WellSense HEALTH PLAN

WellSense Clarity plans in Massachusetts Evidence of Coverage

For Individuals and Families (non-group) enrolled through the Health Connector and for Small Group enrolled through the Health Connector

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
100 City Square, Suite 200 Charlestown, MA 02129
Date of Issue and Effective Date: January 1, 2026
Form No. WSMA_CLARITY_2026_ver.3

WellSense HEALTH PLAN

Notice of Availability

Important! This is about your WellSense Health Plan benefits. We can translate it for you free of charge. Please call **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 **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 **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 **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 **855-833-8120 (TTY: 711)** pou jwenn èd ak tradiksyon. (HAT)

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 **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 **855-833-8120 (TTY: 711)**. (RUS)

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

هام! هذا حول مزايا WellSense Health Plan الخاصة بك. يمكننا ترجمتها لك مجانا. يرجى الاتصال **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 **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 **855-833-8120 (TTY: 711)**번으로 문의하십시오. (KOR)

ចំណុចសំខាន់! ព័ត៌មាននេះគឺ ស្តីអំពីអត្ថប្រយោជន៍នៃ WellSense Health Plan របស់អ្នក។ យើងអាចបកប្រែវាសម្រាប់អ្នកដោយឥតគិតថ្លៃ។ សូមទូរសព្ទទៅលេខ **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 **855-833-8120 (TTY: 711)**, aby uzyskać pomoc w tłumaczeniu. (POL)

Importante! Questo riguarda i benefici del tuoi piano sanitario WellSense. Possiamo tradurlo gratuitamente per te. Chiama il numero **855-833-8120 (TTY: 711)** per assistenza nella traduzione. (ITA)

મહત્તત્તવપૂર્ણ! આ તમારા WellSense આરોગ્ય પ્લાનના લાભ વવશે છે. અમે તમારા માટે તેન ું વનિઃશ લ્ક ભાષાુંતરર્ કરી શકીએ છીએ. ભાષાુંતરર્ને લગતી મદદ માટે કૃપા કરીને અમને **855-833-8120 (TTY: 711)** પર કૉલ કરો. (GUJ)

Important! Cela concerne vos prestations WellSense Health Plan. Nous pouvons traduire ce contenu gratuitement pour vous. Veuillez appeler le **855-833-8120 (TTY: 711)** pour obtenir de l'aide concernant la traduction. (FRC)

Important! This material can be requested in an accessible format by calling 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, primary language, or moral or religious grounds (including limiting or not providing coverage for counseling or referral services). WellSense Health Plan provides:

- free aids and services to people with disabilities to communicate effectively with us, such as TTY, qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats).

- free language services to people whose primary language is not English, such as qualified interpreters and information written in other language.

Please contact WellSense at 855-833-8120 if you need any of the services listed above and we will provide them in a timely manner. You can also find this information at the bottom of wellsense.org in the Nondiscrimination section.

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
100 City Square, Suite 200
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:
hhs.gov/ocr/office/file/index.html

Introduction

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 (with some exceptions – such as emergencies) from network providers who are in the provider network shown on your 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 in Massachusetts ("Clarity plan"). Through an arrangement with the Commonwealth Health Insurance Connector Authority ("Health Connector"), WellSense offers the WellSense Clarity plan in Massachusetts, referred to in this Evidence of Coverage (EOC) as "Clarity plan." Individual and group members meeting the Health Connector's and Clarity plan's eligibility requirements can enroll in a Clarity plan. In exchange for a premium that the individual or group pays, WellSense agrees to provide the coverage described in this EOC to enrolled members for the time period covered by the premium. By sending a signed membership application, and paying applicable premiums, subscribers agree (on behalf of themselves and, if applicable, 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 Clarity plan member. It tells you how the Clarity plan works; describes covered services, non-covered services, and certain benefit limits and conditions. It also describes other important information. In addition, you will find the cost-sharing amount you must pay for covered services in your Schedule of Benefits. We will send an amendment to you, or in the case of a group policy, to your group representative, if changes are made to this EOC. This Evidence of Coverage and any amendments to it are available on our website, wellsense.org. You may call us toll free at 855-833-8120 with any questions or to receive a free paper copy. 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.

For definitions of key terms, see Error! Reference source not found.**.** If you need any help understanding this EOC, please contact us at 855-833-8120. We are 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 877-MA-ENROLL or visit the Health Connector website (mahealthconnector.org).

Minimum Creditable Coverage Standards. This health plan **meets Minimum Creditable Coverage Standards** that are effective January 1, 2025, as part of the Massachusetts Health Care Reform Law. If you purchase this Clarity 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, 2025, 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 visiting its website at mass.gov/doi.

Address and telephone directory

Description	Contact information
Member Service Department	Phone: 855-833-8120 (TTY: 711) toll-free Fax: 617-897-0884 Hours of operation: Monday – Friday 8 a.m. – 6 p.m. The Member Service Department is available to help answer your questions. We strive to provide excellent service and may monitor calls to Member Service to ensure quality. We can help with: • How the Clarity 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, including the status of a review (medical necessity review) decision **Members with total or partial hearing loss:** You may communicate with Member Service by dialing 711 for relay service. **Non-English Speaking members:** You may request a free language translation service when communicating with Member Service. This service provides you with access to interpreters who can translate over 200 languages.
Nurse Advice Line	Phone: 866-763-4695 (24-hour and toll-free). All calls are confidential. Members may speak with 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.
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.)

Member Service Department	Phone: 855-833-8120 (TTY: 711) toll-free Fax: 617-897-0884 Hours of operation: Monday – Friday 8 a.m. – 6 p.m. The Member Service Department is available to help answer your questions. We strive to provide excellent service and may monitor calls to Member Service to ensure quality. We can help with: • How the Clarity 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, including the status of a review (medical necessity review) decision **Members with total or partial hearing loss:** You may communicate with Member Service by dialing 711 for relay service. **Non-English Speaking members:** You may request a free language translation service when communicating with Member Service. This service provides you with access to interpreters who can translate over 200 languages.
Preventive, Routine, Non-Routine, or Urgent Medical Care	For preventive, routine, non-routine, and urgent care inside the service area, always call your PCP.
Behavioral Health Services (includes Mental Health and/or Substance Use Disorder Services)	If you need mental health and substance use disorder services, you may do any of the following: • Call Member Service toll-free at 855-833-8120 for help finding a network mental health/substance use disorder provider • Go directly to a network provider who provides mental health or substance use disorder services • Call your PCP • Visit our website at wellsense.org to look up network providers. • Call or Text the Behavioral Health Help Line (BHHL) at 833-773-2445 or visit masshelpline.com. Available 24 hours a day, 7 days a week

Member Service Department	Phone: 855-833-8120 (TTY: 711) toll-free Fax: 617-897-0884 Hours of operation: Monday – Friday 8 a.m. – 6 p.m. The Member Service Department is available to help answer your questions. We strive to provide excellent service and may monitor calls to Member Service to ensure quality. We can help with: • How the Clarity 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, including the status of a review (medical necessity review) decision **Members with total or partial hearing loss:** You may communicate with Member Service by dialing 711 for relay service. **Non-English Speaking members:** You may request a free language translation service when communicating with Member Service. This service provides you with access to interpreters who can translate over 200 languages.
Durable Medical Equipment, Prosthetics, Orthotics, or Medical Supplies (Including Medical Formulas and Low Protein Food)	WellSense contracts with Northwood, Inc. to manage most of these services. Some equipment and supplies are still managed by us. If you need these services, you may do any of the following: • Contact our Member Service Department at 855-833-8120 • Call your PCP for help finding a network provider • Visit our website at wellsense.org
Pharmacy Services	We contract with Express Scripts. This is our 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 Service at 855-833-8120 • Visit our website at wellsense.org

Member Service Department	Phone: 855-833-8120 (TTY: 711) toll-free Fax: 617-897-0884 Hours of operation: Monday – Friday 8 a.m. – 6 p.m. The Member Service Department is available to help answer your questions. We strive to provide excellent service and may monitor calls to Member Service to ensure quality. We can help with: • How the Clarity 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, including the status of a review (medical necessity review) decision **Members with total or partial hearing loss:** You may communicate with Member Service by dialing 711 for relay service. **Non-English Speaking members:** You may request a free language translation service when communicating with Member Service. This service provides you with access to interpreters who can translate over 200 languages.
Mail Order Drugs	We contract 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. Contact Cornerstone Health Solutions at 844-319-7588 or complete the mail order enrollment form, included in your welcome packet, to enroll. The enrollment form is also available on Cornerstone Health Solutions' website. Your prescribing provider may call Cornerstone Health Solutions at 844-319-7588 or fax your prescription to 781-805-8221. Once you have enrolled, you can refill prescriptions by mail, phone, or online at cornerstonehealthsolutions.org/chs-mail-order-pharmacy.
Report Suspected Fraud	Phone: 888-411-4959 Fax: 866-750-0947 Email: FraudandAbuse@wellsense.org Contact the WellSense Compliance Hotline to report suspected fraud. Available 24 hours a day, 7 days a week.

WellSense General Information	Website: wellsense.org On the WellSense website you can access information about us and your benefits, including: • WellSense services, documents and amendments • Your Clarity plan features • 24/7 online access to your claims, benefits and more on our secure member portal • Log in to view and track cost sharing paid, change your PCP, check authorizations and more • Find network providers in the Provider Directory and covered drugs in the formulary • Can't find what you need online? Use our site search feature or contact Member Service. WellSense Corporate Headquarters: WellSense Health Plan 100 City Square, Suite 200 Charlestown, MA 02129 Phone: 855-833-8120
The Health Connector	For information about eligibility, enrollment options, benefits, and premiums, contact the Health Connector. Commonwealth Health Insurance Connector Authority Phone: 877-MA-ENROLL (877-623-6765) Hours of Operations: 8 a.m. – 6 p.m. Monday to Friday For persons with total or partial hearing loss, please call TTY: 711 Website: mahealthconnector.org

Table of Contents

Chapter 1. Schedule of Benefits and cost-sharing information

Understanding your benefits and costs

Schedule of Benefits

When you enroll with us, you will receive a Schedule of Benefits and this EOC document. The Schedule of Benefits for your selected Clarity plan is an important document. It has details of covered services and benefit limits. It tells you the amount of your cost sharing (deductibles, copayments, and coinsurance) and out-of-pocket maximums. It tells you the provider network you must use to obtain your covered services. Make sure to keep your Schedule of Benefits with this EOC. Please read about your benefits in detail in Chapter 3 of this EOC, including non-covered services (exclusions).

Cost-sharing Information

You may be responsible for cost sharing when getting health care services. Your cost-sharing responsibility is based on the allowed amount for the covered service. The allowed amount is the amount we negotiate with network providers to provide covered services to our members. Your cost sharing may vary depending on the service or supply, provider type and medical setting. You pay only the allowed amount if the allowed amount is less than your cost sharing amount.

Pay your cost-sharing amounts directly to your providers.

Cost sharing may include one or more of the following:

Deductible

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

- **Individual Deductible:** The amount an individual member pays for certain covered services before we pay 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 deductible are applied toward the family deductible. However, the most an individual can contribute to the family deductible per benefit year is equal to the individual deductible amount. *
        - In such case, the individual deductible is embedded. Once the member meets the individual deductible amount, that individual's deductible is considered met.
    - 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 rest of that benefit year.

*For some Health Savings Account (HSA)-compatible Clarity plans, the family deductible amount applies if there are two or more members enrolled on the Clarity plan. The family deductible is met when the full amount has been paid by one or more members on the Clarity plan. In such case, the individual deductible is non-embedded and there is only a family deductible. See your Schedule of Benefits for more information.

The following are not included in the deductible: copayments, coinsurance, prescription drug (Rx) deductibles (when accumulated separately from medical deductible), premiums, member costs that are more than the Clarity 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 will reset to zero.

In most cases, the amount credited toward a member's deductible is based on the Clarity 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 Clarity plans may have a separate prescription drug (Rx) deductible. See the next paragraph.

Prescription drug (Rx) deductible

Your Clarity plan 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 we must 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 for details.

- **Individual Rx deductible:** The amount an individual member pays for certain covered prescription drugs before any payments are made by the Clarity 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.

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 will reset to zero.

In most cases, the amount credited toward a member's Rx deductible is based on the Clarity 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" 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).

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, the copayments counted toward your out-of-pocket maximum resets to zero.

Coinsurance

An amount you must pay for certain covered services, stated as a percentage. In most cases, you pay the applicable percentage of the Clarity 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" for further information on allowed amounts.

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 out-of-pocket maximum resets to zero, and coinsurance you pay counts toward your out-of-pocket maximum.

Out-of-pocket maximum

Your Clarity plan may have an out-of-pocket maximum. This is the maximum amount of cost sharing you must 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 Clarity 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 must 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 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 out-of-pocket maximum amount. In such case, the individual out-of-pocket maximum is embedded.
    - 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.

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 Clarity plan may have an Rx out-of-pocket maximum. If so, this is the maximum amount of cost sharing you must 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 Clarity 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*.

Your Clarity plan may have 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 must 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 bought and administered, deductibles, coinsurance, and the out-of-pocket maximums are calculated, and

most benefit limits apply.

For individual subscribers: The benefit year is a calendar year. However, in some cases, depending on your coverage effective date, your first benefit year will not be a full 12 months. You will be notified if this is the case. The notice will tell you whether your deductibles and out-of-pocket maximums, if any, will be prorated for that short benefit year.

For subscribers enrolled through a group contract: The benefit year follows a plan year cycle. 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. Some benefit limits include:

- Extended Care in a Rehabilitation Hospital: 60 calendar days per benefit year
- Extended Care in a Skilled Nursing Facility: 100 calendar days per benefit year
- Habilitative Services and Devices: Up to 60 visits consisting of any combination of physical and occupational therapy services per benefit year.
- Hearing Aids for Children (Ages 21 or under): Covered for one hearing aid up to two thousand dollars ($2,000) every 36 months per hearing impaired ear.
- Hospital Care at Home: 90 calendar days per benefit period
- Pediatric Vision (Ages 18 or under): One complete set of prescription frames and lenses per calendar year. (Contact lenses covered once every calendar year instead of eyeglasses)
- Preventive Eye Exams: One exam per member every 24 months, except every 12 months until the end of the calendar month member turns age 19.
- Rehabilitation Therapies: Up to 60 visits consisting of any combination of physical and occupational therapy services per benefit year

See Chapter 3 and your Schedule of Benefits for additional limitations, exceptions and details.

