



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. **This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.wellsense.org](http://www.wellsense.org) or by calling 1-855-833-8122. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call 1-855-833-8122 to request a copy.

| Important Questions                                                                   | Answers                                                                                                                                                                       | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall <a href="#">deductible</a>?</b>                                | \$6,000 Individual/\$12,000 Family (Medical and RX)                                                                                                                           | See the Common Medical Event chart below for your costs for services this <a href="#">plan</a> covers.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Are there services covered before you meet your <a href="#">deductible</a>?</b>    | Preventive Services, Urgent Care Services, PCP Office Visits, Physical, Speech and Occupational Therapy Services, and Specialist Office Visits are covered with no Deductible | You must pay up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for services other than those listed.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Are there other <a href="#">deductibles</a> for specific services?</b>             | No                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b> | \$8,900 Individual/\$17,800 Family (Medical and RX)                                                                                                                           | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                                                             |
| <b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>               | Premiums, balance-billed charges, and health care this plan doesn't cover                                                                                                     | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Will you pay less if you use a <a href="#">network provider</a>?</b>               | Yes. See <a href="http://www.wellsense.org">www.wellsense.org</a> or call 1-855-833-8122 for a list of <a href="#">network providers</a>                                      | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| <b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>    | No                                                                                                                                                                            | You can see the <a href="#">network specialist</a> you chose without a <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event                                                                                                                                                                                      | Services You May Need                                            | What You Will Pay                                                          |                                                       | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                           |                                                                  | Network Provider<br>(You will pay the least)                               | Out-of-Network<br>Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>If you visit a health care <a href="#">provider's</a> office or clinic</b>                                                                                                                             | Primary care visit to treat an injury or illness                 | \$40<br>Deductible does not apply                                          | Not covered                                           | <a href="#">Specialist</a> visits may require a <a href="#">pre-authorization</a> .                                                                                                                                                                                                                                                                                                                                                        |
|                                                                                                                                                                                                           | <a href="#">Specialist</a> visit                                 | \$80<br>Deductible does not apply                                          | Not covered                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                           | <a href="#">Preventive care/screening/Immunization</a>           | No charge                                                                  | Not covered                                           | Gynecological (GYN) exam limited to once per calendar year. You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your plan will pay for. Visit <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> for info on services that are considered preventive. |
| <b>If you have a test</b>                                                                                                                                                                                 | <a href="#">Diagnostic test</a> (x-ray, blood work, ultrasounds) | 40% coinsurance                                                            | Not covered                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                           | Imaging (CT/PET scans, MRIs)                                     | 40% coinsurance                                                            | Not covered                                           | <a href="#">Pre-authorization</a> is required; if <a href="#">pre-authorization</a> is not obtained payment for services could be denied.                                                                                                                                                                                                                                                                                                  |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.wellsense.org">www.wellsense.org</a> | Generic drugs                                                    | \$20 retail and \$50 mail order/prescription<br>Deductible does not apply  | Not covered                                           | Covers up to a 30-day retail (90-day mail order); prescription contraceptives and certain oral anti-cancer drugs are covered in full; step therapy and <a href="#">pre-authorization</a> may be required for certain drugs and supplies. When prescribed by your physician, the plan will supply contraceptives in quantities sufficient for a 12-month duration.                                                                          |
|                                                                                                                                                                                                           | Preferred brand drugs                                            | \$40 retail and \$100 mail order/prescription<br>Deductible does not apply | Not covered                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                           | Non-preferred brand drugs                                        | \$80 retail and \$200 mail order/prescription                              | Not covered                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                            |

