

2025 Summary of Benefits

January 1, 2025 – December 31, 2025

WellSense Added Value (HMO)

H6851-001

Summary of Benefits

WellSense Health Plan is an HMO plan with a Medicare contract. Enrollment in WellSense Medicare Advantage HMO plans 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 Added Value (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.

Coverage outside of the United States

Our plan does not cover emergency services, urgently needed services, nor any other services for care received outside of the United States and its territories. Our plan cannot cover a drug purchased outside the United States or its territories. Your membership must end if you are no longer a United States citizen or lawfully present in the United States.

How to file a complaint

Contact us promptly to file a complaint, either by phone or in writing. Usually, calling Member Service at the number below is the first step. If there is anything else you need to do, Member Service will let you know. If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us. The investigation will be completed as quickly as possible. You can mail your complaint to:

WellSense Health Plan, Attn: Member Service
100 City Square, Suite 200, Charlestown, MA 02129

Most complaints are answered within 30 calendar days. If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint.

Right to cancel

Beneficiaries have the right to cancel their enrollment by notifying WellSense either by calling to request cancellation by the last day of the month before their coverage starts OR within seven days from the date of the Outbound Enrollment Verification letter they receive from WellSense once they are enrolled, whichever is later.

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.

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Services that are covered for you	What you must pay when you get these services
Premium and Benefits	
Monthly Plan Premium	<p>\$33.80 per month</p> <p>(Your premium could be less if you qualify for "Extra Help". Please see our <i>Evidence of Coverage</i>, Chapter 2, Section 7 for more information.)</p> <p>You must continue to pay your Medicare Part B premium.</p>
Deductible	<p>Part B Deductible</p> <p>(In 2025, the Part B Deductible is \$257.)</p>
Maximum Out-of-Pocket Responsibility (Does not include Part D prescription drugs or supplemental benefits)	<p>You pay no more than \$8,850 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).</p> <p>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.</p>
Medicare cost sharing	<p>If you have full Medicaid benefits or are a Qualified Medicare Beneficiary (QMB), you will pay \$0 for your Medicare-covered services as noted in this benefit chart.</p>
Inpatient Hospital Care <i>Prior authorization is required.</i>	<p>Depending on your level of Medicaid eligibility, you pay a \$0 copay per stay, or \$595 copay each day for days 1 – 4 of each hospital stay.</p>

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Outpatient Hospital Services, including outpatient observation <i>Prior authorization may be required.</i>	Depending on your level of Medicaid eligibility, \$0 copay or Part B deductible and 20% coinsurance
Ambulatory Surgical Services (Day Surgery, Surgical Day Care, Surgi-Centers, Ambulatory Surgical Centers) <i>Prior authorization may be required.</i>	Depending on your level of Medicaid eligibility, \$0 copay or Part B deductible and 20% coinsurance
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. <i>Prior authorization may be required for some services.</i>	Depending on your level of Medicaid eligibility, \$0 copay or Part B deductible and 20% coinsurance

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<p>Preventive Care</p> <p>Coverage is provided for the following Medicare-covered preventive services:</p> <ul style="list-style-type: none">• 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) <p>Other preventive services are available and may have a cost and/or may be subject to prior authorization such as a CT scan for Lung Cancer Screening</p>	<p>There is no coinsurance, copayment or deductible applied to this benefit by the Plan.</p>

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<p>Emergency Care</p> <p>Emergency care refers to services that are:</p> <ul style="list-style-type: none">• Furnished by a provider qualified to furnish emergency services, and• Needed to evaluate or stabilize an emergency medical condition. <p>Coverage is limited to services provided in the U.S. and its territories.</p>	<p>Depending on your level of Medicaid eligibility, \$0 copay or \$110 copay per visit</p> <p>Cost-sharing for necessary emergency services furnished out-of-network is the same as services furnished in-network.</p> <p>If you are admitted to the hospital within 24 hours of discharge from the emergency room, this cost-sharing will be waived.</p>
<p>Urgent Care Services</p> <p>Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care.</p> <p>Coverage is limited to services provided in the U.S. and its territories.</p>	<p>Depending on your level of Medicaid eligibility, \$0 copay or \$45 copay per visit</p> <p>Cost-sharing for necessary urgent care services furnished out-of-network is the same as services furnished in-network.</p> <p>If you are admitted to the hospital within 24 hours of discharge from an urgent care center, this cost-sharing will be waived.</p>