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 may call Member Service toll-free at 855-833-8120. You may also submit a request for this information on our website: 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 and may change based on the actual services provided. Coverage is based on meeting all the applicable rules in this EOC. (For example, you must be a member of the Clarity plan on the date the service is given to you.) There is no coverage for non-covered services.

Additional cost sharing, as 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 Clarity plan works

Your benefits and the role of a Primary Care Provider

Benefit packages

WellSense Clarity plan of Massachusetts ("Clarity plan") has different benefit packages. Benefit packages differ in premium and 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 each benefit package are listed in your Schedule of Benefits.

Choose a Primary Care Provider (PCP)

When you enroll in the Clarity plan, you must choose a primary care provider, known as PCP. You must obtain all primary care from your designated PCP. 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 Service.

You may choose any PCP who is:

- In your provider network
- Available to accept you

A PCP may be a:

- Doctor of internal medicine, family practice, general practice, or pediatric medicine
- Physician assistant
- Nurse practitioner
- Pediatricians. Child members only. This is a PCP who specializes in treating children.
- Obstetrician/gynecologist (OB/GYN). Female members only.

Each member of a family may choose a different PCP.

Assignment of PCP for members enrolled in certain benefit packages

WellSense will assign an appropriate PCP to you if you do not select a PCP. 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. We will tell you the PCP's name and offer to help you schedule an appointment with the PCP if you are assigned a PCP. You must obtain all primary care from your assigned PCP. See "Changing Your PCP," below, if you wish to change your assigned PCP.

PCPs are listed in the WellSense 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 may also call Member Service 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 at wellsense.org.

Visit your PCP

After enrolling, if you have not met your PCP, we recommend that you call your PCP. Introduce yourself as a new Clarity plan member and schedule an appointment. You should also ask your previous doctor to send your medical records to your new PCP.

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 and then call Member Service. Tell Member Service 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, WellSense will require you to change your PCP. If this happens, you must choose a new PCP by calling Member Service. This can happen if your PCP is no longer a network provider in your provider network. In this case, we will notify you in writing. We will do our best to give you notice at least 60 calendar 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 60 calendar 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 healthcare

- 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.

Routine care is defined as a service provided routinely to monitor an existing condition, such as pregnancy or diabetes. Non-routine care are services to evaluate and/or treat a new or worsening condition, illness or injury. Preventive care is defined as any periodic screening or

service designed for the prevention and early detection of illness that a carrier must provide pursuant to Massachusetts or federal law.

When you need specialty care

We encourage you to first call your PCP if you think you need specialty care. You may self-refer by going to a network specialist on your own.

Your PCP can tell you if you need specialty care and can refer you to an appropriate network specialist. Your PCP may refer you for ongoing care from a network specialist, when appropriate. They will stay in contact to help meet your health needs.

Care from non-network providers

The Clarity plan does not cover care you receive from non-network providers, except in certain situations. We will cover out-of-network services when receiving care from non-network providers in the following situations:

- 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 Clarity plan will pay the remainder of the allowed amount after you pay your applicable cost sharing for these covered services, per state and federal law. (Please contact Member Service if you have any questions after receiving a provider bill in this situation.)
- In certain specific continuity of care situations (See "Continuity of Care," below).
- In rare cases when no network provider has the professional expertise needed to provide the required service. In such case, your PCP or the Clarity plan may arrange for you to see a non-network provider. Your PCP must first get prior authorization from a WellSense authorized reviewer. (If you are authorized to see a non-network provider, your applicable cost sharing does not change.) The WellSense 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.

Help finding network providers

You may request help from WellSense if you or your PCP has difficulty identifying network providers who can provide you with medically necessary services. If you ask us, we will find 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 Service 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 Clarity 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 Clarity 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 us 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 our website at wellsense.org for a description of the cities and towns in the Clarity plan 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 Clarity plan 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. In the Provider Directory, you can also find information about providers, including contact information, office location, board certification status, specialty, languages spoken, handicap accessibility, hours of operation, and, when applicable, hospital affiliation. The provider directory is available on our website at wellsense.org. A free paper copy of the Provider Directory is available by calling Member Service at 855-833-8120. Since it is frequently updated, the online directory is more current than a paper directory. You may also call Member Service 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 do not 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 let you know at least 60 calendar days in advance. Member Service can help you select a new PCP.

Financial compensation to network providers: WellSense enters into contracts with network providers that may have 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 following 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, physician assistants, and certified registered nurse anesthetists: We provide coverage on a non-discriminatory basis for covered services provided by a network nurse practitioner, physician assistant, or certified registered nurse anesthetist. This means the Clarity 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; call 911; or call a local emergency number. We will not discourage you from using the local pre-hospital emergency medical services system, 911, or other local emergency numbers. No member will be denied coverage for medical and transportation expenses incurred because of an emergency.

Cost-sharing:

- Cost-sharing may apply for: emergency care in an emergency room; or observation services in a hospital setting without the use of an 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 for an inpatient stay immediately after receiving emergency care 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, we will

pay up to the allowed amount after member cost sharing. You pay applicable cost sharing.

What qualifies as an emergency

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; 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 us within 2 working days of your admission. This is essential so that we can: manage and coordinate your care; and arrange for any medically appropriate transfer. (Note: Notice from the provider of emergency services to your PCP or us satisfies this notice requirement.)
- Your PCP can arrange for you to be directly admitted for inpatient hospital care. In such case, your PCP must obtain prior authorization from a WellSense authorized reviewer.

Transferring to a network facility after an emergency

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 we 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 Clarity 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 do not have 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.
- There is coverage for emergency and urgent services outside the United States and its territories but not to return you to the service area after an emergency or urgent condition is stabilized.

The Clarity plan will **not** cover the following types of care when you are outside the service area, including outside of the U.S. and its territories:

- 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 you are in 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:

- Applicable 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 Clarity 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 (balance billing).

Inpatient hospital care

- 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 WellSense 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; we 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 60 calendar 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 60 calendar 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 non-elective 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 Clarity 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 Clarity 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 Service.

Continuity of Care for new members

If you are a new member, the Clarity 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 calendar days from your coverage effective date if:
    - No other health plan options offered by your group (if applicable) include this physician, physician assistant, or nurse practitioner; and
    - This physician, physician assistant, or nurse practitioner provides 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 us for the continued services; the services would otherwise be covered services under this EOC; and the provider agrees to:

- Accept payment from WellSense 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.
- Follow our quality standards.
- Provide us with necessary medical information related to the care provided; and
- Follow our policies and procedures. These include procedures about obtaining prior authorization and providing covered services pursuant to a treatment plan, if any, approved by us.

Concierge services

There may be some network providers who charge extra fees for special services or amenities. These may include help 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 Clarity plan. The Clarity plan does not cover fees for such services. It is your choice whether to buy and pay for these special services directly from your provider.

Member identification (ID) cards

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

Chapter 3. Covered services

This Chapter describes:

- Covered services
- What is not covered (exclusions)
- Certain limits or conditions on coverage.

Cost-sharing

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

Providers may refuse to provide covered services if you do not pay the required cost sharing.

When prior approval is needed before getting a service

Prior authorization from a WellSense authorized reviewer

There are certain covered services – both inpatient and outpatient – that must be authorized (approved) in advance by a WellSense authorized reviewer. These requirements are known as "prior authorization." Your network provider will request prior authorization from us on your behalf. The WellSense authorized reviewer will review your request, within legally set time limits, and determine if the proposed service should be covered as medically necessary for you. We will then tell your provider and you if coverage for the 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 us 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 WellSense authorized reviewer. He or she may also seek reconsideration from us. 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 us

- High-tech imaging. For example: CT/CTA, MRI/MRA, PET, and NCI/NPI (nuclear cardiac imaging).
- Musculoskeletal (MSK) services (i.e., spine surgeries, joint surgeries, and interventional pain treatments).
- Genetic testing (lab management).
- Covered non-emergency transportation. (See "Ambulance Services" in Chapter 3.)
- Durable medical equipment and orthotics.
- Prosthetic

- 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 calendar days are covered for admission).
- Inpatient rehab services.
- Long term care services or long term support services (LTSS).
- 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 Member Service, for more information about specific services, supplies, and drugs subject to prior authorization. From time to time, we may change the services subject to prior authorization.

Basic requirements for coverage

All covered services and supplies **must** meet all the following requirements:

- Described in this Chapter 3 as a covered service.
- Medically necessary.
- Received while you are a member of the Clarity plan.
- Provided by a network provider in your provider network, except as described in Chapter 2. See "Care from Non-Network Providers" in Chapter 2.
- Authorized in advance by a WellSense authorized reviewer (Prior authorization), when applicable.
- 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 a WellSense authorized reviewer

Certain inpatient covered services described below require prior authorization (approval) by a WellSense authorized reviewer. If the provider of the service does not obtain prior authorization, we will not cover the service. Always check with your provider to make sure he or she has obtained necessary approval.

Inpatient hospital care

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

- Semiprivate 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. (For example: lab, x-ray, and other imaging tests.)
- Dialysis.
- Intensive cardiac care.
- Lab and imaging services.
- Medications during an inpatient stay.
- Nursing care.
- Physical therapy.
- Occupational therapy.
- Speech therapy.
- Cardiac therapy.
- Respiratory therapy.
- Surgery. This includes the following:

Reconstructive surgery and procedures

The Clarity 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
- A covered surgical procedure

The Clarity 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).

Related exclusions to post-mastectomy services

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

Donor human milk and donor human milk-derived products

The Clarity plan covers medically necessary pasteurized donor human milk and donor human milk-derived products when the covered child is:

- Under the age of 6 months.
- Undergoing treatment in an inpatient setting for a congenital or acquired condition that places the child at a high risk for development of necrotizing enterocolitis or a congenital or acquired condition that may benefit from the use of such human breast milk as determined by the department of public health.
- Medically or physically unable to receive maternal breast milk or participate in breastfeeding or whose mother is medically or physically unable, despite receiving lactation support, to produce maternal breast milk in sufficient quantities or caloric density.

A prescription from a licensed medical provider is required. The milk must be obtained from a human milk bank that meets the criteria established by Massachusetts Department of Public Health (DPH).

Human organ transplants

The Clarity 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 WellSense authorized reviewer and provided at a network transplant facility. Network transplant facilities may include facilities that are out of the service area. In such case, we will pay for related medically necessary transportation for the member.

The Clarity 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.

Human organ transplant exclusions

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

Maternity care

The Clarity plan covers:

- Hospital and delivery services for the mother. Note: The mother's inpatient stay is covered for at least: 48 hours following vaginal delivery; and 96 hours following caesarean delivery. Decisions to reduce the mother and child's inpatient stay are made only by the attending physician and mother, not by WellSense. Attending physician includes the obstetrician, pediatrician, or certified nurse midwife attending the mother and newly born child.
- 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 not allow subscribers to enroll newborns as dependents: WellSense does not cover any costs (inpatient or outpatient) related to your newborn, except routine nursery charges and well newborn care. See Chapter 4 for more information.

If you are enrolled in a benefit package that allows you to enroll newborns as dependents: WellSense covers routine nursery charges and well newborn care. The newborn must be enrolled with us within 60 calendar days of date of birth in order for us to cover other medically necessary services rendered to the newborn.

You should not travel outside the service area:
- after 37 weeks 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 37 weeks 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 Chapter 3.

Extended care

The Clarity 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
- Use of durable medical equipment while you are in the facility

Extended care in a skilled nursing facility is limited to 100 calendar days per benefit year. Extended care in a rehabilitation hospital is limited to 60 calendar days per benefit year.

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, we may arrange for the hospital you are in to provide you with extended care services until a bed becomes available. These additional calendar days, in the acute hospital, will be counted toward the applicable extended care benefit limits.

Related exclusions to all inpatient care

The Clarity plan does not cover the following related to any inpatient admission:

- Personal items. For example: telephone and television charges.
- Private duty nursing services.
- All charges over the semi-private room rate, except when a private room is medically necessary.
- Rest, custodial care, or adult foster care.
- Charges after your hospital discharge.
- Charges after the date you are no longer a Clarity plan member.

Outpatient services

Prior authorization from a WellSense authorized reviewer

Certain outpatient covered services require prior authorization (approval) by a WellSense authorized reviewer. If the provider of the service does not obtain prior authorization, we will not cover the service. Always check with your provider to make sure he or she has obtained necessary approval.

Abortion

The Clarity plan covers:

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

Allergy services

The Clarity 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 Clarity 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, a non-emergency air ambulance or other air transport to transfer the member from one inpatient facility to another inpatient facility for covered services.

Ambulance service 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" later in this Chapter.

Cardiac rehabilitation

The Clarity 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 Clarity 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.

Cardiac rehabilitation exclusions

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

Chemotherapy and radiation therapy

The Clarity plan covers outpatient chemotherapy and radiation therapy.

Chiropractic care

The Clarity 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 scan), and other imaging tests.
- Outpatient supportive medical treatment services.

Cleft lip and cleft palate

The Clarity plan covers the following outpatient medical, dental, oral surgery, and orthodontic treatment for members: who are children 18 and under; 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-related follow up care, and surgical management.
- Outpatient dental and orthodontic services, including but not limited to:
    - Preventive 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 the necessary approval from us.

Cleft lip and cleft palate exclusions

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

Clinical trials

The Clarity plan covers services for members enrolled in a qualified clinical trial or approved clinical trial for treatment for 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 Clarity 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 Clarity plan covers **only** the following dental services:

Emergency dental services

The Clarity 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 Clarity 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.
- To a network ambulatory surgical facility, as an outpatient, in order for you to receive non-covered dental services. The Clarity 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 Clarity plan covers medically necessary dental (including preventive and restorative dentistry) and orthodontic services for the treatment of cleft lip and cleft palate for members ages 18 and under. Please see "Cleft Lip and Cleft Palate" earlier in Chapter 3 for more details.

