




The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.wellsense.org](http://www.wellsense.org) or by calling 1-855-833-8120. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call 1-855-833-8120 to request a copy.

| Important Questions   | Answers  | Why This Matters:   |
|---|--|---|
| <b>What is the overall <a href="#">deductible</a>?</b>                                | <b>\$3,000</b> Individual / <b>\$6,000</b> Family  | Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .  |
| <b>Are there services covered before you meet your <a href="#">deductible</a>?</b>    | Yes. <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a> .                                | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .   |
| <b>Are there other <a href="#">deductibles</a> for specific services?</b>             | Yes, for pediatric Dental Type II and Type III services ONLY, <b>\$50</b> per individual   | You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.  |
| <b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b> | <b>\$9,450</b> Individual / <b>\$18,900</b> Family (\$350 Pediatric Dental)  | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.   |
| <b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>               | Premiums, balance-billed charges, and health care this plan doesn't cover.   | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .   |
| <b>Will you pay less if you use a <a href="#">network provider</a>?</b>               | Yes. See <a href="http://www.wellsense.org">www.wellsense.org</a> or call 1-855-833-8120 for a list of <a href="#">network providers</a> . | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| <b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>    | No.  | You can see the <a href="#">network specialist</a> you chose without a <a href="#">referral</a> .   |

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event   | Services You May Need                                  | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information  |
|--|--|---|--|---|
|  |  | Network Provider<br>(You will pay the least)                            | Out-of-Network Provider<br>(You will pay the most) |   |
| If you visit a health care <a href="#">provider's</a> office or clinic   | Primary care visit to treat an injury or illness       | \$30 / Visit ( <a href="#">Deductible</a> does not apply)               | Not Covered  | <ul style="list-style-type: none"> <li>- <a href="#">Specialist</a> visits may require a <a href="#">Preauthorization</a>.</li> <li>- You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your plan will pay for. Visit <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> for info on services that are considered preventive.</li> </ul> |
|  | <a href="#">Specialist</a> visit                       | \$60 / Visit ( <a href="#">Deductible</a> does not apply)               | Not Covered  |   |
|  | <a href="#">Preventive care/screening/immunization</a> | No charge, <a href="#">Deductible</a> does not apply                    | Not Covered  |   |
| If you have a test   | <a href="#">Diagnostic test</a> (x-ray, blood work)    | 35% Coinsurance / Visit (X-Ray)<br>35% Coinsurance / Visit (Blood Work) | Not Covered  | <ul style="list-style-type: none"> <li>- <a href="#">Preauthorization</a> is required. If <a href="#">preauthorization</a> is not obtained payment for services could be denied.</li> </ul>   |
|  | Imaging (CT/PET scans, MRIs)                           | 35% Coinsurance / Visit   | Not Covered  |   |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.wellsense.org">www.wellsense.org</a> | Generic drugs  | \$30 / Retail and \$60 / mail order prescription                        | Not Covered  | <ul style="list-style-type: none"> <li>- Covers up to a 30-day supply (retail);</li> <li>- Covers up to a 90-day supply (mail order).</li> <li>- Oral and other forms of prescription contraceptives are covered in full.</li> <li>- Certain oral anti-cancer drugs are covered in full.</li> <li>- Step therapy may be required.</li> <li>- <a href="#">Preauthorization</a> may be required.</li> </ul>   |
|  | Preferred brand drugs                                  | 35% Coinsurance / Retail and 35% Coinsurance / mail order prescription  | Not Covered  |   |
|  | Non-preferred brand drugs                              | 35% Coinsurance / Retail and 35% Coinsurance / mail order prescription  | Not Covered  |   |
|  | <a href="#">Specialty drugs</a>                        | 35% Coinsurance / Retail and 35% Coinsurance / mail order prescription  | Not Covered  |   |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.wellsense.org](http://www.wellsense.org).

| Common Medical Event  | Services You May Need                            | What You Will Pay  |   | Limitations, Exceptions, & Other Important Information   |
|---|--|--|---|--|
|   |  | Network Provider<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most)        |  |
| If you have outpatient surgery  | Facility fee (e.g., ambulatory surgery center)   | \$750/Visit  | Not Covered   | <ul style="list-style-type: none"> <li>- Includes diagnostic colonoscopies and endoscopies.</li> <li>- <a href="#">Preauthorization</a> may be required.</li> </ul>  |
|   | Physician/surgeon fees                           | No Charge  | Not Covered   |  |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$750 / Visit  | \$750 / Visit   | <ul style="list-style-type: none"> <li>- ER <a href="#">Copayment</a> is waived if admitted directly to the hospital from the ER</li> <li>- If you receive emergency services from a non-network provider, the plan pays up to the allowed amount.</li> </ul>                      |
|   | <a href="#">Emergency medical transportation</a> | No Charge  | No Charge   | <ul style="list-style-type: none"> <li>- Emergency transportation only. Non-emergency transportation requires <a href="#">Preauthorization</a>. If <a href="#">preauthorization</a> is not obtained payment for services could be denied.</li> </ul>                               |
|   | <a href="#">Urgent care</a>                      | \$60 / Visit ( <a href="#">Deductible</a> does not apply)  | \$60 / Visit ( <a href="#">Deductible</a> does not apply) | <ul style="list-style-type: none"> <li>- <a href="#">Urgent care</a> from non-network providers outside of the service area is covered for medically necessary covered services.</li> </ul>  |
| If you have a hospital stay   | Facility fee (e.g., hospital room)               | 35% Coinsurance / Admission  | Not Covered   | <ul style="list-style-type: none"> <li>- Inpatient Rehabilitation hospitals are limited to 60 days per benefit year.</li> <li>- <a href="#">Preauthorization</a> is required. If <a href="#">preauthorization</a> is not obtained payment for services could be denied.</li> </ul> |
|   | Physician/surgeon fees                           | No Charge  | Not Covered   |  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | \$30 / Visit ( <a href="#">Deductible</a> does not apply)  | Not Covered   | <ul style="list-style-type: none"> <li>- <a href="#">Preauthorization</a> may be required from our 3<sup>rd</sup> party contractor, Carelon Behavioral Health.</li> </ul>  |
|   | Inpatient services                               | 35% Coinsurance / Admission  | Not Covered   |  |
| If you are pregnant   | Office visits                                    | \$30/Visit with a PCP<br>\$60/Visit with a Specialist ( <a href="#">Deductible</a> does not apply) | Not Covered   | <ul style="list-style-type: none"> <li>- <a href="#">Cost-sharing</a> does not apply to preventive services</li> </ul>   |
|   | Childbirth/delivery professional services        | No Charge  | Not Covered   |  |
|   | Childbirth/delivery facility services            | 35% Coinsurance / Admission  | Not Covered   |  |

| Common Medical Event   | Services You May Need                     | What You Will Pay                            |  | Limitations, Exceptions, & Other Important Information   |
|--|---|--|--|--|
|  |   | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |  |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | No Charge                                    | Not Covered  | - <a href="#">Preauthorization</a> is required. If <a href="#">preauthorization</a> is not obtained payment for services could be denied.  |
|  | <a href="#">Rehabilitation services</a>   | 35% Coinsurance / Visit                      | Not Covered  | - Outpatient Physical and Occupational therapy is limited to 60 combined visits per benefit year.<br>- PT/OT limits do not apply to members with Autism Spectrum Disorders or for children under age 3 who are receiving Early Intervention Services.<br>- No limit on speech therapy visits<br>- <a href="#">Preauthorization</a> may be required after initial evaluation.<br>- \$30 copayment per visit for members with autism spectrum disorder. ( <a href="#">Deductible</a> does not apply) |
|  | <a href="#">Habilitation services</a>     | 35% Coinsurance / Visit                      | Not Covered  | - Outpatient Physical and Occupational therapy is limited to 60 combined visits per benefit year.<br>- <a href="#">Preauthorization</a> may be required after initial evaluation.<br>- \$30 copayment per visit for members with autism spectrum disorder. ( <a href="#">Deductible</a> does not apply)  |
|  | <a href="#">Skilled nursing care</a>      | 35% Coinsurance / Admission                  | Not Covered  | - Limited to 100 days per benefit year.<br>- <a href="#">Preauthorization</a> is required. If <a href="#">preauthorization</a> is not obtained payment for services could be denied.   |
|  | <a href="#">Durable medical equipment</a> | 35% Coinsurance                              | Not Covered  | - Coinsurance does not apply to wigs.<br>- <a href="#">Preauthorization</a> may be required from our 3 <sup>rd</sup> party vendor, Northwood, Inc.   |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.wellsense.org](http://www.wellsense.org).

