
DentaQuest

DELTA DENTAL®

# NEW HAMPSHIRE SMILES ADULT DENTAL PROGRAM

## MEMBER HANDBOOK

## APRIL 1, 2023

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# Chapter 1. Getting started as a member

## Section 1.1 Welcome

### You are enrolled in DentaQuest

The New Hampshire Department of Health and Human Services (DHHS) has contracted with Northeast Delta Dental and DentaQuest (subcontractor) to manage the New Hampshire Smiles Adult dental program. Northeast Delta Dental and DentaQuest (subcontractor) will work with us to help implement and improve the dental program.

Some of the things Northeast Delta Dental / DentaQuest will do include:

• working to increase the number of dental providers;

• helping you find a dental provider near where you live;

• helping you schedule an appointment with a dental provider if needed;

• providing you with information about the best ways to care for your teeth and maintain good oral health; and

• answering questions about your dental benefit.

You will need to call the DentaQuest Dental Customer Service team at the telephone number listed in this booklet for your questions about your dental benefits.

You should continue to call DHHS Customer Service if you have questions about enrollment in Medicaid or any of your other benefits.

Please read this booklet carefully and keep it handy. It contains important information about your dental benefits.

You will get most of your dental and oral health coverage through our plan, DentaQuest, a New Hampshire Smiles Adult dental 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.

DentaQuest, 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 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 DentaQuest for covered services*).

As a DentaQuest, member, you will get your New Hampshire Smiles Adult dental and oral health coverage through our plan. All members have the right to receive free of charge a written copy of the Member Handbook.

Your feedback is important to us. Several times each year DentaQuest, convenes Member Advisory Council meetings to hear from members like you. If you are interested in joining the plan Member Advisory Council, let us know by calling Member Services at (844) 583-6151 (phone numbers are also 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 to receive and dental coverage.

You are eligible for our plan as long as:

- You are eligible and remain eligible for New Hampshire Smiles Adult dental program*
- *And* you are age 21 and older;
- *and* you live in New Hampshire (the DentaQuest service area);
- *and* you are a United States citizen or are lawfully present in the United States
- *and* you are not in an excluded eligibility category such as presumptive eligibility or are an individual with a spend down.

Contact NH DHHS Customer Service Center toll-free at **1-844-ASK-DHHS** (1-844-275-3447) (TDD Relay Access: 1-800-735-2964), Monday through Friday, 8:00 a.m. to 4:00 p.m. ET to find out more about New Hampshire Smiles Adult dental program and its programs.

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

## Section 1.3 What to expect from the plan

### Member Handbook

This Member Handbook describes how the plan works and is in effect beginning April 1, 2023, through each month you are enrolled with DentaQuest. The Member Handbook is also available on our website at DentaQuest.com/newhampshire.

## Your DentaQuest membership card – Use it to get all covered services

While you are a member of the plan, you must use your DentaQuest, ID card whenever you get covered services. However, even if you don't have your DentaQuest ID card, a provider should never deny care to you. If a provider refuses to treat you, call DentaQuest Member Services at (844) 583-6151. We will verify your eligibility for the provider.

Here is a sample membership card, as an example:

***SAMPLE ID Card (front/back)***


As long as you are a member of the plan, **you must use your DentaQuest ID card** to get covered services. Keep your New Hampshire Smiles Adult dental card too. Present **both** your DentaQuest ID card and New Hampshire Smiles Adult dental card whenever you get services.

Always carry your dental ID card and show it each time you go to a dental appointment or the hospital. Never give your dental ID card to anyone else to use. If your dental ID card is lost or stolen, call Member Services at (844) 583-6151 and DentaQuest will send you a new card.

## Welcome Call

We conduct welcome calls to all new and reinstated enrollees to warmly welcome them to our program within 90 days of enrollment. We will conduct three separate attempts to reach the member by phone. The purpose of the Welcome Call is to make sure the member knows about and understands their dental benefits, provide education on the importance of 6-month checkups and cleanings, and to offer assistance to confirm or change their Primary Dental Provider (PDP), scheduling a dental appointment, and address any questions related to enrollment with DentaQuest.

As a key part of the Welcome Call, we will also conduct a limited Oral Health Assessment to identify special health care needs or other unique circumstances that could impact the enrollee's dental health, including barriers to care such as transportation needs or limited English proficiency. Enrollees who have Special Health Care Needs (SHCN) or barriers to accessing care will be referred to our Care Coordination and Case Management program for additional assistance.

When you first join DentaQuest, we will call to welcome you as a plan member. During the call, we will explain plan rules and answer any questions you might have about the plan. As described in the next section, we will explain the importance of completing your Oral Health Assessment (OHA).

## Oral Health Assessment (OHA)

The Oral Health Assessment (OHA) is the main tool used by the Case Management team to identify members who maybe experiencing significant challenges getting the dental care they need or maintaining optimal oral health. This assessment can be administered in a variety of ways: It will be imbedded in our Welcome Call script, allowing us to collect risk data within 90 days of enrollment; included in paper form in your Welcome Packet with a prepaid envelope for prompt return and intake by DentaQuest. The OHA will also be in the Member Handbook which is posted on the DentaQuest website; an electronic version will be available in the Member Section of our website for NH members.

The OHA assessment includes questions covering the following health topics:

- Tooth pain.
- Emergency room usage for dental problems.
- Last dental visit.
- Brushing habits.
- Smoking/tobacco use and assistance with quitting.
- Special health care needs.
- Presence of development, physical, or intellectual disability.
- Pregnancy.
- Health problems, including presence of chronic health conditions.
- Specific barriers/Social Determinants of Health.

NH DHHS requires us to ask you to complete your Oral Health Assessment (OHA). The information you provide in the OHA helps us plan and work with you to meet your dental and oral health needs.

We will reach out to you to complete the OHA by telephone or mail. Your completion of the OHA is optional. However, we encourage you to complete the assessment, and return it to DentaQuest.

## Explanation of Benefits Notice

Explanation of Benefits (EOB) includes all dental and oral health services covered by our plan. You pay nothing for preventive and diagnostic services as long as you follow the plan's rules described in this handbook.

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

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

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

### Let us know about these changes:

- Changes to your name, your address, or your phone number;
- Changes in any other health or dental insurance coverage you have, including:
  - An employer's group health insurance policy for employees or retirees, either for yourself, or anyone in your household covered under the plan;
  - Workers' Compensation coverage because of a job-related illness or injury;
  - Veteran's benefits or other government health plan coverage;
  - Medicare;
  - COBRA or other health insurance continuation coverage. (COBRA is a law that requires certain employers to let employees and their dependents keep their group health coverage for a period of time after leaving employment, changes in employment, and other life events.); or
  - If you have any liability claims, such as claims from an automobile accident.
- Changes in your income or other financial support;
- If you have been admitted to a nursing home;
- If you are pregnant;
- If you receive dental or oral health care in an out-of-area or out-of-network hospital or emergency room; or
- If your guardian, conservator, authorized representative, or personal representative changes, or if your Durable Power of Attorney is activated.

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

### Member personal health information is kept private

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

## Section 1.5 How other insurance works with our plan

### Which plan pays first when you have other insurance

### Prior Authorization

Before you get a service or go to some dental appointments, we have to make sure that you need the service and that it is medically right for you. This is called prior authorization. To do this, we look at your medical history and information from your dentist or other health care providers. Then we will decide if that service can help you. We use rules from the Agency for Health Care Administration to make these decisions. Some services will need to be approved by DentaQuest before you can get them. You can only get the services DentaQuest and your plan cover. Your PDP can tell you which services will require prior authorization. You can also call DentaQuest Member Services at 1-844-583-6151 (TDD/TTY 711 or 1-800-466-7566) Monday - Wednesday from 8 a.m. to 8 p.m. or Thursday - Friday from 8 a.m. to 5 p.m.

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 and dental 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 DentaQuest for covered services under our plan**.** For claims to pay correctly, it is important that you use providers that are in both your primary insurance network and our network.

When you receive services, tell your dentist if you have other health and/or dental insurance. Your provider will know how to process claims when you have primary insurance and New Hampshire Smiles Adult dental program through DentaQuest**.**

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

If another person or party injures you, DentaQuest 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 or dental services directly.

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

If you have other coverage available because of an accidental injury (such as an auto accident), call DentaQuest Member Services at (844) 583-6151 as soon as possible (phone numbers are also 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 DentaQuest. 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 DentaQuest Member Services at (844) 583-6151 (phone numbers are also printed on the back cover of this handbook).

# Chapter 2. Important phone numbers and resources

## Section 2.1 How to contact DentaQuest Member Services

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

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

| Method | DentaQuest Member Services – Contact Information |
|---|---|
| **CALL** | **1-844-583-6151**<br><br>Calls to this number are toll-free. Office hours are Monday through Wednesday, 8:00 a.m. to 8:00 p.m., Thursday and Friday 8:00 a.m. to 5:00 p.m. ET.<br><br>Member Services also has free language interpreter services available for non-English speakers. |
| **TTY/TDD** | **1-800-466-7566**<br><br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br><br>Calls to this number are free. |
| **FAX** | **1-262-834-3452** |
| **WRITE** | 11100 W. Liberty Drive, Milwaukee, WI 53224 |
| **WEBSITE** | DentaQuest.com/newhampshire |

## 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 is covered by the plan. The coverage decision may also include information about the amount of any cost-sharing 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 – DentaQuest Contact Information |
|---|---|
| **CALL** | **1-844-583-6151**<br><br>Calls to this number are toll-free. Office hours are Monday through Wednesday, 8:00 a.m. to 8:00 p.m., Thursday and Friday 8:00 a.m. to 5:00 p.m. ET.<br><br>Member Services also has free language interpreter services available for non-English speakers. |
| **TTY/TDD** | **1-800-466-7566**<br><br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br><br>Calls to this number are free. |
| **FAX** | **1-262-834-3452** |
| **WRITE** | 11100 W. Liberty Drive, Milwaukee, WI 53224 |
| **WEBSITE** | DentaQuest.com/newhampshire |

## 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 cost-sharing. 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 – DentaQuest Contact Information |
|---|---|
| **CALL** | **1-844-583-6151**<br><br>Calls to this number are toll-free. Office hours are Monday through Wednesday, 8:00 a.m. to 8:00 p.m., Thursday and Friday 8:00 a.m. to 5:00 p.m. ET. |
| **TTY/TDD** | **1-800-466-7566**<br><br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br><br>Calls to this number are free. |
| **FAX** | **1-262-834-3452** |
| **WRITE** | 11100 W. Liberty Drive, Milwaukee, WI 53224 |

## Section 2.4 How to contact the plan about Care Coordination

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

| Method | Care Coordination – Contact Information |
|---|---|
| **CALL** | **1-844-583-6151**<br><br>Calls to this number are toll-free. Office hours are Monday through Wednesday, 8:00 a.m. to 8:00 p.m., Thursday and Friday 8:00 a.m. to 5:00 p.m. ET.<br><br>Member Services also has free language interpreter services available for non-English speakers. |
| **TTY/TDD** | **1-800-466-7566**<br><br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br><br>Calls to this number are free. |
| **FAX** | **1-262-834-3452** |
| **WRITE** | 11100 W. Liberty Drive, Milwaukee, WI 53224 |
| **WEBSITE** | DentaQuest.com/newhampshire |

## Section 2.5 How to contact the plan's DentaQuest Member Service Line

The DentaQuest Member Service Line is a free service provided by DentaQuest. The DentaQuest Member Service Line is ready to answer your questions. Contact the DentaQuest Member Service Line when you have questions about your plan.