Pediatric dental

This Clarity plan includes coverage of pediatric dental services as per the federal Patient Protection and Affordable Care Act for members aged 18 and under. A member is eligible for this benefit until the end of the calendar month in which they turn age 19.

Delta Dental MA manages all pediatric dental covered services for eligible members. For assistance, call Delta Dental at 844-260-6097. Visit our website or deltadentalma.com/epo-find-a-dentist to find a network pediatric dentist.

Coverage is provided for the pediatric dental services described below. Cost sharing applies to type II, type III, and type IV services. The separate pediatric dental annual 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
• Comprehensive Evaluation • Periodic Oral Exams • Limited Oral evaluation	• Amalgam • Restoration • Composite Resin Restorations • Re-cement	• Crown, resin • Porcelain/ceramic crowns • Porcelain fused to metal/noble/high noble crowns	(Covered only when medically necessary; patient must have severe and

• 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	• Crown/onlays • Rebase or reline 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	• Partial & complete dentures	handicapping malocclusion as defined by HLD index score of 22 and/or one or more auto qualifiers; requires prior authorization)

Diabetes treatment

The Clarity 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 Clarity plan's lab benefit, the Clarity plan covers: diabetes lab tests, including glycosylated hemoglobin or HbA1c tests; and urinary protein/microalbumin and lipid profiles.
- Under the Clarity plan's durable medical equipment benefit, the Clarity plan covers: insulin pumps and related 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 Clarity plan's prosthetics benefit, the Clarity 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 Clarity plan's prescription drug benefit, the Clarity plan covers: prescribed oral diabetes medications that influence blood sugar levels; insulin; insulin needles and syringes; insulin pens; lancets; select blood glucose monitoring strips; urine glucose strips; and ketone 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: insulin needles and syringes; and diabetic test strips and lancets.

Dialysis

The Clarity 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 Clarity plan decides whether to rent or buy the equipment.
- If you are traveling outside the service area, the Clarity 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 WellSense 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), we will cover only those costs that exceed what would be payable by Medicare.

Home dialysis exclusions

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

Down syndrome services

The Clarity plan covers medically necessary treatment of Down syndrome through speech therapy, occupational therapy, physical therapy, and applied behavior analysis services.

Benefit limits do not apply to Down syndrome services.

Durable Medical Equipment and Orthotics (DME)

The Clarity plan covers medically necessary DME. The DME must be prescribed by a network physician. We 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
- 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 we decide that you chose a DME that costs more than the least costly DME adequate to allow you to engage in activities of daily living, we 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 Clarity plan's allowed amount (balance billing).
- 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 a covered DME.

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

Examples of covered DME include

- Wheelchairs
- Crutches, canes, or walkers
- Respiratory and oxygen equipment
- Hospital beds
- Insulin pumps and related supplies; insulin needles and syringes; insulin test strips and lancets; blood glucose monitors for home use; voice-synthesizers and visual magnifying aids 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 (See "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: insulin needles and syringes; and diabetic test strips and lancets.

Examples of non-covered DME include

- Comfort or convenience items
- Heating pads or 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 Clarity 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.
- Behavioral therapy.

Benefit limits and cost-sharing does not apply to early intervention services.

Emergency services

The Clarity 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; call 911; or call a local emergency number.
- The Clarity 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:
    - Mobile crisis intervention services for youth
    - Mobile crisis intervention services for adults
    - Emergency service provider community-based locations
    - Adult community crisis stabilization services
- The Clarity 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.
- There is coverage for emergency and urgent services outside the United States and its territories but not for transportation back to the service area after an emergency or urgent condition is stabilized.

Cost-sharing

See your Schedule of Benefits for information about specific cost-sharing amounts.

- Cost sharing may 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 Clarity plan will pay up to the allowed amount. You pay applicable cost sharing.

Emergency defined

See "Appendix A" for the definition of emergency services.

Notice to PCP or WellSense

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 WellSense within 2 working days of admission. This is essential so that we can: manage and coordinate your care; and arrange for any medically appropriate transfer.

Note: Notice by the provider of emergency services to your PCP or us satisfies your requirement to notify us.

Transfer

Following emergency care, if you are admitted to a non-network facility, and your PCP determines that transfer is appropriate, you will be transferred to a network facility. We 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 Clarity plan covers the following outpatient family planning services when received from a network physician (PCP, obstetrician, or gynecologist); nurse practitioner; or certified nurse midwife:

- Preventive 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: 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.

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.

Family planning service 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 affirming care, 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 us.

Hearing aids for children

The Clarity plan provides coverage towards the cost of hearing aids for eligible child 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. Hearing aids are not covered for members over the age of 21.

Benefit limit of 1 hearing aid per hearing impaired ear up to $2,000 for each hearing aid every 36 months. Once you reach your benefit limit, no more benefits will be provided toward the cost of hearing aids.

Hearing aids for children exclusions

No hearing aid coverage for members aged 22 and over.

Fertility preservation services

The Clarity plan covers medically necessary fertility preservation services, according to MA law, when:

- Diagnosed with a medical or genetic condition that may directly or indirectly cause impairment of fertility by affecting reproductive organs or processes.
- Recommended by a board-certified obstetrician gynecologist, reproductive endocrinologist,

or other physician.

"Directly or indirectly cause impairment of fertility" is defined as: causing "circumstances where a disease or the necessary treatment for a disease has a likely side effect of infertility."

The Clarity plan will cover the following procedures for fertility preservation services when approved in advance by a WellSense authorized reviewer including, but not limited to, coverage for procurement, cryopreservation and storage of gametes, embryos, or other reproductive tissue.

You can find network providers by filtering by the "Fertility Preservation" Special Services type on our provider directory at wellsense.org.

See "Infertility Services" below for more information.

Hearing (audiology) examinations

The Clarity plan covers exams and evaluations performed by a PCP or a network hearing specialist.

Home healthcare

The Clarity 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.
- 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 Clarity 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 consultation.
- 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 Clarity 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.

Home healthcare exclusions

- Custodial care or adult foster care
- Housekeeping services
- Household repairs
- Meals
- Respite care
- Private duty nursing
- Personal care attendants
- Homemakers

Hospice services

The Clarity 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.
- On a short-term inpatient basis. (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 Clarity plan's DME benefit.

- Prescription drugs are covered under the Clarity plan's prescription drug benefit.

Hospital care at home

The Clarity plan covers acute hospital care at home, per MA law, for a period of 90 calendar days. These are acute inpatient services provided in the member's home.

Coverage is for: members who are deemed medically necessary; meet inpatient admission criteria; and are approved for transfer from an emergency room or inpatient acute care facility with our service area, in accordance with the following:

- Services are provided by network providers approved by CMS to provide acute inpatient hospital care in the member's home.
- Prior authorization is obtained, including concurrent review.

House calls

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

Immunizations

The Clarity plan covers:

- Preventive immunizations (See "Preventive Health Services" below.)
- Medically necessary immunizations

Infertility services for Massachusetts residents:

The Clarity 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 or more if the female is age 35 or younger; or
- 6 months or more 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 Clarity 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 medical eligibility requirements of network infertility services providers.

- 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 Clarity 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.
    - Procurement, processing, and long term banking of sperm when the Clarity plan's medical necessity criteria are met.

The following procedures, when approved in advance by a WellSense authorized reviewer, in accordance with the Clarity plan's clinical review criteria:

- Artificial insemination (intracervical or intrauterine) when done with donor sperm* and/or gonadotropins.
- 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 pre-implantation genetic testing (PGT) when a couple meets the criteria for PGT.

The following "assisted reproductive technology" (ART) procedures* when approved in advance by a WellSense authorized reviewer, in accordance with the Clarity plan's clinical review criteria:

- In vitro fertilization and embryo transfer (IVF-ET).
- In conjunction with IVF, PGT 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.

Infertility services exclusions

- Infertility services for any member who is not a MA resident.
- Any experimental infertility/assisted reproductive service not listed as covered in applicable MA regulation and the service does not meet the Clarity plan's medical necessity criteria which are based on scientific evidence. Surrogacy/gestational carrier.
- Reversal of voluntary sterilization.

Laboratory tests, radiology, and other outpatient diagnostic procedures

The Clarity plan covers the following outpatient services to diagnose illness, injury, or pregnancy. Some tests are subject to prior authorization by a WellSense 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 Clarity 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 Clarity 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 Clarity 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 Clarity 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.
- Universal postpartum home visiting services: Screenings for unmet health needs including reproductive health services, maternal and infant nutritional needs and emotional health supports including postpartum depression supports. 1 visit at an agreed upon location within 8 weeks postpartum. No cost sharing applies.
- Postpartum depression and major depressive disorders screening: Covered within 12 months of any of the following: giving birth; assuming custodial care of a child; still birth; miscarriage; medical termination. These screenings can be provided by a network PCP, OB/GYN, midwife, or pediatrician (during the newborn's visit). No separate cost sharing applies to this screening apart from the visit cost sharing.

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.)

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

Medical formulas

The Clarity 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; homocystrinuria; 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 Clarity 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.
- Supplies for insulin pumps.

Call Member Service 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)

We manage all mental health and substance use disorder services for members. See your Schedule of Benefits for cost-sharing information.

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 Member Service toll-free at 855-833-8120 for help finding a network mental health/substance use disorder provider.
- Call your PCP for help finding a network provider.
- Call or Text the Behavioral Health Help Line (BHHL) at 833-773-2445 or visit masshelpline.com.
- Visit our website at wellsense.org to look up network providers.

In an emergency

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

Prior authorization

- Coverage for certain mental health and substance use disorder services is subject to prior authorization by a WellSense authorized reviewer. Prior authorization is not required for emergency care, including emergency ambulance transportation.
- Notification by the facility to WellSense is required within 72 hours of the admission for certain services.
- Always check with your provider to make sure he or she has obtained the necessary approval from WellSense.
- 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 Clarity 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 disorders; autism; and other psychotic disorders or other biologically based mental disorders.
- All other non-biologically based mental disorders.
- 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 *
- 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
- In-home therapy service

The Clarity 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.

Note regarding autism spectrum disorder (ASD)

The Clarity 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 Clarity plan is unable to provide adequate access to network ASD providers, members should call WellSense at 855-833-8120 to arrange for

out-of-network ASD services.
- Coverage for ASD services may require prior authorization by a WellSense authorized reviewer. Always check with your provider to make sure he or she has obtained the necessary approval from us.

*Applied behavioral analysis: 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.

**Behavioral analyst: Healthcare professional credentialed by the behavior analyst certification board as a board-certified behavior analyst.

Outpatient mental health and substance use disorder services

The Clarity 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
- Physician who specializes in the practice of psychiatry
- Licensed alcohol and drug counselor I

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 Clarity 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:

- A licensed general hospital.
- A facility under the direction and supervision of the Department of Mental Health.
- A private mental health hospital licensed by the Department of Mental Health.
- A substance use facility licensed by the Department of Public Health.

Inpatient services are provided without annual, lifetime or visit/unit/day limits.

Intermediate mental health and substance use disorder services

The Clarity 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. 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
- Clinical stabilization services
- Acute residential treatment, such as community based acute treatment.
- Clinically managed detoxification services
- Level III community-based detoxification
- Adult community crisis stabilization (ACCS)
- Youth community crisis stabilization (YCCS)
- In-home therapy services

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 with no cost sharing for opioid antagonist medication approved for use in a take-home setting or by a health care professional.
- No prior authorization or prescription required.

Opioid antagonists and substance use recovery coaches

- Coverage is provided with no cost sharing for services by a licensed recovery coach, regardless of the setting in which these services are provided.
- Services must be within the lawful scope of practice of a recovery coach.
- Recovery coach services shall not require prior authorization.

You may not be balanced billed for services received from non-network providers.

Other related services

The Clarity plan covers:

- Psychopharmacological services, such as mental health and substance use disorder medication management services.
- Neuropsychological assessment and psychological testing.

Smoking and tobacco cessation

The Clarity 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 Service at 855-

833-8120.

Related exclusions

- Custodial care or adult foster 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.

Services noted with an * do not require prior approval 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 Clarity 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 Clarity plan covers medically necessary newborn care for newborns and adoptive children properly enrolled in the Clarity 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 Clarity 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 Clarity plan covers outpatient PCP and specialist office visits to evaluate and treat illness or injury. Services include:

- Medically necessary immunizations, and
- 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.)

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 Clarity 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 Clarity plan provides coverage for all abortion services and abortion-related services that are legally permitted under applicable law. When applicable, in accordance with federal law, the premium (collected by the Health Connector) is separated to allocate funds for coverage of the abortion services for which federal funding is prohibited.
- Male voluntary sterilizations (See “Preventive Health Services,” below, for female voluntary sterilization.)
- Diagnostic procedures. Examples: a colonoscopy or endoscopy.

Pain management services

The Clarity plan covers pain management services. If you are interested in pain management alternatives to opioid products, speak to your provider. No prior authorization required. These include, but are not limited to:

- Non-opioid medications or injections
- Chiropractic care (See “Chiropractic care”)
- Physical therapy services (See “Rehabilitation therapies”)
- Behavioral health providers with pain management-related specialties, such as cognitive behavioral therapy, pain management and treatment of chronic pain. (See “Mental health and substance use disorder services”)
- Surgery

PANDAS and PANS

Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infection and Pediatric Acute Onset Neuropsychiatric Syndrome

- This Clarity 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 Clarity plan covers the following:

- For diabetic members: all podiatry (foot) care is covered: whether routine or non-routine. Routine care is defined as services provided routinely to monitor an existing condition. Non-routine care are services to evaluate and/or treat a new or worsening condition, illness, or injury.
- For all other members: the Clarity plan only covers non-routine medically necessary podiatry (foot) care by a network provider, including a network podiatrist. Examples include 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 Clarity 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 our website (wellsense.org) or call us toll-free at 855-833-8120 to find out whether a drug is covered.

Conditions of coverage

Our Pharmacy Program does not cover all drugs and prescriptions. The Clarity plan covers prescription drugs listed on the Clarity plan's formulary, when they are provided in accordance with the Clarity plan's Pharmacy Programs and when they meet all of the following rules described below. (Note: this includes the requirement that coverage for certain drugs is subject to prior authorization (approval) by a WellSense authorized reviewer. Always check with your provider to make sure he or she has obtained the necessary approval from us.)

