WellSense Clarity plans of New Hampshire Evidence of Coverage

WellSense Health Plan
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Date of Issue and Effective Date: January 1, 2027 – December 31, 2027

Welcome to WellSense Health Plan. Please read this contract carefully. This contract may, at any time within 30 calendar days after its receipt by the contract holder, be returned by delivering it or mailing it to the company or the agent through whom it was purchased. Immediately upon such delivery or mailing, the contract will be deemed void from the beginning, and any premium paid on it will be refunded.

IMPORTANT INFORMATION: This Evidence of Coverage reflects the known requirements for compliance under the Affordable Care Act passed on March 23, 2010. As additional guidance is forthcoming from the US Department of Health and Human Services and the New Hampshire Insurance Department, those changes will be incorporated into this Evidence of Coverage. The coverage represented by this Evidence of Coverage is under the jurisdiction of the New Hampshire Insurance Commissioner.

This Evidence of Coverage does not include pediatric dental services. Members may purchase a standalone pediatric dental product. Members may contact or access assistance through Healthcare.gov if they wish to purchase a standalone pediatric dental product.

This Evidence of Coverage, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this Evidence of Coverage shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

WellSense HEALTH PLAN

Multilanguage Interpreter Services

Important! This is about your WellSense Health Plan benefits. We can translate it for you free of charge. Please call **855-833-8122 (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 **855-833-8122 (TTY: 711)** para obtener ayuda de traducción. (ESA)

Important! Cela concerne vos prestations WellSense Health Plan. Nous pouvons traduire ce contenu gratuitement pour vous. Veuillez appeler le **855-833-8122 (TTY: 711)** pour obtenir de l'aide concernant la traduction. (FRC)

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 **855-833-8122 (TTY: 711)**。(CHS)

هام! هذا حول مزايا WellSense Health Plan الخاصة بك. يمكننا ترجمتها لك مجانا. يرجى الاتصال **855-833-8122 (TTY: 711)** للمساعدة في الترجمة. (ARA)

Wichtig! In diesem Dokument geht es um Ihre WellSense Health Plan-Vorteile. Wir können es kostenlos für Sie übersetzen. Bitte rufen Sie uns unter **855-833-8122 (TTY: 711)** an, um Übersetzungshilfe zu erhalten. (DEU)

Importante! Esta comunicação é sobre os benefícios da WellSense Health Plan. Podemos traduzir para você gratuitamente. Ligue para **855-833-8122 (TTY: 711)** para obter ajuda com a tradução. (PTB)

Σημαντικό! Πρόκειται για τις παροχές του WellSense Health Plan. Μπορούμε να σας το μεταφράσουμε δωρεάν. Καλέστε στο **855-833-8122 (TTY: 711)** για βοήθεια σχετικά με τη μετάφραση. (ELG)

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 **855-833-8122 (TTY: 711)**. (RUS)

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 **855-833-8122 (TTY: 711)** để được trợ giúp dịch thuật. (VIT)

ముఖ్యమైనది! ఇది మీ WellSense Health Plan ప్రయోజనాల గురించి.
మేము దానిని మీ కోసం ఉచితంగా అనువదించగలము. అనువాద సహాయం
కోసం దయచేసి **855-833-8122 (TTY: 711)** కు కాల్ చేయండి. (TELG)

중요! 이것은 WellSense Health Plan 혜택에 대한 내용입니다. 무료로 번역해 드릴 수 있습니다. 번역 도움이 필요하면 **855-833-8122 (TTY: 711)**번으로 문의하십시오. (KOR)

NHACA

Enpotan! Sa a se sou avantaj WellSense Health Plan ou an. Nou ka tradui li pou ou gratis. Tanpri relel **855-833-8122 (TTY: 711)** pou jwenn èd ak tradiksyon. (HRV)

Ważne! To dotyczy Twoich świadczeń w ramach planu zdrowotnego WellSense Health Plan. Możemy nieodpłatnie przetłumaczyć dla Ciebie te informacje. Zadzwoń pod numer **855-833-8122 (TTY: 711),** aby uzyskać pomoc w tłumaczeniu. (POL)

Penting! Informasi ini terkait manfaat WellSense Health Plan Anda. Kami dapat menerjemahkannya untuk Anda tanpa biaya. Hubungi **855-833-8122 (TTY: 711)** untuk bantuan terjemahan. (IND)

महत्त्वपूर्ण! यो तपाईंको WellSense हेल्थ प्लान लाभहरूको बारेमा हो। हामी यसलाई तपाईंको निमित्त नि: शुल्क रूपमा अनुवाद गर्न सक्छौं। कृपयाअनुवाद सहायताको लागि यस नम्बरमाकल गनुहोस् - **855-833-8122 (TTY: 711)**. (NEP)

Important! This material can be requested in an accessible format by calling 855-833-8122 (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 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: 855-833-8122 (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 New Hampshire licensed Health Maintenance Organization (HMO). 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 (SOB). 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, but you do not need a referral to see any network providers.

Through an arrangement with the New Hampshire Insurance Department and the Centers for Medicare and Medicaid (CMS), WellSense offers the WellSense Clarity Plan, referred to in this Evidence of Coverage (EOC) as the "plan". Individuals meeting the requirements of the Affordable Care Act (ACA), New Hampshire Insurance Department (NHID), CMS and the plan's eligibility requirements may enroll in our plan. In exchange for a premium that the individual pays, WellSense agrees to provide the coverage described in this EOC to enrolled members for the time period covered by the premium. By submitting a signed membership application, and 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, which includes your Schedule of Benefits, is an important legal document. It describes the relationship between you and WellSense. It also describes your rights and obligations as a member. It tells you how the plan works; describes covered services, non-covered services, and certain benefit limits and conditions. It also describes other important information. In addition, you will find the cost-sharing amounts you must pay for covered services in your Schedule of Benefits. 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 Appendix A: Definitions. If you need any help understanding this EOC, please contact us at 855-833-8122. We are here to help!

Guaranteed availability

Individuals meeting the Affordable Care Act, New Hampshire Insurance Department, CMS and the plan's eligibility requirements may enroll in our plan. In exchange for a premium that the individual pays, WellSense agrees to provide the coverage described in this EOC to individuals who are enrolled in our plan, our members, for the time period covered by the premium. By submitting 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.

Guaranteed renewable

Annually, we must file this product, the cost share, and the rates associated with it for approval. Guaranteed renewable means that your plan will be renewed into the next year's approved product on the anniversary date unless terminated earlier in accordance with contract terms. You may keep this plan (or the new plan you are mapped to for the following year) by timely payment of the required premiums. In most cases you will be moved to a new contract each year, however, we may decide not to renew the contract as of the renewal date if: (1) we decide not to renew all contracts issued on this form, with a new contract at the same metal level with a similar type and level of benefits, to residents of the state where you then live; or (2) there is fraud or an intentional material misrepresentation made by or with the knowledge of a member in filing a claim for contract benefits.

In addition to the above, this guarantee for continuity of coverage shall not prevent us from cancelling or non -renewing the contract in the following events: (1) non-payment of premium, (2) a member moves outside the service area, (3) a member fails to pay any deductible or copayment amount owed to us and not the provider of service, (4) a member is found to be in material breach of this contract, or (5) a change in federal or state law, no longer permits the continued offering of such coverage, such as CMS guidance related to individuals who are Medicare eligible.

Annually, we may change the rate table used for this plan. Each premium will be based on the rate table in effect on that premium's due date. The contract plan, and age of members, type and level of benefits, and place of residence on the premium due date are some of the factors used in determining your premium rates. We have the right to change premiums, however, all premium rates charged will be guaranteed for a rating period of at least 12 months.

At least 60 calendar days' notice of any plan to take an action or make a change permitted by this clause will be delivered to you at your last address as shown in our records. We will make no change in your premium solely because of claims made under this contract or a change in a member's health. While this contract is in force, we will not restrict coverage already in force.

Address and telephone directory

Description	Contact Information and Details
Member Service Department	Phone: 855-833-8122 (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. Calls to Member Service may be monitored to ensure quality service. We can help with: • How the plan works • Selecting a Primary Care Provider (PCP) • Benefits • Enrollment, eligibility, and claims • Network provider information • ID cards, registering a concern, billing, and change of address notification • Member Satisfaction Process (grievances or appeals) • Utilization review information, including the status of a review (medical necessity) decision **Members with total or partial hearing loss** can contact Member Service by dialing 711 for relay services. **Non-English speaking members** can call Member Service for help. Free translation services are available to members upon request, including access to interpreters in over 200 languages who can assist with questions about your plan.
Nurse Advice Line	Phone: 855-537-3463 (24 hours and toll free) All calls are confidential. Members can call and speak to a nurse over the phone to get answers to health-related questions. Call any day at any time. A registered nurse will help you. After you explain your symptoms, the nurse may: give you advice about caring for yourself at home, suggest you go to an emergency room, or call your doctor.

Description	Contact Information and Details
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).
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 the toll-free mental health/substance use disorder telephone line at 855-833-8122 for help finding a network provider • Go directly to a network provider who provides mental health or substance use disorder services • Call your PCP • Visit the plan's website, wellsense.org, to look up network providers If you or someone you know is in need of emotional or mental health support/services (or if there is a risk of suicide), call, text, or chat 988 – the Suicide & Crisis Lifeline 24 hours a day, 7 days a week to connect with a trained crisis counselor. The Lifeline provides free and confidential emotional support to people in suicidal crisis or emotional distress. You can also call or text the toll-free NH Rapid Response Access Point (1-833-710-6477) anytime, day or night. Crisis response services are available over the phone, by text, or face-to-face.

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 the plan. If you need these services, you may do any of the following: • Contact WellSense at 855-833-8122 for assistance • Call your PCP for help finding a network provider • Visit wellsense.org to look up network providers

Description	Contact Information and Details
Pharmacy Services	WellSense contracts with Express Scripts. This is the plan's pharmacy benefits manager. Express Scripts manages your prescription drug benefit. If you need help with this benefit, such as information about covered drugs or network pharmacies, you may do any of the following: Phone: 855-833-8122 Website: wellsense.org Hours of operation: Available 24 hours, 7 days a week Express Scripts PO Box 14718 Lexington, KY 40512-4718
Mail Order Drugs	WellSense contracts with Cornerstone Health Solutions for mail order drug services. Only certain maintenance drugs are available through mail order. To use the mail order service, you must first enroll with Cornerstone Health Solutions. To enroll in this service and begin getting medications in the mail you must either contact Cornerstone Health Solutions by phone at 844-319-7588 or complete the mail order enrollment form that was included in your welcome packet and is also available on the Cornerstone Health Solutions website. Your prescribing provider may also call Cornerstone Health Solutions at 844-319-7588 or fax your prescription to them at 781-805-8221. Once you have enrolled, you can refill prescriptions by mail, phone, or online at cornerstonehealthsolutions.org/chs-mail-order-pharmacy.

Medical Drugs	These are drugs you obtain through a provider or facility rather than a pharmacy. We contract with Care Continuum (CCUM), a medical drug management vendor, to administer utilization management requirements for medical drugs. To obtain coverage for medical drugs that require prior authorization, requests may be submitted to CCUM: • Contact Care Continuum at 877-817-4042 • Visit Pharmacy programs | NH Clarity plans | WellSense Health Plan
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.

Description	Contact Information and Details
WellSense General Information	WellSense website: wellsense.org On the WellSense website you can access information about us and your benefits, including: • Learn about your benefits (including your pharmacy benefit) • Learn about our extras (such as national urgent care access or vision discount program) • Register for a WellSense member portal • Make a payment • Complete your health survey • Manage your health (care management program) • Access documents and forms • Find a provider • Nurse advice line • How Telehealth appointments work and common Telehealth concerns • Estimate costs WellSense Corporate Headquarters: WellSense Health Plan 100 City Square, Suite 200 Charlestown, MA 02129 Phone: 855-833-8122

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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 plan is an important document. It contains a summary of covered services and any related 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 be sure to 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 sharing the costs of covered services. Cost-sharing refers to a portion of healthcare costs that a patient is required to pay out-of-pocket, in addition to what we cover. See your Schedule of Benefits for the cost-sharing that applies to the plan in which you are enrolled. 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 WellSense is obligated to pay for those covered services. Once you meet your deductible, you pay either: nothing, or the applicable copayment, or coinsurance for those covered services for the remainder of the benefit year. See your Schedule of Benefits for details.

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

*For some Health Savings Account (HSA)-compatible Clarity plans, the family deductible amount applies if there are two or more members enrolled in the Clarity plan. The family deducible is met when the full amount has been satisfied by one or more members on the Clarity plan. In such case, the

individual deductible is non-applicable 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 services deductible), premiums, member costs that are more than the plan's allowed amount paid to non-network providers, and any payments you make for non-covered services.

Payments you made for covered services received prior to the start of a benefit year are not counted toward your deductible in the current benefit year. At the start of each new benefit year, your deductible accumulation will begin at zero and you will start building again toward your deductible for the new benefit year

In most cases, the amount credited toward a member's deductible is based on the plan's allowed amount on the date of service. In some cases, involving certain covered services provided to you by certain non- network providers, your deductible is calculated based on applicable state law, if any, or under applicable federal law. See 'Appendix A: Definitions' for further information on allowed amounts

Some plans may have a separate prescription drug (Rx) deductible. See 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 the plan is obligated to pay for those covered drugs. Once you meet your Rx deductible, you pay only the applicable copayment or coinsurance for those drugs for the remainder of the benefit year. See your Schedule of Benefits for details.

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

Payments you made for covered prescription drugs received prior to the start of a benefit year are not counted toward your Rx deductible in the current benefit year. At the start of each new benefit year, your Rx deductible accumulation will begin at zero and you will start building again toward your Rx deductible for the new benefit year.

In most cases, the amount credited toward a member's Rx deductible is based on the plan's allowed amount on the date of service. In some cases involving non-network pharmacies, your Rx deductible may be calculated based on applicable state law, if any, or under applicable federal law. See "Appendix A" 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, your accumulation will begin at zero and you will start building again toward your annual out-of-pocket maximum for the new benefit year.

Coinsurance

An amount you must pay for certain covered services, stated as a percentage. In most cases, you pay the applicable percentage of the plan's allowed amount on the date of service. In some cases, involving certain covered services provided to you by certain non-network providers, your coinsurance may be calculated based on applicable state law, if any, or under applicable federal law. See "Appendix A" 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 accumulation will begin at zero and you will start building again toward your annual out-of-pocket maximum for the new benefit year.

Out-of-pocket maximum

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

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

- Premiums
- Member costs that are more than the allowed amount for covered services paid by the plan to non-network providers, and
- Costs for non-covered services

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

- **Individual out-of-pocket maximum:** The maximum amount of cost-sharing an individual is required to pay in a benefit year for most covered services.
- **Family out-of-pocket maximum:**
    - All amounts any members in a family pay toward their individual 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
    - Once the family out-of-pocket maximum has been met during the benefit year, all family

members will thereafter have satisfied their individual out-of-pocket maximum for the remainder of that benefit year

*If you enroll in a Health Savings Account (HSA) plan, and you select family coverage, there is no individual out-of-pocket maximum.

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.

Benefit year

The benefit year is the consecutive 12-month period during which benefits are purchased and administered, deductibles, coinsurance, and the out-of-pocket maximums are calculated, and most benefit limits apply. The benefit year starts on January 1 and ends in the same year on December 31. 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.

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. Benefit limits apply to the following services:

- Chiropractor Care: Coverage includes up to 12 visits per benefit year
- Hearing Aids: 1 hearing aid per ear is covered
- Pediatric Vision: One pair of frames and lenses per benefit year. Contact lenses are covered once per benefit year instead of eyeglasses
- Habilitation Services: Up to 20 visits per benefit year for each type of therapy, including Physical, Occupational, and Speech therapy
- Rehabilitation Services: Up to 20 visits per benefit year for each type of therapy, including Physical, Occupational, and Speech therapy

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 can call Member Service at toll-free at 855-833-8122. You can also make 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. Coverage is based on meeting all the applicable rules in this EOC. (For example, you must be a member of the plan on the date the service is given to you.) There is no coverage for non-covered services.

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

Chapter 2. How the plan works

Your benefits and the role of a Primary Care Provider

Benefit packages

WellSense Clarity NH plan (the "plan") has different benefit packages. Benefit packages differ in premium and cost-sharing. The specific covered services, 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 plan, you must choose a primary care provider (PCP). You may choose any PCP who is available to see you and accepts your plan. A PCP may be a doctor of internal medicine, family practice, general practice or pediatric medicine, or may be a physician assistant or nurse practitioner. Each member of a family may choose a different PCP. Network pediatricians can be chosen as a PCP for a child. (This is a PCP who specializes in treating children.) Female members may select a designated network obstetrician/gynecologist (OB/GYN) as their PCP. PCPs provide routine, non-routine, and preventive health care.

Routine care is defined as 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. Non-routine or diagnostic 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 plan is required to provide pursuant to New Hampshire or federal law. PCPs can arrange and coordinate your care with other network providers. PCPs or their covering providers are available 24 hours a day. You can select your PCP by entering their name on your enrollment application or by calling Member Service. You must obtain all primary care from your designated PCP.

Assignment of PCP for members enrolled in certain benefit packages

If you do not select a PCP, the plan will assign a PCP to you. This assignment is based on your zip code and may also be based, in our judgment, on other relevant information we get from you and from other records. If you are assigned a PCP, we will tell you the PCP's name. You must obtain all primary care from your assigned PCP. If you wish to change your assigned PCP, see "Changing Your PCP," below.

PCPs are listed in the 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 can also call Member Service at 855-833-8122, and we will provide you with a list of providers in your area. The most up-to-date version of the Provider Directory is on our website: wellsense.org. For help selecting a PCP, call Member Service.

Visiting your PCP

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

Note: Your previous doctor may charge you for copies.

Changing your PCP

You may change your PCP at any time, but no more than three times (if it is a voluntary change) in a benefit year. To change your PCP, select a new one from the Provider Directory, then call Member 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, the plan will require you to change your PCP. If this happens, you must choose a new PCP by calling Member Service or by updating your PCP through the member portal. This can happen if your PCP is no longer a network provider. In this case, the plan will notify you in writing. We will do our best to give you notice at least 30 days before your PCP leaves the provider network. In some cases, you may receive continued coverage of services from your prior PCP for at least 30 days after your PCP leaves the provider network. (See "Continuity of Care for Existing Members" later in this Chapter.)

Your PCP provides and arranges for 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

Getting care from specialty or out-of-network providers

When you need specialty care

If you think you need specialty care, we encourage you to first call your PCP. Your PCP can tell you whether you need specialty care and can refer you to an appropriate network specialist. Or you can self-refer by going to a network specialist on your own. Refer to the list of services you can get without getting approval in advance from your PCP or plan. Example: Members may self-refer to any OB/GYN in our network.

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 plan will pay for these covered services as if they had been provided by a network provider in accordance with state and federal law. Please contact Member 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 plan may arrange for you to see a non-network provider. Your PCP must first get prior authorization from a plan authorized reviewer. (If you are authorized to see a non-network provider, your applicable cost-sharing does not change.) The plan authorized reviewer considers several important factors when evaluating a request to authorize care at a non-network provider. These include: your specific medical needs; the medical necessity of the requested covered service or provider; cost-effectiveness of the non-network options; quality, and access
- If you are an American Indian or Alaska Native (AI/AN) of a federally recognized tribe or another individual determined eligible for Indian health care services, special coverage rules apply. You may get out -of-network services at an Indian health facility without prior authorization. Contact Member Service for more information (phone numbers are printed on the back cover of this handbook)

Get help finding network providers

You may request assistance from the plan if you or your PCP has difficulty identifying network providers who can provide you with medically necessary services. If you ask us, we will identify and confirm the availability of these services directly. This information is also available on the plan's website and through the member portal, in addition to calling Member Service. 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.

If you need after-hours care, you can also call our Nurse Advice Line, as they can answer questions and

possibly save you a trip to the emergency department or urgent care. If you are unable to see your PCP, you can go to an Urgent Care Center. They provide care for injuries or illnesses that require immediate attention but are not serious enough to require an emergency department visit. You do not have to call your PCP before seeking emergency care. See "Emergency Services" later in this Chapter.