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

| Method | DentaQuest Member Service Line – Contact Information |
|---|---|
| **CALL** | **1-844-583-6151**<br><br>Calls to this number are toll-free. Office hours are Monday through Wednesday, 8:00 a.m. to 8:00 p.m., Thursday and Friday 8:00 a.m. to 5:00 p.m. ET.<br><br>Member Services also has free language interpreter services available for non-English speakers. |
| **TTY/TDD** | **1-800-466-7566**<br><br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br><br>Calls to this number are free. |
| **FAX** | **1-262-834-3452** |
| **WRITE** | 11100 W. Liberty Drive, Milwaukee, WI 53224 |
| **WEBSITE** | DentaQuest.com/newhampshire |

## Section 2.6 Behavioral health services

"Behavioral health services" is another term used to describe mental health or substance abuse use disorder services. In case of a behavioral health (mental health and substance use) emergency or crisis – Call, text, or chat 988 **– the Mental Health Lifeline 24 hours a day, 7 days a week to connect with a trained crisis counselor. The Lifeline provides free and confidential emotional support to people in suicidal crisis or emotional distress.**

Or call or text the toll-free NH Rapid Response Access Point (1-833-710-6477) anytime day or night. Crisis response services are available over the phone, by text, or face-to-face.

| Method | NH DHHS Customer Service Center – Contact Information |
|---|---|
| **CALL** | **1-888-901-4999** (For plan information)<br>**1-844-ASK-DHHS** (1-844-275-3447) (For all other calls)<br><br>Calls to this number are toll-free. Office hours are Monday through Friday, 8:00 a.m. to 4:00 p.m. ET.<br><br>Free language interpreter services are available for non-English speakers.<br><br>Contact Information:<br>**BUREAU OF DRUG & ALCOHOL SERVICES (BDAS)**<br>Email Address: bdas@dhhs.nh.gov<br>Phone: 603-271-6738<br>**BUREAU OF MENTAL HEALTH SERVICES**<br>Email Address: BMHS@dhhs.nh.gov<br>Phone: (603) 271-5000<br>**CHILDREN'S BEHAVIORAL HEALTH**<br>Email Address: BCBHInquiry@dhhs.nh.gov<br>Phone: 603-271-5000 |
| **TTY/TDD** | **1-800-735-2964**<br><br>Calls to this number are free. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. |
| **WEBSITE** | Behavioral Health [dhhs.nh.gov] |

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

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

| Method | Non-Emergency Medical Transportation – Contact Information |
|---|---|
| **CALL** | **1-844-304-6630** |
| **TTY/TDD** | **1-800-466-7566**<br><br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br><br>Calls to this number are free. |
| **FAX** | **1-262-834-3452** |
| **WRITE** | 11100 W. Liberty Drive, Milwaukee, WI 53224 |
| **WEBSITE** | DentaQuest.com/newhampshire |

## 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 Smiles Adult dental program eligibility, or other benefits provided by NH DHHS as described in Section 4.4 *(New Hampshire Smiles Adult dental program benefits covered outside the plan*).

If you are in need of a new or replacement New Hampshire Smiles Adult dental program ID card, please contact DentaQuest directly. DentaQuest may also provide assistance regarding an appeal or grievance.

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

## Section 2.9 How to contact the DentaQuest Ombudsman/Complaints, Grievances, & Appeals

DentaQuest Ombudsman assists NH DHHS plan members in the resolution of disagreements, including complaints or problems involving Medicaid eligibility or coverage. Before contacting the NH DHHS when you have a problem related to your dental benefit, seek resolution through the DentaQuest 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 | DentaQuest Complaints, Grievances, and Appeals – Contact Information |
|---|---|
| **CALL** | **1-844-583-6151**<br><br>Calls to this number are toll-free. Office hours are Monday through Friday, 8:00 a.m. – 5:00 p.m. ET. |
| **TTY/TDD** | TDD Access Relay (DentaQuest): **1-800-466-7566**<br><br>Calls to this number are free. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. |
| **FAX** | **1-262-834-3452** |
| **WRITE** | DentaQuest: Attn CGA<br>11100 W. Liberty Drive<br>Milwaukee, WI 53224 |
| | |

## Section 2.10 How to contact ServiceLink Aging & Disability Resource Center

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

| Method | ServiceLink Aging & Disability Resource Center – Contact Information |
|---|---|
| **CALL** | **1-866-634-9412**<br><br>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<br><br>Office hours are Monday through Friday, 8:30 a.m. - 4:30 p.m. ET.<br><br>Free language interpreter services are available for non-English speakers. |
| **TTY/TDD** | Call the number above or visit the website below for TTY/TDD services for your local office. |
| **FAX** | Call the number above or visit the website below for the fax number of your local office. |
| **WRITE** | Call the number above or visit the website below for the address of your local office |
| **WEBSITE** | http://www.servicelink.nh.gov/ |

## Section 2.11 How to report suspected cases of fraud, waste, or abuse

You play a vital role in protecting the integrity of the New Hampshire Smiles Adult dental program. To prevent and detect fraud, waste, and abuse, DentaQuest 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 or dental services you never received.
- Lack of information in member health or dental records 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 Smiles Adult dental program 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 | DentaQuest to report fraud, waste, or abuse – Contact Information |
|---|---|
| **CALL** | **1-844-583-6151**<br><br>Calls to this number are toll-free. Office hours are Monday through Wednesday, 8:00 a.m. to 8:00 p.m., Thursday and Friday 8:00 a.m. to 5:00 p.m. ET.<br><br>Member Services also has free language interpreter services available for non-English speakers. |
| **TTY/TDD** | **1-800-466-7566**<br><br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br><br>Calls to this number are free. |
| **FAX** | **1-262-834-3452** |
| **WRITE** | 11100 W. Liberty Drive, Milwaukee, WI 53224 |
| **WEBSITE** | DentaQuest.com/newhampshire |

| Method | New Hampshire Office of the Attorney General to report fraud waste or abuse – Contact Information |
|---|---|
| **CALL** | **1-603-271-1246**<br><br>Office hours are Monday through Friday, 8:00 a.m. - 5:00 p.m. ET. |
| **TTY/TDD** | TDD Access Relay (NH): **1-800-735-2964**<br><br>Calls to this number are free. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. |
| **FAX** | **1-603-271-2110** |
| **WRITE** | Office of the Attorney General<br>33 Capitol Street<br>Concord, NH 03301 |
| **WEBSITE** | http://www.doj.nh.gov/consumer/complaints/index.htm |

## Section 2.12 Other important information and resources

- **You may designate an authorized representative or personal representative** – You may designate a person to whom you give authority to act on your behalf. Your representative will be able to provide the plan with information or receive information about you in the same manner that the plan would discuss or disclose information directly to you. To have someone represent you, you must authorize your representative in writing and tell us how they may represent you. An authorization and release form are available at DentaQuest.com/newhampshire.

- Your authorized representative or personal representative designation is valid until you revoke or amend it in writing. For more information, contact Member Services at (844) 583-6151 (phone numbers are also printed on the back cover of this handbook.)

- **Alternative formats and interpretation services** –

  If you need interpretation/translation services, please call 1-844-583-6151 (TDD/TTY 711 or 1-800-466-7566) Monday through Wednesday from 8 a.m. to 8 p.m. or Thursday - Friday from 8 a.m. to 5 p.m. We can provide a translator for you over the phone.

  You have the right to materials and information, including this handbook in:

  • Audio

  • Braille

  • Larger print

  • Other languages

  Call DentaQuest Member Services at 1-844-583-6151 (TDD/TTY 711 or 1-800-466-7566) Monday - Wednesday from 8 a.m. to 8 p.m. or Thursday – Friday from 8 a.m. to 5 p.m. for these materials.

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

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

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

- **Member material requests** – Contact DentaQuest Member Services at (844) 583-6151 to request a copy of our Member Handbook or Provider Directory. Document(s) will be

sent within 5 business days of your request. (Phone numbers for Member Services are also printed on the back cover of this Handbook.)

# Chapter 3. Using DentaQuest 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 dental and oral health services covered by the plan. For more definitions, refer to Section 13 (*Acronyms and definitions of important words*).

DentaQuest will work with you and your primary dental provider (PDP) to ensure you receive dental and oral health 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 506, He-W 530, and He-W 566. The rules are available online at http://www.gencourt.state.nh.us/rules/about_rules/listagencies.htm.

## What are "network providers" and "covered services"?

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

- **"Providers"** are dentists, specialists and health care professionals licensed by the state to provide dental and oral health services. The term "providers" also includes hospitals and other health care facilities, as well as pharmacies. (Prescriptions may be covered under Medicaid and other insurance you may have as a subscriber.)
- **"Network providers"** are the dentists, specialists, and health care professionals, dental groups, hospitals, and other health care facilities that have an agreement with the plan to accept our payment and cost-sharing, if any, as payment in full. The providers in our network bill us directly for care they give you.
- **"Covered services"** include all dental and oral health services, covered by our plan. Refer to the Benefits Chart in Chapter 4 for a list of covered services.

## Rules for getting your dental and oral health services covered by the plan

DentaQuest covers all services required in our contract with NH DHHS.

