Schedule of Benefits

Massachusetts

Standard High Silver:
WellSense Clarity Silver 2000 II

A Qualified Health Plan¤

Provider Network: Clarity 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 Service at 855-833-8120.

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***Deductible* (per *benefit year*)**	**Amount**
Per Individual *Member*	$2,000 (Medical and Rx)
	$50 (Pediatric Dental**** – Type II and type III services only)
Per Family	$4,000 (Medical and Rx)
***Out-of-Pocket Maximum* (per *benefit year*)**	**Amount**
Per Individual *Member*	$9,200 (includes Medical, Pediatric Dental****, and Rx) $350 (Pediatric Dental****, if applicable, counts toward the Individual and Family OOPM)
Per Family	$18,400 (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. Note: See Newborn Coverage, below, for newborn benefit details.	$1,000 *copayment* after *deductible* per admission
	Extended care in a chronic disease hospital.	$1,000 *copayment* after *deductible* per admission
	Extended care in a rehabilitation hospital. *Benefit limit:* Limited to 60 calendar days per *benefit year*.	$1,000 *copayment* after *deductible* per admission
	Extended care in a skilled nursing *facility*. *Benefit limit:* Limited to 100 calendar days per *benefit year*.	$1,000 *copayment* after *deductible* per admission
	Inpatient admission to a general or mental hospital, or substance abuse *facility* for mental health acute treatment and substance use disorder treatment. [+]	$1,000 *copayment* after *deductible* per admission
	Physician, surgeon, and other covered professional *provider* services during *inpatient* hospital care.	$0 *copayment* after *deductible* per admission
Abortion and Abortion-Related Services	*Outpatient surgery*, including physician, surgeon, and other covered professional *provider* services during *outpatient surgery*.	$0 *copayment* per visit
Allergy Services	Testing and treatment.	$60 *copayment* per visit
	Lab tests.	See Lab Tests, below.
	Allergy injections.	$10 *copayment* per injection
Ambulance	Covered ambulance.	$0 *copayment* after *deductible* per transport
Autism Spectrum Disorder Services[+]	• Habilitative services • Lab tests and other diagnostic tests • *Outpatient* office visits • *Outpatient* rehabilitation (physical, occupational, speech therapy, and social work visits) – as is *medically necessary*	You pay the *cost sharing* applicable to the service(s) rendered.
Cardiac Rehabilitation	*Outpatient* services.	$60 *copayment* per visit
Chemotherapy and Radiation Therapy	*Outpatient* services.	$0 *copayment* after *deductible* per visit
Chiropractor Care	*Outpatient* office visits, including supportive medical treatment services and spinal manipulation.	$60 *copayment* per visit

Covered Services Some services require prior authorization. See your EOC for more information.	**Description**	**Your Cost (*Cost sharing*)**
	Outpatient lab test and x-rays.	See Lab Tests, Radiology, and Other *Outpatient* Diagnostic Procedures, below.
Dialysis Services	*Outpatient* services.	$0 *copayment* after *deductible* per visit
Durable Medical Equipment, Prosthetics, Orthotics, Medical Supplies, Medical Formulas, and Low Protein Foods[++]	• Breast pumps and related supplies	0% *coinsurance*
	• Durable medical equipment • Low protein foods • Medical formulas • Medical supplies • Orthotics • Ostomy supply • Oxygen and respiratory equipment • Prosthetics	20% *coinsurance* after *deductible*
	• Wigs (scalp hair prostheses)	0% *coinsurance* after *deductible*
Early Intervention Services	For an eligible child *member* through age 2.	$0 *copayment* per visit
Emergency Services	Visits to an emergency room. Note: If you are admitted as an *inpatient* immediately following the provision of *emergency services* to a non-network hospital, you or someone acting for you must call the *plan* within 2 working days.	$350 *copayment* after deductible per visit; *Copayment* waived if held for observation or admitted.
	Physician, surgeon, and other covered professional *provider* services during emergency room care.	$0 *copayment* after *deductible* per visit
Emergency Services Programs	Including, but not limited to: • Community-based emergency psychiatric services, • Behavioral health crisis assessment, intervention and stabilization services 24 hours per day, 7 days per week, through: - Mobile crisis intervention services for youth; - Mobile crisis intervention services for adults; - *Emergency service provider* community-based locations; and - Adult community crisis stabilization services.	*Cost sharing* is dependent on the location of services.