Canceling provider appointments

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

No waiting period or pre-existing condition limitations

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

The provider network

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

Your provider network: As a member, you must get all your care from providers who are in our provider network. When using the provider search tool on our website (see next paragraph) or when requesting a paper copy of the plan's Provider Directory, please be sure to check the correct provider network for the benefit plan in which you are enrolled (WellSense NH Clarity plan).

Provider Directory: The Provider Directory lists our network providers. These include PCPs, physician specialists, other health care professionals, outpatient birthing centers, 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, telehealth availability, 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 855-833-8122. 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 Office of Professional Licensure and Certification (OPLC) at oplc.nh.gov. Information about individual licenses can be found at forms.nh.gov/license verification.

Changes to provider network: Sometimes, providers in your provider network may change during the year. Changes can occur for a number of reasons: a provider may move outside of the service area; retire; or fail to continue to meet our credentialing or other contract requirements. Also, WellSense and the provider might not reach agreement on a contract. This means that we cannot guarantee that any particular provider will continue to be a network provider during the entire time you are a member. If

your PCP leaves the network, we will make every effort to notify you at least 30 days in advance. Member Service can help you select a new PCP.

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

Nurse Practitioners, 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 a certified registered nurse anesthetist. This means the plan provides you with the same coverage whether the service was given to you by a network nurse practitioner or by another network provider. The covered services provided by these providers must be within the lawful scope of their license and/or authorization to practice.

Emergency services

What to do in an emergency

You are always covered for care in an emergency. You do not need prior authorization or a referral from your PCP. (This includes emergency mental health or substance use disorder services). In an emergency, whether you are inside or outside the service area, go to the nearest emergency facility, call 911 or another local emergency number, or, in a mental health or substance use emergency or crisis situation, go to the nearest Community Mental Health Center (CMHC) or emergency medical facility. The plan 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 as a result of an emergency.

If you or someone you know is in need of emotional or mental health supports/services (or if there is a risk of suicide), call, text, or chat 988 – the Mental Health Lifeline 24 hours a day, 7 days a week to connect with a trained crisis counselor.

The Lifeline provides free and confidential emotional support to people in suicidal crisis or emotional distress. You can also call or text the toll-free NH Rapid Response Access Point at 1- 833-710-6477, anytime day or night. Crisis response services are available over the phone, by text, or face-to-face.

Cost-Sharing

- 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
- Cost-sharing for emergency services is waived if you are admitted as an inpatient immediately following receipt of emergency services in an emergency room. However, any applicable cost-sharing for inpatient hospital care will apply to your inpatient stay

If you get emergency covered services from a non-network hospital emergency room, the plan will pay up to the allowed amount. You pay applicable cost-sharing.

What qualifies as an emergency

An emergency means health care services that are provided to an enrollee, insured, or subscriber in an emergency department of a hospital or in an independent freestanding emergency department by a provider after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity that a prudent layperson with average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could result in any of the following:

- Serious jeopardy to the patient's health
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Notice following emergency care

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

Transferring to a network facility after an emergency

If you receive emergency care from a non-network provider continued services with that provider after the emergency condition has been treated and stabilized may not be covered if the plan determines, in coordination with your providers, that it is safe, appropriate and cost-effective for you to be transported to a network facility and you choose not to go to the network facility.

Coverage for care when you are outside the service area

- If you are outside the service area and you get hurt or sick, the plan will pay for medically necessary covered services for urgent care that you receive from non-network providers. (Please see “Emergency Services”, above, for coverage of emergency care when you are outside the service area)
- We recommend, but you are not required, to call your PCP for guidance, when appropriate, prior to seeking urgent care

- 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 services outside the United States and its territories but not to return you to the service area after your emergent 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, except as described in the Continuity of Care section within this EOC

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 receive urgent care from a non-network provider, the plan will pay up to the allowed amount. You pay applicable cost-sharing and, in some cases, any difference between the provider's charge and our payment (balance billing)

Inpatient hospital care

- Except in an emergency, always call your PCP or behavioral health provider first before going to a hospital
- If you need hospital care, your PCP or behavioral health provider 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 or behavioral health provider may arrange for you to go to a non-network hospital. In such case your PCP or behavioral health provider must obtain prior authorization from a plan authorized reviewer

Charges after the discharge hour

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

Continuity of Care

Continuity of Care for existing members:

- **Disenrollment of PCP:** If you are a member whose PCP leaves the network, we will use our best efforts to provide you with written notice at least 30 days prior to the date your PCP leaves. That

notice will tell you how to choose a new PCP. Unless your PCP was disenrolled due to fraud or quality of care concerns, we will continue to pay for covered services from the disenrolled PCP, under the terms of this Evidence of Coverage (EOC), for at least 30 days after the disenrollment date

- **Disenrollment of PCP, specialist or other provider:** If you are a member whose PCP, specialist or other provider leaves the network (for reasons other than fraud or quality of care) and you are (1) undergoing active treatment for a serious and complex chronic behavioral health or medical condition 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 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). If you are pregnant at the start of your coverage and you are in your second or third trimester (13 weeks or more), maternity care benefits will be covered at the in-network level – even if you receive care from an out of network provider
- **Terminal Illness:** If you are a member with a terminal illness (having a life expectancy of 6 months or less) and the network provider you are seeing in connection with your illness is disenrolled from the plan (for reasons other than fraud or quality of care): you may continue to receive coverage for covered services provided by that provider, under the terms of this EOC, until death

Note: Not covered for new enrollees

Electing Continuity of Care:

To learn about continuity of care coverage described above, call Member Service. They can explain what is covered under this benefit, however prior authorization may need to be submitted by your provider.

Conditions for coverage of Continuity of Care as described in this section

Services provided by a disenrolled provider or non-network provider as described in this "Continuity of Care" section are covered only when the member or provider obtains prior approval from the plan for the continued services, the services would otherwise be covered services under this EOC, and the provider agrees to:

- Accept payment from the plan at the rates we pay network providers, or as otherwise required by state or federal law
- Accept such payment as payment in full and not charge you anymore than you would have paid in cost-sharing if the provider was a network provider
- Comply with the plan's quality standards
- Provide the plan with necessary medical information related to the care provided, and
- Comply with the plan's policies and procedures: these include procedures regarding obtaining prior

authorization, and providing covered services pursuant to a treatment plan if any, approved by the plan

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 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 in itself is not enough to entitle you to plan benefits. To be entitled to plan benefits, you must be a properly enrolled member at the time you receive health care services.

Chapter 3. Covered services

This chapter describes:

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

Cost-sharing

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

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

When prior approval is needed before getting a service

Prior Authorization from WellSense authorized reviewer

There are certain covered services – both inpatient and outpatient – that must be authorized (approved) in advance by a plan authorized reviewer. These requirements are known as "prior authorization." Your network provider will request prior authorization from the plan on your behalf. The plan authorized reviewer will: review your request within legally set timeframes and determine if the proposed service should be covered as medically necessary for you. The plan will then tell your provider and you if coverage for a proposed service has been approved or denied. To check on the status of a request or the outcome of a prior authorization decision: call your provider or call the plan at 855-833-8122.

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

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

Examples of covered services that may require prior authorization

- High-tech imaging. For example: CT/CTA, MRI/MRA, PET, and NCI/NPI (nuclear cardiac imaging)
- Musculoskeletal (MSK) (Spine, Join, Interventional Pain)
- Genetic testing (lab management)
- Durable medical equipment and orthotics
- Prosthetics
- Medical formulas
- Low protein food
- Home health care

- Infertility treatment
- Services to treat gender identity disorder and gender incongruence
    - New Hampshire law restricts certain medical treatments for individuals under the age of 18. This includes procedures such as breast surgery and medications intended to change a minor's gender or delay puberty. Specifically, NH law prohibits gender-affirming chest surgeries for minors, explicitly preventing transgender chest surgery for gender transition purposes while still permitting medically necessary breast surgeries for other conditions such as injury or malignancy
- Non-emergency inpatient admissions and some elective surgeries
- Skilled nursing-based services
- Inpatient rehab services
- Nutritional counseling
- Organ transplants
- Outpatient rehabilitation therapy services. Including physical therapy, occupational therapy, and speech therapy
- Certain prescription drugs from a pharmacy or that are given to you (by injection or infusion)
- Certain behavioral health services

These are examples of services that may require prior authorization. Please check with your provider or call Member Service, for more information about specific services, supplies, and drugs subject to prior authorization on the date of service. From time to time, the plan may change the services subject to prior authorization.

Prior authorization requirements for court-ordered services (for minors)

The provider, member or the member's representative must request prior authorization for any services requiring prior authorization, within 48 hours of the effective date of a court-ordered service, placement, or program. The determination of this request for a minor shall be made as soon as possible, taking into account the medical urgency, but no later than 48 hours after receipt of the request as long as all necessary information is supplied. If more information is needed, the plan will contact the provider, member or the member's representative within 24 hours of receipt of the original request. The plan will allow the provider, member or the member's representative a reasonable amount of time to respond. The provider, member or the member's representative will have no less than 48 hours to provide the necessary information.

The health plan then will make a determination no later than 48 hours after the earlier of:

- The plan's receipt of the requested information, or
- The end of the time period allotted to the provider, member, or the member's representative to provide the additional information

Basic requirements for coverage

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

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

Essential health benefits

Essential Health Benefits are defined by federal and state law and refer to benefits in at least the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care. Essential Health Benefits provided within this contract are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, may be subject to either a lifetime and/or annual dollar maximum.

Inpatient services

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 days as medically necessary. This includes:

- Semi-private room and board (private room covered only when medically necessary)
- Anesthesia
- Chemotherapy and radiation therapy
- Doctor's visits and specialist consults, while you are inpatient
- Diagnostic tests (for example: lab, x-ray, and other imaging tests)
- Dialysis
- Intensive\cardiac care
- Lab and imaging services
- Medication administered during inpatient care
- Nursing care
- Physical therapy
- Occupational therapy
- Speech therapy
- Cardiac therapy
- Respiratory therapy

- Surgery, includes the following:

Bariatric surgery

Benefits are available for bariatric surgery that is medically necessary when ordered by your physician. The plan covers treatment for diseases and ailments caused by obesity when deemed medically necessary, if the treatment meets the guidelines set by the American Society for Metabolic and Bariatric Surgery or the American College of Surgeons. Medically necessary bariatric surgery may include, but is not limited to, the following services:

- Preoperative psychiatric screening and counseling
- Behavior modification
- Weight loss
- Exercise regimens
- Nutritional counseling, and
- Post-operative follow-up, including advice on diet, exercise, and lifestyle changes

The member must be at least 18 years of age. Coverage for these treatments will follow the same rules and limits as other similar medical treatments in your plan.

Weight loss programs are not included in your benefits, regardless of medical supervision, unless such programs are specifically identified as a covered service within this EOC. See the "Exclusions from covered services" section for further information.

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, or
- 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 the implant (such as a breast implant rupture).

Related exclusions to post-mastectomy services

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

Human organ transplants

The Clarity plan covers:

- Bone marrow transplants. This includes members diagnosed with breast cancer that have progressed to metastatic disease. Members must meet the criteria established by the plan and any applicable state laws/requirements
- Solid human organ transplants provided to members
- Hematopoietic stem cell transplants provided to members

You must be approved by the transplant facility as a candidate for the recommended transplant. Transplant services must also be approved by a plan authorized reviewer and provided at a network or preferred transplant facility. Network transplant facilities may include facilities that are out of the service area. In such case, the plan will pay for 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

Upon notification to the plan by a member or provider of a member's pregnancy, the member will receive written information outlining available benefits related to prenatal, maternity, and postpartum care. This includes details on prenatal appointments, diagnostic testing, prenatal education, hospital stay coverage, postpartum services, homemaker support, and contraceptive counseling and referrals.

The Clarity plan covers:

- Prenatal and postpartum homemaker services. Coverage is available for homemaker services only when deemed medically necessary. For instance, if a physician orders bed rest or places restrictions on daily activities, these services may qualify as medically necessary. In such cases, the physician will coordinate with WellSense's case manager to determine the necessity of the services. Non-medically necessary homemaker visits are not covered
- Hospital and delivery services for the mother
  Note: The mother's inpatient stay is covered for at least: 48 hours following a vaginal delivery, and 96 hours following a caesarean delivery. Decisions to reduce the mother and child's inpatient stay

are made only by the attending physician and mother (and not by the plan)
- Routine nursery charges for a healthy newborn*
- Well newborn care.* This includes pediatric care, routine circumcision furnished by a physician, and newborn hearing screening tests performed by a network provider before the newborn child (an infant under three months of age) is discharged from the hospital. 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.

*For newborns, we cover routine nursery charges and well newborn care as well as all medically necessary services up to 31 days after the date of birth. The newborn must be enrolled in the plan, effective as of the date of birth, within 60 days of date of birth in order for the plan to continue coverage beyond such 31-day period.

For inpatient mental health and substance use disorder services

See "Mental Health and Substance Use Disorder Services" later in this Chapter 3.

Extended care

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

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

Related exclusions to all inpatient care:

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

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

Inpatient physician and surgical services

The Clarity plan covers the services of physicians, surgeons, assistant surgeons, anesthesiologists, etc., as part of your inpatient hospital stay. Cost-sharing for these professional services are listed in your Schedule of Benefits.

Outpatient services

Abortion

The Clarity plan covers:

- Termination of pregnancy when the life of the mother is endangered or when the pregnancy is the result of rape or incest

Allergy services

The Clarity plan covers:

- Allergy testing, including sensitivity tests (limited to 1 per benefit year) and blood and pulmonary function tests (limited to 3 per benefit year)
- Allergy treatment
- Allergy injections

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, 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 and treatment of pervasive development disorders

The Clarity plan covers:

- Outpatient office visits
- Outpatient rehabilitation (physical, occupational, speech therapy and social work visits) as medically necessary
- Lab tests and other diagnostic tests
- Outpatient habilitation services as medically necessary
- Applied behavior analysis therapy

Breast examinations

The Clarity plan covers breast examinations, including MRI and/or ultrasound, for preventive, diagnostic and supplemental examinations, with no cost-sharing, except for plans that fall under a High-Deductible Health Plan (HDHP) benefit plan*. A diagnostic breast exam is used to diagnose an abnormality seen from a breast cancer screening or examination or another means of examination. A supplemental exam is used when there is no abnormality seen or suspected and there is a personal or family medical history or other factors that may increase an individual's risk of breast cancer.

*For plans that meet the definition of High-Deductible Health Plan's, the deductible will still have to be met, except for preventive exams and screenings, before the cost-sharing for all other examinations is waived.

Cardiac rehabilitation

The Clarity plan covers:

- Cardiac rehabilitation services, such as exercise, education, and counseling
- Intensive cardiac rehabilitation programs

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 up to 12 visits a benefit year for musculoskeletal adjustments and spinal manipulations when they are furnished by a licensed chiropractor.

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 under the terms and conditions provided for under New Hampshire state and federal law. This includes clinical trials that are approved by one of the National Institutes of Health, the Food and Drug Administration, and any other state or federal agency authorized by law to approve clinical trials.

Coverage is provided for all medically necessary routine care costs incurred as a result of treatment being provided with a clinical trial for the treatment of your condition consistent with the study protocol of the clinical trial and for which coverage is otherwise available under the plan.

Dental services

The Clarity plan does not cover most dental services. Coverage under this plan is limited to the following limited Dental Care described below:

Dental care for accidental injury

The Clarity plan will cover medically necessary dental care as a result of an injury to sound natural teeth and gums. This would not include injury to teeth as a result of chewing, grinding of teeth, or other types of normal activities of daily living or extraordinary use of the teeth. Treatment must be sought or provided within 3 months of the date of the injury.

Hospital and anesthesia charges for dental procedures that must be done in a hospital or outpatient surgery

The Clarity plan will cover the hospital and anesthesia services in a hospital or outpatient surgical setting for members under the age of 13 due to a member having a significant dental condition or a medical condition, behavioral condition, or a developmental disability, that would place the member at serious risk or prohibit the services being done in a dentist's office.

Preparing the mouth for medical treatments

The Clarity plan will cover dental services necessary to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and prepare for transplants. Covered services include:

- Evaluation
- Dental x-rays
- Extractions, including surgical extractions, and
- Anesthesia

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 plan's lab benefit, the plan covers diabetes lab tests, including glycosylated hemoglobin, or HbA1c, tests, and urinary protein/microalbumin and lipid profiles

- Under the plan's durable medical equipment benefit, the plan covers insulin pumps and insulin pump supplies as well as infusion devices, insulin needles and syringes, diabetic test strips and lancets, blood glucose monitors for home use, voice-synthesizers when medically necessary for home use for the legally blind
- Visual magnifying aids when medically necessary for home use for the legally blind
- Under the plan's prosthetics benefit, the plan covers: therapeutic and molded shoes and shoe inserts for severe diabetic foot disease. Shoes/shoe inserts must be prescribed by a network podiatrist or other qualified doctor, and furnished by a network podiatrist, orthotist, prosthetist or pedorthist
- Under the plan's prescription drug benefit, the plan covers: prescribed oral diabetes medications that influence blood sugar levels, insulin, insulin needles and syringes, insulin pens, lancets, blood glucose, urine glucose, and ketone monitoring strips
- Insulin is covered at the cost-sharing indicated in the member's Schedule of Benefits, however, the cost-sharing will not exceed $30 copayment per 30-day prescription

Note regarding diabetes supplies:

Certain diabetes supplies are covered when obtained through a contracted pharmacy such as test strips, lancets, continuous glucose monitors and supplies. Prior approval is required for coverage of continuous glucose monitors.

Dialysis

The Clarity plan covers the following:

- Inpatient kidney dialysis
- Outpatient kidney dialysis in a network hospital, or free-standing dialysis facility
- Home dialysis. This includes non-durable medical supplies such as dialysis membrane and solution, tubing and drugs needed during dialysis, and the cost to install, maintain or fix dialysis equipment. The plan decides whether to rent or buy the equipment
- If you are traveling outside the service area, the plan covers dialysis for up to one month per benefit year. You must first make advance arrangements with your network provider; and your network provider must obtain prior approval from a plan authorized reviewer

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

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

Durable Medical Equipment and Orthotics (DME)

The Clarity plan covers medically necessary DME. The DME must be prescribed by a network physician. The plan will decide whether to rent or buy the DME. The DME must be purchased or rented from a network provider. (See also, "Prosthetics" further in this Chapter).

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

- Able to withstand repeated use
- Reasonable and necessary to sustain a minimum threshold of independent daily living
- Used primarily to serve a medical purpose
- Not generally useful in the absence of disease or injury
- Able to be used in the home, and
- Medically necessary for you

Coverage for DME is available only for:

- The least costly DME, adequate to allow you to engage in activities of daily living. If the plan decides that you chose DME that costs more than the least costly DME adequate to allow you to engage in activities of daily living, the plan will pay only for those costs that would have been paid for the least costly DME that meets your needs. In this case, you will have to pay the provider's charges that are more than the plan's allowed amount (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 covered DME

The following are examples of covered DME:

- Wheelchairs
- Crutches, canes, walkers
- Respiratory and oxygen equipment
- Hospital beds
- Insulin pumps and insulin pump supplies, blood glucose monitors for home use, voice- synthesizers when medically necessary for home use for the legally blind
- Certain types of braces
- Non-foot or non-shoe orthotics, such as those used as part of a brace or prosthetic
- Breast pumps and related supplies (covered under the "Preventive Health Services" benefit below)

Note regarding diabetes supplies

Certain diabetes supplies are covered when obtained through a contracted pharmacy such as test strips, lancets, continuous glucose monitors and supplies. Prior approval is required for continuous glucose monitors.

