



WellSense Clarity plans Evidence of Coverage Employer Choice Direct

For Small Group members enrolled through
WellSense Platinum, Gold, Silver, Bronze



This health *plan* meets Minimum Creditable Coverage standards and will satisfy the individual mandate that you have health insurance. Please see page 3 for additional information.

WellSense Health Plan
529 Main Street Suite 500 Charlestown, MA 02129

Date of Issue and Effective Date: January 1, 2024
Form No. WS-EmpChoiceDirect2024ver.4

Important! This is about your WellSense Health Plan benefits. We can translate it for you free of charge. Please call **1-855-833-8120 (TTY: 711)** for translation help.

¡Importante! Esta información es sobre sus beneficios de WellSense Health Plan. Podemos traducirlo para usted de forma gratuita. Llame al **1-855-833-8120 (TTY: 711)** para obtener ayuda de traducción. (ESA)

Importante! Esta comunicação é sobre os benefícios da WellSense Health Plan. Podemos traduzir para você gratuitamente. Ligue para **1-855-833-8120 (TTY: 711)** para obter ajuda com a tradução. (PTB)

重要提示！此信息与您的 WellSense Health Plan 福利有关，我们可免费提供翻译。如需获得翻译服务，请拨打 **1-855-833-8120 (TTY: 711)**。(CHS)

Enpotan! Sa a se sou avantaj WellSense Health Plan ou an. Nou ka tradui li pou ou gratis. Tanpri relel **1-855-833-8120 (TTY: 711)** pou jwenn èd ak tradiksyon. (HRV)

Quan trọng! Đây là thông tin về quyền lợi trong WellSense Health Plan của quý vị. Chúng tôi có thể dịch thông tin này miễn phí cho quý vị. Vui lòng gọi số **1-855-833-8120 (TTY: 711)** để được trợ giúp dịch thuật. (VIT)

Важно! Здесь содержится информация о преимуществах вашего медицинского страхового плана WellSense Health Plan. Мы можем перевести для вас этот документ бесплатно. За помощью в переводе позвоните по телефону **1-855-833-8120 (TTY: 711)**. (RUS)

Σημαντικό! Πρόκειται για τις παροχές του WellSense Health Plan. Μπορούμε να σας το μεταφράσουμε δωρεάν. Καλέστε στο **1-855-833-8120 (TTY: 711)** για βοήθεια σχετικά με τη μετάφραση. (ELG)

هام! هذا حول مزايا WellSense Health Plan الخاصة بك. يمكننا ترجمتها لك مجاناً. يرجى الاتصال
بـ **1-855-833-8120 (TTY: 711)** للمساعدة في الترجمة. (ARA)

महत्वपूर्ण! यह आपके WellSense Health Plan लाभों के बारे में है। हम आपके लिए इसका निःशुल्क अनुवाद कर सकते हैं। कृपया अनुवाद संबंधित सहायता के लिए **1-855-833-8120 (TTY: 711)** पर फ़ोन करें। (HIN)

중요! 이것은 WellSense Health Plan 혜택에 대한 내용입니다. 무료로 번역해 드릴 수 있습니다. 번역 도움이 필요하면 **1-855-833-8120 (TTY: 711)**번으로 문의하십시오. (KOR)

ចំណុចសំខាន់! ព័ត៌មាននេះគឺ ស្តីអំពីអត្ថប្រយោជន៍នៃ WellSense Health Plan របស់អ្នក។ យើងអាចបកប្រែវាសម្រាប់អ្នកដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅលេខ **1-855-833-8120 (TTY: 711)** សម្រាប់ជំនួយផ្នែកបកប្រែ។ (KHM)

Ważne! To dotyczy Twoich świadczeń w ramach planu zdrowotnego WellSense Health Plan. Możemy nieodpłatnie przetłumaczyć dla Ciebie te informacje. Zadzwoń pod numer **1-855-833-8120 (TTY: 711)**, aby uzyskać pomoc w tłumaczeniu. (POL)

ສິ່ງສໍາຄັນ! ນີ້ແມ່ນກ່ຽວກັບຜົນປະໂຫຍດຂອງແຜນປະກັນ WellSense Health Plan ຂອງທ່ານ. ພວກເຮົາສາມາດແປພາສາໃຫ້ທ່ານໄດ້ໂດຍບໍ່ເສຍຄ່າ. ກະລຸນາໂທ **1-855-833-8120 (TTY: 711)** ເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາ. (LAO)

Important! This material can be requested in an accessible format by calling 1-855-833-8120 (TTY: 711).

Notice About Nondiscrimination and Accessibility

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

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

Please contact WellSense if you need any of the services listed above.

If you believe we have failed to provide these services or discriminated in another way on the basis of any of the identifiers listed above, you can file a grievance or request help to do so at:

Civil Rights Coordinator
529 Main Street, Suite 500
Charlestown, MA 02129
Phone: 855-833-8120 (TTY: 711)
Fax: 617-897-0805

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

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

Complaint Portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Printable complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

INTRODUCTION

Welcome to WellSense Health Plan.

WellSense Health Plan (“WellSense”) is a not-for-profit Massachusetts licensed health maintenance organization. We arrange for the provision of health care services to *members* through *contracts* with *network providers*. *Network providers* include doctors, other health care professionals, and hospitals. All *network providers* are located in our *service area*. As a *member*, you agree to receive all your health care (the some exceptions – such as *emergencies*) from *Network Providers* who are in the *provider network* shown on you Schedule of Benefits. When you become a *member*, you will need to choose a *Primary Care Provider (PCP)* to manage your care. Your *PCP* is a *network* doctor, physician assistant or nurse practitioner. Your *PCP* will provide you with primary care services. If the need arises, your *PCP* can arrange for you to receive care from other *network providers*.

WellSense Clarity plan Employer Choice Direct. WellSense offers WellSense Clarity *plan* Employer Choice Direct – referred to in this EOC as the “*plan*.” Group members meeting the *plan’s* eligibility requirements for Employer Choice Direct can enroll in our *plan*. In exchange for a *premium* that the group pays to WellSense, WellSense agrees to provide the coverage described in this EOC to enrolled *members* for the time period covered by the *premium*. By submitting a signed membership application, and/or by paying applicable *premium* contributions, *subscribers* agree (on behalf of themselves and their enrolled *dependents*) to all the terms of this EOC.

This Evidence of Coverage (EOC), which includes your Schedule of Benefits, is an important legal document. It describes the relationship between you and WellSense. It also describes your rights and obligations as a *member*. It tells you how the *plan* works; describes *covered services*, *non-covered services*, and certain *benefit limits* and conditions; and tells you what *cost-sharing* you must pay for *covered services*. It also describes other important information. We hope you will read this EOC and save it for future use. The Table of Contents will help you find what you need to know.

Definitions: Italicized words in this EOC have meanings that are explained in the Definitions section (Appendix A) located toward the end of the EOC. If you need any help understanding this EOC, please contact us. We’re here to help!

MINIMUM CREDITABLE COVERAGE AND MANDATORY HEALTH INSURANCE REQUIREMENTS

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or *individual* hardship. For more information call the Health Connector at 1-877-MA-ENROLL or visit the Health Connector website (mahealthconnector.org).

Minimum Creditable Coverage Standards. This health plan **meets applicable Minimum Creditable Coverage standards** that are effective as of January 1, 2022 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you **will satisfy** the statutory requirement that you have health insurance meeting these standards.

THIS DISCLOSURE IS FOR MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE JANUARY 1, 2022. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIAL EACH YEAR TO DETERMINE WHETHER YOUR PLAN MEETS THE LATEST STANDARDS.

If you have questions about this notice, you may: contact the Division of Insurance by calling 617-521-7794; or visit its website at [mass.gov/doi](https://www.mass.gov/doi). -

ADDRESS AND TELEPHONE DIRECTORY

Member Services Department: 855-833-8120 (toll-free) Monday – Friday 8 a.m. – 6 p.m.

We're Here to Help: The Member Services Department is available to help answer your questions. We strive to provide excellent service. Calls to Member Services may be monitored to ensure quality service. We can help with:

- How the *plan* works.
- Selecting a *Primary Care Provider (PCP)*.
- Benefits.
- Enrollment, eligibility and claims.
- *Network Provider* information.
- ID cards, registering a concern, billing and change of address notification.
- Member Satisfaction Process (grievances or *appeals*).
- **Utilization Review Information:** Call Member Services if you want to find out the status of a utilization review (*medical necessity* review) decision.
- **Members with total or partial hearing loss:** You may communicate with Member Services by calling our TTY machine at 711.
- **Non-English Speaking Members:** A free language translation service is available to *members* upon request. This service helps with questions about *plan* administrative procedures. This service provides you with access to interpreters who can translate over 200 languages. Call Member Services.

Nurse Advice Line: 866-763-4695 (24 hours and toll free). All Calls are Confidential.

Members can call and speak to a nurse over the phone to get answers to health related questions. Call any day at any time. A registered nurse will help you. After you explain your symptoms, the nurse may: give you advice about caring for yourself at home; suggest you go to an emergency room; or call your doctor.

To Obtain Emergency Medical Care: In an *emergency*, seek care at the nearest emergency facility. If needed, call 911 for emergency medical assistance. (If 911 services are not available in your area, call the local number for emergency medical services.)

To Obtain Routine or Urgent Medical Care: For routine and *urgent care* inside the *service area*, always call your *PCP*.

To Obtain Mental Health and Substance Use Disorder Services: The *plan* contracts with Carelon Behavioral Health, (Carelon), to manage all mental health and substance use disorder services. If you need these services, you may do any of the following:

- Call the toll-free 24-hour mental health/substance use disorder telephone line – staffed by Carelon – at 877-957-5600 for help finding a *network provider*.
- Go directly to a *network provider* who provides mental health or substance use disorder services.
- Call your *PCP*.
- Visit Carelon's website ([carelonbehavioralhealth.com](https://www.carelonbehavioralhealth.com)); or follow the link on the *plan's* website ([wellsense.org](https://www.wellsense.org)) to look up *network providers*.

To Obtain Durable Medical Equipment, Prosthetics, Orthotics or Medical Supplies (Including Medical Formulas and Low Protein Food): The *plan* contracts with Northwood, Inc. to manage most of these services. Some equipment and supplies are still managed by the *plan*. If you need these services, you may do any of the following:

- Contact our Member Services Department at 855-833-8120.
- Call your *PCP* for help finding a *network provider*.
- Visit our website ([wellsense.org](https://www.wellsense.org)) to look up *network providers*.

To Obtain Pharmacy Services: The *plan* contracts with Express Scripts. This is the *plan's* pharmacy benefits manager. Express Scripts manages your *prescription drug* benefit. If you need help with this benefit, such as information about covered drugs or *network pharmacies*, you may do any of the following:

- Contact Member Services at 855-833-8120 or visit our website (wellsense.org)
- Contact Express Scripts:
PO Box 14718
Lexington, KY 40512-4718
- Customer Service Hours of Operation: Available 24 hours, 7 days a week.

To Obtain Mail Order Drugs: The *plan* contracts with Cornerstone Health Solutions for mail order drug services. Only certain maintenance drugs are available through mail order. To use the mail order service you must first enroll with Cornerstone Health Solutions. To enroll in this service and begin getting medications in the mail you must either contact Cornerstone Health Solutions by phone at 844-319-7588 or complete the mail order enrollment form that was included in your *member* welcome packet and is also available on the Cornerstone Health Solutions website. Your prescribing provider may also call Cornerstone Health Solutions at 844-319-7588 or fax your prescription to them at 781-805-8221. Once you have enrolled, you can refill prescriptions by mail, phone, or online at cornerstonehealthsolutions.org/chs-mail-order-pharmacy.

To Report suspected fraud: Contact the WellSense Compliance Hotline, which is available 24 hours a day, 7 days a week:

- Fax: 866-750-0947
- Phone: 888-411-4959
- Email: FraudandAbuse@wellsense.org

WellSense Website: wellsense.org

WellSense Address: WellSense Corporate Headquarters:

WellSense Health Plan, Inc.
529 Main Street
Suite 500
Charlestown, MA 02129
855-833-8120

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CHAPTER 1. SCHEDULE OF BENEFITS AND COST-SHARING INFORMATION

Schedules of Benefits:

When you enroll in the *plan* you receive a **Schedule of Benefits** and this EOC document. The Schedule of Benefits for your selected benefit package is an important document. It contains a summary of *covered services* and any related *benefit limits*; and it tells you the amount of your **cost-sharing** (*deductibles, copayments* and *coinsurance*) and *out-of-pocket maximums*. **Make sure to keep your Schedule of Benefits with this EOC.** And please be sure to read about **all your benefits** in detail in Chapter 3 of this EOC, including non-covered services (exclusions).

Cost-Sharing Information:

You may be required to share the costs of many *covered services*. See your Schedule of Benefits for the *cost-sharing* that applies to the benefit package in which you are enrolled. *Cost-sharing* may include one or more of the following:

Deductible:

Your benefit package **may** have an annual *deductible*. The *deductible* is the amount you pay for certain *covered services* in a *benefit year* before the *plan* is obligated to pay for those *covered services*. Once you meet your *deductible*, you pay either: nothing, or the applicable *copayment* or *coinsurance* for those *covered services* for the remainder of the *benefit year*. See your Schedule of Benefits.

Individual Deductible: The amount an individual *member* pays for certain *covered services* before any payments are made by the *plan* for those services.

Family Deductible:

- The family deductible applies to all *members* of a family.
- All amounts any *member* in a family pays toward his/her individual deductibles are applied toward the family deductible. However, the most an individual can contribute toward the family deductible per benefit year is equal to the individual deductible amount.*
- Once the family deductible has been met during a benefit year, all members in a family will thereafter have satisfied their individual deductibles for the remainder of that benefit year.

*If your benefit package is a Health Savings Account (HSA)-compatible *plan*, and you select family coverage, there is no individual *deductible*. In such case, no benefits are payable for any enrolled individual family member until the family *deductible* has been satisfied. See your Schedule of Benefits for more information.

Notes:

- The following are not included in the *deductible*: *copayments; coinsurance; prescription drug (Rx) deductibles* (if applicable); *premiums*; member costs that are more than the plan's allowed amount paid to non-network providers; and any payments you make for non-covered services.
- Payments you made for *covered services* received prior to the start of a *benefit year* are not counted toward your deductible in the current *benefit year*. At the start of each new *benefit year*, your *deductible* accumulation will begin at zero and you will start accumulating again toward your *deductible* for the new *benefit year*.
- In most cases, the amount credited toward a member's *deductible* is based on the plan's allowed amount on the date of service. In some cases involving certain covered services provided to you by certain non-network providers, your *deductible* is calculated based on applicable state law, if any, or under applicable federal law. See Appendix A: Definitions for further information on allowed amounts.
- Some benefit packages may have a separate prescription drug (Rx) *deductible*. See next paragraph.

Prescription Drug (Rx) Deductible:

Your benefit package may have a separate *deductible* for certain *prescription drugs*. This is called an Rx *deductible*. This is the amount you pay for certain covered *prescription drugs* in a benefit year before the plan is obligated to pay

for those covered drugs. Once you meet your Rx *deductible*, you pay only the applicable *copayment* or *coinsurance* for those drugs for the remainder of the *benefit year*. See your Schedule of Benefits.

Individual Rx Deductible: The amount an individual *member* pays for certain covered *prescription drugs* before any payments are made by the plan for those drugs.

Family Rx Deductible:

- The family Rx *deductible* applies to all members of a family.
- All amounts any *member* in a family pays toward his/her individual Rx *deductible* are applied toward the family Rx *deductible*. However, the most an individual can contribute toward the **Rx deductible** per *benefit year* is equal to the individual Rx *deductible* amount.
- Once the family Rx deductible has been met during a benefit year, all members in a family will thereafter have satisfied their individual Rx deductibles for the remainder of that *benefit year*.

Notes:

- Payments you made for covered prescription drugs received prior to the start of a *benefit year* are not counted toward your Rx *deductible* in the current *benefit year*. At the start of each new *benefit year*, your Rx *deductible* accumulation will begin at zero and you will start building again toward your Rx *deductible* for the new *benefit year*.
- In most cases, the amount credited toward a *member's* Rx *deductible* is based on the *plan's* allowed amount on the date of service. In some cases involving non-network pharmacies, your Rx *deductible* may be calculated based on applicable state law, if any, or under applicable federal law. See Appendix A: Definitions for further information on *allowed amounts*.

Copayment:

A fixed amount you must pay for certain covered services. *Copayments* are paid directly to the provider at the time you receive care (unless the provider arranges otherwise).

Note: *Copayments* you paid for covered services received prior to the start of a *benefit year* are not counted toward your *out-of-pocket maximum* for your current *benefit year*. At the start of each new *benefit year*, your accumulation will begin at zero and you will start building again toward your annual *out-of-pocket maximum* for the new *benefit year*.

Coinsurance:

An amount you must pay for certain covered services – stated as a percentage. In most cases, you pay the applicable percentage of the *plan's* allowed amount on the date of service. In some cases involving certain covered services provided to you by certain non-network providers, your *coinsurance* may be calculated based on applicable state law, if any, or under applicable federal law. See Appendix A: Definitions for further information on allowed amounts.

Note: *Coinsurance* you paid for covered services received prior to the start of a *benefit year* is not counted toward your *out-of-pocket maximum* for your current *benefit year*. At the start of each new *benefit year*, your accumulation will begin at zero and you will start building again toward your annual *out-of-pocket maximum* for the new *benefit year*.

Out-of-Pocket Maximum:

Your benefit package **may** have an *out-of-pocket maximum*. This is the maximum amount of cost-sharing you are required to pay in a *benefit year* for most covered services.

The *out-of-pocket maximum* consists of all*: *deductibles*, *copayments* and *coinsurance*. **However, it does not include*:**

- *premiums*;
- *member costs* that are more than the allowed amount for covered services paid by the *plan* to non-network providers; and
- costs for non-covered services.

Once you meet your *out-of-pocket maximum*, you no longer pay *deductibles*, *copayments* or *coinsurance* for the rest of that *benefit year**.

Individual Out-of-Pocket Maximum: The maximum amount of *cost-sharing* an individual is required to pay in a *benefit year* for most covered services.

Family Out-of-Pocket Maximum:

- All amounts any *members* in a family pay toward their *individual* (or self only) *out-of-pocket maximum* are applied toward the family *out-of-pocket maximum*. However, the most an individual can contribute toward the family *out-of-pocket maximum* per *benefit year* is equal to the individual (or self only) *out-of-pocket maximum* amount.
- Once the family *out-of-pocket maximum* has been met during the *benefit year*, all family *members* will thereafter have satisfied their individual *out-of-pocket maximum* for the remainder of that *benefit year*.

*If your benefit package is a Health Savings Account (HSA)-compatible *plan*, and you select family coverage, there is no *individual Out-Of-Pocket Maximum*.

Please note:

- *Deductibles, copayments* and *coinsurance* you paid prior to the start of a *benefit year* are not counted toward your *out-of-pocket maximum* for your current *benefit year*. At the start of each new *benefit year*, your accumulation will begin at zero and you will start building again toward your annual *out-of-pocket maximum* for the new *benefit year*.

Prescription Drug Out-of-Pocket Maximum (“Rx Out-of-Pocket Maximum”):

Your benefit package **may** have an Rx *out-of-pocket maximum*. If so, this is the maximum amount of *cost-sharing* you are required to pay in a *benefit year* for covered prescription drugs.

The Rx *out-of-pocket maximum* consists of: Rx *deductibles**, Rx *copayments* and Rx *coinsurance*. **However, it does not include:**

- *member* costs that are more than the allowed amount for covered *prescription drugs* paid by the *plan* to non-network pharmacy providers; and
- costs for non-covered *prescription drugs*.

Once you meet your Rx *out-of-pocket maximum*, you no longer pay any Rx *deductible*, Rx *copayments* or Rx *coinsurance* for the rest of that *benefit year**.

*Note: Unless your Schedule of Benefits states otherwise.

Your benefit package **may** contain just an *individual Rx out-of-pocket maximum*, or both an *individual* and family Rx *out-of-pocket maximum*:

- *Individual Rx Out-of-Pocket Maximum:* The maximum amount of *cost-sharing* an *individual* is required to pay in a *benefit year* for covered prescription drugs.
- *Family Rx Out-of-Pocket Maximum:*
 - All amounts any *members* in a family pay toward their *individual Rx out-of-pocket maximum* are applied toward the family Rx *out-of-pocket maximum*. However, the most an *individual* can contribute toward the family Rx *out-of-pocket maximum* per *benefit year* is equal to the *individual Rx out-of-pocket maximum* amount.
 - Once the family Rx *out-of-pocket maximum* has been met during the *benefit year*, all family *members* will thereafter have satisfied their *individual Rx out-of-pocket maximum* for the remainder of that *benefit year*.

Benefit Year:

The *benefit year* is the consecutive 12 month period during which: benefits are purchased and administered; *deductibles, coinsurance* and the *out-of-pocket maximums* are calculated; and most *benefit limits* apply.

Note: In some cases, described below, your first *benefit year* will not be a full 12 months.

For *subscribers* enrolled through a *group contract*: Your *benefit year* begins on the group effective date (always the first of a calendar month) and continues for 12 months from that date. (For example, if the group effective date is April 1, your *benefit year* runs from April 1 to March 31.) The *benefit year* then renews thereafter for 12 month periods. (If you were a new employee who became a *subscriber* after the group effective date, your *benefit year* is the same as the *benefit year* for all *subscribers* in your group. That means that your first *benefit year* will not be a full 12 months.)

For new *dependents* that are added during a *benefit year* (for example, a new baby or new spouse): the new *dependent's benefit year* begins on his or her coverage effective date and runs for the same time period as the *subscriber's benefit year*.

Benefit Limits:

For certain *covered services*, day, visit or dollar benefit maximums may apply. Your Schedule of Benefits describes *benefit limits*. Once the amount of the benefits you have received reaches the *benefit limit* for the specific covered service, no more benefits will be provided for that service for the remainder of the *benefit year* (or other designated time period). If you receive more services beyond the *benefit limit*, you must pay the full amount for those services.

For More Information:

To obtain information about the estimated or maximum *allowed amount* for a proposed (*medically necessary*) *covered service* (such as a proposed hospital admission) and the estimated amount of your *cost-sharing* for that proposed *covered service*, you can call Member Services toll-free at 855-833-8120. You can also make a request for this information on our website: [wellsense.org](https://www.wellsense.org).

Based on the information available to us at the time of your request, we will tell you the estimated allowed amounts and your estimated *cost-sharing*. Any estimates we give you do not guarantee coverage. Coverage is based on meeting all the applicable rules in this EOC. (For example, you must be a *member* of the *plan* on the date the service is given to you.) There is no coverage for non-*covered services*.

Note: Additional *cost-sharing*, as set forth in your Schedule of Benefits, may apply for unforeseen *covered services* given to you during the provision of the proposed *covered service*.

CHAPTER 2. HOW THE PLAN WORKS

Benefit Packages: WellSense Clarity *plan* Employer Choice Direct (the “*plan*”) has different benefit packages. Benefit packages differ in *premium* and in *cost-sharing*. They may also differ in the provider *network* available to you. **The specific covered services, provider network, deductibles, copayments, coinsurance, and out-of-pocket maximums for your benefit package are listed in your Schedule of Benefits.**

Choose a Primary Care Provider (PCP):

When you enroll in the *plan*, you must choose a primary care provider, known as a *PCP*. You may choose any *PCP* who is in our *network* and who is available to accept you. A *PCP* may be a doctor of internal medicine, family practice, general practice or pediatric medicine; or may be a physician assistant or nurse practitioner. Each *member* of a family may choose a different *PCP*. *Network* pediatricians can be chosen as a *PCP* for a child. (This is a *PCP* who specializes in treating children.) Female *members* may select a designated *network* obstetrician/gynecologist (OB/GYN) as their *PCP*. *PCPs* provide routine and preventive health care. They also can arrange and coordinate your care with other *network providers*. *PCPs* or their covering providers are available 24 hours a day. Select a *PCP* by writing the *PCP*’s name on your enrollment application or calling Member Services. You must obtain all primary care from your designated *PCP*.

Assignment of PCP for members enrolled in certain benefit packages:

If you do not select a *PCP* within 15 days of your *coverage effective date*, the *plan* will assign an appropriate *PCP* to you. This assignment is based on your zip code and may also be based, in our judgment, on other relevant information we get from you and from other records. If you are assigned a *PCP*, we will tell you the *PCP*’s name and offer to help you schedule an appointment with the *PCP*. You must obtain all primary care from your assigned *PCP*. If you wish to change your assigned *PCP*, see “Changing Your *PCP*,” below.

PCPs are listed in the plan’s Provider Directory.

You can search all providers in your *provider network* by going to our website at wellsense.org. (Simply click on the “Find a Provider” link.) Make sure to look up a *PCP* in the *provider network* that is listed on your Schedule of Benefits. You can also call Member Services at 855-833-8120 and we will provide you with a list of providers in your area. The most up-to-date version of the *Provider Directory* is on our website: wellsense.org. For help selecting a *PCP*, call Member Services.

Visit Your PCP:

After enrolling, if you have not met your *PCP*, we recommend that you call your *PCP*. Introduce yourself as a new *plan member* and schedule an appointment. You should also ask your previous doctor to send your medical records to your new *PCP*. (Note: your previous doctor may charge you for copies.)

Changing Your PCP:

You may change your *PCP* at any time, but no more than three times (if it is a voluntary change) in a *benefit year*. To change your *PCP*, select a new one from the *Provider Directory*. Then call Member Services. Tell Member Services that you want to change your *PCP* and obtain approval of the change. (If you do not obtain our approval, care you receive from the new *PCP* may not be covered.) *PCP* changes are effective the next working day. (Under certain circumstances, the change can be effective on the same day or on a later date.)

In certain cases, the *plan* will require you to change your *PCP*. If this happens, you must choose a new *PCP* by calling Member Services. This can happen if your *PCP* is no longer a *Network Provider* in your *provider network*. In this case, the *plan* will notify you in writing. We will do our best to give you notice at least 30 days before your *PCP* leaves the *provider network*. In some cases you may receive continued coverage of services from your prior *PCP* for at least 30 days after your *PCP* leaves the *provider network*. (See “Continuity of Care for Existing Members” later in this Chapter.)

Your PCP Provides and Arranges for Health Care:

- Whenever you need care, you should first call your *PCP* – except in an *emergency*.

- Your *PCP* will provide you with preventive care and primary care when you are sick or injured.
- Your *PCP* can arrange for you to see other *Network Providers* (for example, *network* specialists) for other types of care. Your *PCP* knows other *Network Providers* and is an excellent person to help you choose other *Network Providers* who can provide specialty services. Call your *PCP* for advice.
- Even if you go on your own (self-refer) to a *network* specialist for specialty care, we strongly recommend that you keep your *PCP* informed about self-referred care. This allows your *PCP* to have a full understanding of your medical needs and services. This helps to maintain the quality of your care.

When You Need Specialty Care:

If you think you need specialty care, we encourage you to first call your *PCP*. Your *PCP* can tell you whether you need specialty care and can refer you to an appropriate *network* specialist. Or, you can self-refer by going to a *network* specialist on your own. But see the next paragraph about prior authorization requirements.

Care from Non-Network Providers:

The *plan* does not cover care you receive from non-*network providers*, except:

- in an *emergency* (see “*Emergency Services*,” below);
- for *urgent care* when you are outside the *service area* (see “*Coverage for Urgent Care When You are Outside the Service Area*,” below);
- in the event you receive *covered services* from a non-*network provider* (such as an anesthesiologist or radiologist) in a *network* hospital or other *network* facility, under certain circumstances the *plan* will pay for these *covered services* as if they had been provided by a *network provider* in accordance with state and federal law. Please contact Member Services if you have any questions after receiving a provider bill in this situation.
- certain specific continuity of care situations (see “*Continuity of Care*,” below); and
- in rare cases when no *network provider* has the professional expertise needed to provide the required service. In such case, your *PCP* or the *plan* may arrange for you to see a non-*network provider*. Your *PCP* must first get prior authorization from a *plan* authorized reviewer. (If you are authorized to see a non-*network provider*, your applicable *cost-sharing* does not change.) The *plan* authorized reviewer considers several important factors when evaluating a request to authorize care at a non-*network provider*. These include: your specific medical needs; the *medical necessity* of the requested *covered service* or provider; cost-effectiveness of the non-*network* options; quality; and access.

Plan Help Finding Network Providers:

You may request assistance from the *plan* if you or your *PCP* has difficulty identifying *network providers* who can provide you with *medically necessary* services. If you ask us, we will identify and confirm the availability of these services directly. If *medically necessary* services are not available from *network providers*, we will arrange for non-*network providers* to provide these services to you.

If You Can’t Reach Your PCP:

Your *PCP* or covering provider is available to provide and arrange for care 24 hours a day. If your *PCP* cannot take your call right away, always leave a message with the office staff or answering service. Except in an *emergency*, wait a reasonable amount of time for someone to call you back. If you are unable to reach your *PCP* or the covering provider, call Member Services during regular business hours. You do not have to call your *PCP* before seeking *emergency* care. See “*Emergency Services*” later in this Chapter.

Canceling Provider Appointments:

Sometimes you may need to cancel an appointment with your *PCP* or any provider. Always do so as far in advance of your appointment as possible. Providers may charge you for missed appointments. The *plan* does not pay for any missed appointment charges.

No Waiting Period or Pre-Existing Condition Limitations:

There are no waiting periods or pre-existing condition limitations in the *plan*. All *covered services* are available to you as of your coverage effective date, unless you are an inpatient on your coverage effective date and you have not notified

the *plan* that you are an inpatient.

The Provider Network:

Service Area: The *service area* is the geographical area in which *network providers* are located. Please visit the *plan's* website at wellsense.org for a description of the cities and towns in the *plan's service area*.

Your Provider Network: As a *member*, you must get all your care from providers who are in **the provider network named in your Schedule of Benefits**. (Exceptions apply – see “Care from Non-Network Providers” above.) WellSense maintains several *provider networks*. Therefore, when using the provider search tool on our website (see next paragraph) or when requesting a paper copy of the *plan's* Provider Directory, please be sure to check the correct *provider network* for the benefit package in which you are enrolled.

Provider Directory: The Provider Directory lists our *Network Providers*. These include *PCPs*, physician specialists, other health care professionals and hospitals. The provider directory is available on our website at wellsense.org. A free paper copy of the Provider Directory is available by calling Member Services at 1-855-833-8120. Since it is frequently updated, the online directory is more current than a paper directory. You may also call Member Services for information about *Network Providers*.

Physician Profiling Information: Information about licensed physicians (such as: physician qualifications, malpractice history, medical school and residency information) is available. Contact the Commonwealth of Massachusetts Board of Registration in Medicine at findmydoctor.mass.gov.

Changes to Provider Network: Sometimes, providers in your *provider network* may change during the year. Changes can occur for a number of reasons: a provider may move outside of the *service area*; retire; or fail to continue to meet our credentialing or other *contract* requirements. Also, WellSense and the provider might not reach agreement on a *contract*. This means that we cannot guarantee that any particular provider will continue to be a *Network Provider* during the entire time you are a *member*. If your *PCP* leaves the *network*, we will make every effort to notify you at least 30 days in advance. Member Services can help you select a new *PCP*.

Financial Compensation to Network Providers: WellSense enters into *contracts* with *Network Providers* that may contain a variety of mutually-agreed upon methods of compensation. The Provider Directory indicates the method of payment for *Network Providers*. Our goal in compensating *Network Providers* is to encourage and reward *Network Providers* to provide: preventive care in accordance with generally accepted guidelines; quality management of illness; and appropriate access to care. Regardless of how we pay *Network Providers*, we expect them to: use sound medical judgment when providing and arranging for care; provide only medically necessary care; and avoid unnecessary medical care that could be harmful and costly.

Nurse Practitioners and Certified Registered Nurse Anesthetists: The *plan* provides coverage on a non-discriminatory basis for *covered services* provided by a *network*: nurse practitioner; or a certified registered nurse anesthetist. This means the *plan* provides you with the same coverage whether the service was given to you by a *network* nurse practitioner or by another *Network Provider*. The *covered services* provided by these providers must be within the lawful scope of their license and/or authorization to practice.

Emergency Services:

What to Do in an Emergency: You are always covered for care in an *emergency*. You do not need prior authorization or a referral from your *PCP*. (This includes *emergency* mental health or substance use disorder services). In an *emergency*, whether you are inside or outside the *service area*: go to the nearest *emergency* facility; or call 911 or other local *emergency* number. The *plan* will not discourage you from using the local pre-hospital *emergency* medical services system, 911, or other local *emergency* number. No *member* will be denied coverage for medical and transportation expenses incurred as a result of an *emergency*.