- The drug by law requires a prescription
- The drug is prescribed by a provider licensed to prescribe medications
- The prescription meets all legal requirements for a prescription
- The prescription is filled by a network pharmacy (except in an emergency, or for urgent care, or for emergency/urgent care when you are temporarily traveling outside the service area)
- The prescribed drug is medically necessary
- The drug is being 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.

Drugs to Treat Chronic Conditions
We provide reduced cost-sharing for prescription drugs used to treat the following chronic conditions:

- Diabetes
- Asthma
- The 2 most prevalent heart conditions among our members (Hypertension and Coronary
- Artery Disease)

Reduced Cost-sharing:

- Generic drugs are covered at no cost-sharing.
- Brand name drugs are capped at $25 copayment per 30-day supply.

Continuity of Care for New Members:

If you are a new member, the Clarity plan will provide coverage for your medications prescribed by your existing non-network physician, non-network physician assistant or non-network nurse practitioner under the terms of this EOC, for the chronic conditions listed in this section, for up to 30 calendar days from your coverage effective date.

Schedule II and III Drugs
If you fill a lesser quantity than is prescribed of a schedule II or III opioid and then decide to fill the remainder of the original prescription at the same pharmacy within 30 days of the original prescription date, no additional cost sharing will be applied.

Where to get your prescription drugs

Take your prescription or refill to any network pharmacy. Bring your ID card. 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 Service.
- Specialty pharmacy providers: For certain drugs, the Clarity 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

We contract 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. Contact Cornerstone Health Solutions at 844-319-7588 or complete the mail order enrollment form, included in your welcome packet, to enroll. The enrollment form is also available on Cornerstone Health Solutions' website. Your prescribing provider may call Cornerstone Health Solutions at 844-319-7588 or fax your prescription to 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 emergency/urgent care when outside the service area, you will have to pay for your prescription and seek reimbursement from the Clarity plan. The Clarity plan will pay up to the allowed amount for eligible claims minus your cost sharing. (See Chapter 7 "Bills from Providers" or call Member Service for information about how to seek Clarity plan reimbursement.)

What is covered

Subject to all of the Conditions of Coverage described earlier in this section, the Clarity 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.
- Oral and other forms of prescription 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. Certain tobacco cessation products are provided at no cost. Please check the Clarity 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 which meet the requirements of Massachusetts and federal law.
- Certain compounded medications: as long as one or more active ingredients within the compound require 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" and "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 Medications: No cost sharing and prior authorization is not required.
- Pre-exposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition.
- Medication-Assisted Treatment (MAT) Medications
- Formulary GLP-1 drugs for the treatment of diabetes.

What is not covered

The Clarity 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 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 emergency/urgent care 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 Clarity plan does not cover.
    - Experimental or investigational drugs. 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 ("FDA"). This includes herbal and/or alternative drugs and medical foods that require a prescription.
    - Drugs used primarily for weight loss or weight loss maintenance
    - Drugs used primarily for cosmetic purposes
    - Drugs for the treatment of sexual dysfunction
    - Drugs that have been deemed less-than-effective by the FDA, i.e. DESI drugs. For a complete list of DESI drugs please visit: fda.gov/drugs/enforcement-activities-fda/drug-efficacy-study-implementation-desi
    - 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 federal law, 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 Clarity 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. These may be covered under your outpatient or inpatient benefits.
    - Certain medical devices. These may be covered under the durable medical equipment benefit.
    - Certain drugs administered by a healthcare provider in an outpatient setting. These

may be covered under your outpatient benefit.

Pharmacy programs

The Clarity 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 Clarity plan's formulary and may change from time to time. To find out what drugs are subject to any of these programs, check the Clarity plan's formulary at wellsense.org or call Member Service. The following is a description of these programs:

- **Prior authorization:** In the case of certain drugs, the Clarity plan requires your physician to obtain prior authorization from a WellSense authorized reviewer before prescribing the drug. The drugs subject to prior authorization may include certain high-cost drugs; brand name drugs when a generic equivalent is available; and new-to-market drugs that have not yet been reviewed by us for coverage.
- **Quantity limits:** The Clarity plan limits the quantity of certain drugs 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. Example: the use of generic antidepressants before prescribing brand name antidepressants.
- **Specialty pharmacy providers:** We have 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 us and request an exception from a WellSense authorized reviewer. The exception request must be supported by patient-specific clinical history for our review. We 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 Service.

Pharmacy Benefit Manager

We contract with a separate organization, known as a pharmacy benefit manager, to administer its prescription drug benefit. See "Address and Telephone Directory" in the front of this EOC for more information.

Preventive health services

The Clarity 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 Clarity plan's medical policy guidelines; and with applicable laws and regulations.

The following is a summary of covered preventive health services. A listing of all preventive health services covered by the Clarity plan, pursuant to Massachusetts or federal law, can be found at the end of this EOC or on wellsense.org.

Preventive healthcare services for 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 and Advisory Committee on Immunization Practices.
- Preventive physical exams for children aged 6 and older.
- Preventive eye exams: One preventive exam per member every 12 months until the end of the calendar month member turns age 19. Note: If you have an existing medical eye condition, your periodic eye exams are no longer considered preventive and are subject to applicable cost sharing.
- Certain preventive screening tests and procedures.

Preventive healthcare services for adults

- Annual physical exams (once per benefit year); and related preventive lab tests and x-rays. Routine and non-routine tests are subject to applicable cost-sharing.
- Mental health wellness exam
- Preventive hearing exams and screenings.
- Preventive immunizations as recommended by the Advisory Committee on Immunization Practices.
- Preventive screening tests and procedures. (Example: screening colonoscopies). If these procedures are accompanied by treatment/surgery, they become subject to applicable cost sharing.
- Nutritional counseling and health education.
- Preventive eye exams: One preventive exam per member every 24 months. If you have an existing medical eye condition, your periodic eye exams are no longer considered preventive and are subject to applicable cost sharing.
- Screening for postpartum depression and major depressive disorders
- Diagnostic examinations for breast cancer including digital breast tomosynthesis screening, screening with breast magnetic resonance imaging, and screening breast ultrasound

Preventive healthcare services for women, including pregnant women:

- Yearly gynecological exam and cytologic screening (Pap smear). You must see a network physician (PCP, obstetrician, 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 yearly screening mammograms for women aged 40 and older.
- Laboratory tests associated with routine maternity care.
- Voluntary sterilization procedures.

- Breast pumps and related supplies.
- Prenatal and postnatal lactation counseling and support from a trained network provider for the duration of breastfeeding.
- Prescription contraceptive methods approved by the FDA, including drugs and devices
- Family Planning

Other preventive health services, screenings, and counseling, as required by Massachusetts General Laws and federal laws including: Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC); United States Preventive Services Task Force (USPSTF) A or B rated recommendations; Health Resources and Services Administration (HRSA); Women's Health and Cancer Rights Act; and Women's Health and Newborn Act. .

Cost-sharing

There is no cost-sharing for covered preventive health services.

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.

Preventive health services 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 preventive exam.

Prosthetic devices

The Clarity plan covers medically necessary prosthetic devices when prescribed by a network physician. We 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.
- 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 we decide that you choose a prosthetic that costs more than the least costly prosthetic adequate to allow you to engage in activities of daily living, we 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 we pay.
- 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.

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 prescribed by a network physician, when the member has hair loss due to treatment for any form of cancer or leukemia; alopecia areata; alopecia totalis; or permanent loss of scalp hair due to injury (such as from burns or other traumatic injury).

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 and habilitative therapy (outpatient) – short term physical, occupational, speech and pulmonary rehabilitation therapies

The Clarity plan covers medically necessary outpatient short term physical, occupational, speech 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.
- When your PCP and the Clarity 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

Physical (PT) and occupational therapy (OT) are limited to 60 combined visits/benefit year (other than for autism, down syndrome, early intervention, home health care and speech therapy). PT and OT for rehabilitation and habilitative purposes accumulate separately.

Prior authorization

Coverage for rehabilitation therapies requires prior authorization by a WellSense authorized reviewer. Always check with your provider to make sure he or she has obtained the necessary approval from us.

Therapy 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 Clarity 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, we will cover third surgical opinions when the first and second opinions differ.

Speech-language and hearing disorder services

The Clarity 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.

Speech-language and hearing disorder service exclusions

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

Telehealth

The Clarity plan covers telehealth. Your cost share for telehealth services shall not exceed the cost sharing 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 Clarity 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.

Coverage for TMJ disorder may require prior authorization by a WellSense authorized reviewer. Always check with your provider to make sure he or she has obtained the necessary approval from us.

TMJ disorder 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 Clarity plan covers:

Vision services (all members)

- Preventive eye exams: Coverage for one exam per member every 24 months, except every 12 months until the end of the calendar month member turns age 19.
- Routine periodic, non-routine, and diabetic retinal eye exams and treatment: The Clarity plan covers routine periodic and non-routine eye exams. You must use a network provider who is an eye doctor. These are optometrists or ophthalmologists. See your Schedule of Benefits for cost-sharing amount.
- 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.
- Eyewear discounts are available for members aged 19 and above. See "Member Extras."
- The Clarity plan covers eyewear for pediatric members until the end of the calendar month member turns age 19, as listed below.

Preventive eye exams: Periodic exams when the member has no obvious signs or symptoms of disease or vision loss. If you have a medical eye condition, such as cataract, then your visits to your eye doctor are no longer considered preventive and subject to applicable cost share.

Routine eye exams: Periodic exams for detection, treatment and management of eye conditions that produce symptoms that, if left untreated, may result in loss of vision.

Non-routine care: Exams and treatment to evaluate and/or treat a new or worsening condition, illness, or injury.

Pediatric vision services (pediatric members only until the end of the calendar month in which they turn age 19):

In addition to the preventive eye exam noted above, the Clarity plan covers one (1) pair of eyeglasses, including frames and lenses, or contact lenses per calendar year. Services include:

- Lenses: single vision, conventional (lined) bifocal, conventional (lined) trifocal, lenticular
- 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.

Vision services 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 Clarity 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 contraception; and covered preventive health services.
- 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 bed boards; bathtub lifts; bath/shower chair; over bed tables; adjustable 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 Clarity plan's 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 Clarity plan. This includes before your Clarity plan membership began and after your Clarity plan membership ends.
- Charges for services you receive after you choose to stay in a hospital or facility beyond the discharge time determined by the Clarity plan.

- For members over the age of 21 years of age: hearing aid devices, ear molds, impressions, batteries, accessories, supplies, and instruction in use and care of a hearing aid.
- Acupuncture; biofeedback (except for the treatment of urinary incontinence, fecal incontinence, and/or dyssynergia-type constipation); 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, except as otherwise expressly stated in Chapter 3. 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, fecal incontinence, and/or dyssynergia-type constipation).
    - 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
    - Any diagnostic services related to any of the above 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 (Except for medically necessary services as specifically set forth in Chapter 3): 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, adult foster care, long term care, or care in a rest home.
- Dental Services: The Clarity plan does not pay for any dental services, except:
    - The emergency dental and pediatric dental services specifically set forth in Chapter 3 under "Outpatient Services – Dental Services"; and
    - 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 Clarity plan also does not pay for splints or oral appliances.
- Dentures
- Equipment that does not meet the definition of durable medical equipment in Chapter 3. Example: equipment that is used primarily and customarily for nonmedical purposes-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 Clarity 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. Examples: exercycles; treadmills; bidet toilet seats; bathtub seats; and handheld shower devices.
    - Physician's equipment. Examples: blood pressure cuffs and stethoscopes.
    - Assistive technology and adaptive equipment. Examples: 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. These include 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 to these treatments. If a service is an experimental or investigational treatment, the Clarity 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 Clarity 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 coverage rights under government programs. Examples: 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.
- 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 Clarity plan's clinical review criteria.
- Long term sperm, oocyte, or embryo cryopreservation unless Clarity plan's medical necessity criteria are met.
- 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.
- 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 WellSense 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 Clarity 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:
    - Psychoanalysis
    - Pastoral counseling
    - Interactive individual psychotherapy
    - Family psychotherapy (without member present) or multiple-family group therapy.
    - Narcosynthesis, individual psychophysiological therapy incorporating biofeedback.
    - Hypnotherapy
    - Massage and relaxation therapies
    - Psychiatric evaluation of records and reports
    - Developmental testing

    - Neurobehavioral status exams administered/interpreted by physicians and computer.
    - Neuropsychological rehabilitation
    - Behavioral health hotline service
    - Assertive community treatment
    - Mental health clubhouse services; halfway house services; and 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.
    - Mental health or substance use disorder services provided by the Department of Mental Health.
    - Long term residential treatment
    - Custodial care or adult foster care
    - Programs in which the member has a pre-defined duration of care without the Clarity plan's ability to conduct concurrent determinations of continued medical necessity; and
    - 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; and 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.
- Preimplantation genetic testing except as specifically allowed under medically necessary 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": 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. Except as otherwise expressly stated in Chapter 3.
- 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 drugs; 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, termination and premium payments

The WellSense Clarity plan in Massachusetts is a health plan for individuals, group members, and, if applicable, their eligible dependents.

Eligibility

The Health Connector and Clarity plan establish eligibility rules for subscribers and dependents in accordance with state and federal laws. Subscribers and their eligible dependents must meet the eligibility rules to enroll in the Clarity plan through the Health Connector.

Please contact the Health Connector at 877-623-6765 (TTY: 711) for more information about eligibility, annual open enrollment periods, special enrollment periods, premiums and enrolling in the Clarity plan. The Clarity plan and the Health Connector may require reasonable verification of eligibility from time to time. Individuals enrolling through a qualified employer should contact their group representative for eligibility, enrollment periods, etc.

If you meet the applicable eligibility rules, we will accept you into the Clarity plan upon referral from the Health Connector. You may continue to be enrolled in the Clarity plan if you continue to meet eligibility rules and the applicable premium is paid. When we receive notice of your enrollment from the Health Connector, we will send you an ID card and other information about the Clarity plan.

Acceptance into the Clarity 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; preexisting 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.

Once you are properly enrolled in the Clarity plan, we will pay for covered services that are given to you on or after your coverage effective date. There are no waiting periods or preexisting condition limits or exclusions. The Clarity plan does not pay for any services you received prior to your coverage effective date with the Clarity plan.

