Schedule of Benefits

Massachusetts

WellSense HEALTH PLAN

WellSense Clarity Gold 1000
WellSense Clarity Gold 1000SG

A Qualified Health Plan¤

Provider Network: Clarity Network¤¤

This Schedule of Benefits provides a summary of your benefits and member cost sharing. It also tells you the name of your provider network (see above). Please be sure to read the WellSense Health Plan Clarity Evidence of Coverage (EOC) for a full description of your benefits, including exclusions, and other plan provisions. All covered services must be medically necessary and some require prior approval. Always check with your provider to find out if necessary prior approval has been obtained. If any terms in this summary differ from those in your EOC, the terms of your EOC apply. Important words and terms in this Schedule of Benefits are defined in your EOC. For more information about your benefits, and to find network providers, go to wellsense.org or call Member Service at 855-833-8120.

WSMA_Gold 1000 and 1000SG_2026_ver.1

Deductible (per benefit year)	**Amount**
Per Individual Member	$1,000 (Medical and Rx)
	$50 (Pediatric Dental**** – Type II and type III services only)
Per Family	$2,000 (Medical and Rx)
Out-of-Pocket Maximum (per benefit year)	**Amount**
Per Individual Member	$7,000 (Medical, Pediatric Dental**** and Rx included) $350 (Pediatric Dental****, if applicable, counts toward the Individual and Family OOPM)
Per Family	$14,000 (Medical, Pediatric Dental**** and Rx included)

Covered Services Some services require prior approval. See your EOC for more information.	**Description**	**Your Cost (Cost sharing)**
Inpatient Hospital Care	Inpatient acute hospital care for medical, surgical and maternity services. Note: See Newborn Coverage, below, for newborn benefit details.	$300 copayment after deductible per admission
	Extended care in a chronic disease hospital.	$300 copayment after deductible per admission
	Extended care in a rehabilitation hospital. Benefit limit: Limited to 60 calendar days per benefit year.	$300 copayment after deductible per admission
	Extended care in a skilled nursing facility. Benefit limit: Limited to 100 calendar days per benefit year.	$300 copayment after deductible per admission
	Inpatient admission to a general or mental hospital, or substance abuse facility for mental health acute treatment and substance use disorder treatment. [+]	$300 copayment after deductible per admission
	Physicians, surgeons and other covered professional provider services during inpatient hospital care.	$0 copayment after deductible per admission
Abortion and Abortion-Related Services	Outpatient surgery, including physician, surgeon and other covered professional provider services during outpatient surgery.	$0 copayment per visit
Allergy Services	Testing and treatment.	$40 copayment per visit
	Lab tests.	See Lab Tests below.
	Allergy injections.	$10 copayment per injection
Ambulance	Covered ambulance.	$0 copayment per transport
Treatment of Pervasive Developmental Disorders and Autism Spectrum Disorder Services[+]	• Habilitative services • Lab tests and other diagnostic tests • Outpatient office visits • Applied behavior analysis services. • Outpatient rehabilitation (physical, occupational and speech therapy and social work visits), as medically necessary	You pay the cost sharing applicable to the service(s) rendered.
Cardiac Rehabilitation	Outpatient services.	$40 copayment per visit
Chemotherapy and Radiation Therapy	Outpatient services.	$0 copayment after deductible per visit
Chiropractor Care	Outpatient office visits, including supportive medical treatment services and spinal manipulation.	$40 copayment per visit
	Outpatient lab test and x-rays.	See Lab Tests, Radiology and Other Outpatient Diagnostic Procedures below.