Cost-Sharing:

- *Cost-sharing* will apply: for *emergency* care you get in an *emergency* room; or for observation services in a hospital setting without use of the *emergency* room. Please see your Schedule of Benefits for applicable *cost-sharing*.
- *Cost-sharing* applies even if you go to an *emergency* room for non-*emergency* care.
- *Copayments* for *emergency* services are waived if you are admitted as an inpatient immediately following receipt of *emergency* services in an *emergency* room. However, any applicable *cost-sharing* for inpatient hospital care will apply to your inpatient stay.
- If you get *emergency covered services* from a non-*network* hospital *emergency* room, the *plan* will pay up to the allowed amount. You pay applicable *cost-sharing*.

Emergency Defined: An *emergency* means a medical condition, whether physical, behavioral, related to substance use disorder, or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that, in the absence of prompt medical attention, could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing the health of a *member* or another person, or, in the case of a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any body organ or part; or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B).

Examples of Emergencies: heart attack or suspected heart attack; stroke; shock; major blood loss; choking; severe head trauma; loss of consciousness; seizures; and convulsions.

Notice Following Emergency Care:

- If you receive *emergency* care at an *emergency* facility (whether in or out of the *service area*), but are not admitted to the hospital, you or someone acting on your behalf should call your *PCP* after receiving care. This helps your *PCP* to provide or arrange for any follow up care.
- If you receive *emergency* care at an *emergency* facility (whether in or out of the *service area*) AND you are admitted as an inpatient (hospitalized) to a non-*network* facility, you or someone acting on your behalf MUST call the *plan* within 2 working days of your admission. This is essential so that the *plan* can: manage and coordinate your care; and arrange for any medically appropriate transfer. (Note: notice by the provider of *emergency* services to your *PCP*, the *plan* or, in the case of *emergency* mental health or substance use disorder services, to Carelon, satisfies this notice requirement.)

Transfer: If you receive *emergency* care from a non-*Network Provider* (inside or out of the *service area*): continued services with that provider after the *emergency* condition has been treated and stabilized may not be covered if the *plan* determines, in coordination with your providers, that it is safe, appropriate and cost-effective for you to be transported to a *network* facility and you choose not to go to the *network* facility.

Coverage for Care When You Are Outside the Service Area:

- If you are outside the *service area* and you get hurt or sick, the *plan* will pay for *medically necessary covered services for urgent care* that you receive from non-*network providers*. (Please see “*Emergency Services*”, above, for coverage of *emergency* care when you are outside the *service area*.)
- We recommend that you call your *PCP* for guidance, when appropriate, prior to seeking *urgent care* -but you are not required to do so.
- You should seek *urgent care* at the nearest and most appropriate health care provider.
- Applicable *member cost-sharing* amounts apply.
- *Urgent care* is *medically necessary* care that is required to prevent serious deterioration of your health when you have an unforeseen illness or injury. Examples: care for broken bones or a high fever.

The *plan* will **not** cover the following types of care when you outside the *service area*:

- Care you could have foreseen the need for before leaving the *service area*. This includes care for chronic medical conditions requiring ongoing medical treatment.
- Routine care or preventive care.
- Elective *inpatient* admissions, *outpatient surgery* or other *covered services* that can be safely delayed until you are in the *service area*.

- Follow-up care that can wait until your return to the *service area*.
- Routine maternity services for prenatal or postpartum care; or delivery (including postpartum care and care provided to the newborn) or problems with pregnancy beyond the 37th week of pregnancy or any time after you have been told by your provider that you are at risk for early delivery.

Cost-Sharing:

- *Cost-sharing* (such as *deductibles* and *copayments*) will apply for *urgent care*. Please see your Schedule of Benefits for applicable *cost-sharing*.
- If you get *urgent care* from a non-*network provider*, the *plan* will pay up to the *allowed amount*. You pay applicable *cost-sharing* and, in some cases, any difference between the provider's charge and our payment.

Inpatient Hospital Care:

Inpatient Hospital Services: Except in an *emergency*, always call your *PCP* first before going to a hospital.

- If you need hospital care, your *PCP* will arrange for you to go to a *network* hospital.
- In rare instances when the hospital services you need are not available from any *network* hospital, your *PCP* may arrange for you to go to a non-*network* hospital. In such case your *PCP* must obtain prior authorization from a *plan* authorized reviewer.

Charges after the Discharge Hour: If you choose to stay as an inpatient after a physician has scheduled your discharge or determined that further *inpatient* services are no longer *medically necessary*, the *plan* will not pay for any costs incurred after that time.

Continuity of Care:

Continuity of Care for Existing Members:

- *Disenrollment of PCP.* If you are a *member* whose *PCP* leaves the *network*, we will use our best efforts to provide you with written notice at least 30 days prior to the date your *PCP* leaves. That notice will tell you how to choose a new *PCP*. Unless your *PCP* was disenrolled due to fraud or quality of care concerns, we will continue to pay for *covered services* from the disenrolled *PCP*, under the terms of this EOC, for at least 30 days after the disenrollment date.
- *Disenrollment of PCP, Specialist or Other Provider:* If you are a *member* whose *PCP*, specialist or other provider leaves the *network* (for reasons other than fraud or quality of care) and you are (1) undergoing active treatment for a serious and complex chronic or acute illness or condition with that provider, (2) undergoing a course of institutional or inpatient care with that provider, or (3) scheduled to undergo nonelective surgery from that provider (including postoperative care from such provider with respect to such surgery), we will cover continued treatment of such care with the *PCP*, treating specialist or provider through the current period of active treatment or care, or for up to 90 calendar days (whichever is shorter).
- *Pregnancy.* If you are a *member* who is pregnant and the *Network Provider* you are seeing in connection with your pregnancy is disenrolled from the *plan* (for reasons other than fraud or quality of care): you may continue to receive coverage for *covered services* for your pregnancy provided by that provider, under the terms of this EOC, for up to 90 calendar days or through your first postpartum visit (whichever is later).
- *Terminal Illness.* If you are a *member* with a terminal illness (having a life expectancy of 6 months or less) and the *Network Provider* you are seeing in connection with your illness is disenrolled from the *plan* (for reasons other than fraud or quality of care): you may continue to receive coverage for *covered services* provided by that provider, under the terms of this EOC, until death.

Electing Continuity of Care: To arrange for the continuity of care coverage described above, call Member Services.

Continuity of Care for New Members: If you are a new *member*, the *plan* will provide coverage for *covered services* provided by your existing non-*network* physician, non-*network* physician assistant or non-*network* nurse practitioner, under the terms of this EOC, as follows:

- For up to 30 days from your coverage effective date if:
 - No other health *plan* options offered by your group include this physician, physician assistant or nurse

- practitioner; and
 - This physician, physician assistant or nurse practitioner is providing you with an ongoing course of treatment or is your primary care provider.
- Through your first postpartum visit, if you are a new *member* in her second or third trimester of pregnancy.
- Until death, if you are a new *member* with a terminal illness (having a life expectancy of 6 months or less).

Conditions for Coverage of Continuity of Care as Described in this Section: Services provided by a disenrolled provider or non-*Network Provider* as described in this “Continuity of Care” section are covered only when: the *member* or provider obtains prior approval from the *plan* for the continued services; the services would otherwise be covered services under this EOC; and the provider agrees to:

- accept payment from the *plan* at the rates we pay *Network Providers*, or as otherwise required by state or federal law;
- accept such payment as payment in full and not charge you any more than you would have paid in *cost-sharing* if the provider was a *Network Provider*;
- comply with the *plan*’s quality standards;
- provide the *plan* with necessary medical information related to the care provided; and
- comply with the *plan*’s policies and procedures: these include procedures regarding obtaining prior authorization, and providing *covered services* pursuant to a treatment *plan* if any, approved by the *plan*.

Concierge Services:

There may be some *network providers* who charge extra fees for special services or amenities. These may include: assistance with transportation to medical appointments; guaranteed non-*medically necessary* same day or next day appointments; and going with *members* to specialist visits. These special services are not *covered services* under the *plan*. The *plan* does not cover fees for such services. It is your choice whether to purchase and pay for these special services directly from your provider.

Member Identification (ID) Cards:

We will give each *member* an ID card. When you receive it, please look at it carefully. If any information is wrong, please call Member Services. Your *member* ID card is important. It identifies your membership in the *plan*. You should carry it with you at all times. Always show your ID card to any provider before you receive services. If your card is lost or stolen, call Member Services for a new card. An ID card in itself is not enough to entitle you to *plan* benefits. To be entitled to *plan* benefits, you must be a properly enrolled *member* at the time you receive health care services.

CHAPTER 3. COVERED SERVICES

Introduction: This Chapter describes:

- *covered services*;
- what is not covered (exclusions); and
- certain limits or conditions on coverage.

Cost Sharing:

See your Schedule of Benefits for information about: *deductibles*; *copayments*; *coinsurance*; and *out-of-pocket maximums*.

Note: *Providers* may refuse to provide *covered services* if you do not pay required *cost-sharing*.

Prior Authorization from Plan Authorized Reviewer:

There are certain *covered services* – both *inpatient* and *outpatient* – that must be authorized (approved) in advance by a *plan authorized reviewer*. These requirements are known as “prior authorization.” Your *network provider* will request *prior authorization* from the *plan* on your behalf. The *plan* authorized reviewer will: review your request within legally set timeframes; and determine if the proposed service should be covered as *medically necessary* for you. The *plan* will then tell your provider and you if coverage for a proposed service has been approved or denied. To check on the status of a request or the outcome of a *prior authorization* decision: call your provider; or call the *plan* at 855-833-8120.

You should always check with your provider before you obtain services or supplies. Make sure he or she has obtained any required *prior authorization*.

If coverage for a service is denied as not *medically necessary*, your provider may discuss your case with a *plan* authorized reviewer. He or she may also seek reconsideration from the *plan*. If the denial is not reversed, you have *Appeal* rights. See Chapter 6. (Your right to *Appeal* does not depend on whether your provider sought reconsideration.)

Examples of covered services requiring prior authorization from the plan:

- High-tech imaging: for example, CT/CTA, MRI/MRA, PET, and NCI/NPI (nuclear cardiac imaging).
- Musculoskeletal (Spine, Joint, Interventional Pain).
- Genetic Testing (Lab Management).
- Covered non-*emergency* transportation. (See Ambulance Services in Chapter 3).
- Durable medical equipment and orthotics
- Prosthetics
- Medical formulas.
- Low protein food.
- Home health care.
- Hospice.
- Infertility treatment.
- Services to treat gender identity disorder and gender incongruence.
- Non-*emergency* inpatient admissions and some elective surgeries.
- Skilled nursing based services (The initial 3 days are covered for admission).
- Inpatient rehab services.
- Long term care (LTAC) services.
- Nutritional counseling.
- Organ *transplants*.
- Outpatient rehabilitation therapies. (For example: physical, occupational and speech therapies).
- Certain prescription drugs from a pharmacy or that are given to you (by injection or infusion).

These are examples only. Please check with your provider, or call the *plan*, for more information about specific services, supplies, and drugs subject to *prior authorization*. From time to time, the *plan* may change the services

subject to *prior authorization*.

Basic Requirements for Coverage:

To be covered services, all services and supplies **must** meet all of the following requirements:

- Described in this Chapter 3 as a covered service.
- Medically necessary.
- Received while you are a *member* of the *plan*.
- Provided by a *network provider* in your *provider network*, except as described in Chapter 2. See Chapter 2: "Care from Non-Network Providers."
- In some cases, authorized in advance by a *plan authorized reviewer*. (*Prior authorization*.)
- Not listed as excluded in this EOC.
- Provided to treat an injury, illness or pregnancy; or for preventive care.
- Consistent with applicable state and federal law.

INPATIENT SERVICES:

Prior Authorization from Plan Authorized Reviewer: Certain *inpatient covered services* described below require prior authorization (approval) by a *plan authorized reviewer*. If the *provider* of the service does not obtain the prior authorization, the *plan* will not cover the service. Always check with your *provider* to make sure he or she has obtained necessary approval.

Inpatient Hospital Care:

The *plan* covers acute hospital *inpatient* care. This care is covered in a general or chronic disease hospital. Coverage is for as many days as *medically necessary*. This includes:

- Semi-private room and board. (Private room covered only when *medically necessary*).
- Anesthesia.
- Chemotherapy and radiation therapy.
- Doctor's visits and specialist consults, while you are *inpatient*.
- Diagnostic tests (Examples: lab, x-ray and other imaging tests).
- Dialysis.
- Intensive cardiac care.
- Lab and imaging services.
- Medications when you are an *inpatient*.
- Nursing care.
- Physical therapy.
- Occupational therapy.
- Speech therapy.
- Cardiac therapy.
- Respiratory therapy.
- Surgery. This includes the following:

Reconstructive Surgery and Procedures: The *plan* covers medically necessary reconstructive surgery and procedures. These are covered only when the services are required: to relieve pain; or to improve or restore bodily function that is impaired as a result of:

- a birth defect;
- accidental injury;
- disease; or
- a covered surgical procedure.

The *plan* also covers the following post-mastectomy services:

- Reconstruction of the breast affected by the mastectomy.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of all stages of mastectomy. (This includes lymphedema.)

Removal of breast *implants* is covered only when:

- there is a medical complication related to an *implant* (such as a breast *implant* rupture); or
- there is documented evidence of auto-immune disease.

Related Exclusions: Cosmetic procedures, except for post-mastectomy coverage described in this section.

Human Organ Transplants: The *plan* covers:

- Bone marrow *transplants*. This includes for *members* diagnosed with breast cancer that has progressed to metastatic disease. Members must meet the criteria established by the Massachusetts Department of Public Health (DPH).
- Solid human organ *transplants* provided to *members*.
- Hematopoietic stem cell *transplants* provided to *members*.

You must be approved by the *transplant* facility as a candidate for the recommended *transplant*. *Transplant* services must also be: approved by a *plan* authorized reviewer; and provided at a *network transplant* facility. (Note: *network transplant* facilities may include facilities that are out of the *service area*. In such case, the *plan* will pay for related medically necessary transportation for the *member*.)

The *plan* covers the following services when the person receiving the organ *transplant* is a *member*:

- Care for the person receiving the organ.
- Donor search costs through established organ donor registries.
- The following charges incurred by the donor in donating the stem cells or organ to the *member*, but only to the extent these charges are not covered by the donor's or any other health *plan*:
 - Evaluation and preparation of the donor.
 - Surgery and recovery services directly related to donating the organ to the *member*.

Related Exclusions:

- Donor charges of *members* who donate stem cells or solid organs to non-*members*.
- Experimental or investigational organ *transplants*.

Maternity Care: The *plan* covers:

- Hospital and delivery services for the mother. Note: The mother's inpatient stay is covered for at least: 48 hours following a vaginal delivery; and 96 hours following a caesarean delivery. Decisions to reduce the mother and child's *inpatient* stay are made only by the attending physician and mother (and not by the *plan*).
- Routine nursery charges for a healthy newborn.*
- Well newborn care.* This includes: pediatric care; routine circumcision furnished by a physician; and newborn hearing screening tests performed by a *network provider* before the newborn child (an infant under three months of age) is discharged from the hospital, or as provided by regulations of the Massachusetts DPH.
- One home visit by a *network provider* who is a: registered nurse; physician; or certified nurse midwife. Additional home visits by *network providers* when *medically necessary*. These home visits may include: parent education; assistance and training in breast or bottle feeding; and necessary and appropriate tests.

If you are enrolled in a benefit package that does allow you to enroll newborns as *dependents*: For newborns, the *plan* covers routine nursery charges and well newborn care. The newborn must be enrolled in the *plan* within 30 days of date of birth in order for the *plan* to cover other *medically necessary* services rendered to the newborn.

Note: You should not travel outside the *service area*:

- after your 37th week of pregnancy; or
- any time after you have been told by your provider that you are at risk for early delivery.

There is no coverage for delivery (including postpartum care and care provided to the newborn) or problems with pregnancy outside the *service area*: after your 37th week of pregnancy; or any time after being told by your provider that you are at risk for early delivery.

For Inpatient Mental Health and Substance Use Disorder Services: See “Mental Health and Substance Use Disorder Services” later in this Chapter 3.

Extended Care: The *plan* covers *medically necessary* care in an extended care facility **up to any benefit limits in your Schedule of Benefits**. An extended care facility is: a skilled nursing facility; rehabilitation hospital; or chronic hospital. You must need *inpatient* daily skilled nursing care or rehabilitative services. Coverage includes:

- semiprivate room and board;
- facility services; and
- use of durable medical equipment while you are in the facility.

Note: You may no longer need acute care hospital services but cannot be transferred to an extended care facility because a bed is not available. In such case, the *plan* may arrange for the hospital you are in to provide you with extended care services until such bed becomes available. These additional days in the acute hospital will be counted toward the applicable extended care *benefit limits*.

Related Exclusions to all Inpatient Care: The *plan* does not cover the following related to any inpatient admission:

- Personal items. Examples include: telephone; and television charges.
- Private duty nursing services.
- All charges over the semiprivate room rate, except when a private room is medically necessary.
- Rest or custodial care.
- Charges after your hospital discharge.
- Charges after the date you are no longer a *plan member*.

OUTPATIENT SERVICES:

Prior Authorization from Plan Authorized Reviewer: Certain outpatient covered services require prior authorization (approval) by a plan authorized reviewer. If the provider of the service does not obtain the prior authorization, the plan will not cover the service. Always check with your provider to make sure he or she has

Abortion: The *plan* covers:

- Abortion
- Abortion-related care
- Abortion and Abortion-related care services shall not be subject to any *cost-sharing*.

Allergy Services: The *plan* covers:

- Allergy testing.
- Allergy treatment.
- Allergy injections.
- Sensitivity tests. Limited to one per *benefit year*.
- Blood and pulmonary function tests. Limited to three per *benefit year*.

Ambulance Services: The *plan* covers:

- Ground ambulance transportation to the nearest medical facility for *emergency* medical care. (Air ambulance

transportation is covered only when: a ground ambulance cannot be used to access the *member*; or when these forms of transport are medically necessary for your *emergency* medical condition.)

- Ambulance services to transfer the *member* being discharged from one inpatient facility and admitted into another inpatient facility.
- When medically necessary, non-*emergency* air ambulance or other air transport to transfer the *member* from one inpatient facility to another inpatient facility for *covered services*.

Related Exclusions:

- Transport to or from medical appointments (except when covered as described above).
- Transport by taxi or public transportation.

Autism Spectrum Disorder Services: See Mental Health and Substance Use Disorder Services later in this Chapter.

Cardiac Rehabilitation: The *plan* covers outpatient cardiac rehabilitation. This must meet the requirements of the Massachusetts DPH. Your first visit must be within 26 weeks of the date you were first diagnosed with cardiovascular disease or after a cardiac event. The *plan* covers:

- Outpatient convalescent phase of the rehab program following hospital discharge.
- Outpatient phase of the program that addresses: multiple risk reduction; adjustment to illness; and therapeutic exercise.

Related Exclusions:

- The program phase that maintains rehabilitated cardiovascular health.
- Fitness or health club fees.
- Exercise equipment.

Chemotherapy and Radiation Therapy: The *plan* covers outpatient chemotherapy and radiation therapy.

Chiropractic Care: The *plan* covers the following *outpatient services* when they are furnished by a chiropractor who is licensed to furnish the specific covered service:

- Spinal manipulation.
- Diagnostic x-rays other than magnetic resonance imaging (MRI). Computerized axial tomography (CT Scans), and other imaging test.
- Outpatient supportive medical treatment services.

Cleft Lip and Cleft Palate: The *plan* covers the following outpatient medical, dental, oral surgery and orthodontic treatment for *members* who are children under the age of 18 only when it is medically necessary and consequent to the treatment of cleft lip, cleft palate or both:

- Outpatient medical services including but not limited to:
 - Audiology services.
 - Nutrition services.
 - Speech therapy.
 - Oral and facial surgery and related follow up care and surgical management.
- Outpatient dental and orthodontic services including but not limited to:
 - Preventative and restorative services to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management therapy.
 - Orthodontic treatment and management.

Prior Authorization: Some services for the treatment of cleft lip and cleft palate require prior authorization. Always check with your provider to make sure he or she has obtained necessary *plan* approval.

Related Exclusions:

- Cosmetic procedures except when needed to improve or restore physiologic function that is impaired as a result of cleft lip, cleft palate or both.
- Dental or orthodontic treatment not related to the management of the congenital conditions of cleft lip and cleft palate.

Clinical Trials: The *plan* covers services for *members* enrolled in a qualified clinical trial or approved clinical trial for treatment of any form of cancer or other life-threatening disease or condition. Coverage will be provided in accordance with the terms and conditions in MA law (M.G.L. ch. 175, section 110L) and/or the Affordable Care Act (42 USC, section 300gg-8). The following services are covered:

- Services that are medically necessary for treatment of your condition; consistent with the study protocol of the clinical trial; and for which coverage is otherwise available under the *plan*.
- The reasonable cost of an investigational drug or device that has been approved for use in the clinical trial; however, coverage is only to the extent the drug or device is not paid for by its distributor, manufacturer or the provider.

Dental Services: The *plan* covers only the following dental services:

Emergency Dental Services: The *plan* covers the following *emergency* dental services only when: there is a traumatic injury to sound, natural and permanent teeth caused by a source external to the mouth; and the *emergency* dental services are provided by a physician in a hospital *emergency* room or operating room within 48 hours following the injury:

- X-rays; and
- *emergency* oral surgery related to the repair of damaged tissues and/or the repositioning of displaced or fractured teeth.

Inpatient or Outpatient Surgery for Non-Covered Dental Services: The *plan* covers facility charges (and related medical charges, such as radiology, lab and anesthesia) only when it is medically necessary, due to your having a serious non-dental medical condition, for you to be admitted:

- to a *network* hospital;
- to a surgical day care unit of a *network* hospital; or
- to a *network* ambulatory surgical facility as an outpatient in order for you to receive non-covered dental services. The *plan* does not cover the dental services.

Examples of serious non-dental medical conditions include: hemophilia and heart disease.

Cleft Lip and Cleft Palate: The *plan* covers medically necessary dental (including preventative and restorative dentistry) and orthodontic services for the treatment of cleft lip and cleft palate. Please see Cleft Lip and Cleft Palate earlier in this chapter for more details.

Pediatric Dental: This *plan* DOES include coverage of pediatric dental services as per the federal Patient Protection and Affordable Care Act for *members* age 18 and under. A *member* is eligible for this benefit until the end of the calendar month in which they turn age 19. Coverage is provided for the pediatric dental services described below. *Cost-sharing* applies to Type II, Type III, and Type IV services. *Deductible* applies only to Type II and Type III services. Type I services are covered in full. There is some coverage for orthodontia treatment as noted in Type IV, below. Coverage is described and includes the following:

Type I Services: Preventive & Diagnostic	Type II Services: Basic Covered Services	Type III Services: Major Restorative Services	Type IV Services: Orthodontia
<ul style="list-style-type: none"> • Comprehensive Evaluation • Periodic Oral Exams • Limited Oral evaluation • Oral evaluation under 3 years of age • Full Mouth X-Ray • Panoramic X-Ray • Bitewing X-Rays • Single Tooth X-Ray • Teeth Cleaning • Fluoride Treatments • Space Maintainers • Sealants 	<ul style="list-style-type: none"> • Amalgam Restoration • Composite Resin Restorations • Re-cement crown/onlays • Rebase or relined dentures • Root canals on permanent teeth • Prefabricated Stainless Steel Crowns • Periodontal Scaling and Root Planing • Simple Extractions • Surgical Extractions • Vital pulpotomy • Apicoectomy • Palliative care • Anesthesia 	<ul style="list-style-type: none"> • Crown, resin • Porcelain/ceramic crowns • Porcelain fused to metal/noble/high noble crowns • Partial & complete dentures 	<p>(Covered only when medically necessary; patient must have severe and handicapping malocclusion as defined by HLD index score of 28 and/or one or more auto qualifiers; requires prior authorization)</p>

Diabetes Treatment: The *plan* covers the following for *members* with diabetes if these are medically necessary to diagnose or treat: insulin-*dependent*; insulin-using; non-insulin *dependent*; or gestational diabetes.

- Diabetes outpatient self-management training and educational services. This includes medical nutrition therapy. These must be provided by a *Network Provider* who is a certified diabetes provider.
- Podiatry services to treat podiatric conditions for *members* diagnosed with diabetes, including: diagnostic lab tests and X-rays; surgery and necessary postoperative care; routine foot care (such as trimming of corns, nails or other hygienic care); and other medically necessary foot care.
- Under the *plan's* lab benefit, the *plan* covers: diabetes lab tests, including glycosylated hemoglobin, or HbA1c, tests; and urinary protein/microalbumin and lipid profiles.
- Under the *plan's* durable medical equipment benefit, the *plan* covers: insulin pumps and insulin pump supplies; insulin needles and syringes; diabetic test strips and lancets; blood glucose monitors for home use; voice-synthesizers when medically necessary for home use for the legally blind.
- Visual magnifying aids when medically necessary for home use for the legally blind
- Under the *plan's* prosthetics benefit, the *plan* covers: therapeutic and molded shoes and shoe inserts for severe diabetic foot disease. Shoes/shoe inserts must be: prescribed by a *network* podiatrist or other qualified doctor; and furnished by a *network* podiatrist, orthotist, prosthetist or pedorthist.
- Under the *plan's* prescription drug benefit, the *plan* covers: prescribed oral diabetes medications that influence blood sugar levels; insulin; insulin needles and syringes; insulin pens; lancets; and blood glucose, urine glucose, and ketone monitoring strips.

Note regarding certain diabetes supplies: When obtained from a *network* pharmacy, certain diabetes supplies are covered under your prescription drug benefit; when obtained from a *network* DME provider, these supplies are covered under your durable medical equipment benefit. Examples are: insulin needles and syringes; and diabetic test strips and lancets.

Dialysis: The *plan* covers the following:

- Outpatient kidney dialysis in a *network*: hospital; or free-standing dialysis facility.
- Home dialysis. This includes non-durable medical supplies such as: dialysis membrane and solution; tubing and drugs needed during dialysis; and the cost to install, maintain or fix dialysis equipment. The *plan* decides

whether to rent or buy the equipment.

If you are outside the *service area*, the *plan* covers dialysis for up to one month per *benefit year*. You must first make advance arrangements with your *Network Provider*; and your *Network Provider* must obtain prior approval from a *plan* authorized reviewer.

When federal law permits Medicare to be the primary payer, you must apply for Medicare. You must also pay any Medicare *premium*. When Medicare is primary (or would be primary if you had enrolled in a timely manner): the *plan* will cover only those costs that exceed what would be payable by Medicare.

Related Exclusions to home dialysis:

- Costs to get or supply power, water or waste disposal systems.
- Costs of a person to help with the dialysis.
- Home hemodialysis.

Durable Medical Equipment and Orthotics (DME): The *plan* covers *medically necessary* DME. The DME must be prescribed by a *network* physician. The *plan* will decide whether to rent or buy the DME. The DME must be purchased or rented from a *network provider*.

DME is defined as devices or instruments of a durable nature that must be:

- able to withstand repeated use;
- reasonable and necessary to sustain a minimum threshold of *independent* daily living;
- used primarily to serve a medical purpose;
- not generally useful in the absence of disease or injury;
- able to be used in the home; and
- *medically necessary* for you.

Coverage for DME is available only for:

- The least costly DME adequate to allow you to engage in activities of daily living. If the *plan* decides that you chose DME that costs more than the least costly DME adequate to allow you to engage in activities of daily living, the *plan* will pay only for those costs that would have been paid for the least costly DME that meets your needs. In this case, you will have to pay the provider's charges that are more than the *plan's* allowed amount.
- One item of each type of equipment that meets your needs. (No back up items or items that serve a duplicate purpose are covered.)
- Repair and maintenance of covered DME.

The following are **examples** of covered and non-covered DME: (Please call Member Services for questions about whether a particular piece of DME is covered.)

Covered DME includes the following:

- Wheelchairs.
- Crutches, canes, walkers.
- Respiratory and oxygen equipment.
- Hospital beds.
- Insulin pumps and insulin pump supplies; insulin needles and syringes; insulin test strips and lancets; blood glucose monitors for home use; voice-synthesizers when medically necessary for home use for the legally blind.
- Certain types of braces.
- Non-foot or non-shoe orthotics.
- Breast pumps and related supplies (covered under the "Preventive Health Services" benefit, below).

Note regarding certain diabetes supplies: When obtained from a *network* pharmacy, certain diabetes supplies are covered under your prescription drug benefit; when obtained from a *network* DME provider, these supplies are covered under your DME benefit. Examples are: insulin needles and syringes; and diabetic test strips and lancets.

Related Exclusions:

- Comfort or convenience items.
- Heating pads, hot water bottles.
- Foot and shoe orthotics; arch supports; shoe inserts; or fittings, casting and other services related to devices for the feet (except for *members* with severe diabetic foot disease).
- Bed pans and bed rails.
- Exercise equipment.
- Equipment for sports or employment purposes.
- Wigs (or hair pieces) for hair loss due to: male or female pattern baldness; or natural or premature aging.

Early Intervention Services: The *plan* covers early intervention services provided by a *Network Provider*. These services must be an early intervention program meeting the standards of the Massachusetts DPH. This benefit is only for *members* through the age of 2 who meet established criteria. There is no *cost-sharing*. Early intervention services include the following:

- Physical therapy.
- Speech therapy.
- Occupational therapy.
- Nursing care.
- Psychological counseling.

Note: Benefit limits applicable to rehabilitation therapies do not apply to early intervention services.

Emergency Services: The *plan* covers *emergency* services in an *emergency* room.

- You are always covered for medical care in an *emergency*. You do not need prior authorization or a referral from your *PCP*. In an *emergency*, you should: go to the nearest *emergency* facility; or call 911 or other local *emergency* number.
- The *plan* provides coverage for all *emergency* services programs for both youth and adults. These are all programs for community-based *emergency* psychiatric services, including, but not limited to, behavioral health crisis assessment, intervention and stabilization services 24 hours per day, 7 days per week, through: (i) mobile crisis intervention services for youth; (ii) mobile crisis intervention services for adults; (iii) *emergency* service provider community-based locations; and (iv) adult community crisis stabilization services.
- The *plan* provides coverage for post-stabilization services. These are *covered services* that are needed to stabilize your condition following an *emergency* until such time as your treating physician determines you are sufficiently stabilized for transfer or discharge

Cost-Sharing: See your Schedule of Benefits for information about specific *cost-sharing* amounts.

- *Cost-sharing* will apply: for *emergency* care you get in an *emergency* room; or for observation services in a hospital setting without use of the *emergency* room. Please see your Schedule of Benefits for applicable *cost-sharing*.
- *Cost-sharing* applies even if you go to an *emergency* room for non-*emergency* care.
- *Copayments* for *emergency* services, if any, are waived if you are admitted as an inpatient immediately following receipt of *emergency* services in an *emergency* room. However, any applicable *cost-sharing* for inpatient hospital care will apply to your inpatient stay.
- If you get *emergency covered services* from a non-*network* hospital *emergency* room, the *plan* will pay up to the allowed amount. You pay applicable *cost-sharing*.

Emergency Defined: See Appendix A for the definition of *emergency*.

Notice to PCP or Plan: If you receive *emergency* care at an *emergency* facility (whether inside or outside the *service area*), but are not admitted to the hospital, you or someone acting on your behalf should call your *PCP* after receiving care. This helps your *PCP* to provide or arrange for any follow up care.

If you receive *emergency* care at an *emergency* facility (whether inside or outside the *service area*) **AND** you are admitted as an inpatient (hospitalized) to a non-*network* facility: you or someone acting on your behalf **MUST** call the *plan* within 2 working days of admission. This is essential so that the *plan* can: manage and coordinate your care; and arrange for any medically appropriate transfer. (Note: notice by the provider of *emergency* services to your *PCP*, the *plan* or, in the case of *emergency* mental health or substance use disorder services, to Carelon, satisfies your requirement to notify the *plan*.)

Transfer: Following *emergency* care, if you are admitted to a facility that is not a *Network Provider*, and your *PCP* determines that transfer is appropriate, you will be transferred to a *network* facility. The *plan* will not pay for inpatient care provided in the facility to which you were first admitted after your *PCP* determined that a transfer is medically appropriate and transfer arrangements have been made.

Family Planning Services: The *plan* covers the following outpatient family planning services when received from a *network*: physician (*PCP*, obstetrician or gynecologist); nurse practitioner; or certified nurse midwife:

- Routine medical exams.
- Medical consults.
- Diagnostic tests.
- Pregnancy testing.
- Birth control counseling.
- Genetic testing and related counseling: for certain genetically linked inheritable disorders, when the results of the testing will directly affect the care you receive. The *member* must either have a direct risk factor for, or have symptoms of, the disorder.
- Prescription and non-prescription contraceptives when given to you by a *Network Provider* during an office visit. Examples are: *implantable* contraceptives; intrauterine devices; diaphragms; cervical caps; injectable birth control drugs; and other medically necessary contraceptive devices that have been approved by the U.S. Food and Drug Administration.