DentaQuest will generally cover your dental and oral 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 are needed for the prevention, diagnosis, or treatment of your dental or oral health condition and meet accepted standards of medical or dental 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 dental provider (a PDP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PDP.

  **Choosing a Primary Dental Provider (PDP)**
  One of the first things you will need to do when you enroll in our plan is choose a primary dental provider (PDP). This is a general dentist or pediatric dentist. You will contact your PDP to make an appointment for services such as regular dental visits, or when you have a dental problem. Your PDP will also help you get care from other providers or specialists. This is called a referral. You can choose your PDP by calling Member Services at (844) 583-6151.

  You can choose a different PDP for each family member, or you can choose one PDP for the entire family. If you do not choose a PDP, we will assign a PDP for you and your family.

  You can change your PDP at any time. To change your PDP, call Member Services.
- Referrals from your PDP are not required for emergency care or urgently needed services. There are also some other kinds of care you can get without having approval in advance from your PDP (for more information, refer to Chapter 4 (Covered services).]

- **The care you receive is from a network provider** (for more information, refer to Section 3.3 (*How to get care from specialists and other network providers).* Most care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered, except with prior approval from the plan or for emergency services. For more information about when out-of-network services may be covered, refer to Section 3.5 (*Getting care from out-of-network providers*).

  Here are two 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 dental or oral health care that New Hampshire Smiles Adult dental program 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 dentist or other doctor, refer to Section 6.3 (*Getting out-of-network services*).

## Section 3.1 Your Primary Dental Provider (PDP) provides and oversees your dental and oral health care

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

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

Your PDP may include a network. If you need help selecting or changing your PDP, call Member Services (phone numbers are printed on the back cover of this handbook).

Each person in your family who has dental benefits through this program is assigned a PDP. A PDP is a dentist your household sees every six months. The dentist will provide the care your family needs to stay healthy.

Your household's PDP was chosen by looking for:

- The dental office of your last dental visit or
- The dental office close to your home zip code

Call DentaQuest if you have questions about your PDP. You can change your household's PDP by calling Member Services at 1-844-583-6151, TTY: 1-800-466-7566.

### How do you choose your PDP?

Our Member Services can answer all your questions. You will be assigned a primary dental provider; however, you are free to seek care with any in-network provider. DentaQuest can help you choose or change your primary dental provider (PDP).

### Changing your PDP

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

## Section 3.2 Services you can get without getting approval in advance

You can get the services listed below without getting approval in advance from your PDP or DentaQuest.

- 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).

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

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

A specialist is a doctor who provides dental or oral health care services for a specific disease or a specific part of the body. When your PDP 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:

- Oral surgeon for dental extractions, as applicable.

- Dental specialists care for patients with cancer.

- Dental specialists care for patients with certain bone, joint or muscle conditions.

### Find a Dental Provider

DentaQuest can help you find a Dentist who accepts your plan. Follow these steps to use our online search tool to find a provider or dental specialist near you.

1. Go to DentaQuest.com/newhampshire
2. Click "Find a Provider" at the top of the page and select your state
3. Click on "Use my Location" or enter your address, zip code or city
4. Click on the All-Plans link. If you don't see your plan listed, select on "Find a Different Plan" and select your plan in the drop-down menu.3

You may request a copy of the *Provider Directory* from Member Services at (844) 583-6151. (Phone numbers are also printed on the back cover of this handbook). The Provider Directory lists network providers. Also, you may ask Member Services for more information about our network providers, including their qualifications.

### Ways to search for a dentist online with the FAD tool:

1. **Find a Dentist by Name** – Enter the last name of the dental provider you are looking for and select the name in the drop-down menu.
2. **Find a Dentist by Specialty** – Use this to search for specific kinds of dental providers like general dentists, orthodontists, and periodontists.
3. **Find Services by Location** – Use this if you know the name of the provider and would like to know the address, phone number, office hours and other information. Customer Service can assist you with locating a provider or changing your primary care dental provider. Please call 1-844-583-6151 (TDD/TTY 711 or 1-800-466-7566) Monday through Friday from 8 a.m. to 5p.m.
4. **Places by Type** – Use this to look for locations like health care clinics and Federally Qualified Health Centers.

No matter which way you search, you can get more information on the dentists like office hours, whether they are accepting new patients or if their location is wheelchair accessible. You can also get directions to their office.

### Urgent Care

Urgent Care is not emergency care. Urgent care is needed when you have an injury or illness that must be treated right away. Urgent conditions that are treated within 24 hours are usually not something that require prior authorization. If they do require authorization, you must get treated within 48 hours. Urgent care can be used when your life is not in danger, but you still need to see a doctor right away. You may need to go to an urgent care if you or a member of you family need care and your doctor's office is closed. Be sure to call DentaQuest Member Services before you use an urgent care center, or you may have to pay for those services. Call DentaQuest Member Services at 1-844-583-6151 (TDD/TTY 711 or 1-800-466-7566) Monday - Wednesday from 8 a.m. to 8 p.m. or Thursday – Friday from 8 a.m. to 5 p.m.

### Emergency Care

Emergency services are services for the treatment of any dental issue needing attention right away for the relief of pain, severe bleeding, infection, or serious injury to the teeth, gums, or jaw.

If you have an urgent dental need or dental emergency, contact your PDP. If your condition is severe, call 911 or go to the closest emergency facility right away. You can go to any hospital or emergency facility.

We pay for emergency services that are provided by a dental provider, even if they are not part of our plan or in our service area. Medicaid or your Medicaid health plan pays the cost of the hospital or emergency facility and for any care not provided by a dental provider. You also do not need to get approval ahead of time to get emergency care or for the services that you receive in an emergency room to treat your condition.

If you have an emergency when you are away from home, get the medical care you need. Be sure to call DentaQuest Member Services at (844) 583-6151 when you are able and let us know.

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

We may make changes to the dentists, specialists (providers), and hospitals 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 PDP or other provider who you receive routine treatment from leaves the plan's network. We will notify you the earlier of 15 calendar days after the plan receives notice of your provider leaving the network, or 30 calendar days prior to the effective date of the provider termination so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing dental 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 dentist or specialist is leaving our plan, please contact us so we can assist you in finding a new provider to manage your care.
- You may choose your preferred network health providers to the extent possible and appropriate.
- If you are receiving a prior authorized ongoing course of treatment with a participating provider who becomes unavailable to continue to provide services, the plan shall notify you in writing within 7 calendar days from the date the plan becomes aware of such unavailability and will develop a transition plan to help you with your continued ongoing care.

## Section 3.5 Getting care from out-of-network providers

### Specialist Care and Referrals

Sometimes, you may need to see a provider other than your PDP for dental problems like special conditions, injuries, or illnesses. Talk to your PDP first. Your PDP will refer you to a specialist. A specialist is a provider that focuses on one type of dental service.

If you have a case manager, make sure you tell your case manager about your referrals. The case manager will work with the specialist to get you care.

Your PDP, case manager or Member Services can help find a provider to give you a second opinion. You can pick any of our providers. If you are unable to find a provider with us, we will help you find a provider that is not in our provider network. If you need to see a provider that is not in our provider network for the second opinion, we must approve it before you see them.

When you receive prior authorization from the plan for treatment from an out-of-network provider, you should never be charged more than 10% of allowed costs, if any, up to certain limits or maximum out-of-pocket costs for covered services. If you believe you were over 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.

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 PDP.
- **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. 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, DentaQuest or your PDP 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 PDP 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 dental medical emergencies include*:*

- Heavy bleeding
- Severe headaches or other pain
- Shock (symptoms often include sweating, feeling thirsty, dizzy, pale skin)

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

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

Please see your member handbook for a list of medical emergencies.

### 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 dental or oral health illness, injury, or a condition that requires immediate 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.

### Hospital Care

If you need to go to the hospital for an appointment, surgery or overnight stay, your PDP will help to request approval for dental services. We must approve a dental provider's services in the hospital before you go, except for emergencies. We will not pay for a dental provider's services in a hospital unless we approve them if you have a case manager, they will work with you and your dental provider to get services in place for after you leave the hospital.

## Emergency Care

You have a dental emergency when you need immediate attention to stop bleeding, relieve severe pain, or save a tooth. Some examples are:

- Abscess
- Bleeding that will not stop
- Infection

Emergency services are what you get when you are very ill or injured. These services try to keep you alive or to keep you from getting worse. They are usually delivered in an emergency room.

If your condition is severe, call 911 or go to the closest emergency facility right away. You can go to any hospital or emergency facility. If you are not sure if it is an emergency, call your PDP. Your PDP will tell you what to do.

We pay for emergency services that are provided by a dental provider, even if they are not part of our plan or in our service area. Medicaid or your Medicaid health plan pays the cost of the hospital or emergency facility and for any care not provided by a dental provider. You do not need to get approval ahead of time to get emergency care or for the services that you receive in an emergency room to treat your condition.

If you have an emergency when you are away from home, get the medical care you need. Be sure to call Member Services when you are able and let us know.

## Urgent Care

Urgent Care is not Emergency Care. Urgent Care is needed when you have an injury or illness that must be treated within 48 hours. Your health or life are not usually in danger, but you cannot wait to see your PDP, or it is after your PDP's office has closed. Be sure to ask us before you use an Urgent Care center, or you may have to pay for those services.
If you need Urgent Care after office hours and you cannot reach your PDP, call DentaQuest Member Services at 1-844-583-6151, TTY 1-800-466-7566.

You may also find the closest Urgent Care center to you by calling DentaQuest Member Services at 1-844-583-6151, TTY 1-800-466-7566.

There are a few ways to access care after normal business hours, depending on your needs:

### Providers with Extended Hours

Some providers offer evening or weekend office hours.

Call your PDP or visit their website to find out when they are open.

### Urgent Care Centers

Urgent care centers see patients who need immediate, but not emergency attention and their primary dentist is not available.

Some urgent care centers require you to make an appointment, while others allow walk-ins. Be sure to call ahead and ask.

Urgent care centers usually focus on medical problems and may not treat dental problems. Be sure to call ahead and ask.

### Emergency Room

If you're experiencing a life-threatening emergency, call 911 or go to your nearest emergency room.