The following are examples of non-covered DME:

- Comfort or convenience items
- Heating pads, hot water bottles
- Foot and shoe orthotics (over the counter and custom), 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

Early intervention services

The Clarity plan covers early intervention services provided by a network provider for children with a development disability or delay. This benefit is only for members through the age of 2 (up to the age of 36 months) who meet established criteria. There is no cost-sharing. Early intervention services are covered when provided by the following providers:

- Physical therapists
- Speech-language pathologists
- Occupational therapists
- Clinical social workers

Benefit limits applicable to rehabilitation and habilitation therapies do 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, regardless of the provider's network status. 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 another local emergency number
- The plan provides coverage for post-stabilization services. These are covered services that are needed to stabilize your condition following an emergency until such time as your treating physician determines you are sufficiently stabilized for transfer or discharge
- If you need follow-up care after you are treated in an emergency room, you should call your PCP. Your PCP can provide or arrange the care you need
- Emergency Room Boarding is covered while the member is waiting in an acute care medical hospital located in the State of New Hampshire for up to 21 calendar days or discharge, whichever is sooner

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

Emergency defined

See "Appendix A" for the definition of emergency.

Notice to PCP or 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 the plan within 2 working days of admission. This is essential so that the plan can manage and coordinate your care and arrange for any medically appropriate transfer. Note: Notice by the provider of emergency services to your PCP, the plan or, in the case of emergency mental health or substance use disorder services, satisfies your requirement to notify the plan.

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. The plan will not pay for inpatient care provided in the facility to which you were first admitted after your PCP determined that a transfer is medically appropriate, and transfer arrangements have been made.

Family planning services

The 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:

- Family planning consultation(s)
- Diagnostic tests
- Pregnancy testing
- Birth control counseling and contraceptive monitoring
- Genetic testing and related counseling for certain genetically linked inheritable disorders, when the results of the testing will directly affect the care you receive. The member must either have a direct risk factor for, or have symptoms of, the disorder
- Prescription and non-prescription contraceptives when given to you by a network provider during an office visit. Examples are implantable contraceptives, intrauterine devices, diaphragms, cervical caps, injectable birth control drugs, and other medically necessary contraceptive devices that have been approved by the U.S. Food and Drug Administration

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.

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)

Habilitative services and devices

See Rehabilitation Services further in this Chapter.

Hearing aids

The Clarity plan provides coverage for hearing aids to the extent required by New Hampshire law. Coverage is provided for the cost of one hearing aid for each hearing- impaired ear, as needed, as well as 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 Exclusions

Hearing aid batteries and cleaning fluid are not covered.

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, and
- There is a defined medical goal set by your PCP that he or she reasonably expects you will meet

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

- Part time skilled nursing visits for as many visits as medically necessary
- Part time physical, occupational and speech therapy, when these services are a medically necessary component of skilled nursing, and they are needed to restore function lost or impaired due to your illness or injury
- Medical social work
- Nutritional 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 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

- Housekeeping services
- Household repairs
- Meals
- Respite care
- Private duty nursing
- Personal care attendants
- Homemakers, except as described within this EOC

Hospice services

The Clarity plan covers the hospice services described below. Coverage is for members who are terminally ill. (Terminally ill means having a life expectancy of six months or less as certified by a network physician.)

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

- In a home setting
- On an outpatient basis, or
- On a short-term inpatient basis (this is only when medically necessary to control pain and manage acute and severe clinical problems that cannot, for medical reasons, be managed in a home setting)

Covered services provided by the hospice agency may include the following:

- 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 caregiving functions)
- Volunteer services
- Counseling services (bereavement counseling for the member's family is covered for up to one year following the member's death)
- Private duty nursing
- Personal care attendant services

In addition:

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

House calls

The Clarity plan covers house calls when medically necessary. Providers include PCPs, nurse practitioners and physicians' assistants. House calls are subject to the applicable office visit cost-

sharing. Your PCP must arrange for house calls.

Immunizations

The Clarity plan covers:

- Preventive immunizations (see "Preventive Health Services")
- Medically necessary immunizations

Infertility treatment

The Clarity plan covers diagnostic services to identify and treat the causes of infertility. Covered services may include:

- Consultation with plan providers
- Evaluation
- Diagnostic procedures and laboratory tests
- Medically necessary treatment and surgical procedures to treat the underlying cause of the infertility

Infertility treatment to promote the conception resulting in a diagnosis of pregnancy is not covered. This includes services such as artificial insemination (AI), intra-uterine insemination (IUI) and in-vitro fertilization (IVF) as non-covered services.

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 plan authorized reviewer.

- Diagnostic laboratory tests
    - **Examples:** Glycosylated hemoglobin (HgbA1C) tests; urinary protein/microalbumin tests; lipid profiles to diagnose and treat diabetes; and other tests, such as blood lead testing
    - Perfluoroalkyls (PFAS) and Perfluorinated Compound (PFC) blood testing
    - Blood-lead testing: no cost-sharing applies to the preventive or follow-up blood test(s)
- 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 state guidelines

Long-term antibiotic therapy

The Clarity plan covers long-term antibiotic therapy for a member with a Tick-Borne Illness 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 acids 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
- Services in a licensed healthcare facility or at home and within the scope of practice of a certified midwife

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

Medical drugs

The Clarity plan covers the following:

- Medical drugs when used in the treatment of covered conditions. Medical drugs are administered by physicians in outpatient settings
- Prior Authorization may be required. Coverage updates are made throughout the year. The online services and code tool is updated to reflect prior authorization requirements. Go to the plan's website (wellsense.org) or call Member Service at 855-833-8122 to find out whether a medical drug is covered

Medical drug management

The plan contracts with a separate organization, to administer its medical drug management requirements. See the Address and Telephone Directory in the front of this EOC for more information.

Medical formulas

The Clarity plan covers the following to the extent required by NH law:

- Coverage is provided for non-prescription enteral formulas, ordered by a physician for home use, for persons with inherited diseases of amino acids and organic acids
- Coverage is provided for the treatment of impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, or motility of the gastrointestinal tract

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 and
- 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.

How to get care

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

- Go directly to a network provider who provides mental health or substance use disorder services
- Call the plan's toll-free mental health/substance use disorder telephone line at 855-833-8122 for help finding a network provider
- Call your PCP for help finding a network provider
- Visit the plan's website (wellsense.org) to look up network providers In an emergency or crisis:
- If you or someone you know is in need of emotional or mental health support/services (or if there is a risk of suicide), call, text, or chat 988 – the Suicide & Crisis Lifeline 24 hours a day, 7 days a week to connect with a trained crisis counselor. The Lifeline provides free and confidential emotional support to people in suicidal crisis or emotional distress
- Call or text the toll-free NH Rapid Response Access Point at 1-833-710-6477, anytime day or night Crisis response services are available over the phone, by text, or face-to-face
- Go to the nearest Community Mental Health Center (CMHC) or emergency medical facility or
- Call 911 or local number for emergency services

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:

- Under New Hampshire law, we cover medically necessary treatment of Serious Mental Illness including Biologically based mental disorders, at the same level as any other medical condition. These diagnoses include schizophrenia and other psychotic disorders, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia, panic disorder, obsessive-compulsive disorder including pediatric autoimmune neuropsychiatric disorders (PANS/PANDAS – covered when provided by contracted WellSense providers), delirium and dementia, affective disorders, eating disorders, post-traumatic stress disorder, substance use disorders, pervasive developmental disorder or autism, and other psychotic disorders or other biologically– based mental disorders

Treatment for PANS/PANDAS may include intravenous immunoglobulin therapy (IVIG) when ordered by a physician.

- Coverage for other conditions as listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (except for those conditions designated by a "Z Code"). Services can be provided by the following providers:
    - Licensed mental health counselors (LMHC)
    - Licensed alcohol and drug counselors (LADC)

- Master licensed drug and alcohol counselor (MLADC)
- Licensed independent clinical social workers (LICSW)
- Licensed psychiatric nurses who are certified as clinical specialists in psychiatric and mental health nursing
- Licensed marriage and family therapists
- Psychiatrists
- Psychologists
- Community mental health center (CMHC)
- Certified Community Behavioral Health Center (CCBHC)
- Licensed psychotherapy provider
- Federally qualified health center (FQHC)
- Rural health center (RHC), and
- Outpatient mental health facilities

- Mental Health and Substance Use Disorder Treatment
- Inpatient services include:
  - Mental Health services
  - Substance Use Disorder services
  - Eating Disorder services
- Detoxification services
- Partial Hospitalization Services
- Outpatient services include:
  - Crisis intervention services
  - Substance use disorder services
  - Detoxification services
  - Medication management
  - Medication-assisted treatment
  - Treatment for opioid use disorder
  - Psychological testing
  - Individual, group and family therapy
  - Diagnostic evaluations
  - Intensive outpatient program (IOP)
  - Emergency psychiatric and psychotherapy services
  - Electroconvulsive therapy (ECT)
  - Transcranial magnetic stimulation
  - Crisis intervention and related post-stabilization services
  - Services for Mental and Nervous Conditions and treatment for Chemical Dependency – as required by state law. Benefits are for 2 visits to determine a diagnosis and up to 3 treatment visits each year without prior authorization. Services may not be denied solely because they are ordered by a court

Mental health and substance use disorder exclusions

- Custodial care
- Psychoanalysis
- Hypnotherapy
- Massage and relaxation therapies
- Developmental testing
- Services for problems of school performance
- Educational services or testing services
- Behavioral health services provided to a member who is in jail, a house of correction, prison or custodial facility
- Long term residential treatment

Prior authorization

- Coverage for certain mental health services are subject to prior authorization by a plan authorized reviewer
- No prior authorization is required for short-term inpatient withdrawal management or the first 2 routine outpatient visits for substance use disorder. Other Substance Use Disorder services may require prior authorization by a plan authorized licensed clinician. Please contact the plan at 855-833-8122 with any questions
- Always check with your provider to make sure they have obtained 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

Newborn infants and adoptive children services

The Clarity plan covers medically necessary newborn care for newborns and adoptive children properly enrolled in the plan. This includes medically necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, or premature birth for 31 days after the newborn's birth. In order for coverage to continue after 60 days, the newborn needs to be enrolled as a dependent on the plan. 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.

Newborn Hearing Screenings are covered by the plan and include both the newborn hearing screening and diagnostic hearing evaluation for cytomegalovirus (CMV) screenings for any infant who does not pass the final newborn hearing screening, as long as the newborn's parent agrees to such screenings.

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.

Observation services

The Clarity plan covers short-term treatment, assessment and reassessment for up to 48 hours of observation in an acute care facility to determine if a member needs admission for additional treatment or if the member can be discharged from the hospital.

Oral surgery

The Clarity plan covers the following medically necessary services; treatment of cleft lip, cleft palate, orthognathic surgery when needed to correct the function of upper or lower jaw abnormalities, treatment and/or surgery of tumors and biopsies or incision and drainage of infections of soft tissue.

Orthotics

See "Durable Medical Equipment" earlier in this Chapter.

Ostomy supplies

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
- 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. An office visit is subject to cost-sharing. During your office visit, you may be provided with other services such as labs, immunizations, x-rays, or other services that are subject to separate cost-sharing.

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:

- Therapeutic termination of pregnancy (abortions), as described previously described in this document
- Male voluntary sterilizations (See "Preventive Health Services," below, for female voluntary sterilization)
- Diagnostic procedures. **Examples**: a colonoscopy or endoscopy

Pediatric vision (ages 18 and under)

The Clarity plan covers routine and non-routine vision services as well as vision hardware. Please see the Schedule of Benefits under Pediatric Vision for details on the vision hardware available under this benefit. Please see the Schedule of Benefits under Preventive Services and Vision Services for details on the eye exams and other services covered by the Plan.

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 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, and the online formulary is updated as changes are made.

Members who may be affected by formulary changes will be notified via mail, unless the change is beneficial to the member. If you have filled a prescription for a drug that is being removed from the formulary, you will receive a written notice at least 60 days before the change takes effect, unless the U.S. Food and Drug Administration (FDA) determines the drug is unsafe. The notice will explain how to request coverage for a medically necessary non-formulary drug through the plan's exception process and will include a toll-free Member Service number for more information. If you request an exception, your medication will continue to be covered until a decision is made. If your exception request is denied, you have the right to appeal the decision.

Go to the plan's website (wellsense.org) or call Member Service at 855-833-8122 to find out whether a drug is covered or to learn more about the exception process.

Conditions of Coverage

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

- 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, pregnancy, or for preventive care purposes

Cost-sharing

See your Schedule of Benefits for prescription drug cost-sharing.

Where to get your prescription drugs

Take your prescription or refill to any network pharmacy. Bring your ID card and pay the applicable cost-sharing.

- Network pharmacies includes many retail pharmacies in New Hampshire. For a list of network pharmacies, see the Pharmacy Directory on our website at wellsense.org or call Member Service at 855-833-8122
- Specialty pharmacy providers: For certain drugs, the plan contracts with one or more specialty pharmacy
- providers (see below under "Pharmacy Programs" for more information about specialty pharmacy providers)

How to obtain mail order drugs

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. To enroll in this service and begin receiving medications in the mail, you must either contact Cornerstone Health Solutions by phone at 844-319-7588 or complete the mail order enrollment form that was included in your member welcome packet, and is also available on the Cornerstone Health Solutions website, as well as wellsense.org. Your prescribing provider may also call Cornerstone Health Solutions at 844-319- 7588 or fax your prescription to them at 781-805-8221. Once you have enrolled, you can refill prescriptions by mail, phone, or online at cornerstonehealthsolutions.org/chs-mail-order- pharmacy. Please refer to the Schedule of Benefits for cost-sharing information. Mail order does not apply to Tier 4, specialty prescription drugs.

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 plan. The 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 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
- Drugs to stop smoking and treat tobacco addiction. These are covered only when your provider has given you a prescription that meets all legal requirements for a prescription. Please check the plan's formulary for coverage information on these drugs
- Hypodermic syringes or needles when medically necessary
- Insulin; insulin pens, insulin needles and syringes; blood glucose, urine glucose and ketone monitoring strips; lancets; and oral diabetes medications only when your provider has given you a prescription that meets all legal requirements for a prescription
- Benefits are available for Prescription Drugs prescribed for off-label use if recognized for treatment of the indication in one of the standard reference compendia; or in the medical literature, as recommended by current American Medical Association policies. However, no benefits are available for a Drug Prescribed for off-label use if the FDA has determined its use to be contraindicated for the prescribed use
- Maintenance Medications are covered up to a 90 day supply obtained at network pharmacies
- Certain compounded medications: as long as one or more active ingredients within the compound requires a prescription by law, is FDA-approved, and covered on the formulary. Note: All active and inactive ingredients must be covered, or pharmacy may enter clarification code to bypass reimbursement for non-covered ingredients
- Epinephrine Auto-Injectors
- Orally administered anti-cancer medications used to kill or slow the growth of cancerous cells. (Cost-sharing does not apply to certain of these medications)
- Opioid Antagonist Medications
- Pre-exposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition (Cost-sharing does not apply to these medications)
- Medication-Assisted Treatment (MAT) Medications
- Coverage for one early refill of a prescription for eye drops if the following criteria are met:
    - (a) For prescription eye drops dispensed as a 30 -day supply, the member requests the refill no earlier than 21 days after the later of the following dates:
        - (1) The date the original prescription was dispensed to the member, or
        - (2) The date that the most recent refill of the prescription was dispensed to the member
    - (b) For prescription eye drops dispensed as a 90 -day supply, the member requests the refill no earlier than 63 days after the later of the following dates:
        - (1) The date the original prescription was dispensed to the member; or
        - (2) The date that the most recent refill of the prescription was dispensed to the member
    - (c) The prescribing health care provider indicated on the original prescription that a specific number of refills are authorized
    - (d) The refill requested by the enrollee does not exceed the number of refills indicated on the original prescription
    - (e) The prescription has not been refilled more than once during the 30-day or 90- day

period prior to the request for an early refill; and
    - (f) The prescription eye drops are a covered benefit under the member's health plan
- Statins and Aspirin are available with no cost-sharing as they are considered preventive medications under the United States Preventive Services Task Force Grade A or B recommendations

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 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 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 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)
    - Prescription drugs used primarily for weight loss or weight maintenance

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

- **Prior authorization**: In the case of certain drugs, the plan requires your physician to obtain prior authorization from a plan authorized reviewer before prescribing the drug. The drugs subject to prior authorization include: certain very expensive drugs; brand name drugs when a generic equivalent is available; and new-to-market drugs that have not yet been reviewed by the plan for coverage
- **Quantity limits:** The plan limits the quantity of certain 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:** The plan has contracts with network specialty pharmacies to provide certain specialized drugs. You must obtain these drugs from one of our network specialty pharmacies

Prescription drug exception requests

If your physician believes it is medically necessary for you to take a prescription drug that is not on our formulary or is restricted by any of the Pharmacy Programs above, he or she should contact the plan and request an exception from a plan authorized reviewer. The exception request must be supported by patient-specific clinical history for plan review. The plan will consider if the drug is medically necessary for you. If so, it will make an exception and cover the drug. For more information, call Member Service. If you are using a contracted network pharmacy and we have given your drug prior approval, you should only have to pay your applicable outpatient prescription drug copayment. However, if, for any reason, you have to pay for your prescription up-front, please contact Member Service at the phone number listed in Chapter 2 and we will instruct you how to submit for reimbursement. Exception requests fall under Tier 3 Non-Specialty Drugs, and Tier 4 Specialty Drugs. The cost-sharing for your specific plan for each of these tiers will apply to the drugs approved as an exception.

Pharmacy Benefit Manager

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

Medical Drug Management

We contract with a separate organization to manage prior authorizations for medical drugs. 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 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 plan, pursuant to New Hampshire 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
- Annual physical exams for children age 6 and older
- Preventive eye exams: One preventive exam per member every 12 months until age 19.
  Note: If you have an existing eye condition, your periodic eye exams are no longer considered preventive and are subject to applicable cost-sharing

Preventive healthcare services for adults

- Annual physical exams (once per benefit year), and related preventive lab tests and x-rays.
  Note: If accompanied by routine tests, they may become subject to applicable cost-sharing
- Preventive immunizations as recommended by the Advisory Committee on Immunization Practices
- Preventive screening tests and procedures. (Example: screening colonoscopies). Note: If these procedures are accompanied by treatment/surgery, they become subject to applicable cost-sharing

*Routine eye examinations for adults are not covered.

Preventive healthcare services for women, including pregnant women

- Annual gynecological exam. This includes a cytologic screening (pap smear) once per benefit year. You must see a network physician (PCP, obstetrician or gynecologist), physician assistant, nurse practitioner, or certified nurse midwife
- Routine prenatal care including one postpartum visit
- Screening by low-dose mammography for all women 35 years of age or older for the presence of occult breast cancer, including:
    - Baseline mammograms for women between the ages of 35 and 40, and
    - Annual screening mammograms once per benefit year for women age 40 and older
- Laboratory tests associated with routine maternity care
- Voluntary sterilization procedures
- Breast pumps and related supplies
- Lactation counseling and support from a trained network provider
- Prescription drug contraceptives (up to a 12-month supply)

- Family Planning services with a network provider

Other preventive health services, screenings, and counseling, as required by New Hampshire or federal law.

Cost-sharing:

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

While 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 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.

*Some court-ordered services may be covered if they are related to medically necessary services for Mental and Nervous Conditions and treatment for Chemical Dependency as required by state law.

Prosthetic devices

The Clarity plan covers medically necessary prosthetic devices when prescribed by a network physician. The prostheses must be purchased from a network provider.

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

- Able to withstand repeated use
- Reasonable and necessary to sustain a minimum threshold of independent daily living
- Made primarily to serve a medical purpose
- Not generally useful in the absence of disease or injury
- Able to be used in the home
- Medically necessary for you, and
- To replace the function of a missing body part and made to be fitted to your body as an external substitute

Coverage for prosthetics is available only for:

- The least costly device adequate to allow you to engage in activities of daily living. If the plan decides that you chose a prosthetic that costs more than the least costly prosthetic adequate to allow you to engage in activities of daily living, the plan will pay only for those costs that would have been paid for the least costly device that meets your needs. In this case, you will have to pay the provider's charges that are more than the amount the plan pays
- One item of each type of prosthetic device that meets your needs is covered. No back up items or items that serve a duplicate purpose are covered
- Activity-related prosthetics are covered by the plan for members under the age of 19, who are residents of the state of NH, and are covered by WellSense. The activity-specific prosthetic device is limited to one activity- specific prosthetic device per plan year
- 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)

Prosthetic exclusions

- Electronic and myoelectric artificial limbs
- Medically necessary prosthetic devices are not subject to any annual limits
- Wigs when hair loss is due to male or female pattern baldness, or natural or premature aging

Radiology Services

See Laboratory Tests, Radiology, and Other Diagnostic Procedures.

