Schedule of Benefits

WellSense Clarity Gold 1800
WellSense Clarity Gold 1800SG
Provider Network: WellSense Clarity Network
WSMA_ Gold 1800 and Gold 1800SG_2027_ver.1

About your Schedule of Benefits

This document, in addition to your Evidence of Coverage (EOC), contains a list of the services covered under your plan, along with the associated cost and coverage information. Should you need it, the glossary below provides definitions for terms you may see throughout this document.

Copayment

An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug.

Coinsurance

Coinsurance is a portion of the medical cost you pay after your deductible has been met. Coinsurance is a way of saying that you and your insurance carrier each pay a share of eligible costs that add up to 100 percent.

Limits

A cap on the benefits your insurance company will pay in a year while you're enrolled in a particular health insurance plan. These caps are sometimes placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service. After an annual limit is reached, you must pay all associated health care costs for the rest of the year.

Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles.

Maximum Out-of-Pocket

The most you could pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit, the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

Prior Approval

Approval from a health plan that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by your plan.

Your Deductible and Out-of-Pocket Maximum

This Benefit Overview describes your coverage and Cost Sharing Amounts, including Deductible and Out-of-Pocket Maximum, under this plan.

General Cost Share & Features	In Network
Deductible: • Per Benefit Year • Medical, Dental, and Drug Combined	$1,800/Individual $3,600/Family
Dental Deductible	$50/Individual
Out-of-Pocket Maximum: • Per Benefit Year • Medical, Dental, and Drug Combined	$6,250/Individual $12,500/Family
Dental Out-of-Pocket Maximum	$350/Individual

If you are the Subscriber, and the only Member covered under your Plan, the Individual Deductible amount applies. If you have other Family Members on your Plan the Family Deductible amount applies. The Plan has an embedded Individual Deductible within the Family Deductible. If one Family Member meets their Individual Deductible, the plan will then begin paying for the member's services. Once the total Family Deductible is met, benefits are available for all Family Members. No one Member can contribute more than their Individual Deductible amount to the Family Deductible. Copayment or Coinsurance amounts a member pays for services shown as covered without a Deductible will not count toward meeting the Individual or Family Deductible.*

If you are the Subscriber, and the only Member covered under your Plan, the Individual maximum applies. If you have other Family Members on your Plan the Family maximum applies. Under Family coverage the Individual maximum applies separately to each covered Family Member. Once the total Family coverage maximum is met the Family maximum amount is satisfied. No one Member can contribute more than their Individual maximum amount to the Family limit.

*This does not apply to any services not subject to deductible such as preventive care.

Benefit Details

The following table provides basic information about your benefits under this plan.

Benefit	In Network
Office Visits	
Allergy Testing and Treatment	$60 Copayment per visit
Allergy Injections	$10 Copayment per injection
Chiropractic Care	$60 Copayment per visit
Infertility Services	You pay the cost-sharing applicable to the service(s) rendered.
Nutritional Counseling	$60 Copayment per visit
Office Visit - Primary Care	$30 Copayment per visit
Office Visit - Specialist	$60 Copayment per visit
Office Visit - Non-Routine Maternity Visits	You pay the cost-sharing applicable to the service(s) rendered.
Office Visit - Mental Health	$30 Copayment per visit
Office Visit - Substance Use Disorder Services	$30 Copayment per visit
Office Visit - Substance Use Disorder Services - Medication Assisted Treatment (MAT) and Associated Services for Opioid Dependence	$30 Copayment per visit
Podiatry Services - Routine (members with diabetes or systemic circulatory disease or peripheral artery disease)	$60 Copayment per visit
Podiatry Services - Non-Routine	$60 Copayment per visit
Second Opinions	See Outpatient Office Visits for Medical Care.
Recovery coach services	No Copayment or Coinsurance
Mental Health Wellness Exam	No Copayment or Coinsurance
Preventive Care	
Preventive health services for children	No Copayment or Coinsurance
Preventive health services for adults	No Copayment or Coinsurance
Preventive health services for women	No Copayment or Coinsurance
Family Planning	No Copayment or Coinsurance
Annual Physical Examinations (including GYN)	No Copayment or Coinsurance
Prenatal and Postnatal Care, Routine	No Copayment or Coinsurance

Benefit	In Network
Screening/Immunization	No Copayment or Coinsurance
Well Baby Visits and Care	No Copayment or Coinsurance
Therapy	
Habilitation Services and Devices 60 combined PT/OT visits per year. Limit does not apply to members with autism spectrum disorder, down syndrome, early intervention, and home health care	$60 Copayment per visit
Rehabilitation Services (including Physical, Occupational, and Speech Therapy, including Aural and Pulmonary Therapy) 60 combined PT/OT visits per year. Limit does not apply to members with autism spectrum disorder, down syndrome, early intervention, and home health care	$60 Copayment per visit
Infusion Therapy	No Copayment or Coinsurance after deductible
Speech-Language and Hearing Disorder Services - Outpatient speech therapy, as medically necessary.	$60 Copayment per visit
Chemotherapy	No Copayment or Coinsurance after deductible
Radiation	No Copayment or Coinsurance after deductible
Diagnostic & Imaging	
Advanced Imaging (CT/MRI/PET Scans, Nuclear Cardiac Imaging)	$300 Copayment per visit after deductible
Laboratory	$50 Copayment per visit after deductible
X-rays	$75 Copayment per visit after deductible
Outpatient Care	
Abortion and Abortion-Related Services	No Copayment or Coinsurance
Clinical Trials	You pay the cost-sharing applicable to the service(s) rendered.
Cardiac Rehabilitation	$60 Copayment per visit
Diabetes Equipment/Supplies and Services and Education	You pay the cost-sharing applicable to the service(s) rendered.
Dialysis Services	No Copayment or Coinsurance after deductible
Early Intervention Services	No Copayment or Coinsurance

Benefit	In Network
Intermediate Non-Inpatient Services for Mental Health and Substance Use Disorder Services	No Copayment or Coinsurance after deductible
Long-Term Antibiotic Therapy for Lyme Disease	PCP: $30 Copayment per visit Specialist: $60 Copayment per visit
Observation Services	$300 Copayment per admission after deductible. Waived if Admitted as an Inpatient.
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	$300 Copayment per visit after deductible
Outpatient Surgery Physician/Surgical Services	No Copayment or Coinsurance after deductible
TMJ Disorder Treatment	You pay the cost-sharing applicable to the service(s) rendered.
Treatment of Pervasive Developmental Disorders and Autism Spectrum Disorder Services	You pay the cost-sharing applicable to the service(s) rendered.
Inpatient Care	
Delivery and All Inpatient Services for Maternity Care	$750 Copayment Per Stay after deductible
Donor Human Milk	No Copayment or Coinsurance after deductible
Inpatient Hospital Services (e.g. acute licensed general hospital, extended care and chronic disease hospital)	$750 Copayment Per Stay after deductible
Inpatient Physician and Surgical Services	No Copayment or Coinsurance after deductible
Mental/Behavioral Health Inpatient Services	$750 Copayment Per Stay after deductible
Rehabilitation Hospital 60 days per year	$750 Copayment Per Stay after deductible
Skilled Nursing Facility 100 days per year	$750 Copayment Per Stay after deductible
Substance Abuse Disorder Inpatient Services	$750 Copayment Per Stay after deductible
Hospice Care	
Hospice Services	No Copayment or Coinsurance after deductible
Home Health Care	
Home Health Care Services	No Copayment or Coinsurance after deductible
Hospital Care at Home *90 days per benefit period*	No Copayment or Coinsurance after deductible
Urgent Care	