Coverage effective dates for subscribers and dependents

The Health Connector establishes coverage effective dates for new subscribers and eligible dependents, in accordance with state and federal law. Please contact the Health Connector for more information.

- Individuals who do not meet the requirements to enroll outside of the annual open enrollment period may seek an enrollment waiver. A waiver permits enrollment outside the open enrollment period. Contact the Health Connector or the Office of Patient Protection for more information about enrollment waivers.

This section applies to those benefit packages that allow subscribers to enroll newborns and adopted children under the age of 26 as dependents. Contact the Health Connector for eligibility information.

Newborn and adoptive children – enrollment and coverage

- A newborn infant of a member is eligible for coverage under the Clarity plan from the moment of birth as required by Massachusetts law.
    - The subscriber must properly enroll the newborn in the Clarity plan by contacting the Health Connector within 60 calendar days of the newborn's birth for the newborn to be covered from birth. Otherwise, the subscriber must wait until the next open enrollment period to enroll the child.
    - If the subscriber does not enroll a newborn within 60 calendar days of the newborn's birth, the Clarity plan will only cover the costs of routine nursery charges and well newborn care. See Chapter 3 – "Inpatient Services-Maternity Care". Any other charges for services to the newborn will not be covered.
- The subscriber must enroll an adoptive child within 60 calendar 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 the Health Connector for further information about enrollment of a newborn or an adoptive child.

This section applies to those benefit packages that do NOT allow subscribers to enroll newborns or adoptive children under the age of 26 as dependents contact the Health Connector for eligibility information.

Newborn and adoptive children – enrollment and coverage

- If you are enrolled in a benefit package that does not allow you to add newborns as dependents, and you have a newborn, you cannot enroll your newborn in this Clarity plan. The Clarity plan does not cover any health care costs (inpatient or outpatient) related to the newborn except for routine nursery charges and well newborn care. Your newborn baby may be eligible for coverage directly under MassHealth. For information about MassHealth eligibility for your newborn, call Member Service or the Health Connector.
- If you are enrolled in a benefit package that does not allow you to add children under the age of 26 as dependents, and you adopt a child under the age of 26, you cannot enroll your adoptive child in this Clarity plan. Adoptive children may be eligible for coverage directly

under MassHealth. For information about MassHealth eligibility for your adoptive child, call Member Service or the Health Connector.

Change in eligibility status

It is the subscriber's responsibility to notify the Health Connector of all changes that may affect his/her or a dependents' eligibility or the amount of premium that must be paid for coverage under the Clarity plan. Notification must occur **within 60 calendar days** of the event. These include the following:

- Having a baby, adopting a child, or fostering-to-adopt child placement.
- The marriage of a dependent.
- Enrolled dependent having a baby.
- Address changes
- Moving out of the Clarity plan's service area.
- Job changes
- Changes in marital status
- Death of a member
- Enrollment in a state or federal health insurance program such as Medicaid or Medicare.
- When you or a dependent no longer meets the Connector's or Clarity plan's eligibility rules.

Changes in dependents covered by the Clarity plan may result in a change to the premium that must be paid.

Please contact the Health Connector, WellSense, and your group representative to report eligibility, address, or phone number changes. We must have your current information so we can contact you about benefits and correctly process claims.

Health Connector Customer Service Center
Phone: 877-MA-ENROLL or 877-623-6765. For persons with total or partial hearing loss, call TTY: 711.
Hours of operation: Monday through Friday from 8:00 a.m. to 5:00 p.m.

If hospitalized when membership begins

If you are in an inpatient stay on your coverage effective date, you will be covered by the Clarity plan under this EOC as of your coverage effective date as long as you call the Clarity plan and allow us to manage your care. This may include a transfer to a network hospital, if medically appropriate.

Coverage for Small Group members who live outside the service area

If you are a properly enrolled member who lives outside the service area in accordance with the Health Connector's and Clarity plan's eligibility rules: you must still comply with all Clarity plan rules regarding use of network providers for your care. Outside the service area you are only entitled to coverage 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 in the service area. All cost sharing and other payment rules apply to services received outside the service area.

Premium payments

Individuals and groups are required to pay applicable monthly premiums in advance of the month in which coverage is provided. You will be told the premium amount and due date. Premium must be sent by the due date stated on the bill. Only members for whom applicable premium have been received are entitled to covered services. In the event an individual or group is late (delinquent) in paying the required premium, the Clarity plan, in accordance with applicable state and federal law, may suspend payment of claims and/or prior authorization of services until full premium payment is received.

Grace period

When a non-group Clarity plan member is receiving a premium subsidy

A 3-month grace period begins when you do not pay your monthly premium in full by the due date. Written or electronic notices will be sent after each missed payment.

- First missed payment: Considered past due, risk of losing coverage.
- Failure to pay 2 months: Considered delinquent, coverage will be terminated if full payment is not received by date indicated on notice.
- Failure to pay 3 months: Considered delinquent, coverage will be terminated if full payment is not received by date indicated on notice.
- If full payment is not received within the grace period, coverage will be terminated retroactively as of the last day of the first month during the grace period.

When a non-group Clarity plan member is not receiving a premium subsidy

- A member who fails to pay their monthly premium in full by the due date will be considered delinquent and notified by mail or electronically after the first missed payment. The termination warning notice will be sent in the beginning of the first month of delinquency. It will inform the member of their delinquent status and that, if payment is not received in full on or before the due date indicated in the notice, then their coverage will be terminated retroactively to the last day of the coverage month for which the monthly premium was paid in full.
- Claims for covered services provided during the grace period may be placed on hold.

Reinstatement

A non-group Clarity plan member who was terminated for non-payment of premiums has 35 calendar days from the date of the Notice of Termination to reinstate coverage by paying all outstanding premiums. You must meet Clarity plan eligibility criteria.

Notes

- The amount of premium an individual or group is required to pay may change during the term of this EOC. You will be notified of any changes in premium.
- We will send subscribers an annual notice stating the premium that must be paid.

Termination of plan coverage

The Health Connector determines when your enrollment is to be terminated**.** All terminations are done in accordance with federal and state law. Your enrollment in the Clarity plan can be terminated if:

- You are an individual who has not paid the required premium, or you are a group member, and your group has not paid the required premium.
- You commit an act of physical or verbal abuse unrelated to your physical or mental condition which poses a threat to any provider, any other member, or to WellSense or a WellSense employee.
- You fail to comply with our or the Health Connector's reasonable request for information.
- You commit an act of intentional misrepresentation or fraud related to coverage; obtaining health care services; or payment for such services. Examples: obtaining or trying to obtain benefits under this EOC for a person who is not a member; or misrepresenting your eligibility for enrollment under the Clarity plan. Termination may be retroactive: to your effective date; the date of the fraud or misrepresentation; or to another date determined by the Clarity plan.
- You fail to comply in a material manner with the Clarity plan's rules under this EOC or, for individuals, with the individual contract. For groups, this includes the group's failure to meet requirements related to group premium contributions; or that the group is not actively engaged in business.
- You fail to continue to meet the Health Connector's or Clarity plan's eligibility rules, including applicable residency or work location requirements.
- An individual or a group chooses to end coverage by notifying the Health Connector.

Effective date of termination

The Health Connector will notify you of the date your coverage under the Clarity plan ends.

Benefits after termination

The Clarity plan will not pay for services, supplies, or drugs you receive after your 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, which requires medical care after your coverage ends.

Health Connector termination of Group for non-payment of premium

- Any group that does not pay its monthly premium in full on or before 2 months after the payment deadline is subject to termination of its group contract.
- Coverage for all group members (subscribers and dependents) will end as of the last day of the month for which the monthly premium was paid in full.
- The Health Connector will send written notices to each subscriber (at his or her last known address) about the group's termination due to nonpayment of premium. The notice will include the effective date of the termination of the group contract and information about your continuation of coverage options.
- Unless a subscriber elects the continuation of coverage option and makes the required

premium payment, the subscriber is responsible for all claims for services received after the effective date of termination.

Voluntary and involuntary disenrollment rates for members

We will notify you of the voluntary and involuntary member disenrollment rate annually.

Questions about eligibility, enrollment and termination

Please contact the Health Connector:

Commonwealth Health Insurance Connector Authority
P.O. Box 120089
Boston, MA 02112-9914

Phone: 877-MA-ENROLL (877-623-6765). For persons with total or partial hearing loss, please call TTY: 711
Hours of Operation: 8 a.m. – 6 p.m., Monday through Friday
Website: mahealthconnector.org

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 Health Connector (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 calendar 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 calendar 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 Clarity plan under a group contract.

For more information about COBRA contact your group or the Health Connector.

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 calendar 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 Clarity plan under a group contract.

For more information about MA Continuation Coverage contact your group or the Health Connector.

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 calendar days after the plant closing. The subscriber and his/her group will each pay your shares of the premium cost for up to 90 calendar days after the plant closing, if this happens to you. The group is responsible to notify subscribers of their eligibility. Call your group or the Health Connector 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 Clarity plan under the subscriber's group contract, whether or not the judgment was entered prior to the effective date the 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 Clarity 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 offered through the 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 Service.

Chapter 6. Member satisfaction process

Introduction

We are committed to solving any concerns you may have about: how the Clarity 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 WellSense asking us to address a WellSense action, policy, or procedure.

Internal inquiry process

This is an informal process used to resolve most Inquiries. Call Member Service at 855-833-8120 to discuss your concern.

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 Service will begin our Internal Grievance Process (see below).
- An Adverse Determination, Member Service will begin our Internal Appeals Process (see below).

Member Service staff will review and investigate your Inquiry and, in most cases, respond to you by phone within 3 working days. During our call, we will tell you our decision or 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:

- WellSense Health Plan Administration (how WellSense is operated): any action taken by a WellSense employee, any aspect of WellSense's services, policies or procedures, or a billing issue.
- Provider Access, Attitude, or Service: any dissatisfaction with a 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 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.)

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 Service at **855-833-8120**, including those pertaining to **mental health and/or substance** use disorder services**.** 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
- Clarity 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, including those pertaining to mental health and/or substance use disorder services to:

WellSense Health Plan
100 City Square, Suite 200
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.

When to file a Grievance

You can file your Grievance any time within 180 calendar 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 5 working days of our receipt of your Grievance. If you filed your Grievance orally, our written summary of your Grievance will be sent to you within 48 hours of receipt of your Grievance in the form of an acknowledgement letter. 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 a 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 Service will promptly send you a blank form. It is 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

Appeals & Grievances Specialist will investigate and review Clarity plan or provider Administrative Grievances. He or she will also talk with other appropriate departments or providers 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 a mutual written agreement between you and us. Any extension will not exceed 30 calendar days from the date of the agreement. If we do not 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 review of your Grievance by WellSense.

No Grievance shall be considered received by us until actual receipt of the Grievance by us 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 WellSense 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 WellSense decision to deny coverage for a service, supply, or drug because you are no longer eligible for coverage under the Clarity plan. (This means you no longer meet the Clarity plan's eligibility criteria.)
- Adverse Determination: A WellSense 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 WellSense 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 our 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 Clarity 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 file your Appeal orally by calling Member Service at 855-833-8120, including those pertaining to **mental health and/or substance** use disorder services.
- 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) in the form of an acknowledgement letter.

Written Appeals should include:

- Your name
- Address
- Clarity 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, including those pertaining to mental health and/or substance use disorder services to:

WellSense Health Plan
Attention: Member Appeals
100 City Square, Suite 200
Charlestown, MA 02129
Fax: 617-897-0805

If you want to file an Appeal in person, you can go to our office location listed above.

When to file an Appeal

You can file your Appeal any time within 180 calendar days of the date of the original coverage denial. Appeals received after 180 calendar 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 15 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 in the form of an acknowledgment letter. 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 WellSense.

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. You or your Authorized Representative must sign and date the form. (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 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

Administrative Appeal will be investigated and reviewed by an Appeals & Grievances specialist. 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 WellSense.

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 a mutual written agreement between you and us. Any extension will not exceed 30 calendar days from the date of the agreement.

An Appeal shall only be considered received by us when we receive it at the 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 do not 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 we receive 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, we 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 file 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 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 WellSense Medical Director, decides that the effectiveness of the proposed service would be materially reduced if not given 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 with a written decision.

If we do not 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

We 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) WellSense 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 WellSense employee who is coordinating the review of your Grievance or Appeal, or Member Service. If we receive or rely on any new or more 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 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 WellSense 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 our written notice of the final Appeal decision. A copy of the OPP's External Review forms and other information will be enclosed with our 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 at the same time as you file a request for an Expedited Internal Appeal.

Requirements for an External Review

- The request must be filed on the OPP's application form called: "Request for Independent External Review of a Health Insurance Grievance." 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 Service, by calling the OPP at 800-436-7757, or from the OPP's website 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 our 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 heath 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 our 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. OPP will notify you and WellSense of the assignment. The External Review Agency will make a final decision. It will send the written decision to you and WellSense. 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 working days from receipt of the case from the OPP. The decision of the External Review Agency is binding on WellSense. 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, for 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
Website: mass.gov/hpc/opp

Compliance with law

We administer our 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

You must notify us if you have any other health insurance coverage in addition to WellSense. You must contact us when there are changes to your other insurance coverage. Some other types of insurance coverage include:

- Personal injury insurance
- No-fault or liability insurance (automobile or homeowners')
- Workers' compensation

Coordination of Benefits (COB)

Coordination of Benefits 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. 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 Clarity 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.; 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). 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 Clarity 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 Clarity 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 Clarity plan, you agree to cooperate with our COB program. This includes providing us or the Health Connector 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. The Health Connector or 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 Service.

Our 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. WellSense's right of subrogation from the recovery has 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 Clarity 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 that 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 WellSense in exercising our rights under this section. This cooperation includes:

- Giving us notice 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 prompt notice of significant events during 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 and 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 Clarity 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 we have 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 Clarity 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:

- Evidence 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 Clarity plan; and the three most common reasons for physician disenrollment
- The percentage of premium revenue spent by the Clarity 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.