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<p>Diagnostic Services, Labs, Therapeutic Services/Supplies, and Imaging</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none">• 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 <p><i>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. Prior authorization does not apply to X-ray services.</i></p>	<p>Depending on your level of Medicaid eligibility, \$0 copay or Part B deductible and 20% coinsurance</p> <p>Outpatient laboratory services: \$0 copay</p>
<p>Hearing Services</p> <p>Coverage is provided for diagnostic Medicare-covered hearing and balance evaluations to determine if you need medical treatment</p> <p>Additional hearing services</p> <ul style="list-style-type: none">• A yearly routine hearing exam	<p>Medicare-covered hearing exam: Depending on your level of Medicaid eligibility, \$0 copay or Part B deductible and 20% coinsurance</p> <p>Additional hearing services</p> <p>Routine hearing exam (1 every year): \$0 copay</p>

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<p>Dental Services</p> <p>Covered services include:</p> <ul style="list-style-type: none">• Medicare-covered dental services <p>Additional dental services</p> <ul style="list-style-type: none">• Preventive dental care<ul style="list-style-type: none">- Cleanings (2 every year)- Exams (2 every year)- Fluoride treatments (2 every year)- X-rays (2 every year)- Other diagnostic (1 every year)- Other preventive services (1 every 3 years per tooth on unrestored permanent molars)• Comprehensive dental care<ul style="list-style-type: none">- Extractions- Restorative care- Endodontic care- Periodontic care- Crowns (limitations apply)- Dentures- Surgical procedures• \$1,500 annual benefit amount for covered comprehensive services. Any costs you pay for non-Medicare covered services will not count toward member's maximum out of pocket. .	<p>Medicare-covered dental services: Depending on your level of Medicaid eligibility, \$0 copay or Part B deductible and 20% coinsurance</p> <p>Additional dental services</p> <p>Preventive Dental: \$0 copay</p> <p>Comprehensive Dental: 0% coinsurance</p>

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<p>Vision Services</p> <p>Covered services include:</p> <ul style="list-style-type: none">• Medicare-covered vision services, including:<ul style="list-style-type: none">○ A yearly glaucoma screening and diabetic eye exam○ Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration○ One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens	<p>Medicare-covered eyewear: \$0 copay</p> <p>All other Medicare-covered services: Depending on your level of Medicaid eligibility, \$0 copay or Part B deductible and 20% coinsurance</p> <p>Additional vision services</p> <p>Our plan offers the OTC + Vision debit card. The plan provides \$400 per calendar year towards costs of eligible vision services and items. The vision allowance can be spent on routine vision exams, eyeglasses, frames, lenses, contact lenses, or hardware upgrades.</p> <p>Once your annual allowance is exhausted, you will be responsible for the entire cost of these services and items</p>
<p>Mental Health Care</p> <p>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.</p> <p>Outpatient: Services include, but are not limited to: individual and group counseling, psychotherapy, and psychological testing.</p> <p><i>Prior authorization is required for inpatient mental health services and outpatient psychiatric services, this includes transcranial magnetic stimulation (TMS) and Applied Behavioral Analysis (ABA).</i></p>	<p>Inpatient: Depending on your level of Medicaid eligibility, you pay a \$0 copay per stay, or \$405 copay each day for days 1 – 5 of each hospital stay</p> <p>Outpatient: Depending on your level of Medicaid eligibility, \$0 copay or Part B deductible and 20% coinsurance</p>

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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. <i>Prior authorization is required.</i>	Depending on your level of Medicaid eligibility, you pay a \$0 copay per day: days 1-100, or \$0 copay per day for days 1 – 20 \$214 copay per day for days 21-100
Outpatient Rehabilitation Services Coverage is provided for physical, occupational, and speech language therapy. <i>Prior authorization is required but is waived for the initial evaluation for each therapy.</i>	Depending on your level of Medicaid eligibility, \$0 copay or Part B deductible and 20% coinsurance
Ambulance <i>Prior authorization may be required for non-emergency ambulance transportation and for air ambulance transportation services.</i>	Depending on your level of Medicaid eligibility, \$0 copay or Part B deductible and 20% coinsurance
Transportation	Not covered