Rehabilitation therapies (outpatient) – short term physical, occupational, and pulmonary rehabilitation therapies

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

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

Benefit limits

Rehabilitation and habilitative therapies are limited to 20 visits per benefit year for each type of therapy, including Physical, Occupational, and Speech therapy. These benefit limits do not apply when these services are provided to members:

- Receiving early intervention services – see "Early Intervention Services", above, or
- With Pervasive Developmental Disorder or Disability, Autism Spectrum Disorder (ASD) - see "Mental Health and Substance Use Disorder Services", above

Rehabilitation 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, the plan will cover third surgical opinions when the first and second opinions differ.

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 for more details. For information about this benefit, call Member Service at 855-833-8122.

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. Please see the Schedule of Benefits for benefit limits.

Speech-language and hearing disorder exclusions

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

Telemedicine virtual visit services

The Clarity plan covers telemedicine virtual visit services. Your cost share for virtual services shall not exceed the cost share charged for the same services delivered in-person. Telemedicine virtual visit 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 virtual services, the cost- sharing is the same as if you access care with a mental health provider in person. Prior authorization may apply. Visit our Provider Directory at wellsense.org to find out whether your network provider offers telemedicine virtual visit services.

Available telemedicine virtual 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 plan authorized reviewer. Always check

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

TMJ 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

Urgent care

The Clarity plan covers urgent care services when you are inside the service area and need immediate attention for services that are urgent but not life-threatening. You are also covered for urgent care services outside the service area for unexpected illness or injury.

Vision services:

The Clarity plan covers:

- Preventive eye exams: These are periodic eye and vision examinations when the member has no obvious signs or symptoms of disease or vision loss. Preventive eye exams are covered for children up to the benefit limit – one exam per member is allowed every 12 months until age 19. If you have a medical eye condition, such as cataract, then your visits to your eye doctor are no longer considered preventive
- Routine (children only) and non-routine eye exams and treatment: The plan covers routine (children only) and non-routine eye exams. (This includes diabetic retinal eye exams.) You must use a network provider who is an eye doctor. These are Optometrists or Ophthalmologists. Routine eye exams are for detection, treatment and management of eye conditions that produce symptoms that, if left untreated, may result in loss of vision. *Routine eye examinations for adults are not covered
- Non-routine care are services to evaluate and/or treat a new or worsening condition, illness, or injury
- Medically necessary vision therapy only for: accommodative insufficiency; amblyopia; convergence insufficiency; and esotropia acquired (prior to surgery)
- Contact lenses or eyeglasses (one pair per prescription change) if one of the following conditions exists: postoperative cataract extraction, keratoconus, anisometropia of more than 3.00D, or more than 7.00D of myopia or hyperopia
- Visual magnifying aids when medically necessary for home use for the legally blind
- Pediatric Vision Service: A member is eligible for this benefit until the end of the calendar month in which they turn age 19. In addition to the preventive eye exam noted above, the plan covers one (1) pair of eyeglasses, including frames and lenses, or contact lenses per benefit 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 service 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
- Routine and preventive eye exams for adults are not covered

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 to return a member to the service area except as described 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: therapeutic 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; adjust-a-beds; telephone arms; hot tubs; and water beds
- Services to accommodate your religious preference; to improve athletic performance; to promote a desired lifestyle; or to improve your appearance or your feelings about your appearance
- Services received outside the service area except as specifically described in this EOC
- Services provided by non-network providers, except as specifically allowed in this EOC
    - Note: Except as otherwise stated by this agreement, any services (emergency and non-emergency), supplies or prescription drugs are not covered
- Services provided while incarcerated in prison or jail, except while pending charges and actively enrolled with the plan
- Services that do not conform to the plans clinical review criteria and guidelines

- Services for which there is a less intensive level of service or more cost-effective alternative that can be safely and effectively provided, or if the service can be safely and effectively provided to you in a less intensive setting
- Services that you received when you were not enrolled as a member under this plan. This includes before your plan membership began and after your plan membership ends
- Charges for services you receive after you choose to stay in a hospital or facility beyond the discharge time determined by the plan
- Acupuncture, biofeedback (except for the treatment of urinary incontinence, 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 (Note: medically necessary covered services provided by a Naturopathic Physician are covered if they are provided within the scope of the Naturopathic Physician's license)
    - Hypnotherapy, meditation, prayer, mental healing
    - Massage
    - Myotherapy
    - Pulsed or magnetic fields
    - Electromagnetic or alternating-current or direct-current fields including TENS units and related supplies and electrolysis
    - Reiki, reflexology, relaxation therapies, therapeutic touch
    - Therapies that use creative outlets such as art, music, dance, or yoga pet therapy
    - Treatment at sports medicine clinics
    - Services by a personal trainer, and
    - Any diagnostic services related to any of 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: 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
  - Electrolysis or laser hair removal, except for what is medically necessary as part of gender affirming services
  - Hair removal or restoration, including, but not limited to, transplantation or drug therapy
  - Liposuction, except for what is medically necessary as part of gender affirming services

- Dermabrasion or other procedures to plane the skin; acne related services, such as the removal of acne cysts or injections to raise acne scars; wigs (except when expressly covered – see Chapter 3); rhinoplasty (except as part of a medically necessary reconstructive surgery); liposuction; brachioplasty; treatment of spider veins; treatment of melasma; tattooing or reversal of tattooing; reversal of inverted nipples; body piercing; or removal or destruction of skin tags
- Custodial care: long term care or care in rest home
- Dental Services: The plan does not pay for any dental services, except:

  - Emergency dental and dental services specifically set forth in Chapter 3 under "Outpatient Services – Dental Services", and
  - Dental services are any service provided by a licensed dentist involving the diagnosis or treatment of any disease, pain, injury, deformity or other condition of the human teeth, alveolar process, gums, jaw, or associated structures of the mouth. The plan also does not pay for splints or oral appliances

- Dentures
- Equipment that does not meet the definition of durable medical equipment in Chapter 3. Example: equipment that is used primarily and customarily for nonmedical purposes - even if such equipment has a medically related use, except as described in this Evidence of Coverage
- Activity-specific prosthetics for members age 19 and over
- Devices and Clothing:

  - 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 unless attached to an integral part of a brace; shoe inserts (except for therapeutic and molded shoes and shoe inserts for members with severe diabetic foot disease)
  - Special clothing, except for gradient pressure support aids for lymphedema or venous disease,
  - Clothing needed to wear a covered device (for example, mastectomy bras and stump

socks), and therapeutic/molded shoes for members with severe diabetic foot disease
    - Non-rigid appliances and supplies, such as: elastic stockings, garter belts, arch supports, corsets, and corrective shoes
    - Safety equipment, such as: safe beds, crib enclosures, chest harness/seat belts, alert emergency response systems, and bath/shower grab bars
    - Self-help devices that are not primarily medical items, such as: sauna baths, elevators, stair lifts, ramps, and special telephone or communication devices
    - Self-monitoring devices, except if the plan decides that a device would give a member having certain symptoms the ability to detect or stop the onset of a sudden life- threatening condition
    - Electronic and myoelectric artificial limbs
    - Replacement or repair of durable medical equipment or prosthetic devices due to loss, intentional damage, negligence, or theft
    - Hospital-grade breast pumps
    - Exercise and hygienic equipment. 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."
- Experimental or investigational treatments, or services related to these treatments. If a service is an experimental or investigational treatment, the plan will not pay for that treatment or any related services that are provided to the member for the purpose of furnishing the experimental or investigational treatment. Exception: the plan will cover costs of clinical trials as specifically set forth in Chapter 3 – "Covered Services"
- Government Program Benefits: Services for which you have the right to benefits under government programs. 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 drugs
    - Infertility treatment including, but not limited to, therapeutic donor insemination, including related sperm procurement and banking; donor egg procedures, including related egg and

inseminated egg procurement, processing and banking; assisted hatching; gamete intra-fallopian transfer (GIFT); intra-cytoplasmic sperm injection (ICSI); intra-uterine insemination (IUI); in-vitro fertilization (IVF); zygote intra-fallopian transfer (ZIFT); preimplantation genetic testing (PGT); microsurgical epididymal sperm aspiration (MESA); and testicular sperm extraction (TESE).Reversal of voluntary sterilization
    - Infertility treatment needed as a result of prior voluntary sterilization, unless: the diagnosis of infertility is unrelated to a previous sterilization procedure, and if for a female, the diagnostic testing provides at least one patent fallopian tube, and if for a male, the sperm count meets the definition of normal as set forth in the plan's clinical review criteria
    - Sperm or embryo cryopreservation
    - Costs associated with donor recruitment, testing and compensation
    - Donor sperm and associated laboratory services
    - Infertility services necessary for conception as a result of voluntary sterilization or following an unsuccessful reversal of a voluntary sterilization
    - Drugs for anonymous or designated egg donors that are directly related to a stimulated Assisted Reproductive Technology (ART) cycle, unless the ART service has been approved by a plan authorized reviewer, is provided at a network infertility services provider, and the member is the sole recipient of the donor's eggs
    - Surrogacy/gestational carrier-related costs: this means all procedures and costs incurred by a fertile woman to achieve a pregnancy as a surrogate or gestational carrier for an infertile member
    - Experimental or investigational infertility procedures
- Routine Maternity Services: When you are outside the service area, the plan will not cover:
    - Routine maternity services for prenatal or postpartum 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
    - Programs in which the member has a pre-defined duration of care without the plan's ability to conduct concurrent determinations of continued medical necessity, 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 you, or another person's, personal comfort or convenience. Examples are; telephones, radios, televisions and personal care items
- Routine podiatric services and related durable medical equipment and medical supplies (except for members with diabetes – see "Diabetes" benefit in this Chapter 3). Exclusions include but are not limited to routine foot care (trimming of corns, nails or other hygienic care), foot and shoe orthotics, arch supports, shoe inserts, fittings, casting and other services related to devices for the feet or orthopedic or corrective shoes that are not part of a covered leg brace
- Pre-implantation genetic diagnosis
- 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 (except when allowed under this EOC)
    - Examples of services include exams and tests required for recreational activities or employment, court - ordered exams (except when allowed under this EOC), 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 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, except as described within this EOC
- Weight loss/anti-obesity medications are not covered, except as described within this EOC
- 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 is a health plan for individuals and, if applicable, their eligible dependents.

Eligibility and enrollment

The plan establishes eligibility rules for subscribers and dependents in accordance with state and federal laws. Subscribers and their eligible dependents must meet these eligibility rules in order to be enrolled in the plan.

Please contact the plan for more information about eligibility. The plan may require reasonable verification of eligibility from time to time. Social security numbers are not required to obtain coverage under an individual or family contract.

If you meet the applicable eligibility rules, we will accept you into the plan. You may continue to be enrolled in the plan as long as you continue to meet eligibility rules and applicable premium is paid. When we receive your enrollment, we will send you an ID card and other information about the plan.

Acceptance into the plan is never based on your income, physical or mental condition age, occupation, claims experience, duration of coverage, medical condition, gender, sexual orientation, religion, physical or mental disability, ethnicity or race, previous status as a member, 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 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 plan does not pay for any services you received prior to your coverage effective date with the plan.

Dependent eligibility

To be covered as a dependent under the plan, an individual must be one of the following:

- The legal spouse or domestic partner of the subscriber
- The dependent child of a subscriber, either by blood or by law, who is under age 26
    - For members enrolled through the New Hampshire Federally Operated Health Insurance Marketplace, a child (including an adopted child) of the subscriber or spouse of the subscriber until the end of the year in which the child turns 26
    - For members enrolled directly through WellSense, a child (including an adopted child) of the subscriber or spouse of the subscriber until the end of the month in which the child turns 26
- A child (including an adopted child) of the subscriber or spouse of the subscriber, who is no longer

eligible as described in the bullets above and meets each of the following requirements: (a) is currently disabled, and (b) remains chiefly financially dependent on the subscriber. An individual will be determined to be "disabled" by WellSense only if he or she is mentally or physically incapable of earning his or her own living. In the event of a dispute concerning eligibility under this paragraph, WellSense shall apply the standard for determining disability under Title II of the Social Security Act. WellSense will require proof of such disability within 31 days following the date the individual would no longer be eligible due to age as described under the 2nd bullet, above

- A child under 18 years of age, for whom the subscriber or subscriber's spouse is the court appointed legal guardian. Proof of guardianship must be submitted to WellSense prior to enrollment
- The child of an eligible dependent of the subscriber until such time as the parent is no longer a dependent

Reasonable evidence of eligibility may be required from time to time.

Newborn and adoptive children – enrollment and coverage:

- A newborn infant of a member is eligible for coverage under the plan from the moment of birth and beyond up to 31 days for all medical medically necessary care, as required by New Hampshire law
    - The subscriber must properly enroll the newborn in the plan, through Healthcare.gov, 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 plan will not cover any services beyond the 31-day period. See Chapter 3 – "Inpatient Services-Maternity Care". Any other charges for services to the newborn will not be covered
    - Coverage for newborns will be coverage under the subscriber during the first 31-days, even if the newborn child is enrolled for coverage as an eligible dependent on day 32.
    - Note: Duplicate cost-sharing will not apply for the newborn and birth mother during birth care. Cost-sharing for follow-up care for the newborn will be applied to the mothers individual cost-sharing amounts and limits
- 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

Coverage effective dates for subscribers and dependents

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

Change in eligibility status

It is the subscriber's responsibility to notify Healthcare.gov of all changes that may affect your or your dependents' eligibility under the plan or the amount of premium you pay. Notification must occur within 60 calendar days of the event.

These include the following:

- Having a baby or adopting a child
- Address changes
- Moving out of the 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 plan's eligibility rules

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

The plan needs your current address and phone number so we can send you important information about benefits and services. To report eligibility, address or phone number changes, please update your information through Healthcare.gov. You may also contact Member Service for assistance at:

WellSense Health Plan
100 City Square, Suite 200
Charlestown, MA 02129
Phone: 855-833-8122

If hospitalized when membership begins

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

Coverage for members who live outside the service area

If you are a properly enrolled member who lives outside the service area in accordance with the plan's eligibility rules: you must still comply with all 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 are required to pay applicable monthly premiums. 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 has been received are entitled to covered services. In the event an individual is late (delinquent) in paying required premium, the 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 member is receiving a premium subsidy:

If a member is late paying their premium and they have paid at least one full month's premium, the member will be granted a grace period of 3 months (90 days) in which to pay their late premium. Coverage will remain in force during the grace period. If full payment of premium is not received within the grace period coverage will be terminated as of the last day of the first month during the grace period if advance premium tax credits are received.

We will continue to pay all appropriate claims for covered services rendered to the member during the first month of the grace period and may pend claims for covered services rendered to the member in the second and third month of the grace period. We will notify HHS of the non-payment of premiums, the member, as well as providers of the possibility of denied claims when the member is in the second and third month of the grace period. We will continue to collect advanced premium tax credits on behalf of the member from the

Department of the Treasury and will return the advanced premium tax credits on behalf of the member for the second and third month of the grace period if the member exhausts their grace period as described above.

When a member is not receiving a premium subsidy:

Premium payments are due in advance on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. There is a 31-day grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the contract will stay in force however, claims may pend for covered services rendered to the member during the grace period. We will notify HHS, as necessary, of the non-payment of premiums, the member, as well as providers of the possibility of denied claims when the member is in the grace period.

Notes:

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

Misstatement of age

If a member's age has been misstated, the member's premiums may be adjusted to what it should have been based on the member's actual age.

Termination of WellSense coverage

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

- You are an individual who 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 the plan or a plan employee
- You fail to comply with the plan'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 plan. Termination may be retroactive: to your effective date, the date of the fraud or misrepresentation, or to another date determined by the plan
- You fail to comply in a material manner with the plan's rules under this EOC or, for individuals, with the individual contract
- You fail to continue to meet the plan's eligibility rules, including applicable residency or work location requirements
- An individual chooses to end coverage

Effective date of termination

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

Benefits after termination

The 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, that requires medical care after your coverage ends

Refund upon cancellation

The plan will refund any premium paid and not earned due to contract termination. You may cancel the contract at any time by providing written notice to the entity with which you enrolled. Such cancellation shall become effective upon receipt, or on such later date specified in the notice. If you cancel, we shall promptly return any unearned portion of the premium paid, but in any event shall return the unearned portion of the premium within 30 calendar days. The earned premium shall be computed on a pro-rata basis. Cancellation shall be without prejudice to any claim originating prior to the effective date of the cancellation.

Voluntary and involuntary disenrollment rates for members

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

Questions about eligibility, enrollment and termination:

Please call Member Service:

WellSense Health Plan
100 City Square, Suite 200
Charlestown, MA 02129
Phone: 855-833-8122 (TTY 711)

Chapter 5. Member satisfaction process

Introduction

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

- Internal Inquiry Process
- Internal Grievance Process
- Internal Appeals Process (including Expedited Appeals)
- External Review by the New Hampshire Insurance Department (NHID)

Internal inquiry process

What is an inquiry?

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

Internal inquiry process:

This is an informal process used to resolve most Inquiries. Call Member Service at 855-833-8122 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 refer your concern directly to our Internal Grievance Process (see below)
- An Adverse Determination. Member Service will refer your concern directly to our Internal Appeals Process (see below)

Internal grievance process

What is a grievance?

A Grievance is a formal complaint by you about:

- Plan Administration (how the plan is operated): any action taken by a plan employee, any aspect of the Plan's services, policies or procedures, or a billing issue
- Provider Access, Attitude, or Service: any dissatisfaction with a plan network provider due to lack of provider availability, how you feel you were treated by a provider or a member of their staff or lack

of cleanliness of a provider office
- Quality of Care: The quality of care you received from a plan network provider. We refer to this type of Grievance as a "quality of care Grievance." (If you are comfortable doing so, we encourage you to talk first with the network provider about quality of care concerns before filing a quality of care Grievance. However, you are not required to do so before filing this type of Grievance with us.)

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 855-833-8122. If you file your Grievance orally, we will write a summary of your Grievance and send you a copy within 48 business hours of receipt. Written Grievances should include:

- Your name
- Address
- Plan ID number
- Daytime phone number
- Detailed description of the Grievance (including relevant dates and provider names)
- Any applicable documents that relate to your Grievance, such as billing statements; and
- The specific result you are requesting You must send your written Grievance to:

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

If you want to submit a Grievance in person, you can make an appointment to file it at the address above by calling Member Service.

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

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

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 48 business hours of receipt of our receipt of your Grievance. If you filed your Grievance orally, our written summary of your Grievance will be mailed to you within 48 business hours of receipt of your Grievance. This summary will serve as both a written record of your Grievance as well as an acknowledgment of our receipt.

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 we ask you to complete an Authorization to Release Medical Records form, it is very important that you fill out and send us this form. This allows us to obtain medical information we will need to address your Grievance. If we do not receive this form by the due date of 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 may 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 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 upon receipt of the verbal or written grievance.

These time limits may be extended in limited circumstances and will not exceed 14 calendar days from the original due date of the grievance.

Our written response to your Grievance will describe our findings along with other options, if any, for further plan review of your Grievance.

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

Internal appeals process

What is an appeal?

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

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

How and where you can file an appeal

- The preferred way for you to file an appeal is for you to put it in writing and send it to us by regular mail or by fax at 617-897-0805
- You can also deliver it in person to our office. (See Address listed below in this section)
- You may also submit your appeal orally by calling Member Service at 855-833-8122
- For oral appeals related to mental health and/or substance use disorder services, you must call 877-957- 5600
- If you file your appeal orally, we will write a summary of your appeal and send you a copy within 48 business hours of receipt

Written appeals should include:

- Your name
- Address
- Plan ID number
- Daytime phone number
- Detailed description of the appeal (including relevant dates and provider names) any applicable documents that relate to your appeal, such as billing statements, and
- The specific result you are requesting

You must send your written appeal to:

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

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

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

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

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 be dismissed and not reviewed. We encourage you to file your appeal as soon as possible.

