2023 Summary of Benefits

January 1, 2023 – December 31, 2023

WellSense Signature (HMO)

H6851-002

WellSense HEALTH PLAN

WellSense Signature (HMO) Summary of Benefits

WellSense Signature (HMO) is an HMO plan with a Medicare contract. Enrollment in the plan depends on contract renewal.

The benefit information provided does not list every service we cover or list every limitation or exclusion. To get a complete list of services we cover, call us at 800-967-4497 (TTY users should call 711) and ask for the Evidence of Coverage. You can also see our Evidence of Coverage at our website, **wellsense.org/medicare.**

To join WellSense Signature (HMO) you must have both Medicare Part A and Part B, and live in our service area. Our service area includes all counties in New Hampshire.

Except in emergent, urgent care situations, or other situations as described in our Evidence of Coverage, if you use a non-contracted, out-of-network provider, we may not pay for these services.

For coverage and costs of Original Medicare, you can read the "Medicare & You" handbook. You can view it online at **Medicare.gov** or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

This document is available in other formats such as braille, large print, or other alternate formats at no cost if you need it.

For more information, please call us at:

- Current members: **855-833-8128**
- Prospective members: **800-967-4497**
- TTY users: 711
- Hours are Monday – Friday, 8:00 a.m. – 8:00 p.m. (Representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m. from October 1 – March 31)

You can also visit our website at **wellsense.org/medicare** for more information.

WellSense Signature (HMO) Summary of Benefits

Services that are covered for you	What you must pay when you get these services
Premium and Benefits	
Monthly Plan Premium	$0 per month You must continue to pay your Medicare Part B premium.
Deductible	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility (Does not include Part D prescription drugs or supplemental benefits)	You pay no more than $4,900 annually for services you receive from in-network providers. Includes copayments and other costs for medical services for the year (does **not** include supplemental benefit cost-sharing). If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services, and we will pay the full cost for the rest of the year.
Inpatient Hospital Care *Prior authorization is required.*	$375 copay each day for days 1 – 6 of each hospital stay. Beyond day 90 of an inpatient stay, members can choose to use their Lifetime Reserve Days (LRD) and will be subject to their daily LRD cost-sharing.
Outpatient Hospital Services, including outpatient observation *Prior authorization may be required.*	$375 copay for outpatient hospital surgery $375 copay for outpatient hospital observation services
Ambulatory Surgical Services (Day Surgery, Surgical Day Care, Surgi-Centers, Ambulatory Surgical Centers) *Prior authorization may be required.*	$300 copay per visit

Services that are covered for you	What you must pay when you get these services
Doctor's Office Visits – Primary Care Providers (PCP) or Specialist These visits may be available in-person or by telehealth. There is no cost-sharing for the "Welcome to Medicare" physical or annual wellness visit. *Prior authorization may be required for some services.*	PCP: $0 copay per visit Specialist: $30 copay per visit

Services that are covered for you	What you must pay when you get these services
Preventive Care Coverage is provided for the following Medicare-covered preventive services: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Annual wellness visit • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Depression screening • Diabetes screening • HIV screening • Immunizations, including flu shots, hepatitis B shots, pneumonia shots • Medical nutrition therapy services • Medicare Diabetes Prevention Program (MDPP) • Obesity screening and therapy • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Welcome to Medicare preventive visit (one-time) • Other preventive services are available and may have a cost.	There is no coinsurance, copayment or deductible applied to this benefit by the Plan.

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Services that are covered for you	What you must pay when you get these services
Emergency Care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. You may get covered emergency medical care/ urgently needed services whenever you need it, anywhere in the world, up to a combined $50,000 per calendar year.	$110 copay per visit Cost-sharing for necessary emergency services furnished out-of-network is the same as services furnished in-network. If you are admitted to the hospital within 24 hours of discharge from the emergency room, this cost-sharing will be waived.
Urgent Care Services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. You may get covered emergency medical care/ urgently needed services whenever you need it, anywhere in the world, up to a combined $50,000 per calendar year.	$40 copay per visit Cost-sharing for necessary urgent care services furnished out-of-network is the same as services furnished in-network. If you are admitted to the hospital within 24 hours of discharge from an urgent care center, this cost-sharing will be waived.

