Schedule of Benefits
Qualified Health Plan

Low Gold Plan

WellSense HEALTH PLAN

A Qualified Health Plan and Employer Choice Direct Plan¤

Provider Network: Select Network¤¤

This Schedule of Benefits provides a summary of your benefits and *member cost-sharing*. It also tells you the name of your *provider network* (see above). Please be sure to read the WellSense Health Plan Evidence of Coverage (EOC) for a full description of your benefits, including exclusions, and other *plan* provisions. All *covered services* must be *medically necessary* and some require prior authorization. Always check with your provider to find out if necessary prior authorization has been obtained. If any terms in this summary differ from those in your EOC, the terms of your EOC apply. Italicized words in this Schedule of Benefits are defined in your EOC. For more information about your benefits, and to find *network providers*, go to wellsense.org or call Member Services at 855-833-8120.

WS-LWGLD2023ver.2

Deductible (*per benefit year*)	**Amount**
Per Individual *Member*	$1,750 (Medical and RX)
	$50 (Pediatric Dental – Type II and Type III Services Only)
Per Family	$3,500 (Medical and RX)
Out-of-Pocket Maximum (*per benefit year*)	**Amount**
Per Individual *Member*	$5,250 (includes Medical, Pediatric Dental*, and Rx) $350 (Pediatric Dental, if applicable, counts toward the Individual and Family OOPM)
Per Family	$10,500 (includes Medical, Pediatric Dental, and Rx)

Covered Services Some services require prior authorization. See your EOC for more information.	**Description**	**Your Cost (*Cost-sharing*)**
***Inpatient* Hospital Care**	Acute hospital *inpatient care* for medical, surgical and maternity services. See also, "Newborn Coverage", below.	$750 *copayment* per admission after de*ductible*
	Extended care in a chronic disease hospital.	$750 *copayment* per admission after *deductible*
	Extended care in a rehabilitation hospital. *Benefit limit:* limited to 60 days per *benefit year*.	$750 *copayment* per admission after *deductible*
	Extended care in a skilled nursing facility. *Benefit limit:* limited to 100 days per *benefit year*.	$750 *copayment* per admission after *deductible*
	Mental health and substance abuse+ *Inpatient* admission to a general or mental hospital, or substance abuse facility.	$750 *copayment* per admission after *deductible*
Abortion	Outpatient Surgery	Nothing
Allergy Services	Testing and Treatment.	$55 *copayment* per visit
	Lab tests.	See Lab Tests, below
	Allergy injections.	$10 per injection
Ambulance	Covered ambulance.	Nothing after deductible
Autism Spectrum Disorder Services+	• *Outpatient* office visits. • *Outpatient* rehabilitation (physical, occupational, speech therapy and social work visits) – as is *medically necessary*. • Lab tests and other diagnostic tests. • Habilitative services.	You pay the *cost-sharing* applicable to the service(s) rendered.
Cardiac Rehabilitation	*Outpatient* services.	$55 *copayment* per visit
Chemotherapy and Radiation Therapy	*Outpatient* services.	Nothing after *deductible*
Chiropractor Care	*Outpatient* office visits, including supportive medical treatment services and spinal manipulation	$55 *copayment* per visit
	Outpatient lab test and x-rays	See lab test, x-rays, and other test
Dialysis Services	*Outpatient* services.	Nothing after *deductible*
Durable Medical Equipment, Prosthetics, Orthotics, Medical Supplies, Medical Formulas and Low Protein Foods++	• Durable medical equipment • Prosthetics • Orthotics • Medical supplies • Medical formulas • Wigs (scalp hair prostheses): • *Coinsurance* does not apply • Low protein foods • Ostomy supply • Oxygen and respiratory equipment	20% *coinsurance after deductible*

