




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> ?	\$2,000 Individual or \$4,000 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> ?	\$7,050 Individual / \$14,100 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)	
If you visit a health care <a href="#">provider's office</a> or clinic	Primary care visit to treat an injury or illness	\$30 <a href="#">copay</a> /visit	Not covered	None.
	<a href="#">Specialist</a> visit	\$60 <a href="#">copay</a> /visit	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.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$75 X-ray and \$60 Blood work <a href="#">copay</a> /visit	Not covered	None.
	Imaging (CT/PET scans, MRIs)	\$500 <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.
If you need drugs to treat your illness or condition 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	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	\$105 Retail and \$315 Mail order <a href="#">copay</a> /prescription	Not covered	
	<a href="#">Specialty drugs – Tier 4</a>	\$105 Retail and \$315 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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$500 <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	

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>	\$300 <a href="#">copay</a> /visit	\$300 <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>	\$60 <a href="#">copay</a> /visit	\$60 <a href="#">copay</a> /visit	
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	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>	\$60 <a href="#">copay</a> /visit	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
	<a href="#">Habilitation services</a>	\$60 <a href="#">copay</a> /visit	Not covered	

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)	
				spectrum disorders or as part of covered home health care or early 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.
<b>If your child needs dental or eye care</b>	Children's eye exam	\$60 <a href="#">copay</a> /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% <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>	\$2,000
■ <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>	\$2,000
<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>\$2,800</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>	\$2,000
■ <a href="#">Specialist copayment</a>	\$60
■ 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>	\$2,000
<a href="#">Copayments</a>	\$800
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is*</b>	<b>\$2,800</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>	\$2,000
■ <a href="#">Specialist copayment</a>	\$60
■ <a href="#">Emergency room copayment</a>	\$300
■ <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>	\$2,000
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$10
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is*</b>	<b>\$2,400</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.