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Additional Benefits	
<p>Substance Use Services</p> <p>Inpatient: Coverage is provided for substance use services, including detoxification.</p> <p>Outpatient: Coverage is provided for individual and group therapy visits.</p>	<p>Inpatient: Depending on your level of Medicaid eligibility, \$0 copay per stay or \$595 copay for days 1-4 of each hospital stay</p> <p>Outpatient: Depending on your level of Medicaid eligibility, \$0 copay or Part B deductible and 20% coinsurance</p>
<p>Opioid Treatment Program Services</p>	<p>Depending on your level of Medicaid eligibility, \$0 copay or Part B deductible and 20% coinsurance</p>
<p>Foot Care</p> <p>Coverage is provided for Medicare-covered podiatry services.</p> <p><i>Prior authorization may be required.</i></p>	<p>Depending on your level of Medicaid eligibility, \$0 copay or Part B deductible and 20% coinsurance</p>
<p>Durable Medical Equipment (DME)</p> <p>Coverage is provided for Medicare-covered Durable Medical Equipment including but not limited to wheelchairs, oxygen, etc.</p> <p><i>Prior authorization is required for DME that costs \$500 or more.</i></p>	<p>Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance</p>
<p>Prosthetic Devices</p> <p>Coverage is provided for Medicare-covered prosthetic devices, including but not limited to braces, artificial limbs, etc.</p> <p><i>Prior authorization is required for prosthetic devices that cost \$500 or more.</i></p>	<p>Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance</p>

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<p>Diabetes Supplies and Services</p> <p>Coverage is provided for Medicare-covered diabetes supplies and services, including but not limited to:</p> <ul style="list-style-type: none">• 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 <p><i>Prior authorization is required for diabetes supplies and services that cost \$500 or more.</i></p>	<p>Depending on your level of Medicaid eligibility, \$0 copay or Part B deductible and 20% coinsurance</p>
<p>Over-the-Counter (OTC) items</p> <p>Coverage is provided for Medicare-covered services and supplies available over-the-counter at a participating retailer.</p> <ul style="list-style-type: none">• \$275 will be added to the OTC + Vision debit card per calendar quarter. Any unused amounts will not be rolled-over to the next calendar quarter within the same calendar year.	<p>There is no coinsurance, copayment or deductible applied to this benefit.</p>
<p>Fitness Benefit - SilverSneakers®</p> <p>SilverSneakers can help you live a healthier, more active life through fitness and social connection. You are covered for a fitness benefit through SilverSneakers at participating locations, where you can take classes and use exercise equipment and other amenities, at no additional cost to you.</p>	<p>There is no coinsurance, copayment or deductible applied to this benefit.</p>

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Nursing Hotline	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.	Depending on your level of Medicaid eligibility, \$0 copay or Part B deductible and 20% coinsurance
Home Health Care <i>Prior authorization is required.</i>	\$0 copay
Renal Dialysis Coverage is provided for Medicare-covered dialysis equipment and supplies.	Depending on your level of Medicaid eligibility, \$0 copay or Part B deductible and 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. You are eligible to receive 28 home-delivered meals upon discharge from an inpatient acute care setting. You will receive two meals a day for 14 days delivered to your home. The meals benefit must be requested within 30 days of discharge.	There is no coinsurance, copayment or deductible applied to this benefit.

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Medicare Part B Drugs (including Insulin 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 out-of-pocket costs. This plan offers step therapy from one Part B drug to another Part B drug. <i>Prior authorization may be required for some drugs, including Insulin drugs.</i>	Depending on your level of Medicaid eligibility, \$0 copay or Part B deductible and 20% coinsurance Insulin drugs are subject to a \$35 copayment for a 30-day supply.
Prescription Drug Benefits	
Deductible Before the Part D plan starts to pay for any of your Part D medications, you must pay your annual deductible.	\$590
Initial Coverage After you pay your yearly deductible, you pay the coinsurance listed until your drug costs reach \$2,000 in out-of-pocket costs within the calendar year	25% coinsurance for all Tiers Part D Insulin Drugs: 30 day supply: \$35 copay 60 day supply: \$70 copay 90 day supply: \$105 copay
Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$2,000, you will pay the amount(s) listed.	\$0

Pre-Enrollment Checklist



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

- ☐ **Effect on current coverage:** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- ☐ 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. If you enroll in a plan with a Part B buy-down, you may pay less for your Medicare Part B premium each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2026.
- ☐ 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).
- ☐ **PPO plans** - Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers.