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 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:
What is the overall deductible?	$3,600 Individual or $7,200 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	Yes. For pediatric dental type II and type III services only, $50 per individual.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$8,000 Individual / $16,000 Family ($350 Pediatric Dental)	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit
Will you pay less if you use a network provider?	Yes. See www.wellsense.org or call 1-855-833-8120 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the network specialist you chose without a referral.

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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$60 copay/visit	Not covered	None.
	Specialist visit	$90 copay/visit	Not covered	Specialist visits may require a preauthorization.
	Preventive care/screening/ immunization	$0 copay/visit Deductible does not apply	Not covered	*See Preventive Health Services section. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Visit https://www.healthcare.gov/coverage/preventive-care-benefits/ for info on services that are considered preventive.
If you have a test	Diagnostic test (x-ray, blood work)	$135 X-ray and $55 Blood work copay/visit	Not covered	None.
	Imaging (CT/PET scans, MRIs)	$750 copay/visit	Not covered	Preauthorization is required; if preauthorization is not obtained payment for services could be denied.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.wellsense.org**	Generic drugs – Tier 1	$30 Retail and $60 Mail order copay/prescription	Not covered	*See Prescription Drugs section. Covers up to a 30-day supply (Retail); 90-day supply (Mail order). Step therapy and preauthorization may be required for certain drugs and supplies.
	Preferred brand drugs – Tier 2	$120 Retail and $240 Mail order copay/prescription	Not covered	
	Non-preferred brand drugs – Tier 3	$200 Retail and $600 Mail order copay/prescription	Not covered	
	Specialty drugs – Tier 4	$200 Retail and $600 Mail order copay/prescription	Not covered	*See Prescription Drugs section. Covers up to a 30-day supply. Preauthorization may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$500 copay/visit	Not covered	Preauthorization may be required.
	Physician/surgeon fees	$0 copay/visit	Not covered	
If you need immediate medical attention	Emergency room care	$875 copay/visit	$875 copay/visit	*See Emergency Services section. Copayment is waived if admitted or held for observation.
	Emergency medical transportation	$0 copay/transport	$0 copay/transport	*See Emergency Services section. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Urgent care	$90 copay/visit	$90 copay/visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,500 copay/admission	Not covered	60 calendar day limit/benefit year for inpatient rehabilitation hospital admissions. *See Inpatient Hospital Care section. Preauthorization is required; if preauthorization is not obtained, payment for services may be denied.
	Physician/surgeon fees	$0 copay/admission	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$60 copay/visit	Not covered	Preauthorization may be required from our 3rd party contractor, Carelon Behavioral Health.
	Inpatient services	$1,500 copay/admission	Not covered	
If you are pregnant	Office visits	$0 copay/routine visit Deductible does not apply	Not covered	*See Maternity Care and Maternity Services-Outpatient sections. Depending on the type of services, a copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	$0 copay/admission	Not covered	
	Childbirth/delivery facility services	$1,500 copay/admission	Not covered	
If you need help recovering or have other special health needs	Home health care	$0 copay/visit	Not covered	Preauthorization is required; if preauthorization is not obtained payment for services could be denied.
	Rehabilitation services	$90 copay/visit	Not covered	60 outpatient visit limit/benefit year. Includes

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	$90 copay/visit	Not covered	occupational, physical, and speech therapies. No benefit limit for speech therapy or when any of these covered services are furnished to treat autism spectrum disorders or as part of covered home health care or early intervention services. *See Rehabilitation Therapies section. Preauthorization required for certain services.
	Skilled nursing care	$1,500 copay/admission	Not covered	100 calendar day limit/benefit year. Preauthorization is required; if preauthorization is not obtained, payment for services could be denied.
	Durable medical equipment	20% coinsurance	Not covered	*See Durable Medical Equipment section. Coinsurance does not apply to wigs; and no cost share applies to breast pumps. Preauthorization may be required from our 3rd party vendor, Northwood, Inc.
	Hospice services	$0 copay/visit	Not covered	Preauthorization is required; if you do not get preauthorization, payment for services could be denied.
If your child needs dental or eye care	Children's eye exam	$90 copay/routine and non-routine exams	Not covered	1 exam/12 months for preventive eye exams. Cost sharing does not apply to preventive eye exams. *See Vision Services section.
	Children's glasses	20% coinsurance	Not covered	1 pair of eyeglasses or contact lenses/calendar year. *See Vision Services section.
	Children's dental check-up	No charge/visit Deductible does not apply	Not covered	2 exams/12 months. *See Pediatric Dental section. Type II, type III, and type IV dental services are subject to cost sharing.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture • Cosmetic surgery • Dental care (Adult) • Early intervention services for children age 3 and older.	• Long-term care • Non-emergency care when traveling outside the U.S • Private-duty nursing	• Services beyond any listed benefit or monetary limit • Vision hardware except as described in the Evidence of Coverage

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Abortion • Bariatric surgery • Chiropractic care	• Hearing aids ($2,000 per ear every 36 months for child members age 21 or younger) • Infertility treatment • Routine eye care (Adult)	• Routine foot care (only for members with diabetes) • Weight loss programs (25% of qualifying membership fees for one member per family per calendar year)

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, The U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or 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. 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 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
- 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, kwiijigo holne' 1-855-833-8120.

****Small Group Coverage Period: 12 months from effective date**

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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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 plan's overall deductible** **$3,600**
- **Specialist copayment (*prenatal care*)** **$0**
- **Hospital (facility) copayment** **$1,500**

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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3,600
Copayments	$1,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is*	**$5,100**

Managing Joe's Type 2 Diabetes

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

- **The plan's overall deductible** **$3,600**
- **Specialist copayment** **$90**
- **Primary care visit copayment** **$60**
- **Durable medical equipment coinsurance** **20%**

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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:	
Cost Sharing	
Deductibles	$3,600
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is*	**$4,000**

Mia's Simple Fracture

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

- **The plan's overall deductible** **$3,600**
- **Specialist copayment** **$90**
- **Emergency room copayment** **$875**
- **Durable medical equipment coinsurance** **20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is*	**$2,800**

The plan would be responsible for the other costs of these EXAMPLE covered services. *Note: Patient Pays Amount is capped at the individual out-of-pocket limit. Total Amounts may not add up due to rounding.