WellSense 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 48 business hours of receipt of your appeal. If you filed your appeal orally, the Appeals & Grievances Specialist's written summary of your appeal will be mailed to you within 48 business hours of receipt of your appeal. This summary will serve as both a written record of your appeal as well as an acknowledgment of our receipt. If we require any additional information such as an Authorization of Representative (AOR) Form or Medical Records, you shall have 45 calendar days from the date of our notification to provide the necessary documentation. If the documentation is not received, your appeal may be dismissed or reviewed solely on the documentation available to us with your appeal. Additional details below in Timelines for Review and Response to Your Appeal section.

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 we ask you to complete an Authorization to Release Medical Records form it is very important that you fill out and send us this form. This allows us to obtain medical information we will need to address your appeal. If we do not receive this form within 45 calendar days of providing notification to you that the form is required, 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 may respond to your appeal without having reviewed relevant medical information

Who will review your appeal

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

Decisions will be based on: the terms of this EOC; the opinions of your treating providers; the opinions of our professional reviewers; applicable records provided by you or providers; and any other relevant information available to the plan. Note: The persons reviewing the appeal shall not be the same person or persons making the initial determination, and shall not be in a reporting relationship, nor the supervisor of, the person making the initial determination.

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 unless additional information is required. If additional information is required, we will notify you and you will have 45 days from the date of our notification to supply it to us for a review of your appeal. The appeal review period begins as follows:

- If your appeal requires us to review your medical records, and all records are included with the appeal request, the 30-calendar day period begins from when the appeal was received
    - If the records are missing, you will have 45 calendar days from the date we notify you that we need medical records for us to perform an appeal review
    - If the documentation is not received within 45 days from our notification to you, your appeal may be reviewed solely on the documentation available to us with your appeal. This may result in a denial due to incompleteness of the appeal. The appeal may be reopened upon receipt of the required information
- If your appeal is received from someone on your behalf such as your provider or a family member, you must grant permission in writing by completing an Authorization of Representation Form,

- If the appeal is received with a properly executed Form, the 30- calendar day period begins from when the appeal was received
- If the appeal is received without a properly executed Form, you will have 45 calendar days from the date we notify you that we need a completed Authorization of Representation Form to supply the Form for us to perform an appeal review
- If the documentation is not received, your appeal may be dismissed. The appeal may be reopened upon receipt of the required information

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

Written responses to Adverse Determinations that deny all or part of your request for coverage will explain your right to request an External Review from an independent External Review Agency. This Agency contracts with the New Hampshire Insurance Department.

If we don't respond to your appeal within the time frames described in this section, we will immediately notify you of your external appeal rights. When we notify you, we will send the Notice Of Right To An External Appeal Of Your Health Insurer's Decision and provide the NH Managed Care Consumer Guide to External Appeal and the Independent External Review Application Form.

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 applied to appeals pertaining to services you have already received, Benefit Denials or Rescissions of Coverage.

An Expedited Appeal means we will review and resolve your appeal and send you a written decision within 72 hours of receipt provided you or your Authorized Representative have given us the specific information needed to make a decision as soon as you can but no later than 48 hours after we have asked you for the information.

To assure you receive notice of our decision, we will contact you or your Authorized Representative by telephone or fax to provide the decision quickly. We will attempt to provide verbal notification to you in addition to providing written notification of the appeal decision.

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 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
- 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 we don't respond to your appeal within the time frames described in this section, we will immediately notify you of your external appeal rights. When we notify you, we will send the Notice Of Right To An External Appeal Of Your Health Insurer's Decision and provide the NH Managed Care Consumer Guide to External Appeal and the Independent External Review Application Form.

Post-service appeal of a claim denial (retrospective)

If your appeal is for a post-service claim denial, we will notify you of our decision as soon as possible but no later than 30 calendar days after we have received your appeal. If the reason we need more time to make a decision is because you have not given us necessary information, we will notify you within 15 days regarding what additional information is needed in order to process the claim. You will have 45 calendar days from the date we notify you to give us the information. The 30-day period for appeal of a post-service claim determination will be on hold until such time as you submit the required information.

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.

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 three exceptions: no final Adverse Determination is necessary if (1) the patient does not need to meet this requirement, if the insurer agrees in writing to allow the patient to skip its Internal Appeal process (2) the plan has failed to comply with timelines for the Internal Appeals Process; or (3) you (or your Authorized Representative) file a request for an Expedited External Review at the same time that you file a request for an Expedited Internal Appeal. For more information, see below:

Independent External Review process

Coverage pending resolution of your Appeal

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

Access to medical information

You are entitled to have free access to and copies of any of your medical information related to your Grievance or Appeal that is: in our possession; and under our control. To obtain this information, please contact the plan employee who is coordinating the review of your Grievance or Appeal, or Member Service. If we receive or rely on any new or additional information in connection with your Grievance or Appeal, we will provide you with a copy of such information in accordance with law.

Independent External Review process

You may contest a final appeal decision regarding an Adverse Determination. To do this, you must request an External Review of the decision. External Reviews are done by an independent organization under contract with the New Hampshire Insurance Department (NHID). Benefit Denials, Member Cost Share Disputes, and Retroactive Terminations of Coverage are eligible for External Review. Instructions and forms for filing an External Appeal will be included in the denial notice sent to you. The forms are also available within this handbook.

You may also file a request for an External Review before receiving a final appeal decision regarding an Adverse Determination if the plan fails to comply with the timelines for the Internal Appeals Process. When we notify you that we missed the internal appeal timeframe, we will send the Notice Of Right To An External Appeal Of Your Health Insurer's Decision and provide the NH Managed Care Consumer Guide to External Appeal and the Independent External Review Application Form.

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 NHID within 180 calendar days of your receipt of the plan's written notice of the final appeal decision or our notification that we did not decide your appeal timely. A copy of the NHID's External Review forms and other information will be enclosed with the plan's notice denying your appeal.

Expedited External Review

You can request an Expedited External Review. To do so, you must include a written certification

from a physician that a delay in providing or continuing the health services that are the subject of the final appeal decision would pose a serious and immediate threat to your health. If the NHID 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

- If you have any questions about the external review process, please call the New Hampshire Insurance Department at 1-800-852-3416 and ask to speak to a consumer assistant
- If your medical condition is such that waiting for the standard external review process to be completed would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, you may be eligible for expedited external review. If you have any questions about the external review process, please call the New Hampshire Insurance Department at 1-800-852-3416 and ask to speak to a consumer assistant
- You may file a request for an External Review by submitting your request in writing:

  Independent External Review
  New Hampshire Insurance Department
  21 South Fruit Street, Suite 14
  Concord, NH 03301

You can request an external appeal through the NHID, which you can download from the NHID website at http://www.nh.gov/insurance/consumers/documents/ex_rev_app.pdf .

Please refer to Appendix F for a copy of the Managed Care Consumer Guide to External Appeal, along with the Application Form for an Independent External Appeal.

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. However, if the decision is ultimately upheld, you may be responsible for paying any outstanding claims for services provided after receiving notification of the adverse External Appeal determination.

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 New Hampshire Insurance Department will screen requests for External Review to determine whether your case is eligible. If the NHID determines that your case is eligible, it will be assigned to an External Review Agency. NHID will notify you and the plan of the assignment. We will provide all relevant documentation used to make our Internal Appeal decision to the External Review Agency. The External Review Agency will make a final decision and send the written decision to you and the plan. For non-expedited External Reviews, the External Review Agency shall render a decision upholding or reversing the adverse determination and notify you or your authorized representative in writing within 20 calendar days of the date that any new or additional information from the member was due. For Expedited External Reviews, the decision and notification to you will be made as expeditiously as your medical condition requires, but in no event more than 72 hours after the expedited external review is requested. The decision of the External Review Agency is binding on the plan. If the NHID decides that a request is not eligible for External Review, you will be notified: within 10 calendar days of receipt of the request; or, for request for Expedited External Review, within 72 hours of the receipt of the request.

How to reach the New Hampshire Insurance Department:

Telephone: 800-852-3416
TTY: 800-735-2964
Website: NH.gov/insurance

Compliance with law

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

Chapter 6. When you have other coverage

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 NH law. Regarding coordinating benefits with Medicare, we conduct COB in accordance with applicable federal law. Nothing in COB requires us to pay benefits for non-covered services under this EOC.

Other plans

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

- Individual health benefit plans offered by medical or hospital service corporation plans, commercial insurance companies, HMOs, PPOs, other prepaid plans, or self-insured plans
- Insured or self-insured dental plans
- Automobile insurance ("no fault" or medical payments coverage, also known as Part B in the personal automobile policy or med pay)
- Government plans, as permitted by law, such as Medicare, but not Medicare supplemental policies or a state plan under Medicaid

Primary and secondary plans

We coordinate benefits by determining, in accordance with NH 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 plan is secondary, no benefits will be paid until after the primary plan determines what it is required to pay.

If you are covered by more than one plan that requires prior approval (or pre-certification) in order to obtain services, you shall obtain prior approval from the primary plan. Although you shall not be required to obtain prior approval from the secondary plan, the secondary plan shall not be required to treat these services as covered services if the services do not meet its medical necessity criteria. The secondary plan shall not refuse payment for such services solely on the basis that the services were not authorized by the secondary plan.

Note: After 31 days, a newborn must be added as a permanent dependent to continue coverage.

The plan will apply coordination of benefits (COB) rules between all plans the newborn is enrolled in. The newborn will be treated as a separate dependent when calculating their deductible and out- of-pocket limits.

Medicare program

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

Member cooperation

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

Right to recover overpayment

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

For more information about COB, call Member 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 insurance ("no fault" or medical payments coverage, also known as Part B in the personal automobile policy or med pay), or worker's compensation insurance company, or your own insurance company. In such a case if we paid (or will pay) for health care services to treat your illness or injury, we have a right to recover (get back) – in accordance with all applicable laws and regulations - what we paid, in your name, directly from the recovery received from that person or entity (the "recovery") regardless of whether this recovery is classified as payment for medical expenses, lost wages, pain and suffering, loss of consortium or any other type of recovery. Our right to recover from the recovery is up to the full amount that we paid or will pay for your health care services (regardless of what your provider billed us for the services). This is known as the plan's right of subrogation which applies to the recovery.

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

- Whether the total recovery is less than the amount needed to reimburse you completely for your illness or injury
- Where or by whom the recovered money is held
- How the recovered money is described or designated
- 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.

Definition of plan

Plan includes:

- Group and nongroup insurance contracts and subscriber contracts
- Uninsured arrangements of group or group-type coverage
- Group and nongroup coverage through closed panel plans
- Group-type contracts
- The medical care components of long-term care contracts, such as skilled nursing care
- The medical benefits coverage in automobile "no fault", not including medical payments coverage, also known as Part B in the personal automobile policy or med pay
- Medicare or other governmental benefits, as permitted by law, except as provided below. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program, and
- Group insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care

Plan does not include:

- Hospital indemnity coverage or benefits or other fixed indemnity coverage
- Accident only coverage
- Specified disease or specified accident coverage
- Limited benefits health coverage, as defined in Ins 1901.06(l)
- School accident-type coverages that cover students for accidents only, including athletic injuries, either on a 24- hour basis or on a "to and from school" basis
- Medical payments coverage in a personal automobile policy, also known as Part B or med pay
- Benefits provided in long-term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services
- Medicare supplement policies
- A state plan under Medicaid, or
- A governmental plan, which, by law, provides benefits that are in excess of those of any

private insurance plan or other non-governmental plan

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 NH law on any recovery you obtain. If so, you agree to fully cooperate with us in our exercising our lien rights.

Assignment of benefits

By enrolling in this plan, you assign to us any benefits you may be entitled to receive (up to the costs of health care services paid or to be paid by us) from another person or entity that caused, or is legally responsible to reimburse you for, your illness or injury. Your assignment is up to the cost of health care services and supplies, and expenses 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 the plan in exercising our rights under this section. This cooperation includes:

- Notifying us of any events that may give rise to or affect our right to recover, such as an injury caused by someone else (for example, in a car accident) or job-related injuries
- Giving us timely notice of significant events during the negotiation, litigation or settlement with any third party (such as if you start a claim, sue someone, or start settlement discussions) and before you settle any claim
- Giving us information and documents we ask for, 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 plan does not cover health care services that are or could be covered under: a Workers' Compensation plan; other similar employer program; or under another federal, state or local government program. If the plan has information that services being provided to you are covered by any of these plans or programs, we may suspend payment of further covered services until a decision is made whether the other plan or program will cover the services. If we paid for services that were covered (or legally should have been covered) by these other plans or programs, we have a right to recover our payments from these other plans or programs.

Insurance with other insurers

If there is other valid coverage, not with the plan, providing benefits for the same loss on a provision of service basis or an expense incurred basis, payment shall not be prorated or reduced. If such is the case, the member shall be entitled to payment from both insurers. Provided, however, that the provisions of this subparagraph shall not prohibit the issuance of a benefits deductible. Benefits deductible, as used herein, means the value of any benefits provided on an expense incurred basis which are provided with respect to covered medical expenses by any other hospital, surgical or medical insurance contract or hospital or medical service subscriber contract or medical practice or other prepayment plan, or any other plan or program whether on an insured or uninsured basis.

Provided, however, that the term benefits deductible shall not mean the value of benefits provided with respect to medical or liability insurance offered under either a general liability insurance contract or an auto insurance contract. If there is other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis, payment shall not be prorated or reduced. In such a case, the insured shall be entitled to payment from both insurers.

Chapter 7. Other plan administration provisions

Utilization management

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

Concurrent utilization review

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

Timeframes for determinations

- Electronic Submission: Prospective non-urgent review: no later than 7 calendar days from receipt of all information needed to make the determination
- Non-Electronic Submission: Prospective non-urgent review: no later than 14 calendar days from receipt of all information needed to make the determination
- Prospective urgent review (must meet criteria for urgent): within 72 hours of receiving the request
- Concurrent review: within 24-72 hours of receiving the request

If the plan fails to render a determination on the prior authorization request within the applicable time frame, the request shall be deemed approved by default.

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

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

The UM Program is structured to encourage appropriate care. The plan bases all utilization management decisions only on the medical necessity and appropriateness of care and services, as well as on the existence of coverage. The plan does not: compensate utilization management staff based on denials; or provide incentives to network providers to provide inappropriate types or levels of care.

You can call us to check the status or outcome of a utilization review decision by calling 855-833-8122 (toll free) or TTY 711.

Translation services are available (see page 2).

Care Management (Case Management)

The Clarity plan may provide care management services to members with serious or complex health conditions. These services may include, but are not limited to, access to chronic disease management programs for conditions such as asthma, diabetes, sickle cell, and depression. Chronic/ complex care management is designed for members with multiple or more serious health conditions, such as heart disease, cancer, behavioral health conditions, or substance use disorders. Care management services provide coordinated support to:

- Monitor your treatment progress
- Help ensure you receive appropriate and cost-effective care

Clarity plan care management team may contact you or your provider to discuss case management services. This may include:

- Reviewing treatment plans
- Setting health goals
- Connecting you to appropriate resources
- Suggesting alternative treatments and care settings, when appropriate

You may be enrolled in the program through:

- Your Health Needs Assessment
- Claims or utilization management information
- A referral from a hospital case manager
- A referral from a provider
- Self-referral or Caregiver

If you feel you would benefit from care management, to learn more, or to opt out call 866-853-5241 for Care Management services.

Process to develop and adopt clinical review criteria and guidelines for medical and behavioral health conditions

Medical and pharmacy clinical guideline and utilization review criteria:

- The plan's Utilization Management Committee (UMC) oversees medical policy, criteria, technology, and assessment, and
- The plan has a Pharmacy and Therapeutics Committee (P&T)
- At least annually, UMC and P&T review and adopt clinical review criteria and guidelines used to determine the medical necessity of health care services and drug coverage guidelines to ensure consistent plan decision-making
- The plan receives input from internal network providers and/or external specialists who have clinical expertise and appropriate credentials in the applicable clinical area

- In the process of developing or adopting clinical review criteria and guidelines, the UMC assesses treatments to determine that they are: consistent with generally accepted principles of professional medical practice; known to be effective; based on objective, scientifically derived and evidence-based information in improving health outcomes; and consistent with applicable legal and national accreditation organization standards. Reputable sources evaluated include, but are not limited to, the Medicare National Coverage
- Determinations (NCDs) and Local Coverage Determinations (LCDs), InterQual, and American Society of Addiction Medicine (ASAM) Criteria guidelines
- The UMC and P&T, receive input and recommendations from other plan committees, network providers and/or external specialists (as appropriate), review and update clinical review criteria and guidelines periodically, or as needed. These reviews and updates incorporate the most 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

Medical Necessity Criteria varies according to state and/or contractual requirements and member benefit coverage.

Behavioral health and substance use disorder services clinical guideline and utilization review criteria

For behavioral health care the plan uses the following Medical Necessity Criteria:

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

Change Healthcare employs a multi-step standardized content development process that synthesizes valid, relevant scientific evidence and real-world best practices to ensure that the criteria reflect unmatched clinical rigor and integrity. Change Healthcare utilizes a proprietary automated surveillance system which monitors 3,000+ key sites and topical areas for newly published and updated guidelines in addition to deep dive literature searches combined with validation by panels of conflict of interest screened, actively practicing clinicians across all relevant disciplines.

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

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

WellSense disseminates criteria set via the provider manual and Internet site. In addition, members are provided copies free of charge upon request.

Quality management and improvement programs

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

- Adoption and sharing of clinical guidelines to assist providers to deliver high quality evidence-based care
- Health promotion initiatives to encourage providers and members to prioritize preventive care services
- Care management and education programs offering provider and member support services for chronic illnesses
- Credentialing of network providers, and
- Processes to receive and address quality of care concerns from members

Process to evaluate experimental or investigational treatments

Since the plan does not cover experimental or investigational treatment for a medical or behavioral health condition, the plan evaluates whether a service, treatment, procedure, supply, device, biological product, or drug is an experimental or investigational treatment for the requested indication. The plan does this by reviewing relevant documents related to the proposed service, such as informed consent documents, and reviewing "authoritative evidence" as defined in the definition of experimental or investigational treatments (as stated in 'Appendix A' of this EOC). The plan considers all of the following:

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

Process to evaluate and assess new technology

As new medical technologies are developed, or when new uses of existing technologies arise, the plan evaluates whether to include these as a covered service.

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

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

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

Disagreement with recommended treatment by network providers

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

Quality incentives

The plan may, from time to time, offer some or all members certain incentives to encourage improvements in health status and the quality of health care. Examples include additional benefits, waiver of copayments, and rewards cards. If we offer such incentives, we will notify you about them. either by sending you a letter and/or we may put the notice on our website (wellsense.org).

Confidentiality of protected health information

The plan 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 plan provides members with a Notice of Privacy Practices that can be found below titled "Notice of Privacy

Practices". This Notice describes how the plan uses and discloses your PHI. It also describes the rights you have 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 plan for covered services provided to you. The plan will pay network providers for covered services. If you do receive a bill for any amount other than the applicable cost-sharing, call Member 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 plan a bill on a standard health care claim form to:

  WellSense Health Plan
  Claims Department
  P.O. Box 55049
  Boston, MA 02205-5049

- If you paid the non-network provider for these services, we will reimburse you, consistent with your Schedule of Benefits and the terms under this EOC, if we determine they are covered services. (Please see Chapter 2 regarding payment up to the allowed amount.) To process your reimbursement, we must receive from you:
  - Your name
  - Address
  - Phone number
  - Date of birth
  - Your plan ID number (see your member ID card)
  - The date the care was provided to you
  - A brief description of the illness or injury
  - A copy of the provider's bill to you, and
  - A receipt from the provider as proof of payment

Send reimbursement requests to:

WellSense Health Plan
Attention: Member Service
100 City Square, Suite 200
Charlestown, MA 02129
Phone: 855-833-8122
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. In some cases, subject to state requirements, we may provide you with a reimbursement check made out to you and the provider. For ambulance services, reimbursement checks will be issued only to the ambulance provider.

