2025 Summary of Benefits

January 1, 2025 – December 31, 2025

WellSense Signature (HMO)

H6851-002

WellSense HEALTH PLAN

Summary of Benefits

WellSense Health Plan is an HMO plan with a Medicare contract. Enrollment in WellSense Medicare Advantage HMO plans depends on contract renewal.

The benefit information provided does not list every service we cover or list every limitation or exclusion. To get a complete list of services we cover, call us at 800-967-4497 (TTY users should call 711) and ask for the Evidence of Coverage. You can also see our Evidence of Coverage at our website, **wellsense.org/medicare.**

To join WellSense Signature (HMO) you must have both Medicare Part A and Part B, and live in our service area. Our service area includes all counties in New Hampshire.

Except in emergent, urgent care situations, or other situations as described in our Evidence of Coverage, if you use a non-contracted, out-of-network provider, we may not pay for these services.

Coverage outside of the United States

Our plan only provides coverage for emergency services and urgently needed services received outside of the United States and its territories. Our plan cannot cover a drug purchased outside the United States or its territories. Your membership must end if you are no longer a United States citizen or lawfully present in the United States.

How to file a complaint

Contact us promptly to file a complaint, either by phone or in writing. Usually, calling Member Service at the number below is the first step. If there is anything else you need to do, Member Service will let you know. If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us. The investigation will be completed as quickly as possible. You can mail your complaint to:

WellSense Health Plan, Attn: Member Service
100 City Square, Suite 200, Charlestown, MA 02129

Most complaints are answered within 30 calendar days. If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint.

Right to cancel

Beneficiaries have the right to cancel their enrollment by notifying WellSense either by calling to request cancellation by the last day of the month before their coverage starts OR within seven days from the date of the Outbound Enrollment Verification letter they receive from WellSense once they are enrolled, whichever is later.

For coverage and costs of Original Medicare, you can read the "**Medicare & You**" handbook. You can view it online at Medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

This document is available in other formats such as braille, large print, or other alternate formats at no cost if you need it.

For more information, please call us at:

- Current members: **855-833-8128**
- Prospective members: **800-967-4497**
- TTY users: **711**
- Hours are Monday – Friday, 8:00 a.m. – 8:00 p.m. (Representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m. from October 1 – March 31)

You can also visit our website at **wellsense.org/medicare** for more information.

WellSense Signature (HMO) Summary of Benefits

Services that are covered for you	What you must pay when you get these services
Premium and Benefits	
Monthly Plan Premium	$0 per month You must continue to pay your Medicare Part B premium.
Deductible	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility (Does not include Part D prescription drugs or supplemental benefits)	You pay no more than $4,900 annually for services you receive from in-network providers. Includes copayments and other costs for medical services for the year (does **not** include supplemental benefit cost-sharing). If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services, and we will pay the full cost for the rest of the year.
Inpatient Hospital Care *Prior authorization is required.*	$365 copay each day for days 1 – 6 of each hospital stay.
Outpatient Hospital Services, including outpatient observation *Prior authorization may be required.*	$360 copay for outpatient hospital surgery $365 copay per day for outpatient hospital observation services
Ambulatory Surgical Services (Day Surgery, Surgical Day Care, Surgi-Centers, Ambulatory Surgical Centers) *Prior authorization may be required.*	$300 copay per visit
Doctor's Office Visits – Primary Care Providers (PCP) or Specialist These visits may be available in-person or by telehealth. There is no cost sharing for the "Welcome to Medicare" physical or annual wellness visit. *Prior authorization may be required for some services.*	PCP: $0 copay per visit Specialist: $25 copay per visit

WellSense Signature (HMO) Summary of Benefits

Services that are covered for you	What you must pay when you get these services
Preventive Care Coverage is provided for the following Medicare-covered preventive services: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Annual wellness visit • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Depression screening • Diabetes screening • HIV screening • Immunizations, including flu shots, hepatitis B shots, pneumonia shots • Medical nutrition therapy services • Medicare Diabetes Prevention Program (MDPP) • Obesity screening and therapy • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Welcome to Medicare preventive visit (one-time) Other preventive services are available and may have a cost and/or may be subject to prior authorization such as a CT scan for Lung Cancer Screening.	There is no coinsurance, copayment or deductible applied to this benefit by the Plan.

WellSense Signature (HMO) Summary of Benefits

Services that are covered for you	What you must pay when you get these services
Emergency Care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. You may get covered emergency medical care/ urgently needed services whenever you need it, anywhere in the world, up to a combined $50,000 per calendar year.	$125 copay per visit Cost-sharing for necessary emergency services furnished out-of-network is the same as services furnished in-network. If you are admitted to the hospital within 24 hours of discharge from the emergency room, this cost-sharing will be waived.
Urgent Care Services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. You may get covered emergency medical care/ urgently needed services whenever you need it, anywhere in the world, up to a combined $50,000 per calendar year.	$40 copay per visit Cost-sharing for necessary urgent care services furnished out-of-network is the same as services furnished in-network. If you are admitted to the hospital within 24 hours of discharge from an urgent care center, this cost-sharing will be waived.

WellSense Signature (HMO) Summary of Benefits

Services that are covered for you	What you must pay when you get these services
Diagnostic Services, Labs, Therapeutic Services/Supplies, and Imaging Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used • Other outpatient diagnostic tests *Prior authorization may be required for some services, including but not limited to genetic testing, CT Scans, MRIs, PET/Nuclear Medicine, Intensity Modulated Radiation Therapy and other select services. Prior authorization does not apply to X-ray services.*	**Outpatient Procedures and Tests:** PCP office: $0 copay, all other locations: $10 copay **Outpatient Laboratory Tests:** PCP office: $0 copay, all other locations: $10 copay **Therapeutic Radiological Services**: 20% coinsurance **Outpatient X-ray Services**: $80 copay per X-ray **Outpatient Diagnostic Radiological Services:** • **CT Scan:** $80 copay per test • **MRI:** $150 copay per test • **PET/Nuclear Imaging:** $350 copay per test
Hearing Services Coverage is provided for diagnostic Medicare-covered hearing and balance evaluations to determine if you need medical treatment. **Additional hearing services** • A yearly routine hearing exam • Hearing aid fitting and evaluation: one hearing aid fitting and evaluation every year • Hearing aids: up to two hearing aids (one per ear) every year. Benefit is limited to TruHearing's Advanced and Premium Hearing Aids. Fitting and evaluation exams: You must use a TruHearing provider for these exams as they are an integral part of the process for obtaining hearing aids. To use your hearing aid benefit, please call Member Services at 855-833-8128 (for TTY, dial 711) to schedule an appointment.	**Medicare-covered hearing exam:** $25 copay per visit **Additional hearing services** Routine hearing exam (1 per year): $0 copay Fitting and evaluation exams for hearing aids: $0 copay Advanced Hearing Aid: $699 copay per hearing aid; Premium Hearing Aid: $999 copay per hearing aid

WellSense Signature (HMO) Summary of Benefits

Services that are covered for you	What you must pay when you get these services
Dental Services Covered services include: • Medicare-covered dental services **Additional dental services** • Preventive dental care - Cleanings (2 every year) - Exams (2 every year) - Fluoride treatments (2 every year) - X-rays (2 every year) - Other diagnostic (1 every year) - Other preventive services (1 every 3 years per tooth on unrestored permanent molars) • Comprehensive dental care - Extractions - Restorative care - Endodontic care - Periodontic care - Crowns (limitations apply) - Dentures - Surgical procedures • $3,500 annual benefit amount for covered preventive and comprehensive services combined. Any costs you pay for non-Medicare covered services will not count toward member's maximum out of pocket.	**Medicare-covered dental services**: $25 copay per visit **Additional dental services** Preventive Dental: $0 copay Comprehensive Dental: 0% coinsurance
Vision Services Covered services include: • Medicare-covered vision services, including: - A yearly glaucoma screening and diabetic eye exam - Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration - One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens **Additional vision services** • A yearly routine vision exam • $150 annual benefit towards the purchase of 1 pair of eyeglasses, frames, lenses or contact lenses (in lieu of glasses) or hardware upgrades	**Medicare-covered eyewear**: $0 copay **All other Medicare-covered services**: $25 copay **Additional vision services** Routine vision exam (1 per year): $0 copay

