, limit, suspend, or end services, you may have a right to request continuation of benefits from AmeriHealth Caritas New Hampshire 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 AmeriHealth Caritas New Hampshire 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, AmeriHealth Caritas New Hampshire 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 two 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 AmeriHealth Caritas New Hampshire **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 AmeriHealth Caritas New Hampshire **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 two calendar days.
- **You have the right to file a grievance with AmeriHealth Caritas New Hampshire if the plan denies your request for an expedited appeal.** If the plan denies your request for an expedited appeal, AmeriHealth Caritas New Hampshire will treat your appeal as part of the standard appeal process.
- **If AmeriHealth Caritas New Hampshire reverses its decision to deny, reduce, limit, suspend, or end services that were not provided while the appeal was pending, AmeriHealth Caritas New Hampshire 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 AmeriHealth Caritas New Hampshire, 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 questions and help with filing your appeal, contact Member Services (phone numbers are printed on the back cover of this handbook).

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

If you are dissatisfied with the results of your first level appeal from AmeriHealth Caritas New Hampshire, 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*).
  - 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: **1-603-271-8422**.
- **If you appeal the plan's decision to deny, reduce, limit, suspend, or end services, you may have a right to request continuation of benefits from AmeriHealth Caritas New Hampshire 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 Administrative Appeals Unit (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 a.m. – 4 p.m. ET. You may also contact the NH DHHS Customer Service Center at **1-ASK-DHHS (1-844-275-3447) (TTY 1-800-735-2964**), Monday through Friday, 8 a.m. – 4 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 AmeriHealth Caritas New Hampshire 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: **1-603-271-8422**.
- **You may designate someone to file the appeal for you, including your provider.** However, you must give written permission to name your provider or another person to file an appeal for you. For more information about how to appoint another person to represent you, refer to Section 2.13 (*Other important information: You may designate an authorized representative or personal representative).*
- **If you appeal the plan's decision to deny, reduce, limit, suspend, or end services, you may have a right to request continuation of benefits from AmeriHealth Caritas New Hampshire 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 Administrative Appeals Unit (AAU) **accepts** your request for an expedited State Fair Hearing appeal, the AAU will issue its written decision as expeditiously as your health condition requires, but no later than 3 business days after the AAU receives the plan's case file and any additional information for your appeal.
- If the AAU **denies** your request for an expedited State Fair Hearing appeal, the AAU will make reasonable efforts to give prompt oral notice to you, and provide written notice of the denial. If your expedited request is denied, your appeal will be treated as a standard State Fair Hearing appeal described in Section 10.4 (*How to file a standard State Fair Hearing appeal and what to expect after you file (second level appeal)).*
- The AAU will let you know where the hearing will take place. Hearings are usually held at the AAU in Concord, or at your local NH DHHS District Office.
- A hearing officer from the AAU will conduct the hearing.
- You may bring witnesses, present testimony and evidence in person as well as in writing, and question other witnesses at your State Fair Hearing.
- **If the AAU reverses the plan's decision to deny, reduce, limit, suspend, or end previously authorized benefits that were not provided while the first level appeal and/or State Fair Hearing were pending, the plan will authorize the services as expeditiously as your health condition requires, but no later than 72 hours from the date the plan receives notice that the AAU reversed the plan's decision.**
- If you received continued benefits while the appeal was pending:

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

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

For more information, contact the AAU at **1-800-852-3345**, extension **14292**, Monday through Friday, 8 a.m. – 4 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 a.m. – 4 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 AmeriHealth Caritas New Hampshire pending the outcome of one or both of your first and/or second level appeal(s). **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)
• **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 • The service was ordered by an authorized provider; and • The original authorization period for the service has not expired.	**Within 10 calendar days of the date you receive the first level appeal notice of action from the plan or the intended effective date of the plan's action, you file your second level appeal in writing AND you request continuation of benefits pending the outcome of one or both your first and/or second level appeal, orally or in writing.** If you did not request continuation of benefits during your first level appeal with the plan, the following conditions also apply: • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. • The service was ordered by an authorized provider. • The original authorization period for the service has not expired.

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

AmeriHealth Caritas New Hampshire
P.O. Box 7389
London, KY 40742-7389

To file an appeal by phone, call Member Services at **1-833-704-1177 (TTY 1-855-534-6730)**.

You can call 24 hours a day, seven days a week.

By fax: **1-833-810-2264**.

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

For standard and expedited plan appeals (first level appeal)	For standard and expedited State Fair Hearing appeals (second level appeal)
• 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.	• 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 questions and help with filing your first and/or second level appeal and continuation of benefits, contact Member Services (phone numbers are printed on the back cover of this handbook). You may also contact the NH DHHS Customer Service Center at **1-844-ASK-DHHS (1-844-275-3447) (TTY 1-800-735-2964**), Monday through Friday, 8 a.m. – 4 p.m. ET.