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Services that are covered for you	What you must pay when you get these services
Diagnostic Services, Labs, Therapeutic Services/Supplies, and Imaging Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used • Other outpatient diagnostic tests *Prior authorization may be required for some services, including but not limited to genetic testing, CT Scans, MRIs, PET/Nuclear Medicine, Intensity Modulated Radiation Therapy and other select services.*	**Outpatient Procedures and Tests:** PCP office: $0 copay, all other locations: $10 copay **Outpatient Laboratory Tests:** PCP office: $0 copay, all other locations: $10 copay **Outpatient Diagnostic/ Therapeutic Radiological Services**: 20% coinsurance **Outpatient X-ray Services**: $65 copay per X-ray **Outpatient Diagnostic Radiological Services:** • **CT Scan:** $75 copay per test • **MRI:** $150 copay per test • **PET/Nuclear Imaging:** $350 copay per test
Hearing Services, Medicare-covered Coverage is provided for diagnostic Medicare-covered hearing and balance evaluations to determine if you need medical treatment.	$30 copay per visit **Additional hearing services** Routine hearing exam (1 every year): $0 copay Fitting and evaluation exams for hearing aids: $0 copay A maximum of 2 hearing aids per year (or one hearing aid per ear per year): TruHearing Advanced Hearing Aid: $699 copay per hearing aid; TruHearing Premium Hearing Aid: $999 copay per hearing aid

Services that are covered for you	What you must pay when you get these services
Dental Services Covered services include: • Medicare-covered dental services • Preventive Care, including up to 2 visits per year (exam, X-rays, cleaning) • Comprehensive Dental Care, including extractions, restorative care, endodontic care, periodontic care, crowns (limitations apply), dentures, surgical procedures related to full and partial dentures, and diagnostic care	Medicare-covered dental services: $30 copay per visit **Additional dental services** Preventive Dental: $0 copay Comprehensive Dental: 50% coinsurance up to a maximum of $1,250 paid by the Plan per calendar year. This cost-sharing does NOT count toward the member's out-of-pocket maximum.
Vision Services, Covered services include: • Medicare-covered vision services, including: o A yearly glaucoma screening and diabetic eye exam o Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration o One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens	Medicare-covered eyewear: $0 copay All other Medicare-covered services: $30 copay **Additional vision services** Routine vision exam (1 per year): $0 copay $150 allowance every year toward eyeglasses, contact lenses, or hardware upgrades

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Services that are covered for you	What you must pay when you get these services
Mental Health Care **Inpatient:** There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to Mental Health Services provided in a psychiatric unit of a general hospital. Beyond day 90 of an inpatient general hospital stay, members can choose to use their Lifetime Reserve Days (LRD) and will be subject to their daily LRD cost-sharing. **Outpatient:** Services include, but are not limited to: individual and group counseling, psychotherapy, and psychological testing. *Prior authorization is required for inpatient mental health services. Some outpatient specialty services, such as transcranial magnetic stimulation (TSM), may be subject to prior authorization.*	**Inpatient**: $350 copay each day for days 1 – 6 of each hospital stay **Outpatient**: $45 copay per visit
Skilled Nursing Facility Care (SNF) Coverage is provided for up to 100 medically necessary days per benefit period. Prior hospital stay is not required. A benefit period begins on the first day a member is admitted to a skilled nursing facility and ends when the member has been out of a skilled nursing facility for 60 consecutive days. There may be more than one benefit period per year. Beyond day 100 of a SNF stay in a benefit period, members can choose to use their Lifetime Reserve Days (LRD) and will be subject to their daily LRD cost-sharing. *Prior authorization is required.*	$0 copay per day for days 1-20 $196 copay per day for days 21-100 If you use any Lifetime Reserve Days (LRD), you would pay a LRD per day copay.

Services that are covered for you	What you must pay when you get these services
Outpatient Rehabilitation Services Coverage is provided for physical (PT), occupational (OT), and speech language therapy (ST). *Prior authorization is required but is waived for the initial evaluation for each therapy.*	PT: $45 copay per visit OT: $40 copay per visit ST: $45 copay per visit
Ambulance *Prior authorization may be required for non-emergency ambulance transportation.*	Ground ambulance: $295 copay per trip Air ambulance: 50% coinsurance per trip
Transportation	Not covered
Additional Benefits	
Substance Use Services **Inpatient**: Coverage is provided for substance use services, including detoxification. Members may use their Lifetime Reserve Days when their inpatient stay exceeds 90 days and will be subject to their daily LRD cost-sharing. **Outpatient**: Coverage is provided for individual and group therapy visits.	**Inpatient**: $350 copay each day for days 1 – 6 of each hospital stay **Outpatient**: $45 copay per visit
Foot Care Coverage is provided for Medicare-covered podiatry services. *Prior authorization may be required.*	$30 copay per visit
Durable Medical Equipment Coverage is provided for Medicare-covered Durable Medical Equipment including but not limited to wheelchairs, oxygen, etc. *Prior authorization may be required.*	20% coinsurance

Services that are covered for you	What you must pay when you get these services
Prosthetic Devices Coverage is provided for Medicare-covered prosthetic devices, including but not limited to braces, artificial limbs, etc. *Prior authorization may be required.*	20% coinsurance
Diabetes Supplies and Services Coverage is provided for Medicare-covered diabetes supplies and services, including but not limited to: • Blood glucose meter • Blood glucose test strips • Lancing devices and glucose lancets • Syringes and pen needles • Glucose control solutions for checking the accuracy of test strips, glucose meters and glucose monitors *Prior authorization may be required for select diabetes supplies.*	Meters, Test Strips, Lancets, Syringes, Pen Needles, Solution, and Monitors will be 0% coinsurance and all other diabetic supplies will be 20% coinsurance
Over-the-Counter (OTC) items Coverage is provided for Medicare-covered services and supplies available over-the-counter at a pharmacy or contracted retailer. • $50 per calendar quarter. Any unused amounts will not be rolled-over to the next calendar quarter within the same calendar year.	There is no coinsurance, copayment or deductible applied to this benefit.

