




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:
What is the overall <a href="#">deductible</a> ?	\$1,500 Individual or \$3,000 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> .
Are there services covered before you meet your <a href="#">deductible</a> ?	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>
Are there other <a href="#">deductibles</a> 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 <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$5,250 Individual / \$10,500 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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	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>
Will you pay less if you use a <a href="#">network provider</a> ?	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.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$30 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	Not covered	None.
	<a href="#">Specialist</a> visit	\$55 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	Not covered	<a href="#">Specialist</a> visits may require a <a href="#">preauthorization</a> .
	<a href="#">Preventive care/screening/immunization</a>	\$0 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	Not covered	*See Preventive Health Services section. 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.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$75 X-ray and \$50 Blood work <a href="#">copay</a> /visit	Not covered	None.
	Imaging (CT/PET scans, MRIs)	\$250 <a href="#">copay</a> /visit	Not covered	<a href="#">Preauthorization</a> is required; if <a href="#">preauthorization</a> is not obtained payment for services could be denied.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.wellsense.org">www.wellsense.org</a>	Generic drugs – Tier 1	\$30 Retail and \$60 Mail order <a href="#">copay</a> /prescription <a href="#">Deductible</a> does not apply	Not covered	*See Prescription Drugs section. Covers up to a 30-day supply (Retail); 90-day supply (Mail order). Step therapy and <a href="#">preauthorization</a> may be required for certain drugs and supplies.
	Preferred brand drugs – Tier 2	\$60 Retail and \$120 Mail order <a href="#">copay</a> /prescription	Not covered	
	Non-preferred brand drugs – Tier 3	\$90 Retail and \$270 Mail order <a href="#">copay</a> /prescription	Not covered	
	<a href="#">Specialty drugs – Tier 4</a>	\$90 Retail and \$270 Mail order <a href="#">copay</a> /prescription	Not covered	*See Prescription Drugs section. Covers up to a 30-day supply. <a href="#">Preauthorization</a> may be required.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$250 <a href="#">copay</a> /visit	Not covered	<a href="#">Preauthorization</a> may be required.
	Physician/surgeon fees	\$0 <a href="#">copay</a> /visit	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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$250 <a href="#">copay</a> /visit	\$250 <a href="#">copay</a> /visit	*See Emergency Services section. <a href="#">Copayment</a> is waived if admitted or held for observation.
	<a href="#">Emergency medical transportation</a>	\$0 <a href="#">copay</a> /transport	\$0 <a href="#">copay</a> /transport	*See Emergency Services section. If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).
	<a href="#">Urgent care</a>	\$55 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	\$55 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$750 <a href="#">copay</a> /admission	Not covered	60 calendar day limit/benefit year for inpatient rehabilitation hospital admissions. *See Inpatient Hospital Care section. <a href="#">Preauthorization</a> is required; if <a href="#">preauthorization</a> is not obtained, payment for services may be denied.
	Physician/surgeon fees	\$0 <a href="#">copay</a> /admission	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	Not covered	<a href="#">Preauthorization</a> may be required from our 3 <sup>rd</sup> party contractor, Carelon Behavioral Health.
	Inpatient services	\$750 <a href="#">copay</a> /admission	Not covered	
If you are pregnant	Office visits	\$0 <a href="#">copay</a> /routine visit <a href="#">Deductible</a> does not apply	Not covered	*See Maternity Care and Maternity Services-Outpatient sections. Depending on the type of services, a <a href="#">copayment</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	\$0 <a href="#">copay</a> /admission	Not covered	
	Childbirth/delivery facility services	\$750 <a href="#">copay</a> /admission	Not covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	\$0 <a href="#">copay</a> /visit	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>	\$55 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	Not covered	60 outpatient visit limit/benefit year. Includes 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
	<a href="#">Habilitation services</a>	\$55 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				intervention services. *See Rehabilitation Therapies section. <a href="#">Preauthorization</a> required for certain services.
	<a href="#">Skilled nursing care</a>	\$750 <a href="#">copay</a> /admission	Not covered	100 calendar day limit/benefit year. <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>	20% <a href="#">coinsurance</a>	Not covered	*See Durable Medical Equipment section. <a href="#">Coinsurance</a> does not apply to wigs; and no cost share applies to breast pumps. <a href="#">Preauthorization</a> may be required from our 3 <sup>rd</sup> party vendor, Northwood, Inc.
	<a href="#">Hospice services</a>	\$0 <a href="#">copay</a> /visit	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	\$55 <a href="#">copay</a> /routine and non-routine exams <a href="#">Deductible</a> does not apply	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% <a href="#">coinsurance</a>	Not covered	1 pair of eyeglasses or contact lenses/calendar year. *See Vision Services section.
	Children's dental check-up	No charge/visit <a href="#">Deductible</a> 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](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.

**\*\*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,500
■ <a href="#">Specialist copayment</a> ( <i>prenatal care</i> )	\$0
■ Hospital (facility) <a href="#">copayment</a>	\$750

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>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$800
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is*</b>	<b>\$2,300</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>	\$1,500
■ <a href="#">Specialist copayment</a>	\$55
■ Primary care visit <a href="#">copayment</a>	\$30
■ <a href="#">Durable medical equipment coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$300
<a href="#">Copayments</a>	\$1,200
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is*</b>	<b>\$1,500</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>	\$1,500
■ <a href="#">Specialist copayment</a>	\$55
■ <a href="#">Emergency room copayment</a>	\$250
■ <a href="#">Durable medical equipment coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$60
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is*</b>	<b>\$1,900</b>

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.