| Common Medical Event                                                     | Services You May Need                            | What You Will Pay                                             |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                    |
|--------------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------------------------|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                          |                                                  | Network Provider<br>(You will pay the least)                  | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                           |
|                                                                          | <a href="#">Specialty drugs</a>                  | \$350 retail/prescription mail order prescription not covered | Not covered                                        | Covers up to a 30-day supply from participating specialty pharmacies; 90-day mail order not available; <a href="#">pre-authorization</a> may be required. |
| If you have outpatient surgery                                           | Facility fee (e.g., ambulatory surgery center)   | 40% coinsurance                                               | Not covered                                        | Includes diagnostic colonoscopies and endoscopies; <a href="#">pre-authorization</a> may be required.                                                     |
|                                                                          | Physician/surgeon fees                           | 40% coinsurance                                               | Not covered                                        |                                                                                                                                                           |
| If you need immediate medical attention                                  | <a href="#">Emergency room care</a>              | 40% coinsurance                                               | 40% coinsurance                                    | If you receive emergency services from a non-network provider, the plan pays up to the allowed amount.                                                    |
|                                                                          | <a href="#">Emergency medical transportation</a> | 40% coinsurance                                               | 40% coinsurance                                    | None                                                                                                                                                      |
|                                                                          | <a href="#">Urgent care</a>                      | \$60<br>Deductible does not apply                             | \$60<br>Deductible does not apply                  | <a href="#">Urgent care</a> from non-network providers outside of the service area is covered for medically necessary covered services.                   |
| If you have a hospital stay                                              | Facility fee (e.g., hospital room)               | 40% coinsurance                                               | Not covered                                        | <a href="#">Pre-authorization</a> is required; if <a href="#">pre-authorization</a> is not obtained, payment for services may be denied.                  |
|                                                                          | Physician/surgeon fees                           | 40% coinsurance                                               | Not covered                                        |                                                                                                                                                           |
| If you need mental health, behavioral health, or substance use disorders | Outpatient services                              | \$40<br>Deductible does not apply                             | Not covered                                        | <a href="#">Pre-authorization</a> may be required.                                                                                                        |
|                                                                          | Inpatient services                               | 40% coinsurance                                               | Not covered                                        |                                                                                                                                                           |
| If you are pregnant                                                      | Office visits                                    | 40% coinsurance                                               | Not covered                                        | <a href="#">Cost-sharing</a> does not apply to routine prenatal and postpartum services.                                                                  |
|                                                                          | Childbirth/delivery professional services        | 40% coinsurance                                               | Not covered                                        |                                                                                                                                                           |
|                                                                          | Childbirth/delivery facility services            | 40% coinsurance                                               | Not covered                                        |                                                                                                                                                           |
| If you need help recovering or have other special health                 | <a href="#">Home health care</a>                 | 40% coinsurance                                               | Not covered                                        | <a href="#">Pre-authorization</a> is required; if <a href="#">pre-authorization</a> is not obtained payment for services could be denied.                 |

| Common Medical Event                          | Services You May Need                     | What You Will Pay                                                                                       |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                            |
|-----------------------------------------------|-------------------------------------------|---------------------------------------------------------------------------------------------------------|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                               |                                           | Network Provider<br>(You will pay the least)                                                            | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                   |
| <b>needs</b>                                  | <a href="#">Rehabilitation services</a>   | \$40 for outpatient services Deductible does not apply<br><br>40% coinsurance for inpatient services    | Not covered                                        | Limited to 20 visits per therapy per calendar year (except for early intervention services, and members with Autism Spectrum Disorders); limited to 60 calendar days per calendar year for inpatient admissions; <a href="#">Pre-authorization</a> required for certain services. |
|                                               | <a href="#">Habilitation services</a>     | \$40<br>Deductible does not apply                                                                       | Not covered                                        | Limited to 20 visits per therapy per calendar year (except for early intervention services, and members with Autism Spectrum Disorders); <a href="#">Pre-authorization</a> may be required after initial evaluation.                                                              |
|                                               | <a href="#">Skilled nursing care</a>      | 40% coinsurance                                                                                         | Not covered                                        | Limited to 100 calendar days per calendar year; <a href="#">Pre-authorization</a> is required; If <a href="#">pre-authorization</a> is not obtained, payment for services could be denied.                                                                                        |
|                                               | <a href="#">Durable medical equipment</a> | 40% coinsurance                                                                                         | Not covered                                        | Coinsurance does not apply to wigs and breast pumps and related supplies; <a href="#">Pre-authorization</a> may be required from our 3 <sup>rd</sup> party vendor, Northwood, Inc.                                                                                                |
|                                               | <a href="#">Hospice services</a>          | 40% coinsurance                                                                                         | Not covered                                        | <a href="#">Pre-authorization</a> is required. If you do not get <a href="#">pre-authorization</a> , payment for services could be denied.                                                                                                                                        |
|                                               |                                           |                                                                                                         |                                                    |                                                                                                                                                                                                                                                                                   |
| <b>If your child needs dental or eye care</b> | Children's eye exam                       | No charge for preventive exams;<br>\$80 for non-routine and routine exams.<br>Deductible does not apply | Not covered                                        | Preventive eye exams are limited to one every 12 months until the end of the calendar month in which the member turns 19 years of age.                                                                                                                                            |
|                                               | Children's glasses                        | 40% coinsurance                                                                                         | Not covered                                        | Limited to one set of prescription lenses and frames or contact lenses per calendar year until the end of the calendar month in which the member turns 19 years of age.                                                                                                           |
|                                               | Children's dental check-up                | Not covered                                                                                             | Not covered                                        | Members may purchase a separate stand-alone dental plan.                                                                                                                                                                                                                          |