Covered Services Some services require prior authorization. See your EOC for more information.	**Description**	**Your Cost (*Cost sharing*)**
Habilitative Services and Devices	Short-term *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 or home health care.	$60 *copayment* per visit
Hearing Aids for Children (Ages 21 and under)	Hearing aid device. *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.	$60 *copayment* per visit
	Hearing aid-related services and supplies. *Exclusion*: Hearing aid batteries and cleaning fluid are not covered.	20% *coinsurance* after *deductible*
Hearing Exams	*PCP* exams and evaluations.	$25 *copayment* per visit
	Specialist exams and evaluations.	$60 *copayment* per visit
Home Health Care	Home care program, including home infusion therapy.	$5 *copayment* after *deductible* per visit
Hospice Services	Hospice services for terminally ill.	$0 *copayment* after *deductible* per visit
Hospital Care at Home	Acute hospital care at home. Acute *inpatient* services provided in the *member*'s home by a *network provider* who is approved by CMS to perform these services. *Benefit limit:* Limited to 90 calendar days per benefit period. Prior authorization and *concurrent review* required.	$5 *copayment* after *deductible* per visit
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, including HLA testing.	$25 *copayment* after *deductible* per visit
	X-rays and other imaging tests (such as fluoroscopic tests).	$50 *copayment* after *deductible* per visit
	Diagnostic advanced imaging: CT/CTA scan, MRI/MRA, PET scan and NCI/NPI (nuclear cardiac imaging).	$350 *copayment* after *deductible* per visit

Covered Services Some services require prior authorization. See your EOC for more information.	**Description**	**Your Cost (*Cost sharing*)**
Lipodystrophy Syndrome Treatment	Medical and/or drug treatment, including reconstructive surgery (such as suction assisted lipectomy).	You pay the *cost sharing* applicable to the service(s) rendered.
	Other restorative procedures, including dermal injections or fillers.	
Long Term Antibiotic Therapy for Lyme Disease	*Primary care provider* (*PCP*) office visit.	$25 *copayment* per visit
	Specialist office visit.	$60 *copayment* per visit
Maternity Services	*Outpatient routine* prenatal office visits, including one postpartum visit.	$0 *copayment* per visit
	Outpatient non-routine prenatal and postpartum office visits.	You pay the *cost sharing* applicable to the service(s) rendered.
Medical Formulas	Non-prescription enteral formulas and prescription formulas.	See Durable Medical Equipment.
Medical Supplies	Including, but not limited to: ostomy, tracheostomy, and oxygen supplies; and supplies for insulin pumps.	See Durable Medical Equipment.
Mental Health and Substance Use Disorder Services+	*Inpatient* admission to a general or mental hospital, or substance abuse *facility*. Note: Prior authorization is not required, but the *facility* should notify the *plan* within 72 hours of admission.	$1,000 *copayment* after *deductible* per admission; $0 *copayment* after *deductible* per admission for physician and other covered professional *provider* during *inpatient* admission.
	Intermediate non-inpatient services that provide more intensive services than *outpatient* services and less intensive than *inpatient* services, such as, *Community Based Acute Treatment (CBAT)* and *Intensive Community-Based Acute Treatment (ICBAT)*. Note: Prior authorization is not required, but the *facility* should notify the *plan* within 72 hours of admission.	$0 *copayment* after *deductible* per visit
	Medication-Assisted Treatment (MAT) and Associated Services for Opioid Dependence.	$25 *copayment* per visit
	Outpatient office visits.	$25 *copayment* per visit
Mental Health Wellness Exam	An annual mental health wellness examination provided by a licensed mental health professional or *primary care provider*. This may be provided by the *primary care provider* during an annual preventive visit.	$0 *copayment* per visit