Notes: Many family *planning* services are covered as “Preventive Health Services”, including prescription contraceptives such as: birth control pills and patches. See “Preventive Health Services” below.

For coverage of pregnancy terminations (abortions) and male voluntary sterilization: see “Outpatient Surgery” later in this Chapter. For coverage of female voluntary sterilization: see “Preventive Health Services” later in this Chapter. For coverage of infertility services: see “Infertility Services” later in this Chapter.

Related Exclusions:

- Reversal of voluntary sterilization.
- Services or fees related to using a surrogate to achieve pregnancy.
- Birth control that, by law, does not require a prescription. (Exception: when it is given to you by a *Network Provider* during an office visit).

Gender Reassignment or Sex Change Services: The *plan* provides coverage for medically necessary gender identity- and gender incongruence-related health care services. Services are subject to prior authorization by the *plan*.

Hearing Aids for Children: The *plan* provides coverage towards the cost of hearing aids for *members* 21 years of age or younger. Coverage includes all related services prescribed by a licensed audiologist or hearing instrument specialist, including the initial hearing aid evaluation, fitting and adjustments, and supplies, including ear molds. Hearing

aid batteries and cleaning fluid are not covered.

Benefit limits apply. See your Schedule of Benefits for the *benefit limit*. Once you reach your *benefit limit*, no more benefits will be provided toward the cost of hearing aids and related services.

Hearing (Audiology) Examinations: The *plan* covers exams and evaluations performed by a *PCP* or a *network* hearing specialist.

Home Health Care: The *plan* covers the home health care services listed below when:

- the *member* is homebound for medical reasons;
- Homebound means that your medical condition normally prevents you from leaving the home; or that leaving your home requires a substantial effort.
- your *PCP* orders a home health care services *plan* that includes part time skilled nursing care as an essential part of your treatment; and
- there is a defined medical goal set by your *PCP* that he or she reasonably expects you will meet.

When you qualify for home health care, the *plan* will cover:

- Part time skilled nursing visits for as many visits as *medically necessary*.
- Part time physical, occupational and speech therapy, when these services: are a medically necessary component of skilled nursing; and they are needed to restore function lost or impaired due to your illness or injury.
- Medical social work.
- Nutritional consult.
- The *medically necessary* services of a part time home health aide while you are receiving home skilled nursing or rehabilitation therapies.
- Home visits by a *network* physician.
- Inhalation therapy.
- Home infusion therapy.
- Total parenteral nutritional therapy.

In addition, under the *plan's* DME benefit, DME is covered when determined to be a *medically necessary* component of nursing and physical therapy services. See your Schedule of Benefits for DME cost- sharing.

Related Exclusions:

- *Custodial care*.
- Housekeeping services.
- Household repairs.
- Meals.
- Respite care.
- Private duty nursing.
- Personal care attendants.
- Homemakers.

Hospice Services: The *plan* covers the hospice services, in accordance with MA law, described below.

Coverage is for *members* who are terminally ill. (Terminally ill means having a life expectancy of six months or less as certified by a *network* physician.)

Hospice services are a coordinated licensed program of services provided during the life of a terminally ill *member*. The *member* and his/her physician must agree to a *plan* of care that stresses pain control and symptom relief rather than treatment aimed at curing the *member's* condition. Services can be provided:

- in a home setting;
- on an outpatient basis; or

- on a short-term inpatient basis. (This is only when medically necessary to control pain and manage acute and severe clinical problems that cannot, for medical reasons, be managed in a home setting.)

Covered services are provided in accordance with MA law, as follows:

- Physician services. (These are covered when the condition or diagnosis is unrelated to the condition or diagnosis for which you are receiving hospice care.)
- Skilled nursing care.
- Social work services.
- Medically necessary home health aide visits.
- Respite care. (This care is furnished to the hospice patient in order to relieve the family or primary care person from care-giving functions.)
- Volunteer services.
- Counseling services. (Bereavement counseling for the *member's* family is covered for up to one year following the *member's* death.)
- Private duty nursing.
- Personal care attendant services.

In addition:

- DME is covered under the *plan's* DME benefit.
- Prescription drugs are covered under the *plan's* prescription drug benefit.

House Calls: The *plan* covers house calls when medically necessary. Providers include *PCPs*, nurse practitioners and physicians' assistants. House calls are subject to the applicable office visit *cost-sharing*. Your *PCP* must arrange for house calls.

Immunizations: The *plan* covers:

- Routine preventive immunizations. (See Preventive Health Services benefit).
- Medically necessary immunizations.

Infertility Services for Massachusetts Residents:

The *plan* covers the diagnosis and treatment of infertility. Services must be provided by *Network Providers* in accordance with MA law.

"Infertility" is defined as: the condition of an *individual* who is unable to conceive or produce conception during a period of:

- 1 year if the female is age 35 or younger; or
- 6 months if the female is over the age of 35.

For purposes of meeting the criteria for infertility: if a person conceives but is unable to carry that pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy shall be included in the calculation of the 1 year or 6 month period, as applicable.

Infertility services are *covered services* only for *members* who are diagnosed with infertility and:

- who are MA residents;
- who meet the *plan's* clinical review criteria for coverage of infertility services, which are based on the *member's* medical history, diagnostic testing and medical evaluations;
- who meet the eligibility requirements of *network* infertility services providers; and
- with respect to the procurement and processing of donor eggs, sperm or inseminated eggs, or banking of donor sperm or embryos: to the extent the costs of such services are not covered by the donor's health insurance or other health coverage and the *member* is in active infertility treatment.

The *plan* covers the following medically necessary infertility services:

- The following services and supplies provided in connection with an infertility evaluation and/or treatment:
 - diagnostic tests and procedures;
 - artificial insemination (intracervical or intrauterine) when done with non-donor (partner) sperm; and/or
 - procurement, processing, and long-term (longer than 90 days) banking of sperm when associated with active infertility treatment.
- The following procedures when approved in advance by a *plan* authorized reviewer in accordance with the *plan's* clinical review criteria:
 - artificial insemination (intracervical or intrauterine) when done with donor sperm* and/or gonadotropins; and
 - procurement and processing of eggs or inseminated eggs and banking of embryos when associated with active infertility treatment.

*Donor sperm is only covered when: the partner has a male factor infertility diagnosis; or donor sperm is being used as an alternative to Preimplantation Genetic Diagnosis (PGD) when a couple meets the criteria for PGD.

- The following "assisted reproductive technology" (ART) procedures* when approved in advance by a *plan* authorized reviewer in accordance with the *plan's* clinical review criteria:
 - In Vitro Fertilization and Embryo Transfer (IVF-ET).
 - In conjunction with IVF, PGD is covered when either of the partners is a known carrier for certain genetic disorders.
 - Gamete Intra-Fallopian Transfer (GIFT).
 - Intracytoplasmic Sperm Injection (ICSI) for the treatment of male factor infertility.
 - Zygote Intra-Fallopian Transfer (ZIFT).
 - Frozen Embryo Transfer (FET).
 - Donor Oocyte (DO).
 - Cryopreservation of eggs.
 - Assisted hatching.

*ART procedures include: diagnostic evaluation; testing; ovarian stimulation; egg retrieval; procurement and processing of sperm and eggs or inseminated eggs; transfer of embryos; and banking of extra embryos when associated with active infertility treatment.

- Under your prescription drug benefit: oral and injectable drugs used in the treatment of covered infertility services are covered: when the *member* has been approved for covered infertility treatment; and when obtained from a *network* pharmacy. See your Schedule of Benefits for applicable *cost-sharing*.

Related Exclusions:

- Infertility services for any *member* who is not a MA resident.
- Any experimental infertility procedure. This is defined by applicable MA regulation.
- Surrogacy/gestational carrier.
- Reversal of voluntary sterilization.

Laboratory Tests, Radiology and other Outpatient Diagnostic Procedures: The *plan* covers the following *outpatient services* to diagnose illness, injury or pregnancy. Some tests are subject to prior authorization by a *plan* authorized reviewer.

- Diagnostic laboratory tests.
 - Examples: Glycosylated hemoglobin (HgbA1C) tests; urinary protein/microalbumin tests; and lipid profiles to diagnose and treat diabetes.
- Diagnostic X-ray and other imaging tests.
 - Example: fluoroscopic tests.
- Diagnostic: CT/CTA scans; MRI/MRA; PET scans; and NCI/NPI (nuclear cardiac imaging). Note: Prior authorization is required for these tests.
- Human leukocyte antigen testing or histocompatibility locus antigen testing that is necessary to establish

bone marrow *transplant* donor suitability. This includes testing for A, B or DR antigens, or any combination, in accordance with Massachusetts DPH guidelines.

Lipodystrophy Syndrome: The *plan* covers the following medical or drug treatments to correct or repair disturbance of body composition caused by HIV associated lipodystrophy syndrome:

- Reconstructive surgery, such as suction assisted lipectomy
- Other restorative procedures and dermal injections or fillers for reversal of facial lipoatrophy syndrome

Long-Term Antibiotic Therapy: The *plan* covers long-term antibiotic therapy for a patient with lyme disease when determined to be medically necessary and ordered by a licensed physician after making a thorough evaluation.

Low Protein Foods: The *plan* covers food products modified to be low-protein when: ordered by a physician; and medically necessary to treat inherited diseases of amino and organic acids.

Maternity Services - Outpatient: The *plan* covers the following outpatient maternity services:

- Prenatal exams and tests: Routine outpatient prenatal care, including evaluation and progress screening; physical exams; and recording of weight and blood pressure monitoring.
- Postpartum exams and tests: Routine outpatient postpartum care for the mother. This includes lactation consultations.
- Childbirth classes.

You must obtain outpatient maternity care from a *Network Provider*. Your *Network Provider* must make arrangements for inpatient care. (See "Inpatient Hospital Care" earlier in this Chapter.)

Note: Some services above are considered Preventive Health Services. Please see "Preventive Health Services" later in this Chapter for more information.

Medical Formulas: The *plan* covers the following to the extent required by MA law:

- Non-prescription enteral formulas, ordered by a physician for home use, for the treatment of: malabsorption caused by Crohn's disease; ulcerative colitis; gastroesophageal reflux; gastrointestinal motility; chronic intestinal pseudo-obstruction; and inherited diseases of amino acids and organic acids.
- Prescription formulas for the treatment of: phenylketonuria; tyrosinemia; homocystinuria; maple syrup urine disease; propionic academia or methylmalonic academia in infants and children; or to protect the unborn fetuses of pregnant women with phenylketonuria.

Medical Supplies: The *plan* covers the cost of certain types of medical supplies. You must obtain these from a *network provider*. Medical supplies include:

- Ostomy supplies;
- Tracheostomy supplies;
- Catheter supplies;
- Oxygen supplies; and
- Supplies for insulin pumps.

Notes: Call Member Services for more information on whether:

- a particular medical supply is a *covered service*; and
- a particular medical supply is covered under the *prescription drug* benefit. (See "Prescription Drugs" later in this Chapter.)

Mental Health and Substance Use Disorder Services (Inpatient, Intermediate and Outpatient): The *plan contracts* with Carelon Behavioral Health to manage all mental health and substance use disorder services for *members*.

How to Get Care: If you need mental health or substance use disorder services, you may do any of the following:

- Go directly to a *Network Provider* who provides mental health or substance use disorder services.
- Call the *plan's* toll-free mental health/substance use disorder telephone line – staffed by Carelon at 877-957-5600 for help finding a *Network Provider* 24 hours a day.
- Call your *PCP* for help finding a *Network Provider*.
- Call or text the Behavioral Health Help Line (BHHL) 833-773-2445
- Visit Carelon's website (carelonbehavioralhealth.com) or follow the link on the *plan's* website (wellsense.org) to look up *Network Providers*.

In an *emergency*:

- Go to the nearest Community Behavioral Health Center (CBHC) or *emergency* medical facility; or
- Call 911 or local number for *emergency* services.

Prior Authorization:

- Coverage for certain mental health and substance use disorder services is subject to prior authorization by a *plan authorized reviewer*.
- Always check with your *provider* to make sure he or she has obtained necessary approval from Carelon.
- Any decision that a requested mental health or substance use disorder services is not *medically necessary* will be made by a *licensed mental health professional*.

Benefits: The *plan* covers medically necessary outpatient, inpatient and intermediate mental health and substance use disorder services to diagnose and treat *mental disorders*. This includes:

- Biologically-based *mental disorders*, including: schizophrenia; schizoaffective disorder; major depressive disorder; bipolar disorder; paranoia; panic disorder; obsessive-compulsive disorder; delirium and dementia; affective disorders; eating disorders; post-traumatic stress disorder; substance use disorder disorders; autism; and other psychotic disorders or other biologically-based *mental disorders*.
- Note regarding autism spectrum disorder (ASD): The *plan* provides coverage for ASD in accordance with MA law, including the following:
 - ASD includes any of the pervasive *developmental disorders* (as defined by the most recent edition of the DSM), including autistic disorder; Asperger's disorder; and pervasive *developmental disorders* not otherwise specified.
 - Diagnosis of ASD includes: medically necessary assessments; evaluations (including neuropsychological evaluations); genetic testing; or other tests to diagnose whether a *member* has an ASD.
 - Treatment for ASD includes: habilitative or rehabilitative care (including applied behavioral analysis*); pharmacy care (under the Prescription Drug benefit); psychiatric care (direct or consultative services provided by a licensed psychiatrist); psychological care (direct or consultative services provided by a licensed psychologist); and therapeutic care (services provided by licensed or certified: speech therapists, occupational therapists, physical therapists or social workers). Benefit limits applicable to the Rehabilitation Therapies benefit do not apply to therapeutic care services provided to *members* with ASD.
 - Services must be rendered by *network* autism services providers (providers who treat ASDs). These include board certified behavior analysts**, psychiatrists; psychologists; licensed or certified: speech therapists, occupational therapists, physical therapists and social workers; and pharmacies. However, in the event the *plan* is unable to provide adequate access to *network* ASD providers, *members* should call Carelon at 877-957- 5600 to arrange for out-of-*network* ASD services.

*Applied behavioral analysis is defined as: the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior. This includes the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

**Defined as a behavioral analyst credentialed by the behavior analyst certification board as a board certified behavior analyst.

- Rape-related mental or emotional disorders to victims of rape or victims of an assault with intent to commit rape.
- For *members* who are under the age of 19: non-biologically based mental, behavioral or emotional *mental*

disorders, which substantially interfere with or substantially limit the functioning and social interactions of such child or adolescent; provided, that the interference or limitation is documented by and the referral for such diagnosis and treatment is made by the *PCP*, primary pediatrician or a licensed mental health professional of such a child or adolescent, or is evidenced by conduct, including but not limited to: (1) an inability to attend school as a result of such a disorder; (2) the need to hospitalize the child or adolescent as a result of such a disorder; (3) a pattern of conduct or behavior caused by such a disorder which poses a serious danger to self or others.

- Mental Health Acute Treatment*
- Community-Based Acute Treatment (CBAT)*
- Intensive Community-Based Acute Treatment (ICBAT)*
- Intensive Care Coordination
- Family Stabilization Team
- In-home Behavioral Services
- Mobile Crisis Intervention
- Community-Based Acute Treatment for Children and Adolescents (CBAT)
- Intensive Community-Based Treatment for Children and Adolescents
- Therapeutic Mentoring Services

Note: The *plan* will continue to provide such benefits to any adolescent who is engaged in an ongoing course of treatment beyond their 19th birthday until:

- the course of treatment, as specified in the treatment *plan*, is completed, and
- while the benefit *contract* under which such benefits first became available remains in effect, or subject to a subsequent benefits *contract* which is in effect.
- All other non-biologically based *mental disorders*.

Outpatient Mental Health and Substance Use Disorder Services: The *plan* covers medically necessary *outpatient services* to diagnose and treat *mental disorders*. (Services include ambulatory detoxification and methadone maintenance treatment.) *Outpatient services* may be provided in a *network*: licensed hospital; a mental health or substance use disorder clinic licensed by DPH; a public community mental health center; a professional office; or home-based services. The services are available from any of the following *network* licensed professionals acting within the scope of his/her license:

- Licensed mental health counselors.
- Licensed *independent* clinical social workers.
- Licensed psychiatric nurses who are certified as clinical specialists in psychiatric and mental health nursing.
- Licensed marriage and family therapists
- Psychiatrists.
- Psychologists.

Biologically-based and non-biologically based *outpatient services* are provided without annual, lifetime or visit/unit/day limits.

Inpatient Acute Mental Health and Substance Use Disorder Services*: The *plan* covers medically necessary inpatient acute mental health and substance use disorder services for *mental disorders*. Inpatient services for *mental disorders* are provided in a *network*: general hospital; mental health hospital; or a substance abuse facility. Inpatient services are provided without annual, lifetime or visit/unit/day limits.

Intermediate Mental Health and Substance Use Disorder Services: The *plan* covers medically necessary intermediate services for *mental disorders*. Intermediate services are: a range of non-inpatient services that provide more intensive services than *outpatient services* and less intensive than inpatient services. Intermediate services are provided without annual, lifetime or visit/unit/day limits. Examples include:

- Community-Based Acute Treatment (CBAT)*
- Intensive Community-Based Acute Treatment (ICBAT)*
- Day treatment programs.
- Partial hospital programs.

- Intensive outpatient programs.
- Crisis stabilization services.
- Acute residential treatment, such as community based acute treatment.
- Clinically managed detoxification services.
- Level III community based detoxification.

Medication-Assisted Treatment (MAT) and Associated Services

- Medication-Assisted Treatment visits include but are not limited to, counseling and drug screening.

Opioid Antagonist Medication

- Coverage is provided for opioid antagonist medication approved for use in a take-home setting or by a health care professional.

Other Related Services: The *plan* covers:

- Medication management services.
- Neuropsychological assessment and psychological testing.

Smoking and Tobacco Cessation: The *plan* covers *individual* and group counseling services for *members* who smoke or use tobacco products. Also covered are related prescription drugs - see the "Prescription Drug" benefit later in this Chapter. For information about this benefit, call Member Services at 1-855-833- 8120.

Related Exclusions:

- Custodial care.
- Psychoanalysis.
- Hypnotherapy.
- Massage and relaxation therapies.
- Developmental testing.
- Services for problems of school performance.
- Educational services or testing services.
- Mental health services provided to a *member* who is in jail, a house of correction, prison or custodial facility.
- Mental health services provided by the Massachusetts DPH.
- Long term residential treatment.
- The following ASD services are excluded:
 - ASD services provided under:
 - an *individualized* family service *plan* (ISFP);
 - an *individualized* education program (IEP); or
 - an *individualized* service *plan* (ISP).
 - ASD services provided by school personnel.

*Please Note: Services noted with an * do not require pre-authorization but do require that the facility notify WellSense of the admission and the initial treatment *plan* within 72 hours of admission.

Mental Health Wellness Examination: The *plan* covers an annual mental health wellness examination provided by a licensed mental health professional or primary care provider, which may be provided by the primary care provider as part of an annual preventive visit. No *cost-sharing* will apply to this examination.

Newborn Infants and Adoptive Children Services: The *plan* covers medically necessary newborn care for newborns and adoptive children properly enrolled in the *plan*. This includes medically necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, or premature birth.

See "Maternity Care" earlier in this Chapter; and see Chapter 4 "Newborn and Adoptive Children – Enrollment and

Coverage” for more information about enrollment and coverage of newborns and adoptive children.

Nutritional Counseling: The *plan* covers nutrition-related diagnostic, therapeutic and counseling services furnished by a registered dietician or nutritional professional for the purpose of disease management. Nutritional counseling includes an initial assessment of nutritional status followed by additional *planned* visits for dietary interventions to treat medical illness.

Orthotics: See Durable Medical Equipment earlier in this Chapter.

Outpatient Office Visits for Medical Care: The *plan* covers outpatient *PCP* and specialist office visits to evaluate and treat illness or injury. Services include:

- Medically necessary (non-routine) immunizations.
- Pediatric specialty care by *network providers* with expertise in specialty pediatrics. (See Mental Health and Substance Use Disorder Services for mental health and substance use disorder services for children and adolescents.)

Note: Some outpatient office visit services are considered Preventive Health Services. Please see “Preventive Health Services” later in this Chapter for more information.

Outpatient Surgery: The *plan* covers outpatient surgery:

- that is done under anesthesia in an operating room of a facility licensed to perform surgery; and
- where you are expected to be discharged the same day.

This coverage includes:

- Voluntary termination of pregnancy (abortions). The *plan* provides coverage for all abortion services and abortion-related services that are legally permitted under applicable law.
- Male voluntary sterilizations (See “Preventive Health Services”, below, for female voluntary sterilization).
- Diagnostic procedures such as a colonoscopy or endoscopy.

PANDAS and PANS: Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infection and Pediatric Acute Onset Neuropsychiatric Syndrome)

- This *plan* covers services required under Massachusetts state law for the treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections, and pediatric acute onset neuropsychiatric syndrome, including, but not limited to, the use of intravenous immunoglobulin therapy (IVIG).

Podiatry Services: The *plan* covers the following:

- For diabetic *members*: all podiatry (foot) care whether routine or non-routine is covered.
- For all other *members*: the *plan* only covers non-routine medically necessary podiatry (foot) care by a *Network Provider*, including a *network* podiatrist. Examples are treatment for hammertoe and osteoarthritis. This does not include routine foot care. (Examples of routine foot care: trimming of corns, nails or other hygienic care).

Prescription Drugs: The *plan’s* formulary is a list of prescription drugs that indicates coverage, *cost-sharing*, and any limitations, or restrictions. Formulary updates are made throughout the year. The online formulary is updated as changes are made. Members who may be affected by formulary changes are notified via mail, unless the change is beneficial to the *member*. Go to the *plan’s* website (wellsense.org) or call Member Services at 1-855-833-8120 to find out whether a drug is covered or excluded.

Conditions of Coverage: Our Pharmacy Program does not cover all drugs and prescriptions. The *plan* covers prescription drugs listed on the *plan’s* formulary, when they are provided in accordance with the *plan’s* Pharmacy Programs and when they meet all of the following requirements described below. (Note: this includes the requirement that coverage for certain drugs is subject to prior authorization (approval) by a *plan* authorized reviewer. Always check

with your provider to make sure he or she has obtained necessary *plan* approval.)

- Prescribed drugs that by law require a prescription.
- Prescribed by a provider licensed to prescribe medications.
- The prescription meets all legal requirements for a prescription.
- Filled by a *network* pharmacy (except in an *emergency*, or for *urgent care*, or an *emergency/urgent care* when you are outside the *service area*).
- Medically necessary.
- Prescribed to treat an illness, injury, or pregnancy; or for preventive care purposes.

Cost-Sharing: See your Schedule of Benefits for *prescription drug cost-sharing*.

Where to get your *prescription drugs*: Take your prescription or refill to any *network* pharmacy, along with your ID card, and pay the applicable *cost-sharing*.

- *Network* pharmacies: includes many retail pharmacies in Massachusetts. For a list of *network* pharmacies, see the Pharmacy Directory on our website at wellsense.org or call Member Services.
- Specialty pharmacy providers: For certain drugs, the *plan* contracts with one or more specialty pharmacy providers. (See below under "Pharmacy Programs" for more information about specialty pharmacy providers.)

How to obtain Mail Order Drugs: The *plan* contracts with Cornerstone Health Solutions for mail order drug services. Only certain maintenance drugs are available through mail order. To use the mail order service you must first enroll with Cornerstone Health Solutions. To enroll in this service and begin getting medications in the mail you must either contact Cornerstone Health Solutions by phone at 844-319-7588 or complete the mail order enrollment form that was included in your member welcome packet and is also available on the Cornerstone Health Solutions website. Your prescribing provider may also call Cornerstone Health Solutions at 844-319-7588 or fax your prescription to them at 781-805-8221. Once you have enrolled, you can refill prescriptions by mail, phone, or online at cornerstonehealthsolutions.org/chs-mail-order-pharmacy.

Non-*network* pharmacies: If you have to fill a prescription at a non-*network* pharmacy due to an *emergency* or for *urgent care*, or an *emergency/urgent care* when outside the *service area*, you will have to pay for your prescription and seek reimbursement from the *plan*. The *plan* will pay up to the allowed amount for eligible claims minus the applicable *cost-sharing*. (See Chapter 7 – "Bills from Providers" or call Member Services for information about how to seek *plan* reimbursement.)

What is covered: Subject to all of the Conditions of Coverage described earlier in this section, the *plan* covers the following prescription drugs and supplies:

- Hormone replacement therapy for peri- and post-menopausal women (HRT).
- Oral and other forms of prescription drug contraceptives (birth control drugs). See "Preventive Health Services" below.
- Drugs to stop smoking and treat tobacco addiction. These are covered only when your provider has given you a prescription that meets all legal requirements for a prescription. Please check the *plan's* formulary for coverage information on these drugs.
- Hypodermic syringes or needles when medically necessary.
- Insulin; insulin pens, insulin needles and syringes; blood glucose, urine glucose and ketone monitoring strips; lancets; and oral diabetes medications only when your provider has given you a prescription that meets all legal requirements for a prescription.
- Off-label use of FDA-approved prescription drugs for the treatment of cancer or HIV/AIDS
- Certain compounded medications, as long as one or more active ingredients within the compound requires a prescription by law, is FDA-approved, and covered on the formulary. (Note: All active and inactive ingredients must be covered or pharmacy may enter clarification code to bypass reimbursement for non-covered ingredients.)

- Oral and injectable drug therapies used in the treatment of covered infertility services. (See Chapter 3–*Outpatient Services/Infertility Services*.) These are covered only when the *member* has been approved for covered infertility treatment.
- Orally administered anti-cancer medications used to kill or slow the growth of cancerous cells.
- Opioid Antagonist Medication
- Pre-exposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition
- Medication-Assisted Treatment (MAT) Medications

What is not covered: The *plan* does not cover the following under the prescription drug benefit:

- Prescriptions filled at non-*network* pharmacies, except in cases of: *emergency care*; or *urgent care*, or an *emergency/urgent care* when you are outside the *service area*
- Prescriptions that were written by a non-*Network Provider*, except: in an *emergency*; or in an *urgent care* setting or an *emergency/urgent care* setting when you are outside the *service area*.
- Drugs falling into any of the following categories:
 - Drugs that are not prescribed to treat an illness, injury, or pregnancy, or for preventive care purposes or drugs prescribed as part of a course of treatment that the *plan* does not cover.
 - Experimental or investigational drugs. (Note: This exclusion does not apply to long-term antibiotic treatment of chronic Lyme disease)
 - Drugs that have not been approved by the U.S. Food and Drug Administration. This includes herbal and/or alternative medications and medical foods that require a prescription.
 - Drugs used primarily for cosmetic purposes.
 - Drugs for the treatment of sexual dysfunction.
 - Drugs that have been deemed less-than-effective by the U.S. Food and Drug Administration, i.e. DESI drugs. For a complete list of DESI drugs please visit: cms.hhs.gov/MedicaidDrugRebateProgram/12_LTEIRS Drugs.asp
 - Prescription drugs used primarily for the treatment of the symptoms of a cough or cold.
 - Convenience packaged drugs that contain topical medications and/or medical supplies. (For example: topical rinses, alcohol pads, and combs.)
 - Prescription drugs related to non-covered dental services.
 - Vitamins and dietary supplements (except prescription prenatal vitamins, vitamins as required by the Affordable Care Act, fluoride for children and supplements for the treatment of mitochondrial disease). Topical and oral fluorides for adults
 - Prescription medications once the same active ingredient or a modified version of an active ingredient that is therapeutically equivalent to a covered prescription medication becomes available over the counter. In this case, the specific medication may not be covered and the entire class of prescription medications may also not be covered.
 - Drugs prescribed as part of a course of treatment that the *plan* does not cover.
 - Delivery, shipping and handling costs related to delivering drugs to you.
 - Compounded medications, if no active ingredients by law require a prescription, is not FDA-approved, and is not covered on the formulary.
 - Compounded medication and non-compounded medication flavoring.
 - Immunizing agents not listed in the formulary; toxoids; blood; and blood products. (Note: these may be covered under your outpatient or inpatient benefits.)
 - Certain medical devices. (Note: these may be covered under the Durable Medical Equipment benefit.)
 - Certain drugs administered by a healthcare provider in an outpatient setting (Note: these may be covered under your outpatient benefit.)

Pharmacy Programs: The *plan* has several Pharmacy Programs. These Programs seek to ensure that *members* are provided safe, clinically appropriate and cost-effective drugs. The drugs subject to these programs are listed on the *plan's* formulary and may change from time to time. To find out what drugs are subject to any of these Programs, check the *plan's* formulary at [wellsense.org](https://www.wellsense.org) or call Member Services. The following is a description of these Programs:

- **Prior Authorization:** In the case of certain drugs, the *plan* requires your physician to obtain prior

authorization from a *plan* authorized reviewer before prescribing the drug. The drugs subject to prior authorization include certain very expensive drugs, brand name drugs when a generic equivalent is available, and new-to-market drugs that have not yet been reviewed by the *plan* for coverage.

- **Quantity Limits:** The *plan* limits the quantity of certain medications that you can be provided in a given period of time. This is done for safety, cost and/or clinical reasons.
- **Step Therapy:** This Program requires providers to use certain designated “first line” therapies or drugs prior to prescribing certain other drugs. An example is the use of generic antidepressants before prescribing brand name antidepressants.
- **Specialty Pharmacy Providers:** The *plan* has *contracts* with *network* specialty pharmacies to provide certain specialized drugs. You must obtain these drugs from one of our *network* specialty pharmacies.

EXCEPTION REQUESTS: If your physician believes it is medically necessary for you to take a prescription drug that is not on our formulary or is restricted by any of the Pharmacy Programs above, he or she should contact the *plan* and request an exception from a *plan* authorized reviewer. The exception request must be supported by patient-specific clinical history for *plan* review. The *plan* will consider if the drug is medically necessary for you. If so, it will make an exception and cover the drug. For more information, call Member Services.

Pharmacy Benefit Manager: The *plan* *contracts* with a separate organization, known as a pharmacy benefit manager, to administer its prescription drug benefit. See the Address and Telephone Directory in the front of this EOC for more information.

Preventive Health Services: The *plan* covers preventive health services. These are services to prevent disease or injury rather than diagnose or treat a complaint or symptom. Preventive health services are provided by your *PCP*, *network* obstetrician or other qualified *Network Providers*. To be covered, all preventive health services must be provided: in accordance with the *plan*'s medical policy guidelines; and with applicable laws and regulations.

The following is a summary of covered preventive health services. A complete listing of all preventive health services covered by the *plan* under the Affordable Care Act (ACA) can be found at the end of this EOC or on the *plan*'s website wellsense.org.

Preventive health care services for *members* who are children:

- Physical exam, history, measurements, sensory screening, neuropsychiatric evaluation and developmental screening, and assessment at the following intervals from birth to age 6:
 - Six times during the child's first year after birth.
 - Three times during the second year of life (age one to age two). Annually from age two through age five (until age 6).
 - Hereditary and metabolic screening at birth.
 - Newborn hearing screening test prior to discharge from the hospital or birthing center.
 - Preventive immunizations; tuberculin tests; hematocrit; hemoglobin; blood lead screening; or other appropriate blood tests and urinalysis as recommended by the physician.
 - Routine physical exams for children age 6 and older.
 - Preventive eye exams up to the *benefit limit*. See your Schedule of Benefits.
- Preventive health care services for adults:
 - Annual physical exams (once per benefit year); and related routine lab tests and x-rays.
 - Preventive hearing exams and screenings.
 - Preventive immunizations as recommended by the Advisory Committee on Immunization Practices.
 - Preventive screening tests and procedures. (Example: screening colonoscopies). (In some cases, if these procedures are accompanied by treatment/surgery, they become subject to applicable cost-sharing.)
 - Nutritional counseling and health education.
 - Preventive eye exams – Please see the Vision Service section for more details. Preventive

eye exams are covered up to the benefit limit. See your Schedule of Benefits.

- Preventive health care services for women, including pregnant women:
 - Annual gynecological exam. This includes a routine cytologic (Pap smear) screening once per benefit year. You must see a network: physician (PCP, obstetrician or gynecologist); nurse practitioner; or certified nurse midwife.
 - Routine prenatal care including one postpartum visit.
 - Baseline mammograms for women between the ages of 35 and 40; and annual screening mammograms once per benefit year for women age 40 and older.
 - Laboratory tests associated with routine maternity care.
 - Voluntary sterilization procedures.
 - Breast pumps and related supplies
 - Lactation counseling and support from a trained Network Provider.
 - Prescription drug contraceptives. Family Planning
- Other preventive health services, screenings and counseling, as required by the Affordable Care Act (ACA).