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.

Claim forms

The plan, upon receipt of a notice of claim from a provider or member, will furnish such forms as are usually needed for filing claims (proof of loss). If such forms are not provided within 15 calendar days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Premium payments

You pay applicable premium payments to the plan or its designee. (Some individuals, at their option, may be eligible to pay premiums directly to the plan.) If you do not pay your premium on time your enrollment in the plan may be cancelled in accordance with applicable state and federal law. The plan may change the premium that individuals are required to pay. This will be done in accordance with applicable laws.

Limitation on actions

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

Time limit on certain defenses

After 2 years from the date of issue of this contract no misstatements, except fraudulent misstatements, made by you in the application for such contract shall be used to void the contract or to deny a claim for loss incurred or disability as defined in this Evidence of Coverage, commencing after the expiration of such 2-year period.

Conformity with state laws

Any part of this contract in conflict with the laws of New Hampshire on this contract's effective date is changed to conform to the minimum requirements of New Hampshire state laws.

Legal actions

No suit may be brought by you on a claim no sooner than 60 calendar days after written proof of loss is given. No suit may be brought more than three years after the written proof of loss is required to be furnished.

Physical examination and autopsy

The plan shall have the right and opportunity to examine a member while a claim is pending or while a dispute over the claim is pending, as well as having an autopsy performed. These examinations are made at our expense and as often as we may reasonably require.

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

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

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

Circumstances beyond the plan's reasonable control

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

Enforcement of terms

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

Subcontracting

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

This EOC; changes to this EOC

This EOC is issued and effective as of the date on the front cover. The EOC consists of this document and the applicable Schedule of Benefits. This EOC supersedes (takes the place of) all previous EOCs issued by the plan. This EOC is a contract between you and the plan. This contract consists of this document, the applicable Schedule of Benefits, your enrollment form, and any amendments, riders, or additional attachments issued to this document. By signing and returning your enrollment application form to the plan, you: apply for coverage under the plan, and you agree to all the terms and conditions of the Qualified Health Care Program (NH Clarity Plan) as set forth by WellSense, Healthcare.gov, 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 other material changes, we will send written notice to the subscriber. Changes do not require your consent. Changes will apply to all plan members in the applicable benefit package, not just to you. Changes will apply to all covered services received on or after the effective date of the change.

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

Chapter 8. Your responsibility to report suspected fraud

You play a vital role in helping prevent health care Fraud, Waste, and Abuse (FWA). We encourage you to stay alert and report any suspected FWA. Definitions of Fraud, Waste, and Abuse are provided in the section below for your reference. FWA can involve a wide range of individuals and organizations, including health care providers such as doctors and pharmacists, as well as companies that supply medical equipment.

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 plan

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

Method	Contact Information
Call	888-411-4959 (Anonymous Hotline), available 24 hours a day, 7 days a week
Fax	866-750-0947
Email	FraudandAbuse@wellsense.org
Write	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 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 as well as how you may access this information. Please review this notice of privacy practices carefully. This Notice of Privacy Practices is effective July 1, 2026, and supersedes all previous versions.

Your information. Your rights. Our Responsibilities.

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	See pages 3-4 for more information on these rights and how to exercise them
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	See page 4 for more information on your options and protections
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	See pages 5-9 for more information on these uses and disclosures

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.

If you have any questions or would like a copy of this Notice, please contact Member Service.

WellSense Member Service	
MassHealth	888-566-0010 (English and other languages) 888-566-0012 (Spanish)
Clarity plans in Massachusetts	855-833-8120
NH Medicaid	877-957-1300
Clarity plans in New Hampshire	855-833-8122
NH Medicare Advantage	855-833-8128
Corporate office WellSense Health Plan 100 City Square, Suite 200 Charlestown, MA 02129 wellsense.org	**New Hampshire office** WellSense Health Plan 6 Bedford Farms Drive, Suite 107 Bedford, NH 03110 wellsense.org

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 information	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.
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-related benefits and services	We may contact you to provide appointment or refill reminders, or information about possible treatment options or alternatives and other health-related benefits, or services that may be of interest to you.
As required by law	We will disclose PHI about you when we are required to do so by international, federal, state or local law.
Law enforcement requests, legal disputes and as otherwise required by law	We may release your PHI upon request by a law enforcement official in response to a valid court order, subpoena or similar process. If you are involved in a lawsuit or dispute, we may communicate PHI about you in response to a court or administrative order. We

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
	may also communicate PHI about you because of a subpoena or other lawful process, subject to all applicable legal requirements. We will disclose PHI about you when we are required to do so by international, federal, state or local law. Where state or federal law provide greater protections or safeguards, we will follow the more stringent law. For example, we may be prohibited from disclosing information related to reproductive health services you obtained if such disclosure is for the purpose of assisting in a criminal, civil, or administrative investigation against (1) you for obtaining reproductive health services in a state where such services are legal or (2) your health care provider for providing or facilitating such services in a state where the furnishing of such services are legal.
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. In New Hampshire, Sensitive Data also includes the processing of genetic or biometric data for the purpose of uniquely identifying an

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
	individual; personal data collected from a known child; or precise geolocation data. 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.
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.

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
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.

If you have any questions, or would like a copy of this Notice of Privacy Practices, please contact the WellSense Member Service Department at 855-833-8122.

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

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.

This Notice of Privacy Practices applies to WellSense Health Plan.

How we may use and disclose your Protected Health Information (PHI)

For treatment

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

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

For payment

We may use and disclose your PHI to administer your health benefits, which may include claims payment, utilization review activities, determination of eligibility, medical necessity review, coordination of benefits, and appeals. For example, we may pay claims submitted to us by a provider or hospital.

For healthcare 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 r eminders/treatment alternatives/health-related benefits and services

We may contact you to provide appointment or refill reminders, or information about possible treatment options or alternatives and other health-related benefits, or services that may be of interest to you.

As required by law

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

Business associates

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

Coroners, medical examiners, and funeral directors

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

Correctional facilities

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

Disaster relief

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

Family and friends

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

Food and Drug Administration (FDA)

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

Health oversight activities

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

Law enforcement

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

Lawsuits and disputes

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

Military, Veterans, National Security and Intelligence

If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may be required by other government authorities to release your PHI for national security activities.

Minors

We may disclose PHI of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

Organ and tissue donation

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

Personal representative

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

Public health and safety

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

Research

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

Worker's compensation

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

Uses and disclosures that require us to give you an opportunity to object and opt out

Fundraising

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

Special protections for HIV, alcohol and substance use disorders, mental health, and genetic information

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

Your rights regarding protected health information about you

Right to access and copy

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

Right to an electronic copy of PHI

You have the right to require that an electronic copy of your health information be given to you or transmitted to another individual or entity if it is readily producible. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic record.

Right to get notice of a security breach

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

- A short description of what happened, the date of the breach, and the date it was discovered
- The steps you should take to protect yourself from potential harm from the breach
- The steps we are taking to investigate the breach, mitigate 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 Health Plan Privacy

Officer and include a reason that supports your request. In certain cases, we may deny your request for amendment, but we will advise you of the reason within 60 days. For example, we may deny a request if we did not create the information, or if we believe the current information is correct.

Right to an accounting of disclosures

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

Right to request restrictions

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

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

Right to Notice of Privacy Practice

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

How to exercise your rights

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

Assistance in preparing written documents

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

Your written authorization is required for other uses and disclosures

Other uses and disclosures of PHI

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

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

Compliance with state and federal laws

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

Complaints

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

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

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

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

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

You may also contact OCR's Voice Hotline Number at 800 -368-1019 or send the information online at 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 of New Hampshire Mental Health Parity Laws and the Federal Mental Health Parity and Addiction Equity Act (MHPAEA)

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

The plan manages mental health and substance use disorder services for its members, including the review and authorization of these services and member appeals. If we make a decision 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 plan is not handling your benefits for mental health and substance use disorder services in the same way to that of medical/surgical services, you may file a complaint with the New Hampshire Insurance Department – Consumer, Health Insurance (nh.gov) or call 1-800-852-3416.

Filing a written complaint with the New Hampshire Insurance Department is not the same as filing an appeal with us under your plan benefits. In order to have a denial or reduction in coverage of a mental health or substance use disorder service reviewed, you must file an appeal with the plan. (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 Member Service toll-free at 855-833-8122 for more information about filing an appeal.

Appendix A: Definitions

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

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

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

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

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

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

- For providers with a payment agreement with the plan: For providers who have a payment agreement with the plan, the allowed amount is the negotiated amount set forth in the agreement.
- For providers with no payment agreement with the plan:
    - For covered services provided by providers who do not have a payment agreement with the plan, the allowed amount is either; the amount allowed or required by applicable state or federal law, or the amount the plan determines, in its sole discretion, is usual, customary and reasonable ("UCR")
    - UCR determinations are based on nationally accepted means and amounts of claims payment. These include, without limitation Medicare fee schedules and allowed amounts, American Medical Association CPT coding guidelines, CMS medical coding policies, and nationally recognized academy and society coding and clinical guidelines (when the plan has delegated claims processing to a third party, that third party shall have the same discretion as the plan with respect to UCR determinations)
    - The allowed amount is the maximum amount the plan will pay for covered services (minus any applicable member cost-sharing) rendered by providers who do not have a payment agreement with the plan

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

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

Alternative payment contract: Any contract between a carrier and a provider or provider organization that utilizes alternative payment methodologies, which are methods of payment that are not solely based on fee-for-service reimbursements and that may include, but is not limited to, shared savings arrangements, bundled payments, global payments, and fee-for- service payments that are settled or reconciled with a bundled or global payment.

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

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

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

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

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

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

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

Balance billing: When a non-network provider bills you for the balance remaining on the bill that the 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 plan does not provide any further coverage for such service or supply for that benefit year (or other time period.) If you get more of the service or supply beyond the benefit limit, you are responsible for all charges. Benefit limits are in your Schedule of Benefits.

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

- Benefits are purchased and administered
- Deductibles, coinsurance, copayments, and the out-of-pocket maximum are calculated; and
- Applicable benefit limits apply

See Chapter 1 for more information about benefit year.

Behavioral health manager: A company, organized under the laws of the State of New Hampshire or organized under the laws of another state and qualified to do business in the State, 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 coverage, 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.

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.

Case management or Care Management: A coordinated set of activities conducted for individual patient management of serious, complicated, long-lasting, or other health conditions.

Catastrophic plan: A health benefit 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): The following individuals, until their 26th birthday:The subscriber or spouse's biological 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 of the applicable information requested from the provider by the Carrier.

Clinical peer reviewer: A physician or other health care professional, other than the physician or other health care professional who made the initial decision, who holds a non-restricted license from the appropriate professional licensing board in the commonwealth, current board certification

from a specialty board approved by the American Board of Medical Specialties or of the Advisory Board of Osteopathic Specialists from the major areas of clinical services or, for non-physician health care professionals, the recognized professional board for their specialty, who actively practices in the same or similar specialty as typically manages the medical condition, procedure or treatment under review, and whose compensation does not directly or indirectly depend upon the quantity, type or cost of the services that such person approves or denies.

Clinical review criteria: The written screening procedures, decisions, abstracts, clinical protocols and practice guidelines used by a carrier to determine the medical necessity and appropriateness of health care services.

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

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.

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.

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

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

Covered services: The services, supplies, and drugs for which the plan will pay according to this EOC. Covered services must be: described as such in the EOC medically necessary, received while you are an active member of the plan, provided by a network provider (except in an emergency, for urgent care, or emergency/urgent care needed while you are outside the service area, or in rare cases when approved in advance by the plan), in some cases, approved in advance by a plan authorized reviewer, not listed as excluded in this EOC, provided to treat an injury, illness, or pregnancy, or for preventive care, and consistent with applicable state or federal law.

Covering provider: A provider who has an arrangement with your 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.

Custodial care: Care that is provided: mainly to assist in the activities of daily living;, 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.

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

Dental benefit plan: A policy, contract, certificate, or agreement of insurance entered into, offered, or issued by a dental carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs solely for dental care services.

Dental care professional: A dentist or other dental care practitioner licensed, accredited, or certified to perform specified dental services consistent with the law

Dental care provider: A dental care professional or facility licensed to provide dental care services.

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

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

Dependent: A subscriber's spouse, domestic partner, child, or other dependent. Not all dependents are allowed to enroll in all benefit packages offered.

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

NHID: The New Hampshire Insurance Department.

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 year in which they turn 26.

Eligible individual: An individual who is a resident of the state.

Emergency services: An emergency means health care services that are provided to an enrollee, insured, or subscriber in a licensed hospital emergency facility by a provider after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity that a prudent layperson with average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could result in any of the following:

- Serious jeopardy to the patient's health
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

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

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

- In the case of a drug, device, or biological product, it cannot be marketed lawfully without the approval of the
- U.S. Food and Drug Administration ("FDA") and final approval has not been given by the FDA
- The treatment is described as experimental (or investigational, unproven, or under study) in the written informed consent document provided, or to be provided, to the member by the health care professional or facility providing the treatment
- Authoritative evidence does not permit conclusions concerning the effect of the treatment on health outcomes

- There is insufficient authoritative evidence that the treatment improves the net health

outcome. (Net health outcome means that the treatment's beneficial effects on health outcomes outweigh any harmful effects of the treatment on health outcomes.). There is insufficient authoritative evidence that the treatment is as beneficial as any established alternative. This means that the treatment does not improve net outcome as much as or more than established alternatives

- There is insufficient authoritative evidence that the treatment's improvement in health outcomes is attainable outside the investigational setting "Authoritative evidence," as used in this definition, shall mean only the following:
- Reports and articles, of well-designed and well-conducted studies, published in authoritative English- language medical and scientific publications. The publications must be subject to peer review by qualified medical or scientific experts prior to publication. In evaluating this evidence, the plan takes into consideration both the quality of the published studies and the consistency of results
- Opinions and evaluations by national medical associations, other reputable technology assessment bodies, and health care professionals with recognized clinical expertise in treating the medical condition or providing the treatment. In evaluating this evidence, the plan takes into consideration the scientific quality of the evidence upon which the opinions and evaluations are based. The fact that a treatment is offered as a last resort does not mean that it is not an experimental or investigational treatment

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

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

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 the plan, 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 the state

Grievance: A formal complaint by you about:

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

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.

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

In-home behavioral services: A combination of medically necessary behavior management therapy and behavior management monitoring provided, however, 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 you to the plan asking us to address a plan action, policy, or procedure. It does not include questions about adverse determinations, which are plan decisions to deny coverage based on medical necessity.

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

Intensive care coordination (ICC): 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 support, 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.

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

JCAHO: The Joint Commission on Accreditation of Healthcare Organizations.

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

Licensed mental health professional: A licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a pastoral psychotherapist/counselor, a licensed clinical mental health counselor, psychiatric/mental health advanced practice registered nurse, 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.

Managed Care Organization or MCO: A Health Maintenance Organization (HMO) licensed in the state of New Hampshire.

Medically necessary or medical necessity: means health care services or products provided to an enrollee for the purpose of preventing, stabilizing, diagnosing, or treating an illness, injury, or disease or the symptoms of an illness, injury, or disease in a manner that is:

- Consistent with generally accepted standards of medical practice
- Clinically appropriate in terms of type, frequency, extent, site, and duration
- Demonstrated through scientific evidence to be effective in improving health outcomes
- Representative of "best practices" in the medical profession, and
- Not primarily for the convenience of the enrollee or physician or other health care provider. Health care services that are consistent with generally accepted principles of professional medical practice as determined by whether:

(a) the service is the most appropriate available supply or level of service for the member in question considering the potential benefits and harms to the member; (b) the service is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or (c) for services and interventions not in widespread use, the service is based on scientific evidence

Member: A person enrolled in the plan under a family 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 (Diagnostic and Statistical Manual of Mental Disorders).

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 authorization is required, but notification by the facility to WellSense is required within 72 hours of the admission.

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

NCQA: The National Committee for Quality Assurance.

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

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

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

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

Non-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.

Open enrollment period: The period of time each year when eligible persons (including eligible dependents) are able to apply for individual coverage (under an individual contract) or family coverage.

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

Outpatient or outpatient services: Services provided to an individual who is not a registered

bed patient in a facility. For example, you receive outpatient services in a provider's office, an emergency room, health center, or outpatient clinic.

Outpatient surgery: Surgery that is done under anesthesia in an operating room of a facility licensed to perform surgery and where you are expected to be discharged the same day. Examples are outpatient surgery in a hospital or free-standing ambulatory surgery center.

Participating provider: A provider who, under a contract with the carrier or with its contractor or subcontractor, has agreed to provide health care services to insured with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the carrier.

Physician assistant: A person who is a graduate of an approved program for the training of physician assistants who is supervised by a registered physician.

Plan: The benefits described in this EOC (including your Schedule of Benefits). The plan is also known as WellSense Health Plan.

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.

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 New Hampshire 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.

Prior authorization: means the approval from WellSense or a utilization review entity that is required before a particular health care service, item, or prescription drug is received by the member in order for that service, item or prescription drug to be covered under the health plan.

Prior authorization determination: means a determination by WellSense or a utilization review entity that a health care service, item or prescription drug has been reviewed pursuant to a request for prior authorization and, based on the information provided, satisfies or does not satisfy the health plans or the utilization review entity's requirements for coverage.

Prospective review: Utilization review conducted prior to an admission or a course of treatment and shall include any prior 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 plan's Provider Directory.

Provider directory: A listing of our network providers.

Provider network or network: The providers with whom the plan has an agreement to provide covered services to members. The plan has different provider networks. The provider network applicable to you is listed in your Schedule of Benefits.

Resident: A natural person living in New Hampshire. 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 a preexisting 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.

Second opinion: An opportunity or requirement to obtain a clinical evaluation by a health care professional other than the health care professional who made the original recommendation for a proposed health service, to assess the clinical necessity and appropriateness of the initial proposed health service.

Serious harm: Circumstances which could: seriously jeopardize the member's life, health, or ability to regain maximum function or result in severe pain.

Service area: The geographical area in which network providers are located. Please visit the plan's website at wellsense.org for more information about our service area. (Our service area may change periodically.)

Spouse: It includes a subscriber's divorced or separated spouse as required by NH 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 family contract or an individual contract (as applicable), and
- For an individual contract, is a NH resident

Note: 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.

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).

URAC: The American Accreditation HealthCare Commission/URAC, formerly known as the Utilization Review Accreditation Commission.

Urgent care: Medically necessary care that is required to prevent serious deterioration of your health when you have an unforeseen illness or injury. Urgent care does not include, among other things: routine care (including routine maternity or prenatal or postpartum care), preventive care; care for chronic medical conditions that require ongoing medical treatment, elective inpatient admissions or elective outpatient surgery.

Utilization review: A set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include, but are not limited to, ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.

Utilization review organization: An entity that conducts utilization review, other than a carrier performing utilization review for its own health benefit plans.

Vision care professional: An ophthalmologist, optometrist, or other practitioner licensed, accredited, or certified to perform specified vision services consistent with the law.

Vision care provider: A vision care professional or a facility licensed to perform and provide

vision care services.

Vision care services or vision services: Services for the diagnosis, prevention, treatment, cure, or relief of a vision condition, illness, injury, or disease.

Vision carrier: An entity that offers a policy, certificate, or contract that provides coverage solely for vision care services.

Wellness Program or "Health Management Program": An organized system designed to improve the overall health of participants through activities that may include, but shall not be limited to, education, health risk assessment, lifestyle coaching, behavior modification and targeted disease management.

WellSense or WellSense Health Plan: WellSense Health Plan, WellSense, is a not-for-profit NH-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 is sometimes referred to as “we,” “our,” or “us.”

WellSense Clarity Plan (or the “Plan”): The program of health benefits described in this EOC, along with the corresponding Schedules of Benefits. It is also referred to as the plan. WellSense offers the plan to individuals meeting applicable eligibility requirements.

You: See “Member”.