## Excluded Services & Other Covered Services:

### Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- |                                                                     |                                                      |                                                        |
|---------------------------------------------------------------------|------------------------------------------------------|--------------------------------------------------------|
| • Acupuncture                                                       | • Long-term care                                     | • Private-duty nursing                                 |
| • Cosmetic surgery                                                  | • Non-emergency care when traveling outside the U.S. | • Services beyond any listed benefit or monetary limit |
| • Dental care except as described in the Evidence of Coverage (EOC) | • Weight loss/ anti-obesity medications              |                                                        |
| • Early intervention services for children age 3 and older          |                                                      |                                                        |

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- |                                                                                                                                                                             |                                                                                                                                                                           |                                                                                                                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|
| • Abortion                                                                                                                                                                  | • Hearing aids (1 hearing aid per each time a hearing aid prescription changes)                                                                                           | • Non-Prescription Enteral Formulas and Low Protein Food                                                          |
| • Bariatric surgery                                                                                                                                                         | • Infertility treatment (limited to diagnostic tests to find the cause of infertility and services to treat the underlying medical condition that causes the infertility) | • Non-routine vision as described in the EOC                                                                      |
| • Chiropractic care (up to 12 visits per calendar year)                                                                                                                     | • Routine vision care (Pediatric)                                                                                                                                         | • Routine foot care (only for members with diabetes or systemic circulatory disease or peripheral artery disease) |
| • Diagnostic laboratory tests including coverage for: Perfluoroalkyls (PFAS) and Perfluorinated Compound (PFC) Blood Testing, HLA (bone marrow testing), Blood Lead Testing |                                                                                                                                                                           |                                                                                                                   |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: New Hampshire Insurance Department - Consumer, Health Insurance at 1-800-852-3416 or [www.nh.gov](http://www.nh.gov), or The U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the Department of Health and Human Service's Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact:

- WellSense Health Plan Member Service at 1-855-833-8122
- The U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa)

**Does this plan provide Minimum Essential Coverage? Yes**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet the Minimum Value Standards? Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-833-8122.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-833-8122.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-833-8122.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-833-8122.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$6,000
- [Specialist copayment](#) \$80
- [Hospital \(facility\)](#) 40% coinsurance after deductible

**This EXAMPLE event includes services like:**

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)  
[Prescription drugs](#)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,970</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$6,000 |
| <a href="#">Copayments</a>  | \$20    |
| <a href="#">Coinsurance</a> | \$1,700 |

| What isn't covered                |                |
|-----------------------------------|----------------|
| Limits or exclusions              | \$80           |
| <b>The total Peg would pay is</b> | <b>\$7,800</b> |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$6,000
- [Specialist copayment](#) \$80
- [Primary care visit copayment](#) \$40
- [Durable medical equipment](#) 40% coinsurance after deductible

**This EXAMPLE event includes services like:**

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,720</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$900   |
| <a href="#">Copayments</a>  | \$1,000 |
| <a href="#">Coinsurance</a> | \$0     |

| What isn't covered                |                |
|-----------------------------------|----------------|
| Limits or exclusions              | \$0            |
| <b>The total Joe would pay is</b> | <b>\$1,900</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$6,000
- [Specialist copayment](#) \$80
- [Emergency room](#) 40% coinsurance after deductible
- [Durable medical equipment](#) 40% coinsurance after deductible

**This EXAMPLE event includes services like:**

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$2,100 |
| <a href="#">Copayments</a>  | \$400   |
| <a href="#">Coinsurance</a> | \$0     |

| What isn't covered                |                |
|-----------------------------------|----------------|
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,500</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.