Services that are covered for you	What you must pay when you get these services
Fitness Benefit - SilverSneakers® SilverSneakers® is a complete health and fitness program designed for Medicare beneficiaries at all fitness levels. Members will have access to participating gyms and fitness centers to help them meet their personal wellness goals. Please note nonstandard fitness centers that usually have an extra fee are not included in your membership.	There is no coinsurance, copayment or deductible applied to this benefit.
Chiropractic Care Coverage is provided only for manual manipulation of the spine to correct subluxation.	$20 copay per visit
Home Health Care *Prior authorization is required.*	There is no coinsurance, copayment or deductible applied to this benefit.
Renal Dialysis Coverage is provided for Medicare-covered dialysis equipment and supplies.	20% coinsurance
Hospice Care Coverage is provided by Original Medicare when you enroll in a Medicare-certified hospice program. Your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare.	There is no coinsurance, copayment or deductible applied to this benefit by the Plan.
Home Meals Program Coverage is provided for home delivered meals to a member's residence, in the following situations: • Immediately following surgery or an inpatient hospitalization – up to a maximum of 14 meals • Request must be within 30 days of discharge	There is no coinsurance, copayment or deductible applied to this benefit.

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Prescription Drug Benefits	
Medicare Part B Drugs Some drugs are covered by Medicare Part B and some are covered by Medicare Part D. Part B drugs do not count toward your Part D initial coverage limit or out-of-pocket costs. *Prior authorization may be required.*	20% coinsurance
Deductible Before the Part D plan starts to pay for any of your Part D Tier 3, 4 or 5, medications, you must pay your annual deductible.	$95
Initial Coverage After you pay your yearly deductible, you pay the copayment or coinsurance listed until your drug costs reach $4,660. Total yearly drug costs are the total drug costs paid by both you and the Part D plan.	Copayments or coinsurance up to a maximum of $4,660
Retail – 30 day supply Tier 1: Preferred Generic Tier 2: Generic Tier 3: Preferred Brand Tier 4: Non-Preferred Drug Tier 5: Specialty Tier	Tier 1: $0 copay Tier 2: $12 copay Tier 3: $47 copay Tier 4: $100 copay Tier 5: 31% coinsurance
Retail – 90 day supply Tier 1: Preferred Generic Tier 2: Generic Tier 3: Preferred Brand Tier 4: Non-Preferred Drug Tier 5: Specialty Tier	Tier 1: $0 copay Tier 2: $30 copay Tier 3: $132 copay Tier 4: $280 copay Tier 5: Not Covered

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Mail Order – 30 day supply Tier 1: Preferred Generic Tier 2: Generic Tier 3: Preferred Brand Tier 4: Non-Preferred Drug Tier 5: Specialty Tier	Tier 1: $0 copay Tier 2: $11 copay Tier 3: $45 copay Tier 4: $97 copay Tier 5: 31% coinsurance
Mail Order – 90 day supply Tier 1: Preferred Generic Tier 2: Generic Tier 3: Preferred Brand Tier 4: Non-Preferred Drug Tier 5: Specialty Tier	Tier 1: $0 copay Tier 2: $28 copay Tier 3: $130 copay Tier 4: $275 copay Tier 5: Not Covered
Coverage Gap Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,660. After you enter the coverage gap, you pay 25% of the plan's cost for covered generic and brand name drugs until your costs total $7,400 which is the end of the coverage gap. Not everyone will enter the coverage gap.	25% coinsurance up to a maximum of $7,400 (combined with what the member and the Plan pays)
Catastrophic Coverage After your yearly out-of-pocket drug costs reach $7,400, you will pay the amount(s) listed.	The greater of 5% or $4.15 for generic (including brand drugs treated as generic) and $10.35 for all other drugs

Pre-Enrollment Checklist

WellSense HEALTH PLAN

Before making an enrollment decision it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 800-967-4497 (TTY: 711) Monday through Friday 8 a.m. to 8 p.m. We are open daily Oct. 1 through March 31.

Understanding the Benefits

- ◯ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It's important to review plan coverage, cost and benefits before you enroll. Visit wellsense.org/medicare or call 800-967-4497 (TTY: 711) to view a copy of the EOC.
- ◯ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ◯ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ◯ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ◯ In addition to your monthly premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ◯ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2024.
- ◯ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

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