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 http://www.wellsense.org/members/ma/clarity-plans or by calling Member Service at 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 855-833-8120 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,000 Individual / $2,000 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, most office visits (including mental/behavioral health and substance use disorder), urgent and emergency care and therapy visits.	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 www.wellsense.org/members/ma/clarity-plans
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?	$7,000 Individual / $14,000 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 billing 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/find-a-provider or call Member Service at 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	$20 copay/visit Deductible does not apply	Not covered	Same cost share applies to equivalent telehealth services...
	Specialist visit	$40 copay/visit Deductible does not apply	Not covered	Same cost share applies to equivalent telehealth services. Prior authorization may be required.
	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 www.wellsense.org/members/ma/clarity-plans for info on services that are considered preventive.
If you have a test	Diagnostic test (x-ray, blood work)	$35 X-ray and $25 Blood work copay/visit	Not covered	None.
	Imaging (CT/PET scans, MRIs)	$150 copay/visit	Not covered	Prior authorization may be required.
If you need drugs to treat your illness or condition For more information about prescription drug coverage visit www.wellsense.org/members/ma/clarity-plans/prescriptions or call 855-833-8120	Generic drugs – Tier 1	$25 Retail and $50 Mail order copay/prescription Deductible does not apply	Not covered	*See Prescription Drugs section. Covers up to a 30-day supply (Retail); 90-day supply (Mail order). Specialty drugs are covered through designated specialty pharmacies. Step therapy and prior authorization may be required for certain drugs and supplies. Cost share may be waived or reduced for certain covered prescription drugs.
	Preferred brand drugs – Tier 2	$45 Retail and $90 Mail order copay/prescription Deductible does not apply	Not covered	
	Non-preferred brand drugs – Tier 3	$75 Retail and $225 Mail order copay/prescription	Not covered	
	Specialty drugs – Tier 4	$75 Retail and $225 Mail order copay/prescription	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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 copay/visit	Not covered	Prior authorization may be required.
	Physician/surgeon fees	$0 copay/visit	Not covered	
If you need immediate medical attention	Emergency room care	$250 copay/visit Deductible does not apply	$250 copay/visit Deductible does not apply	*See Emergency Services section. Copayment is waived if admitted or held for observation.
	Emergency medical transportation	$0 copay/transport Deductible does not apply	$0 copay/transport Deductible does not apply	*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	$40 copay/visit Deductible does not apply	$40 copay/visit Deductible does not apply	
If you have a hospital stay	Facility fee (e.g., hospital room)	$300 copay/admission	Not covered	60 calendar day limit/benefit year for inpatient rehabilitation hospital admissions. Prior authorization may be required.
	Physician/surgeon fees	$0 copay/admission	Not covered	
If you need mental health, behavioral health, or substance use services	Outpatient services	$20 copay/visit Deductible does not apply	Not covered	$0 copay/visit (Deductible does not apply) for Recovery Coach services. $0 copay after deductible/visit for Intermediate services. Prior authorization may be required.
	Inpatient services	$300 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.
	Childbirth/delivery professional services	$0 copay/admission	Not covered	
	Childbirth/delivery facility services	$300 copay/admission	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 help recovering or have other special health needs	Home health care	$0 copay/visit	Not covered	Prior authorization may be required.
	Rehabilitation services	$40 copay /outpatient visit Deductible does not apply	Not covered	$300 copay after deductible/admission. 60 combined visits/benefit year for physical and occupational therapy (other than for autism, down syndrome, early intervention, home health care and speech therapy). 60 calendar day limit/benefit year for inpatient services in a rehabilitation hospital. Prior authorization required for certain services. Services for rehabilitation purposes and habilitation purposes have separate limits.
	Habilitation services	$40 copay /outpatient visit Deductible does not apply	Not covered	
	Skilled nursing care	$300 copay/admission	Not covered	100 calendar day limit/benefit year. Prior authorization required.
	Durable medical equipment	20% coinsurance	Not covered	0% coinsurance for breast pumps. Prior authorization may be required.
	Hospice services	$0 copay/visit	Not covered	Prior authorization required.
If your child needs dental or eye care	Children's eye exam	$40 copay/routine and non-routine exams Deductible does not apply	Not covered	Preventive exams are limited to 1 exam/12 months until the end of the calendar month they turn age 19 and cost sharing does not apply. *See Vision Services section.
	Children's glasses	20% coinsurance	Not covered	1 pair of eyeglasses or contact lenses/calendar year until the end of the calendar month they turn age 19.
	Children's dental check-up	No charge/visit Deductible does not apply	Not covered	2 exams/12 months until the end of the calendar month they turn age 19. *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 877-563-4467 or mass.gov/doi, The U.S. Department of Labor's Employee Benefits Security Administration at 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 877-267-2323 x61565 or www.cms.gov/CCIIO. 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 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 855-833-8120
- The U.S. Department of Labor's Employee Benefits Security Administration at 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.