Benefit	In Network
Urgent Care Centers or Facilities	$60 Copayment per visit
Emergency Care/Ambulance	
Emergency Room Services	$300 Copayment per visit after deductible. Waived if Admitted.
Emergency Room Physician, Surgeon and Other Covered Professional Provider services during Emergency Care	No Copayment or Coinsurance after deductible
Emergency Transportation/Ambulance	No Copayment or Coinsurance after deductible
Durable Medical Equipment	
Durable Medical Equipment	20% Coinsurance after deductible
Prosthetics, Orthotics, Medical Supplies, Medical Formulas, including Non-Prescription Enteral Formulas, Low Protein Foods, Ostomy Supplies, and Oxygen and Respiratory Equipment	20% Coinsurance after deductible
Wigs (scalp hair prostheses) for hair loss due to alopecia areata, alopecia totalis, alopecia medicamentosa resulting from the treatment from any form of cancer or leukemia or permanent loss of scalp hair due to injury	No Copayment or Coinsurance after deductible
Breast Pump and Related Supplies	No Copayment or Coinsurance
Pediatric Dental Care (must be under the age of 19)	
Type I Services: Preventive & Diagnostic	No Copayment or Coinsurance
Type II Services: Basic Covered Services	25% Coinsurance after pediatric dental deductible
Type III Services: Major Restorative Services	50% Coinsurance after pediatric dental deductible
Type IV Services: Orthodontia	50% Coinsurance
Vision Care	
Eye Glasses for Children, must be under the age of 19 • Lenses - one pair every calendar year • Frames - covered once every calendar year • Contact Lenses - covered once every calendar year (in place of eyeglasses)	20% Coinsurance after deductible
Hardware for Medical Conditions Contact Lenses or Eyeglasses needed for Keratoconus, post-cataract surgery with or without an intraocular lens implant	You pay the cost-sharing applicable to the service(s) rendered.

Benefit	In Network
Routine and Non-Routine Eye Exams	$60 Copayment per visit
Preventive Eye Exam: • Children: one exam every 12 months until age 19 • Adult: one exam every 24 months	No Copayment or Coinsurance
Hearing Care Services	
Hearing Examinations Includes Hearing Aid evaluations and exams	PCP: $30 Copayment per visit Specialist: $60 Copayment per visit
Hearing Aid Related Services and Supplies when needed as part of a covered Hearing Aid	20% Coinsurance after deductible
Hearing Aids for Children (must be under the age of 22) One Hearing Aid per hearing impaired ear up to a maximum of $2000 per hearing aid every 36 months	20% Coinsurance after deductible
Additional Services	
Reconstructive Surgery	You pay the cost-sharing applicable to the service(s) rendered.
Transplant	You pay the cost-sharing applicable to the service(s) rendered.
Treatment for Down Syndrome	You pay the cost-sharing applicable to the service(s) rendered.
Emergency Services Programs	Cost sharing is dependent on the location of services.
Fertility Preservation Services	You pay the cost-sharing applicable to the service(s) rendered.
Lipodystrophy Syndrome Treatment	You pay the cost-sharing applicable to the service(s) rendered.
Pain Management	You pay the cost-sharing applicable to the service(s) rendered.

Prescription Drugs

Rx Deductible and Out of Pocket Maximum (OOPM)

Rx Cost Share & Features	In Network
Deductible (Combined with Medical Deductible)	$1,800/Individual $3,600/Family
Maximum Out of Pocket (Combined with Medical Maximum Out of Pocket)	$6,250/Individual $12,500/Family

Retail Pharmacy (up to a 30-day supply) *	
Tier	**In Network**
Generic Drugs – Tier 1	$30 Copayment per prescription
Preferred Brand Drugs – Tier 2	$60 Copayment per prescription after deductible
Non-Preferred Brand Drugs – Tier 3	$90 Copayment per prescription after deductible
Specialty Drugs – Tier 4	$90 Copayment per prescription after deductible

Mail Order (up to a 90-day supply) *	
Tier	**In Network**
Generic Drugs – Tier 1	$60 Copayment per prescription
Preferred Brand Drugs – Tier 2	$120 Copayment per prescription after deductible
Non-Preferred Brand Drugs – Tier 3	$270 Copayment per prescription after deductible
Specialty Drugs – Tier 4	$270 Copayment per prescription after deductible
*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.	

Prescription Drugs for Chronic Conditions	
Tier	**In Network**
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.	No Copayment or Coinsurance

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.
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.
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.

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.
¤¤ 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, 2027 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, 2027. 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)

MAQHP

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 ભાષાંતરર કરી શકીએ છીએ. ભાષાંતરર્ને 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