Health Policy Commission-Office of Patient Protection:
Phone: 800-436-7757
Fax: 617-624-5046
Website: mass.gov/hpc/opp

Utilization Management

We have a Utilization Management Program ("UM Program"). The UM Program's purpose is to manage health care costs by reviewing whether certain medical and behavioral health services are medically necessary; and are being given in the most clinically appropriate and cost-effective manner. We use and accept designated prior authorization forms as required by state regulation. 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 medical, surgical or behavioral health treatments.

Concurrent utilization review

Used to review your situation to ensure that the right care is given in the right place at the right level of care. If we deny authorization for a longer stay or more services, you can keep getting

the service at no cost to you until we let you know our decision. Examples include review of an inpatient stay or continuous course of treatment.

Retrospective utilization review

Used to evaluate treatment after it has been provided.

Timeframes for determination

Following receipt by the Clarity plan of all necessary information:

- Prospective review: Within 2 working days
- Concurrent review: Within 1 working day

Timeframes for notification

The Clarity plan will call and send notices to providers or facilities. The member will receive a copy of the notice.

Coverage approval

Prospective review

- Phone call: Within 24 hours
- Written/electronic notice: Within 2 working days of the phone call

Concurrent review

- Phone call: Within 1 working day
- Written/electronic notice: Within 1 working day of the phone call (Notice includes: number of days approved; next review date; new total number of approved days or services; and date of admission or the approved services will begin.)

Coverage denial

Prospective and concurrent reviews

- Phone call: Within 24 hours (The Clarity plan and provider will discuss other treatment options)
- Written/electronic notice: Within 1 working day of the phone call

Adverse determinations

Licensed healthcare professionals in the related specialty will review Adverse Determinations and other denials of requests for health services. We will send a written (or electronic) notice to you and to the provider. The notice will explain the coverage decision and will:

- Discuss your condition or symptoms, and diagnosis. It will give specific reasons why the information your Provider sent did not meet medical review criteria.
- Include the clinical guidelines and review criteria used in our decision.
- List other covered treatment options or supplies, if appropriate.
- Describe if your provider needs to send more information to complete the request and why.
- Explain your Appeal and Grievance rights.
- List contact information for the Office of Patient Protection and the Massachusetts consumer assistance program.

- Details on requesting interpretation and translation services.

Reconsideration of adverse determination

Your provider may ask us to reconsider an adverse decision. In this case, we will arrange for the decision to be reviewed between your provider and a clinical peer reviewer within 1 working day of the request. If the initial decision is not reversed, you or the provider may file a grievance and expediated appeal. The processes are described in Chapter 6 of this EOC. You may file even if your provider has not asked for the decision to be reconsidered.

The UM Program is structured to encourage appropriate care. The Clarity 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 Clarity 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 access utilization review requirement information on our website or by calling Member Service. In addition, you can call us to find out the status or outcome of utilization review decisions, including decisions regarding mental health or substance use disorder services:

- 855-833-8120 (toll-free) or dial 711 for relay service
- Translation services are available (see page 2)

Exceptions

- **Obstetrical care or gynecological care:** Prospective review from your PCP is not required in order for you to access obstetrical or gynecological care from any network provider that specializes in this type of care. The network provider may be required to comply with certain prospective review requirements, such as an inpatient admission other than for maternity care.
- **Substance use disorder acute treatment service or clinical stabilization services:** Prospective review will not be required for medically necessary admission in a network facility licensed by the Massachusetts Department of Public Health. Coverage will be provided for up to a total of 14 days without prior approval if the facility notifies the Clarity plan and provides the initial treatment plan within 48 hours of your admission. Concurrent Review will start on or after day 7 of your admission.
- **All other substance use disorder treatment services:** Prospective review will not be required if the network provider or facility, licensed by the Department of Public Health (DPH), provides a covered medically necessary substance use disorder treatment service. Including, but not limited to, early intervention services for substance use disorder treatment, outpatient services, medically assisted therapies, intensive outpatient, and partial hospitalization services, residential or inpatient services, and medically intensive inpatient services.

Care Management (Case Management)

The Clarity plan may provide some members who have serious or complicated health conditions

with care management services. Case management programs include disease management (for chronic conditions such as asthma, diabetes, sickle cell, and depression) and complex care management. Complex care management is for members with more serious or multiple health issues and conditions (including more serious conditions managed in the disease management programs). Examples of serious conditions are rare diseases or cancer. These care management 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. Clarity 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 case manager or one of your providers, or self-referral. If you feel you would benefit from care management, to learn more, or to opt out call 866-853-5241 for medical Care Management.

Process to develop and adopt clinical review criteria and guidelines

We have a Utilization Management Committee (UMC) and a Pharmacy and Therapeutics Committee (P&T).

- These committees develop, or review at least annually and adopt, clinical review criteria and guidelines to determine the medical necessity of health care services and drug coverage guidelines and ensure consistent decision-making.
- Clarity plan-adopted written clinical review criteria (i.e., the Clarity plan's internal medical policies and pharmacy policies, guidance from the Centers for Medicare & Medicaid Services for medical necessity and coverage determinations, including but not limited to National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs), InterQual® criteria utilized by the Clarity plan, state-mandated policies, and clinical guidelines implemented by the Clarity plan's delegated management partners for related services provided to Clarity plan members by Clarity plan product type) are objective, scientifically derived, and evidence-based for the requested service(s) and indication(s) for treatment and are compliant with applicable legal obligations, regulatory requirements, and national accreditation organization standards. Clarity plan-adopted clinical review criteria are reviewed by the Clarity plan at least annually.
- In the process of developing or adopting clinical review criteria and guidelines, the UMC and P&T assess 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. Reputable sources evaluated include, but are not limited to, the Centers for Medicare and Medicaid (CMS) National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs).
- The development and review of the Clarity plan's internal clinical criteria include input from participating internal network providers and consultant specialists with clinical expertise and

appropriate credentials in the applicable clinical area.

- The UMC and P&T, with input and recommendations from other Clarity 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 and implemented.
- The clinical review criteria and guidelines are available at wellsense.org and upon request by calling Member Service.

Healthcare services and drug coverage clinical criteria

- Reviewed and updated at least annually
- Clarity plan's internal medical policies and pharmacy policies
- Centers for Medicare and Medicaid (CMS) Criteria
    - The Medicare Coverage Database (MCD) contains all National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)
- Clarity plan's InterQual® criteria
- State-mandated policies
- Clinical guidelines implemented by the Clarity plan's delegated management partners for related services provided to Clarity plan members by Clarity plan product type

Behavioral health services (includes mental health and/or substance use disorder services) clinical criteria

- Reviewed and updated at least annually to ensure criteria reflects the latest developments in serving individuals with behavioral health diagnoses.
- 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.

For more information on our clinical criteria, visit wellsense.org or call Member Service at 855-833-8120.

Quality management and improvement programs

We develop an annual quality management and improvement work plan designed to assess and help improve the quality of health care and service. The work plan may vary over time to: address different aspects of care and service and respond to changing priorities. The Clarity 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.
- Complaint processes to address member complaints about quality of care.

Process to evaluate experimental or investigational treatments

Since the Clarity plan does not cover experimental or investigational treatment for a medical or behavioral health condition, the Clarity plan evaluates whether a service, treatment, procedure, supply, device, biological product, or drug is an experimental or investigational treatment for the requested indication. The Clarity 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 Clarity plan considers all the following when determining if a service is considered medically necessary (rather than experimental and investigational):

- 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 Clarity plan evaluates whether to include these as covered services.

Examples are medical and behavioral health therapies, devices, surgical procedures, diagnostics, and/or drugs. The technology assessment process is applied to both the development of new clinical review criteria and the updating of existing criteria included in the Clarity plan medical policies, Clarity plan pharmacy policies, Clarity plan-adopted criteria (e.g., InterQual criteria from Change Healthcare), and criteria utilized by the Clarity plan's partner clinical vendors. The Clarity plan conducts an evidence-based assessment of new technologies and the new applications of existing technologies through the Utilization Management Committee (UMC) and/or the Pharmacy & Therapeutics (P&T) Committee to evaluate the safety and effectiveness of the treatment and make final coverage decisions for services based on scientific evidence. 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 established by nationally recognized and applicable medical associations and specialty societies.

The Clarity plan's partner clinical vendors are delegated to conduct utilization management on behalf of Clarity plan members. Clinical review criteria developed from partner clinical vendors and other Clarity 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 Clarity plan verification that quality standards are met.

Disagreement with recommended treatment by network providers

When you enroll in the Clarity 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 does 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 Clarity plan has no further duty to provide coverage for the care in question. If you seek care from non-network providers because of such 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 Clarity 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; the 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

WellSense has a strong commitment to protecting the confidentiality of your protected health information ("PHI"); and using and disclosing it only in accordance with applicable law. The Clarity plan provides members with a Notice of Privacy Practices that can be found below titled "Notice of Privacy Practices." This Notice describes how the Clarity plan uses and discloses your PHI. It also describes your rights regarding your PHI. Call Member Service 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 Clarity plan for covered services provided to you. The Clarity 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 Service.

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 Clarity plan a bill on a standard health care claim form to:

  WellSense Health Plan
  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 Clarity 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
  100 City Square, Suite 200
  Charlestown, MA 02129
  Attention: Member Service

  Phone: 855-833-8120
  Fax: 617-748-6132

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 Service if you have further questions.

Time limits on claims

For us to reimburse you for covered services, we must receive your claim within 6 months from the date you received care.

Premium payments

You or your group pay applicable premium payments to the Health Connector. (Some individuals, at their option, may be eligible to pay premiums directly to WellSense.) When the Health Connector receives your premium, it forwards applicable premium to us. We are not responsible if the Connector fails to pay premium to us for your coverage. If the Connector fails to pay us the premium on time, your enrollment in the Clarity plan may be cancelled in accordance with applicable state and federal law. The Clarity plan may change the premium that individuals or groups are required to pay. This will be done in accordance with Health Connector policies and applicable laws.

Advance Premium Tax Credit (APTC) and ConnectorCare plans

We offer low-cost plans through the Health Connector, including individual plans with subsidies for those who qualify. You might be eligible for Advance Premium Tax Credits (APTCs). If you are eligible for APTCs, the United States government pays part of your premium directly to WellSense. Alternatively, you can claim the credit when you file your tax return for the year. You might also be eligible for a lower-cost ConnectorCare plan. If you are eligible, the Commonwealth of Massachusetts pays part of your premium directly to WellSense. This is in addition to any APTCs you might qualify for. The Health Connector can help you find out if you are eligible for APTCs and/or a ConnectorCare plan; call 1-877-MA-ENROLL (1-877-623-6765), or TTY 711 for people who are deaf, hard of hearing, or speech disabled.

Limitation on actions

You must complete the internal Member Satisfaction Process before you can file a lawsuit against WellSense 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).

Notices

We will mail all member notices which are required to be sent to the last address of the member that is on file with us. Depending on the type of notice, we may send notices to the active email address of the member. If you move, please let the Health Connector and us know your new address. Members should send notice to the Clarity plan as follows:

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

Circumstances beyond our reasonable control

WellSense 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 WellSense 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

WellSense 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 Clarity 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 Clarity plan. This EOC is a contract between you and WellSense. 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 to the Health Connector, you: apply for coverage under the Clarity plan; and you agree to all the terms and conditions of the Qualified Health Care Program as set forth by the Health Connector, and to the terms and conditions of this EOC.

We may change this EOC without sending you advance notice if we need to comply with changes in state or federal law. If we make material changes in covered services, we will send written notice, at least 60 days before the effective date of the change, as follows: if you are enrolled under an individual contract, to the subscriber; and if you are enrolled under a group contract, to the group. The notice will include any changes in clinical review criteria and the impact on your cost-sharing responsibilities because of the changes. Changes do not require your consent. Changes will apply to all Clarity 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 at 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 Card(s) to others so they can get services or drugs they are not supposed to have access to.
- Selling medical supplies you get under your Clarity plan.

You must notify WellSense when you think that someone has purposely misused the Clarity 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	Corporate Headquarters: WellSense Health Plan Attn: Special Investigations Unit 100 City Square, Suite 200 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 Clarity 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 WellSense Member Service at 855-833-8120, TTY: 711.

Corporate office:

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

Fax: 617-897-0884
Website: wellsense.org

Your rights	• Right to access and copy • Right to an electronic copy of PHI • Right to get notice of a security breach • Right to amend • Right to an accounting of disclosures • Right to request confidential information • Right to notice of privacy practice
Your options and protections	• Tell family and friends about your condition • Opportunity to object and opt out • Revoke authorization at any time • Assistance in preparing written documentations
Our uses and disclosures	• Right to access and copy • Right to an electronic copy of PHI • Right to get notice of a security breach • Right to amend • Right to an accounting of disclosures • Right to request confidential information • Right to notice of privacy practice

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

By law, we are required to:

- Maintain the privacy and confidentiality of your PHI
- 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 the minimum amount of PHI 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.

Your Rights	When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help 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 Privacy Officer. You will be provided with a copy or a summary of your records, usually within 30 days. Certain information may not be easily available, and your request to inspect and copy may be denied, in certain, limited circumstances.
Right to an electronic copy of PHI	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 Privacy Officer. You will be provided with a copy or a summary of your records, usually within 30 days. Certain information may not be easily available, and your request to inspect and copy may be denied, in certain, limited circumstances.
Right to get notice of 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 loses, 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 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 healthcare 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 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 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 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.
Right to be notified	You have the right to be notified following a breach of Unsecured PHI if your PHI is affected.

Your Options and Protections	**For certain health information, you can choose your options about what we share**
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 Privacy Officer.
Special protections for HIV, alcohol and substance use disorder, mental health, and genetic	Special privacy protections apply to HIV-related information, alcohol and substance use disorder information, mental health, and genetic information that require your written permission, and therefore some parts of this Notice may not apply to these more restricted kinds of PHI.

information	
Assistance in preparing written documents	We 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.
Opportunity to participate in research	You have the opportunity to participate in research, and your personal information will only be used or disclosed for research purposes with your written authorization.
Opt out of marketing	We never share your information unless you give us written permission for marketing purposes.