Covered Services Some services require prior authorization. See your EOC for more information.	**Description**	**Your Cost (*Cost sharing*)**
Nutritional Counseling	*Outpatient* office visits by a registered dietician.	$0 *copayment* per visit
Observation Services	If you are admitted to observation status from the emergency room, the emergency room *copayment* is waived.	$350 *copayment* after *deductible* per admission
***Outpatient* Office Visits for Medical Care (To evaluate, monitor, and/or treat an illness or injury)**	*Primary care provider* (*PCP*) office visit.	$25 *copayment* per visit
	Specialist office visit.	$60 *copayment* per visit
Outpatient Surgery	Same day surgery in a hospital or ambulatory surgical center setting, including diagnostic colonoscopies and endoscopies.	$500 *copayment* after *deductible* per visit
	Physician, surgeon, and other covered professional *provider* services during *outpatient surgery*.	$0 *copayment* after *deductible* per visit
Pediatric Dental†††† (Ages 18 and under)	Type I Services: Preventive & Diagnostic • Bitewing X-Rays: Two per dentist location every 12 months • Comprehensive Evaluation: Once per dentist per location • Fluoride Treatments: Once every 3 months • Full Mouth X-Ray: Once per dentist location every 36 months • Limited Oral evaluation: Two per calendar year per *member* • Oral evaluation under 3 years of age • Panoramic X-Ray: Once per dentist location every 36 months • Periodic Oral Exams: Twice per dentist location every 12 months • Sealants: Once per tooth per dentist location every 26 months • Single Tooth X-Ray: As needed • Space Maintainers • Teeth Cleaning: Twice every 12 months	0% *coinsurance*

Covered Services Some services require prior authorization. See your EOC for more information.	**Description**	**Your Cost (*Cost sharing*)**
	Type II Services: Basic Covered Services • Amalgam Restoration: Once per tooth surface every 12 months • Anesthesia: Allowed with covered surgical procedures • Apicoectomy • Composite Resin Restorations: Once per tooth surface every 12 months • Palliative care • Periodontal Scaling and Root Planing: Once per quadrant every 24 months • Prefabricated Stainless Steel Crowns: Once per tooth • Rebase or reline dentures: Once within 24 months • Recement crown/onlays • Root canals on permanent teeth: Once per tooth • Simple Extractions • Surgical Extractions • Vital pulpotomy: Limited to deciduous teeth	25% *coinsurance* after *pediatric dental deductible*
	Type III Services: Major Restorative Services • Crown, resin: Once per tooth within 60 months • Partial & complete dentures: Once within 60 months • Porcelain/ceramic crowns: Once per tooth within 60 months • Porcelain fused to metal/noble/high noble crowns: Once per tooth within 60 months	50% *coinsurance* after *pediatric dental deductible*
Pediatric Dental†††† (Ages 18 and under) (Continued)	Type IV Services: Orthodontia: Once per lifetime *Benefit limit:* Covered only when medically necessary; *member* must have severe and handicapping malocclusion as defined by HLD index score of 22 and/or one or more auto qualifiers; requires prior authorization.	50% *coinsurance*
Pediatric Vision (Ages 18 and under)	• Contact Lenses: Covered once every calendar year – instead of eyeglasses. • Conventional* Frames: Covered once every calendar year. • Conventional* Lenses: One pair every calendar year.	20% *coinsurance* after *deductible*
Podiatry Services	*Non-routine* foot care (such as treatment for hammertoe and osteoarthritis).	$60 *copayment* per visit
	Outpatient lab tests and x-rays.	See Lab Tests, Radiology, and Other *Outpatient* Diagnostic Procedures, above.
	Routine foot care for diabetic *members* (such as trimming of corns, nails or other hygienic care).	$0 *copayment* per visit

Covered Services Some services require prior authorization. See your EOC for more information.	**Description**	**Your Cost (*Cost sharing*)**
Prescription Drugs¤¤¤ From a *network* Retail Pharmacy: (Up to a 30-day supply)	Generic - Tier 1	$30 *copayment* per prescription
	Preferred brand - Tier 2	$55 *copayment* per prescription
	Non-preferred brand - Tier 3	$75 *copayment* after *deductible* per prescription
	Specialty - Tier 4	$75 *copayment* after *deductible* per prescription
Prescription Drugs¤¤¤ From Mail Service Pharmacy: (Up to a 90-day supply)	Generic - Tier 1	$60 *copayment* per prescription
	Preferred brand - Tier 2	$110 *copayment* per prescription
	Non-preferred brand - Tier 3	$225 *copayment* after *deductible* per prescription
	Specialty - Tier 4	$225 *copayment* after *deductible* per prescription
Note: You pay nothing for: (1) Oral and other forms of prescription drug contraceptives; (2) Certain oral anti-cancer drugs; (3) Statins; (4) Smoking cessation items; (5) Aspirin; and (6) Pre-exposure prophylaxis (PrEP) with effective antiretroviral therapy.		
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: • Annual Exam: 6 years or older • Physical exams at specific intervals: From birth to 6 years • Preventive hearing exams and tests, including newborn hearing screening • Preventive immunizations • Preventive screening tests • Preventive vision exams: One exam per *member* every 12 months until age 19 *Preventive health services* for adults: • Annual physical exams • Preventive hearing exams and tests • Preventive immunizations • Preventive screening tests and procedures, including screening colonoscopies • 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: One exam per three calendar years • Breast pumps and related supplies • Family Planning • *Routine* prenatal care, including one postpartum visit • Screening mammograms • Voluntary sterilization procedures	$0 *copayment* per visit