Covered Services Some services require prior authorization. See your EOC for more information.	**Description**	**Your Cost (*Cost-sharing*)**
Early Intervention Services	For an eligible *child* through age 2.	Nothing
Emergency Services	Visits to an emergency room (or for observation services in a hospital setting without use of the emergency room). If you are admitted as an inpatient immediately following the provision of *emergency* services: • Your *emergency* services *copayment* is waived; and • If admitted to a non-*network hospital*, you or someone acting for you must call the *plan* within 2 working days. If you receive *emergency* services from a non-network provider, the plan pays up to the *allowed amount*.	$250 *copayment after deductible* per visit
Habilitative Services and Devices	*Outpatient* physical and occupational therapy as well as medically necessary habilitative devices. *Benefit limit:* limited to 60 combined visits per *benefit year*. (*Benefit limit* does not apply to these services when provided to *members* with autism spectrum disorder, or when receiving early intervention services)	$55 copayment per visit
Hearing Aids for Children	For an eligible *child* age 21 or younger *Benefit limit:* Covered for one hearing aid up to two thousand dollars ($2,000) every 36 months per hearing impaired ear.	20% *coinsurance after deductible*
	Hearing aid evaluations and exams	$55 *copayment* per visit
	Hearing aid related services and supplies	20% *coinsurance after deductible*
Hearing Exams	PCP exams and evaluations.	$30 *copayment* per visit
	Specialist exams and evaluations.	$55 *copayment* per visit
Home Health Care	Home care program.	Nothing after *deductible*
Hospice Services	Hospice services for terminally ill.	Nothing after *deductible*
Infertility Services	*Inpatient, outpatient surgery*; lab and x-rays; *outpatient* office visits; and prescription drugs.	You pay the *cost-sharing* applicable to the service(s) rendered.
Lab Tests, Radiology and Other Outpatient Diagnostic Procedures (Non-Routine Diagnostic Services)	Diagnostic laboratory tests (includes HLA testing).	$50 copayment after *deductible*
	X-rays.	$75 copayment after *deductible*

Covered Services Some services require prior authorization. See your EOC for more information.	**Description**	**Your Cost (*Cost-sharing*)**
	Diagnostic high tech imaging: CT/CTA scan, MRI/MRA, PET scan and NCI/NPI (nuclear cardiac imaging).	$250 *copayment* per visit after *deductible*
Lipodystrophy Syndrome Treatment	Medical and/or drug treatment such as reconstructive surgery (for example, suction assisted lipectomy)	You pay the *cost-sharing* applicable to the service(s) rendered.
	Other restorative procedures including dermal injections or fillers	You pay the *cost-sharing* applicable to the service(s) rendered.
Long Term Antibiotic Therapy for Lyme Disease	Primary care provider (PCP) office visit.	$30 *copayment* per visit
	Specialist office visit.	$55 *copayment* per visit
Maternity Services	Outpatient prenatal office visits.	You pay the cost-sharing applicable to the service(s) rendered. No charge for services considered preventive
	Outpatient postpartum office visits	
Medical Formulas	Nonprescription enteral formulas and prescription formulas	See Durable Medical Equipment
Medical Supplies	Includes ostomy, tracheostomy and oxygen supplies; and supplies for insulin pumps.	See Durable Medical Equipment
Mental Health and Substance Abuse Treatment – Outpatient+	*Outpatient* office visits.	$30 *copayment* per visit
	Medication-Assisted Treatment (MAT) and Associated Services for Opioid Dependence	$30
Nutritional Counseling	*Outpatient* office visits by a registered dietician.	Nothing
Observation Services	If you are admitted to observation status from the emergency room, the emergency room copayment is waived.	$250 *copayment* after *deductible* per visit.
Outpatient Office Visits for Medical Care (to evaluate and treat illness or injury)	Primary care provider (PCP) office visit.	$30 *copayment* per visit
	Specialist office visit.	$55 *copayment* per visit
Outpatient Surgery	Same day surgery in a hospital or ambulatory surgery setting. (Includes diagnostic colonoscopies and endoscopies.)	$250 *copayment* per visit after *deductible*

Covered Services Some services require prior authorization. See your EOC for more information.	**Description**	**Your Cost (*Cost-sharing*)**
Pediatric Dental++++ (Ages 18 and under)	Type I Services: Preventive & Diagnostic • Comprehensive Evaluation (Once per dentist per location) • Periodic Oral Exams (Twice per dentist location every 12 months) • Limited Oral evaluation (Two per calendar year per patient) • Oral evaluation under 3 years of age • Full Mouth X-Ray (Once per dentist location every 36 months) • Panoramic X-Ray(Once per dentist location every 36 months) • Bitewing X-Rays (Two per dentist location every 12 months) • Single Tooth X-Ray (As needed) • Teeth Cleaning (Twice every 12 months) • Fluoride Treatments (Once every 3 months) • Space Maintainers (covered) • Sealants (Once per tooth per dentist location every 26 months)	Nothing
	Type II Services: Basic Covered Services • Amalgam Restoration (Once per tooth per surface every 12 months) • Composite Resin Restorations (Once per tooth per surface every 12 months) • Recement crown/onlays (covered) • Rebase or reline dentures (Once with 24 months) • Root canals on permanent teeth (Once per tooth) • Prefabricated Stainless Steel Crowns (Four per patient per day) • Periodontal Scaling and Root Planing (Once per quadrant every 24 months) • Simple Extractions (covered.) • Surgical Extractions (covered.) • Vital pulpotomy (Limited to deciduous teeth) • Apicoectomy (Once per permanent tooth per lifetime) • Palliative care • Anesthesia (Allowed with covered surgical procedure)	25% *coinsurance* after *deductible*
	Type III Services: Major Restorative Services • Crown, resin (Once per tooth within 60 months) • Porcelain/ceramic crowns (Once per within 60 months)	50% *coinsurance* after *deductible*