Our Uses and Disclosures	How do we typically use or share your health information? We typically use or share your health information in the following ways
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 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-	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

related benefits and services	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.
Restrictions on Use and Disclosure of Reproductive Healthcare PHI	We will not disclose your PHI related to reproductive healthcare services for the purpose of conducting criminal, civil or administrative investigation or to impose criminal, civil or administrative liability on any person for the mere act of seeking, obtaining, providing or facilitation lawful reproductive healthcare. Reproductive healthcare is healthcare that affects the health of an individual in all matters relating to the reproductive system and to its functions and processes. This includes, but is not limited to, lawfully obtained contraception, including emergency contraception; management of pregnancy and pregnancy-related conditions including miscarriage and pregnancy termination; fertility or infertility diagnosis and treatment, assistive reproductive technology, and other diagnosis, treatment and care that affect the reproductive system. When we receive a request for PHI relating to reproductive healthcare for healthcare oversight activities, judicial or administrative proceedings, law enforcement purposes, or disclosures to coroners and medical examiners, we will obtain a signed and dated attestation from the person or entity requesting the use or disclosure. The attestation will identify the types of PHI being requested and state that the requested use or disclosure is not for a prohibited purpose.
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 healthcare or payment related to your care.
Appropriate use of Sensitive Data	Sensitive Data is personal data that includes race, ethnicity, language, gender identity, sexual orientation, sexual preference, religious beliefs, citizenship or immigration status. We may collect information about things like race, ethnicity, sexual orientation, and gender identity to help improve your healthcare. We might share this information with your healthcare providers to give you better care or we may use language preference to determine the need for translated outreach materials. Your information is protected by law and won't affect your coverage or benefits. You don't have to provide this information if you don't want to.
42 C.F.R. Part 2 ("Part 2")	We will comply with all Health Insurance Portability and Accountability Act (HIPAA) regulations and Part 2 requirements related to substance use disorder (SUD) information. Part 2 Data is subject to the restrictions on use or disclosure set forth in 42 CFR Part 2 (related to an individual who has applied for or been given diagnosis, treatment or referral for treatment for a substance use disorder at a Part 2 program.)
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. 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.

To learn more about how WellSense protects your PHI and other data, please visit https://www.wellsense.org/about-us/protecting-phi.

To learn more about how WellSense uses Cookies, Pixel and other Tracking Technologies, please visit https://www.wellsense.org/about-us/privacy.

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

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

Email: compliance@wellsense.org

Or you may contact our Compliance Hotline at 888-411-4959.

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

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

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

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

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 based on any of the identifiers listed above, you can file a grievance or request help to do so at:

Civil Rights Coordinator / Section 1557 Coordinator
100 City Square, Suite 200
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. HHS, 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

Phone: 800-368-1019 (TTD: 800-537-7697)
Complaint Portal: hhs.gov/ocr/office/file/index.html

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

This Notice gives you information about your Clarity plan benefits for mental health and substance use disorder services. Under both Massachusetts and federal laws, the Clarity 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 Clarity 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.

WellSense manages mental health and substance use disorder services for its members, including the review and authorization of these services and member appeals. If we decide to deny or reduce authorization of a service, we will send you a letter explaining the reason for the denial or reduction We 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 Clarity plan 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, 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 WellSense under your Clarity 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 us. (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 us toll-free at 855-833-8120 for more information about filing an appeal.

Appendix A: Definitions

Accreditation: A written determination by the Bureau of Managed Care of compliance with M.G.L. c. 176O, 211 CMR 52.00 and 958 CMR 3.000: Health Insurance Consumer Protection.

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.

Administrative disenrollment: A change in the status of a member whereby the member stays with WellSense but his or her membership may appear under a different identification number. Examples of administrative disenrollment are a change in employers, a move from an individual plan to a spouse's plan, or any similar change recorded by WellSense as both a disenrollment and an enrollment.

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 Clarity 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 the Clarity plan: For providers who have a payment agreement with the Clarity plan, the allowed amount is the negotiated amount set forth in the agreement.
- For providers with no payment agreement with the Clarity plan:
    - For covered services provided by providers who do not have a payment agreement with the Clarity plan, the allowed amount is either: the amount allowed or required by applicable state or federal law; or the amount the Clarity 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 Clarity plan has delegated claims processing to a third party, that third party shall have the same discretion as the Clarity plan with respect to UCR determinations.)
    - The allowed amount is the maximum amount the Clarity plan will pay for covered services (minus any applicable member cost sharing) rendered by providers who do not have a payment agreement with the Clarity 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 decision by WellSense, 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 decision by WellSense to deny coverage for a service, supply, or drug because you are no longer eligible for coverage under the Clarity plan. (This means you no longer meet the Clarity plan's eligibility criteria.)
- Adverse Determination: A decision by WellSense, 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 Clarity 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 Clarity 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 Clarity 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.

Balance billing: When a non-network provider bills you for the balance remaining on the bill that the Clarity plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount.

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 Clarity 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 level: The health benefits, including the benefit payment structure or service delivery and network, provided by the Clarity plan.

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 year.

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.

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 Massachusetts 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.

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.

Child or children or child dependent: The following individuals, until their 26th birthday:

- The subscriber or spouse's natural child, stepchild, or adoptive child. *A child is an adoptive child as of the date he or she is:
    - Legally adopted by the subscriber; or
    - Placed for adoption with the subscriber. Placed for adoption means that the subscriber has assumed a legal obligation for the partial or total support of a child in anticipation of adoption. If the legal obligation ends, the child is no longer considered to be placed for adoption. (As required by state law, a foster child is considered an adoptive child as of the date that a petition to adopt was filed.)
- The dependent child of an enrolled child.
- A child for whom the subscriber or spouse is the court appointed legal guardian.
- A subscriber or spouse's disabled dependent.

Clean and complete credentialing application: A credentialing application which is appropriately signed and dated by the provider, and which includes all 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 nonrestricted license from the appropriate professional licensing board in Massachusetts, 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.

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.

No prior approval is required but notification by the facility to WellSense is required within 72 hours of the admission.

Commissioner: The commissioner of insurance appointed pursuant to M.G.L. c. 26, § 6, or his or her designee.

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 3 working 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 solely change or improve appearance.

Cost sharing or cost-sharing: The costs you pay for certain covered services. Cost sharing includes deductibles, coinsurance, and copayments, but does not include premiums, balance-billing amounts for out-of-network providers, or spending for non-covered benefits. 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 Clarity plan.

Covered services or covered benefits or benefits: The services, supplies, and drugs for

which the Clarity 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 Clarity 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 Clarity plan); in some cases, approved in advance by a WellSense 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 primary care provider (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 calendar 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)(I)(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, 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 CMR52.00 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 Clarity 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 and is: an insurer licensed or otherwise authorized to transact accident or health insurance under M.G.L. c. 175; a nonprofit hospital service corporation organized under M.G.L. c. 176A; a nonprofit medical service corporation organized under M.G.L. c. 176B; a dental service corporation organized under M.G.L. c. 176E, or an organization entering into a preferred provider arrangement under M.G.L. c. 176I, but not including an employer purchasing coverage or acting on behalf of its employees or the employees or one or more subsidiaries or affiliated corporations of the employer, who 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 benefit packages offered. 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 Massachusetts Division of Insurance established pursuant to M.G.L. c. 26, § 1.

Eligible child, child-only subscriber: 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 subscriber plan offered by a carrier.

Eligible employee: An employee who: (1) works on a full-time basis with a normal work week of 30 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 5 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 26th 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 50 percent of its working days during the preceding year employed from among 1 to not more than 50 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 50 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)(l)(B) of the Social Security Act, 42 U.S.C. 1395dd(e)(l)(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.

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 pursuant to § 104(b)(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1024(b), issued to an Insured specifying the Benefits to which the Insured is entitled. For workers' compensation preferred provider arrangements, the Evidence of Coverage will be considered to be the information annually distributed pursuant to 211 CMR 51.04(3)(i)1. through 3.

Exclusions or non-covered service: Services, treatments, procedures, tests, devices, supplies, equipment, or medications that are not covered by the Clarity plan, regardless of setting.

Experimental or investigational or experimental and 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 Clarity 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 Clarity 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.

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.

Facility fee: A fee that clinics, hospitals, or free-standing facilities may charge to cover the costs of maintaining those facilities. For certain outpatient services, you may be billed both a facility fee and a separate physician fee for a single episode of care.

Family Stabilization Team (FST): 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: Any oral or written complaint submitted to the carrier that has been initiated by an insured, or on behalf of an insured with the consent of the insured, concerning any aspect or action of the carrier relative to the insured, including, but not limited to, review of adverse determinations regarding scope of coverage, denial of services, rescission of coverage, quality of care and administrative operations, in accordance with the requirements of M.G.L. c. 176O and 958 CMR 3.000: Health Insurance Consumer Protection.

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 Clarity plan; and
- The group agrees to pay the premium to the Health Connector for coverage under the Clarity plan.
- The group contract includes this EOC and the applicable Schedule of Benefits.

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

Health 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 of health care services. An individual or group health maintenance contract issued by a health maintenance organization under chapter 176G. Unless otherwise noted, health benefit plan shall not include any policy, certificate, or contract that is not a health benefit plan as defined in M.G.L. c. 176J, § 1. .

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

Healthcare provider or provider: A health care professional or a facility.

Healthcare 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.

Incentive Plan: Any compensation arrangement between a carrier and health care professional or licensed health care provider group or organization that employs or utilizes services of one or more licensed health care professionals that may directly or indirectly have the effect of reducing or limiting specific services furnished to Insureds of the organization. Incentive plan does not mean contracts that involve general payments such as capitation payments or shared risk agreements.

Individual: A category of subscriber for which there is no employer financial contribution to the premiums under this Clarity 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 Clarity plan; and
- The individual agrees to pay the full applicable premium to the Health Connector for coverage under the Clarity plan.
- The individual contract includes this EOC and the applicable Schedule 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.

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 or on behalf of an insured to the carrier or utilization review organization that has not been the subject of an adverse determination and that requests redress of an action, omission or policy of the carrier.

Insured: An enrollee, covered person, insured, member, policyholder, or subscriber of a carrier, including a dental or vision 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 the provisions of M.G.L. c. 176O, 211 CMR 52.00 and 958 CMR 3.000: Health Insurance Consumer Protection..

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 can 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. 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. Note: No prior approval is required but notification by the facility to WellSense is required within 72 hours of the admission.

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.

Involuntary disenrollment: A member's coverage may be canceled, or its renewal refused only in the circumstances of misrepresentation or fraud on the part of the member and commission of acts of physical or verbal abuse by the member which pose a threat to providers or other WellSense members and which are unrelated to the physical or mental condition of the member.

JCAHO: The Joint Commission on Accreditation of Healthcare Organizations.

Licensed healthcare 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 Clarity 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, which provides psychiatric evaluation, management, treatment, and discharge planning in a structured treatment setting. Note: No prior approval 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: JCAHO, NCQA, URAC or any other national accreditation entity approved by the Division that accredits carriers that are subject to the provisions of M.G.L. c. 176O and 211 CMR 52.00.

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 group of health, dental or vision care providers who contract with a carrier, including a dental or vision carrier, or affiliate to provide health, dental or vision care services to Insureds covered by any or all of the carrier's, including a dental or vision carrier's or affiliate's, plans, policies, contracts or other arrangements. Network shall not mean those participating providers who provide services to subscribers of a nonprofit hospital service corporation organized under M.G.L. c. 176A, or a nonprofit medical service corporation organized under M.G.L. c. 176B.

Network pharmacy: A retail, specialty, or mail order pharmacy that is a network provider.

Network provider: A provider with whom the Clarity plan has a direct or indirect agreement to provide covered services to members. Network providers are not the Clarity plan’s employees, agents, or representatives. Network providers are listed in the Clarity 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.

Non-routine care: Services to evaluate and/or treat a new or worsening condition, illness, or injury.

Nurse practitioner: A registered nurse who holds authorization in advanced nursing practice as a nurse practitioner under M.G.L. c. 112, § 80B.

Office of patient protection: The office within the health policy commission established by M.G.L. c. 6D, § 16,, responsible for the administration and enforcement of M.G.L. c. 176O, §§ 13, 14, 15 and 16.

Open enrollment period: The period of time each year when eligible persons (including eligible dependents) can 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, including a dental or vision carrier, or with its contractor or subcontractor, has agreed to provide health, dental or vision care services to insureds with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the carrier, including a dental or vision 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 in accordance with M.G.L. c. 112, §§ 9C through 9H and who has passed the Physician Assistant National Certifying Exam or its equivalent.

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 Clarity plan to individuals and groups.

Podiatrist: A network professional that provides for any podiatric medical or surgical service which is within the lawful scope of practice of a licensed podiatrist, shall be entitled to such services whether the service is performed by a physician or licensed podiatrist, including authorized referral services on a nondiscriminatory basis.

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 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. Network providers are listed in the Clarity plan's Provider Directory.

Provider directory: A listing of our network providers.

Provider network or network: The providers with whom the Clarity plan has an agreement to provide covered services to members. The Clarity 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.

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.

Qualified Health Plan Program: The Qualified Health Plan Program overseen by the Health Connector.

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

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.

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.

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.

Routine, routine service, or visit: Services provided routinely to monitor an existing condition, such as pregnancy or diabetes. Examples include routine prenatal visits and routine foot care for diabetic members. Some routine services may be subject to cost sharing.

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.

Schedule II opioid drugs: Drugs or substances that: have a high potential for abuse; have a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions; or abuse may lead to severe psychological or physical dependence.

Schedule III opioid drugs: Drugs or substances that: have a potential for abuse less than the drugs or other substances in schedules I and II; have a currently accepted medical use in treatment in the United States; or abuse may lead to moderate or low physical dependence or high psychological dependence.

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 as approved by the Commissioner within which the carrier,

including a dental or vision carrier, has developed a network of providers to afford adequate access to members for covered health, dental or vision services.. Please visit the WellSense website at wellsense.org for more information about our service area. (Our service area may change 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.

An eligible child who enrolls in an individual contract may have the membership application form signed by that child's parent or legal guardian on behalf of that child.

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.

Telehealth: 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 6 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).

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 under contract with or on behalf of a carrier but does not include a carrier performing utilization review for its own health benefit plans. A behavioral health manager is considered a utilization review organization.

