

**WellSense Health Plan  
Addendum to the  
Member Handbook Effective October 2025**

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

We previously sent you a NH Medicaid Member Handbook and/or provided notice where you can find a copy of our Member Handbook online. The Member Handbook includes information about your coverage. This notice is to let you know there are changes in your Member Handbook. Below you will find information describing these changes. Please keep this information for your reference.

If you have any questions or to request a hard copy of the Handbook or Addendum at no cost to you, please call Member Services at **877-957-1300**. Calls to this number are toll-free. Representatives are available Monday through Wednesday, 8:00 a.m. to 8:00 p.m ET; Thursday through Friday, 8:00 a.m. to 6:00 p.m ET.

**Changes to your Member Handbook:**

Where you can find the change in your Member Handbook	Original Information	New or Corrected Information	What does this mean for you?
<p><b>Section 4.2 Benefits Chart</b></p> <p>Page 77</p>	<p><b>Prescription drugs</b></p> <p>The plan covers prescription drugs (and over the counter drugs with a prescription) included on the plan’s list of covered drugs approved by NH DHHS. Drug coverage rules and restrictions may apply.</p> <p>Retail Pharmacy Copayment</p> <ul style="list-style-type: none"> <li>• \$1 copayment – up to a 30-day supply</li> <li>• \$1 copayment for a prescription drug that is not identified as either a preferred or non-preferred prescription drug</li> </ul>	<p><b>Prescription drugs</b></p> <p>The plan covers prescription drugs (and over the counter drugs with a prescription) included on the plan’s list of covered drugs approved by NH DHHS. Drug coverage rules and restrictions may apply.</p> <p>Retail Pharmacy Copayment</p> <ul style="list-style-type: none"> <li>• \$4 copayment – up to a 30-day supply</li> </ul> <p>Mail Order Copayment (only certain drugs available through mail order)</p> <ul style="list-style-type: none"> <li>• \$4 copayment for a 90-day supply</li> <li>• \$0 copayment for family planning products, Clozaril® (Clozapine)</li> </ul>	<p>Beginning October 20, 2025, you will be charged a \$4 copayment at the pharmacy for your covered prescription drugs unless the prescription category is exempted, or you are in one of the member exempt categories.</p> <p>For information on who is exempt from copayments, refer to Section 7.7 (<i>Prescription drug copayments: Members who are exempt from copayments</i>) below.</p>

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	<ul style="list-style-type: none"> <li>\$2 copayment for each non-preferred prescription drug (if the prescribing provider determines that a preferred drug will be less effective and/or will have adverse effects for the member, the non-preferred drug will be \$1.00)</li> </ul> <p>Mail Order Copayment (only certain drugs available through mail order)</p> <ul style="list-style-type: none"> <li>\$1 copayment for each preferred prescription drug up to a 90-day supply</li> <li>\$2 copayment for each non-preferred prescription drug (if the prescribing provider determines that a</li> </ul>	<p>prescriptions, Pre-Exposure Prophylaxis (PrEP) drugs, or nicotine cessation products</p> <p>For information on prescription drug coverage, refer to Chapter 7 (<i>Getting covered prescription drugs</i>).</p>	

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	<p>preferred drug will be less effective and/or will have adverse effects for the member, the non-preferred drug will be \$1.00)</p> <ul style="list-style-type: none"> <li>• \$1 copayment for a prescription drug that is not identified as either a preferred or non-preferred prescription drug</li> <li>• \$0 copayment for family planning products or for Clozaril® (Clozapine) prescriptions or tobacco or other nicotine cessation products</li> </ul> <p>For information on prescription drug coverage, refer to Chapter 7 (<i>Getting covered prescription drugs</i>).</p>		