### 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 for services covered under our plan, 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 DentaQuest 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 506, He-W 530, and He-W 566. The rules are available online at http://www.gencourt.state.nh.us/rules/about_rules/listagencies.htm

### About covered services:

- The Benefits Chart lists the services DentaQuest covers. The chart is for your general information and may not include all the benefits available to you. Please call DentaQuest Member Services at (844) 583-6151 with questions about covered services (phone numbers are also 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 Smiles Adult dental program.
    - 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 DentaQuest for covered services*).
    - You pay nothing for preventive and diagnostic services as long as you follow the plan's rules described in this handbook. Some members may be responsible for paying cost-sharing at the time they receive services. Refer to the end of this handbook to learn where there is an addendum which describes any cost-sharing you are required to pay at the time of service.
- With the exception of Members who are exempt from cost sharing as described in the Medicaid Cost Sharing State Plan Amendment, DentaQuest shall require point of service (POS) Cost Sharing for Covered Services for Members deemed by the Department to have annual incomes at or above one hundred percent (100%) of the FPL, as follows:
    - A copayment equal to 10% of the cost of the treatment rendered at a dental appointment, excluding preventive and diagnostic services. Cost-sharing cannot

exceed 5% of annual household income for Covered Services.

- The following services are exempt from cost-sharing:
    - Preventive and diagnostic services,
    - Pregnancy-related services,
    - Services resulting from potentially preventable events, and,
    - Members are exempt from Copayments when:
        - The Member falls under the designated income threshold (one hundred percent (100%) or below the FPL).
        - The Member is in a nursing facility or in an ICF for Members with IDs.
        - The Member participates in one (1) of the HCBS waiver programs.
        - The Member is pregnant and receiving services related to their pregnancy or any other medical condition that might complicate the pregnancy.
        - The Member is in the Breast and Cervical Cancer Treatment Program.
        - The Member is receiving hospice care; or
        - The Member is an American Indian/Alaska Native.
- Any American Indian/Alaskan Native who has ever received or is currently receiving an item or service furnished by an IHCP or through referral under contract health services shall be exempt from all cost sharing including Copayments and Premiums. [42 CFR 447.52(h); 42 CFR 447.56(a)(1)(x); ARRA 5006(a); 42 CFR 447.51; SMDL 10-001]
- New Hampshire Smiles Adult dental program benefits may change over time. You will be notified of those changes by mail.

If you have questions about covered services, call DentaQuest Member Services at (844) 583-6151 (phone numbers are also printed on the back cover of this handbook).

## Section 4.2 Benefits Chart

**Services covered by the plan**

**Dental services**

The plan covers the following dental services up to $1,500 yearly limit on dental services in an office setting (cost-sharing may apply* with the exception of diagnostic and preventive services) for adults age 21 and older, including:

- Preventive services
  - Annual comprehensive oral exam
  - Annual X-rays or other radiological imaging
  - Prophylaxis - Dental cleaning every 150 days
  - Topical fluoride every 150 days
  - Oral hygiene instruction
  - Behavior management
  - Smoking cessation counseling
- Comprehensive restorative dental services necessary to prevent or treat oral health conditions (frequency varies by specific procedure)
- Limited periodontic services
- Extractions and other oral surgery dental services necessary to relieve pain, eliminate infection or prevent imminent tooth loss
- Removable prosthetic coverage for certain individuals referenced by an addendum at the end of this Member Handbook, if any
- Outpatient facility services when medically necessary, Prior Authorization is required

*For information on any cost-sharing you may be required to pay, refer to the addendum at the back of this Member Handbook. You are responsible for all costs over your $1,500 yearly maximum benefit limit for covered services (excluding diagnostic and preventive services).

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

*Prior authorization is required for all other services listed above.*

*Prior authorization from the plan is not required for in-network and out-of-network emergency medical care.*

For more information, please call DentaQuest Member Services at (844) 583-6151.

| Services covered by the plan |
| --- |
| **Outpatient surgery**<br>The plan covers medically necessary dental and oral health outpatient surgery performed in hospital outpatient facilities and ambulatory surgical centers.<br><br>*Prior authorization may be required for certain procedures.*<br><br>For more information, please call DentaQuest Member Services at 1-844-583-6151. |
| **Prescription drugs**<br>Medically necessary prescription drugs (and over the counter drugs with a prescription) prescribed by network providers may be covered under your Medicaid health plan. Plan rules and copayments may apply.<br><br>To reduce NH Medicaid spending while still ensuring access to quality care, the Department of Health and Human Services (DHHS) implemented NH Medicaid Pharmacy Benefit Program initiatives as indicated below. Magellan Rx Management is the Pharmacy Benefit Administrator for NH Medicaid.<br><br>For more information, refer to your Medicaid health plan's Member Handbook and List of Covered Drugs, or contact the Medicaid health plan's Member Services at 1-866-664-4506. |

| Services covered by the plan |
| --- |
| **Telemedicine services**<br><br>The plan covers all modes of telemedicine, including audio and video interactive services, audio-only or other electronic media for Medicaid-covered services when services are delivered by the following providers as a method of medical care service delivery:<br><br>• Dentist<br>• Oral health specialist<br>• Allied health professional (e.g., technician, assistant, therapist, technologist)<br><br>Eligible sites where video interactive telemedicine services may originate and/or be delivered include, but are not limited to the following sites:<br><br>• Medical practitioner's office<br>• Allied health professionals' office<br>• Hospital<br>• Skilled nursing facility<br>• Federally Qualified Health Center (FQHC)<br>• Rural Health Center (RHC)<br>• Member's home<br><br>**24/7 Emergency Care Available via Teledentistry.com bit.ly/NH-teledentistry 866-302-0905**<br><br>For more information, please call DentaQuest Member Services at (844) 583-6151. |
| **Tobacco use treatment services**<br><br>The plan supports *QuitNowNH* tobacco use treatment services whether you smoke, chew, snuff, or vape. Call toll-free **1-800-QUIT-NOW** (1-800-784-8669) (TDD Relay Access **1-800-833-1477**), 24 hours a day, 7 days a week; or log on to www.QuitNowNH.org.<br><br>For more information, please call DentaQuest Member Services at (844) 583-6151. |

**Services covered by the plan**

**Transportation services – non-emergency medical transportation (NEMT)**

The plan covers non-emergency medical transportation services if you are unable to pay for the cost of transportation to network provider offices and facilities (and out-of-network providers with prior authorization) for medically necessary New Hampshire Smiles Adult dental program covered services listed in the Benefits Chart in Chapter 4.

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

Plan rules include:

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

  **Exceptions to the Family and Friends Mileage Reimbursement Program**

- You must use the Family and Friends Mileage Reimbursement Program if you have a car, or when a friend or family member with a car can drive you to your medically necessary service

- If you have a car and do not want to enroll in the Family and Friends Program, you must meet one (1) of the following criteria to qualify for transportation services:
  - Do not have a valid driver's license;
  - Do not have a working vehicle available in the household;
  - Are unable to travel or wait for services alone; or
  - Have a physical, cognitive, mental or developmental limitation

- If no car is owned or available, you must use public transportation if you meet one (1) of the following criteria:
  - You live less than one half mile from a bus route;
  - Your provider is less than one half mile from the bus route;
  - You are an adult under the age of sixty-five (65)

  **Exceptions to the public transportation requirement are:**

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

*Continued on the next page*

**Services covered by the plan**

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

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

To schedule Family and Friends Mileage Reimbursement, public transportation or a ride to a provider office or facility for services listed in the Member Handbook, call CTS toll-free at **1-844-304-6630** in advance of the appointment, Monday through Wednesday, 8:00 a.m. to 8:00 p.m. ET and Thursday through Friday, 8:00 a.m. to 6:00 p.m. ET.

For more information, please call DentaQuest Member Services at (844) 583-6151.

**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 dental or oral health illness
- A dental injury
- A dental or oral health condition that needs care right away

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

If you require urgently needed care, you should first try to get it from a network urgent care center or call the plan's at (844) 583-6151. You should inform your PDP 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 DentaQuest Member Services at (844) 583-6151.

## 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 Smiles Adult dental program.

Extra benefits include:

### Healthy Behavior Incentive: Opioid Education

The individuals targeted for this program will be members who recently had a tooth extraction. They will qualify for the gift card reward if they complete an online course designed to reduce the likelihood of new opioid addictions by promoting opioid safety and alternative pain management options at NH State Dental Plans | Medicaid CHIP Dental Insurance - DentaQuest. This program is intended to bring awareness to opioid epidemic and opioid safety. The incentive offered to members is a $25 gift card that can be used toward health-related over the counter products, healthy food, and/or baby care items. Member will receive gift card by mail and is eligible to receive this award one time per year.

### Healthy Behavior Incentive: Two Preventive Dental Visits in a 12-Month Period

This program is for all members. Qualifying members will receive a $25 gift card reward if they complete two preventive dental visits in a 12-month period. Promoting regular dental care at the right intervals will optimize oral health outcomes as well as detect and resolve issues early. The gift card reward can be used toward health-related over the counter products, healthy food, and/or baby care items. Member will receive gift card by mail and is eligible to receive this award one time per year. This benefit will be automatic; the member will receive the gift card if they complete two preventive visits in a 12-month period.

## Section 4.4 New Hampshire Smiles Adult dental program benefits covered outside the plan

New Hampshire Smiles Adult dental program 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 DentaQuest ID card and New Hampshire Medicaid membership card. Always show your DentaQuest ID card to receive dental services covered by the plan. If you need help getting any covered services, please call DentaQuest Member Services at (844) 583-6151. (Phone numbers are also printed on the back cover of this handbook).

**ALWAYS CARRY BOTH YOUR DENTAQUEST DENTAL ID CARD AND**

**NEW HAMPSHIRE MEDICAID MEMBERSHIP CARDS.**

The following services are not covered by our plan for individuals over age 21. However, these services are available through New Hampshire Medicaid, or a Medicaid health plan contracted with NH DHHS as long as the provider is enrolled with New Hampshire Smiles Adult dental program:

- NH Medicaid covered physical health, behavioral health, and prescription benefits. For more information, refer to covered services provided in your Medicaid health plan Member Handbook.
- Nursing home or nursing facility services (sometimes called long-term care nursing facility services), including: skilled nursing facility services, long-term care nursing facility services, and intermediate care facility services (nursing homes and acute care swing beds)
- Intermediate care facility services (nursing home and acute care swing beds)
- Glencliff Home services
- Home and Community-Based Care waiver services for:
    - Members with acquired brain disorders;
    - Members with developmental disabilities;
    - Members with age-related disabilities, chronic illnesses, or physical disabilities under the Choices for Independence waiver.