Appendix B: Member rights and responsibilities

1. You have the right to be treated with respect and with recognition of your dignity and right to privacy.
2. You have both the right and the responsibility to understand your health conditions and, to the extent possible, to actively participate with your practitioners in making decisions about your care and in developing mutually agreed-upon treatment goals.
3. You have the right to be told in advance, in a manner you understand, of any treatment(s) and alternatives that a provider feels should be done.
4. You have the right to take part, with practitioners, in making decisions regarding your healthcare, including the right to refuse treatment as far as the law allows, and to know what the outcome may be.
5. You have the right to have an open and honest discussion of appropriate or medically necessary treatment options for your health conditions, regardless of cost or benefit coverage. You may be responsible for payment of services not included in the Covered and Excluded Services list for your coverage type.
6. You have the right to expect your healthcare providers to keep your records private, as well as anything you discuss with them. No information will be released to anyone without your consent, unless required by law.
7. You have the right to request an interpreter when you receive healthcare. Call Member Service if you need help with this service.
8. You have the right to request an interpreter when you call or visit WellSense. Call Member Service if you need help with this service.
9. You have the right to choose your own Primary Care Provider (PCP) and you can change your PCP at any time. You must call Member Service if you would like to change your PCP.
10. You have the right to receive healthcare within the timeframes described in your member documents, and to file an Internal Appeal if you do not receive your care within those timeframes.
11. You have the right to voice a complaint and file a Grievance with Member Service, about services you received from the plan or from a healthcare provider. You also have the right to appeal certain decisions made by WellSense. The reasons for Grievances and Internal Appeals are described in your member documents.
12. You have the right to talk about your health records with your provider and obtain a complete copy of those records. You also have the right to request a change to your health records.
13. You have the right to know and receive all of the benefits, services, rights, and responsibilities you have under the plan.
14. You have the right to have your member documents and any printed materials from WellSense translated into your primary language, and/or to have these materials read aloud to you if you have trouble seeing or reading. Oral interpretation services will be made available upon request and free of charge.
15. You have the right to ask for a second opinion about any healthcare that your PCP advises you to have. WellSense will pay for the cost of your second opinion visit.
16. You have the right to receive emergency care 24 hours a day, seven days a week. Please see your member documents for complete information.

17. You have the right to be free from any form of physical restraint or seclusion that would be used as a means of coercion, force, discipline, convenience or retaliation.
18. You have the right to freely exercise these rights without adversely affecting the way WellSense and its providers treat you (including retaliation).
19. You have the right to receive health treatment from WellSense providers without regard to race, age, gender, sexual preference, national origin, religion, health status, economic status, or physical disabilities. No provider should engage in any practice, with respect to any WellSense member, that constitutes unlawful discrimination under any state or federal law or regulation.
20. You have the right to be disenrolled from WellSense in certain situations. Please refer to the section on Disenrollment in this EOC for more information.
21. You have the right to receive information about WellSense, our services, practitioners, providers, and your rights and responsibilities.
22. You have the right to make recommendations about our Rights and Responsibilities statement. Members have the right to refuse services via telehealth and be asked to be seen in person. You have the right to be informed of any changes in state law that may affect your coverage. The plan will provide you with any updated information at least 30 calendar days before the effective date of the change whenever practical.
23. You have a responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
24. You have a responsibility to follow plans and instructions for care that you have agreed to with your practitioners.

Appendix C: List of covered preventive care services

Preventive health services

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

Important Information: In some cases, a diagnoses 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 service 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.

Preventive services (no cost-sharing), such as a mammogram or colonoscopy, may be classified as diagnostic if something is found that requires further investigation. In such cases, you may be responsible for cost-sharing for the service. (e.g., if a polyp is removed during a screening colonoscopy).

Note: The information included in this document 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 policies. Please feel free to contact Member Service at 855-833-8122, 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	Frequency
Abdominal Aortic Aneurysm: Screening: men aged 65 to 75 years who have ever smoked	The USPSTF recommends 1-time screening for abdominal aortic aneurysm (AAA) with ultrasonography in men aged 65 to 75 years who have ever smoked.	1 per lifetime
Anxiety Disorders in Adults: Screening	The USPSTF recommends screening for anxiety disorders in adults, including pregnant and postpartum persons.	Adults age 64 years or younger, including pregnant and postpartum persons
Anxiety in Children and Adolescents: Screening: children and adolescents aged 8 to 18 years	The USPSTF recommends screening for anxiety in children and adolescents aged 8 to 18 years.	
Aspirin Use to Prevent Preeclampsia and Related Morbidity and Mortality: Preventive Medication: pregnant persons at high risk for preeclampsia	The USPSTF recommends the use of low-dose aspirin (81 mg/day) as preventive medication after 12 weeks of gestation in persons who are at high risk for preeclampsia.	Once daily after 12 weeks of gestation
Asymptomatic Bacteriuria in Adults: Screening: pregnant persons	The USPSTF recommends screening for asymptomatic bacteriuria using urine culture in pregnant persons.	
Blood Pressure Screening		
BR.CA-Related Cancer: Risk Assessment, Genetic Counseling, and Genetic Testing: women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or an ancestry associated with brcal/2 gene mutation	The USPSTF recommends that primary care clinicians assess women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or who have an ancestry associated with breast cancer susceptibility land 2 (BRCAl/2) gene mutations with an appropriate brief familial risk assessment tool. Women with a positive result on the risk assessment tool should receive genetic counseling and, if indicated after counseling, genetic testing.	

Breast Cancer: Medication Use to Reduce Risk: women at increased risk for breast cancer aged 35 years or older	The USPSTF recommends that clinicians offer to prescribe risk-reducing medications, such as tamoxifen, raloxifene, or aromatase inhibitors, to women who are at increased risk for breast cancer and at low risk for adverse medication effects.	
Breast Cancer: Screening: women aged 40 to 74 years	The USPSTF recommends biennial screening mammography for women aged 40 to 74 years.	Every 2 years
Cervical Cancer: Screening: women aged 21 to 65 years	The USPSTF recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting).	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
Chlamydia and Gonorrhea: Screening: sexually active women, including pregnant persons	• The USPSTF recommends screening for chlamydia in all sexually active women 24 years or younger and in women 25 years or older who are at increased risk for infection. • The USPSTF recommends screening for gonorrhea in all sexually active women 24 years or younger and in women 25 years or older who are at increased risk for infection.	
Colorectal Cancer: Screening: adults aged 45 to 49 years	The USPSTF recommends screening for colorectal cancer in adults aged 45 to 49 years.	
Colorectal Cancer: Screening: adults aged 50 to 75 years	The USPSTF recommends screening for colorectal cancer in all adults aged 50 to 75 years.	
Congenital Hypothyroidism Screening		
Depression and Suicide Risk in Adults: Screening	The USPSTF recommends screening for depression in the adult population, including pregnant and postpartum persons, as well as older adults.	Adults, including pregnant and postpartum persons, and older adults (65 years or older)

Depression and Suicide Risk in Children and Adolescents: Screening: adolescents aged 12 to 18 years	The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years.	
Diabetes Mellitus Type 2, Adults, Screening		Every 3 years for adults with normal test results
Diabetes Self-Management Training		Initial year - up to 10 hours of training, after that up to 2 hours per year for follow-up training
Falls Prevention in Community-Dwelling Older Adults: Interventions: adults 65 years or older	The USPSTF recommends exercise interventions to prevent falls in community-dwelling adults 65 years or older who are at increased risk for falls.	
Folic Acid for the Prevention of Neural Tube Defects: Preventive Medication: women who are planning or capable of pregnancy	The 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 folic acid.	
Gestational Diabetes: Screening: asymptomatic pregnant persons at 24 weeks of gestation or after	The USPSTF recommends screening for gestational diabetes in asymptomatic pregnant persons at 24 weeks of gestation or after.	
Healthy Diet and Physical Activity for Cardiovascular Disease Prevention in Adults With Cardiovascular Risk Factors: Behavioral Counseling Interventions: adults with cardiovascular disease risk factors	The USPSTF recommends offering or referring adults with cardiovascular disease risk factors to behavioral counseling interventions to promote a healthy diet and physical activity.	
Healthy Weight and Weight Gain In Pregnancy: Behavioral Counseling Interventions: pregnant persons	The USPSTF recommends that clinicians offer pregnant persons effective behavioral counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight gain in pregnancy.	
Hepatitis B Virus, Screening for Adolescents and Adults	The 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	The 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	The 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 past history of injection drug use
Human Immunodeficiency Virus (HIV) Infection: Screening: adolescents and adults aged 15 to 65 years	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults aged 15 to 65 years. Younger adolescents and older adults who are at increased risk of infection should also be screened.	Born 1945-1965: no diagnosis code restrictions
Human Immunodeficiency Virus (HIV) Infection: Screening: pregnant persons	The USPSTF recommends that clinicians screen for HIV infection in all pregnant persons, including those who present in labor or at delivery whose HIV status is unknown.	Annually for patients aged 15-65 with regard to perceived risk. Annually for patients younger than 15 and adults older than age 65 at increased HIV risk. 3 times per pregnancy

Hypertension in Adults: Screening: adults 18 years or older without known hypertension	The USPSTF recommends screening for hypertension in adults 18 years or older with office blood pressure measurement (OBPM). The USPSTF recommends obtaining blood pressure measurements outside of the clinical setting for diagnostic confirmation before starting treatment.	
Hypertensive Disorders of Pregnancy: Screening	The USPSTF recommends screening for hypertensive disorders in pregnant persons with blood pressure measurements throughout pregnancy.	
Intensive Behavioral Therapy (IBT) for Cardiovascular Disease	The USPSTF recommends offering or referring adults with cardiovascular disease risk factors to behavioral counseling interventions to promote a healthy diet and physical activity.	Annually
Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Screening: women of reproductive age	The USPSTF recommends that clinicians screen for intimate partner violence (IPV) in women of reproductive age and provide or refer women who screen positive to ongoing support services.	
Latent Tuberculosis Infection: Screening: asymptomatic adults at increased risk for infection	The USPSTF recommends screening for latent tuberculosis infection (LTBI) in populations at increased risk.	
Lead Screening, Children		
Lipid Disorder in Adults & Children -- Cholesterol Abnormalities Screening		
Lung Cancer: Screening: adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography (LDCT) in adults aged 50 to 80 years who have a 20 pack- year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.	Annually
Medical Nutrition Therapy (MNT)		

Obesity in Children and Adolescents: Screening: children and adolescents 6 years and older	The USPSTF recommends that clinicians screen for obesity in children and adolescents 6 years and older and offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status.	
Ocular Prophylaxis for Gonococcal Ophthalmia Neonatorum: Preventive Medication: newborns	The USPSTF recommends prophylactic ocular topical medication for all newborns to prevent gonococcal ophthalmia neonatorum.	
Osteoporosis to Prevent Fractures: Screening: postmenopausal women younger than 65 years at increased risk of osteoporosis	The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in postmenopausal women younger than 65 years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool. See the Clinical Considerations section for information on risk assessment.	
Osteoporosis to Prevent Fractures: Screening: women 65 years and older	The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in women 65 years and older.	
Perinatal Depression: Preventive Interventions: pregnant and postpartum persons	The USPSTF recommends that clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions.	
Phenylketonuria, Screening		
Prediabetes and Type 2 Diabetes: Screening: asymptomatic adults aged 35 to 70 years who have overweight or obesity	The USPSTF recommends screening for prediabetes and type 2 diabetes in adults aged 35 to 70 years who have overweight or obesity. Clinicians should offer or refer patients with prediabetes to effective preventive interventions.	
Preeclampsia: Screening: pregnant woman	The USPSTF recommends screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.	

Prevention of Dental Caries in Children Younger Than 5 Years: Screening and Interventions: children younger than 5 years	• The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride. • The UPSPSTF recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.	Up to 5 years old
Prevention of Human Immunodeficiency Virus (HIV) Infection: Pre-exposure Prophylaxis: persons at high risk of HIV acquisition	The USPSTF recommends that clinicians offer pre-exposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition.	
Rh(D) Incompatibility: Screening: pregnant women, during the first pregnancy-related care visit	The USPSTF strongly recommends Rh(D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.	Screen at first visit and then again at 24-28 week visit
Rh(D) Incompatibility: Screening: unsensitized rh(d)-negative pregnant women	The USPSTF recommends repeated Rh(D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D) - negative.	Screen at first visit and then again at 24-28 week visit
Screening for Depression in Adults: general adult population, including pregnant and postpartum women	The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.	
Sexually Transmitted Infections: Behavioral Counseling: sexually active adolescents and adults at increased risk	The USPSTF recommends behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections (STIs).	
Sickle Cell Disease, Screening		Newborn infants

Skin Cancer Prevention: Behavioral Counseling: young adults, adolescents, children, and parents of young children	The USPSTF recommends counseling young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk of skin cancer.	
Statin Use for the Primary Prevention of Cardiovascular Disease in Adults: Preventive Medication: adults aged 40 to 75 years who have 1 or more cardiovascular risk factors and an estimated 10-year cardiovascular disease (cvd) risk of 10% or greater	The USPSTF recommends that clinicians prescribe a statin for the primary prevention of CVD for adults aged 40 to 75 years who have 1 or more CVD risk factors (i.e. dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year risk of a cardiovascular event of 10% or greater.	
Syphilis Infection in Non-pregnant Adolescents and Adults: Screening: asymptomatic, non-pregnant adolescents and adults who are at increased risk for syphilis infection	The USPSTF recommends screening for syphilis infection in persons who are at increased risk for infection.	Once for men at high risk
Syphilis Infection in Pregnant Women: Screening: pregnant women	The USPSTF recommends early screening for syphilis infection in all pregnant women.	Once per pregnancy if high risk, up to 2 additional times in the 3rd trimester and at delivery if continued high risk, up to 2 - 30 minute counseling sessions annually
Tobacco Smoking Cessation in Adults, Including Pregnant Persons: Interventions: non-pregnant adults	The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and US Food and Drug Administration (FDA) -- approved pharmacotherapy for cessation to non- pregnant adults who use tobacco.	

Tobacco Smoking Cessation in Adults, Including Pregnant Persons: Interventions: pregnant persons	The USPSTF recommends that clinicians ask all pregnant persons about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant persons who use tobacco.	
Tobacco Use in Children and Adolescents: Primary Care Interventions: school-aged children and adolescents who have not started to use tobacco	The USPSTF recommends that primary care clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use among school-aged children and adolescents.	
Tuberculosis Testing for Children		
Tuberculosis (Latent) Infection in Adults: Screening	The 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)
Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions: adults 18 years or older, including pregnant women	The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.	
Unhealthy Drug Use: Screening: adults age 18 years or older	The USPSTF recommends screening by asking questions about unhealthy drug use in adults 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	The USPSTF recommends vision screening at least once in all children aged 3 to 5 years to detect amblyopia or its risk factors.	At least once for Children aged 3 to 5 years
Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions: adults	The USPSTF recommends that clinicians offer or refer adults with a body mass index (BMI) of 30 or higher [calculated as weight in kilograms divided by height in meters squared) to intensive, multicomponent behavioral interventions.	

Appendix D: Member extras

In addition to the covered services described above, we offer our members additional benefits that cover your whole health.

National Urgent Care Access

- If you are outside of the service area and get hurt or sick, you can access urgent care services and pay the same as you would at home. This coverage provides peace of mind when you travel within the U.S., when dependents are away at college and when you need care quickly

24/7 Nurse Advice

- Call 855-537-3463 if you need care advice in a pinch. You will be able to speak with a registered nurse who can answer questions and help guide you in the right direction for care

Eyewear Discounts for Adults

- 20% off prescription glasses (when frames and lenses are purchased together)
- 15% off prescription contact lens fitting and evaluation

Discounts are valid through VSP participating eye care providers. Be sure to show your member ID card when purchasing.

Note: This savings program may change over time without advance notice to members. To check on current Member Extras savings programs, you can:

- Call Member Service at 855-833-8122, or
- Visit our website at wellsense.org

Appendix E: Patient's bill of rights

i. The patient shall be treated with consideration, respect, and full recognition of the patient's dignity and individuality, including privacy in treatment and personal care and including being informed of the name, licensure status, and staff position of all those with whom the patient has contact, pursuant to RSA 151:3-b.

ii. The patient shall be fully informed of a patient's rights and responsibilities and of all procedures governing patient conduct and responsibilities. This information must be provided orally and in writing before or at admission, except for emergency admissions. Receipt of the information must be acknowledged by the patient in writing. When a patient lacks the capacity to make informed judgments the signing must be by the person legally responsible for the patient.

iii. The patient shall be fully informed in writing in language that the patient can understand, before or at the time of admission and as necessary during the patient's stay, of the facility's basic per diem rate and of those services included and not included in the basic per diem rate. A statement of services that are not normally covered by Medicare or Medicaid shall also be included in this disclosure.

iv. The patient shall be fully informed by a health care provider of his or her medical condition, health care needs, and diagnostic test results, including the manner by which such results will be provided and the expected time interval between testing and receiving results, unless medically inadvisable and so documented in the medical record, and shall be given the opportunity to participate in the planning of his or her total care and medical treatment, to refuse treatment, and to be involved in experimental research upon the patient's written consent only. For the purposes of this paragraph "health care provider" means any person, corporation, facility, or institution either licensed by this state or otherwise lawfully providing health care services, including, but not limited to, a physician, hospital or other health care facility, dentist, nurse, optometrist, podiatrist, physical therapist, or psychologist, and any officer, employee, or agent of such provider acting in the course and scope of employment or agency related to or supportive of health care services.

v. The patient shall be transferred or discharged after appropriate discharge planning only for medical reasons, for the patient's welfare or that of other patients, if the facility ceases to operate, or for nonpayment for the patient's stay, except as prohibited by Title XVIII or XIX of the Social Security Act. No patient shall be involuntarily discharged from a facility because the patient becomes eligible for Medicaid as a source of payment.

vi. The patient shall be encouraged and assisted throughout the patient's stay to exercise the patient's rights as a patient and citizen. The patient may voice grievances and recommend changes in policies and services to facility staff or outside representatives free from restraint, interference, coercion, discrimination, or reprisal.

vii. The patient shall be permitted to manage the patient's personal financial affairs. If the patient authorizes the facility in writing to assist in this management and the facility so consents, the assistance shall be carried out in accordance with the patient's rights under this subdivision and in conformance with state law and rules.

viii. The patient shall be free from emotional, psychological, sexual and physical abuse and from exploitation, neglect, corporal punishment and involuntary seclusion.

ix. The patient shall be free from chemical and physical restraints except when they are authorized in writing by a physician for a specific and limited time necessary to protect the patient or others from injury. In an emergency, restraints may be authorized by the designated professional staff member in order to protect the patient or others from injury. The staff member must promptly report such action to the physician and document same in the medical records.

x. The patient shall be ensured confidential treatment of all information contained in the patient's personal and clinical record, including that stored in an automatic data bank, and the patient's written consent shall be required for the release of information to anyone not otherwise authorized by law to receive it. Medical information contained in the medical records at any facility licensed under this chapter shall be deemed to be the property of the patient. The patient shall be entitled to a copy of such records upon request. The charge for the copying of a patient's medical records shall not exceed $15 for the first 30 pages or $.50 per page, whichever is greater; provided, that copies of filmed records such as radiograms, x-rays, and sonograms shall be copied at a reasonable cost.

xi. The patient shall not be required to perform services for the facility. Where appropriate for therapeutic or diversional purposes and agreed to by the patient, such services may be included in a plan of care and treatment.

xii. The patient shall be free to communicate with, associate with, and meet privately with anyone, including family and resident groups, unless to do so would infringe upon the rights of other patients. The patient may send and receive unopened personal mail. The patient has the right to have regular access to the unmonitored use of a telephone.

xiii. The patient shall be free to participate in activities of any social, religious, and community groups, unless to do so would infringe upon the rights of other patients.

xiv. The patient shall be free to retain and use personal clothing and possessions as space permits, provided it does not infringe on the rights of other patients.

xv. The patient shall be entitled to privacy for visits and, if married, to share a room with his or her spouse if both are patients in the same facility and where both patients consent, unless it is medically contraindicated and so documented by a physician. The patient has the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, including choice of room and roommate, except when the health and safety of the individual or other patients would be endangered.

xvi. The patient shall not be denied appropriate care on the basis of age, sex, gender identity, sexual orientation, race, color, marital status, familial status, disability, religion, national origin, source of income, source of payment, or profession.

xvii. The patient shall be entitled to be treated by the patient's physician of choice, subject to reasonable rules and regulations of the facility regarding the facility's credentialing process.

xviii. The patient shall be entitled to have the patient's parents, if a minor, or spouse, or next of kin, unmarried partner, or a personal representative chosen by the patient, if an adult, visit the facility, without restriction, if the patient is considered terminally ill by the physician

responsible for the patient's care.

xix. The patient shall be entitled to receive representatives of approved organizations as
xx. provided in RSA 151:28.
xxi. The patient shall not be denied admission to the facility based on Medicaid as a source of payment when there is an available space in the facility.
xxii. Subject to the terms and conditions of the patient's insurance plan, the patient shall have access to any provider in his or her insurance plan network and referral to a provider or facility within such network shall not be unreasonably withheld pursuant to RSA 420 -J:8, XIV.
xxiii. The patient shall not be denied admission, care, or services based solely on the patient's vaccination status.
xxiv. (a) In addition to the rights specified in paragraph XVIII, the patient shall be entitled to designate a spouse, family member, or caregiver who may visit the facility while the patient is receiving care. A patient who is a minor may have a parent, guardian, or person standing in loco parentis visit the facility while the minor patient is receiving care

(b)(1) Notwithstanding subparagraph (a), a health care facility may establish visitation policies that limit or restrict visitation when:

(A) The presence of visitors would be medically or therapeutically contraindicated in the best clinical judgment of health care professionals;
(B) The presence of visitors would interfere with the care of or rights of any patient;
(C) Visitors are engaging in disruptive, threatening, or violent behavior toward any staff member, patient, or another visitor; or
(D) Visitors are noncompliant with written hospital policy.