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 and is: an insurer licensed or otherwise authorized to transact accident or health insurance under M.G.L. c. 175; an optometric service corporation organized under M.G.L. c. 176F, or an organization entering into a preferred provider arrangement under M.G.L. c. 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, that offers a policy, certificate or contract that provides coverage solely for Vision Care Services.

Voluntary disenrollment: Occurs when a member has terminated coverage with the carrier by nonpayment of premium.

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 or WellSense Health Plan: WellSense Health Plan, WellSense, is a not-for-profit MA-licensed health maintenance organization. WellSense is also known as: 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 Clarity plan to members. WellSense is sometimes referred to as "we," "our," or "us."

WellSense Clarity plan in Massachusetts or "Clarity plan": The program of health benefits described in this EOC, along with the corresponding Schedules of Benefits. It is also referred to as the Clarity plan. Through an arrangement with the Health Connector, WellSense offers the Clarity plan to persons meeting applicable eligibility requirements. WellSense Clarity plan is sometimes referred to as Clarity plan.

You: See "Member."

Appendix B: Member rights and responsibilities

Your rights as a member

As a valued WellSense member, you have the right to:

1. Treated with respect and dignity and have your privacy recognized.
2. Have privacy during treatment and expect confidentiality of all records and communications. No information will be released to anyone without your consent, unless required by law.
3. Actively participate in decisions regarding your healthcare, including the right to refuse treatment and potential outcomes.
4. Have an honest discussion of your illnesses, appropriate or medically necessary treatment options and alternatives, regardless of cost or benefit coverage, with your provider in a way understood by you.
5. Receive a second opinion about any healthcare that your PCP advises you to have. WellSense will pay for the cost of your second opinion visit.
6. Obtain emergency care, 24 hours a day, seven days a week. Please see your member documents for complete information.
7. Receive an interpreter when you receive healthcare, including when you call WellSense. Call Member Service if you need help with this service.
8. 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.
9. File a Grievance with Member Service and/or the Health Connector to express dissatisfaction about services you received from WellSense or from a healthcare provider.
10. Appeal certain decisions made by WellSense as described in Chapter 6 of the EOC.
11. Choose a Primary Care Provider (PCP) that participates in the network, including the ability to change your PCP at any time.
12. Discuss 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. Know and receive all the benefits, services, rights, and responsibilities you have under WellSense and/or the Health Connector.
14. Receive documents in alternative formats and languages (e.g., translated, read aloud) free of charge.
15. Be free from any form of physical restraint or seclusion that would be used as a means of coercion, force, discipline, convenience, or retaliation.
16. Freely exercise these rights without adversely affecting the way WellSense and its providers treat you.
17. 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.
18. Disenroll from WellSense and change to another qualifying health plan by calling the Health Connector Customer Service center.

19. Receive information about WellSense, our services, providers, and your rights and responsibilities.
20. Make recommendations about our Rights and Responsibilities statement, including the right to obtain a copy upon enrollment and annually thereafter.
21. Refuse services via telehealth and request to be seen in person.

Your Responsibilities as a member

As a valued WellSense member, you also have the responsibility to:

1. Follow plans and instructions for care that you have agreed to with your healthcare provider.
2. Understand that refusing treatment may have serious effects on your health.
3. Understand that you may be responsible for payment of services you receive when not included in the Covered Services list for your coverage type.
4. Notify WellSense and the Health Connector of any changes in personal information such as address, telephone, marriage, additions to the family, eligibility of other health insurance coverage, and so forth. If you are enrolled in a group plan, also notify your employer.
5. Give complete and accurate information that WellSense and healthcare providers need in order to provide care.

Appendix C: ERISA information for group members

Introduction to ERISA

If you are a group member and your Clarity plan is an ERISA plan, you have certain rights and protections under ERISA. ERISA stands for the Employee Retirement Income Security Act of 1974, as amended. Most plans are ERISA plans, but there are exceptions. Please contact your Clarity plan administrator to learn if your Clarity plan is an ERISA plan.

Information about your Clarity plan and benefits

ERISA entitles all Clarity plan participants to:

- Examine, without charge, at the Clarity plan administrator's office and at other specified locations all documents governing the Clarity 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 Clarity 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 Clarity plan administrator, you are entitled to obtain copies of documents governing the operation of the Clarity plan. These include the documents listed above as well as an updated summary plan description. The Clarity plan administrator may charge you a reasonable charge for the copies.
- Receive a summary of the Clarity plan's annual financial report. The Clarity 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 Clarity 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 Clarity plan because of a qualifying event. The subscriber or dependents may have to pay for such continued coverage.
- Review the Clarity plan's summary plan description and the other documents governing the Clarity plan on the rules governing your continuation coverage rights under COBRA (the 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 Clarity 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 Clarity plan. The people who operate your Clarity plan are called "fiduciaries" of the Clarity plan. They have a duty to operate your Clarity plan prudently and in the interests of Clarity 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 Clarity plan benefit or exercising your ERISA rights.

Enforcing your rights

If your claim for a Clarity 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 Clarity 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 Clarity plan administrator to provide the documents and pay you a daily penalty until you receive the documents, unless the documents were not sent because of reasons beyond the control of the Clarity plan administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a suit in a state or federal court. Also, if you disagree with the Clarity plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file a suit in federal court. If a Clarity plan fiduciary misuses the Clarity 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 a suit in a federal court. The court will decide who must

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 claim is frivolous, you may have to pay court costs and legal fees.

Help with your questions

You should contact your Clarity plan administrator if you have any questions about your Clarity plan. If you have questions about this statement or about your ERISA rights, or if you need help obtaining documents from the Clarity 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 Clarity 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 Clarity 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 Clarity 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 Service at 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 Clarity 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 we need 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 Clarity 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 Clarity 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 Clarity 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 Clarity 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 Service.

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 limit

One member per family per calendar year if you meet all the following requirements:

- Be 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 Clarity 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 Clarity plan no later than March 31 of the following calendar year. Visit our website at wellsense.org or call us at 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 the option to receive a 50% reimbursement on a wearable technology device, up to $50 per calendar year.

Reimbursement limit

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 Clarity plan no later than December 31 of the same calendar year. Visit our website at wellsense.org or call us at 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 must 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 limit

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 Clarity 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 calendar 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 Clarity 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 Service at 855-833-8120; or
- Visit our website at wellsense.org

Appendix E: List of covered preventive care services

Preventive health services

The Clarity 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 Clarity plan's medical policy guidelines; and with applicable laws and regulations.

Important information

In some cases, a diagnosis code may be 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 Service at 855-833-8120 Monday – Friday 8 a.m. – 6 p.m.

Service (Based on Grade A & Grade B Recommendations from the U.S. Preventive Service Task Force – USPSTF)	Description	USPSTF Recommended Frequency
Abdominal Aortic Aneurysm: Screening: men aged 65 to 75 years who have ever smoked	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 Disorders in Adults: Screening: adults 64 years or younger, including pregnant and postpartum persons.	USPSTF recommends screening for anxiety disorders in adults, including pregnant and postpartum persons.	
Anxiety in Children and Adolescents: Screening: children and adolescents aged 8 to 18 years	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	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	USPSTF recommends screening for asymptomatic bacteriuria using urine culture in pregnant persons.	
BRCA-Related Cancer: Risk Assessment, Genetic Counseling, and Genetic Testing: women with a personal or family history of	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	

breast, ovarian, tubal, or peritoneal cancer or an ancestry associated with BRCA1/2 gene mutation	with breast cancer susceptibility 1 and 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	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 40 to 74 years	USPSTF recommends biennial screening mammography for women aged 40 to 74 years.	Every 2 years
Breastfeeding: Primary Care Interventions: pregnant women, new mothers, and their children	USPSTF recommends providing interventions during pregnancy and after birth to support breastfeeding.	
Cervical Cancer: Screening: women aged 21 to 65 years	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, 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 (co-	Ages 21-29: Once every 3 years. Ages 30-65: Once every 3 years, once every 5 years with high risk PHV testing alone or in combination with PAP.

	testing).	
Chlamydia and Gonorrhea: Screening: sexually active women, including pregnant persons	USPSTF recommends screening for chlamydia and 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	USPSTF recommends screening for colorectal cancer in adults aged 45 to 49 years.	
Colorectal Cancer: Screening: adults aged 50 to 75 years	USPSTF recommends screening for colorectal cancer in all adults aged 50 to 75 years.	
Depression and Suicide Risk in Adults: Screening adults, including pregnant and postpartum persons, and older adults (65 years or older)	USPSTF recommends screening for depression in the adult population, including pregnant and postpartum persons, as well as older adults.	
Depression and Suicide Risk in Children and Adolescents: Screening: adolescents aged 12 to 18 years	USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years.	
Falls Prevention in Community-Dwelling Older Adults: Interventions: community-dwelling adults 65 years or older	USPSTF recommends exercise interventions to prevent falls in community-dwelling adults 65 years or older who are at increased risk for falls.	
Folic Acid Supplementation to Prevent Neural Tube Defects: Preventive Medication: persons	USPSTF recommends that all women who are planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 mcg) of	

who plan to or could become pregnant	folic acid.	
Gestational Diabetes: Screening: asymptomatic pregnant persons at 24 weeks of gestation or after	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	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	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 Infection in Adolescents and Adults: Screening: adolescents and adults at increased risk for infection	USPSTF recommends screening for hepatitis B virus (HBV) infection in adolescents and adults at increased risk for infection.	Annually Risk groups for HBV infection with a prevalence of ≥2% that should be screened include: • Persons born in countries and regions with a high prevalence of HBV infection (≥2%), such as Asia, Africa, the Pacific Islands, and parts of South America • US-born persons not

		vaccinated as infants whose parents were born in regions with a very high prevalence of HBV infection (≥8%) • HIV-positive persons • Persons with injection drug use • Men who have sex with men • Household contacts or sexual partners of persons with HBV infection
Hepatitis B Virus Infection in Pregnant Women: Screening: pregnant women	USPSTF recommends screening for hepatitis B virus (HBV) infection in pregnant women at their first prenatal visit.	Once during pregnancy and again at delivery
Hepatitis C Virus Infection in Adolescents and Adults: Screening: adults aged 18 to 79 years	USPSTF recommends screening for hepatitis C virus (HCV) infection in adults aged 18 to 79 years.	Annually for high risk. Once 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 history of injection drug use.
High Body Mass Index in Children and Adolescents: Interventions: children and adolescents 6 years or older	USPSTF recommends that clinicians provide or refer children and adolescents 6 years or older with a high body mass index (BMI) (≥95th percentile for age and sex) to comprehensive, intensive behavioral interventions.	

Human Immunodeficiency Virus (HIV) Infection: Screening: adolescents and adults aged 15 to 65 years	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	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.	3 times per pregnancy
Hypertension in Adults: Screening: adults 18 years or older without known hypertension	USPSTF recommends screening for hypertension in adults 18 years or older with office blood pressure measurement (OBPM). USPSTF recommends obtaining blood pressure measurements outside of the clinical setting for diagnostic confirmation before starting treatment.	
Hypertensive Disorders of Pregnancy: Screening	USPSTF recommends screening for hypertensive disorders in pregnant persons with blood pressure measurements throughout pregnancy.	
Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Screening: women of reproductive age	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 in Adults: Screening: asymptomatic adults at increased risk of latent tuberculosis infection (LTBI)	USPSTF recommends screening for LTBI in populations at increased risk.	Populations at increased risk for LTBI, based on increased prevalence of active disease and increased risk of exposure, include persons who were born in, or are former residents of, countries with high TB prevalence and persons who live in, or have lived in, high-risk congregate settings (e.g., homeless shelters or correctional facilities).
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	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.	Annually
Ocular Prophylaxis for Gonococcal Ophthalmia Neonatorum: Preventive Medication: newborns	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 with 1 or more risk factors for osteoporosis	USPSTF recommends screening for osteoporosis to prevent osteoporotic fractures in postmenopausal women younger than 65 years who are at increased risk for an osteoporotic fracture as estimated by clinical risk assessment.	
Osteoporosis to Prevent Fractures: Screening: women 65 years or older	USPSTF recommends screening for osteoporosis to prevent osteoporotic fractures in women 65 years or older.	
Perinatal Depression: Preventive Interventions: pregnant and postpartum persons	USPSTF recommends that clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions.	
Prediabetes and Type 2 Diabetes: Screening: asymptomatic adults aged 35 to 70 years who have overweight or obesity	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.	Every 3 years for adults with normal test results
Prevention of Acquisition of HIV: Preexposure Prophylaxis: adolescents and adults at increased risk of HIV	USPSTF recommends that clinicians prescribe preexposure prophylaxis using effective antiretroviral therapy to persons who are at increased risk of HIV acquisition to decrease the risk of acquiring HIV.	
Prevention of Dental Caries in Children Younger Than 5 Years:	• USPSTF recommends that primary care clinicians prescribe oral fluoride	Up to 5 years old

Screening and Interventions: children younger than 5 years	supplementation starting at age 6 months for children whose water supply is deficient in fluoride. • 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.	
Rh(D) Incompatibility: Screening: pregnant women, during the first pregnancy-related care visit	USPSTF strongly recommends Rh(D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.	Screen at first visit and then again at 24-28 week-visit
Rh(D) Incompatibility: Screening: unsensitized Rh(D)-negative pregnant women	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 first visit and then again at 24-28 week-visit
Sexually Transmitted Infections: Behavioral Counseling: sexually active adolescents and adults at increased risk	USPSTF recommends behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections (STIs).	
Skin Cancer Prevention: Behavioral Counseling: young adults, adolescents, children, and parents of young children	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	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	USPSTF recommends screening for syphilis infection in persons who are at increased risk for infection.	Annually for men if continued high risk.
Syphilis Infection in Pregnant Women: Screening: pregnant women	USPSTF recommends early screening for syphilis infection in all pregnant women.	Once per pregnancy. If high risk, rescreen in the 3rd trimester and at delivery.
Tobacco Smoking Cessation in Adults, Including Pregnant Persons: Interventions: non-pregnant adults	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	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	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.	
Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions: adults 18 years or older, including pregnant women	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 aged 18 years or older	USPSTF recommends screening by asking questions about unhealthy drug use in adults aged 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	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 aged 3 to 5 years
Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions: adults	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.	