Covered Services Some services require prior authorization. See your EOC for more information.	**Description**	**Your Cost (*Cost sharing*)**
Prosthetic Devices	Including, but not limited to, 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 or home health care.	$60 *copayment* per visit
	Aural and pulmonary therapy.	$60 *copayment* per visit
Second Opinions	*Outpatient* second and third opinions.	See *Outpatient* Office Visits for Medical Care.
Speech-Language and Hearing Disorder Services (No *benefit limit* other than medical necessity)	*Outpatient* office visits for medical care.	See *Outpatient* Office Visits for Medical Care.
	Outpatient speech therapy.	$60 *copayment* per visit
	Outpatient diagnostic tests.	See Lab Tests, Radiology, and Other *Outpatient* Diagnostic Procedures, above.
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		$60 *copayment* per visit
Vision Services	*Routine* and *non-routine* eye exams, including services to treat or diagnose a medical condition of the eye. Note: *Routine care* is defined as services provided routinely to monitor an existing condition. *Non-routine* care are services to evaluate and/or treat a new or worsening condition, illness, or injury.	$60 *copayment* per visit
	Preventive vision exams. Periodic eye and vision exams for no obvious signs or symptoms of disease or vision loss. Note: See *Preventive Health Services*, above, for *benefit limits*.	$0 *copayment* per visit

Covered Services Some services require prior authorization. See your EOC for more information.	**Description**	**Your Cost (*Cost sharing*)**
Member Extras+++	**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 ***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. OR • Reimbursement of 50% on a wearable technology device, up to $50 per calendar year – Limited to one *member* per family per calendar year. Note: Each family is eligible for the fitness reimbursement or fitness tracker reimbursement within one calendar year, not both. **Mom's Meals** You are eligible for free shipping on low-cost meals that are prepared and delivered to you as a *WellSense Clarity plan member*. To qualify for free shipping, place all orders via the following Mom's Meals website link (momsmeals.com/wellsense-clarity). You may start or end this benefit at any time you choose. **Weight Watchers®** Reimbursement of 25% of fees for certain Weight Watchers® programs – Limited to one *member* per family per calendar year.	
Member Incentives and VBID Programs	**Diabetes Incentive Program** *Members* with diabetes will receive a $25 gift card for completing the following within a calendar year. • Eye Exam • Kidney Function Test • One HbA1c Test • *PCP* Visit	
	Insulin VBID Program The *plan* offers an additional program providing coverage of at least one of each type of insulin at the lowest *cost share* tier for your *plan*. Please refer to the *plan* formulary for which products are covered as part of this program and all other insulin coverage available.	
Newborn Coverage	Newborns are automatically covered for routine nursery charges and well newborn care. Newborns must be enrolled in the *plan* within 60 calendar 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*. Maternity services rendered related to complications or risks with pregnancy, may be subject to *cost sharing*.

¤ *WellSense Clarity plans* are *Qualified Health Plans* offered through the MA Health Connector.

¤¤ The WellSense Clarity *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 Clarity *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 use services for *members*. To locate a *network provider* of mental health or substance use services, go to our website wellsense.org or call *Carelon* at 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 Service 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 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 *members*, and *members* 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 qualifying health plan that has limited or no *cost sharing*. Depending on your income, you may have no *copayments*, *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 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 Service 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, 2024 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, 2024. 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
100 City Square, Suite 200
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