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<p><b>Section 7.1 Drug coverage rules and restrictions</b></p> <p>Page 125</p>	<p>Services are managed by Express Scripts for prescription drugs and Cornerstone Health Solutions for mail order services for the plan.</p> <p><b>Drug coverage restrictions</b></p> <p>Drug list rule restrictions described in this section include:</p> <ul style="list-style-type: none"> <li>Restricting access to brand name drugs when a generic version of the drug is available</li> <li>Requiring prior authorization from the plan</li> <li>Requiring you try a different but similar</li> </ul>	<p><b>Drug coverage restrictions</b></p> <p>Drug list rule restrictions described in this section include:</p> <ul style="list-style-type: none"> <li>Restricting access to non-preferred generic drugs when the brand name version of the drug is preferred</li> <li>Requiring prior authorization from the plan</li> <li>Requiring you try a different but similar drug first (“step therapy”)</li> </ul>	<p>Beginning October 1, 2025, for new and renewed covered prescriptions, dispensing of a preferred brand name drug may be required instead of dispensing a non-preferred generic drug.</p>

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<p><b>Section 7.1 Drug coverage rules and restrictions</b></p> <p>Page 125</p>	<p>drug first (“step therapy”)</p> <ul style="list-style-type: none"> <li>Imposing quantity limits on prescription drugs</li> </ul> <p><b>Restricting access to brand name drugs when a generic version is available</b></p> <p>Generally, a “generic” drug works the same as a brand name drug and usually costs less. <b>In most cases, when a generic version of a brand name drug is available and has been proven effective for most people with your condition, network pharmacies will provide you the generic version.</b> We usually will not cover the brand name drug when a generic version is available. However, if your provider has</p>	<ul style="list-style-type: none"> <li>Imposing quantity limits on prescription drugs</li> </ul> <p><b>Restricting access to non-preferred brand name drugs when a preferred generic version is available</b></p> <p>Generally, a “generic” drug works the same as a brand name drug and usually costs less. <b>In most cases, when a generic version of a brand name drug is available and has been proven effective for most people with your condition, network pharmacies will provide you with the generic version.</b> We sometimes will not cover the brand name drug when a generic version is available. For coverage information, refer to the plan’s Preferred Drug List. However, if your provider has told us</p>	<p>Beginning October 1, 2025, for new and renewed covered prescriptions, dispensing of a preferred brand name drug may be required instead of dispensing a non-preferred generic drug.</p>

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<p><b>Section 7.7 Prescription drug copayments</b></p> <p>Page 133</p>	<p>told us the medical reason that the generic drug will not work for you <i>OR</i> has written “Brand Medically Necessary” on your prescription for a brand name drug <i>OR</i> has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then the plan will cover the brand name drug.</p> <p><b>A copayment may be required for each prescription</b></p> <p>You will be charged a copayment at the pharmacy for your covered prescription drugs unless the prescription category is exempted or you are in one of the member exempt categories, as described below (see</p>	<p>the medical reason that the generic drug will not work for you <i>OR</i> has written “Brand Medically Necessary” on your prescription for a brand name drug <i>OR</i> has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then the plan will cover the brand name drug.</p> <p><b>A copayment may be required for each prescription</b></p> <p>You will be charged a copayment at the pharmacy for your covered prescription drugs unless the prescription category is exempted or you are in one of the member exempt categories, as described below (see Members who are exempt from copayments).</p>	<p>Beginning October 20, 2025, you will be charged a \$4 copayment at the pharmacy for your covered prescription drugs unless the prescription category is exempted, or you are in one of the member exempt categories.</p>