Covered Services Some services require prior authorization. See your EOC for more information.	**Description**	**Your Cost (*Cost-sharing*)**
Pediatric Dental++++ (Ages 18 and under) (Continued)	Type IV Services: Orthodontia (Once per lifetime) (Covered only when medically necessary; patient must have severe and handicapping malocclusion as defined by HLD index score of 28 and/or one or more auto qualifiers; requires prior authorization)	50% *coinsurance*
Pediatric Vision (Ages 18 and under)	• Conventional* Lenses: One pair every calendar year • Conventional* Frames: Covered once every calendar year • Contact Lenses: Covered once every calendar year – instead of eyeglasses	20% *coinsurance* after *deductible*
Podiatry Services	Non-routine foot care.	$55 *copayment* per visit
	Outpatient lab tests and x-rays.	See Lab Tests, X-Rays and Other Tests
	Routine foot care for diabetics.	Nothing
Prescription Drugs¤¤¤ From a network Retail Pharmacy: (up to a 30-day supply)	Tier 1	$30 *copayment*
	Tier 2	$60 *copayment after deductible*
	Tier 3	$90 *copayment after deductible*
	Tier 4	$90 *copayment after deductible*
Prescription Drugs¤¤¤ From Mail Service Pharmacy: (up to a 90-day supply)	Tier 1	$60 *copayment*
	Tier 2	$120 *copayment after deductible*
	Tier 3	$270 *copayment after deductible*
	Tier 4	$270 *copayment after deductible*
Note: You pay nothing for: (1) oral and other forms of prescription drug contraceptives; and (2) Certain oral anti-cancer drugs (3) statins (4) smoking cessation items (5) aspirin (6) Preexposure prophylaxis (PrEP) with effective antiretroviral therapy.		

Covered Services Some services require prior authorization. See your EOC for more information.	**Description**	**Your Cost (*Cost-sharing*)**
Preventive Health Services The *plan* covers certain preventive health services, defined as services to prevent any disease or injury rather than diagnose or treat a complaint or symptom, with no *cost-sharing*, in accordance with the *plan*'s medical policy guidelines and the Affordable Care Act (ACA). For more information about which preventive services are included, see the Preventive Health Services section at the end of your EOC, and visit the *plan's* website at wellsense.org or the federal government's website at https://www.healthcare.gov/coverage/preventive-care-benefits/	Preventive health services for children: • Physical exams at specific intervals from birth to 6 years. • Annual Exam (6 years or older). • Preventive immunizations. • Preventive screening tests. • Preventive hearing exams and tests (includes newborn hearing screening) • Preventive vision exams (one exam per member every 12 months). Preventive health services for adults: • Annual physical exams. • Preventive immunizations. • Preventive screening tests and procedures (including screening colonoscopies). • Preventive hearing exams and tests. • Preventive vision exams (one exam per member every 24 months). Preventive health services for women, including pregnant women: • Annual GYN exams, including screening pap smears. • Routine Prenatal care including one postpartum visit. • Screening mammograms. • Voluntary sterilization procedures. • Breast pumps and related supplies. • Family Planning.	Nothing
Prosthetic Devices	Includes wigs (scalp hair prostheses) for hair loss due to treatment for cancer or leukemia.	See Durable Medical Equipment
Rehabilitation Therapies	Short term *outpatient* physical and occupational therapy. *Benefit limit:* limited to 60 combined visits per *benefit year*. (*Benefit limit* does not apply to these services when provided to *members* with autism spectrum disorder; or when receiving early intervention services.)	$55 *copayment* per visit
	Aural and pulmonary therapy.	$55 *copayment* per visit
Second Opinions	*Outpatient second and third opinions*	See Outpatient Office Visits for Medical Care
Speech-Language and Hearing Disorder Services (no limits other than *medical necessity*)	*Outpatient* office visits for medical care.	See Outpatient Office Visits for Medical Care
	Outpatient speech therapy.	$55 *copayment* per visit
	Outpatient diagnostic tests.	See Lab Tests, X-Rays and Other Tests