Cost-Sharing: There is no *cost-sharing* for covered preventive health services.

Note: In the course of receiving certain preventive health services, you may also receive other *covered services* that require separate *cost-sharing*. Also, any medically necessary follow up care as a result of preventive health services is subject to applicable *cost-sharing*.

Related Exclusions: Exams needed to take part in school, camp and sports activities; or exams required by employers, courts or other third parties; unless these exams are furnished as part of a covered routine exam.

Prosthetic Devices: The *plan* covers medically necessary prosthetic devices when prescribed by a *network* physician. The *plan* will decide whether to rent or buy the prostheses. The prostheses must be purchased or rented from a *Network Provider*.

Prosthetic devices are devices of a durable nature that must be:

- able to withstand repeated use;
- reasonable and necessary to sustain a minimum threshold of *independent* daily living;
- made primarily to serve a medical purpose;
- not generally useful in the absence of disease or injury;
- able to be used in the home;
- medically necessary for you; and
- used to replace the function of a missing body part and made to be fitted to your body as an external substitute.

Coverage for prosthetics is available only for:

- The least costly device adequate to allow you to engage in activities of daily living. If the *plan* decides that you chose a prosthetic that costs more than the least costly prosthetic adequate to allow you to engage in activities of daily living, the *plan* will pay only for those costs that would have been paid for the least costly device that meets your needs. In this case, you will have to pay the provider's charges that are more than the amount the *plan* pays.
- One item of each type of prosthetic device that meets your needs is covered. No back up items or items that serve a duplicate purpose are covered.
- Repair and maintenance of covered equipment.

The following are examples of covered prosthetics:

- Breast prostheses. These include replacements and mastectomy bras.

- Prosthetic arms, legs and eyes.
- Therapeutic and molded shoes and shoe inserts for severe diabetic foot disease. (See Diabetes benefit, above.)
- Wigs (scalp hair prostheses), prescribed by a *network* physician, when the *member* has hair loss due to: treatment for any form of cancer or leukemia; alopecia areata or alopecia totalis; or permanent loss of scalp hair due to injury (such as from burns or other traumatic injury).

Related Exclusions:

- Electronic and myoelectric artificial limbs.
- Wigs when hair loss is due to male or female pattern baldness; or natural or premature aging.

Radiology Services: See Laboratory Tests, Radiology and Other Diagnostic Procedures.

Rehabilitation Therapies (Outpatient) – Short Term Physical, Occupational and

Pulmonary Rehabilitation Therapies: The *plan* covers medically necessary outpatient short term physical, occupational, and pulmonary therapy services for rehabilitative and habilitative purposes. These services must be provided:

- to restore function lost or impaired as a result of an accidental injury or an illness;
- when needed to improve your ability to perform activities of daily living; and
- when your *PCP* and the *plan* determine that such therapy is likely to result in significant improvement in your condition within the period of time benefits are covered.

Benefit Limits: Rehabilitation therapies are covered up to the *benefit limit* in your Schedule of Benefits. These *benefit limits* do not apply when these services are provided to *members*:

- receiving early intervention services – see Early Intervention Services, above; or
- with autism spectrum disorder (ASD) – see Mental Health and Substance Use Disorder Services, above.

Prior Authorization: Coverage for rehabilitation therapies requires prior authorization by a *plan* authorized reviewer. Always check with your provider to make sure he or she has obtained necessary *plan* approval.

Related Exclusions:

- Educational services or testing, or services to address school performance.
- Vocational rehabilitation.
- Massage therapy.
- Sensory integrative testing (including praxis).
- Diagnosis or treatment of speech, language or hearing disorders in a school-based setting.

Second Opinions: The *plan* covers second opinions by *Network Providers* about the necessity of a covered service that a *Network Provider* has recommended for you. Second opinions from non-*Network Providers* are covered only when the specific expertise requested is not available from *Network Providers*. When surgery is being considered, the *plan* will cover third surgical opinions when the first and second opinions differ.

Speech-Language and Hearing Disorder Services: The *plan* covers diagnosis and treatment of speech, hearing and language disorders. These are covered to the extent medically necessary when provided by *network* speech-language pathologists and audiologists.

Related Exclusions: Diagnosis or treatment of speech, language and hearing disorders in a school-based setting

Telehealth: The *plan* covers telehealth. Your cost-share for telehealth services shall not exceed the cost share charged for the same services delivered in-person. Telehealth services will be subject to the same

deductible and maximum out of pocket as equivalent in-person services. For instance, if you see a mental health provider for telehealth services, the cost sharing is the same as if you access care with a mental health provider in person. Prior authorization may apply.

Available telehealth visits include:

- 2-way, live interactive telephone communication audio and video communications and digital video consultations
- Asynchronous telecommunication via image and video not provided in real-time (a service is recorded as video or captured as an image; the provider evaluates it later)
- Other methods allowed by state and federal laws

Temporomandibular Joint (TMJ) Disorder: The *plan* covers treatment of TMJ disorders only when the disorders are caused by or result in a specific medical condition. TMJ syndrome is not considered a specific medical condition. Examples of such specific medical conditions are: jaw fractures; jaw dislocations, or degenerative arthritis. The medical condition must be proven to exist by diagnostic x-rays or other generally accepted diagnostic procedures.

Note: Coverage for TMJ disorder may require prior authorization by a *plan authorized reviewer*. Always check with your *provider* to make sure he or she has obtained necessary *plan* approval.

Related Exclusions:

- Treatment of TMJ disorders that are not proven to be caused by or to result in a specific medical condition.
- Treatment for TMJ syndrome.
- Appliances, other than a mandibular orthopedic repositioning appliance (MORA).
- Services, procedures or supplies to adjust the height of teeth or in any other way restore occlusion. Examples include: crowns, bridges or braces.

Vision Services: The *plan* covers:

- Routine eye exams: Routine eye exams are covered up to the *benefit limit*. See your Schedule of Benefits.
- Preventive eye exams: These are periodic eye and vision examinations when the *member* has no obvious signs or symptoms of disease or vision loss. If you have a medical condition such as cataract then your visits to your eye doctor are no longer considered preventive. Preventive eye exams are covered up to the *benefit limit*.
- Non-routine eye exams and treatment: The *plan* covers non-routine eye exams. (This includes diabetic retinal eye exams.) You must use a *Network Provider* who is an eye doctor. These are optometrists or ophthalmologists. Non-routine eye exams are for detection, treatment and management of eye conditions that produce symptoms that, if left untreated, may result in loss of vision.
- Medically necessary vision therapy only for: accommodative insufficiency; amblyopia; convergence insufficiency; and esotropia acquired (prior to surgery).
- Contact lenses or eyeglasses (one pair per prescription change) if one of the following conditions exists: postoperative cataract extraction; keratoconus; anisometropia of more than 3.00D; or more than 7.00D of myopia or hyperopia. Visual magnifying aids when medically necessary for home use for the legally blind
- Pediatric Vision Service – For *members* age 18, a *member* is eligible for this benefit until the end of the calendar month in which they turn age 19. In addition to the routine eye exam noted above, the *plan* covers one (1) pair of eyeglasses, including frames and lenses, or contact lenses per calendar year.
 - Services include:
 - single vision, conventional (lined) bifocal, conventional (lined) trifocal, lenticular glass or plastic lenses,
 - all lens powers,
 - fashion and gradient tinting,
 - ultraviolet protective coating,
 - oversized and glass-grey #3 prescription sunglass lenses.

- Polycarbonate lenses are covered for children, monocular patients and patients with prescriptions greater than or equal to +/- 6.00 diopters.
- All lenses include scratch resistant coating.

Related Exclusions:

- Vision therapy for certain diagnoses where there is not adequate authoritative evidence of effectiveness.
- Glasses, frames and contact lenses are excluded, except as specifically listed in this section as a covered Vision Service.

EXCLUSIONS FROM COVERED SERVICES:

The *plan* does not cover the following services, regardless of the setting:

Note: when the word “services” is used in this section on Exclusions from Covered Services, it means any of the following: services, treatments, procedures, tests, devices, supplies, equipment or medications.

- Services not described as a covered service in this EOC.
- Services related to or furnished along with a non-covered service, except as otherwise expressly stated in Chapter 3- *Covered Services*. This includes costs for professional fees, medical equipment, drugs and facility charges.
- Services that are not medically necessary. The only exceptions are: voluntary termination of pregnancy; voluntary sterilization; prescription birth control drugs used for contraceptive purposes; and preventive health services described in Chapter 3.
- Services provided for your comfort or convenience, as a duplicate or back-up item, or personal or environmental comfort. All comfort or convenience items considered to be so by the Centers for Medicare and Medicaid Services (CMS) are excluded. Examples of excluded items include, without limitation: bedboards; bathtub lifts; bath/shower chair; overbed tables; adjust-a-beds; telephone arms; hot tubs; and water beds.
- Services: to accommodate your religious preference; to improve athletic performance; to promote a desired lifestyle; or to improve your appearance or your feelings about your appearance.
- Services received outside the *service area* except as specifically described in this EOC.
- Services provided by non-*Network Providers*, except as specifically allowed in this EOC.
- Services that do not conform to the *plans* clinical review criteria and guidelines.
- Services for which there is a less intensive level of service or more cost-effective alternative that can be safely and effectively provided, or if the service can be safely and effectively provided to you in a less intensive setting.
- Services that you received when you were not enrolled as a *member* under this *plan*. This includes before your *plan* membership began and after your *plan* membership ends. Also excluded are charges for services you receive after you choose to stay in a hospital or facility beyond the discharge time determined by the *plan*.
- Acupuncture; biofeedback (except for the treatment of urinary incontinence); hypnotherapy; TENS units or other neuromuscular stimulators and related supplies; electrolysis; relaxation therapies; massage therapies; myotherapy; holistic treatments; treatment at sports medicine clinics; services by a personal trainer; and any diagnostic services related to any of these programs, services or procedures.
- Chiropractic and Related Services: Chiropractic services, other than manual manipulation of the spine (up to the applicable *benefit limits*). Excluded services include treatment with or purchase of TENS units or other neuromuscular stimulators and related supplies.
- Claim Fees: A provider’s charges to file a claim.
- Cognitive rehabilitation programs; cognitive retraining programs; and diagnostic services related to these programs.
- Complementary or Alternative Medicine: This includes the following: acupuncture; Ayurveda; biofeedback (except for medically necessary treatment of urinary incontinence); craniosacral therapy; homeopathic, holistic and naturopathic treatments; hippotherapy; hypnotherapy; meditation;

prayer; mental healing; massage; myotherapy; pulsed or magnetic fields; electromagnetic or alternating-current or direct-current fields including TENS units and related supplies and electrolysis; Reiki; reflexology; relaxation therapies; therapeutic touch; therapies that use creative outlets such as art, music, dance, or yoga; pet therapy; treatment at sports medicine clinics; services by a personal trainer; and any diagnostic services related to any of these programs, services or procedures.

- Concierge Services: Any fees charged by a provider for so-called “concierge services.” These are fees charged: as a condition of selecting or using the services of the provider; or fees for amenities offered by the provider.
- Cosmetic Services/Cosmetic Surgery: These are services given solely for the purpose of making you look better, whether or not these services are meant to make you feel better about yourself or treat your mental condition. Examples of non-covered services are: injection of collagen or other bulking agents to enhance appearance; thigh, leg, hip or buttock lift procedures; blepharoplasty, unless it is medically necessary to prevent vision occlusion; facelift surgery or rhytidectomy; abdominal liposuction or suction assisted lipectomy of the abdomen; abdominoplasty; partial abdominoplasty; or repair of diastasis recti.
- Dermabrasion or other procedures to *plane* the skin; acne related services, such as the removal of acne cysts or injections to raise acne scars; electrolysis; wigs (except when expressly covered – see Chapter 3); hair removal, hair *transplants* or hair restoration; rhinoplasty (except as part of a medically necessary reconstructive surgery); liposuction; brachioplasty; treatment of spider veins; treatment of melasma; tattooing or reversal of tattooing; reversal of inverted nipples; body piercing; or removal or destruction of skin tags.
- Custodial care; long term care; or care in a rest home.
- Dental Services: The *plan* does not pay for any dental services, except
 - the *emergency* dental services and pediatric dental
 - those dental and orthodontic services specifically related to the treatment of Cleft Lip, Cleft Palate or both as set forth in Chapter 3.
 - Dental services are any service provided by a licensed dentist involving the diagnosis or treatment of any disease, pain, injury, deformity or other condition of the human teeth, alveolar process, gums, jaw or associated structures of the mouth. The *plan* also does not pay for splints or oral appliances.
- Dentures
- Equipment that does not meet the definition of “durable medical equipment” set forth in Chapter 3: Covered Services/Durable Medical Equipment and Orthotics. For example, equipment that is used primarily and customarily for a nonmedical purpose is not considered durable medical equipment, even if such equipment has a medically related use.
- Devices and Clothing, such as the following:
 - Devices such as: air conditioners; car seats; arch supports; bath seats; bed pans; chair lifts; computers; computerized communication devices; computer software; dentures; dental appliances; elevators; heating pads; hot water bottles; room humidifiers; air purifiers; medical bracelets; door alarms; raised toilet seats; bedding (such as dust mite covers); disposable supplies (such as sheets, bags, gloves, diapers, under pads, alcohol wipes and elastic stockings); sports-related braces; enuresis alarms; reachers; shoe horns; foot and shoe orthotics; shoe inserts (except for therapeutic and molded shoes and shoe inserts for *members* with severe diabetic foot disease).
 - Special clothing, except for: gradient pressure support aids for lymphedema or venous disease; clothing needed to wear a covered device (for example, mastectomy bras and stump socks); and therapeutic/molded shoes for *members* with severe diabetic foot disease.
 - Non-rigid appliances and supplies, such as: elastic stockings; garter belts; arch supports; corsets; and corrective shoes.
 - Safety equipment, such as: safe beds; crib enclosures; chest harness/seat belts; alert *emergency* response systems; and bath/shower grab bars.
 - Self-help devices that are not primarily medical items, such as: sauna baths, elevators, stair lifts, ramps, and special telephone or communication devices.
 - Self-monitoring devices, except if the *plan* decides that a device would give a *member* having certain symptoms the ability to detect or stop the onset of a sudden life-threatening condition.
 - Electronic and myoelectric artificial limbs.
 - Replacement or repair of durable medical equipment or prosthetic devices due to loss, intentional damage, negligence or theft.

- Hospital-grade breast pumps.
- Exercise and hygienic equipment: such as exercycles, treadmills, bidet toilet seats, bathtub seats, and hand held shower devices.
- Physician's equipment, such as: blood pressure cuffs and stethoscopes.
- Assistive technology and adaptive equipment: such as communication boards and computers; supine boards; prone standers; gait trainers; and other such equipment not intended for use in the home.
- Cryotherapy (i.e. Game Ready).
- Hot/cold compression therapy.
- Polar packs.
- Drugs that are described as not covered in Chapter 3 under "Prescription Drugs."
- Educational-Related Services: Examinations, evaluations or services for educational or developmental purposes, including: physical therapy, speech therapy and occupational therapy. Also excluded are services to treat learning disabilities, behavior problems and developmental delays and services to treat speech, hearing and language disorders in a school-based setting.
- Experimental or investigational treatments; or services related these treatments. If a service is an experimental or investigational treatment, the *plan* will not pay for that treatment or any related services that are provided to the *member* for the purpose of furnishing the experimental or investigational treatment. Exception: the *plan* will cover costs of clinical trials as specifically set forth in Chapter 3 – *Covered Services*.
- Government Program Benefits: Services for which you have the right to benefits under government programs. These include: the Veterans Administration for illness or injury related to military service; schools; and other programs set up by local, state, federal or foreign laws or regulations that provide or pay for health care services or that require care or treatment to be provided in a public facility. No coverage is provided if you could have received governmental benefits by applying for them on time.
- Harvesting of a human organ *transplant* donor's organ or stem cells when the recipient is not a *member*.
- For *members* over the age of 21 years of age: hearing aid devices; hearing aid supplies; ear molds; impressions; batteries; accessories; and instruction in use and care of hearing aid
- Hearing aid batteries or cleaning fluid
- Home improvements and home adaptation equipment
- Infertility services: The following are not covered:
 - Infertility services for any *member* who is not a Massachusetts resident.
 - Infertility services for *members* who are not "infertile" as defined under the Infertility Services section in Chapter 3.
 - Reversal of voluntary sterilization.
 - Infertility treatment needed as a result of prior voluntary sterilization, unless: the diagnosis of infertility is unrelated to a previous sterilization procedure; and if for a female, the diagnostic testing provides at least one patent fallopian tube; and if for a male, the sperm count meets the definition of normal as set forth in the *plan's* clinical review criteria.
 - Long term (longer than 90 days) sperm or embryo cryopreservation unless the *member* is in active infertility treatment.
 - Costs associated with donor recruitment, testing and compensation.
 - Donor sperm and associated laboratory services in the absence of diagnosed male factor infertility in the partner.
 - Infertility services necessary for conception as a result of voluntary sterilization or following an unsuccessful reversal of a voluntary sterilization.
 - Drugs for anonymous or designated egg donors that are directly related to a stimulated Assisted Reproductive Technology (ART) cycle, unless the ART service has been approved by a *plan* authorized reviewer, is provided at a *network* infertility services provider; and the *member* is the sole recipient of the donor's eggs.
 - Surrogacy/gestational carrier-related costs: this means all procedures and costs incurred by a fertile woman to achieve a pregnancy as a surrogate or gestational carrier for an infertile *member*.
 - Experimental or investigational infertility procedures.
- Maternity Services: Services or costs associated with *planned* home births. When you are outside the *service area*, the *plan* will not cover:
 - routine maternity services for prenatal or postpartum care; or

- delivery (including postpartum care and care provided to the newborn) or problems with pregnancy beyond the 37th week of pregnancy or any time after you have been told by your provider that you are at risk for early delivery. See Chapter 3: Inpatient Services/Maternity Care.
- Non-Members: Services for non-*members*, except as specifically described in this Chapter 3 under “Human Organ Transplants” or under “Hospice Services.”
- Medical Record Fees: Fees charged by providers for copies of your medical records.
- The following mental health/substance use disorder -related services are excluded:
- Equine-assisted psychotherapy
 - Psychoanalysis
 - Spiritual Direction
 - Interactive *individual* psychotherapy
 - *Individual* psychophysiological therapy incorporating biofeedback
 - Psychiatric evaluation of records and reports.
 - Neuropsychological rehabilitation.
 - Behavioral Health hotline service.
 - Mental health clubhouse services.
 - Halfway house services.
 - Mental health or substance use disorder services provided to Members who are in jail, prison, a house of correction or custodial facility.
 - Alcohol or drug testing for legal or other purposes unrelated to *Medical Necessity*.
 - Long-term residential treatment.
 - Custodial care.
 - Programs in which the Member has a pre-defined duration of care without the *Plan’s* ability to conduct concurrent determinations of continued *Medical Necessity*
 - Programs that only provide meetings or activities that are not based on *individualized* treatment *plans*.
 - Programs that focus solely on improvement in interpersonal or other skills rather than treatment directed toward symptom reduction and functional recovery related to lessening of specific psychiatric symptoms or syndromes.
 - Tuition-based programs that offer educational, vocational, recreational or personal development activities, such as a therapeutic school, camp or wilderness program.
- Missed or Cancelled Appointment Charges: Charges by providers for missed or cancelled appointments.
- Personal Comfort Items: Items that are primarily for your, or another person’s, personal comfort or convenience. Examples are telephones, radios, televisions and personal care items.
- Routine podiatric services and related durable medical equipment and medical supplies (except for *members* with diabetes – see “Diabetes” benefit in this Chapter 3). Exclusions include but are not limited to: routine foot care (trimming of corns, nails or other hygienic care); foot and shoe orthotics; arch supports; shoe inserts; fittings, casting and other services related to devices for the feet; or orthopedic or corrective shoes that are not part of a covered leg brace.
- Pre-*implantation* genetic diagnosis – except as specifically allowed under Infertility Services.
- Private Room Charges: Charges greater than the rate for a semi-private room (except when a private room is medically necessary).
- Private duty nursing (except as part of the Hospice benefit); and personal care attendants.
- Refractive eye surgery (including laser surgery, radial keratotomy and orthokeratology).
- Respite care, except when provided as part of a licensed hospice program.
- Safety items used in the absence of a disease or medical condition, such as: door alarms; and protective beds or bedding.
- Sensory integrative praxis tests.
- Services for which you are not legally obligated to pay; or services for which no charge would be made in the absence of health insurance.
- Services Furnished to You by Immediate Family: Services given to you by your immediate family (by blood or marriage) or anyone who ordinarily lives with you. “Immediate family” means: spouse or spouse equivalent; parent; child; brother; sister; stepparent; stepchild; stepbrother or stepsister; father-in-law; mother-in-law; daughter- in-law; brother-in-law; sister-in-law; grandparent; or grandchild.

- Third Party Required Treatment: Services required by a third party that are not otherwise medically necessary. Examples of third parties include: an employer; insurance company; licensing organization/agency; school; or court. Examples of services include: exams and tests required for recreational activities or employment; court-ordered exams; vocational evaluations on job adaptability; vocational rehabilitation; job placement; or therapy to restore function for a specific occupation. Also excluded are: tests to establish paternity; tests for forensic purposes; and post-mortem exams and tests.
- Snoring: Services to treat or reduce snoring. Examples include: laser-assisted uvulopalatoplasty; somnoplasty; snore guards; and any other snoring-related appliances.
- Taxes: A provider's charge for taxes; or sales tax related to any product delivered or given to a *member*.
- Services to treat TMJ (temporomandibular joint) syndrome; all TMJ-related appliances, other than a mandibular orthopedic repositioning appliance (MORA); services, procedures or supplies to adjust the height of teeth or in any other way restore occlusion, such as crowns, bridges or braces; and treatment of TMJ disorders that are not proven to be caused by or to result in a specific medical condition.
- Transportation and Lodging: Transportation (other than as described under "Ambulance Services" or "Human Organ Transplants" in Chapter 3) or lodging related to receiving any medical service.
- The following vision-related items and services:
 - Vision therapy for certain diagnoses where there is not adequate authoritative evidence of effectiveness.
 - Glasses, frames and contact lenses, except as specifically listed as covered under the Vision Services benefit.
- Weight – Related Services/Equipment: Commercial diet *plans*; weight loss or weight control programs and clinics (except those related to covered bariatric surgery or programs); and any services in connection with such *plans* or programs; and exercise equipment.
- Workers' Compensation: Care for conditions for which benefits are available under a workers' compensation *plan* or an employer under state or federal law.

CHAPTER 4. ELIGIBILITY, ENROLLMENT, PREMIUM PAYMENTS AND TERMINATION

Eligibility

Subscribers: You are eligible to enroll as a *subscriber* if you are an employee of a group and you meet WellSense's and your group's eligibility and verification requirements.

Dependents: You are eligible to enroll as a *dependent* of the *subscriber* if you meet any of the following:

- you are the *subscriber's* spouse or child as defined in Appendix A; or
- you are the *subscriber's* legal civil union partner according to the law of the state in which the *subscriber* resides; and the group provides for such civil union partner eligibility; or
- you are the domestic partner of the *subscriber*; and the group provides for domestic partner eligibility; or
- you are a disabled *dependent* as defined in Appendix A.

Dependents must also meet any other WellSense and group eligibility and verification requirements, including any residency requirements that are consistent with state and federal law.

Note: If you are properly enrolled in the *plan* but live outside the *service area* in accordance with the *plan's* eligibility rules: you are only covered for *emergency* and *urgent care*; you may come into the *service area* at any time to obtain full coverage for *covered services* from *Network Providers*; and all *cost-sharing* and other payment rules apply to services received outside the *service area*.

Acceptance: Acceptance into the *plan* is never based on: your income; physical or mental condition; age; occupation; claims experience; duration of coverage; medical condition; gender; sexual orientation; religion; physical or mental disability; ethnicity or race; previous status as a *member*; pre-existing conditions; or actual or expected health condition. We do not use the results of genetic testing in making decisions about enrollment, eligibility, renewal, payment or coverage of healthcare services. Also, we do not consider any history of domestic abuse or actual or suspected exposure to diethylstilbestrol (DES) in making these decisions.

Verification of Eligibility: The *plan* may require reasonable verification of eligibility from time to time. Examples include proof of: residence; marital status; disabled *dependent* status; or birth or adoption of a child. You must provide us with proof when asked. Your enrollment in the *plan* may continue for as long as you continue to meet eligibility requirements and applicable *premium* is paid. A *member's* failure to cooperate with our reasonable requests for proof of eligibility or continuing eligibility may result in termination from the *plan*.

Coverage:

- Once you are properly enrolled in the *plan*, we will pay for *covered services* that are given to you on or after your coverage effective date in accordance with this EOC.
- If Hospitalized When Membership Begins: If you are an inpatient on your coverage effective date, you will be covered by the *plan* under this EOC as of your coverage effective date as long as you or someone acting on your behalf call the *plan* and allow us to manage your care. This may include a transfer to a *network* hospital, if medically appropriate.
- WellSense does not impose any waiting periods or pre-existing condition limits or exclusions. Your group may have its own waiting period – contact your group for more information.
- The *plan* does not pay for any services, supplies or drugs you received prior to your coverage effective date with the *plan*.

Enrollment

Initial Enrollment: A *subscriber*, along with eligible *dependents*, may enroll in this *plan* on his/her initial group eligibility date. This date is determined by your group and the *plan*. Your group will tell you how and when you may enroll. If you

choose not to enroll for coverage on your initial eligibility date, you may enroll only: during your group's annual open enrollment period; or as a result of a special enrollment event as provided by law. See below.

Open Enrollment Period: If you do not enroll on your initial eligibility date, or you did enroll but now want to make enrollment changes, you may enroll or make enrollment changes during your group's open enrollment period. This is the time each year when eligible persons are able to apply for coverage or make changes to existing coverage for the next year. The group will tell you the time of your open enrollment period and how to enroll or make changes.

Special Enrollment: If you chose not to enroll in the *plan* on the initial group eligibility date, federal or MA law may allow you to enroll when:

- You have a loss of other qualified coverage – see Loss of Other Qualified Coverage below; or
- The employee gains a new eligible *dependent* – see Adding New Dependents below; or
- You become eligible for assistance under a state Medicaid or CHIP program.

There may be additional special enrollment rights under state or federal law. Please ask your group or call the *plan* for further information.

Loss of Other Qualified Coverage: An eligible employee may choose not to enroll himself/herself, or an eligible *dependent*, in this *plan* on the initial group eligibility date because he or she had other qualified health coverage as defined by federal law. In this case, the eligible employee and/or *dependent* may enroll if, at a later date, he or she loses that other qualified health coverage due to any of the following reasons:

- You involuntarily cease to be eligible for the other qualified health coverage. (Example, this could mean that the loss of other qualified coverage was due to the loss of: a spouse's coverage; divorce; death of a spouse; loss of *dependent* status; involuntary termination; or loss of coverage under a Medicaid or CHIP program.)
- The employee or eligible *dependents* exhaust their continuation of group coverage under the other qualified group health *plan*.
- The employer sponsoring the other qualified group health *plan* coverage ceases to make employer contributions for that coverage.

This special enrollment right does not apply if the loss of other qualified coverage is due to the employee or *dependent's* failure to pay applicable *premiums*.

Adding New Dependents: After the *subscriber* enrolls, he or she may apply to add any eligible *dependents* who are not currently enrolled in the *plan* only as follows:

- During the group's open enrollment period; or
- Within 30 days after any of the following events:
 - Your marriage, divorce, legal separation or marriage annulment.
 - The birth of a child.
 - The adoption of a child as of the earlier of the date the child is placed with you for the purpose of adoption or the date you file a petition to adopt.
 - A court orders you to cover a child through a Qualified Medical Child Support Order, or otherwise.
 - Other reasons as may be required by state or federal law.

Time Requirement for Special Enrollments:

- You must notify your group no later than 30 days after: the date of loss of other qualified coverage; or the date of the event qualifying you to add a new *dependent*. If you do not request enrollment within 30 days, you will have to wait until the group's next open enrollment period to enroll in this *plan*.
- Special Rule: If your special enrollment right is the result of a termination of coverage, or eligibility for assistance, under a state Medicaid or CHIP program, you must notify your group no later than 60 days after: the date coverage terminates; or the date you are determined to be eligible for assistance.

How to Enroll: Talk to your group about specific enrollment procedures or call Member Services.

Newborn and Adoptive Children - Coverage:

- A newborn infant of a *member* is eligible for coverage under the *plan* from the moment of birth as required by

MA law. The *subscriber* must properly enroll the newborn in the *plan* within 60 days of the birth. If the *subscriber* enrolls the newborn within these 60 days, the newborn is covered from the time of birth for all *covered services*. However, if the *subscriber* does not enroll the newborn within 60 days of the birth: the *plan* will only cover the costs of routine nursery charges and well newborn care (see Chapter 3 – Inpatient Services/Maternity Care); and the *subscriber* must wait until the next open enrollment period to enroll the child.

- The *subscriber* must enroll an adoptive child within 60 days after: the date of filing a petition to adopt the child; or the date the child is placed with the *subscriber* for the purpose of adoption. Otherwise, the *subscriber* must wait until the next open enrollment period to enroll an adoptive child.
- Choose a *PCP* for your newborn or adoptive child within 48 hours: after the newborn's birth, or after the date of adoption or placement for adoption. This *PCP* can manage your child's care from the time of birth or adoption.
- Contact Member Services or your group for further information about enrolling a newborn or adoptive child.

Change in Eligibility Status: It is the *subscriber's* responsibility to notify the group of all family changes that may affect: his/her or a *dependents'* eligibility under the *plan*; or the amount of *premium* that must be paid for coverage under the *plan*. Notification must occur within 60 days of the event. Changes requiring notice include the following:

- Having a baby or adopting a child.
- Marriage, divorce or legal separation; or the remarriage of a former spouse enrolled in the *plan*.
- Address changes and/or moving out of the *plan's* service area.
- Death of a *member*.
- When the *subscriber* or a *dependent* no longer meets the *plan's* or group's eligibility requirements.

Note: Changes in *dependents* covered by the *plan* may result in a change to the *premium*.

Address and Phone Changes: Notify the *plan* if your address or phone number changes. This will ensure that you receive important notices and information from us.

Premium Payments: Groups are required to pay a monthly *premium* to the *plan* or its designee. The *plan* will tell your group the *premium* amount and monthly due date. The *premium* must be paid by the due date stated on the *premium* bill. Only *members* for whom the *plan* has received applicable *premium* are entitled to *covered services*. In the event a group is late (delinquent) in paying required *premiums*, and to the extent permitted by law, the *plan*, in its sole discretion, may suspend payment of claims and/or prior authorization of services until full *premium* payment is received. Note:

- The amount of *premium* a group is required to pay may change during the term of this EOC. The *plan* will notify your group of any changes in *premium*.
- The *plan* will send *subscribers* an annual notice stating the *premium* that is paid by your group.

Termination of Group Coverage: Coverage under the *group contract* will end under any of the following circumstances:

Loss of Eligibility for Group Coverage: Your coverage under the *plan* will be terminated when you are no longer eligible for group coverage (subject to the continuation of coverage provisions described in Chapter 5).

- *Subscriber's* Eligibility Ends. A *subscriber's* coverage will end when he or she loses eligibility for the group's health coverage. Reasons include: the *subscriber* leaves employment; the *subscriber's* hours are reduced; or the *subscriber* no longer meets the rules set by the *plan* or group for coverage under the *group contract*. If a *subscriber's* coverage ends, coverage of all his/her enrolled *dependents* also ends.
- *Dependent's* Status Ends. A *dependent's* coverage will end when he or she loses their status as a *dependent*.

You no longer meet the *plan's* residency or work location requirements. In this case, your group may be able to provide you with alternative coverage if you are still eligible under the group's health benefit *plan*. Call your group for more information. Notify your group of this change.