  These programs provide long-term services and supports in your home, as well as in assisted living facilities, community residences, and residential care homes.
- Crisis intervention mental health services, including mobile crisis response services, related post-intervention stabilization services, and emergency psychiatric and psychotherapy services when delivered by a Community Mental Health Center Rapid Response Team.

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

## Section 4.5 Dental and oral health benefits not covered by our plan or New Hampshire Smiles Adult dental program

### What Do I Have to Pay For?

You may have to pay for appointments or dental services that are not covered. A covered service is a service we must provide in the Medicaid program. All of the services listed in this handbook are covered services. Remember, just because a service is covered, does not mean you will need it. You may have to pay for services if we did not approve it first.

If you get a bill from a provider, call DentaQuest Member Service at (844) 583-6151. Do not pay the bill until you have spoken to us. We will help you.

This section tells you what benefits are excluded by the plan and New Hampshire Smiles Adult dental program. “Excluded” means that neither the plan nor NH Medicaid pays for these benefits. The list below describes some services and items that are not covered.

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

# Chapter 5. Using DentaQuest to help manage your health

## Section 5.1 Special services and programs

The member incentive programs below are incentive programs designed to reward and reinforce healthy behaviors, improve health literacy, and promote preventive care for Medicaid enrollees in New Hampshire. The goal of the Healthy Behaviors Program is to engage Medicaid recipients in their behaviors and emphasizes the importance of personal choices in determining their oral health.

### Dental Risk Assessment Screening:

DentaQuest shall conduct a Dental Risk Assessment Screening of all existing and newly enrolled members within ninety (90) calendar days of the effective date of enrollment. This risk assessment provides preliminary information to identify members who are in need of dental care and/or additional support which extends beyond dental care. Qualifying members will receive a $25 gift card after they submit an Oral Health Assessment form to DentaQuest via mail or on-line at DentaQuest.com/newhampshire through the DentaQuest website. Member is eligible to receive this award once per year and is responsible for submitting the Oral Health Assessment form via mail or online.

### Healthy Behavior Incentive: Opioid Education

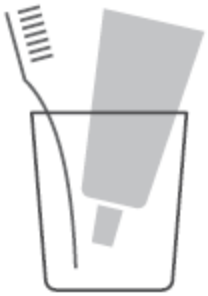
The individuals targeted for this program will be members who recently had a tooth extraction. They will qualify for the gift card reward if they complete an online course designed to reduce the likelihood of new opioid addictions by promoting opioid safety and alternative pain management options at DentaQuest.com/newhampshire. This program is intended to bring awareness to opioid epidemic and opioid safety. The incentive offered to Members is a $25 gift card that can be used toward health-related over the counter products, healthy food, and/or baby care items. Member will receive gift card by mail and is eligible to receive this award one time per year. The member needs to have received tooth extraction and completed the opioid safety online course.

### Healthy Behavior Incentive: Two Preventive Dental Visits in a 12-Month Period

This program is for all members. Qualifying members will receive a $25 gift card reward if they complete two preventive dental visits in a 12-month period. Promoting regular dental care at the right intervals will optimize oral health outcomes as well as detect and resolve issues early. The gift card reward can be used toward health-related over the counter products, healthy food, and/or baby care items. Member will receive gift card by mail and is eligible to receive this award one time per year. This benefit will be automatic; the member will receive the gift card if they complete two preventive visits in a 12-month period.

# ORAL HEALTH ASSESSMENT

Please fill out this form so we can help provide you with the best care. Complete one form for each member of your household who is a DentaQuest Plan member. Once you are done, mail the form(s) back to the mailing address listed below. You can download new member surveys by visiting DentaQuest.com/newhampshire.



Name: _____

Date of Birth: _____

Phone: _____ (Cell) _____ (Home)

Today's Date (mm/dd/yyyy): _____

DentaQuest Member ID Number: _____

1. **Do you have tooth pain or a dental problem right now?**
   ☐ Yes ☐ No

2. **Have you been to the Emergency Room for a dental problem in the past 12 months?**
   ☐ Yes ☐ No

3. **Was your last visit to the dentist more than 12 months ago?**
   ☐ Yes ☐ No

4. **Do you brush your teeth *less than* twice a day?**
   ☐ Yes ☐ No

5. **Do you smoke or use tobacco/vaping products?**
   ☐ Yes ☐ No

   If "yes" above, would you like assistance to stop using tobacco/vaping products?

   ☐ Yes ☐ No

6. **Do you have a special need that makes it hard for you to see the dentist?**
   ☐ Yes ☐ No

   If yes, which one? (*select all that apply*)

   ☐ I have an intellectual and/or physical disability
   ☐ I am nervous or afraid to visit the dentist
   ☐ I use a wheelchair or stretcher
   ☐ Other (*please explain*) _____

7. **Are you pregnant?**
   ☐ Yes ☐ No

8. **Do you have a health problem or illness that makes it hard for you to see the dentist?**
   ☐ Yes ☐ No

   If yes, which one? (*select all that apply*)

   ☐ Diabetes
   ☐ Kidney Disease
   ☐ Heart Disease
   ☐ Lung Disease
   ☐ Cancer
   ☐ Mental Illness or Mental Health Problem
   ☐ Drug or Alcohol use or abuse
   ☐ Other (*please explain*) _____

9. **Do you have any other type of problem that makes it hard for you to see the dentist? (*For example*, "I don't have a way to get to the dentist.")**
   ☐ Yes ☐ No

   If yes, (*please explain*) _____

**Mail this form to:**
DentaQuest
ATTN: Case Management
PO Box 2906
Milwaukee, WI 53201-9292
844-583-6151
Monday - Friday 8 a.m. to 7 p.m.

DentaQuest®

DQ2708 (3/23)

# VALORACIÓN DE LA SALUD BUCAL

Complete este formulario para poder proporcionarle la mejor atención. Complete un formulario para cada integrante de su grupo familiar que esté afiliado al plan de DentaQuest. Cuando haya terminado, envíe los formularios por correo a la dirección indicada abajo. Puede descargar las encuestas para nuevos afiliados en DentaQuest.com/newhampshire.

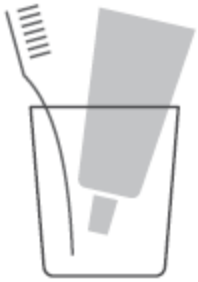
Nombre: _____

Fecha de nacimiento: _____

Teléfono: _____ (Celular) _____ (Hogar)

Fecha de hoy (mm/dd/aaaa): _____

Número de identificación del afiliado a DentaQuest: _____



1. **¿Tiene dolor de muelas o un problema dental en este momento?**
   ☐ Sí ☐ No
2. **¿Ha tenido que ir a la sala de emergencias por un problema dental en los últimos 12 meses?**
   ☐ Sí ☐ No
3. **¿Visitó al dentista por última vez hace más de 12 meses?**
   ☐ Sí ☐ No
4. **¿Se cepilla los dientes menos de dos veces al día?**
   ☐ Sí ☐ No
5. **¿Fuma o usa productos derivados del tabaco o productos para vapear?**
   ☐ Sí ☐ No

   Si respondió "sí" a la pregunta anterior, ¿le gustaría que le ayudaran a dejar de usar productos derivados del tabaco o productos para vapear?

   ☐ Sí ☐ No
6. **¿Tiene alguna necesidad especial que le dificulte ir al dentista?**
   ☐ Sí ☐ No

   De ser así, ¿cuál de las siguientes? (*Marque todos los que se apliquen.*)

   ☐ Tengo una discapacidad física o intelectual.
   ☐ Siento ansiedad o me da miedo ir al dentista.
   ☐ Uso una silla de ruedas o una camilla.
   ☐ Otro (*explique, por favor*): _____
7. **¿Está embarazada?**
   ☐ Sí ☐ No
8. **¿Tiene algún problema de salud o enfermedad que le dificulte ir al dentista?**
   ☐ Sí ☐ No

   De ser así, ¿cuál de los siguientes? (*Marque todos los que se apliquen.*)

   ☐ Diabetes
   ☐ Enfermedad renal
   ☐ Enfermedad cardiaca
   ☐ Enfermedad pulmonar
   ☐ Cáncer
   ☐ Enfermedad mental o problema de salud mental
   ☐ Drogadicción o alcoholismo
   ☐ Otro (*explique, por favor*): _____
9. **¿Tiene algún otro tipo de problema que le dificulte ir al dentista? (*Por ejemplo*, "No tengo transporte para ir al dentista.")**
   ☐ Sí ☐ No

   Si es así, *explique por qué*: _____

**Envíe este formulario por correo a:**
DentaQuest
ATTN: Case Management
PO Box 2906
Milwaukee, WI 53201-9292
844-583-6151
Lunes a viernes de 8 a.m. a 7 p.m.

DentaQuest®

DQ2708 (323)

## Section 5.2 Care Coordination Support

DentaQuest's Case Management Department has Outreach Coordinators and Case Managers on staff dedicated to assist members with complex medical or behavioral care needs. We provide care coordination for members experiencing barriers to care, including those who suffer severe mental or physical disability, poorly managed chronic health conditions, or who otherwise require specially trained dental providers and accommodations. Members or authorized representatives who call DentaQuest Member Services at (844) 583-6151, may also ask to be referred to Case Management if the Member Services Representative is unable to assist them due to the presence of complex care needs such as described above. Members who submit an Oral Health Assessment that indicates the presence of special health care needs or special assistance to obtain needed dental care, will be contacted by a member of the Case Management team.

## Section 5.3 Continuity of care, including transitions of care

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

- Health care facilities
- Member or community residence
- Providers
- Service areas
- Managed care health plans
- Medicaid fee-for-service (FFS)
- Private insurance and managed care coverage

When you first enroll with our plan, you may already be receiving services from a provider(s). We will make sure you keep getting the care you need. If your provider is not in our plan, we will help you find a new provider that is in our plan, schedule an appointment, and move your health records to the new provider. If you have questions, call DentaQuest Member Services at (844) 583-6151.