## Multilanguage Interpreter Services

Important! This is about your WellSense Health Plan benefits. We can translate it for you free of charge. Please call **855-833-8122 (TTY: 711)** for translation help.

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ilimportante! Esta información es sobre sus beneficios de WellSense Health Plan. Podemos traducirlo para usted de forma gratuita. Llame al **855-833-8122 (TTY: 711)** para obtener ayuda de traducción. (ESA)

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Important! Cela concerne vos prestations WellSense Health Plan. Nous pouvons traduire ce contenu gratuitement pour vous. Veuillez appeler le **855-833-8122 (TTY: 711)** pour obtenir de l'aide concernant la traduction. (FRC)

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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 **855-833-8122 (TTY: 711)**。(CHS)

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هنا! هذا حول مزايا WellSense Health Plan الخاصة بك. يمكننا ترجمتها لك مجاناً. يرجى الاتصال  
**855-833-8122 (TTY: 711)** للمساعدة في الترجمة. (ARA)

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Wichtig! In diesem Dokument geht es um Ihre WellSense Health Plan-Vorteile. Wir können es kostenlos für Sie übersetzen. Bitte rufen Sie uns unter **855-833-8122 (TTY: 711)** an, um Übersetzungshilfe zu erhalten. (DEU)

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Importante! Esta comunicação é sobre os benefícios da WellSense Health Plan. Podemos traduzir para você gratuitamente. Ligue para **855-833-8122 (TTY: 711)** para obter ajuda com a tradução. (PTB)

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Σημαντικό! Πρόκειται για τις παροχές του WellSense Health Plan. Μπορούμε να σας το μεταφράσουμε δωρεάν. Καλέστε στο **855-833-8122 (TTY: 711)** για βοήθεια σχετικά με τη μετάφραση. (ELG)

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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 **855-833-8122 (TTY: 711)**. (RUS)

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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 **855-833-8122 (TTY: 711)** để được trợ giúp dịch thuật. (VIT)

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ముఖ్యమైనది! ఇది మీ WellSense Health Plan ప్రయోజనాల గురించి.  
మేము దానిని మీ కోసం ఉచితంగా అనువదించగలము. అనువాద సహాయం  
కోసం దయచేసి **855-833-8122 (TTY: 711)** కు కాల్ చేయండి. (TELG)

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중요! 이것은 WellSense Health Plan 혜택에 대한 내용입니다. 무료로 번역해 드릴 수 있습니다. 번역  
도움이 필요하면 **855-833-8122 (TTY: 711)**번으로 문의하십시오. (KOR)

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NHACA

Enpotan! Sa a se sou avantaj WellSense Health Plan ou an. Nou ka tradui li pou ou gratis. Tanpri relel **855-833-8122 (TTY: 711)** pou jwenn èd ak tradiksyon. (HRV)

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Ważne! To dotyczy Twoich świadczeń w ramach planu zdrowotnego WellSense Health Plan. Możemy nieodpłatnie przetłumaczyć dla Ciebie te informacje. Zadzwoń pod numer **855-833-8122 (TTY: 711)**, aby uzyskać pomoc w tłumaczeniu. (POL)

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Penting! Informasi ini terkait manfaat WellSense Health Plan Anda. Kami dapat menerjemahkannya untuk Anda tanpa biaya. Hubungi **855-833-8122 (TTY: 711)** untuk bantuan terjemahan. (IND)

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महत्त्वपूर्ण! यो तपाईंको WellSense हेल्थ प्लान लाभहरूको बारेमा हो। हामी यसलाई तपाईंको निमित्त निः शुल्क रूपमा अनुवाद गर्न सक्छौं। कृपया अनुवाद सहायताको लागि यस नम्बरमाकल गर्नुहोस् - **855-833-8122 (TTY: 711)**. (NEP)

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Important! This material can be requested in an accessible format by calling 855-833-8122 (TTY: 711).

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### 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 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](https://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: 855-833-8122 (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](https://hhs.gov/ocr/office/file/index.html)