- Your Group Fails to Pay Premiums. Coverage of all group *members* will end if the group fails to pay *premium* to WellSense by the date specified in the *group contract*. In this case, WellSense will notify you in writing (at your last known address) within 60 days after the effective date of termination of your group coverage in accordance with MA law. The effective date of termination is retroactive to the last day of the coverage month for which *premium* was paid. Our notice to you will describe: your right to elect Temporary Continuation of Coverage (TCC) and coverage under an *individual contract*; and how to elect TCC. If you elect TCC and pay the required *premium* to WellSense, TCC coverage will cover you during the period between the effective date of termination of your *group contract* coverage and the date our written notice of termination to you was effective. (TCC *covered services* are exactly the same as those under your *group contract* coverage.) Unless a *subscriber* elects the TCC option and makes the required *premium* payment, the *subscriber* is responsible for all claims for services received after the effective date of termination (which can be up to 60 days back). Upon termination of TCC, you may be eligible to elect coverage under an *individual contract*. For more information about *individual contracts*, call Member Services.
- Relationship Between Group and WellSense Ends. Your coverage will end if the relationship between your group and WellSense ends for reasons other than the group's non-payment of *premium*. Examples are: the *group contract* is terminated by the group or WellSense as permitted by that *contract*; the *group contract* is not renewed; your group no longer qualifies for group coverage (e.g., your group is no longer operating); or WellSense stops operating. If coverage terminates under this subsection, we will send a notice of termination to your group with the effective date of termination. Your group is responsible to notify you of the termination. WellSense is not responsible if your group does not notify you of the termination.

Termination of Group Coverage by the Subscriber: Your coverage in this *plan* will end when the *subscriber* chooses to cancel his/her coverage as permitted by the group. Contact your group for more information.

Termination of Member Coverage by WellSense: WellSense may cancel your coverage under the *group contract* under the following situations:

- You commit acts of physical or verbal abuse that pose a threat to any provider, other *plan members*, WellSense or any WellSense employee, and these acts are unrelated to your physical or mental condition.
- You commit intentional misrepresentation or fraud to the group or WellSense. Examples include:
 - You gave false or misleading information on the enrollment form.
 - You enrolled as a *dependent* someone who is not your *dependent*.
 - You let another person use your ID card to attempt to get coverage to which they are not entitled.

Termination under this subsection may go back to your effective date or to the date of the misrepresentation or fraud, as determined by WellSense in accordance with applicable law. If your coverage was terminated under this subsection, you will not be allowed to enroll under another WellSense *plan*.

- You fail to comply in a material way with any provision of the *group contract* or EOC. Example: you fail to comply with our reasonable request for information to verify eligibility.
- WellSense discontinues this *plan*. We may discontinue this *plan* for any reason as of a date approved by the Massachusetts Commissioner of Insurance.

Other Information Related to Termination:

Benefits after termination: We will pay for all *covered services* you received between: your coverage effective date and your termination date. The *plan* will not pay for any services or drugs you receive after coverage ends, even if:

- you were receiving inpatient or outpatient care before your coverage ended; or
- you had a medical condition (known or unknown), including pregnancy, that requires medical care after your coverage ends.

Voluntary and Involuntary Disenrollment Rates for Members: The *plan* will annually notify you of the voluntary and involuntary *member* disenrollment rate.

Continuation of Coverage: Once your coverage ends, you may be eligible to continue your coverage with us under the group *contract* or to enroll under an *individual contract*. See Chapter 5 below.

CHAPTER 5: CONTINUATION OF GROUP COVERAGE

Continuation of Group Coverage Under Federal Law (COBRA): Under the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), group *members* may be eligible to continue coverage under the *group contract* if: you were enrolled in a group which has 20 or more eligible employees; you experience a qualifying event which would cause you to lose coverage under your group; and you elect coverage as provided under COBRA. Below is a brief summary of COBRA continuation coverage.

- **Qualifying Events:** Qualifying events that may entitle you to COBRA continued coverage are as follows:
 - Termination of the *subscriber's* employment (for reasons other than gross misconduct).
 - Reduction in the *subscriber's* work hours.
 - The *subscriber's* divorce or legal separation.
 - Death of the *subscriber*.
 - The *subscriber's* entitlement to Medicare.
 - Loss of status as an eligible *dependent*.
- **Period of Continued Coverage Under COBRA:** The period of continued group coverage begins with the date of your qualifying event. The length of this continued group coverage will be up to 36 months from that qualifying event. This is true except for termination of the *subscriber's* employment or the reduction in the *subscriber's* work hours, in which cases continued group coverage is available for only 18 months, or, if you are qualified for disability under Title II or XVI of the Social Security Act, up to 29 months. COBRA coverage will end at the end of the maximum period of coverage; however, coverage may end earlier if: *premium* is not paid on time; your group ceases to maintain any group health *plan*; the group terminates its *group contract* with the *plan* (in which case your coverage may continue under another health *plan*); or for other reasons such as the end of disability, or becoming eligible for or obtaining other coverage.
- **Cost of Coverage:** In most cases, you are responsible for payment of 102% of the cost of coverage.
- **Continued Coverage for Disabled Subscribers:** At the time of the *subscriber's* termination of employment or reduction in work hours (or within 60 days of the qualifying event under federal law), if a *subscriber* or his or her eligible *dependent* is determined to be disabled under Title II or Title XVI of the Social Security Act, continued group coverage will be available for up to 29 months from the date of the qualifying event. The *premium* cost for the additional 11 months may be up to 150% of the *premium* rate.
- **Enrollment:** In order to enroll, you must complete an election form and return it to your group. The form must be returned within 60 days from your date of termination of group coverage or your notification (by your group) of eligibility, whichever is later. If you do not return the completed form, it will be considered a waiver. This means you will not be allowed to continue coverage in this *plan* under a *group contract*.
- **For more information about COBRA:** contact your group or Member Services.

Continuation of Group Coverage Under Massachusetts (MA) Law: Under MA continuation coverage law, group *members* may be eligible to continue coverage under the *group contract* if: you were enrolled in a group which has 2 – 19 eligible employees; you experience a qualifying event which would cause you to lose coverage under your group; and you elect coverage as provided by MA law. Below is a brief summary of MA continuation coverage.

- **Qualifying Events:** Qualifying events that may entitle you to continued coverage under MA law are as follows:
 - Termination of the *subscriber's* employment (for reasons other than gross misconduct).
 - Reduction in the *subscriber's* work hours.
 - The *subscriber's* divorce or legal separation.
 - Death of the *subscriber*.
 - The *subscriber's* entitlement to Medicare.
 - Loss of status as an eligible *dependent*.
- **Period of Continued Coverage:** In most cases, continuation coverage is effective on the date following

the day group coverage ends. In most cases, it ends 18 or 36 months from the date of the qualifying event, depending on the type of qualifying event.

- **Cost of Coverage:** In most cases, you are responsible for payment of 102% of the group *premium*.
- **Enrollment:** In order to enroll, you must complete an election form and return it to your group. The form must be returned within 60 days from your date of termination of group coverage or your notification (by your group) of eligibility, whichever is later. If you do not return the completed form, it will be considered a waiver. This means you will not be allowed to continue coverage in this *plan* under a *group contract*.
- **For more information about MA Continuation Coverage:** contact your group or the *plan*.

Plant Closing: Under MA law, group *members* who lose eligibility for coverage under a *group contract* due to a *plant* closing or a partial *plant* closing (as defined by law) may be eligible to continue coverage under the *group contract* for up to 90 days after the *plant* closing. If this happens to you, the *subscriber* and his/her group will each pay your shares of the *premium* cost for up to 90 days after the *plant* closing. The group is responsible to notify *subscribers* of their eligibility. Call your group or the *plan* for further information.

Divorce or Separation: In the event of a divorce or legal separation, the person who was the spouse of the *subscriber* prior to the divorce or legal separation will remain eligible for coverage in this *plan* under the *subscriber's* *group contract*, whether or not the judgment was entered prior to the effective date of the *group contract*. This coverage requires no additional *premium* other than the normal cost of covering a current spouse. The former spouse remains eligible for this coverage only until the first to occur of the following: the *subscriber* is no longer required by the judgment to provide health insurance for the former spouse; or the *subscriber* or former spouse remarries. If the *subscriber* remarries, and the judgment so provides, the former spouse may continue coverage under the *plan* in accordance with MA law.

Coverage Under an Individual Contract: If your group coverage ends, you may be eligible to enroll in coverage under an *individual contract*. This coverage may be offered through the Commonwealth Health Insurance Connector Authority ("Health Connector") or directly by WellSense. Please be aware that coverage under an *individual contract* may differ from coverage under a *group contract*. For more information, call the Health Connector (877-MA-ENROLL), go to the Health Connector website (mahealthconnector.org) or call WellSense Member Services.

CHAPTER 6. MEMBER SATISFACTION PROCESS

Introduction: The *plan* is committed to solving any concerns you may have about: how the *plan* is operated; your benefits; or the quality of health care you received from *Network Providers*. To do so, we have the following processes (each one described in greater detail below) depending on the type of concern you have:

- Internal *Inquiry* Process.
- Internal *Grievance* Process.
- Internal *Appeals* Process (including *Expedited Appeals*).
- External Review by the Massachusetts Health Policy Commission/Office of Patient Protection.

Internal Inquiry Process:

What is an *Inquiry*? An *Inquiry* is any communication you make to the *plan* asking us to address a *plan* action, policy or procedure.

Internal *Inquiry* Process: This is an informal process used to resolve most *Inquiries*. Call Member Services at 855-833-8120 to discuss your concern.

Note: The Internal *Inquiry* Process is not used to resolve concerns about the quality of care received by you or an Adverse Determination (coverage denial based on *Medical Necessity*). If your concern involves:

- the quality of care you received from a *Network Provider* - Member Services will refer your concern directly to our Internal *Grievance* Process (see below).
- an Adverse Determination - Member Services will refer your concern directly to our Internal *Appeals* Process (see below).

Member Services staff will review and investigate your *Inquiry* and in most cases respond by phone to you within 3 working days. During our call we will: tell you our decision; or tell you that we were unable to resolve your *Inquiry* within 3 working days. If you tell us that you are not satisfied with our decision, or we were unable to resolve your *Inquiry* within 3 working days, we will offer to start a review of your concern through our formal Internal *Grievance* or *Appeal* Process (see below). The process we use depends on the type of *Inquiry* that you made.

Internal Grievance Process:

What is a *Grievance*? A *Grievance* is a formal complaint by you about:

- *Plan Administration* (how the *plan* is operated): any action taken by a *plan* employee, any aspect of the *Plan's* services, policies or procedures, or a billing issue.
- *Provider Access, Attitude, or Service*: any dissatisfaction with a *plan Network Provider* due to lack of provider availability, how you feel you were treated by a provider or a member of their staff or lack of cleanliness of a provider office
- *Quality of Care*: The quality of care you received from a *plan Network Provider*. We refer to this type of *Grievance* as a "quality of care *Grievance*." (If you are comfortable doing so, we encourage you to talk first with the *Network Provider* about quality of care concerns before filing a quality of care *Grievance*. However, you are not required to do so before filing this type of *Grievance* with us.)

Note: The Internal *Grievance* Process is not used to resolve complaints that are or could be *Appeals*. These types of complaints are addressed through the Internal *Appeals* Process. (See below).

How and Where You Can File a *Grievance*: The preferred way for you to file a *Grievance* is for you to put it in writing and send it to us by regular mail or by fax. You can also deliver it in person to one of our offices. (See Address and Telephone Directory in the beginning of this EOC.). You may also submit your *Grievance* orally in person or by calling Member Services at **855-833-8120**. For oral *Grievances* related to **mental health and/or substance use disorder services**, you must call **877-957-5600**. If you file your *Grievance* orally, we will write a summary of your *Grievance* and send you a copy within 48 hours of receipt (unless the time limit is extended by mutual written agreement).

Written *Grievances* should include:

- your name;
- address;
- *plan* ID number;
- daytime phone number;
- detailed description of the *Grievance* (including relevant dates and provider names);
- any applicable documents that relate to your *Grievance*, such as billing statements; and
- the specific result you are requesting.

You must send your written Grievance to:

WellSense Health Plan Employer Choice Direct

529 Main Street, Suite 500
 Charlestown, MA 02129
 Attention: Member Grievances
 Fax: 617-897-0805

If you want to submit a *Grievance* in person, you can go to the address above.

Written Grievances pertaining to **mental health and/or substance use disorder services** should include the information referenced above and must be sent to:

**Quality Department
 Carelon Behavioral Health, Inc.**

P.O. Box 1856
 Hicksville, NY 11802
 Telephone: 877-957-5600
 Fax: 781-994-7642

When to File a *Grievance*: You can file your *Grievance* any time within 180 days of the date of the applicable event, situation or treatment. We encourage you to file your *Grievance* as soon as possible.

Plan Acknowledgment of Your *Grievance*: If you filed a written *Grievance*, we will send you a letter ("acknowledgement") telling you that we received your *Grievance*. We will send this letter within 15 working days of our receipt of your *Grievance*. If you filed your *Grievance* orally, our summary of your *Grievance* will be sent to you within 48 hours of receipt of your *Grievance*. This summary will serve as both a written record of your *Grievance* as well as an acknowledgment of our receipt. These time limits may be extended by mutual written agreement between you and us.

Release of Medical Records: We may request a signed Authorization to Release Medical Records form. This form authorizes providers to release medical information to us. It must be signed and dated by you or your Authorized Representative. (When signed by an Authorized Representative, appropriate proof of authorization to release medical information must be provided.) If an Authorization to Release Medical Records form is not included with your *Grievance*, Member Services will promptly send you a blank form. It is very important that you fill out and send us this form. This allows us to obtain medical information we will need to address your *Grievance*. If we do not receive this form within 30 calendar days of the date we received your *Grievance*, we may respond to your *Grievance* without having reviewed relevant medical information. In addition, if we receive the form from you but your provider does not give us your medical records in a timely fashion, we will ask you to agree to extend the time limit for us to respond to your *Grievance* (see "Timelines for Review and Response to Your *Grievance*," below). If we cannot reach agreement with you on a timeline extension, we may respond to your *Grievance* without having reviewed relevant medical information.

Who Will Review Your *Grievance*: *Plan* or provider administrative *Grievances* will be investigated and reviewed by an *Appeals & Grievances* Specialist. He or she will also talk with other appropriate departments or provider and/or members of their staff. Quality of care *Grievances* will be investigated and reviewed by a clinical staff member within the Office of Clinical Affairs. All reviews will be done by appropriate *individuals* who know about the issues involved in

your *Grievance*. Resolutions will be based on: the terms of this EOC; the opinions of your treating providers; the opinions of our professional reviewers; applicable records provided by you or providers; and any other relevant information available to us.

Timelines for Review and Response to Your *Grievance*: We will send you a written response within 30 calendar days of our receipt of your *Grievance*. The 30 calendar day period begins as follows:

- If your *Grievance* requires us to review your medical records, the 30 calendar day period does not begin until we receive from you a signed Authorization to Release Medical Information form.
- If your *Grievance* does not require us to review your medical records, the 30 calendar day period begins: on the next working day following the end of the 3 working day period for processing Inquiries through the Internal *Inquiry* Process, if the *Inquiry* was not addressed within that time period; or on the day you notified us that you were not satisfied with the response to the *Inquiry*.

These time limits may be extended by mutual written agreement between you and us. Any extension will not exceed 30 calendar days from the date of the agreement. If we don't respond to a *Grievance* that involves benefits within the time frames described in this section, including any mutually agreed upon written extension, your *Grievance* will be deemed resolved in your favor.

Our written response to your *Grievance* will describe your other options, if any, for further *plan* review of your *Grievance*.

No *Grievance* shall be considered received by us until actual receipt of the *Grievance* by the *plan* at the appropriate address or telephone number listed above under "How and Where You Can File a *Grievance*."

Internal Appeals Process:

What is an *Appeal*? An *Appeal* is a formal complaint by you about a Benefit Denial, an Adverse Determination, or a Retroactive Termination of Coverage – all as specifically defined as follows:

- Benefit Denial:
 - A *plan* decision, made before or after you have obtained services, to deny coverage for a service, supply or drug that is specifically limited or excluded from coverage in this EOC; or
 - A *plan* decision to deny coverage for a service, supply or drug because you are no longer eligible for coverage under the *plan*. (This means you no longer meet the *plan's* eligibility criteria.)
- Adverse Determination: A *plan* decision, based on a review of information provided, to deny, reduce, modify or terminate an admission, continued inpatient stay or the availability of any other health care services, for failure to meet the requirements for coverage based on: *Medical Necessity*; appropriateness of health care setting and level of care; or effectiveness. These are often known as *Medical Necessity* denials because in these cases the *plan* has determined that the service is not medically necessary for you.
- Retroactive Termination of Coverage: A retroactive cancellation or discontinuance of enrollment as a result of the *plan's* determination that: you have performed an act, practice or omission that constitutes fraud; or you have intentionally misrepresented a material fact with regard to the terms of the *plan*.

How and Where You Can File an *Appeal*:

- The preferred way for you to file an *Appeal* is for you to put it in writing and send it to us by regular mail or by fax at 617-897-0805
- You can also deliver it in person to our office. (See Address listed below in this section).
- You may also submit your *Appeal* orally by calling Member Services at 855-833-8120.
- For oral *Appeals* related to **mental health and/or substance** use disorder services, you must call **877-957-5600**.
- If you file your *Appeal* orally, we will write a summary of your *Appeal* and send you a copy within 48 hours of receipt (unless the time limit is extended by mutual written agreement).

Written *Appeals* should include:

- your name;
- address;

- *plan* ID number; daytime phone number;
- detailed description of the *Appeal* (including relevant dates and provider names);
- any applicable documents that relate to your *Appeal*, such as billing statements; and
- the specific result you are requesting.

You must send your written Appeal to:

WellSense Health Plan Employer Choice Direct

Attention: Member Appeals

529 Main Street, Suite 500
 Charlestown, MA 02129
 Fax: 617-897-0805

If you want to submit an *Appeal* in person, you can go to any of our office location listed above

Written *Appeals* pertaining to **mental health and/or substance** use disorder services should include the information referenced above and must be sent to:

**Appeals Coordinator
 Carelon Behavioral Health, Inc.**

P.O. Box 1856
 Hicksville, NY 11802
 Telephone: 877-957-5600
 Fax: 781-994-7636

When to File an Appeal: You can file your *Appeal* any time within 180 days of the date of the original coverage denial. *Appeals* received after 180 days of the date of the original coverage denial will not be reviewed. We encourage you to file your *Appeal* as soon as possible.

Plan Acknowledgment of Your Appeal: If you filed a written *Appeal*, we will send you a letter (“acknowledgment”) telling you that we have received your *Appeal*. We will send you this letter within 5 working days of receipt of your *Appeal*. If you filed your *Appeal* orally, the *Appeals & Grievances Specialist’s* written summary of your *Appeal* will be sent to you within 48 hours of receipt of your *Appeal*. This summary will serve as both a written record of your *Appeal* as well as an acknowledgment of our receipt. These time limits may be extended by mutual written agreement between you and the *plan*.

Release of Medical Records: If your *Appeal* requires us to review your medical records, you must include a signed Authorization to Release Medical Records form. This form authorizes providers to release medical information to us. It must be signed and dated by you or your Authorized Representative. (When signed by an Authorized Representative, appropriate proof of authorization to release medical information must be provided.) If an Authorization to Release Medical Records form is not included with your *Appeal*, the *Appeals Specialist* will promptly send you a blank form. It is very important that you fill out and send us this form so that we can obtain medical information we will need to address your *Appeal*. If we do not receive this form within 30 calendar days of the date we received your *Appeal*, we may respond to your *Appeal* without having reviewed relevant medical information. In addition, if we receive the form from you but your provider does not give us your medical records in a timely fashion, we will ask you to agree to extend the time limit for us to respond to your *Appeal* (see “Timelines for Review and Response to Your Appeal,” below). If we cannot reach agreement with you on a timeline extension, we may respond to your *Appeal* without having reviewed relevant medical information.

Who Will Review Your Appeal: *Appeals* will be investigated by an *Appeals & Grievances Specialist*. He or she will also talk with other appropriate departments and your providers. All decisions will be made by appropriate *individuals* who know about the issues involved in your *Appeal*. *Appeals* regarding Adverse Determinations will also be reviewed by at least one reviewer who is an actively practicing health care professional in the same or similar specialty that typically treats the medical condition, performs the procedure or provides the treatment that is the subject of your *Appeal*.

Decisions will be based on: the terms of this EOC; the opinions of your treating providers; the opinions of our professional reviewers; applicable records provided by you or providers; and any other relevant information available to the *plan*.

Timelines for Review and Response to Your Appeal: We will send you a written response within 30 calendar days of our receipt of your *Appeal*. The 30 calendar day period begins as follows:

- If your *Appeal* requires us to review your medical records, the 30 calendar day period does not begin until we receive from you a signed Authorization to Release Medical Information form.
- If your *Appeal* does not require us to review your medical records, the 30 calendar day period begins: on the next working day following the end of the 3 working day period for processing Inquiries through the Internal *Inquiry* Process, if the *Inquiry* was not addressed within that time period; or on the day you notified us that you were not satisfied with the response to the *Inquiry*.

These time limits may be extended by mutual written agreement between you and us. Any extension will not exceed 30 calendar days from the date of the agreement.

No *Appeal* shall be considered received by us until actual receipt of the *Appeal* by the *plan* at the appropriate address or telephone number listed above under "How and Where You Can File an *Appeal*."

Written responses to Adverse Determinations that deny all or part of your request for coverage will explain your right to request an External Review from an *independent* External Review Agency. This Agency *contracts* with the Massachusetts Health Policy Commission/Office of Patient Protection.

If we don't respond to your *Appeal* within the time frames described in this section, including any mutually agreed upon written extension, your *Appeal* will be deemed to be decided in your favor.

Expedited (Fast) Internal Appeals Process:

What Is An Expedited Appeal? An Expedited *Appeal* is a faster process for resolving an *Appeal*. This faster process can be used when there has been a denial of coverage involving immediate or urgently-needed services. The types of *Appeals* that are eligible for the Expedited *Appeals* Process are *Appeals* involving: substantial risk of serious and immediate harm; inpatient care; durable medical equipment; and terminal illness. (See below for further information.) Expedited *Appeals* will not be used to review a Benefit Denial or Rescission of Coverage.

How and Where You Can File an Expedited Appeal: You file an Expedited *Appeal* in the same manner as you file a standard *Appeal*. See above section: "How and Where You Can File an *Appeal*."

Review and Response to Your Expedited Appeal:

- **Substantial Risk of Serious and Immediate Harm:** Your *Appeal* will be an Expedited *Appeal* if it includes a signed certification by a physician that, in the physician's opinion: the service is medically necessary; a denial of such service would create a substantial risk of serious harm to you; and the risk of serious harm is so immediate that the provision of such service should not await the outcome of the standard Internal *Appeals* Process. This means we will review and resolve your Expedited *Appeal* and send you a written decision within 72 hours of receipt of this certification (unless a different time limit, described below, applies to you).
- **Inpatient Care:** Your *Appeal* will be an Expedited *Appeal* if you are an inpatient in a hospital and your *Appeal* concerns an Adverse Determination by us that inpatient care is no longer medically necessary. This means we will review and resolve your Expedited *Appeal* before you are discharged. If our decision continues to deny coverage of continued inpatient care, we will send you a written decision before you are discharged.
- **Durable Medical Equipment ("DME") Needed to Prevent Serious Harm:** Your *Appeal* will be an Expedited *Appeal* if the *Plan* receives certification from your provider responsible for the treatment proposed noting that in the provider's opinion: 1) the durable medical equipment is medically necessary; 2) a denial of coverage for the durable medical equipment would create a substantial risk of serious harm to you; 3) such risk of serious harm is so immediate that the provision of durable medical equipment should not await the outcome of the standard *Appeals* process; and 4) the provider must further certify as to the specific,

immediate and severe harm that will result to the *member* absent action within the 48 hour time period. Also, the *Plan* will automatically reverse an initial denial for durable medical equipment within 48 hours or less, pending the outcome of the internal *Appeal*,

- Terminal Illness: Your *Appeal* will be an Expedited *Appeal* if you have a terminal illness and submit an *Appeal* for coverage of services. (A terminal illness is one that is likely to cause death within 6 months.) This means we will provide you a written resolution within 5 working days of receipt of your *Appeal*. If our decision continues to deny of coverage, you may request a conference with us to reconsider the denial. We will schedule the conference within 10 days of receiving your request. If your physician, after consulting with the *plan's* Medical Director, decides that the effectiveness of the proposed service would be materially reduced if not furnished at the earliest possible date, we will schedule the hearing within 5 working days. You and/or your Authorized Representative may attend the conference. Following the conference, we will provide you a written decision.

If we don't respond to your Expedited *Appeal* within these time frames, including any mutually agreed upon written extension, your Expedited *Appeal* will be deemed to be decided in your favor. Also, you may be entitled to pursue remedies under: applicable state law; or section 502(a) of ERISA (for *members* enrolled through a *group contract* subject to ERISA.

Other Important Information:

Who Can File a *Grievance* or *Appeal*: You may file your own *Grievance* or *Appeal*. Or, you may choose to have another person – known as an *Authorized Representative* – act on your behalf and file for you. You must appoint an Authorized Representative in writing to us on our form entitled: "Appointment of Authorized Representative." (If you are an inpatient, a health care professional or a hospital representative may be your Authorized Representative without your having to fill out this form.) An Authorized Representative may be: a family member; agent under a power of attorney; health care agent under a health care proxy; a health care provider; attorney; or any other person appointed in writing by you to represent you in a specific *Grievance* or *Appeal*. We may require documentation that an Authorized Representative meets one of the above criteria.

Reconsideration of a Final Adverse Determination: The *plan* may offer you the opportunity for reconsideration of its final *Appeal* decision on an Adverse Determination We may offer this when, for example, relevant medical information: was received too late for us to review it within the 30 calendar day time limit for standard *Appeals*; or was not received but is expected to become available within a reasonable time following our written decision on your *Appeal*. If you request reconsideration, you must agree in writing to a new review time period not to be more than 30 calendar days from the agreement to reconsider the *Appeal*.

External Review Process for Your *Appeal*: The External Review process allows you to have a formal *independent* review of a final Adverse Determination made by us through our standard Internal *Appeals* Process or Expedited Internal *Appeals* Process. Only final Adverse Determinations are eligible for External Review – with two exceptions: no final Adverse Determination is necessary if (1) the *plan* has failed to comply with timelines for the Internal *Appeals* Process; or (2) you (or your Authorized Representative) file a request for an Expedited External Review at the same time that you file a request for an Expedited Internal *Appeal*. For more information, see below: *Independent* External Review Process.

Coverage Pending Resolution of Your *Appeal*: If your *Appeal* concerns the termination of ongoing coverage or treatment, the disputed coverage remains in effect at our expense through the completion of the standard Internal *Appeals* Process or Expedited Internal *Appeals* Process (regardless of the outcome of the process) if: the *Appeal* was filed on a timely basis; the services were originally authorized by us prior to your filing your *Appeal* (except for services sought due to a claim of substantial risk of serious and immediate harm); the services were not terminated due to a specific time or episode related exclusion in this EOC; and you continue to be an enrolled *member*.

Access to Medical Information: You are entitled to have free access to and copies of any of your medical information related to your *Grievance* or *Appeal* that is: in our possession; and under our control. To obtain this information, please contact the *plan* employee who is coordinating the review of your *Grievance* or *Appeal*, or Member Services. If we

receive or rely on any new or additional information in connection with your *Grievance* or *Appeal*, we will provide you with a copy of such information in accordance with law.

Independent External Review Process: You may contest a final *Appeal* decision regarding an Adverse Determination. To do this, you must request an External Review of the decision. External Reviews are done by an *independent* organization under *contract* with the Massachusetts Health Policy Commission's Office of Patient Protection ("OPP"). Benefit Denials and Rescissions of Coverage are **not** eligible for External Review.

You may also file a request for an External Review before receiving a final *Appeal* decision regarding an Adverse Determination if the *plan* fails to comply with the timelines for the Internal *Appeals* Process.

You can request the External Review yourself. Or, you can have an Authorized Representative, including a health care provider or attorney, act for you during the external review process.

How To Request an External Review: To request External Review, you must file a written request with the OPP within 4 months of your receipt of the *plan's* written notice of the final *Appeal* decision. A copy of the OPP's External Review forms and other information will be enclosed with the *plan's* notice denying your *Appeal*.

Expedited External Review: You can request an Expedited External Review. To do so, you must include a written certification from a physician that a delay in providing or continuing the health services that are the subject of the final *Appeal* decision would pose a serious and immediate threat to your health. If the OPP finds that such a serious and immediate threat to your health exists, it will qualify your request as eligible for an Expedited External Review.

You may file a request for an Expedited External Review either (1) at the same time as you file a request for an Expedited Internal *Appeal*; or (2) within two days of the *plan's* decision to deny your Expedited Internal *Appeal*.

Requirements for an External Review:

- The request must be submitted on the OPP's application form called: "Request for Independent External Review of a Health Insurance." We will send you this form when we send you the final Adverse Determination letter. Copies of this form may also be obtained by calling Member Services, by calling the OPP at 800-436-7757, or from the OPP's Web site at: mass.gov/hpc/opp.
- The form must include your signature, or the signature of your Authorized Representative, consenting to the release of medical information. If applicable, you must enclose a copy of the *plan's* final *Appeal* decision.
- You must include payment of OPP's filing fee.

If your request for an Expedited External Review includes a final adverse determination that concerns an admission, availability of care, continued stay, or health care service for which you received emergency services, but have not been discharged from a facility, OPP deems that such a request meets the standard for expedited review. In this circumstance, a certification from a health care professional is not necessary to request an Expedited External Review. A certification from a health care professional is necessary for all other requests for Expedited External Review.

Coverage During the External Review Period: If the subject of the External Review involves termination of ongoing services (outpatient or inpatient), you may apply to the External Review agency to seek the continuation of coverage for the service during the period the review is pending. Any request for continuation of coverage must be made to the review panel before the end of the 2nd working day following your receipt of the *plan's* final decision about your *Appeal*. The review panel may order the continuation of coverage: if it finds that substantial harm to your health may result from termination of the coverage; or for such other good cause as the review panel shall determine. The continuation of coverage shall be at our expense regardless of the final External Review decision.

Access to Information: You may have access to any medical information and records related to your External Review that are in our possession or under our control.

Review Process: The OPP will screen requests for External Review to determine whether your case is eligible. If the OPP determines that your case is eligible, it will be assigned to an External Review Agency that *contracts* with the OPP. OPP will notify you and the *plan* of the assignment. The External Review Agency will make a final decision. It will send the written decision to you and the *plan*. For non-expedited External Reviews, the decision will be sent within 60 calendar days of receipt of the case from the OPP. (This is the case unless extended by the External Review Agency). For Expedited External Reviews, the decision will be sent within 4 business days from receipt of the case from the OPP. The decision of the External Review Agency is binding on the *plan*.

If the OPP decides that a request is not eligible for External Review, you will be notified: within 10 working days of receipt of the request; or, in the case of requests for Expedited External Review, within 72 hours of the receipt of the request.

How to Reach the Office of Patient Protection:

Telephone: 800-436 7757

Fax: 617-624-5046

Web Site: mass.gov/hpc/opp

Compliance with Law: The *plan* administers its Member Satisfaction Process in accordance with applicable state and federal law. Any inconsistency between state and federal requirements will be resolved in the *member's* favor.

CHAPTER 7. WHEN YOU HAVE OTHER COVERAGE

Coordination of Benefits (COB):

COB Program: In the event you are entitled to benefits under other health *plans* covering hospital, medical, dental or other health care expenses, we will coordinate our payment of *covered services* with the benefits under these other *plans*. This is known as Coordination of Benefits (COB). The purpose of COB is to prevent duplicate payment of the same health care expenses. We conduct COB in accordance with applicable MA law. (Note: with regard to coordinating benefits with Medicare, we conduct COB in accordance with applicable federal law.) Nothing in COB requires us to pay benefits for non-*covered services* under this EOC.

Other Plans: Benefits under this *plan* will be coordinated with any other *plans* that provide you with health benefits, including:

- *individual* or group health benefit *plans* offered by: medical or hospital service corporation *plans*; commercial insurance companies; HMOs; PPOs; other prepaid *plans*; or self-insured *plans*.
- insured or self-insured dental *plans*;
- automobile or homeowners insurance;
- personal injury insurance, including medical payment policies; and
- government *plans* such as Medicare.

Primary and Secondary Plans: We coordinate benefits by determining, in accordance with MA or federal law, (depending on which law applies): which *plan* has to pay first (the “primary” *plan*); and which *plan* pays second (the “secondary” *plan*). We will always be the secondary payor where permitted by MA or federal law (depending on which law applies.) The primary *plan* pays its benefits without regard to the benefits of the secondary *plan*. The secondary *plan* determines its benefits after the primary *plan*, and may reduce its benefits because of the primary *plan*’s benefits. When coverage under this *plan* is secondary, no benefits will be paid until after the primary *plan* determines what it is required to pay.

Medicare Program: If you are eligible for Medicare, and Medicare is allowed by federal law to be the primary *plan*, coverage under this *plan* will be reduced by the amount of benefits allowed under Medicare for the same *covered services*. This reduction will be made whether or not you actually receive the benefits from Medicare. For example, if you are eligible for Medicare but have not enrolled in Medicare, this reduction will still apply.

