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 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:
What is the overall deductible?	$6,400 Individual/$12,800 Family (Medical and RX)	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Preventive Services, Urgent Care Services, PCP Office Visits, Physical, Speech and Occupational Therapy Services, and Specialist Office Visits are covered with no Deductible	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care benefits.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$10,300 Individual/$20,600 Family (Medical and RX)	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.wellsense.org or call 1-855-833-8122 for a list of network providers	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 Deductible does not apply	Not covered	Specialist visits may require a pre-authorization.
	Specialist visit	$80 Deductible does not apply	Not covered	
	Preventive care/screening/ Immunization	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 provider if the services needed are preventive. Then check what your plan will pay for. Visit https://www.healthcare.gov/coverage/preventive-care-benefits/ for info on services that are considered preventive.
If you have a test	Diagnostic test (x-ray, blood work, ultrasounds)	40% coinsurance	Not covered	
	Imaging (CT/PET scans, MRIs)	40% coinsurance	Not covered	Pre-authorization is required; if pre-authorization is not obtained payment for services could be denied.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.wellsense.org**	Generic drugs	$20 retail and $50 mail order/prescription 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 pre-authorization 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 Deductible does not apply	Not covered	
	Non-preferred brand drugs	$80 retail and $200 mail order/prescription	Not covered	
	Specialty drugs	$350retail/prescription mail order prescription	Not covered	Covers up to a 30-day supply from participating

*For more information about limitations and exceptions, see the plan or policy document at www.wellsense.org.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		not covered		specialty pharmacies; 90-day mail order not available; pre-authorization may be required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	Not covered	Includes diagnostic colonoscopies and endoscopies; pre-authorization may be required.
	Physician/surgeon fees	40% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	40% coinsurance	40% coinsurance	If you receive emergency services from a non-network provider, the plan pays up to the allowed amount.
	Emergency medical transportation	40% coinsurance	40% coinsurance	None
	Urgent care	$60 Deductible does not apply	$60 Deductible does not apply	Urgent care 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	Pre-authorization is required; if pre-authorization 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 Deductible does not apply	Not covered	Pre-authorization may be required.
	Inpatient services	40% coinsurance	Not covered	
If you are pregnant	Office visits	40% coinsurance	Not covered	Cost-sharing 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	Home health care	40% coinsurance	Not covered	Pre-authorization is required; if pre-authorization is not obtained payment for services could be

*For more information about limitations and exceptions, see the plan or policy document at www.wellsense.org.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
other special health needs				denied.
	Rehabilitation services	$40 for outpatient services Deductible does not apply 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; Pre-authorization required for certain services.
	Habilitation services	$40 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); Pre-authorization may be required after initial evaluation.
	Skilled nursing care	40% coinsurance	Not covered	Limited to 100 calendar days per calendar year; Pre-authorization is required; If pre-authorization is not obtained, payment for services could be denied.
	Durable medical equipment	40% coinsurance	Not covered	Coinsurance does not apply to wigs and breast pumps and related supplies; Pre-authorization may be required from our 3rd party vendor, Northwood, Inc.
	Hospice services	40% coinsurance	Not covered	Pre-authorization is required. If you do not get pre-authorization, payment for services could be denied.
If your child needs dental or eye care	Children's eye exam	No charge for preventive exams; $80 for non-routine and routine exams. 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.

*For more information about limitations and exceptions, see the plan or policy document at www.wellsense.org.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	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
- Cosmetic surgery
- Dental care except as described in the Evidence of Coverage (EOC)
- Early intervention services for children age 3 and older
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight loss/ anti-obesity medications
- Private-duty nursing
- Services beyond any listed benefit or monetary limit

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

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

*For more information about limitations and exceptions, see the plan or policy document at www.wellsense.org.

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 ,or The U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or 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.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 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

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, kwiijigo holne' 1-855-833-8122.

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

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*For more information about limitations and exceptions, see the plan or policy document at www.wellsense.org.

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** $6,400
- **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

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$6,400
Copayments	$10
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$8,970**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** $6,400
- **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)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$900
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,920**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** $6,400
- **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)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,100
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,500**

*For more information about limitations and exceptions, see the plan or policy document at www.wellsense.org.

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.

¡Importante! 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)

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)

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)

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

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)

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)

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)

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)

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)

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)

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

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)

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)

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)

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

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