Covered Services Some services require prior approval. See your EOC for more information.	**Description**	**Your Cost (Cost sharing)**
Clinical Trials	Qualified clinical trial for the treatment, prevention, or detection of any form of cancer or other life-threatening disease under the terms and conditions provided for under Massachusetts and federal law.	You pay the cost sharing applicable to the service(s) rendered.
Dialysis Services	Outpatient services. Note: Out of Service Area services - Limited to one month per benefit year if you are traveling outside the service area. Prior approval required.	$0 copayment after deductible per visit
	Home dialysis, including medical supplies and dialysis equipment.	You pay the cost sharing applicable to the service(s) rendered.
Donor Human Milk and Donor Human Milk-Derived Products	Medically necessary pasteurized donor human milk and donor human milk-derived products for eligible child members under the age of 6 months during an inpatient stay.	0% coinsurance after deductible
Treatment for Down Syndrome	• Applied behavior analysis services. • Occupational, physical and speech therapy, as medically necessary	You pay the cost sharing applicable to the service(s) rendered.
Durable Medical Equipment, Prosthetics, Orthotics, Medical Supplies, Medical Formulas, and Low Protein Foods[++]	• Durable medical equipment • Low protein foods • Medical formulas • Medical supplies • Orthotics • Ostomy supply • Oxygen and respiratory equipment • Prosthetics	20% coinsurance after deductible
	• Wigs (scalp hair prostheses)	0% coinsurance after deductible
	• Breast pumps and related supplies	0% coinsurance
Early Intervention Services	Outpatient services for an eligible child member through age 2, as medically necessary.	$0 copayment per visit
Emergency Services	Visits to an emergency room. Note: If you are admitted for an inpatient stay immediately following the provision of emergency services to a non-network hospital, you or someone acting for you must call the WellSense Clarity plan within 2 working days.	$250 copayment per visit. Copayment waived if held for observation or admitted.
	Physicians, surgeons and other covered professional provider services during emergency room care.	$0 copayment per visit

Covered Services Some services require prior approval. See your EOC for more information.	**Description**	**Your Cost (Cost sharing)**
Emergency Services Programs	Including, but not limited to: • Community-based emergency psychiatric services, • Behavioral health crisis assessment, intervention and stabilization services 24 hours per day, 7 days per week, through: o Mobile crisis intervention services for youth. o Mobile crisis intervention services for adults. o Emergency service provider community-based locations; and o Adult community crisis stabilization services.	Cost sharing is dependent on the location of services.
Fertility Preservation Services	Medically necessary fertility preservation services and procedures.	You pay the cost sharing applicable to the service(s) rendered.
Habilitative Services and Devices	Short-term outpatient physical, occupational and speech therapy as well as medically necessary habilitative devices. Benefit limit: Physical and occupational therapy are limited to 60 combined visits/benefit year (other than for autism, down syndrome, early intervention, home health care and speech therapy).	$40 copayment per visit
Hearing Aids for Children (Must be under the age of 22)	Hearing aid device. Benefit limit: Covered for one hearing aid up to two thousand dollars ($2,000) every 36 months per hearing impaired ear.	20% coinsurance after deductible
	Hearing aid evaluations and exams.	$40 copayment per visit
	Hearing aid-related services and supplies. Exclusion: Hearing aid batteries and cleaning fluid are not covered.	20% coinsurance after deductible
Hearing Exams	PCP exams and evaluations.	$20 copayment per visit
	Specialist exams and evaluations.	$40 copayment per visit
Home Health Care	Home care program, including home infusion therapy.	$0 copayment after deductible per visit
Hospice Services	Hospice services for terminally ill.	$0 copayment after deductible per visit

Covered Services Some services require prior approval. See your EOC for more information.	**Description**	**Your Cost (Cost sharing)**
Hospital Care at Home	Acute hospital care at home. Acute inpatient services provided in the member's home by a network provider who is approved by CMS to perform these services. Benefit limit: Limited to 90 calendar days per benefit period. Prior approval and concurrent review required.	$0 copayment after deductible per visit
Infertility Services	Medically necessary inpatient, outpatient surgery; lab and x-rays; outpatient office visits; and prescription drugs.	You pay the cost sharing applicable to the service(s) rendered.
Lab Tests, Radiology, and Other Outpatient Diagnostic Procedures (Diagnostic Services)	Diagnostic laboratory tests, including HLA testing.	$25 copayment after deductible per visit
	X-rays and other imaging tests (such as fluoroscopic tests).	$35 copayment after deductible per visit
	Diagnostic advanced imaging: CT/CTA scan, MRI/MRA, PET scan and NCI/NPI (nuclear cardiac imaging).	$150 copayment after deductible per visit
	Physician and other covered professional provider interpretation of lab tests, radiology and other outpatient diagnostic procedures.	$0 copayment after deductible per visit
Lipodystrophy Syndrome Treatment	Medical and/or drug treatment, including reconstructive surgery (such as suction assisted lipectomy).	You pay the cost sharing applicable to the service(s) rendered.
	Other restorative procedures, including dermal injections or fillers.	
Long Term Antibiotic Therapy for Lyme Disease	Primary care provider (PCP) office visit.	$20 copayment per visit
	Specialist office visit.	$40 copayment per visit
Maternity Services	Outpatient routine prenatal office visits, including one postpartum visit.	$0 copayment per visit
	Outpatient non-routine prenatal and additional postpartum office visits.	You pay the cost sharing applicable to the service(s) rendered.
Medical Formulas	Non-prescription enteral formulas and prescription formulas.	See Durable Medical Equipment.
Medical Supplies	Including, but not limited to ostomy, tracheostomy, and oxygen supplies; and supplies for insulin pumps.	See Durable Medical Equipment.