Member Cooperation: By enrolling in this *plan*, you agree to cooperate with our COB program. This includes providing us with information about any other health coverage you have at the time you enroll, or later if you become eligible for other health benefits after you enroll. We may ask you for information, and may disclose information, for purposes of: our COB program; enrollment; and eligibility.

Right to Recover Overpayment: If we paid more than we should have under COB, we have a right to receive back, from you or another person, organization or insurance company, the amount we overpaid.

For more information about COB, call Member Services.

The Plan’s Rights to Recover Benefit Payments - Subrogation and Reimbursement:

Right of Subrogation: Subrogation is a means by which we can recover the costs of health care services we paid on your behalf when a third party (another person or entity) is, or is alleged to be, legally responsible for your illness or injury. You may have a legal right to recover some or all of the costs of your health care from a person or entity who is, or is alleged to be, responsible for your illness or injury. For example, you may have a right to recover against the person or entity that caused your injury or illness (such as a person who caused your injury in a car accident); his or her liability insurance company (such as an automobile, homeowners, or worker’s compensation insurance company); or your own insurance company (such as your car insurance company – including, but not limited to, uninsured and underinsured motorist coverage, Medpay coverage, Personal Injury Protection; or your rental or homeowner’s insurance company). In such a case, if we paid (or will pay) for health care services to treat your illness or injury, we have a right to recover (get

back) – in accordance with all applicable laws and regulations – what we paid, in your name, directly from the recovery received from that person or entity (the “recovery”) regardless of whether this recovery is classified as payment for medical expenses, lost wages, pain and suffering, loss of consortium or any other type of recovery. Our right to recover from the recovery is up to the full amount that we paid or will pay for your health care services (regardless of what your provider billed us for the services). This is known as the *plan’s* right of subrogation which applies to the recovery.

To enforce our right of subrogation from the recovery, we can take legal action, with or without your consent, against any party to enforce that right. The *plan’s* right of subrogation from the recovery has first priority. We are entitled to recover against the total amount of the recovery, regardless of:

- whether the total recovery is less than the amount needed to reimburse you completely for your illness or injury;
- where or by whom the recovered money is held;
- how the recovered money is described or designated; or
- whether all or part of the recovery is for medical expenses.

The amount we are entitled to from the recovery will not be reduced by any attorney’s fees or expenses you may incur in enforcing your right to recover money from another person or entity.

Right of Reimbursement: We are also entitled to recover directly from the recovery the costs of health care services we paid (or will pay) if you have been, or could be, reimbursed (due to a lawsuit, settlement or otherwise) for the cost of care by another person or entity. In this case, you will be required to reimburse us (pay us back) from the recovery for the cost of health care services we paid (or will pay) for your illness or injury. We have the right to be reimbursed from the recovery up to the amount of any payment received by you, regardless of whether (a) all or a part of the recovery was designated, allocated, or characterized as payment for medical expenses; or (b) the payment is for an amount less than that necessary to reimburse you fully for the illness or injury.

Lien Rights. We may also have lien rights under MA law on any recovery you obtain. If so, you agree to fully cooperate with us in our exercising our lien rights.

Assignment of Benefits: By enrolling in this *plan*, you assign to us any benefits you may be entitled to receive (up to the costs of health care services paid or to be paid by us) from another person or entity that caused, or is legally responsible to reimburse you for, your illness or injury. Your assignment is up to the cost of health care services and supplies, and expenses, which we paid or will pay for your illness or injury. Nothing in this EOC shall be interpreted to limit our right to use any remedy provided by law to enforce our rights under this section.

Member Cooperation: You agree to cooperate with the *plan* in exercising our rights under this section. This cooperation includes:

- notifying us of any events that may give rise to or affect our right to recover, such as an injury caused by someone else (for example, in a car accident) or job-related injuries;
- giving us timely notice of significant events during the negotiation, litigation or settlement with any third party (such as if you start a claim, sue someone, or start settlement discussions) and before you settle any claim;
- giving us information and documents we ask for;
- signing documents;
- promptly paying us any monies you received for services for which we paid; and
- other things that we decide are necessary and appropriate to protect our rights.

You also agree not to do anything to limit, interfere with or prejudice our exercise of our rights under this section. If you do not cooperate as described in this Chapter, and as a result, we have additional expenses (such as attorney’s fees) to enforce our rights, you will be liable to us for the reasonable additional expenses we have to enforce our rights.

Note: We may arrange with a third party to carry out our rights under this Chapter. In such case, that third party is our agent for purposes of carrying out our rights.

Workers Compensation or Other Government Programs: The *plan* does not cover health care services that are or could be covered under: a Workers' Compensation *plan*; other similar employer program; or under another federal, state or local government program. If the *plan* has information that services being provided to you are covered by any of these *plans* or programs, we may suspend payment of further covered services until a decision is made whether the other *plan* or program will cover the services. If we paid for services that were covered (or legally should have been covered) by these other *plans* or programs, we have a right to recover our payments from these other *plans* or programs.

CHAPTER 8. OTHER PLAN ADMINISTRATION PROVISIONS

Office of Patient Protection: The MA Office of Patient Protection (OPP) makes available to consumers certain information about health care *plans*. This information includes:

- Evidences of Coverage, including required consumer disclosures.
- Provider Directories.
- A list of sources of *independently* published information: assessing *member* satisfaction; and evaluating the quality of health care services offered by health *plans*.
- The percentage of physicians who voluntarily and involuntarily terminated *contracts* with the *plan*; and the three most common reasons for physician disenrollment.
- The percentage of *premium* revenue expended by the *plan* for health care services provided to *members* for the most recent year for which information is available.
- A report detailing, for the previous calendar year, the total number of:
 - filed grievances; grievances that were approved internally; grievances that were denied internally; and
 - grievances that were withdrawn before resolution; and
 - external *Appeals* and their resolution.

The OPP can be reached at:

Health Policy Commission–Office of Patient Protection

Telephone: 800-436-7757

Fax: 617-624-5046

Web Site: mass.gov/hpc/opp

Utilization Management: The *plan* has a Utilization Management Program (“UM Program”). The UM Program’s purpose is to manage health care costs by reviewing whether certain medical services, supplies and drugs are: medically necessary; and are being given in the most clinically appropriate and cost-effective manner. The UM Program involves some or all of the following:

Prospective (or prior) review: Used to evaluate whether proposed treatment is medically necessary. This review occurs before the treatment begins. Examples are prior authorization of: elective inpatient admissions; certain specialists; and certain outpatient treatments and outpatient surgery.

Concurrent utilization review: Used to monitor a course of treatment as it is occurring and to determine when treatment may no longer be medically necessary. Examples include ongoing review of an inpatient admission. (Part of concurrent review involves active case management and discharge *planning*.)

Retrospective utilization review: used to evaluate treatment after it has been provided.

Timeframes for determinations:

- Prospective non-urgent review: within 2 working days of receiving all necessary information but no later than 15 calendar days from receipt of the request.
- Prospective urgent review (must meet criteria for urgent): within 72 hours of receiving the request.
- Concurrent review: within 24 hours of receiving the request

You and your provider will be notified of applicable approvals and denials within legally required timeframes. In the case of concurrent reviews, the service shall be continued without liability to you until you have been notified.

If your request for coverage is denied, you have the right to file an *Appeal*. See Chapter 6. Any inconsistency between state and federal legal requirements regarding UM reviews and decisions shall be resolved in favor of the *member*.

The UM Program is structured to encourage appropriate care. The *Plan* bases all utilization management decisions only on the *Medical Necessity* and appropriateness of care and services, as well as on the existence of coverage. The *plan* does not: compensate utilization management staff based on denials; or provide incentives to *Network Providers*

to provide inappropriate types or levels of care. You can call us to find out the status or outcome of utilization review decisions:

- 855-833-8120 (toll-free) or using our TTY Machine at 711
- Regarding mental health or substance use disorder services: 877-957-5600 (toll free).
- Translation services are available (see page 2)

Care Management: The *plan* may provide some *members* who have serious or complicated health conditions with care management services. Examples of serious conditions are high risk pregnancies or cancer. These services are a coordinated set of activities to: help monitor the *member's* treatment progress; and facilitate the use of clinically appropriate and cost-effective care. *Plan* professionals may contact you and your provider about case management services. This may include: talking about treatment *plans*; establishing goals; facilitating appropriate use of resources; and when appropriate, suggesting alternative treatments and settings.

Entry into the program may happen through completing your Health Needs Assessment, our claims or utilization management information, a Referral from a hospital Care Manager or one of your Providers, or self-Referral. If you feel you would benefit from case management, to learn more, or to opt out call 866-853-5241 for medical Care Management.

Individual Benefit Management (“IBM”): *Individual* Benefit Management is an approach to managing care for *members* with severe medical conditions. In certain circumstances, the *plan* may approve an IBM *plan* as an alternative treatment *plan* to the treatment currently being provided or proposed. This alternative treatment *plan* will provide coverage of services that would otherwise not be *covered services*. The purpose of the IBM *plan* is to permit a *member* to be covered for medically necessary services in the most appropriate, least intensive and most cost-effective setting that meets the *member's* needs. An IBM *plan* may be developed if the *member's network* physician and a *plan* authorized reviewer agree that **all** the following criteria are met:

- The *member* has a severe medical condition and is expected to require prolonged medical treatment.
- The alternative services are in place of more costly *covered services* that are currently being provided or are proposed. (For example, *outpatient services* to take the place of a more expensive inpatient admission.)
- The additional services are medically necessary.
- The *member* agrees to receive the alternative services as a substitute for the current or proposed *covered services*.
- The *member* continues to show improvement in her or his condition. This is determined from time to time by a *plan* authorized reviewer.

The *plan* will monitor the appropriateness and effectiveness of the IBM *plan*. We may change or terminate the IBM *plan* at any time when the *plan* authorized reviewer determines: that the IBM *plan* is no longer contributing to improvement of the *member's* condition; or no longer meets the criteria described in this section.

Process to Develop Clinical Review Criteria and Guidelines:

- The *plan* has: a Medical Policy, Criteria, Technology and Assessment Committee (MPCTAC); and Pharmacy and Therapeutics Committee (P&T).
- These committees develop, or review and adopt, clinical review criteria and guidelines to: determine the *Medical Necessity* of health care services and drug coverage guidelines; and ensure consistent *plan* decision-making.
- In doing so, the *plan* receives input from internal *Network Providers* and/or external specialists who have clinical expertise and appropriate credentials in the applicable clinical area.
- In the process of developing or adopting clinical review criteria and guidelines, the MPCTAC assesses treatments to determine that they are: consistent with generally accepted principles of professional medical practice; known to be effective; based on objective, scientifically-derived and evidence based information in improving health outcomes; and consistent with applicable legal and national accreditation organization standards.
- The MPCTAC and P&T, with input and recommendations from other *plan* committees, *Network Providers* and/or external specialists (as appropriate), review and update clinical review criteria and guidelines periodically, or as needed. This review and update incorporates up-to-date standards of practice as new treatment, applications,

drug coverage guidelines and technologies are developed.

- Carelon's *Medical Necessity* Criteria (MNC), also known as clinical criteria, are reviewed and updated at least annually to ensure that they reflect the latest developments in serving *individuals* with behavioral health diagnoses. Carelon's Corporate Medical Management Committee (CMMC) adopts, reviews, revises and approves *Medical Necessity* Criteria per client and regulatory requirements.

Medical Necessity Criteria varies according to state and/or *contractual* requirements and *member* benefit coverage. The following are Carelon's *Medical Necessity* Criteria:

- Centers for Medicare and Medicaid (CMS) Criteria
 - The Medicare Coverage Database (MCD) contains all National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs).
- Custom Criteria
 - The Custom Criteria are *network*- and state-specific *Medical Necessity* Criteria.
- Change Healthcare's InterQual® Behavioral Health Criteria
- American Society of Addiction Medicine (ASAM) Criteria
 - The American Society of Addiction Medicine (ASAM) Criteria focuses on substance use treatment.
- Carelon's National *Medical Necessity* Criteria

Network Providers may give advice on development or adoption of UM criteria and on instructions for applying the criteria. These comments and opinions may be received through practitioner participation on committees, provider newsletter requests for review, and by considering comments from practitioners to whom the criteria have been circulated to for input and feedback.

Carelon disseminates criteria sets via the provider handbook, provider forums, newsletters, Internet site, and *individual* training sessions. In addition, *members* are provided copies free of charge upon request.

In 2019, Carelon moved to utilizing Change Healthcare's InterQual® Behavioral Health Criteria for a majority of its membership for which utilization is managed. In particular, Change Healthcare employs a multi-step standardized content development process that synthesizes valid, relevant scientific evidence and real-world best practices to ensure that the criteria reflect unmatched clinical rigor and integrity. Change Healthcare utilizes a proprietary automated surveillance system which monitors 3,000+ key sites and topical areas for newly published and updated guidelines in addition to deep dive literature searches combined with validation by panels of conflict of interest screened, actively practicing clinicians across all relevant disciplines.

Quality Management and Improvement Programs: The *plan* develops an annual quality management and improvement work *plan* designed to assess and help improve the quality of health care and service. The work *plans* may vary over time in order to: address different aspects of care; and service and respond to changing priorities. The *plan's* clinical programs may include:

- adoption and distribution of clinical guidelines to assist providers to deliver high quality evidence-based care;
- health promotion initiatives to encourage *members* to obtain preventive care services;
- disease management and education programs offering provider and *member* support services for chronic illnesses;
- credentialing of *Network Providers*; and
- complaint processes to address *member* complaints about quality of care.

Process to Evaluate Experimental or Investigational Treatments: Since the *plan* does not cover experimental or investigational treatment the *plan* evaluates whether a service, treatment, procedure, supply, device, biological product, or *drug is an experimental or investigational treatment for the requested indication*. The *plan* does this by: reviewing relevant documents related to the proposed service, such as informed consent documents; and reviewing "authoritative evidence" as defined in the definition of *experimental or investigational treatments* (as stated in Appendix

A of this EOC). The *plan* considers all of the following:

- The treatment must have final approval from the appropriate governmental regulatory bodies (e.g. the U.S. Food and Drug Administration, FDA), or any other federal governmental body with authority to regulate the technology. This applies to drugs, biological products, devices or other products that must have final approval to be marketed.
- The “authoritative evidence” as defined in the definition of *experimental or investigational* must permit conclusions concerning the effect of the treatment on health outcomes.
- The treatment must improve the net health outcome and should outweigh any harmful effect.
- The treatment must be as beneficial as any established alternative.
- The outcomes must be attainable outside the investigational settings.

Process to Evaluate and Assess New Technology: As new medical technologies are developed, or when new uses of existing technologies arise, the *plan* evaluates whether to include these as a covered service.

Examples are: medical and behavioral health therapies devices surgical procedures, diagnostics and/or drugs. The technology assessment process is applied to both the development and adoption of new clinical review criteria and the updating of existing criteria included in *plan* medical policies, *plan* pharmacy policies, *plan*-adopted criteria (e.g., InterQual criteria from Change Healthcare), and criteria utilized by the *plan*'s partner clinical vendors. *s. Plan* medical staff conduct an evidence-based assessment process. The purpose is to evaluate the safety and effectiveness of the new technology. This process includes:

- Consultation with medical experts with expertise in the new technology; and
- Research and review of: published peer-reviewed medical literature reports from appropriate governmental agencies; and polices and standards of nationally recognized and applicable medical associations and specialty societies.

Staff presents proposals to the appropriate internal clinical policy committees for review. These committees in turn present recommendations to the internal clinical management committee responsible for making final coverage decisions. The *plan*'s partner clinical vendors are delegated to conduct utilization management on behalf of *plan members*. Clinical review criteria developed from partner clinical vendors and other *plan*-adopted criteria (e.g., InterQual criteria) are developed using published and generally accepted, scientifically-based standards of care and objective and credible scientific evidence published in peer-reviewed medical/clinical literature, and/or reviewing observational studies for the new technology or new application(s) of an existing technology to establish written clinical review criteria used to make *Medical Necessity* determinations, with *plan* verification that quality standards are met.

Disagreement with Recommended Treatment by Network Providers: When you enroll in the *plan*, you agree that *Network Providers* are responsible to decide the appropriate treatment for you. Some *members* may, for religious or personal reasons: disagree with the recommended treatment; refuse to follow the recommended treatment; or seek treatment (or conditions of treatment) that *network providers* judge do not meet generally accepted professional standards of medical care. In such instances, you have the right to refuse the treatment advice of a *network provider*; however, the *plan* has no further duty to provide coverage for the care in question. If you seek care from non-*network providers* because of such a disagreement, you will be responsible for the cost and outcome of such care. (For coverage of second opinions, see Chapter 3.) Members have the right to submit an *Appeal* regarding coverage decisions. (See Chapter 6 - Member Satisfaction Process.)

Quality Incentives: The *plan* may, from time to time, offer some or all *members* certain incentives to encourage improvements in health status and the quality of health care. Examples include: additional benefits; waiver of *copayments*; and rewards cards. If we offer such incentives, we will notify you about them: we may send you a letter; and/or we may put the notice on our website.

Confidentiality of Protected Health Information: The *plan* has a strong commitment to: protecting the confidentiality of your health information (“PHI”); and using and disclosing it only in accordance with applicable law. The *plan* provides *members* with a Notice of Privacy Practices that can be found below titles “Notice of Privacy

Practices". This Notice describes how the *plan* uses and discloses your PHI. It also describes rights you have regarding your PHI. Call Member Services for additional copies of our Notice of Privacy Practices.

Bills from Providers:

Bills from Network Providers: When you receive *covered services* from *Network Providers*, you should not receive any bill from them (other than for applicable *cost-sharing*). *Network Providers* will bill the *plan* for *covered services* provided to you. The *plan* will pay *Network Providers* for *covered services*. If you do receive a bill for any amount other than the applicable *cost-sharing*, call Member Services.

Bills from Non-Network Providers: If you receive *covered services* from a non-*Network Provider* due to any of the reasons described under "Care from Non-*Network Providers*" in Chapter 2, you may receive a bill from that provider. If you are being billed by the non-*Network Provider*:

- Ask the provider to send the *plan* a bill on a standard health care claim form to: WellSense Clarity *plan* Employer Choice Direct, P.O. Box 55282, Boston, MA 02205-5282
- If you paid the non-*Network Provider* for these services, we will reimburse you, consistent with your Schedule of Benefits and the terms under this EOC, if we determine they are *covered services*. (Please see Chapter 2 regarding payment up to the allowed amount.) To process your reimbursement, we must receive from you: your name; address; phone number; date of birth; your *plan* ID number (see your *member ID card*); the date the care was provided to you; a brief description of the illness or injury; a copy of the provider's bill to you; and a receipt from the provider as proof of payment. Send reimbursement requests to:

WellSense Health Plan Employer Choice Direct

529 Main Street, Suite 500
Charlestown, MA 02129
Attention: Member Services
Telephone: 1-855-833-8120;
Fax: 617-748-6132

Note: in some cases we may need more information from you or the provider before we pay the claim. If so, we will contact you or the provider. Call Member Services if you have further questions.

Time Limits on Claims: In order for us to reimburse you for *covered services*, we must receive your claim within 6 months from the date you received care.

Premium Payments: Your group must pay applicable *premium* payments to the *plan*. The *plan* is not responsible if your group fails to pay *premium* for your coverage. If your group fails to pay *premium* on time, your membership in the *plan* may be cancelled in accordance with the *plan's contract* with your group and with applicable law. The *plan* may change the *premium* that your group is required to pay. This will be done in accordance with *plan* policies and applicable laws.

Limitation on Actions: You must complete the internal Member Satisfaction Process before you can file a lawsuit against the *plan* for failing to pay for *covered services*. Any lawsuit must be filed within 2 years of the time the cause of action arose.

Relationship between WellSense and Providers:

- *WellSense* arranges for health care services. It does not provide health care services.
- *WellSense* contracts with: organizations that contract with *network providers*; and *network providers*, including *network providers* who practice in their private offices throughout the *service area*.
- *Network providers* are independent. They are not employees, agents or representatives of *WellSense*.
- *Network providers* are not authorized by *WellSense* to change anything in this EOC or create any obligation for *WellSense*.
- *WellSense* is not liable for statements about this EOC made by *network providers* or their employees or agents.
- *WellSense* is also not liable for any acts, omissions, representations or any other conduct of any *network*

- *provider*.
- WellSense may change its arrangements with *network providers*, including adding or removing *providers* from its *network*, without prior notice to *members* (except as specifically set forth in this EOC).

Notice: The *plan* will send all notices it is required to send to *members* at the last address of the *member* that is on file with the *plan*. If you move, please let us know your new address. Members should send notice to the *plan* as follows:

WellSense Health Plan

529 Main Street, Suite 500
Charlestown, MA 02129
Attention: Member Services

Circumstances Beyond the *Plan's* Reasonable Control: The *plan* is not responsible for a failure or delay in carrying out its obligations under this EOC in cases of circumstances beyond its reasonable control. These circumstances could include: riot; war; epidemic; strike; civil insurrection; natural disasters; destruction of *plan* offices; or other major disasters. In such cases, we will make a good faith effort to arrange for health care services and carry out our administrative responsibilities. However, we are not responsible for the costs or other outcomes of our inability to perform.

Enforcement of Terms: The *plan* may choose to waive certain terms of this EOC. If we do so, it does not mean that we give up our rights to enforce those terms in the future.

Subcontracting: From time to time the *plan* may subcontract with other entities to perform some of its obligations under this EOC.

This EOC; Changes to this EOC: This EOC is issued and effective as of the date on the front cover. The EOC consists of this document and the applicable Schedule of Benefits. This EOC supersedes (takes the place of) all previous EOCs issued by the *plan*. This EOC is a *contract* between you and the *plan*. This *contract* consists of: this document; the applicable Schedule of Benefits, your enrollment form; and any amendments, riders, or additional attachments issued to this document. By signing and returning your enrollment application form, and/or by paying applicable *premium* contributions, you: apply for coverage under the *plan*; and you agree to all the terms and conditions of this EOC.

The *plan* may change this EOC without sending you advance notice, if we need to comply with changes in state or federal law. If we make other material changes, we will send written notice as required by law. Changes do not require your consent. Changes will apply to all *plan members* in the applicable benefit package, not just to you. Changes will apply to all *covered services* received on or after the effective date of the change.

Please go to our website wellsense.org for the most current version of the EOC.

CHAPTER 9. YOUR RESPONSIBILITY TO REPORT FRAUD

You play an important role in preventing health care Fraud, Waste, and Abuse (FWA). Please help us detect FWA if it happens. The definition of Fraud, Waste, and Abuse is included in the definitions section below. FWA can involve any type of *individual* or *Provider*, such as doctors and pharmacists. It can also involve medical equipment companies. Some examples of health care Fraud are:

- Billing for health care services never provided
- Giving false or misleading health care information
- Loaning your Member ID Cards to others so they can get services or drugs they are not supposed to have access to
- Selling medical supplies you get under your *Plan*

You must notify WellSense when you think that someone has purposely misused the *Plan* benefits or services. You should report something you think is wrong or suspicious behavior related to health care benefits or services to us.

Method	Contact Information
Call	888-411-4959 (Anonymous Hotline), available 24 hours a day, 7 days a week
Fax	866-750-0947
E-mail	FraudandAbuse@wellsense.org
Write	WellSense ATTN: Special Investigations Unit 529 Main Street, Suite 500 Charlestown, MA 02129

You do not need to let us know who you are when you contact us. But it is helpful for you to give us as much information as possible, such as:

- Name of person or Provider you think acted wrong
- Member's Plan Member ID Card number
- Description of the suspected FWA
- Where the services (if any) were provided
- Date of service

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU MAY ACCESS THIS INFORMATION. PLEASE REVIEW THIS NOTICE OF PRIVACY PRACTICES CAREFULLY.

If you have any questions or would like a copy of this Notice of Privacy Practices, please contact the WellSense Health Plan Member Services Call Center.

WellSense Clarity Plans, including ConnectorCare members: 855-833-8120, TTY: 711

Commonwealth Choice / Employer Choice members: 877-492-6967, TTY: 711

WellSense Health Plan
529 Main Street, Suite 500
Charlestown, MA 02129
Website: wellsense.org

This Notice describes how we may use and disclose your health information to carry out treatment, payment or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your health information.

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

By law, we are required to:

Maintain the privacy and confidentiality of your protected health information

- Give you this Notice of Privacy Practices
- Follow the practices in this Notice

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

Other than the situations mentioned in this Notice, we cannot use or share your protected health information without your written permission, and you may cancel your permission at any time by sending us a written notice. We reserve the right to change this Notice and to make the revised notice effective for any of your current or future protected health information. You are entitled to a copy of the Notice currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI)

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

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

For Payment: We may use and disclose your PHI to administer your health benefits, which may include claims

payment, utilization review activities, determination of eligibility, *Medical Necessity* review, coordination of benefits and *Appeals*. For example, we may pay claims submitted to us by a provider or hospital.

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

Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services: We may contact you to provide appointment or refill reminders, or information about possible treatment options or alternatives and other health-related benefits, or services that may be of interest to you.

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

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

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

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

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

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

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

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

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

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

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

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

prohibited by law.

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

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

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

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

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

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT OUT

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

SPECIAL PROTECTIONS FOR HIV, ALCOHOL AND SUBSTANCE ABUSE, MENTAL HEALTH, AND GENETIC INFORMATION

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

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU

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

Right to an Electronic Copy of PHI: You have the right to require that an electronic copy of your health

information be given to you or transmitted to another *individual* or entity if it is readily producible. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic record.

Right to Get Notice of a Security Breach: We are required to notify you by first class mail of any breach of your Unsecured PHI as soon as possible, but no later than 60 days after we discover the breach. "Unsecured PHI" is PHI that has not been made unusable or unreadable. The notice will give you the following information:

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

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

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures". This is a list of the disclosures we made of PHI about you for most purposes other than treatment, payment and health care operations. The right to receive an accounting is subject to certain exceptions, restrictions and limitations. To obtain an accounting, you must submit your request, in writing, to the WellSense Health *Plan* Privacy Officer. We will provide one accounting a year for free but may charge a reasonable, cost-based fee if you submit a request for another one within 12 months. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003.

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

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

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

HOW TO EXERCISE YOUR RIGHTS

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

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

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES |

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

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

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

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

Privacy Officer
WellSense Health Plan
529 Main Street, Suite 500
Charlestown, MA 02129

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

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

Medical Privacy, Complaint Division
Office for Civil Rights (OCR)
United States Department of Health and Human Services 200
Independence Avenue, SW, Room 509F, HHH Building
Washington D.C., 20201.

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

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

Notice About Nondiscrimination and Accessibility

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

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

Please contact WellSense if you need any of the services listed above. If you believe we have failed to provide these services or discriminated in another way on the basis of any of the identifiers listed above, you can file a *Grievance* or request help to do so at:

Civil Rights Coordinator

529 Main Street, Suite 500

Charlestown, MA 02129

Phone: 855-833-8120 (TTY/TDD 711)

Fax: 617-897-0805

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

U.S. Dept. of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

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

Complaint Portal: ocrportal.hhs.gov/ocr/portal/lobby.jsf

Printable complaint forms are available at hhs.gov/ocr/office/file/index.html.

Notice: Massachusetts Mental Health Parity Laws and the Federal Mental Health Parity and Addiction Equity Act (MHPAEA)

This Notice gives you information about your *plan* benefits for mental health and substance use disorder services. Under both Massachusetts and federal laws, the *plan's* benefits for mental health and substance use disorder services must be comparable to benefits for medical/surgical services. This means that your cost-sharing (*copayments, coinsurance* and *deductibles*) for mental health and substance use disorder services must be at the same level as for medical/surgical services. Also, the *plan's* review and authorization of mental health or substance use disorder services must be handled in a way that is comparable to the review and authorization of medical/surgical services.

The *plan* arranges with Carelon to manage mental health and substance use disorder services for its *members*, including the review and authorization of these services and *member Appeals*. If Carelon makes a decision to deny or reduce authorization of a service, Carelon will send you a letter explaining the reason for the denial or reduction. Carelon will also send you or your provider a copy of the criteria used to make this decision, at your request.

If you think that the *plan* or Carelon is not handling your benefits for mental health and substance use disorder services in the same way as for medical/surgical services, you may file a complaint with the Division of Insurance (DOI) Consumer

Services Section.

You may file a written complaint using the DOI's Insurance Complaint Form. You may request the form by phone or by mail or find it on the DOI's webpage at: mass.gov/ocabr/consumer/insurance/file-a-complaint/filing-a-complaint.html

You may also submit a complaint to the DOI by phone by calling 877-563-4467 or 617-521-7794. If you submit a complaint by phone, you must follow up in writing and include your name and address, the nature of your complaint and your signature authorizing the release of any information.

Filing a written complaint with the DOI is not the same as filing an *Appeal* with Carelon under your *plan* benefits. In order to have a denial or reduction in coverage of a mental health or substance use disorder service reviewed, you must file an *Appeal* with Carelon. (See Chapter 6 of this EOC for more information on filing an *Appeal*.) This may be necessary to protect your right to continued coverage of treatment while you wait for an *Appeal* decision. Follow the *Appeal* procedures outlined in Chapter 6 of this EOC. Or, call Carelon toll-free at 877-957-5600 for more information about filing an *Appeal*.

APPENDIX A: DEFINITIONS

The words below, when italicized in this EOC, have the following meanings:

Accreditation: A written determination by the Bureau of Managed Care of compliance

Actively Practices: A Health Care Professional who regularly treats patients in a clinical setting.

Activities of Daily Living: Activities engaged in as part of normal daily life. Examples are: bathing; eating; drinking; walking; dressing; speaking; and maintaining personal hygiene and safety. These do not include special functions needed for occupational purposes or sports.

Adverse Determination: Based upon a review of information provided by a carrier or its designated utilization review organization, to deny, reduce, modify, or terminate an admission, continued inpatient stay or the availability of any other health care services, for failure to meet the requirements for coverage based on *Medical Necessity*, appropriateness of health care setting and level of care, or effectiveness, including a determination that a requested or recommended health care service or treatment is experimental or investigational.

Affordable Care Act: The federal Patient Protection and Affordable Care Act, Public Law 111-148, adopted March 23, 2010, as amended by the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and federal regulations adopted pursuant to that act.

Allowed Amount: The allowed amount is the amount the *plan* pays a provider for *covered services* provided to you. The allowed amount depends on the type of health care provider that provides the *covered services* to you:

For providers with a payment agreement with *plan*: For providers who have a payment agreement with the *plan*, the allowed amount is the negotiated amount set forth in the agreement.

For providers with no payment agreement with the *plan*:

- For *covered services* provided by providers who do not have a payment agreement with the *plan*, the allowed amount is either: the amount allowed or required by applicable state or federal law; or the amount the *plan* determines, in its sole discretion, is usual, customary and reasonable (“UCR”).
- UCR determinations are based on nationally accepted means and amounts of claims payment. These include, without limitation: Medicare fee schedules and allowed amounts; American Medical Association CPT coding guidelines; CMS medical coding policies; and nationally recognized academy and society coding and clinical guidelines. (When the *plan* has delegated claims processing to a third party, that third party shall have the same discretion as the *plan* with respect to UCR determinations.)
- The allowed amount is the maximum amount the *plan* will pay for *covered services* (minus any applicable *member cost-sharing*) rendered by providers who do not have a payment agreement with the *plan*.

In most cases, your *cost-sharing* for *covered services* is calculated based on the initial full allowed amount for the provider. The amount you pay for your *cost-sharing* is generally not subject to future adjustments (up or down) even when the provider’s payment may be subject to future adjustments (due to, for example, *contractual* or risk sharing settlements, or rebates). However, *cost-sharing* may be adjusted due to claims processing or billing modifications or corrections. The claim payment made to the provider will be the full allowed amount less your *cost-sharing* amount.

In some cases involving *covered services* provided to you by certain non-*Network Providers*, your *cost-sharing* may not be calculated based on the allowed amount. Instead, it may be calculated based on applicable state law, if any, or under applicable federal law.

Alternative Payment Contract: Any *contract* between a Carrier and a Provider or Provider organization that utilizes alternative payment methodologies, which are methods of payment that are not solely based on fee-for-

service reimbursements and that may include, but is not limited to, shared savings arrangements, bundled payments, global payments, and fee-for-service payments that are settled or reconciled with a bundled or global payment.

Ambulatory Review: Utilization review of health care services performed or provided in an outpatient setting, including, but not limited to, outpatient or ambulatory surgical, diagnostic and therapeutic services provided at any medical, surgical, obstetrical, psychiatric and chemical dependency facility, as well as other locations such as laboratories, radiology facilities, provider offices and patient homes.