### From Case Management Policy Continuity and Coordination of Care:

Continuity and coordination of care for members will be ensured through collaboration and communication with the Medical Health Plan, Dental Health Plan, state agency, community service providers, medical and dental providers. All members will receive the support needed to coordinate care, receive services needed to improve health and reduce barriers to care. To ensure the member has an ongoing source of care specific to their needs, a Primary Dental Provider (PDP) will be assigned based on the member's needs and preferences to the extent possible and appropriate. Members transitioning into the dental plan will be evaluated to assess needs and assisted to address current issues.

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

<table>
<tr><th>You may continue to get care from your treating provider(s) for a limited time, when one of these clinical circumstances apply to you</th><th>You may continue to get care from your treating provider(s) during this time period</th><th>You may continue to get currently prescribed prescription drugs during this time period</th></tr>
<tr><td>You are receiving a prior authorized ongoing course of treatment from your current provider at the time of transition</td><td rowspan="4">Up to 90 calendar days from your enrollment date or until the completion of a medical necessity review by the plan, whichever occurs first</td><td rowspan="4">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</td></tr>
<tr><td>You are receiving services with your current provider, and you have an acute illness, a condition that is serious enough to require dental care for which a break in treatment could likely result in a reasonable possibility of death or permanent harm</td></tr>
<tr><td>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 dental care or treatment over a prolonged period of time</td></tr>
<tr><td>You are in your second or third trimester of pregnancy and prefer to continue to receive care through your current provider</td></tr>
</table>

| You may continue to get care from your treating provider(s) for a limited time, when one of these clinical circumstances apply to you | 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 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 | Through your pregnancy and up to 60 calendar days after delivery | |
| | For the remainder of your life with respect to care directly related to the treatment of the terminal illness or its medical effects | |

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

For more information, contact DentaQuest Member Services at (844) 583-6151 (phone numbers are also printed on the back cover of this handbook).

# 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 DentaQuest in order for you to get coverage for the service. If you do not get this authorization, DentaQuest 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, New Hampshire Smiles Adult dental program and DentaQuest will consider whether the service is medically necessary

New Hampshire Smiles Adult dental program and DentaQuest determines whether a service is "medically necessary" in a manner that is no more restrictive than the New Hampshire Smiles Adult dental program criteria. For information about criteria used to support a medical necessity decision, call DentaQuest Member Services at (844) 583-6151 and request a copy of written rules specific to your situation. (Phone numbers for DentaQuest Member Services are also printed on the back cover of this handbook.)

In some cases, DentaQuest will review medical necessity after covered services are delivered.

Although a service may be decided as medically necessary, it doesn't mean the service will be covered under the Medicaid Program. Services that are experimental, non-FDA approved, investigational or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."

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

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

- Clinically appropriate in extent, site, and duration;
- Consistent with the established diagnosis or treatment of the recipient's illness, injury, disease, or its symptoms;
- Not primarily for the convenience of the member or the member's family, caregiver, or health care provider;

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

## Section 6.2 Getting plan authorization for certain services

DentaQuest'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 request, the plan issues a written notice of coverage decision to you and your provider. For help with filing an appeal, refer to Section 10.1 (*About the appeals process*).

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

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

**For all other prior authorization decisions by DentaQuest, 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 DentaQuest extends the timeframe, the plan will provide written notice of the reasons for the extension decision and advise of your right to file a grievance if you disagree with our decision. For help with filing a grievance, refer to Section 10.7 (*How to file a grievance and what to expect after you file*).
- Thereafter the plan's decision shall be made as soon as possible, but not later than 14 calendar days after the earlier of:
    - The plan's receipt of specific additional information; or
    - The end of the period afforded you or your authorized representative to provide the additional specified information.
- If you disagree with the plan's adverse prior authorization decision, refer to Section 10.1 (*About the appeals process*).

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

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

For help with your service request, contact DentaQuest Member Services at (844) 583-6151.

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

## Section 6.3 Getting authorization for out-of-network services

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

If you are an American Indian or Alaska Native (AI/AN) of a federally recognized tribe or another individual determined eligible for Indian health care services, special coverage rules apply. You may get out-of-network services at an Indian health facility without prior authorization. Contact DentaQuest Member Services at (844) 583-6151 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 a second opinion

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

### Second Opinions

You have the right to get a second opinion about your care. This means talking to a different provider to see what they have to say about your care. The second provider will give you their point of view. This may help you decide if certain services or treatments are best for you. There is no cost to you to get a second opinion.

Your PDP, Case Manager or Member Services can help find a provider to give you a second opinion. You can pick any of our providers. If you are unable to find a provider with us, we will help you find a provider that is not in our provider network. If you need to see a provider that is not in our provider network for the second opinion, we must approve it before you see them.

## Section 6.6 Utilization Review policies and procedures used

Utilization Management (UM) is the process we use to make sure the care you are getting is "Medically Necessary." This is appropriate care when and where you need it. Our processes include pre-service review, urgent/ongoing review, and post-service review. UM looks at the clinical necessity, appropriateness, efficiency of services, supplies, equipment, drugs, procedures, and/or settings. We make decisions based on criteria developed from scientific and

medical research. The criteria are also developed with input from providers. This process and the criteria support the correct use of services to give our members the best health outcomes. We do not reward any decision-maker for denying coverage of a service or offer them money to discourage them from authorizing services. UM decisions are based on the appropriateness of care and service and the existence of coverage. For help with your service request, contact DentaQuest Member Services at (844) 583-6151.

# Chapter 7. Getting covered prescription drugs

## Section 7.1 Drug coverate rules and restrictions

Medically necessary prescription drugs (and over the counter drugs with a prescription) prescribed by network providers may be covered under your Medicaid health plan. Plan rules and copayments may apply. Please discuss coverage and options directory with your dental provider.

# Chapter 8. Your rights and responsibilities

## Section 8.1 Your rights

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

- You have the right to receive information in an easily understandable and readily accessible format that meets your needs. For more information, refer to Section 2.13 (*Other important information: Alternative formats and interpretation services*).
- You have the right to be treated with respect and with due consideration for your dignity and privacy.
- You have the right to receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand.
- You have the right to participate in decisions regarding your health care, including the right to refuse treatment.
- You have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- You have the right to see, as well as request and receive a copy of your medical records, and the right to request that your medical records be amended or corrected.
- You have the right to covered services and drugs that are available and accessible in a timely manner.
- You have a right to care coordination.
- You have the right to privacy and protection of your personal health information.
- You have the right to receive information about our plan, our network providers, and your covered services.
- You have the right to make decisions about your health care.
- You cannot be retaliated against in any way by the plan or by the New Hampshire Department of Health and Human Services (NH DHHS) for exercising your rights.

- You have the right to a second opinion. For more information, refer to Section 6.6 (*Getting a second medical opinion*).
- You have the right to know what to do if you are being treated unfairly or your rights are not being respected. For more information, refer to Section 10.7 (*How to file a grievance and what to expect after you file*).
- You have the right to be informed of any changes in state law that may affect your coverage. The plan will provide you with any updated information at least 30 calendar days before the effective date of the change whenever practical.
- You have the right to exercise advance care planning for your health care decisions if you so choose. For more information, refer to Section 9.3 (*Advance care planning for your health care decisions*).
- You have the right to make a complaint if a provider does not honor your wishes expressed in your advance directive. For more information, refer to Section 9.3 (*Advance care planning for your health care decisions*).
- You have the right to leave our plan in certain situations. For more information, refer to Section 11 (*Ending your plan membership*).

## Section 8.2 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 DentaQuest, 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; and
        - When we give you authorization in advance to get care from an out-of-network provider.
- **If you have any other health insurance coverage, dental coverage, or prescription drug coverage in addition to our plan, you are required to tell DentaQuest 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, dental, and prescription drug benefits you get from our plan with any other health, dental, 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 dentist and other health care providers that you are enrolled in our plan.** Show your plan membership card and your New Hampshire Smiles Adult dental program ID card whenever you get your covered services, including medical or other health care services and prescription drugs.
- **Help your dentist and other providers help you by giving them information, asking questions, and following through on your care.**
    - To help your dentist and other health care providers give you the best care, learn as much as you are able to about your health conditions. Give your oral health care providers the information they need about you and your health. Follow the treatment plans and instructions that you and your dentist agree upon.
    - Make sure your dentist and other dental health care providers know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
    - Talk to your PDP 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 PDP to get necessary copies of all of your oral health records from other oral health care providers. An authorization and release form is available at DentaQuest.com/newhampshire.
    - If you have any questions, be sure to ask. Your dentist and oral 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. 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*).
- **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 DentaQuest Member Services at (844) 583-6151 (phone numbers are also printed on the back cover of this handbook).

- **Do not allow anyone else to use your DentaQuest ID card 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.
- **Pay what you owe.** As a plan member, you are responsible for these payments, as applicable:
    - If you get any dental or oral health services that are not covered by our plan or by other insurance you have, you are responsible for the full cost.
    - All costs over your $1,500 yearly maximum benefit limit for covered services (excluding diagnostic and preventive services).
    - If you disagree with our decision to deny coverage for a dental or oral health service, 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*).
- **Call DentaQuest Member Services at (844) 583-6151 for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan. (Phone numbers for DentaQuest Member Services are also printed on the back cover of this handbook).

## Section 8.3 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

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

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

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

# Chapter 9. What to do if you want to appeal a plan decision or "action", or file a grievance

As a member of DentaQuest, 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 have 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 DentaQuest 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 DentaQuest grievance process.

For help with your appeal or grievance, contact DentaQuest Member Services at (844) 583-6151 (phone numbers are also printed on the back cover of this handbook). You may also contact the NH DHHS Customer Service Center at **1-844-ASK-DHHS** (1-844-275-3447**)** (TDD Access Relay: 1-800-735-2964), Monday through Friday, 8:00 a.m. – 4:00 p.m. ET.

## Section 9.1 About the appeals process

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

Plan "actions" that may be appealed include:

- A decision to deny or limit a requested health care service or request for prior authorization in whole or in part;
- A decision to reduce, suspend, or end health care service that you are getting;
- A decision to deny a member request to dispute a financial liability, including cost-sharing, copayments, and other enrollee financial liabilities. This includes denial for payment of a service, in whole or in part (except when payment for a service is solely because the claim includes defects or lacks required documentation necessary for timely payment of the claim); and
- When a member is unable to access covered 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 DentaQuest to reconsider its decision to a particular "action". First level appeals include both standard and expedited appeals. The exception to first level appeal requirements is when the plan misses the timeframe to provide you with timely written notice of its decision. When this happens, you have the right to file a State Fair Hearing appeal immediately.