Covered Services Some services require prior authorization. See your EOC for more information.	**Description**	**Your Cost (*Cost-sharing*)**
TMJ Disorder Treatment	*Outpatient* x-rays, surgical services, physical therapy or medical care services.	You pay the *cost-sharing* applicable to the service(s) rendered.
Urgent Care		$55 *copayment* per visit
Vision Services	Eye exams and treatment (to treat or diagnose a medical condition of the eye). Preventive Vision Exams – see "Preventive Health Services" above.	$55 *copayment* per visit
Member Extras+++	***Get Fit!* Fitness Reimbursement or *Wear It!* Fitness Tracker Reimbursement** Reimbursement of 25% of annual membership fees in a Qualifying Health Club – limited to one *member* per family per calendar year. Reimbursement of 50% on a wearable technology device, up to $50 per year – Limited to one member per family per year (Each family is eligible for the fitness reimbursement or fitness tracker reimbursement within one calendar year, not both) **Weight Watchers®** Reimbursement of 25% of fees for certain Weight Watchers® programs – limited to one *member* per family per calendar year. **Eyewear Discounts For Adults** You must use a Vision Services Provider (VSP): • 20% off the retail price of complete sets of prescription glasses – frames and lenses • 15% off the professional fee for prescription contact lens fitting and evaluation	
Member Incentives	**Diabetes Incentive Program** Members with diabetes will receive a $25 gift card for completing the following within a calendar year (or plan year for members enrolled through an employer group). • PCP Visit • Eye Exam • One HbA1c Test • Kidney Function Test	
	Insulin VBID Program Products listed below will be available at the tier 1 cost share (Please see prescription drugs – retail pharmacy) • Insulin Aspart • Novolin R • Novolin N • Lantus • Novolin 70/30	
Newborn Coverage	Newborns are automatically covered for routine nursery charges and well newborn care. Newborns must be enrolled in the *plan* within 30 days of date of birth in order for the *plan* to cover any other *medically necessary* services rendered to the newborn.	

Note: In the course of receiving certain *outpatient* services (which may or may not be subject to *cost-sharing*), you may also receive other *covered services* that require separate *cost-sharing*. (For example, during a preventive health services office visit (no *cost-sharing*), you may have a lab test that does require *cost-sharing*.)

Note: Not all prenatal or postpartum office visits are considered routine/preventive. Maternity services rendered related to complications or risks with pregnancy, may be subject to cost sharing.

¤ Qualified Health Plans are offered through the MA Health Connector. Employer Choice Direct plans are offered directly from WellSense Health Plan to MA businesses.

¤¤ The WellSense Health Plan QHP Select Network may contain different *providers* from those in the *plan's* other *provider networks*. When looking up *Network providers* on our website, please be sure to look under the WellSense Health Plan QHP Select Network.

¤¤¤ The *plan* contracts with Express Scripts, Inc. (ESI) to manage prescription drug benefits for *members*. To locate *network pharmacies*, go to our website wellsense.org or call Express Scripts, Inc. at 855-833-8120.

+ The *plan* contracts with *Carelon Behavioral Health (Carelon)* to manage all mental health and substance abuse services for *members*. To locate a *Network provider* of mental health or substance abuse services, go to our website wellsense.org or call Carelon at 1-877-957-5600.

++ The *plan* contracts with Northwood, Inc. to manage most durable medical equipment, prosthetics, orthotics, medical supplies, medical formulas and low protein foods. Contact the *plan's* Member Services for more information.

+++ See your EOC for further information on member extras and how to access these Member Extras, or visit wellsense.org.

++++ The plan contracts with Delta Dental to manage all pediatric dental covered services for eligible members. For assistance call Delta Dental at 1-844-260-6097.

*Conventional lenses are defined under the Federal Vision Insurance Plan as single vision, lined bifocal, lined trifocal, lenticular glass or plastic lenses, all lens powers, fashion and gradient tinting, ultraviolet protective coating, oversized and glass-grey #3 prescription sunglass lenses. Polycarbonate lenses are covered for children, monocular patients and patients with prescriptions greater than or equal to +/- 6.00 diopters. All lenses include scratch resistant coating.