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	<p>Members who are exempt from copayments).</p> <p>A “copayment” or “copay” is the fixed amount you may pay each time you fill and refill a prescription. Prescription drug copayment amounts are subject to change.</p> <p>For prescription drug copayment amounts refer to Section 4.2 (Benefits Chart, see Prescription drugs).</p>	<p>A “copayment” or “copay” is the fixed amount you may pay each time you fill and refill a prescription. Prescription drug copayment amounts are subject to change.</p> <p>For prescription drug copayment amounts refer to Section 4.2 (Benefits Chart, see Prescription drugs).</p> <p><b>When subject to Medicaid copayments and other out-of-pocket costs for covered services including prescription drugs</b>, you pay no more than five percent (5%) of your household income every quarter (January-March, April-June, etc.).</p> <p>For example: If your household earns \$6,000 each quarter:</p> <ul style="list-style-type: none"> <li>• 5% of that is \$300.</li> <li>• Once you have paid \$300 out-of-pocket in that quarter, you pay</li> </ul>	<p><b>If you are required to pay a Medicaid copayment or other out-of-pocket costs for covered services, keep track of your receipts.</b></p> <p>When you have met your 5% household income limit for the quarter, call the New Hampshire Medicaid Customer Service Center toll-free at <b>1-844-ASK-DHHS</b> (1-844-275-3447) (TDD Access Relay: 1-800-735-2964), Monday through Friday, 8:00 a.m. to 4:00 p.m. ET.</p> <p>For information on who is exempt from copayments, refer to Section 7.7 (Prescription drug copayments: Members</p>

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<p><b>Section 7.7 Prescription drug copayments</b></p> <p>Page 133</p>	<p><b>Members who are exempt from copayments</b></p> <p>NH DHHS determines whether you are exempt from prescription copayments.</p> <p>You do not have to pay a copayment if:</p> <ul style="list-style-type: none"> <li>You fall under the designated income</li> </ul>	<p>nothing for prescriptions until the next quarter.</p> <p><b>Keep track of your receipts.</b> If you find you have met your household income limit for the quarter, call the New Hampshire Medicaid Customer Service Center toll-free at <b>1-844-ASK-DHHS</b> (1-844-275-3447) (TDD Access Relay: 1-800-735-2964), Monday through Friday, 8:00 a.m. to 4:00 p.m. ET.</p> <p><b>Members who are exempt from copayments</b></p> <p>NH DHHS determines whether you are exempt from prescription copayments.</p> <p>You do not have to pay a copayment if:</p>	<p>who are exempt from copayments) below.</p> <p>Clarifies for conditions related to pregnancy, members are exempt from a prescription copayment up to 12 months after the month the pregnancy ended.</p>

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	<p>threshold (100% or below the federal poverty level);</p> <ul style="list-style-type: none"> <li>• You are under age 18 years;</li> <li>• You are in a nursing facility or in an intermediate care facility for individuals with intellectual disabilities;</li> <li>• You participate in one of the Home and Community Based Care (HCBC) waiver programs;</li> <li>• You are pregnant and receiving services related to your pregnancy or any other medical condition that might complicate your pregnancy;</li> <li>• You are receiving services for conditions related to your pregnancy and your prescription is filled or</li> </ul>	<ul style="list-style-type: none"> <li>• You fall under the designated income threshold (100% or below the federal poverty level);</li> <li>• You are under age 18 years;</li> <li>• You are in a nursing facility or in an intermediate care facility for individuals with intellectual disabilities;</li> <li>• You participate in one of the Home and Community Based Care (HCBC) waiver programs;</li> <li>• You are pregnant and receiving services related to your pregnancy or any other medical condition that might complicate your pregnancy;</li> <li>• You are receiving services for conditions related to your pregnancy and your prescription is filled or refilled within 12 months after the month your pregnancy ended;</li> </ul>	

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	<p>refilled within 60 days after the month your pregnancy ended;</p> <ul style="list-style-type: none"> <li>• You are in the Breast and Cervical Cancer Program;</li> <li>• You are receiving hospice care; or</li> <li>• You are a Native American or Alaskan Native.</li> </ul>	<ul style="list-style-type: none"> <li>• You are in the Breast and Cervical Cancer Program;</li> <li>• You are receiving hospice care; or</li> <li>• You are a Native American or Alaskan Native.</li> </ul>	