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 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 plan's overall deductible	$1,000
Specialist copayment (*prenatal care*)	$0
Hospital (facility) copayment	$300

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	$1,000
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is*	**$1,500**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,000
Specialist copayment	$40
Primary care visit copayment	$20
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	$300
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is*	**$1,400**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,000
Specialist copayment	$40
Emergency room copayment	$250
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	$500
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is*	**$1,000**

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.

WellSense HEALTH PLAN

Notice of Availability

Important! This is about your WellSense Health Plan benefits. We can translate it for you free of charge. Please call **855-833-8120 (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 **855-833-8120 (TTY: 711)** para obtener ayuda de traducción. (ESA)

Importante! Esta comunicação é sobre os benefícios da WellSense Health Plan. Podemos traduzir para você gratuitamente. Ligue para **855-833-8120 (TTY: 711)** para obter ajuda com a tradução. (PTB)

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 **855-833-8120 (TTY: 711)**。(CHS)

Enpotan! Sa a se sou avantaj WellSense Health Plan ou an. Nou ka tradui li pou ou gratis. Tanpri relel **855-833-8120 (TTY: 711)** pou jwenn èd ak tradiksyon. (HAT)

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 **855-833-8120 (TTY: 711)** để được trợ giúp dịch thuật. (VIT)

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 **855-833-8120 (TTY: 711)**. (RUS)

Σημαντικό! Πρόκειται για τις παροχές του WellSense Health Plan. Μπορούμε να σας το μεταφράσουμε δωρεάν. Καλέστε στο **855-833-8120 (TTY: 711)** για βοήθεια σχετικά με τη μετάφραση. (ELG)

هام! هذا حول مزايا WellSense Health Plan الخاصة بك. يمكننا ترجمتها لك مجانا. يرجى الاتصال **855-833-8120 (TTY: 711)** للمساعدة في الترجمة. (ARA)

महत्वपूर्ण! यह आपके WellSense Health Plan लाभों के बारे में है। हम आपके लिए इसका निःशुल्क अनुवाद कर सकते हैं। कृपया अनुवाद संबंधित सहायता के लिए **855-833-8120 (TTY: 711)** पर फ़ोन करें। (HIN)

중요! 이것은 WellSense Health Plan 혜택에 대한 내용입니다. 무료로 번역해 드릴 수 있습니다. 번역 도움이 필요하면 **855-833-8120 (TTY: 711)**번으로 문의하십시오. (KOR)

ចំណុចសំខាន់! ព័ត៌មាននេះគឺ ស្តីអំពីអត្ថប្រយោជន៍នៃ WellSense Health Plan របស់អ្នក។ យើងអាចបកប្រែវាសម្រាប់អ្នកដោយឥតគិតថ្លៃ។ សូមទូរសព្ទទៅលេខ **855-833-8120 (TTY: 711)** សម្រាប់ជំនួយផ្នែកបកប្រែ។ (KHM)

Ważne! To dotyczy Twoich świadczeń w ramach planu zdrowotnego WellSense Health Plan. Możemy nieodpłatnie przetłumaczyć dla Ciebie te informacje. Zadzwoń pod numer **855-833-8120 (TTY: 711)**, aby uzyskać pomoc w tłumaczeniu. (POL)

Importante! Questo riguarda i benefici del tuoi piano sanitario WellSense. Possiamo tradurlo gratuitamente per te. Chiama il numero **855-833-8120 (TTY: 711)** per assistenza nella traduzione. (ITA)

મહત્ત્તવપૂર્ણ! આ તમારા WellSense આરોગ્ય પ્લાનના લાભ વવશે છે. અમે તમારા માટે તેન ું વનિઃશ લ્ક ભાષાુંતરર્ કરી શકીએ છીએ. ભાષાુંતરર્ને લગતી મદદ માટે કૃપા કરીને અમને **855-833-8120 (TTY: 711)** પર કૉલ કરો. (GUJ)

Important! Cela concerne vos prestations WellSense Health Plan. Nous pouvons traduire ce contenu gratuitement pour vous. Veuillez appeler le **855-833-8120 (TTY: 711)** pour obtenir de l'aide concernant la traduction. (FRC)

Important! This material can be requested in an accessible format by calling 855-833-8120 (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 at 855-833-8120 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: 855-833-8120 (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