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

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

- **Second level standard or expedited State Fair Hearing appeals**. Before you file a State Fair Hearing appeal with NH DHHS AAU, you must exhaust the first level of appeal through DentaQuest.

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

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

For help with your appeal, contact DentaQuest Member Services at (844) 583-6151 (phone numbers are also printed on the back cover of this handbook).

## Section 9.2 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 DentaQuest over the phone or in writing within 60 calendar days of the date of the plan's written notice to you.**
- In your signed, written appeal request:
  - Include your name, address, phone number, and email address (if you have one);

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

- Send your written plan appeal request to:

| Method | DentaQuest Member Services – Contact Information |
|---|---|
| **CALL** | **1-844-583-6151**<br><br>Calls to this number are toll-free. Office hours are Monday through Wednesday, 8:00 a.m. to 8:00 p.m., Thursday and Friday 8:00 a.m. to 5:00 p.m. ET.<br><br>Member Services also has free language interpreter services available for non-English speakers. |
| **TTY/TDD** | **1-800-466-7566**<br><br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br><br>Calls to this number are free. |
| **FAX** | **1-(262) 834-3452** |
| **WRITE** | 11100 W. Liberty Drive, Milwaukee, WI 53224 |
| **WEBSITE** | DentaQuest.com/newhampshire |

- **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** DentaQuest **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.
- DentaQuest 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, DentaQuest will issue its written decision within 30 calendar days after receipt of your appeal request.** The plan may take up to an additional 14 calendar days if you request the extension, or if the plan needs additional information and feels the extension is in your best interest. If the plan decides to take extra days to make the decision, the plan will tell you in writing within 2 calendar days. If you disagree with the plan's extension, you may file a grievance with the plan. For more information, refer to Section 10.7 (*How to file a grievance and what to expect after you file*).
- **If DentaQuest reverses its decision to deny, reduce, limit, suspend, or end services that were not provided while the appeal was pending, DentaQuest 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 DentaQuest, 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 DentaQuest Member Services at (844) 583-6151 (phone numbers are also printed on the back cover of this handbook).

## Section 9.3 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 DentaQuest. 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 DentaQuest over the phone or in writing within 60 calendar days of the date of the health plan's written notice to you. When you contact the plan, remember to ask for an expedited appeal.**
- For your oral or written expedited appeal request:
    - Include your name, address, phone number, and email address (if you have one);
    - Describe the date of the action or notice from the plan you want to appeal, and attach a copy of the notice;
    - Explain the reason for your expedited request and why you want to appeal the decision; and
    - If the plan's decision was to deny, reduce, limit, suspend or end your previously authorized benefits, indicate whether you want to have previously authorized benefits continued. For more information, refer to Section 10.6 (*How to request continuation of benefits during appeal and what to expect afterward*).
- Send your written appeal request to:

| **Method** | **DentaQuest Member Services – Contact Information** |
|---|---|
| **CALL** | **1-844-583-6151**<br><br>Calls to this number are toll-free. Office hours are Monday through Wednesday, 8:00 a.m. to 8:00 p.m., Thursday and Friday 8:00 a.m. to 5:00 p.m. ET.<br><br>Member Services also has free language interpreter services available for non-English speakers. |
| **TTY/TDD** | **1-800-466-7566**<br><br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br><br>Calls to this number are free. |
| **FAX** | **1-(262) 834-3452** |
| **WRITE** | 11100 W. Liberty Drive, Milwaukee, WI 53224 |
| **WEBSITE** | DentaQuest.com/newhampshire |

- **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 DentaQuest 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 DentaQuest 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, DentaQuest must resolve your request as expeditiously as your health condition requires, but no later than 72 hours after the date the plan receives your request.** The plan may take up to 14 calendar days if you request an extension, or if the plan needs additional information and feels the extension is in your best interest. If the plan decides to take extra days to make a decision, the plan will attempt to inform you with prompt oral notice of the delay and tell you in writing within 2 calendar days. If you disagree with the plan's extension, you may file a grievance with the plan. For more information, refer to Section 10.7 (*How to file a grievance and what to expect after you file*).
- If DentaQuest **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 DentaQuest **denies** your request for an expedited appeal, the plan must make reasonable efforts to give you prompt oral notice of the denial, and then must provide written notice of the denial within 2 calendar days.
- **You have the right to file a grievance with DentaQuest if the plan denies your request for an expedited appeal.** If the plan denies your request for an expedited appeal, DentaQuest will treat your appeal as part of the standard appeal process.
- **If DentaQuest reverses its decision to deny, reduce, limit, suspend, or end services that were not provided while the appeal was pending, DentaQuest 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 DentaQuest, you may file a second level of appeal by requesting a standard or expedited State Fair Hearing.** For more information, refer to Section 10.4 (*How to file a standard State Fair Hearing appeal and what to expect after you file (standard second level appeal*) and Section 10.5 (*How to file an expedited State Fair Hearing and what to expect after you file (expedited second level appeal)*).

For help with your appeal, contact DentaQuest Member Services at (844) 583-6151 (phone numbers are also printed on the back cover of this handbook).

## Section 9.4 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 DentaQuest, 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 <u>in writing</u> within 120 calendar days of the date on the plan's written decision.** In most situations, you cannot request a State Fair Hearing without first going through the plan's standard or expedited (first level appeal) processes described above. For exceptions to when you do not have to exhaust the plan's appeal process before requesting a State Fair Hearing appeal, refer to Section 10.1 (*About the appeals process*).
- In your signed, written standard State Fair Hearing request:
    - Include your name, address, phone number, and email address (if you have one);
    - Describe the date of the action or notice from the plan you want to appeal, and attach a copy of the notice;
    - Explain why you want to appeal the decision;
    - If the plan's decision was to deny, reduce, limit, suspend or end your previously authorized benefits, indicate whether you want to have previously authorized

benefits continued. You must contact the plan to request continuation of benefits. For more information, refer to Section 10.6 (*How to request continuation of benefits during appeal and what to expect afterward*); and

- Describe any special requirements you will need for the hearing (e.g., handicap accessibility, interpretation services).

- Send your written State Fair Hearing request to:

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

- **If you appeal the plan's decision to deny, reduce, limit, suspend or end services, you may have a right to request continuation of benefits from DentaQuest during your appeal. Your provider cannot request continuation of benefits for you.** For more information, refer to Section 10.6 (*How to request continuation of benefits during appeal and what to expect afterward*).

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

- **After you file your standard State Fair Hearing appeal, you have the right to request and receive a copy of your case file that the plan used to make its decision.** A copy of your case file is free of charge and may be requested in advance of the State Fair Hearing decision.
- **For a standard State Fair Hearing appeal, the AAU must resolve your request as expeditiously as your health condition requires, but no later than 90 days after the date you filed your first level appeal with the plan (excluding the number of days it took you to request the State Fair Hearing).**
- The AAU will let you know where the hearing will take place. Hearings are usually held at the AAU in Concord, or at your local NH DHHS District Office.
- A hearing officer from the AAU will conduct the hearing.
- You may bring witnesses, present testimony, and evidence in person as well as in writing, and question other witnesses at your State Fair Hearing.
- **If the AAU reverses the plan's decision to deny, reduce, limit, suspend, or end previously authorized benefits that were not provided while the first level appeal and/or State Fair Hearing were pending, the plan will authorize the services as expeditiously as your health condition requires, but no later than 72 hours from the date the plan receives notice that the AAU reversed the plan's decision.**
- If you received continued benefits while the appeal was pending:

  - If the decision is in your favor, the plan will pay for those services.

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

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

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

## Section 9.5 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 DentaQuest AND any delay of services could seriously jeopardize your life, physical or mental health, or ability to attain, maintain, or regain maximum function, you may file an expedited State Fair Hearing with the NH DHHS Administrative Appeals Unit (AAU).**

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

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

  In most situations, you cannot request a State Fair Hearing without first going through the plan's standard or expedited (first level appeal) processes described above. For exceptions to when you do not have to exhaust the plan's appeal process before requesting a State Fair Hearing appeal, refer to Section 10.1 (*About the appeals process*).
- In your signed, written expedited State Fair Hearing request:
  - Include your name, address, phone number, and email address (if you have one);
  - Describe the date of the action or notice from the plan you want to appeal, and attach a copy of the notice;
  - **Specify that you want an expedited State Fair Hearing;**
  - **Explain how any delay of services could seriously jeopardize your life, physical or mental health, or ability to attain, maintain, or regain maximum function;**
  - If the plan's decision was to deny, reduce, limit, suspend or end your previously authorized benefits, indicate whether you want to have previously authorized benefits continued. You must contact the plan to request continuation of benefits.

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

- Describe any special requirements you will need for the hearing (e.g., handicap accessibility, interpretation services).

- Send your written State Fair Hearing request to:

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

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

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

- **After you file your expedited State Fair Hearing appeal, you have the right to request and receive a copy of your case file that the plan used to make its decision.** A copy of your case file is free of charge and may be requested in advance of the State Fair Hearing decision.
- If the AAU **accepts** your request for an expedited State Fair Hearing appeal, the AAU will issue its written decision as expeditiously as your health condition requires, but no later than 3 business days after the AAU receives the plan's case file and any additional information for your appeal.
- If the AAU **denies** your request for an expedited State Fair Hearing appeal, the AAU will make reasonable efforts to give prompt oral notice to you and provide written notice of the denial. If your expedited request is denied, your appeal will be treated as a standard State Fair Hearing appeal described in Section 10.4 (*How to file a standard State Fair Hearing appeal and what to expect after you file (second level appeal)*).
- The AAU will let you know where the hearing will take place. Hearings are usually held at the AAU in Concord, or at your local NH DHHS District Office.
- A hearing officer from the AAU will conduct the hearing.
- You may bring witnesses, present testimony, and evidence in person as well as in writing, and question other witnesses at your State Fair Hearing.

- **If the AAU reverses the plan's decision to deny, reduce, limit, suspend, or end previously authorized benefits that were not provided while the first level appeal and/or State Fair Hearing were pending, the plan will authorize the services as expeditiously as your health condition requires, but no later than 72 hours from the date the plan receives notice that the AAU reversed the plan's decision.**
- If you received continued benefits while the appeal was pending:
    - If the decision is in your favor, the plan will pay for those services.
    - If you lose your appeal and received continued benefits you may be responsible for the cost of any continued benefits provided by the plan during the appeal period.