Notice for American Indian and Alaskan Native (AI/AN) Members:
According to Federal law, you may be able to enroll in a QHP plan that has limited or no cost sharing. Depending on your income, you may have no copays, deductibles, or coinsurance when you receive services from an Indian Health or Tribal provider, or when your Indian Health or Tribal provider refers you to another provider. The Massachusetts Health Connector will determine your eligibility for this benefit when you submit your QHP application. In addition to verifying your income, the Health Connector may also ask for documentation that proves your AI/AN status. If you qualify, the Health Connector will send us your information so that we can share it with our providers. If you have any questions, you may reach out to the MA Health Connector or to Member Services 855-833-8120

✓ This health plan **meets Minimum Creditable Coverage standards** and will satisfy the individual mandate that you have health insurance.

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE: As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

Minimum Creditable Coverage Standards. This health plan meets applicable Minimum Creditable Coverage standards that are effective January 1, 2021 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards.

This disclosure is for minimum creditable coverage standards that are effective January 1, 2021. Because these standards may change, review your health plan material each year to determine whether your plan meets the latest standards. If you have questions about this notice, you may contact the Division of Insurance: (617) 521-7794 or visiting its website at www.mass.gov/doi.

WellSense HEALTH PLAN

Multilanguage Interpreter Services

Important! This is about your WellSense Health Plan benefits. We can translate it for you free of charge. Please call **855-833-8120 (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 **855-833-8120 (TTY: 711)** para obtener ayuda de traducción. (ESA)

Importante! Esta comunicação é sobre os benefícios da WellSense Health Plan. Podemos traduzir para você gratuitamente. Ligue para **855-833-8120 (TTY: 711)** para obter ajuda com a tradução. (PTB)

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 **855-833-8120 (TTY: 711)**。(CHS)

Enpotan! Sa a se sou avantaj WellSense Health Plan ou an. Nou ka tradui li pou ou gratis. Tanpri relel **855-833-8120 (TTY: 711)** pou jwenn èd ak tradiksyon. (HRV)

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 **855-833-8120 (TTY: 711)** để được trợ giúp dịch thuật. (VIT)

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 **855-833-8120 (TTY: 711)**. (RUS)

Σημαντικό! Πρόκειται για τις παροχές του WellSense Health Plan. Μπορούμε να σας το μεταφράσουμε δωρεάν. Καλέστε στο **855-833-8120 (TTY: 711)** για βοήθεια σχετικά με τη μετάφραση. (ELG)

هام! هذا حول مزايا WellSense Health Plan الخاصة بك. يمكننا ترجمتها لك مجانا. يرجى الاتصال **855-833-8120 (TTY: 711)** للمساعدة في الترجمة. (ARA)

महत्वपूर्ण! यह आपके WellSense Health Plan लाभों के बारे में है। हम आपके लिए इसका निःशुल्क अनुवाद कर सकते हैं। कृपया अनुवाद संबंधित सहायता के लिए **855-833-8120 (TTY: 711)** पर फ़ोन करें। (HIN)

중요! 이것은 WellSense Health Plan 혜택에 대한 내용입니다. 무료로 번역해 드릴 수 있습니다. 번역 도움이 필요하면 **855-833-8120 (TTY: 711)**번으로 문의하십시오. (KOR)

ចំណុចសំខាន់! ព័ត៌មាននេះគឺ ស្តីអំពីអត្ថប្រយោជន៍នៃ WellSense Health Plan របស់អ្នក។ យើងអាចបកប្រែវាសម្រាប់អ្នកដោយឥតគិតថ្លៃ។ សូមទូរសព្ទទៅលេខ **855-833-8120 (TTY: 711)** សម្រាប់ជំនួយផ្នែកបកប្រែ។ (KHM)

MAQHP

Ważne! To dotyczy Twoich świadczeń w ramach planu zdrowotnego WellSense Health Plan. Możemy nieodpłatnie przetłumaczyć dla Ciebie te informacje. Zadzwoń pod numer **855-833-8120 (TTY: 711)**, aby uzyskać pomoc w tłumaczeniu. (POL)

ສິ່ງສຳຄັນ! ນີ້ແມ່ນກ່ຽວກັບຜົນປະໂຫຍດຂອງແຜນປະກັນ WellSense Health Plan ຂອງທ່ານ. ພວກເຮົາສາມາດແປພາສາໃຫ້ທ່ານໄດ້ໂດຍບໍ່ເສຍຄ່າ. ກະລຸນາໂທ **855-833-8120 (TTY: 711)** ເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາ. (LAO)

Important! This material can be requested in an accessible format by calling 855-833-8120 (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, 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.

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
529 Main Street, Suite 500
Charlestown, MA 02129
Phone: 855-833-8120 (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