For help with your second level appeal and continuation of benefits, contact the Administrative Appeals Unit (AAU) at **1-800-852-3345**, extension **14292**, Monday through Friday, 8 a.m. – 4 p.m. ET. You may also contact the NH DHHS Customer Service Center at **1-844-ASK-DHHS (1-844-275-3447) (TTY 1-800-735-2964**), Monday through Friday, 8 a.m. – 4 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 AmeriHealth Caritas New Hampshire or its network providers.
- Dispute of an extension of time proposed by the plan to make an authorization decision.

To file your grievance:

- Call or write to AmeriHealth Caritas New Hampshire. Writing is preferred (remember to keep a copy for your records).
- You may designate someone to file the grievance for you, including your provider.

However, you must give written permission to name your provider or another person to file a grievance for you. For more information about how to appoint another person to represent you, refer to Section 2.13 (*Other important information: You may designate an authorized representative or personal representative).*

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

- **AmeriHealth Caritas New Hampshire 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 two 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) (TTY 1-800-735-2964**), Monday through Friday, 8 a.m. – 4 p.m. ET.

Time frames for appeals

- **Standard appeals:** If we have all the information we need, we will tell you our decision in writing within 30 days from your appeal.
- **Expedited (fast track) appeals:** If we have all the information we need, we will call you and send you a written notice of our decision within three days from your appeal.

If we need more information to make either a standard or an expedited decision about your appeal, we will:

- Write you and tell you what information is needed. For expedited appeals, we will call you right away and send a written notice later.
- Explain why the delay is in your best interest.
- Make a decision no later than 14 days from the day we asked for more information.
- If you need more time to gather your documents and information, just ask. You, your provider or someone you trust may ask us to delay your case until you are ready. We want to make the decision that supports your best health. This can be done by calling Member Services at **1-833-704-1177 (TTY 1-855-534-6730)** or writing to AmeriHealth Caritas New Hampshire, P.O. Box 7389, London, KY 40742-7389.

Your Care While You Wait for a Decision

When the health plan's decision reduces or stops a service you are already receiving, you can ask to continue the services your provider had already ordered while we are making a decision on your appeal. You can also ask a trusted representative to make that request for you.

You must ask us to continue your services within 10 days from the date of the notice that says your care will change or by the time the action takes effect. You or your authorized representative may contact Member Services at **1-833-704-1177 (TTY: 1-855-534-6730)** or contact the Appeals Coordinator on your acknowledgement letter to request a continuation of benefits.

If you ask your health plan to continue services you already receive during your appeal, the health plan will pay for those services if your appeal is decided in your favor. Your appeal might not change

the decision the health plan made about your services. When your appeal doesn't change the health plan's decision, the health plan may require you to pay for the services you received while waiting for a decision.

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

This chapter was prepared by the New Hampshire Department of Health and Human Services 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 how and when 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 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 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 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) (TTY 1-800-735-2964**), Monday through Friday, 8 a.m. – 4 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.
- 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.

AmeriHealth Caritas New Hampshire 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**) (**TTY 1-800-735-2964**), Monday through Friday, 8 a.m. – 4 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.

Discrimination is against the law

AmeriHealth Caritas New Hampshire complies with applicable federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of age, race, ethnicity, national origin or ancestry, mental or physical disability, sexual or affection orientation or preference, gender identity, marital status, genetic information, source of payment, sex, creed, religion, health or mental health status or history, need for health care services, amount payable to AmeriHealth Caritas New Hampshire on the basis of an eligible person's or member's actuarial class or pre-existing medical/health conditions, whether or not the member has executed an advance directive, or any other status protected by federal or state law.

AmeriHealth Caritas New Hampshire complies with all applicable federal and state laws, including:

- 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 CFR part 91.
- The Rehabilitation Act of 1973.
- Title IX of the Education Amendments of 1972 (regarding educations programs and activities).
- Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act.

AmeriHealth Caritas New Hampshire provides free aids and services to people with disabilities. Examples of these aids and services include qualified sign language interpreters and written information in other formats (large print, Braille, audio, accessible electronic formats, other formats). We provide free language services, such as qualified interpreters and information written in other languages, to people with limited English proficiency or whose primary language is not English.

If you need these services, contact AmeriHealth Caritas New Hampshire 24 hours a day, seven days a week, at **1-833-704-1177 (TTY 1-855-534-6730)**.

If you believe that AmeriHealth Caritas New Hampshire has failed to provide these services or has discriminated against you in another way, you or your authorized representative (if we have your written authorization on file) can file a grievance with:

- AmeriHealth Caritas New Hampshire Grievances
  P.O. Box 7389
  London, KY 40742-7389
  1-833-704-1177 (TTY 1-855-534-6730)

- You can also file a grievance by phone at **1-833-704-1177 (TTY 1-855-534-6730)**.
  If you need help filing a grievance, AmeriHealth Caritas New Hampshire Member Services is available to help you. You can contact Member Services 24 hours a day, seven days a week, at **1-833-704-1177 (TTY 1-855-534-6730)**.