Appeal: A formal complaint by you about a Benefit Denial, an Adverse Determination, or a Retroactive Termination of Coverage – all as specifically defined as follows:

- **Benefit Denial:**
 - A *plan* decision, made before or after you have obtained services, to deny coverage for a service, supply or drug that is specifically limited or excluded from coverage in this EOC; or
 - A *plan* decision to deny coverage for a service, supply or drug because you are no longer eligible for coverage under the *plan*. (This means you no longer meet the *plan's* eligibility criteria.)
- **Adverse Determination:** A *plan* decision, based on a review of information provided, to deny, reduce, modify or terminate an admission, continued inpatient stay or the availability of any other health care services, for failure to meet the requirements for coverage based on: *Medical Necessity*; appropriateness of health care setting and level of care; or effectiveness. These are often known as *Medical Necessity* denials because in these cases the *plan* has determined that the service is not medically necessary for you.

Retroactive Termination of Coverage: A retroactive cancellation or discontinuance of enrollment as a result of the *plan's* determination that: you have performed an act, practice or omission that constitutes fraud; or you have intentionally misrepresented a material fact with regard to the terms of the *plan*.

Applied Behavior Analysis: The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

Authorized Reviewer: WellSense's Chief Medical Officer, or someone named by him or her, to review and determine coverage of certain health care services and supplies to *members*.

Autism Services Provider: A person, entity or group that provides treatment of autism spectrum disorders.

Autism Spectrum Disorders: Any of the pervasive *developmental disorders* as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder, Asperger's disorder and pervasive *developmental disorders* not otherwise specified.

Behavioral Health Manager: A company, organized under the laws of the Commonwealth of Massachusetts or organized under the laws of another state and qualified to do business in the Commonwealth, that has entered into a *contractual* arrangement with a Carrier to provide or arrange for the provision of behavioral, substance use disorder and mental health services to voluntarily enrolled *members* of the Carrier.

Behavior Management Monitoring: Monitoring of a child's behavior, the implementation of a behavior *plan* and reinforcing implementation of a behavior *plan* by the child's parent or other caregiver.

Behavior Management Therapy: Therapy that addresses challenging behaviors that interfere with a child's successful functioning; provided, however, that "behavior management therapy" shall include a functional behavioral assessment and observation of the youth in the home and/or community setting, development of a behavior *plan*, and supervision and coordination of interventions to address specific behavioral objectives or performance, including the development of a crisis-response strategy; and provided further, that "behavior management therapy" may include short-term counseling and assistance.

Benefit Level: The health benefits, including the benefit payment structure or service delivery and *network*, provided by a health benefit *plan*.

Benefit Limit: The visit, day or dollar limit maximum that applies to certain *covered services* during a *benefit year* (or other time period, if specified in the EOC). Once the *benefit limit* is reached, the *plan* does not provide any further coverage for such service or supply for that *benefit year* (or other time period.) If you get more of the service or supply beyond the *benefit limit*, you are responsible for all charges. Benefit limits are in your Schedule of Benefits.

Benefit Year: The *benefit year* is the annual period during which:

- benefits are purchased and administered;
- *deductibles, coinsurance, copayments* and the *out-of-pocket maximum* are calculated; and
- applicable *benefit limits* apply.
- See Chapter 1 for more information about benefit years.

Board Certified Behavior Analyst: A behavior analyst credentialed by the behavior analyst certification board as a board certified behavior analyst.

Bureau of Managed Care or Bureau: The bureau in the Division of Insurance.

Capitation: A set payment per patient per unit of time made by a Carrier to a licensed Health Care Professional, Health Care Provider group, or organization that employs or utilizes services of Health Care Professionals to cover a specified set of services and administrative costs without regard to the actual number of services provided.

Carelon: Carelon Behavioral Health. Carelon is an organization *contracted* by WellSense to administer the *plan's* mental health and substance use disorder benefits.

Carrier: An insurer licensed or otherwise authorized to transact accident or health insurance under chapter 175; a nonprofit hospital service corporation organized under chapter 176A; a nonprofit medical service corporation organized under chapter 176B; a health maintenance organization organized under chapter 176G; and an organization entering into a preferred provider arrangement under chapter 176I, but not including an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer. Unless otherwise noted, the term "carrier" shall not include any entity to the extent it offers a policy, certificate or *contract* that is not a health benefit *plan*, as defined in section 1 of chapter 176J.

Case Management: A coordinated set of activities conducted for *individual* patient management of serious, complicated, protracted or other health conditions.

Catastrophic plan: A health benefits *plan* limited exclusively for sale to eligible *individuals* who also meet the requirements of eligibility for catastrophic *plans* as defined in 42 U.S.C. § 18022(e) with *premium* rates that are consistent with section 3. "Class of business", all or a distinct grouping of eligible insureds as shown on the records of the carrier which is provided with a health benefit *plan* through a health care delivery system operating under a license distinct from that of another grouping.

Clean and Complete Credentialing Application: A credentialing application which is appropriately signed and dated by the Provider, and which includes all of the applicable information requested from the Provider by the Carrier.

Clinical Peer Reviewer: A physician or other health care professional, other than the physician or other health care professional who made the initial decision, who holds a non-restricted license from the appropriate professional licensing board in the commonwealth, current board certification from a specialty board approved by the American Board of Medical Specialties or of the Advisory Board of Osteopathic Specialists from the major areas of clinical services or, for non-physician health care professionals, the recognized professional board for their specialty, who actively practices in the same or similar specialty as typically manages the medical condition, procedure or treatment under review, and whose compensation does not directly or indirectly depend upon the quantity, type or cost of the services that such person approves or denies.

Clinical Review Criteria: The written screening procedures, decisions, abstracts, clinical protocols and practice guidelines used by a carrier to determine the *Medical Necessity* and appropriateness of health care services.

Coinsurance: The percentage of costs you must pay for certain *covered services*. See Chapter 1 for more information. *Coinsurance* amounts are in your Schedule of Benefits.

Commissioner: The commissioner of insurance.

Community-Based Acute Treatment for Children and Adolescents (CBAT): Acute mental health services provided in a staff-secure setting on a 24-hour basis, with sufficient clinical staffing to ensure safety for the child or adolescent, while providing intensive therapeutic services including, but not limited to: daily medication monitoring; psychiatric assessment; nursing availability; specializing (as needed); *individual*, group and family therapy; case management; family assessment and consultation; discharge *planning*; and psychological testing, as needed. This service may be used as an alternative to or transition from inpatient acute treatment services. Whenever a Carrier's Acute Residential Treatment (ART) program is substantially similar to CBAT, it may be considered to meet the requirements of this Bulletin. **Note: No pre-authorization is required but notification by the Facility to WellSense is required within 72 hours of the admission.**

Community Behavioral Health Center: Community Behavioral Health Centers (CBHCs) are one-stop shops for a wide range of mental health and substance use treatment programs. The statewide *network* includes 25 CBHCs in communities across Massachusetts. CBHCs offer immediate care for mental health and substance use needs, both in crisis situations and the day-to-day.

Complaint:

- Any *Inquiry* made by or on behalf of an Insured to a Carrier or Utilization Review Organization that is not explained or resolved to the Insured's satisfaction within three business Days of the *Inquiry*;
- any matter concerning an Adverse Determination; or
- in the case of a Carrier or Utilization Review Organization that does not have an internal *Inquiry* process, a Complaint means any *Inquiry*.

Concurrent Review: Utilization review conducted during an insured's inpatient hospital stay or course of treatment.

Connector: The commonwealth health insurance connector, established by chapter 176Q.

Connector Seal of Approval: The approval given by the board of the connector to indicate that a health benefit *plan* meets certain standards regarding quality and value.

Copayment: A fixed amount you pay for certain *covered services*. *Copayments* are paid directly to the provider at the time you receive care (unless the provider arranges otherwise). *Copayment* amounts are in your Schedule of Benefits.

Cosmetic, or Cosmetic Services: Services, including surgery, to change or improve appearance.

Cost-Sharing: The costs you pay for certain *covered services*. *Cost-sharing* consists of *deductibles*, *copayments*, and/or *coinsurance*. Cost sharing amounts are in your Schedule of Benefits.

Coverage Effective Date: The date, according to our records, when you become a *member* and are first eligible for *covered services* under the *plan*.

Covered Services: The services, supplies and drugs for which the *plan* will pay according to this EOC. Covered services must be: described as such in the EOC; medically necessary; received while you are an active *member* of the *plan*; provided by a *Network Provider* (except in an *Emergency*, for *urgent care*, or *Emergency/urgent care* needed while you are outside the *service area*, or in rare cases when approved in advance by the *plan*); in some cases, approved in advance by a *plan* authorized reviewer; not listed as excluded in this EOC; provided to treat an injury,

illness or pregnancy, or for preventive care; and consistent with applicable state or federal law.

Covering Provider: A provider who has an arrangement with your *PCP* to provide or coordinate your care when your *PCP* is not available. *Covering providers* often provide coverage for your *PCP* during evenings, nights, weekends, holidays and vacations.

Creditable Coverage: Coverage of an *individual* under any of the following health *plans* with no lapse of coverage of more than 63 days: (a) a group health *plan*; (b) a health *plan*, including, but not limited to, a health *plan* issued, renewed or delivered within or without the commonwealth to an *individual* who is enrolled in a qualifying student health insurance program under section 18 of chapter 15A or a qualifying student health program of another state; (c) Part A or Part B of Title XVIII of the Social Security Act; (d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928; (e) 10 U.S.C. 55; (f) a medical care program of the Indian Health Service or of a tribal organization; (g) a state health benefits risk pool; (h) a health *plan* offered under 5 U.S.C. 89; (i) a public health *plan* as defined in federal regulations authorized by the Public Health Service Act, section 2701(c)(1)(I), as amended by Public Law 104-191; (j) a health benefit *plan* under the Peace Corps Act, 22 U.S.C. 2504(e); (k) coverage for young adults as offered under section 10 of chapter 176J; or (l) any other qualifying coverage required by the Health Insurance Portability and Accountability Act of 1996, as it is amended, or by regulations promulgated under that act.

Custodial Care: Care that is provided: mainly to assist in the activities of daily living; by *individuals* who do not require specialized medical training or professional skills; or mainly to help maintain your or someone else's safety when there is no other reason for you to receive medically necessary hospital level of care. Also, routine maintenance of colostomies, urinary catheters or ileostomies is considered custodial care.

Date of Enrollment: With respect to an *individual* covered under a group health *plan* or health insurance coverage, the date of enrollment of the *individual* in the *plan* or coverage or, if earlier, the first day of the waiting period for such enrollment.

Days: Calendar days unless otherwise specified in 211 CMR 52.00; provided, that computation of days specified in 211 CMR 52.00 begins with the first day following the referenced action, and provided further that if the final day of a period specified in 211 CMR 52.00 falls on a Saturday, Sunday or state holiday, the final day of the period will be deemed to occur on the next working day.

Deductible: The specific dollar amount you pay for certain *covered services* in a *benefit year* before the *plan* is obligated to pay for those *covered services*. Once you meet your *deductible*, you pay either: nothing, or the applicable *copayment* or *coinsurance* for those *covered services* for the remainder of the *benefit year*. See Chapter 1 for more information. *Deductible* amounts are in your Schedule of Benefits.

Dental Benefit Plan: A policy, *contract*, certificate or agreement of insurance entered into, offered or issued by a Dental Carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs solely for Dental Care Services.

Dental Care Professional: A dentist or other dental care practitioner licensed, accredited or certified to perform specified Dental Services consistent with the law.

Dental Care Provider: A Dental Care Professional or Facility licensed to provide Dental Care Services.

Dental Care Services or Dental Services: Services for the diagnosis, prevention, treatment, cure or relief of a dental condition, illness, injury or disease.

Dental Carrier: An entity that offers a policy, certificate or *contract* that provides coverage solely for dental care services.

Dependent: A *subscriber's* spouse, child or other *dependent* – as defined by the Health Connector. Not all *dependents* are allowed to enroll in all Qualified Health *Plan* Program benefit packages. Call the Health Connector for eligibility information.

Discharge Planning: The formal process for determining, prior to discharge from a Facility, the coordination and management of the care that an Insured receives following discharge from a Facility

Disabled Dependent: A *subscriber's* or spouse's child who:

- became permanently physically or mentally disabled before age 26;
- lives with the *subscriber* or spouse;
- is incapable of supporting him/herself due to the disability; and
- was covered under the *subscriber's* family coverage immediately before age 26, or has been covered by other group health coverage since the disability started.

Division: The division of insurance.

Eligible Child: An eligible *individual* who, as of the beginning of a *plan* year, has not attained the age of 21 and who is seeking to enroll in a child-only *plan* offered by a carrier.

Eligible Employee: An employee who: (1) works on a full-time basis with a normal work week of thirty or more hours, and includes an owner, a sole proprietor or a partner of a partnership; provided however, that such owner, sole proprietor or partner is included as an employee under a health care *plan* of an eligible small business but does not include an employee who works on a temporary or substitute basis, and (2) is hired to work for a period of not less than five months.

Eligible Dependent: The spouse or child of an eligible person, subject to the applicable terms of the health benefit *plan* covering such employee. The child of an eligible *individual* or eligible employee shall be considered an eligible *dependent* until the end of the child's twenty-sixth year of age.

Eligible Individual: An *individual* who is a resident of the commonwealth.

Eligible Small Business or "Group": Any sole proprietorship, firm, corporation, partnership or association actively engaged in business who, on at least fifty percent of its working days during the preceding year employed from among one to not more than fifty eligible employees, the majority of whom worked in the commonwealth; provided, however, that a health carrier may offer health insurance to a business of more than fifty employees in accordance with the provisions of this chapter. In determining the number of eligible employees, a business shall be considered to be 1 eligible small business or group if: (1) it is eligible to file a combined tax return for purpose of state taxation, or (2) its companies are affiliated companies through the same corporate parent. Except as otherwise specifically provided, provisions of this chapter which apply to an eligible small business shall continue to apply through the end of the rating period in which an eligible insured no longer meets the requirements of this definition. An eligible small business that exists within a MEWA shall be subject to this chapter.

Emergency Medical Condition: An *Emergency* means a medical condition, whether physical, behavioral, related to substance use disorder, or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that, in the absence of prompt medical attention, could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing the health of a *member* or another person, or, in the case of a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any body organ or part; or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B).

Emergency Services: Services to treat a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of an insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. 1395dd(e)(1)(B).

Emergency Services Programs: All programs for the provision of community-based *Emergency* psychiatric services, including, but not limited to, behavioral health crisis assessment, intervention and stabilization services 24 hours per day, 7 days per week, through: (i) mobile crisis intervention services for youth; (ii) mobile crisis intervention services for adults; (iii) *Emergency* service provider community-based locations; and (iv) adult community crisis stabilization services.

Experimental or Investigational, or Experimental or Investigational Treatment: A treatment, service, procedure, supply, device, biological product or drug (collectively "treatment") is considered to be experimental or investigational for use in the diagnosis or treatment of a medical condition if **any** of the following is true:

- In the case of a drug, device, or biological product, it cannot be marketed lawfully without the approval of the U.S. Food and Drug Administration ("FDA") and final approval has not been given by the FDA.
- The treatment is described as experimental (or investigational, unproven, or under study) in the written informed consent document provided, or to be provided, to the member by the health care professional or facility providing the treatment.
- Authoritative evidence does not permit conclusions concerning the effect of the treatment on health outcomes.
- There is insufficient authoritative evidence that the treatment improves the net health outcome. (Net health outcome means that the treatment's beneficial effects on health outcomes outweigh any harmful effects of the treatment on health outcomes.) There is insufficient authoritative evidence that the treatment is as beneficial as any established alternative. This means that the treatment does not improve net outcome as much as or more than established alternatives.
- There is insufficient authoritative evidence that the treatment's improvement in health outcomes is attainable outside the investigational setting.

"Authoritative evidence," as used in this definition, shall mean only the following:

- Reports and articles, of well-designed and well-conducted studies, published in authoritative English-language medical and scientific publications. The publications must be subject to peer review by qualified medical or scientific experts prior to publication. In evaluating this evidence, the *plan* takes into consideration both the quality of the published studies and the consistency of results.
- Opinions and evaluations by: national medical associations; other reputable technology assessment bodies; and health care professionals with recognized clinical expertise in treating the medical condition or providing the treatment. In evaluating this evidence, the *plan* takes into consideration the scientific quality of the evidence upon which the opinions and evaluations are based.

The fact that a treatment is offered as a last resort does not mean that it is not an experimental or investigational treatment.

Evidence of Coverage: Any certificate, *contract* or agreement of health insurance including riders, amendments, endorsements and any other supplementary inserts or a summary *plan* description

Facility: A licensed institution providing health care services or a health care setting, including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

Family Stabilization Team: FST is an intensive family therapy model focused on youth who are most at risk for out-of-home placement due to behaviors in the home. Youth and family engage in intensive family therapy, as well as some *individual* skill building to improve functioning.

Finding of Neglect: A written determination by the Commissioner that a Carrier has failed to make and file the materials required by M.G.L. c. 176O or 211 CMR 52.00 in the form and within the time required

Fraud, Waste, and Abuse:

- Fraud: Intentional deception by a person who knows that the deception could result in some unauthorized benefit. An example is if a Member lends their ID Card to others to get health services.

- Waste: Extra costs that happen when health care services are overused; or when bills are not done correctly. Unlike Fraud, Waste is usually caused by mistake rather than intentional wrongful actions.
- Abuse: Provider actions that:
 - Are not consistent with sound fiscal, business or medical practices; and
 - Result in an unnecessary cost to MassHealth; or
 - Are in payment for services that are not Medically Necessary; or
 - That do not meet recognized health care standards.
 - It also includes *member* actions that result in unnecessary cost to MassHealth

Grievance: A formal complaint by you about:

- *Plan* Administration (how the *plan* is operated): any action taken by a *plan* employee; any aspect of the *plan's* services, policies or procedures; or a billing issue.
- Quality of Care: The quality of care you received from a *Network Provider*.

Group: An employer or other legal entity, as defined by the Health Connector, with which the Health Connector has a *group contract* to arrange for the provision of group coverage. An employer group subject to the Employee Retirement Income Security Act of 1974 (ERISA) is the ERISA *plan* sponsor. WellSense is not the *plan* sponsor. If you are a *member* through a group, the group is your agent and is not WellSense's agent.

Group Contract: The agreement between a group and the Health Connector under which:

- the Health Connector agrees to arrange for the group to obtain coverage under the *plan*; and
- the group agrees to pay the *premium* to the Health Connector for coverage under the *plan*.

The *group contract* includes this EOC and the applicable Schedules of Benefits.

Group Member: A category of *subscriber* (and his/her enrolled *dependents*) who receives coverage under the *plan* through a *group contract*.

Health Benefit Plan: Any *individual*, general, blanket or group policy of health, accident and sickness insurance issued by an insurer licensed under chapter 175; an *individual* or group hospital service *plan* issued by a non-profit hospital service corporation under chapter 176A; an *individual* or group medical service *plan* issued by a nonprofit medical service corporation under chapter 176B; and an *individual* or group health maintenance *contract* issued by a health maintenance organization under chapter 176G. Health benefit *plans* shall not include: accident only, credit only, limited scope vision or dental benefits if offered separately; hospital indemnity insurance policies that provide a benefit to be paid to an insured or a *dependent*, including the spouse of an insured, on the basis of a hospitalization of the insured or a *dependent*, that are sold as a supplement and not as a substitute for a health benefit *plan* and that meet any requirements set by the commissioner by regulation; disability income insurance; coverage issued as a supplement to liability insurance; specified disease insurance that is purchased as a supplement and not as a substitute for a health *plan* and meets any requirements the commissioner by regulation may set; insurance arising out of a workers' compensation law or similar law; automobile medical payment insurance; insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self insurance; long-term care if offered separately; coverage supplemental to the coverage provided under 10 U.S.C. 55 if offered as a separate insurance policy; travel insurance; or any policy subject to chapter 176K or any similar policies issued on a group basis, Medicare Advantage *plans* or Medicare Prescription drug *plans*. A health *plan* issued, renewed or delivered within or without the commonwealth to an *individual* who is enrolled in a qualifying student health insurance program under section 18 of chapter 15A shall not be considered a health *plan* for the purposes of this chapter and shall be governed by said chapter 15A. Travel insurance for the purpose of this chapter is insurance coverage for personal risks incident to *planned* travel, including but not limited to: (i) interruption or cancellation of trip or event; (ii) loss of baggage or personal effects; (iii) damages to accommodations or rental vehicles; or (iv) sickness, accident, disability or death occurring during travel, provided that the health benefits are not offered on a stand-alone basis and are incidental to other coverages. The term, "travel insurance" shall not include major medical *plans*, which provide comprehensive medical protection for travelers with trips lasting 6 months or longer, including for example, those working overseas as an expatriate or military personnel being deployed. The commissioner may by regulation define other health coverage as a health benefit *plan* for the purposes of this chapter.

Health Care Professional: A physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with law.

Health Care Provider or Provider: A health care professional or a facility.

Health Care Services or Health Services: Services for the diagnosis, prevention, treatment, cure or relief of a physical, behavioral, substance use disorder or mental health condition, illness, injury or disease.

Health Connector: The Commonwealth Health Insurance Connector Authority. This is an organization established under MA law to oversee and operate the Qualified Health *Plan* Program. The Health Connector is the Affordable Care Act-compliant exchange for Massachusetts. When the term Health Connector is used, it also includes its *subcontractors*.

HMO: A health maintenance organization licensed pursuant to M.G.L. c. 176G.

Individual: A category of *subscriber* for which there is no employer financial contribution to the *premiums* under this *plan*. The *individual* is responsible to pay the full applicable *premium*. The *individual subscriber* (or someone on his/her behalf) enters into an *individual contract* with the *Health Connector*.

Individual Contract: The agreement between an *individual* and the Health Connector under which:

- the *Health Connector* agrees to arrange for the *individual* to obtain coverage under the *plan*; and
 - the *individual* agrees to pay the full applicable *premium* to the Health Connector for coverage under the *plan*.
- The *individual contract* includes this EOC and the *applicable* Schedules of Benefits.

In-home Behavioral Services: A combination of medically necessary behavior management therapy and behavior management monitoring; provided, however, that such services shall be available, when indicated, where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting. In-home behavioral services include:

Inpatient: A patient who is admitted to a hospital or other facility; and registered by that facility as a bed patient.

Inquiry: Any communication by you to the *plan* asking us to address a *plan* action, policy or procedure. It does not include questions about adverse determinations, which are *plan* decisions to deny coverage based on *Medical Necessity*.

Insured: An enrollee, covered person, insured, *member*, policyholder or *subscriber* of a carrier, including an *individual* whose eligibility as an insured of a carrier is in dispute or under review, or any other *individual* whose care may be subject to review by a utilization review program or entity as described under other provisions of this chapter.

Intensive Care Coordination: A collaborative service that provides targeted case management services to children and adolescents with a serious emotional disturbance, including *individuals* with co-occurring conditions, in order to meet the comprehensive medical, behavioral health, and psychosocial needs of an *individual* and the *individual's* family, while promoting quality, cost effective outcomes. This service includes an assessment, the development of an *individualized care plan*, referrals to appropriate levels of care, monitoring of goals, and coordinating with other services and social supports and with state agencies, as indicated. The service shall be based upon a system of care philosophy and the *individualized care plan* shall be tailored to meet the needs of the *individual*. The service shall include both face-to-face and telephonic meetings, as indicated and as clinically appropriate. ICC is delivered in office, home or other settings, as clinically appropriate.

Intensive Community-Based Treatment for Children and Adolescents (ICBAT): provides the same services as CBAT for children and adolescents but of higher intensity, including more frequent psychiatric and psychopharmacological evaluation and treatment and more intensive staffing and service delivery. ICBAT programs

have the capability to admit children and adolescents with more acute symptoms than those admitted to CBAT. ICBAT programs are able to treat children and adolescents with clinical presentations similar to those referred to inpatient mental health services but who are able to be cared for safely in an unlocked setting. This is also defined as an intensive 24-hour clinically managed mental health diversionary or step-down services for children and adolescents that is usually provided as an alternative to mental health acute treatment. **Note: No pre-authorization is required but notification by the Facility to WellSense is required within 72 hours of the admission.**

Children and adolescents may be admitted to an ICBAT directly from the community as an alternative to inpatient hospitalization; ICBAT is not used as a step-down placement following discharge from a locked, 24-hour setting.

Intermediary: A chamber of commerce, trade association, or other organization, formed for purposes other than obtaining insurance, as determined by the commissioner, which offers as a service to its *members* the option of purchasing a health benefit *plan*.

Internet Website: Includes, but shall not be limited to, an internet website, an intranet website, a web portal, or electronic mail.

JCAHO: The Joint Commission on Accreditation of Healthcare Organizations.

Licensed Health Care Provider Group: A partnership, association, corporation, *individual* practice association, or other group that distributes income from the practice among members. An *individual* practice association is a licensed health care provider group only if it is composed of *individual* health care professionals and has no *subcontracts* with licensed health care provider groups.

Licensed Mental Health Professional: A licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed *independent* clinical social worker, a licensed certified social worker, a licensed mental health counselor, a licensed supervised mental health counselor, a licensed psychiatric nurse mental health clinical specialist, a licensed psychiatric mental health nurse practitioner, a licensed physician assistant who practices in the area of psychiatry, a licensed alcohol and drug counselor I, or a licensed marriage and family therapist within the lawful scope of practice for such therapist.

Limited Health Services: Pharmaceutical services and such other services as may be determined by the Commissioner to be Limited Health Services. Limited Health Services shall not include hospital, medical, surgical or *Emergency* services except as such services are provided in conjunction with the Limited Health Services set forth in the preceding sentence.

Limited Network Plan: A limited *network plan* as defined in 211 CMR 152.00: Health Benefit *Plans* Using Limited, Regional or Tiered Provider Networks.

Managed Care Organization or MCO: A Carrier subject to M.G.L. c. 176O.

Material Change: A modification to any of a Carrier's, including a Dental or Vision Carrier's, procedures or documents required by 211 CMR 52.00 that substantially affects the rights or responsibilities of: an Insured; a Carrier, including a Dental or Vision Carrier; and/or a health, Dental, or vision Care Provider.

Medically Necessary (or Medical Necessity): Health care services that are consistent with generally accepted principles of professional medical practice as determined by whether: (a) the service is the most appropriate available supply or level of service for the *member* in question considering the potential benefits and harms to the *member*; (b) the service is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or (c) for services and interventions not in widespread use, the service is based on scientific evidence.

Member: A person enrolled in the *plan* under a *group contract* or *individual contract*. Members include *subscribers* and their enrolled *dependents*. A *member* is also referred to as "you" in this EOC.

Mental Disorders: Psychiatric illnesses or diseases. (These include drug addiction and alcoholism.) The illnesses or diseases that qualify as *mental disorders* are listed in the latest edition, at the time of your treatment, of the DSM.

Mental Health Acute Treatment: 24-hour medically supervised mental health services provided in an inpatient facility, licensed by the department of mental health that provides psychiatric evaluation, management, treatment and discharge *planning* in a structured treatment milieu. Note: No pre-authorization is required but notification by the Facility to WellSense is required within 72 hours of the admission.

Mental Health Wellness Examination: A screening or assessment that seeks to identify any behavioral or mental health needs and appropriate resources for treatment. The examination may include: (i) observation, a behavioral health screening, education and consultation on healthy lifestyle changes, referrals to ongoing treatment, mental health services and other necessary supports, and discussion of potential options for medication; and (ii) age-appropriate screenings or observations to understand a covered person's mental health history, personal history and mental or cognitive state and, when appropriate, relevant adult input through screenings, interviews and questions.

National Accreditation Organization: The American accreditation health care commission/URAC, the National Committee for Quality Assurance, or any other national accreditation entity approved by the division that accredits carriers subject to the provisions of this chapter.

NCQA: The National Committee for Quality Assurance.

NCQA Standards: The Standards and Guidelines for the Accreditation of Health *Plans* published annually by the NCQA.

Network or Provider Network: A grouping of health care providers who *contract* with a carrier to provide services to insureds covered by any or all of the carrier's *plans*, policies, *contracts* or other arrangements.

Network Pharmacy: A retail, specialty or mail order pharmacy that is a *Network Provider*.

Network Provider: A provider with whom the *plan* has a direct or indirect agreement to provide *covered services* to *members*. *Network Providers* are not the *plan's* employees, agents or representatives. *Network Providers* are listed in the *plan's* Provider Directory.

Non-Gatekeeper Preferred Provider Plan: An insured preferred provider *plan* approved for offer under M.G.L. c. 176I which offers preferred Benefits when a covered person receives care from preferred *Network Providers* but does not require the Insured to designate a Primary Care Provider to coordinate the delivery of care or receive referrals from the Carrier or any *Network Provider* as a condition of receiving Benefits at the preferred benefit level.

Nurse Practitioner: A registered nurse who holds authorization in advanced nursing practice as a nurse practitioner

Office of Patient Protection: The office in the health policy commission established by section 16 of chapter 6D, responsible for the administration and enforcement of sections 13, 14, 15 and 16.

Open Enrollment Period: The period of time each year when eligible persons (including eligible *dependents*) are able to apply for *individual* coverage (under an *individual contract*) or group coverage (under a *group contract*).

Out-of-Pocket Maximum: This is the maximum amount of *cost-sharing* you are required to pay in a *benefit year* for most *covered services*. See Chapter 1 for more information. *Out-of-pocket maximum* amounts, if any, are in your Schedule of Benefits.

Outpatient, or Outpatient Services: Services provided to an *individual* who is not a registered bed patient in a facility. For example, you receive *outpatient services* in a provider's office, an *Emergency* room, health center, or

outpatient clinic.

Outpatient Surgery: Surgery that is done under anesthesia in an operating room of a facility licensed to perform surgery; and where you are expected to be discharged the same day. Examples are outpatient surgery in a hospital or free-standing ambulatory surgery center.

Participating Provider: A provider who, under a *contract* with the carrier or with its *contractor* or *subcontractor*, has agreed to provide health care services to insureds with an expectation of receiving payment, other than *coinsurance*, *copayments* or *deductibles*, directly or indirectly from the carrier.

Physician Assistant: A person who is a graduate of an approved program for the training of physician assistants who is supervised by a registered physician

Plan: The benefits described in this EOC (including your Schedule of Benefits). The *plan* is also known as WellSense Health Plan. WellSense has *contracted* with the Health Connector to offer the *plan* to *individuals* and groups.

Premium: The total monthly dollar amount an *individual subscriber* or group is required to pay for coverage under the applicable benefit package described in this EOC. The Health Connector will tell you the amount of your total monthly *premium* payment(s).

Preventive Health Services: Any periodic, routine, screening or other services designed for the prevention and early detection of illness that a Carrier is required to provide pursuant to Massachusetts or federal law.

Primary Care Provider (PCP): A *network* healthcare professional qualified to provide general medical care for common health care problems, who (1) supervises, coordinates, prescribes or otherwise provides or proposes health care services; (2) coordinates and arranges for specialist care; and (3) maintains continuity of care within the scope of practice. *PCPs* are physicians who are doctors of: internal medicine; family practice; general practice; or pediatric medicine. A *PCP* may also be a physician assistant or a nurse practitioner (appropriately credentialed) who provides primary care services. Female *members* may also select an obstetrician/gynecologist as their *PCP*.

Prospective Review: Utilization review conducted prior to an admission or a course of treatment and shall include any pre-authorization and pre-certification requirements of a carrier or utilization review organization.

Provider: Health care professionals or facilities licensed under state law. Providers include but are not limited to: physicians; physician assistants, nurse practitioners, hospitals; skilled nursing facilities; psychologists; licensed mental health counselors; licensed *independent* clinical social workers; licensed marriage and family therapists; licensed psychiatric nurses certified as clinical specialists in psychiatric and mental health nursing; psychiatrists; licensed alcohol and drug counselors, certified nurse midwives; lab and imaging centers; and pharmacies. Some providers may be referred to as practitioners. To find out if a provider is in your provider *network*, call Member Services or look in the Provider Directory.

Provider Directory: A listing of our *network providers*.

Provider Network (or Network): The providers with whom the *plan* has an agreement to provide *covered services* to *members*. The *plan* has different provider networks. The provider *network* applicable to you is listed in your Schedule of Benefits.

Qualified Association: A Massachusetts nonprofit or not-for-profit corporation or other entity organized and maintained for the purposes of advancing the occupational, professional, trade or industry interests of its association members, other than that of obtaining health insurance, and that has been in active existence for at least 5 years, that comprises at least 100 association members and membership in which is generally available to potential association members of such occupation, profession, trade or industry without regard to the health condition or status of a prospective association member or the employees and *dependents* of a prospective association member.