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

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

## Section 9.6 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 DentaQuest pending the outcome of one or both your first and/or second level appeal. **While you may designate someone to file an appeal for you, your provider cannot request continuation of benefits for you.**

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

| For standard and expedited plan appeals (first level appeal) | For standard and expedited State Fair Hearing appeals (second level appeal) |
|---|---|
| ○ **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**<br>○ The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; and | ○ **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** |

| | |
|---|---|
| ○ The service was ordered by an authorized provider; and<br>○ The original authorization period for the service has not expired. | If you did not request continuation of benefits during your first level appeal with the plan, the following conditions also apply:<br>○ The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; and<br>○ The service was ordered by an authorized provider; and<br>○ The original authorization period for the service has not expired. |

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

| Method | DentaQuest Member Services – Contact Information |
|---|---|
| **CALL** | **1-844-583-6151**<br><br>Calls to this number are toll-free. Office hours are Monday through Wednesday, 8:00 a.m. to 8:00 p.m., Thursday and Friday 8:00 a.m. to 5:00 p.m. ET.<br><br>Member Services also has free language interpreter services available for non-English speakers. |
| **TTY/TDD** | **1-800-466-7566**<br><br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br><br>Calls to this number are free. |
| **FAX** | **1-262-834-3452** |
| **WRITE** | 11100 W. Liberty Drive, Milwaukee, WI 53224 |
| **WEBSITE** | DentaQuest.com/newhampshire |

**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<br>○ The plan's first level appeal decision results in an unfavorable decision for you; or<br>○ 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<br>○ 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<br>○ The State Fair Hearing appeal results in an unfavorable decision for you. |

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

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

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

## Section 9.7 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 DentaQuest or its network providers; and
- Dispute of an extension of time proposed by the plan to make an authorization decision

To file your grievance:

- Call or write to DentaQuest. 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:

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

For help with your grievance, contact DentaQuest Member Services at (844) 583-6151 (phone numbers are also printed on the back cover of this handbook).

*This chapter was prepared by NH DHHS with adaptations from Know Your Rights: New Hampshire Smiles Adult Dental Program 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 10. Ending your plan membership

## Section 10.1 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 Smiles Adult dental program.
- 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.

## Section 10.2 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 Smiles Adult dental program as established by NH DHHS;
- When a member is ineligible for enrollment in the plan as established by NH DHHS;
- When a member has established out of state residence;
- When a member uses their plan membership card fraudulently;
- Upon a member's death; and
- Under the terms of the plan's contract with NH DHHS, the plan may request a member's disenrollment in the event of the member's threatening or abusive behavior that jeopardizes the health or safety of other members, plan staff, or providers. If such a request is made by the plan, NH DHHS will be involved in the review and approval of such a request.

DentaQuest cannot ask you to leave the plan for any reason related to your health.

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

## Section 10.3 Policies and procedures for disenrollment

For policies and procedures for disenrollment contact the NH DHHS Customer Service Center at **1-844-ASK-DHHS** (1-844-275-3447) (TDD Access Relay: 1-800-735-2964), Monday through Friday, 8:00 a.m.–4:00 p.m. ET.

# Chapter 11. Addendum

## Section 11.1 Addendum

**Removable Prosthodontics**

Covered populations - Developmental disability waiver, acquired brain disorder waiver, choices for independent waiver, nursing facility residents. For more information on waivers, please visit https://www.dhhs.nh.gov/programs-services/medicaid/medicaid-waivers-demonstrations

**Cost-Sharing**

Cost-sharing refers to any co-payment 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. As a member, you pay nothing for preventive and diagnostic services as long as you follow the plan's rules described in this handbook. Some members may be responsible for paying cost-sharing at the time they receive services.

# Chapter 12. Legal notices

## Section 12.1 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 handbook. For more information, please visit https://www.dhhs.nh.gov/about-dhhs/locations-facilities/new-hampshire-hospital/nhh-patient-rights.

## Notice of Non-Discrimination

DentaQuest follows the Federal civil rights laws. DentaQuest does not treat people differently because of race, color, national origin, age, disability, sex, religion, gender identity or sexual orientation.

DentaQuest will:

- Give you free help if you have a disability. These services are to help you communicate with us. We can give you:
  - Skilled sign language interpreters
  - Written information in other formats (large print, audio, and clear electronic formats)
- Give you free language services if you do not speak English. We can give you:
  - Skilled interpreters
  - Information written in other languages

Our website will give you the phone number you can call to get these free services. These phone numbers may be specific to your state and health plan. Our website address is:

http://www.dentaquest.com/members/

You can file a complaint if you feel we have treated you differently because of your race, color, national origin, age, disability, sex, religion, gender identity or sexual orientation. You can file the complaint with:

Civil Rights Coordinator
Compliance Department
96 Worcester Street
Wellesley Hills, MA 02481
Phone: 888-278-7310
TTY: 711
Fax: 617-886-1390
Email: FairTreatment@greatdentalplans.com

You can file a complaint in person or by mail, fax, or email. If you need help filing a complaint, we can help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html You can file a complaint online or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

**Language Assistance**

| | |
|---|---|
| English | ATTENTION: If you speak another language, you have services available to you free of charge for language assistance. Call 1-844-583-6151 (TTY: 1-800-466-7566). |
| Spanish | ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-583-6151 (TTY: 1-800-466-7566). |
| French | ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-583-6151 (ATS : 1-800-466-7566). |
| Chinese | 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-583-6151 （TTY：1-800-466-7566）。 |
| Nepali | ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-844-583-6151 (टिटिवाइ: 1-800-466-7566) । |
| Vietnamese | CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-583-6151 (TTY: 1-800-466-7566). |
| Portuguese | ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-844-583-6151 (TTY: 1-800-466-7566). |
| Greek | ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-844-583-6151 (TTY: 1-800-466-7566). |
| Arabic | ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-583-6151 (رقم هاتف الصم والبكم: 1-800-466-7566). |
| Serbian Croatian | OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-844-583-6151 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-466-7566). |
| Indonesian | PERHATIAN: Jika Anda berbicara dalam Bahasa Indonesia, layanan bantuan bahasa akan tersedia secara gratis. Hubungi 1-844-583-6151 (TTY: 1-800-466-7566). |
| Korean | 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-583-6151 (TTY: 1-800-466-7566) 번으로 전화해 주십시오. |
| Russian | ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-583-6151 (телетайп: 1-800-466-7566). |
| French Creole (Haitian Creole) | ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-844-583-6151 (TTY: 1-800-466-7566). |
| Bantu-Krundi | ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-844-583-6151 (TTY: 1-800-466-7566). |
| Polish | UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-583-6151 (TTY: 1-800-466-7566). |

# Chapter 13. Acronyms and definitions of important words

## Section 13.1 Acronyms

| Acronym | Description |
|---|---|
| **AAC** | Augmentative Alternative Communication |
| **CMS** | Centers for Medicare and Medicaid Services |
| **COBRA** | Consolidated Omnibus Budget Reconciliation Act (COBRA) |
| **DQ** | DentaQuest |
| **DNA** | Dental Needs Assessment |
| **EOB** | Explanation of Benefits |
| **FFS** | Fee-for-Service |
| **FQHC** | Federally Qualified Health Center |
| **MCO** | Managed Care Organization |
| **NEMT** | Non-emergency Medical Transportation |
| **NH** | New Hampshire |
| **NH DHHS** | New Hampshire Department of Health and Human Services |
| **NH SADP** | New Hampshire Smiles Adult Dental Program |
| **OHA** | Oral Health Assessment |
| **PDP** | Primary Dental Provider |
| **POS** | Point of Service |
| **SHCN** | Special Health Care Needs |

## Section 13.2 Definitions of important words

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

**Action** – When the plan denies, reduces, suspends, or ends your health care service in whole or in part. For more information about coverage decisions and other actions, refer to Chapter 9 (*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.

**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 9 (*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"

**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.

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

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

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

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

**Cost-sharing** – Cost-sharing refers to any co-payment 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.

**Co-payment** – a contribution made by an insured person toward the cost of dental or medical treatment

**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 dental and oral health services covered by our plan as described in this handbook. Chapters He-W 506, He-W 530, and He-W 566 explain covered services under the plan. The rules are available online at http://www.gencourt.state.nh.us/rules/about_rules/listagencies.htm. Refer to the Benefits Chart in Chapter 4 for a list of covered services.

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

**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 Dental Condition** – A "dental emergency" is when you, or any other reasonable person with an average knowledge, believe that you have dental symptoms that require immediate dental attention that is quickly getting worse.

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

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

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

**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*).

**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.

**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.

**List of Covered Drugs (Formulary or "Drug List")** – A list of covered prescription drugs. The list includes both brand name and generic drugs.

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

**Medically Necessary** – Services, supplies, or prescription drugs needed for the prevention, diagnosis, or treatment of a medical condition and meet accepted standards of medical practice.

For more information about medically necessary services, refer to Section 6.1 (*Medically necessary services*).

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

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

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

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

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

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

**Out-of-Network Provider 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 DentaQuest 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".

**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.

**Primary Dental Provider (PDP)** – The network doctor or other provider you see first for most dental and oral health problems. He or she also may talk with other doctors and providers about your care. Refer to Section 3.1 (*Your Primary Dental Provider (PDP) provides and oversees your dental and oral health care*).

**Prior Authorization** – Approval in advance to get services. Some services 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** – Dentist, doctor or other health care professional licensed by the state to provide dental services and/or oral health care. The term "provider" also includes a hospital, and other health care facilities.

**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 DentaQuest is statewide.

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

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

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

## DentaQuest Member Services

| Method | DentaQuest Member Services – Contact Information |
|---|---|
| **CALL** | **1-844-583-6151**<br><br>Calls to this number are toll-free. Office hours are Monday through Wednesday, 8:00 a.m. to 8:00 p.m., Thursday and Friday 8:00 a.m. to 5:00 p.m. ET.<br><br>Member Services also has free language interpreter services available for non-English speakers. |
| **TTY/TDD** | **1-800-466-7566**<br><br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br><br>Calls to this number are free. |
| **FAX** | **1-262-834-3452** |
| **WRITE** | 11100 W. Liberty Drive, Milwaukee, WI 53224 |
| **WEBSITE** | DentaQuest.com/newhampshire |