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 calling1-855-833-8120. 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 1-855-833-8120 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Event chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable	This plan does not have deductible.
Are there other deductibles for specific services?	No.	You do not have to meet deductibles for specific services
What is the out-of-pocket limit for this plan?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable	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 1-855-833-8120 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 network specialist you chose 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	No Charge	Not Covered	Specialist visits may require a Preauthorization.
	Specialist visit	No Charge	Not Covered	
	Preventive care/screening/ immunization	No Charge	Not Covered	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)	No Charge	Not Covered	
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	- Preauthorization is required. If preauthorization 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	No Charge	Not Covered	- Covers up to a 30-day supply (retail); - Covers up to a 90-day supply (mail order). - Oral and other forms of prescription contraceptives are covered in full. - Oral anti-cancer drugs are covered in full. - Step therapy may be required. - Preauthorization may be required.
	Preferred brand drugs	No Charge	Not Covered	
	Non-preferred brand drugs	No Charge	Not Covered	
	Specialty drugs	No Charge	Not Covered	- Covers up to a 30-day supply from participating specialty pharmacies. - Preauthorization may be required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	- Includes diagnostic colonoscopies and endoscopies. - Preauthorization may be required.
	Physician/surgeon fees	No Charge	Not Covered	

* 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)	
If you need immediate medical attention	Emergency room care	No Charge	No Charge	- ER Copayment is waived if admitted directly to the hospital from the ER - If you receive emergency services from a non-network provider, the plan pays up to the allowed amount.
	Emergency medical transportation	No Charge	No Charge	Emergency transportation only. Non-emergency transportation requires Preauthorization. If preauthorization is not obtained payment for services could be denied.
	Urgent care	No Charge	No Charge	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)	No Charge	Not Covered	- Inpatient Rehabilitation hospitals are limited to 60 days per benefit year. - Preauthorization is required. If preauthorization is not obtained payment for services could be denied.
	Physician/surgeon fees	No Charge	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	Not Covered	- Preauthorization may be required from our 3rd party contractor, Beacon Health Strategies, LLC.
	Inpatient services	No Charge	Not Covered	
If you are pregnant	Office visits	No Charge	Not Covered	- Cost-sharing does not apply to preventive services
	Childbirth/delivery professional services	No Charge	Not Covered	
	Childbirth/delivery facility services	No Charge	Not Covered	

* 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)	
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	- Preauthorization is required. If preauthorization is not obtained payment for services could be denied.
	Rehabilitation services	No Charge	Not Covered	- Outpatient Physical and Occupational therapy is limited to 60 combined visits per benefit year. - PT/OT limits do not apply to members with Autism Spectrum Disorders or for children under age 3 who are receiving Early Intervention Services. - No limit on speech therapy visits - Preauthorization may be required after initial evaluation.
	Habilitation services	No Charge	Not Covered	- Outpatient Physical and Occupational therapy is limited to 60 combined visits per benefit year. - Preauthorization may be required after initial evaluation.
	Skilled nursing care	No Charge	Not Covered	- Limited to 100 days per benefit year. - Preauthorization is required. If preauthorization is not obtained payment for services could be denied.
	Durable medical equipment	No Charge	Not Covered	- Coinsurance does not apply to wigs. - Preauthorization may be required from our 3rd party vendor, Northwood, Inc.
	Hospice services	No Charge	Not Covered	-Preauthorization is required. If you do not get preauthorization, payment for services could be denied.

* 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)	
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	- Preventive eye exams are limited to one every 12 months for members age 18 and younger
	Children's glasses	No Charge	Not Covered	
	Children's dental check-up	No Charge	Not Covered	- Only covered for members age 18 and younger - Check-up refers to preventive and diagnostic visits (Type I services)*

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
- Early Intervention services for children age 3 and older.
- Hearing Aids for members over age 21
- Long-term care
- Non-Emergency care when traveling outside the U.S
- Private-duty nursing
- Routine foot care except for members with Diabetes
- Dental Care (Adult)
- Services beyond any benefit or monetary limit listed in this Summary of Benefits and Coverage
- Vision Hardware except as described in the Evidence of Coverage.
- Weight loss programs, except as described in the Evidence of Coverage.

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
- Dental Services for Cleft Lip/Palate Repair
- Hearing Aids for Children
- Infertility Treatment

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: Massachusetts Division of Insurance Consumer Service Section 1-877-563-4467 or mass.gov/doi, 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

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

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 1-855-833-8120
- The U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa
- Massachusetts Division of Insurance at 617-521-7794

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 1-855-833-8120.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-833-8120.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-833-8120.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-833-8120.

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

* 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** **$0**
- **Specialist copayments** **$0**
- **Hospital (facility) copayments** **$0**

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)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$0**

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

- **The plan's overall deductible** **$0**
- **Specialist copayments** **$0**
- **Hospital (facility) copayments** **$0**
- **Durable medical equipment coinsurance**

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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$0**

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

- **The plan's overall deductible** **$0**
- **Specialist copayments** **$0**
- **Emergency room copayments** **$0**
- **Durable medical equipment coinsurance**

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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$0**

The plan would be responsible for the other costs of these EXAMPLE covered services.