Covered Services Some services require prior approval. See your EOC for more information.	**Description**	**Your Cost (Cost sharing)**
Mental Health and Substance Use Disorder Services+	Inpatient admission to a general or mental hospital, or substance abuse facility. Note: Prior approval is not required, but the facility should notify the WellSense Clarity plan within 72 hours of admission.	$300 copayment after deductible per admission. $0 copayment after deductible per admission for physician and other covered professional provider during inpatient admission.
	Intermediate non-inpatient services that provide more intensive services than outpatient services and less intensive than inpatient services, such as Community Based Acute Treatment (CBAT) and Intensive Community-Based Acute Treatment (ICBAT). Note: Prior approval is not required, but the facility should notify the WellSense Clarity plan within 72 hours of admission.	$0 copayment after deductible per visit
	Medication-Assisted Treatment (MAT) and Associated Services for Opioid Dependence.	$20 copayment per visit
	Outpatient office visits.	$20 copayment per visit
	Recovery coach services	$0 copayment per visit
Mental Health Wellness Exam	An annual mental health wellness examination provided by a licensed mental health professional or primary care provider. This may be provided by the primary care provider during an annual preventive visit.	$0 copayment per visit
Nutritional Counseling	Outpatient office visits by a registered dietician.	$40 copayment per visit
Observation Services	If you are admitted to observation status from the emergency room, the emergency room copayment is waived.	$250 copayment per admission
Outpatient Office Visits for Medical Care **(To evaluate, monitor, and/or treat an illness or injury)**	Primary care provider (PCP) office visit.	$20 copayment per visit
	Specialist office visit.	$40 copayment per visit
Outpatient Surgery, including Bariatric Surgery	Same day surgery in a hospital or ambulatory surgical center setting, including diagnostic colonoscopies and endoscopies.	$150 copayment after deductible per visit
	Physician, surgeon, and other covered professional provider services during outpatient surgery.	$0 copayment after deductible per visit

Covered Services Some services require prior approval. See your EOC for more information.	**Description**	**Your Cost (Cost sharing)**
Pain Management	Pain management alternatives to opioid products. Including, but not limited to: • Non-opioid medications or injections • Chiropractic care • Physical therapy services • Behavioral health providers with pain management-related specialties, such as cognitive behavioral therapy, pain management and treatment of chronic pain • Surgery	You pay the cost sharing applicable to the service(s) rendered.
Pediatric Dental++++ **(Must be under the age of 19)**	Type I Services: Preventive & Diagnostic • Bitewing X-Rays: Two per dentist's location every 12 months • Comprehensive Evaluation: Once per dentist per location • Fluoride Treatments: Once every 3 months • Full Mouth X-Ray: Once per dentist location every 36 months • Limited Oral evaluation: Two per calendar year per member • Oral evaluation under 3 years of age • Panoramic X-Ray: Once per dentist location every 36 months • Periodic Oral Exams: Twice per dentist's location every 12 months • Sealants: Once per tooth per dentist's location every 26 months • Single Tooth X-Ray: As needed. • Space Maintainers • Teeth Cleaning: Twice every 12 months	0% coinsurance
	Type II Services: Basic Covered Services • Amalgam Restoration: Once per tooth surface every 12 months. • Anesthesia: Allowed with covered surgical procedures • Apicoectomy • Composite Resin Restorations: Once per tooth surface every 12 months • Palliative care • Periodontal Scaling and Root Planing: Once per quadrant every 24 months • Prefabricated Stainless Steel Crowns: Once per tooth. • Rebase or reline dentures: Once within 24 months. • Recement crown/onlays • Root canals on permanent teeth: Once per tooth • Simple Extractions • Surgical Extractions • Vital pulpotomy: Limited to deciduous teeth	25% coinsurance after pediatric dental deductible