Qualified Health *Plan* Program: The Qualified Health *Plan* Program overseen by the Health Connector.

Qualifying Health *Plan*: Any (i) blanket or general policy of medical, surgical or hospital insurance described in subdivision (A), (C) or (D) of section one hundred and ten of chapter one hundred and seventy-five; (ii) policy of accident or sickness insurance as described in section one hundred and eight of chapter one hundred and seventy-five which provides hospital or surgical expense coverage; (iii) non-group or group hospital or medical service *plan* issued by a non-profit hospital or medical service corporation under chapters one hundred and seventy-six A and one hundred and seventy-six B; (iv) non-group or group health maintenance *contract* issued by a health maintenance organization under chapter one hundred and seventy-six G; (v) insured group health benefit *plan* that includes a preferred provider arrangement under chapter one hundred and seventy-six I; (vi) self-insured or self-funded employer group health *plan*; (vii) health coverage provided to persons serving in the armed forces of the United States; or (viii) medical assistance provided under chapter one hundred and eighteen E. The commissioner may, by regulation, define other health coverage as a qualifying health *plan* for the purposes of this chapter.

Regional Network *Plan*: A regional *network plan* as defined in 211 CMR 152.00: Health Benefit *Plans* Using Limited, Regional or Tiered Provider Networks.

Religious Non-Medical Provider: A Provider who provides no medical care but who provides only religious non-medical treatment or religious non-medical nursing care.

Resident: A natural person living in Massachusetts. Confinement in a nursing home, hospital or other institution is not by itself sufficient to qualify a person as a resident.

Retrospective Review: Utilization review of *Medical Necessity* that is conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

Same or Similar Specialty: The Health Care Professional has similar credentials and licensure as those who typically provide the treatment in question and has experience treating the same condition that is the subject of the *Grievance*. Such experience shall extend to the treatment of children in a *Grievance* involving a child where the age of the patient is relevant to the determination of whether a requested service or supply is Medically Necessary.

Second Opinion: An opportunity or requirement to obtain a clinical evaluation by a health care professional other than the health care professional who made the original recommendation for a proposed health service, to assess the clinical necessity and appropriateness of the initial proposed health service.

Serious Harm: Circumstances which could: seriously jeopardize the *member's* life, health or ability to regain maximum function; or result in severe pain.

Service Area: The geographical area in which *Network Providers* are located. Please visit the *plan's* website at wellsense.org for more information about our *service area*. (We may add or delete cities and towns to our *service area* from time to time.)

Spouse: As defined by the *Health Connector*. It includes a *subscriber's* divorced or separated spouse as required by MA law.

Subscriber: The person who:

- signs the membership application form on behalf of himself/herself* and (if allowed) any *dependents*;
- in whose name the *premium* is paid in accordance with either a *group contract* or an *individual contract* (as applicable);
- for an *individual contract*, is a MA resident; and
- for a *group contract*, is an employee of a *group*.

*Note: in the case of some eligible *individuals* under age 21 who enroll in an *individual contract*, the membership

application form is signed by that *individual's* parent or legal guardian on behalf of that *individual*.

Telehealth: means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

Terminally Ill or Terminal Illness: An illness that is likely, within a reasonable degree of medical certainty, to cause one's death within six months, or as otherwise defined in section 1861(dd)(3)(A) of the Social Security Act, 42 U.S.C. section 1395x(dd)(3)(A).

Therapeutic Mentoring Services: Medically necessary services provided to a child, designed to support age-appropriate social functioning or to ameliorate deficits in the child's age-appropriate social functioning resulting from a DSM diagnosis; provided, however, that such services may include supporting, coaching, and training the child in age-appropriate behaviors, interpersonal communication, problem solving, conflict resolution, and relating appropriately to other children and adolescents and to adults. Such services shall be provided, when indicated, where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting. Therapeutic mentoring is a skill building service addressing one or more goals on the youth's behavioral health treatment *plan*. It may also be delivered in the community, to allow the youth to practice desired skills in appropriate settings.

Tiered Network Plan: A tiered *network plan* as defined in 211 CMR 152.00: Health Benefit Plans Using Limited, Regional or Tiered Provider Networks.

URAC: The American Accreditation HealthCare Commission/URAC, formerly known as the Utilization Review Accreditation Commission.

Urgent Care: Medically necessary care that is required to prevent serious deterioration of your health when you have an unforeseen illness or injury. Urgent care does not include, among other things: routine care (including routine maternity or prenatal or postpartum care); preventive care; care for chronic medical conditions that require ongoing medical treatment; elective inpatient admissions; or elective outpatient surgery.

Utilization Review: A set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include, but are not limited to, ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge *planning* or retrospective review.

Utilization Review Organization: An entity that conducts utilization review, other than a carrier performing utilization review for its own health benefit *plans*.

Vision Benefit Plan: A policy, *contract*, certificate or agreement of insurance entered into, offered or issued by a Carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs solely for Vision Care Services.

Vision Care Professional: An ophthalmologist, optometrist or other practitioner licensed, accredited or certified to perform specified Vision Services consistent with the law.

Vision Care Provider: A Vision Care Professional; or a Facility licensed to perform and provide Vision Care Services.

Vision Care Services or Vision Services: Services for the diagnosis, prevention, treatment, cure or relief of a vision condition, illness, injury or disease.

Vision Carrier: An entity that offers a policy, certificate or *contract* that provides coverage solely for vision care services.

Wellness program or "health management program": An organized system designed to improve the overall health of participants through activities that may include, but shall not be limited to, education, health risk assessment, lifestyle coaching, behavior modification and targeted disease management.

WellSense: WellSense Health Plan, WellSense, is a not-for-profit MA-licensed health maintenance organization. WellSense is also known as: WellSense Health *Plan* or WellSense Health *Plan*. We arrange for the provision of health care services to *members* through *contracts* with *Network Providers* in our *service area*. WellSense *contracts* with the Health Connector to offer the *plan* to *members*. WellSense is sometimes referred to as "we," "our," or "us."

WellSense Clarity plan (or the "Plan"): The program of health benefits described in this EOC, along with the corresponding Schedules of Benefits. It is also referred to as the *plan*. Through an arrangement with the Health Connector, WellSense offers the *plan* to persons meeting applicable eligibility requirements.

You: See "Member."

APPENDIX B: MEMBER RIGHTS AND RESPONSIBILITIES

1. You have the right to be treated with respect and with recognition of your dignity and right to [privacy](#).
2. You have the right to be told about and understand any illness you have.
3. You have the right to be told in advance – in a manner you understand – of any treatment(s) and alternatives that a provider feels should be done.
4. You have the right to take part in decisions regarding your healthcare, including the right to refuse treatment as far as the law allows, and to know what the outcome may be.
5. You have the right to have an open and honest discussion of appropriate or Medically Necessary treatment options for your health conditions, regardless of cost or benefit coverage. You may be responsible for payment of services not included in the Covered and Excluded Services list for your coverage type.
6. You have the right to expect your healthcare Providers to keep your records private, as well as anything you discuss with them. No information will be released to anyone without your consent, unless required by law.
7. You have the right to request an interpreter when you receive healthcare. Call [Member Services](#) if you need help with this service.
8. You have the right to request an interpreter when you call or visit WellSense or [Carelon Behavioral Health](#) (for Behavioral Health). Call Member Services if you need help with this service.
9. You have the right to choose your own Primary Care Provider (PCP) and you can change your PCP at any time. You must call Member Services if you want to change your PCP.
10. You have the right to receive healthcare within the timeframes described in your member documents, and to file an Internal Appeal if you do not receive your care within those timeframes.
11. You have the right to voice a complaint and file a Grievance with Member Services, Carelon Behavioral Health, and/or the MassHealth Member Services center about services you received from the Plan or from a healthcare provider. You also have the right to appeal certain decisions made by WellSense or Carelon Behavioral Health (for Behavioral Health). The reasons for Grievances and Internal Appeals are described in your member documents.
12. You have the right to talk about your health records with your provider and obtain a complete copy of those records. You also have the right to request a change to your health records.
13. You have the right to know and receive all of the benefits, services, rights and responsibilities you have under WellSense and/or MassHealth.
14. You have the right to have your member documents and any printed materials from WellSense translated into your primary language, and/or to have these materials read aloud to you if you have trouble seeing or reading. Oral interpretation services will be made available upon request and free of charge.
15. You have the right to ask for a Second Opinion about any healthcare that your PCP advises you to have. WellSense will pay for the cost of your Second Opinion visit.
16. You have the right to receive Emergency care, 24 hours a day, seven days a week. Please see your member documents for complete information.
17. You have the right to be free from any form of physical restraint or seclusion that would be used as a means of coercion, force, discipline, convenience or retaliation.
18. You have the right to freely exercise these rights without adversely affecting the way WellSense and its providers treat you.
19. You have the right to receive health treatment from WellSense providers without regard to race, age, gender, sexual preference, national origin, religion, health status, economic status, or physical disabilities. And no provider should engage in any practice, with respect to any WellSense Member, that constitutes unlawful discrimination under any state or federal law or regulation.
20. You have the right to disenroll from WellSense and change to another MassHealth health plan by calling the MassHealth Member Services center (MassHealth members).
21. You have the right to receive information about WellSense, our services, providers, and your rights and responsibilities.
22. You have the right to make recommendations about our Rights and Responsibilities statement.
23. Members have the right to refuse services via telehealth and be asked to be seen in person.

APPENDIX C: ERISA INFORMATION FOR GROUP MEMBERS

Introduction to ERISA: If you are a group member and your plan is an ERISA plan, you have certain rights and protections under ERISA – which stands for the Employee Retirement Income Security Act of 1974. Most plans are ERISA plans, but there are some exceptions. Please contact your plan administrator to learn if your plan is an ERISA plan.

Information about Your Plan and Benefits: ERISA entitles all plan participants to:

- Examine, without charge, at the plan administrator’s office and at other specified locations all documents governing the plan. These include, when applicable: insurance contracts; collective bargaining agreements; and a copy of the most current annual report (Form 5500 Series) filed by your plan with the US Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Upon written request to the plan administrator, you are entitled to obtain copies of documents governing the operation of the plan. These include the documents listed above as well an updated summary plan description. The plan administrator may charge you a reasonable charge for the copies.
- Receive a summary of the plan’s annual financial report. The plan administrator is required by law to provide each participant with a copy of this summary annual report.

Continuation of Group Health Plan Coverage: ERISA states that all plan participants are entitled to:

- Continue health care coverage for the subscriber, spouse or other dependents if there is a loss of coverage under the plan as a result of a qualifying event. The subscriber or dependents may have to pay for such continued coverage.
- Review the plan’s summary plan description and the other documents governing the plan on the rules governing your continuation coverage rights under COBRA – the Federal Consolidated Omnibus Budget Reconciliation Act.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under a group health plan, if you have creditable coverage from another plan. You should be provided a free certificate of creditable coverage from your group health plan or health insurance issuer when: you lose coverage under the plan; when you become entitled to elect COBRA continuation coverage; when your COBRA continuation coverage ceases; if you request it before losing coverage; or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. (The coverage described in this EOC does not contain a preexisting condition exclusion.)

Prudent Actions by Plan Fiduciaries: ERISA imposes duties upon people who are responsible for the operation of the plan. The people who operate your plan are called “fiduciaries” of the plan. They have a duty to operate your plan prudently and in the interests of plan participants and beneficiaries. No one, including your employer, union, or any other person, may fire a subscriber or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your ERISA rights.

Enforcing Your Rights: If your claim for a plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to Appeal any denial, all within certain time schedules.

ERISA provides for steps you can take to enforce the above rights. For example, if you request a copy of a plan document and do not receive it within 30 days, you may file suit in a federal court. In such case, the court may require the plan administrator to provide the documents and pay you up to \$110 a day until you receive the documents, unless the documents were not sent because of reasons beyond the control of the plan administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. Also, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If a plan fiduciary misuses the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the US Department of Labor. You may also file suit in a federal court. The court will decide who has to pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees. For

example, if a court finds your claims frivolous, you may have to pay court costs and legal fees.

Help With Your Questions: You should contact your plan administrator if you have any questions about your plan. If you have questions about this statement or about your ERISA rights, or if you need help obtaining documents from the plan administrator, you should contact:

- the nearest office of the Employee Benefits Security Administration, US Department of Labor, listed in your telephone directory; or
- the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, US Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA. Call the publications hotline of the Employee Benefits Security Administration.

PROCESSING OF CLAIMS FOR PLAN BENEFITS: The Department of Labor's (DOL) Employee Benefits Security Administration has published benefit determination procedure regulations for employee benefit plans governed by ERISA. The regulations set forth requirements regarding the processing of claims for plan benefits, including urgent care claims, pre-service claims, post-service claims and review of claims denials.

Who can submit a claim? The DOL regulations apply to claims submitted by ERISA participants or their beneficiaries. In accordance with the regulations, the plan permits an authorized representative (referred to here as the "authorized claimant") to act on your behalf in submitting a claim or obtaining a review of a claim decision. An authorized claimant can be any individual (including, for example, a family member, an attorney, etc.) whom you designate to act on your behalf with respect to a claim for benefits.

How do I designate an Authorized Claimant? An authorized claimant can be designated at any point in the claims process - at the pre-service, post service or Appeal level. Please contact Member Services at 1-855- 833- 8120 for information on appointing an authorized claimant.

Types of claims: There are several different types of claims that you may submit for review. The plan's procedures for reviewing claims depends upon the type of claim submitted (urgent care claims, pre-service claims, post-service claims, and concurrent care decisions).

Urgent care claim: An "urgent care claim" is a claim for medical care or treatment where the application of the claims review procedure for non-urgent claims: (1) could seriously jeopardize your life, health or ability to regain maximum function, or (2) based upon your provider's determination, would subject you to severe pain that cannot adequately be managed without the care or treatment being requested. For urgent care claims, we will respond to you within 72 hours after receipt of the claim. If we determine that additional information is needed to review your claim, we will notify you within 24 hours after receipt of the claim and provide you with a description of the additional information needed to evaluate your claim. You have 48 hours after that time to provide the requested information. We will evaluate your claim within 48 hours after the earlier of our receipt of the requested information, or the end of the extension period given to you to provide the requested information.

Concurrent care decisions: A "concurrent care decision" is a determination relating to the continuation/reduction of an ongoing course of treatment. If the plan has already approved an ongoing course of treatment for you and considers reducing or terminating the treatment, we will notify you sufficiently in advance of the reduction or termination of treatment to allow you to Appeal the decision and obtain a determination before the treatment is reduced or terminated. If you request to extend an ongoing course of treatment that involves urgent care, we will respond to you within 24 hours after receipt of the request (provided that you make the request at least 24 hours prior to the expiration of the ongoing course of treatment). If you reach the end of a pre-approved course of treatment before requesting additional services, the "pre-service" or "post-service" time limits will apply.

Pre-service claim: A "pre-service claim" is a claim that requires approval of the benefit in advance of obtaining the care. For pre-service claims, the plan will respond to you within 15 days after receipt of the claim*. If we determine that an extension is necessary due to matters beyond our control, we will notify you within 15 days informing you of the

circumstances requiring the extension and the date by which we expect to render a decision (up to an additional 15 days). If you make a pre-service claim, but do not submit enough information for us to make a determination, we will notify you within 15 days and describe the information that you need to provide to us. You will have no less than 45 days from the date you receive the notice to provide the requested information.

Post-service claim: A "post-service claim" is a claim for payment for a particular service after the service has been provided. For post-service claims, the plan will respond to you within 30 days after receipt of the claim. If we determine that an extension is necessary due to matters beyond our control, we will notify you within 30 days informing you of the circumstances requiring the extension and the date by which we expect to render a decision (up to an additional 15 days). If you make a post-service claim, but do not submit enough information for us to make a determination, we will notify you within 30 days and describe the information that you need to provide to us. You will have no less than 45 days from the date you receive the notice to provide the requested information. If your request for coverage is denied, you have the right to file an Appeal. See Chapter 6 for information on how to file an Appeal.

* In accordance with MA law, the plan will make an initial determination regarding a proposed admission, procedure, or service that requires such a determination within two working days of obtaining all necessary information.

Statement of Rights Under the Newborns and Mothers' Health Protection Act: Under federal law, group health plans and health insurance issuers offering group health insurance coverage:

- Generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the group health plan or issuer may pay for a shorter stay if the attending provider (e.g., the mother's physician or nurse midwife), after consultation with the mother, discharges the mother or newborn earlier.
- May not set the level of benefits or out of pocket costs so that any later portion of the 48 hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.
- May not require that a physician or other health care provider obtain authorization for prescribing a length of stay up to 48 hours, or 96 hours as applicable. However, to use certain providers or facilities, you may be required to obtain prior authorization. For information on prior authorization, contact Member Services.

APPENDIX D: MEMBER EXTRAS

In addition to the *covered services* described above, we offer our *members additional savings*.

Get Fit! Fitness Reimbursements: You are eligible for reimbursement of 25% of your annual membership fees at a Qualifying Health Club. Reimbursement is limited to one member per family per calendar year if you meet all the following requirements:

- Are a member of a Qualifying Health Club, which is a club that offers both cardiovascular and strength- training exercise equipment such as traditional health and fitness clubs or YMCA/YWCAs. It does not include martial arts centers, gymnastics facilities, social clubs, tennis-or pool-only facilities, country clubs or sports teams or leagues.
- Be a member of the plan and of your Qualifying Health Club for at least the same 3 months in a calendar year.
- Submit a completed reimbursement request form to the plan no later than March 31 of the following calendar year. Visit our website at wellsense.org or call us at 1-855-833-8120 to get the reimbursement request form.
- Each family is eligible for the **Get Fit! Fitness Reimbursement** OR the **Wear it! Fitness Tracker Reimbursement** within one calendar year, not both.

Wear it! Fitness Tracker Reimbursement: As an alternative to the **Get Fit! Fitness Reimbursement**, you have to option to receive a 50% reimbursement on a wearable technology device, up to \$50 per year.

Reimbursement is limited to one member per family per calendar year if you meet all the following requirements:

- Purchase a wearable device that can be worn and tracks your health and activity levels. Wearables include fitness trackers, smart watches, and safety trackers. iPhones do not qualify for reimbursement.
- Submit a completed reimbursement request form and copy of purchase receipt to the plan no later than December 31 of the same calendar year. Visit our website at wellsense.org or call us at 1-855-833- 8120 to get the reimbursement request form.

Each family is eligible for the **Get Fit! Fitness Reimbursement** OR the **Wear it! Fitness Tracker Reimbursement** within one calendar year, not both.

Mom's Meals: You are eligible for free shipping on low-cost meals that are prepared and delivered to you as a WellSense Clarity plan member. To qualify for free shipping, orders may be placed via the following Mom's Meals website link (momsmeals.com/wellsense-clarity). You may start or end this benefit at any time you choose.

Weight Watchers®: You are eligible for reimbursement of 25% of the fees paid for a Weight Watchers program. Reimbursement is limited to one member per family per calendar year if you meet all the following requirements:

- Purchase any online, local meeting, or coaching subscription from Weight Watchers
- Submit a completed reimbursement form to the plan no later than March 31 of the following calendar year. Visit wellsense.org or call us at 855-833-8120 to get the reimbursement request form.

Eyewear Discounts: When you go to a Vision Services Provider ("VSP") participating eye care provider, you can receive:

- 20% off the retail price of complete sets of prescription glasses frames and lenses. Simply present a valid prescription (no older than 12 months) from any qualified optometrist or ophthalmologist.
- 15% off the professional fee for prescription contact lens fitting and evaluation.

Find participating VSP eye care providers at vsp.com. Show your *plan* ID card when purchasing from a VSP-participating provider to receive the discount.

These savings programs may change over time without advance notice to *members*. To check on current Member Extras savings programs, you can:

- Call Member Services at 855-833-8120; or

- Visit our website at wellsense.org

APPENDIX E: LIST OF COVERED PREVENTIVE CARE SERVICES

Preventive Health Services: The plan covers preventive health services. These are services to prevent disease or injury rather than diagnose or treat a complaint or symptom. These services are provided by your *PCP*, network obstetrician or other qualified Network Providers. To be covered, all preventive health services must be provided: in accordance with the plan’s medical policy guidelines; and with applicable laws and regulations.

Important Information: In some cases a diagnosis code maybe required to define a service as preventive, screening, counseling, or wellness. Additionally, these preventive services maybe subject to limitations depending on medical necessity and other reasonable medical management criteria.

In the course of receiving certain outpatient services (which may or may not be subject to cost-sharing), you may also receive other covered services that require separate cost-sharing. For example, during a preventive health services office visit (no cost-sharing), you may have a lab test to check your TCH level and because this test is not preventive you may be responsible for cost-sharing for this service.

Some services may start as preventive (no cost-sharing) but during the course of the visit and or procedure an additional service may be medically necessary. The removal of the polyp may result in changing a preventive procedure to a diagnostic procedure resulting, you may then be responsible for cost-sharing for this service.

Note: The information included herein is intended as a reference tool for your convenience and is not a guarantee of payment. This guide is subject to change based on new or revised laws and/or regulations, additional guidance and/or WellSense medical policy.

Please feel free to contact member services department at 1-855-833-8120 (toll-free) Monday – Friday 8 a.m. – 6 p.m.

Preventive Service (Based on Grade A & Grade B Recommendations from the U.S. Preventive Service Task Force – USPSTF)	Description	Frequency
Abdominal Aortic Aneurysm: Screening: men aged 65 to 75 years who have ever smoked	The USPSTF recommends 1-time screening for abdominal aortic aneurysm (AAA) with ultrasonography in men aged 65 to 75 years who have ever smoked.	1 per lifetime
Anxiety in Children and Adolescents: Screening: children and adolescents aged 8 to 18 years	The USPSTF recommends screening for anxiety in children and adolescents aged 8 to 18 years.	
Aspirin Use to Prevent Preeclampsia and Related Morbidity and Mortality: Preventive Medication: pregnant persons at high risk for preeclampsia	The USPSTF recommends the use of low-dose aspirin (81 mg/day) as preventive medication after 12 weeks of gestation in persons who are at high risk for preeclampsia.	Once daily after 12 weeks of gestation.
Asymptomatic Bacteriuria in Adults: Screening: pregnant persons	The USPSTF recommends screening for asymptomatic bacteriuria using urine culture in pregnant persons.	
Blood Pressure Screening		

BRCA-Related Cancer: Risk Assessment, Genetic Counseling, and Genetic Testing: women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or an ancestry associated with brca1/2 gene mutation	The USPSTF recommends that primary care clinicians assess women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or who have an ancestry associated with breast cancer susceptibility land 2 (BRCA1/2) gene mutations with an appropriate brief familial risk assessment tool. Women with a positive result on the risk assessment tool should receive genetic counseling and, if indicated after counseling, genetic testing.	
Breast Cancer: Medication Use to Reduce Risk: women at increased risk for breast cancer aged 35 years or older	The USPSTF recommends that clinicians offer to prescribe risk-reducing medications, such as tamoxifen, raloxifene, or aromatase inhibitors, to women who are at increased risk for breast cancer and at low risk for adverse medication effects.	
Breast Cancer: Screening: women aged 50 to 74 years	The USPSTF recommends biennial screening mammography for women aged 50 to 74 years.	Every 2 years
Cervical Cancer: Screening: women aged 21 to 65 years	The USPSTF recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting).	Age 21-29 - 1x every 3 years Age 30-65 - 1x every 3 years, 1x every 5 years with high risk PHV testing alone or in combination with PAP
Chlamydia and Gonorrhea: Screening: sexually active women, including pregnant persons	The USPSTF recommends screening for gonorrhea in all sexually active women 24 years or younger and in women 25 years or older who are at increased risk for infection.	
Colorectal Cancer: Screening: adults aged 45 to 49 years	The USPSTF recommends screening for colorectal cancer in adults aged 45 to 49 years.	
Colorectal Cancer: Screening: adults aged 50 to 75 years	The USPSTF recommends screening for colorectal cancer in all adults aged 50 to 75 years.	
Congenital Hypothyroidism Screening	Referred but never finalized	
Depression and Suicide Risk in Children and Adolescents: Screening: adolescents aged 12 to 18 years	The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years.	
Diabetes Mellitus Type 2, Adults, Screening		Every 3 years for adults with normal test results
Diabetes Self-Management Training		Initial year - up to 10 hours of training, after that up to 2 hours per year for follow-up training

Falls Prevention in Community-Dwelling Older Adults: Interventions: adults 65 years or older	The USPSTF recommends exercise interventions to prevent falls in community-dwelling adults 65 years or older who are at increased risk for falls.	
Folic Acid for the Prevention of Neural Tube Defects: Preventive Medication: women who are <i>planning</i> or capable of pregnancy	The USPSTF recommends that all women who are <i>planning</i> or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 mcg) of folic acid.	
Gestational Diabetes: Screening: asymptomatic pregnant persons at 24 weeks of gestation or after	The USPSTF recommends screening for gestational diabetes in asymptomatic pregnant persons at 24 weeks of gestation or after.	
Healthy Diet and Physical Activity for Cardiovascular Disease Prevention in Adults With Cardiovascular Risk Factors: Behavioral Counseling Interventions: adults with cardiovascular disease risk factors	The USPSTF recommends offering or referring adults with cardiovascular disease risk factors to behavioral counseling interventions to promote a healthy diet and physical activity.	
Healthy Weight and Weight Gain In Pregnancy: Behavioral Counseling Interventions: pregnant persons	The USPSTF recommends that clinicians offer pregnant persons effective behavioral counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight gain in pregnancy.	
Hepatitis B Virus, Screening		Annual
Hepatitis B Virus Infection in Pregnant Women: Screening: pregnant women	The USPSTF recommends screening for hepatitis B virus (HBV) infection in pregnant women at their first prenatal visit	1x per pregnancy and 1x add'l at delivery
Hepatitis C Virus Infection in Adolescents and Adults: Screening: adults aged 18 to 79 years	The USPSTF recommends screening for hepatitis C virus (HCV) infection in adults aged 18 to 79 years.	Annually - high risk; one for enrollees born between 1945 and 1965 not at high risk; initial screening for anyone who had a blood transfusion before 1992 and enrollees with current or past history of injection drug use
Human Immunodeficiency Virus (HIV) Infection: Screening: adolescents and adults aged 15 to 65 years	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults aged 15 to 65 years. Younger adolescents and older adults who are at increased risk of infection should also be screened.	Born 1945-1965: no diagnosis code restrictions
Human Immunodeficiency Virus (HIV) Infection: Screening: pregnant persons	The USPSTF recommends that clinicians screen for HIV infection in all pregnant persons, including those who present in labor or at delivery whose HIV status is unknown.	Annually for patients 15-65 with regard to perceived risk, annually for patients younger than 15 and adults older than 65 at increased HIV risk, pregnant patients, 3x per pregnancy

Hypertension in Adults: Screening: adults 18 years or older without known hypertension	The USPSTF recommends screening for hypertension in adults 18 years or older with office blood pressure measurement (OBPM). The USPSTF recommends obtaining blood pressure measurements outside of the clinical setting for diagnostic confirmation before starting treatment.	
Intensive Behavioral Therapy (IBT) for Cardiovascular Disease	The USPSTF recommends offering or referring adults with cardiovascular disease risk factors to behavioral counseling interventions to promote a healthy diet and physical activity.	Annual
Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Screening: women of reproductive age	The USPSTF recommends that clinicians screen for intimate partner violence (IPV) in women of reproductive age and provide or refer women who screen positive to ongoing support services.	
Latent Tuberculosis Infection: Screening: asymptomatic adults at increased risk for infection	The USPSTF recommends screening for latent tuberculosis infection (LTBI) in populations at increased risk.	
Lead Screening, Children		
Lipid Disorder in Adults & Children -- Cholesterol Abnormalities Screening		
Lung Cancer: Screening: adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography (LDCT) in adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.	Annual
Medical Nutrition therapy (MNT)		
Obesity in Children and Adolescents: Screening: children and adolescents 6 years and older	The USPSTF recommends that clinicians screen for obesity in children and adolescents 6 years and older and offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status.	
Ocular Prophylaxis for Gonococcal Ophthalmia Neonatorum: Preventive Medication: newborns	The USPSTF recommends prophylactic ocular topical medication for all newborns to prevent gonococcal ophthalmia neonatorum.	

Osteoporosis to Prevent Fractures: Screening: postmenopausal women younger than 65 years at increased risk of osteoporosis	The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in postmenopausal women younger than 65 years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool. See the Clinical Considerations section for information on risk assessment.	
Osteoporosis to Prevent Fractures: Screening: women 65 years and older	The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in women 65 years and older.	
Perinatal Depression: Preventive Interventions: pregnant and postpartum persons	The USPSTF recommends that clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions.	
Phenylketonuria, Screening		
Prediabetes and Type 2 Diabetes: Screening: asymptomatic adults aged 35 to 70 years who have overweight or obesity	The USPSTF recommends screening for prediabetes and type 2 diabetes in adults aged 35 to 70 years who have overweight or obesity. Clinicians should offer or refer patients with prediabetes to effective preventive interventions.	
Preeclampsia: Screening: pregnant woman	The USPSTF recommends screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.	
Prevention of Dental Caries in Children Younger Than 5 Years: Screening and Interventions: children younger than 5 years	The USPSTF recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.	up to 5 years old
Prevention of Human Immunodeficiency Virus (HIV) Infection: Pre-exposure Prophylaxis: persons at high risk of HIV acquisition	The USPSTF recommends that clinicians offer pre-exposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition.	
Rh(D) Incompatibility: Screening: pregnant women, during the first pregnancy- related care visit	The USPSTF strongly recommends Rh(D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.	screen at 1st visit and then again at 24-28 week visit
Rh(D) Incompatibility: Screening: unsensitized rh(d)- negative pregnant women	The USPSTF recommends repeated Rh(D) antibody testing for all unsensitized Rh(D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh(D)- negative.	screen at 1st visit and then again at 24-28 week visit
Screening for Depression in Adults: general adult population, including pregnant and postpartum women	The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment,	

	and appropriate follow-up.	
Sexually Transmitted Infections: Behavioral Counseling: sexually active adolescents and adults at increased risk	The USPSTF recommends behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections (STIs).	
Sickle Cell Disease, Screening		Newborn infants
Skin Cancer Prevention: Behavioral Counseling: young adults, adolescents, children, and parents of young children	The USPSTF recommends counseling young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk of skin cancer.	
Statin Use for the Primary Prevention of Cardiovascular Disease in Adults: Preventive Medication: adults aged 40 to 75 years who have 1 or more cardiovascular risk factors and an estimated 10-year cardiovascular disease (cvd) risk of 10% or greater	The USPSTF recommends that clinicians prescribe a statin for the primary prevention of CVD for adults aged 40 to 75 years who have 1 or more CVD risk factors (i.e. dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year risk of a cardiovascular event of 10% or greater.	
Syphilis Infection in Non-pregnant Adolescents and Adults: Screening: asymptomatic, non-pregnant adolescents and adults who are at increased risk for syphilis infection	The USPSTF recommends screening for syphilis infection in persons who are at increased risk for infection.	1x for men at high risk,
Syphilis Infection in Pregnant Women: Screening: pregnant women	The USPSTF recommends early screening for syphilis infection in all pregnant women.	1x per pregnancy if high risk, up to 2 add'l times in the 3rd trimester and at delivery if continued high risk, up to 2 - 30 minute counseling sessions annually
Tobacco Smoking Cessation in Adults, Including Pregnant Persons: Interventions: non-pregnant adults	The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and US Food and Drug Administration (FDA) -- approved pharmacotherapy for cessation to non-pregnant adults who use tobacco.	
Tobacco Smoking Cessation in Adults, Including Pregnant Persons: Interventions: pregnant persons	The USPSTF recommends that clinicians ask all pregnant persons about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant persons who use tobacco.	

Tobacco Use in Children and Adolescents: Primary Care Interventions: school-aged children and adolescents who have not started to use tobacco	The USPSTF recommends that primary care clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use among school-aged children and adolescents.	
Tuberculosis Testing for Children		
Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions: adults 18 years or older, including pregnant women	The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.	
Unhealthy Drug Use: Screening: adults age 18 years or older	The USPSTF recommends screening by asking questions about unhealthy drug use in adults age 18 years or older. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred. (Screening refers to asking questions about unhealthy drug use, not testing biological specimens.)	
Vision in Children Ages 6 Months to 5 Years: Screening: children aged 3 to 5 years	The USPSTF recommends vision screening at least once in all children aged 3 to 5 years to detect amblyopia or its risk factors.	At least once for Children 3-5 years
Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions: adults	The USPSTF recommends that clinicians offer or refer adults with a body mass index (BMI) of 30 or higher (calculated as weight in kilograms divided by height in meters squared) to intensive, multicomponent behavioral interventions.	