| Common Medical Event                   | Services You May Need            | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information  |
|--|----------------------------------|---|--|---|
|  |                                  | Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most) |   |
|  | <a href="#">Hospice services</a> | No Charge   | Not Covered  | - <a href="#">Preauthorization</a> is required. If you do not get <a href="#">preauthorization</a> , payment for services could be denied.  |
| If your child needs dental or eye care | Children's eye exam              | No Charge for preventive exam. \$60 / visit for non-routine exams. ( <a href="#">Deductible</a> does not apply) | Not Covered  | - Preventive eye exams are limited to one every 12 months for members age 18 and younger.   |
|  | Children's glasses               | 35% Coinsurance   | Not Covered  |   |
|  | Children's dental check-up       | No Charge   | Not Covered  | - Only covered for members age 18 and younger.<br>- Check-up refers to preventive and diagnostic visits (Type I services). Type II, Type III, and Type IV services are subject to cost-sharing* |

#### Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)                                |  |   |  |
|--|--|---|--|
| <ul style="list-style-type: none"> <li>Acupuncture</li> <li>Cosmetic Surgery</li> <li>Early Intervention services for children age 3 and older.</li> <li>Hearing Aids for members over age 21</li> <li>Long-term care</li> </ul> | <ul style="list-style-type: none"> <li>Non-Emergency care when traveling outside the U.S</li> <li>Private-duty nursing</li> <li>Routine foot care except for members with Diabetes</li> <li>Dental Care (Adult)</li> </ul> | <ul style="list-style-type: none"> <li>Services beyond any benefit or monetary limit listed in this Summary of Benefits and Coverage</li> <li>Vision Hardware except as described in the Evidence of Coverage.</li> <li>Weight loss programs, except as described in the Evidence of Coverage.</li> </ul> |  |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.) |  |  |  |
|--|--|--|--|
| <ul style="list-style-type: none"> <li>Abortion</li> <li>Bariatric Surgery</li> </ul>  | <ul style="list-style-type: none"> <li>Chiropractic Care</li> <li>Dental Services for Cleft Lip/Palate Repair</li> </ul> | <ul style="list-style-type: none"> <li>Hearing Aids for Children</li> <li>Infertility Treatment</li> </ul> |  |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.wellsense.org](http://www.wellsense.org).

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Massachusetts Division of Insurance Consumer Service Section 1-877-563-4467 or [mass.gov/doi](http://mass.gov/doi), The U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the Department of Health and Human Service's Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact:

- WellSense Health Plan Member Service at 1-855-833-8120
- The U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa)
- Massachusetts Division of Insurance at 617-521-7794

**Does this plan provide Minimum Essential Coverage? Yes**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet the Minimum Value Standards? Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-833-8120.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-833-8120.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-833-8120.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-833-8120.

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.



## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

|   |         |
|---|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$3,000 |
| ■ <a href="#">Specialist copayments</a>                         | \$60    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 35%     |

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$3,000        |
| <a href="#">Copayments</a>        | \$60           |
| <a href="#">Coinsurance</a>       | \$2,500        |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Peg would pay is</b> | <b>\$5,560</b> |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|   |         |
|---|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$3,000 |
| ■ <a href="#">Specialist copayments</a>                         | \$60    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 35%     |
| ■ <a href="#">Durable medical equipment coinsurance</a>         | 35%     |

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$3000         |
| <a href="#">Copayments</a>        | \$400          |
| <a href="#">Coinsurance</a>       | \$500          |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Joe would pay is</b> | <b>\$3,900</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|   |         |
|---|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$3,000 |
| ■ <a href="#">Specialist copayments</a>                         | \$60    |
| ■ <a href="#">Emergency room copayments</a>                     | \$750   |
| ■ <a href="#">Durable medical equipment coinsurance</a>         | 35%     |

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$2,500        |
| <a href="#">Copayments</a>        | \$200          |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,700</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.