Covered Services Some services require prior approval. See your EOC for more information.	**Description**	**Your Cost (Cost sharing)**
Pediatric Dental++++ **(Must be under the age of 19)** **(Continued)**	Type III Services: Major Restorative Services • Crown, resin: Once per tooth within 60 months • Partial & complete dentures: Once within 60 months • Porcelain/ceramic crowns: Once per tooth within 60 months Porcelain fused to metal/noble/high noble crowns: Once per tooth within 60 months	50% coinsurance after pediatric dental deductible
	Type IV Services: Orthodontia: Once per lifetime. Benefit limit: Covered only when medically necessary; member must have severe and handicapping malocclusion as defined by HLD index score of 22 and/or one or more auto qualifiers; requires prior approval.	50% coinsurance
Pediatric Eyewear **(Must be under the age of 19)**	• Contact Lenses: Covered once every calendar year – instead of eyeglasses. • Conventional* Frames: Covered once every calendar year. • Conventional* Lenses: One pair every calendar year.	20% coinsurance after deductible
Podiatry Services	Non-routine foot care (such as treatment for hammertoe and osteoarthritis).	$40 copayment per visit
	Outpatient lab tests and x-rays.	See Lab Tests, Radiology and Other Outpatient Diagnostic Procedures above.
	Routine foot care for diabetic members (such as trimming of corns, nails or other hygienic care).	$40 copayment per visit
Prescription Drugs¤¤¤ **From a network Retail Pharmacy:** **(Up to a 30-day supply)**	Generic - Tier 1	$25 copayment per prescription
	Preferred brand - Tier 2	$45 copayment per prescription
	Non-preferred brand - Tier 3	$75 copayment after deductible per prescription
	Specialty - Tier 4	$75 copayment after deductible per prescription
Prescription Drugs¤¤¤ **From Mail Service Pharmacy:** **(Up to a 90-day supply)**	Generic - Tier 1	$50 copayment per prescription
	Preferred brand - Tier 2	$90 copayment per prescription
	Non-preferred brand - Tier 3	$225 copayment after deductible per prescription
	Specialty - Tier 4	$225 copayment after deductible per prescription

Covered Services Some services require prior approval. See your EOC for more information.	**Description**	**Your Cost (Cost sharing)**
Prescription Drugs for Chronic Conditions¤¤¤	Certain generic formulary drugs used to treat: • Diabetes • Asthma • The 2 most prevalent heart conditions among our members See the WellSense Clarity plan formulary for the list of all covered drugs including type, dosage and other tiers.	$0 copayment per prescription

Note: You pay nothing for: (1) Oral and other forms of prescription drug contraceptives; (2) Certain oral anti-cancer drugs; (3) Statins, (4) Smoking cessation items; (5) Aspirin; (6) Opioid antagonists; and (7) Pre-exposure prophylaxis (PrEP) with effective antiretroviral therapy.