- You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, AmeriHealth Caritas New Hampshire is available to help you. You may also file a discrimination complaint through the Department of Health and Human Services (DHHS) Office of the Ombudsman who has been designated to coordinate the efforts of NH DHHS's civil rights compliance for the Department:
  State of New Hampshire, Department of Health and Human Services, Office of the Ombudsman
  129 Pleasant Street
  Concord, NH 03301-3857
  1-603-271-6941 or **1-800-852-3345** ext. **16941**
  Fax: **1-603-271-4632**, **(TDD Access: Relay NH 1-800-735-2964)**
  E-mail: **ombudsman@dhhs.nh.gov**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, 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, DC 20201
1-800-368-1019 (TDD 1-800-537-7697)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Chapter 13. Acronyms and definitions of important words

Section 13.1 Acronyms

Acronym	Description
AAC	augmentative alternative communication
AIDS	acquired immune deficiency syndrome
APRN	advanced practice registered nurse
BiPAP	bilevel positive airway pressure
BMI	body mass index
CMS	Centers for Medicare & Medicaid Services
COBRA	Consolidated Omnibus Budget Reconciliation Act (COBRA)
COPD	chronic obstructive pulmonary disease
CPAP	continuous positive airway pressure
CTS	coordinated transportation solutions
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 and drug counselor
LDCT	low-dose computed tomography
LPN	licensed practical nurse
LTC	long-term care
MLADC	master's 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 and gynecology; obstetrician/gynecologist
OT	occupational therapy
OTC	over-the-counter (drugs)
PCP	primary care provider (or physician)
PAP	Premium Assistance Program
PSA	prostate-specific antigen

Acronym	Description
PT	physical therapy
RHC	rural health center
RN	registered nurse
SBIRT	Screening, Brief Intervention, and Referral to Treatment
ST	speech therapy
STI	sexually transmitted infection
SUD	substance use disorder
TMJ	temporomandibular joint

Section 13.2 Definitions of important words

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

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, seven 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)*.

Adverse action – A decision your plan can make to reduce, stop or restrict your health care services.

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 2.13 (*Other important information: You may designate an authorized representative or personal representative).*

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

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

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

Benefits – A set of health care services covered by your health plan.

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 management – 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 management support*).

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

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

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

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

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

Covered services – Include all health care services, prescription drugs, supplies, and equipment covered by our plan. New Hampshire Department of Health and Human Services rules (Chapters He-W, He-E, He-C, He-M, and He-P) describe covered services under the plan. The rules are available online at **https://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.

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

Fair hearing – A way you can make your case before an administrative law judge if you are not happy about a decision your plan made that reduced, stopped or restricted your services after your appeal.

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

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

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

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

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

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

Managed care – An organized way for providers to work together to coordinate and manage all your health needs. You can think of it as central home for your health.

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

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

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

Member (member of our plan, or "plan member") – A person who is enrolled in our plan.

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

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

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

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

New Hampshire Medicaid – The plan contracts with New Hampshire Department of Health and Human Services (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".

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 AmeriHealth Caritas New Hampshire 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 – Prescription drugs recommended as first choice when prescribing for Medicaid patients.

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 – Medications/drugs requiring a prescription from a licensed provider. The cost of these medications/drugs are covered when filled at a network pharmacy.

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

Primary care provider (PCP) – The network doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may

talk with other doctors and providers about your care. Refer to Section 3.1 (*Your Primary Care Provider (PCP) provides and oversees your medical care).*

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

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

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

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.

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 AmeriHealth Caritas New Hampshire is statewide.

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

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

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

Substance use – A medical disorder that includes the misuse or addiction to alcohol and/or legal or illegal drugs.

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

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

AmeriHealth Caritas New Hampshire Member Services

Method	Member Services – Contact Information
CALL	**1-833-704-1177** Calls to this number are toll-free, 24 hours a day, seven days a week. Member Services also has free language interpreter services available for non-English speakers.
TTY	**1-855-534-6730** This number requires special phone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	**1-833-243-2264**
WRITE	AmeriHealth Caritas New Hampshire P.O. Box 7386 London, KY 40742-7386
WEBSITE	**www.amerihealthcaritasnh.com**

For pharmacy-related questions, contact Pharmacy Member Services at:
1-888-765-6383 (TTY 711).

AmeriHealth Caritas New Hampshire

Member Services: **1-833-704-1177 (TTY 1-855-534-6730)**

Pharmacy Member Services: **1-888-765-6383 (TTY 711)**

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Attention: If you do not speak English, language assistance services, free of charge, are available to you. Call **1-833-704-1177 (TTY 1-855-534-6730)**.

Atención: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-833-704-1177 (TTY 1-855-534-6730)**.

For the full nondiscrimination notice, go to **www.amerihealthcaritasnh.com**.

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