(b)(2) Upon request, the patient or patient's representative, if the patient is incapacitated, shall be provided the reason for denial or revocation of visitation rights under this paragraph.

(A) A health care facility may require visitors to wear personal protective equipment provided by the facility, or provided by the visitor and approved by the facility. A health care facility may require visitors to comply with reasonable safety protocols and rules of conduct. The health care facility may revoke visitation rights for failure to comply with this subparagraph.
(B) Nothing in this paragraph shall be construed to require a health care facility to allow a visitor to enter an operating room, isolation room, isolation unit, behavioral health setting or other typically restricted area or to remain present during the administration of emergency care in critical situations. Nothing in this paragraph shall be construed to require a health care facility to allow a visitor access beyond the rooms, units, or wards in which the patient is receiving care or beyond general common areas in the health care facility.
(C) The rights specified in this paragraph shall not be terminated, suspended, or waived by the health care facility, the department of health and human services, or any governmental entity, notwithstanding declarations of emergency declared by the governor or the legislature. No health care facility licensed pursuant to RSA 151:2 shall require a patient to waive the rights specified in this paragraph.
(D) Each health care facility licensed pursuant to RSA 151:2 shall post on its website:

- Informational materials explaining the rights specified in this paragraph;
- The patients' bill of rights which applies to the facility on its website; and
- Hospital visitation policy detailing the rights and responsibilities specified in this paragraph, and the limitations placed upon those rights by written hospital policy on its website.
- Unless expressly required by federal law or regulation, the department or any other state agency shall not take any action arising out of this paragraph against a health care facility for:
- Giving a visitor individual access to a property or location controlled by the health care facility;
- Failing to protect or otherwise ensure the safety or comfort of a visitor given access to a property or location controlled by the health care facility;
- The acts or omissions of any visitor who is given access to a property or location controlled by the health care facility.

Appendix F: Managed care consumer guide to external appeal and application form for an independent external appeal

The State of New Hampshire
Insurance Department
21 South Fruit Street, Suite 14
Concord, NH 03301

Telephone: 603-271-2261 Fax: 603-271-7066 TDD Access: Relay NH 1-800-735-2964

Email: consumerservices@ins.nh.gov insurance.nh.gov

Consumer Guide to External Appeal

Appealing a Denied Medical or Dental Claim

What is an External Appeal?

New Hampshire law gives individuals who are covered by fully-insured, health or dental insurance plans the right to have a nationally-accredited, independent, medical review organization (IRO), which is not affiliated with his/her insurance company, review and assess whether the company's denial of a specific claim or requested service or treatment is justified. This type of review is available when a recommended service or treatment is denied on the basis that it does not meet the insurer's requirements for medical necessity, appropriateness, healthcare setting, and level of care or effectiveness. This review is often called Independent External Appeal, External Appeal, External Health Review or simply External Review.

What are the eligibility requirements for External Appeal?

To be eligible for External Appeal the following conditions must be met:

- The patient must have a fully-insured health or dental insurance plan.
- The service that is the subject of the appeal request must be either a) a covered benefit under the terms of the insurance policy or b) a treatment that may be a covered benefit.
- Unless the patient meets the requirements for Expedited External Review (see below), the patient must have completed the Internal Appeal process provided by the insurer and have received a final, written decision from the insurer relative to its review.
    - Exception #1: The patient does not need to meet this requirement, if the insurer agrees in writing to allow the patient to skip its Internal Appeal process.
    - Exception #2: If the patient requested an internal appeal from the insurer, but has not received a decision from the insurer within the required time frame, the patient may apply for External Appeal without having received the insurer's final, written decision.
- The patient must submit the request for External Appeal to the Department within 180 days from the date appearing on the insurance company's letter,

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denying the requested treatment or service at the final level of the company's Internal Appeals process.

- The patient's request for External Appeal may not be submitted for the purpose of pursuing a claim or allegation of healthcare provider malpractice, professional negligence, or other professional fault.

What types of health insurance are excluded from External Appeal?

In general, External Appeal is available for most health insurance coverage. Service denials relating to the following types of insurance coverage or health benefit programs are not reviewable under New Hampshire's External Appeal law:

- Medicaid
- The New Hampshire Children's Health Insurance Program (CHIP)
- Medicare
- All other government-sponsored health insurance or health services programs.
- Health benefit plans that are self-funded by employers
    - Note: Some self-funded plans provide external appeal rights which are administered by the employer.

Can someone else represent me in my External Appeal?

Yes. A patient may designate an individual, including the treating health care provider, as his/her representative. To designate a representative, the patient must complete Section II of the External Review Application Form entitled "Appointment of Authorized Representative."

Submitting the External Appeal:

To request an External Appeal, the patient or the designated representative must complete and submit the External Review Application Form, available on the Department's website (https://insurance.nh.gov), and all supporting documentation to the New Hampshire Insurance Department. There is no cost to the patient for an External Appeal.

Please submit the following documentation:

☐ The completed External Review Application Form - signed and dated on page 6.

** The Department cannot process this application without the required signature(s) **

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Email: consumerservices@ins.nh.gov insurance.nh.gov

☐ A photocopy of the front and back of the patient's insurance card or other evidence that the patient is insured by the insurance company named in the appeal.

☐ A copy of the insurance company's letter, denying the requested treatment or service at the

final level of the company's internal appeals process.

☐ Any medical records, statements from the treating health care provider(s) or other

information that you would like the review organization to consider in its review.

☐ If requesting an Expedited External Appeal, the Provider's Certification Form.

If you have questions about the application process or the documentation listed above, please call the Insurance Department at 1-800-852-3416 and select option 3.

Mailing Address:

New Hampshire Insurance Department
Attn: External Review Unit
21 South Fruit Street, Suite 14
Concord, NH 03301

Expedited External Review Applications

- May be faxed to (603) 271-7066, or
- Sent by overnight carrier to the Department's mailing address

What is the Standard External Appeal Process and Time Frame for receiving a Decision?

It may take up to 60 days for the Independent Review Organization (IRO) to issue a decision in a Standard External Appeal.

- Within 7 business days after receiving your application form, the Insurance Department (the Department) will complete a preliminary review of your application to determine whether your request is complete and whether the case is eligible for external review.
    - If the request is not complete, the Department will inform the applicant what information or documents are needed in order to

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Insurance Department
21 South Fruit Street, Suite 14
Concord, NH 03301

Telephone: 603-271-2261 **Fax: 603-271-7066** **TDD Access: Relay NH 1-800-735-2964**

Email: consumerservices@ins.nh.gov **insurance.nh.gov**

process the application. The applicant will have 10 calendar days to supply the required information or documents.

- If the request for external appeal is accepted, the Department will select and assign an IRO to conduct the external review and will provide a written notice of the acceptance and assignment to the applicant and the insurer.
- Within 10 calendar days after assigning your case to an IRO, the insurer must provide the applicant and the IRO a copy of all information in its possession relevant to the appeal.
- If desired, the applicant may submit additional information to the IRO by the 20th calendar day after the date the case was assigned to the selected IRO. During this period, the applicant may also present oral testimony via telephone conference to the IRO. However, oral testimony will be permitted only in cases where the Insurance Commissioner determines that it would not be feasible or appropriate to present only written information.
    - To request a "teleconference," complete Section VII of the application form entitled "Request for a Telephone Conference" or contact the Department no later than 10 days after receiving notice of the acceptance of the appeal.
- By the 40th calendar day after the date the case was assigned to the selected Independent Review Organization, the IRO shall
  a) review all of the information and documents received,
  b) render a decision upholding or reversing the determination of the insurer, and
  c) notify in writing the applicant and the insurer of the IRO's review decision.

What is an Expedited External Appeal?

Whereas a Standard External Appeal may take 60 days, Expedited External Appeal is available for those persons who would be significantly harmed by having to wait. An applicant may request expedited review by checking the appropriate box on the External Review Application Form and by providing a Provider's Certification Form, in which the treating provider attests that in his/her medical opinion adherence to the time frame for standard review would seriously jeopardize the patient's life or health or would jeopardize the patient's ability to regain maximum function. Expedited reviews must be completed in 72 hours.

If the applicant is pursuing an internal appeal with the insurer and anticipates requesting an Expedited External Appeal, please call the Department at 800-852-3416 and select option 3 to speak with a consumer services officer, so that

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Email: consumerservices@ins.nh.gov **insurance.nh.gov**

accommodations may be made to receive and process the expedited request as quickly as possible.

Please note a patient has the right to request an Expedited External Appeal simultaneously with the insurer's Expedited Internal Appeal.

What happens when the Independent Review Organization makes its decision?

- If the appeal was an Expedited External Appeal, in most cases the applicant and insurer will be notified of the IRO's decision immediately by telephone or fax. Written notification will follow.
- If the appeal was a Standard External Appeal, the applicant and insurer will be notified in writing.
- The IRO's decision is binding on the insurer and is enforceable by the Insurance Department. The decision is also binding on the patient except that it does not prevent the patient from pursuing other remedies through the courts under federal or state law.

Have a question or need assistance?

Staff at the Insurance Department is available to help. Call 800-852-3416 and select option 3 to speak with a consumer services officer.

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INDEPENDENT EXTERNAL REVIEW

Appealing a Denied Medical or Dental Claim

New Hampshire law gives individuals who are covered by fully-insured, health or dental insurance plans the right to have a nationally accredited, independent, medical review organization (IRO), which is not affiliated with his/her health insurance company, review and assess whether the company's denial of a specific claim or requested service or treatment is justified. These reviews are available when a recommended service or treatment is denied on the basis that it does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness. This review is called Independent External Appeal, External Health Review or simply **External Review**.

There is no cost to the patient for an external review.

To be eligible for **Standard External Review**, the patient must (1) have a fully-insured health or dental insurance plan, (2) have completed the insurer's internal appeal process, and (3) have received a final denial of services from the insurer. A standard external review must be submitted to the Insurance Department within 180 days of the insurance company's final denial and may take up to 60 days for the IRO to make its decision.

To be eligible for **Expedited External Review**, the patient must (1) have a fully-insured health or dental insurance plan, and (2) the treating provider must certify that delaying treatment will seriously jeopardize the life or health of the patient or will jeopardize the patient's ability to regain maximum function. IROs must complete expedited reviews within 72 hours. An expedited external review may be requested and processed at the same time the patient pursues an expedited internal appeal directly with the insurance company.

For more information about external reviews, see the Insurance Department's Consumer Guide to External Review, available at https://insurance.nh.gov, or call 800-852-3416 to speak with a Consumer Services Officer.

Have a question or need assistance?

Staff at the Insurance Department is available to help.

Call 800-852-3416 to speak with a consumer services officer.

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SUBMITTING A REQUEST FOR EXTERNAL REVIEW

To request an external review, please provide the following documents to the New Hampshire Insurance Department at the address below:

☐ The enclosed, completed application form - signed and dated on page 6.

**** The Department cannot process this application without the required signature(s) ****

☐ A photocopy of the front and back of the patient's insurance card or other evidence that the patient is insured by the health or dental insurance company named in the appeal.

☐ A copy of the Health Insurance Company's letter, denying the requested treatment or service at the final level of the company's internal appeals process.

☐ Any medical records, statements from the treating health care provider(s) or other information that you would like the Independent Review Organization to consider in its review.

☐ If requesting an Expedited External Review, the treating Provider's Certification Form.

If you have questions about the application process or the documentation listed above, please call the Insurance Department at 1-800-852-3416.

Mailing Address:

New Hampshire Insurance Department

Attn: External Review Unit

21 South Fruit Street, Suite 14

Concord, NH 03301

Expedited External Review applications may be faxed to (603) 271-7066 or sent by overnight carrier to the address above.
If you wish to email the application package, please call the Insurance Department at 1-800-852-3416.

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Email: consumerservices@ins.nh.gov **nh.gov/insurance**

EXTERNAL REVIEW APPLICATION FORM

Request for Independent External Appeal of a Denied Medical or Dental Claim

Section I – Applicant Information

Patient's Name: _____ Patient's Date of Birth: _____

Applicant's Name: _____ Applicant's Email: _____

Applicant's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Applicant's Phone Number(s): Daytime: (___)_____ Evening: (___)_____

Section II – Appointment of Authorized Representative

**** Complete this section, only if someone else is representing the patient in this appeal ****

You may represent yourself or you may ask another person, including your treating health care provider, to act as your personal representative. You may revoke this authorization at any time.

I hereby authorize _____ to pursue my appeal on my behalf.

_____ Date: _____

Signature of Enrollee (or legal representative – Please specify relationship or title)

Representative's Mailing Address: _____

City: _____State: _____ Zip Code: _____

Representative's Phone Number(s): Daytime: (___)_____ Evening: (___)_____

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Section III – Insurance Plan Information

Member's Name: _____ Relationship to Patient: _____

Member's Insurance ID #: _____ Claim/Reference #: _____

Health Insurance Company's Name: _____

Insurance Company's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Company's Phone Number: (_____) _____

Name of Insurance Company representative handling appeal: _____

Is the member's insurance plan provided by an employer? Yes _____ No _____

☐ Name of employer: _____

☐ Employer's Phone Number: (_____) _____

☐ Is the employer's insurance plan self-funded? Yes* _____ No _____

*** If you are not certain, please check with your employer. Most self-funded plans are not eligible for external review. However, some self-funded plans may provide external review, but may have different procedures.**

Section IV – Information about the Patient's Health Care Providers

Name of Primary Care Provider (PCP): _____

PCP's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

PCP's Phone Number: (_____) _____

Name of Treating Health Care Provider: _____

Provider's clinical specialty: _____

Treating Provider's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Treating Provider's Phone Number: (_____) _____

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Section V – Health Care Decision in Dispute

Describe the health insurer company's decision in your own words. Include any information you have about the health care services, supplies or drugs being denied, including dates of service or treatment and names of health care providers. Explain why you disagree.

Please attach the following:

☐ Additional pages, if necessary;

☐ Pertinent medical records;

☐ If possible, a statement from the treating health care provider indicating why the disputed service, supply, or drug is medically necessary.

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Section VI – Expedited Review

**** Complete this section, only if you would like to request expedited review ****

The patient may request that the external review be handled on an expedited basis. To request expedited review, the treating health care provider must complete the attached Provider Certification Form, certifying that a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function.

Do you request an expedited review? Yes _____ No _____

Section VII – Request for a Telephone Conference

** Complete only if you would like to request a telephone conference **

If the patient, the authorized representative or the treating health care provider would like to discuss this case with the Independent Review Organization and the insurer in a telephone conference, select "Yes" below and explain why you think it is important to be allowed to speak about the case. If you do not request a telephone conference, the reviewer will base its decision on the written information only. The request for a telephone conference will be granted only if there is a good reason why the written information would not be sufficient.

** Telephone conferences often cannot be completed within the timeframe for expedited reviews **

Do you request a telephone conference? Yes _____ No _____

My reason for requesting a phone conference is:

_____

_____

_____

_____

_____

_____

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Section VIII – Authorization and Release of Medical Records

I, _____, hereby request an external review and authorize the patient's insurance company and the patient's health care providers to release all relevant medical or treatment records to the Independent Review Organization (IRO) and the New Hampshire Insurance Department. I understand that the IRO and the Department will use this information to make a determination to either reverse or uphold the insurer's denial. I also understand that the information will be kept confidential. I further understand that neither the Commissioner nor the IRO may authorize services in excess of those covered by the patient's health care plan. This release is valid for one year.

_____

Signature of Enrollee (or legal representative – Please specify relationship or title)

_____

Date

Before submitting this application, please verify that you have ...

Completed all relevant sections of the External Review Application Form

If appointing an authorized representative, the patient must complete Section II.

If requesting an Expedited External Review, Section VI must be completed and the Provider Certification Form must be submitted.

If requesting a telephone conference, Section VII must be completed.

Signed and dated the External Review Application Form in Section VIII.

Attached the following documents:

A photocopy of the front and back of the patient's insurance card or other evidence that the patient is insured by the health or dental insurance company named in the appeal.

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☐ A copy of the Health Insurance Company's letter, denying the requested treatment

or service at the final level of the company's internal appeals process.

☐ Any medical records, statements from the treating health care provider(s) or other

information that you would like the Independent Review Organization to consider

in its review.

☐ If requesting an Expedited External Review, the treating Provider's Certification

Form.

Applications for Expedited External Review may be faxed to (603) 271-7066 or sent by overnight carrier to the address on the top of this form. To email the appeal, please call the Insurance Department at 1-800-852-3416 for additional instructions.

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PROVIDER'S CERTIFICATION FORM

For Expedited Consideration of a Patient's External Review

The New Hampshire Insurance Department administers the external review process for all fully-insured health and dental plans in New Hampshire. A patient may submit an application for External Review, when his/her health or dental insurer has denied a health care service or treatment, including a prescription, on the basis that the requested treatment or service does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.

The time frame for receiving a decision from an Independent Review Organization (IRO) for a Standard External Review is up to 60 days. Expedited External Review is available, ***only if*** the patient's treating health care provider certifies that, in his/her professional judgment, adherence to the time frame for standard review ***would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function.*** The time frame for receiving a decision from an IRO for an Expedited External Review is within 72 hours. An Expedited External Review may be requested and processed at the same time the patient pursues an Expedited Internal Appeal directly with the insurance company.

**** Expedited External Review is not available, when services have already been rendered ****

General Information

Name of Treating Health Care Provider: _____

Mailing Address: _____

City: _____State: _____ Zip Code: _____

Phone Number: (___)_____ Fax Number: (___)_____

Email Address: _____

Licensure and Area of Clinical Specialty: _____

Name of Patient: _____

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PROVIDER CERTIFICATION

I hereby certify that I am a treating health care provider for _____ (hereafter referred to as "the patient"); that adherence to the time frame for conducting a standard review of the patient's external review would, in my professional judgment, seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function; and that for this reason, the patient's appeal of the denial by the patient's health insurer of requested medical services should be processed on an expedited basis.

I am aware that the Independent Review Organization (IRO) may need to contact me during non-business hours for medical information and that a decision will be made by the IRO within 72 hours of receiving this Expedited External Review request, regardless of whether or not I provide medical information to the IRO.

During non-business hours I may be reached at: (___) _____

I certify that the above information is true and correct. I understand that I may be subject to professional disciplinary action for making false statements.

_____

Treating Health Care Provider's Name (Please Print)

_____ _____

Signature Date