Covered Services Some services require prior approval. See your EOC for more information.	**Description**	**Your Cost (Cost sharing)**
Preventive Health Services The WellSense Clarity plan covers certain preventive health services, defined as services to prevent any disease or injury rather than diagnose or treat a complaint or symptom, with no cost sharing, in accordance with the WellSense Clarity plan's medical policy guidelines and the Affordable Care Act (ACA). For more information about which preventive services are included, see the Preventive Health Services section at the end of your EOC, and visit our website at wellsense.org or the federal government's website at https://www.healthcare.gov/coverage/preventive-care-benefits/ .	Preventive health services for children: • Annual Exam: 6 years or older • Physical exams at specific intervals: From birth to 6 years • Preventive hearing exams and tests, including newborn hearing screening. • Preventive immunizations • Preventive screening tests • Preventive vision exams: One exam per member every 12 months until the end of the calendar month they turn age 19. Preventive health services for adults: • Annual physical exams • Preventive hearing exams and tests • Preventive immunizations • Preventive screening tests and procedures, including screening colonoscopies. • Preventive vision exams: One exam per member every 24 months Preventive health services for women, including pregnant women: • Yearly GYN exams, including screening pap smears. • Breast pumps and related supplies • Family Planning • Routine prenatal care, including one postpartum visit. • Prenatal and postnatal lactation counseling and support • Screening for postpartum depression and major depressive disorders • Prescription contraceptive methods approved by the FDA, including drugs and devices. • Breast cancer screenings and diagnostic breast exams, including breast MRIs and ultrasounds • Voluntary sterilization procedures	$0 copayment per visit
Prosthetic Devices	Including, but not limited to, wigs (scalp hair prostheses) for hair loss due to treatment for cancer or leukemia.	See Durable Medical Equipment.

Covered Services Some services require prior approval. See your EOC for more information.	**Description**	**Your Cost (Cost sharing)**
Rehabilitation Therapies	Short-term outpatient physical, occupational and speech therapy. Benefit limit: Physical and occupational therapy are limited to 60 combined visits/benefit year (other than for autism, down syndrome, early intervention, home health care and speech therapy).	$40 copayment per visit
	Aural and pulmonary therapy.	$40 copayment per visit
Second Opinions	Outpatient second and third opinions.	See Outpatient Office Visits for Medical Care.
Speech-Language and Hearing Disorder Services	Outpatient office visits for medical care.	See Outpatient Office Visits for Medical Care.
	Outpatient speech therapy, as medically necessary.	$40 copayment per visit
	Outpatient diagnostic tests.	See Lab Tests, Radiology and Other Outpatient Diagnostic Procedures above.
Telehealth Services	The cost sharing for covered telehealth services with contracted providers is the same as if you access care in person. Prior approval may be required.	You pay the cost sharing applicable to the service(s) rendered.
TMJ Disorder Treatment	Outpatient x-rays, surgical services, physical therapy or medical care services.	You pay the cost sharing applicable to the service(s) rendered.
Transplant Services	Inpatient and outpatient medically necessary human organ, tissue, stem cell and bone marrow transplants.	You pay the cost sharing applicable to the service(s) rendered.
Urgent Care		$40 copayment per visit
Vision Services	• Routine periodic eye exams • Non-routine eye exams and treatment Note: Eyewear is covered for pediatric members until the end of the calendar month they turn age 19. See Pediatric Vision Eyewear above. Eyewear discounts are available for members aged 19 and over. See Member Extras below.	$40 copayment per visit
	Preventive vision exams. Benefit limit: One preventive exam per member every 12 months until the end of the calendar month they turn age 19, then every 24 months thereafter. If you have an existing medical eye condition, your periodic eye exams are no longer considered preventive and are subject to applicable cost sharing.	See Preventive Health Services above.

Covered Services Some services require prior approval. See your EOC for more information.	**Description**	**Your Cost (Cost sharing)**
Member Extras+++	**Eyewear Discounts for Adults** You must use a Vision Services Provider (VSP): • 20% off the retail price of complete sets of prescription glasses – frames and lenses • 15% off the professional fee for prescription contact lens fitting and evaluation. **Get Fit! Fitness Reimbursement or Wear It! Fitness Tracker Reimbursement** • Reimbursement of 25% of annual membership fees in a qualifying health club – Limited to one member per family per calendar year. OR • Reimbursement of 50% on a wearable technology device, up to $50 per calendar year – Limited to one member per family per calendar year. Note: Each family is eligible for a fitness reimbursement or fitness tracker reimbursement within one calendar year, not both. **Mom's Meals** You are eligible for free shipping on low-cost meals that are prepared and delivered to you as a WellSense Clarity plan member. To qualify for free shipping, place all orders via the following Mom's Meals website link (momsmeals.com/wellsense-clarity). You may start or end this benefit at any time you choose. **Weight Watchers®** Reimbursement of 25% of fees for certain Weight Watchers® programs – Limited to one member per family per calendar year.	
Member Incentives and VBID Programs	**Diabetes Incentive Program** Members with diabetes will receive a $25 gift card for completing the following within a calendar year. • Eye Exam • Kidney Function Test • One HbA1c Test • PCP Visit	
	Insulin VBID Program The WellSense Clarity plan offers an additional program providing coverage of at least one of each type of insulin at the lowest cost share tier for your WellSense Clarity plan. Please refer to the WellSense Clarity plan formulary for which products are covered as part of this program and all other insulin coverage available.	
Newborn Coverage	Newborns are automatically covered for routine nursery charges and well newborn care under the enrolled mother's inpatient hospital stay. Newborns must be enrolled in WellSense within 60 calendar days of their date of birth in order for Wellsense to cover any other medically necessary services rendered to the newborn.	

Note: In the course of receiving certain outpatient services (which may or may not be subject to cost sharing), you may also receive other covered services that require separate cost sharing. (For example, during a preventive health services office visit (no cost sharing), you may have a lab test that does require cost sharing.)

Note: Not all prenatal or postpartum office visits are considered routine. Maternity services rendered related to complications or risks with pregnancy may be subject to cost sharing.

¤ WellSense Clarity plans in Massachusetts are Qualified Health Plans offered through the MA Health Connector.

¤¤ The WellSense Clarity network in Massachusetts may contain different providers from those in WellSense's other provider networks. When looking up network providers on our website, please be sure to look under the WellSense Clarity network in Massachusetts.

¤¤¤ The WellSense Clarity plan contracts with Express Scripts, Inc. (ESI) to manage prescription drug benefits for members. To locate network pharmacies, go to our website wellsense.org or call toll-free at 855-833-8120.

+ The WellSense Clarity plan manages all mental health and substance use services for members. To locate a network provider of mental health or substance use services, go to our website wellsense.org or call toll-free at 855-833-8120.

++ The WellSense Clarity plan contracts with Northwood, Inc. to manage most durable medical equipment, prosthetics, orthotics, medical supplies, medical formulas, and low protein foods. Contact Member Service at 855-833-8120 for more information.

+++ See your EOC for further information on member extras and how to access these member extras or visit wellsense.org.

++++ The WellSense Clarity plan contracts with Delta Dental to manage all pediatric dental covered services for eligible members. To find network pediatric dentists, go to our website wellsense.org or for assistance, call Delta Dental at 844-260-6097.

*Conventional lenses are defined under the Federal Vision Insurance Plan as single vision, lined bifocal, lined trifocal, lenticular glass or plastic lenses, all lens powers, fashion and gradient tinting, ultraviolet protective coating, oversized and glass-grey #3 prescription sunglass lenses. Polycarbonate lenses are covered for children, monocular members, and members with prescriptions greater than or equal to +/- 6.00 diopters. All lenses include scratch resistant coating.

Notice for American Indian and Alaskan Native (AI/AN) Members:
According to Federal law, you may be able to enroll in a qualifying health plan that has limited or no cost sharing. Depending on your income, you may have no copayments, deductibles, or coinsurance when you receive services from an Indian Health or Tribal provider, or when your Indian Health or Tribal provider refers you to another provider. The Massachusetts Health Connector will determine your eligibility for this benefit when you submit your application. In addition to verifying your income, the Health Connector may also ask for documentation that proves your AI/AN status. If you qualify, the Health Connector will send us your information so that we can share it with our providers. If you have any questions, you may reach out to the MA Health Connector or to our Member Service at 855-833-8120.

This health plan **meets Minimum Creditable Coverage standards** and will satisfy the individual mandate that you have health insurance.

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE: As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

Minimum Creditable Coverage Standards. This health plan meets applicable Minimum Creditable Coverage standards that are effective January 1, 2025 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards.

This disclosure is for minimum creditable coverage standards that are effective January 1, 2025. Because these standards may change, review your health plan material each year to determine whether your plan meets the latest standards. If you have questions about this notice, you may contact the Division of Insurance: 617-521-7794 or visiting its website at www.mass.gov/doi.

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 ભાષાુંતર૨ કરી શકીએ છીએ. ભાષાુંતરર્ને લગતી મદદ માટે કૃપા કરીને અમને **855-833-8120 (TTY: 711)** પર કૉલ કરો. (GUJ)

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- 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