WellSense Signature (HMO) Summary of Benefits

Services that are covered for you	What you must pay when you get these services
Mental Health Care **Inpatient:** There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to Mental Health Services provided in a psychiatric unit of a general hospital. **Outpatient:** Services include, but are not limited to: individual and group counseling, psychotherapy, and psychological testing. *Prior authorization is required for inpatient mental health services and outpatient psychiatric services. This includes outpatient specialty services, such as transcranial magnetic stimulation (TMS) and Applied Behavioral Analysis (ABA).*	**Inpatient**: $365 copay each day for days 1 – 6 of each hospital stay **Outpatient**: $60 copay per visit
Skilled Nursing Facility Care (SNF) Coverage is provided for up to 100 medically necessary days per benefit period. Prior hospital stay is not required. A benefit period begins on the first day a member is admitted to a skilled nursing facility and ends when the member has been out of a skilled nursing facility for 60 consecutive days. There may be more than one benefit period per year. *Prior authorization is required.*	$0 copay per day for days 1-20 $214 copay per day for days 21-100
Outpatient Rehabilitation Services Coverage is provided for physical (PT), occupational (OT), and speech language therapy (ST). *Prior authorization is required but is waived for the initial evaluation for each therapy.*	PT: $65 copay per visit OT: $45 copay per visit ST: $65 copay per visit
Ambulance *Prior authorization may be required for non-emergency ground ambulance transportation and for air ambulance transportation services.*	Ground ambulance: $295 copay per trip Air ambulance: 50% coinsurance per trip
Transportation	Not covered

WellSense Signature (HMO) Summary of Benefits

Services that are covered for you	What you must pay when you get these services
Additional Benefits	
Substance Use Services **Inpatient**: Coverage is provided for substance use services, including detoxification. **Outpatient**: Coverage is provided for individual and group therapy visits	**Inpatient**: $365 copay each day for days 1 – 6 of each hospital stay **Outpatient**: $45 copay per visit
Opioid Treatment Program Services	**PCP**: $0 copay per visit **Psychiatrist**: $60 copay per visit
Foot Care Coverage is provided for Medicare-covered podiatry services. *Prior authorization may be required.*	$25 copay per visit
Durable Medical Equipment (DME) Coverage is provided for Medicare-covered Durable Medical Equipment including but not limited to wheelchairs, oxygen, etc. *Prior authorization is required for DME that costs $500 or more.*	20% coinsurance
Prosthetic Devices Coverage is provided for Medicare-covered prosthetic devices, including but not limited to braces, artificial limbs, etc. *Prior authorization is required for prosthetic devices that cost $500 or more. .*	20% coinsurance

WellSense Signature (HMO) Summary of Benefits

Services that are covered for you	What you must pay when you get these services
Diabetes Supplies and Services Coverage is provided for Medicare-covered diabetes supplies and services, including but not limited to: • Blood glucose meter • Blood glucose test strips • Lancing devices and glucose lancets • Syringes and pen needles • Glucose control solutions for checking the accuracy of test strips, glucose meters and glucose monitors *Prior authorization is required for diabetes supplies and services that cost $500 or more.*	0% coinsurance for covered Meters, Test Strips, Lancets, Syringes, Pen Needles, Solution, and Monitors 20% coinsurance for all other diabetic supplies
Over-the-Counter (OTC) items Coverage is provided for Medicare-covered services and supplies available over-the-counter at a pharmacy or contracted retailer. • $100 per calendar quarter. Any unused amounts will not be rolled-over to the next calendar quarter within the same calendar year.	There is no coinsurance, copayment or deductible applied to this benefit.
Fitness Benefit - SilverSneakers® SilverSneakers can help you live a healthier, more active life through fitness and social connection. You are covered for a fitness benefit through SilverSneakers at participating locations, where you can take classes and use exercise equipment and other amenities, at no additional cost to you.	There is no coinsurance, copayment or deductible applied to this benefit.
Nursing Hotline	There is no coinsurance, copayment or deductible applied to this benefit.

WellSense Signature (HMO) Summary of Benefits

Services that are covered for you	What you must pay when you get these services
Chiropractic Care Coverage is provided only for manual manipulation of the spine to correct subluxation.	$20 copay per visit
Home Health Care *Prior authorization is required.*	$0 copay
Renal Dialysis Coverage is provided for Medicare-covered dialysis equipment and supplies.	20% coinsurance
Hospice Care Coverage is provided by Original Medicare when you enroll in a Medicare-certified hospice program. Your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare.	There is no coinsurance, copayment or deductible applied to this benefit by the Plan.
Home Meals Program Coverage is provided for home delivered meals to a member's residence. You are eligible to receive 28 home-delivered meals upon discharge from an inpatient acute care setting. You will receive two meals a day for 14 days delivered to your home. The meals benefit must be requested within 30 days of discharge.	There is no coinsurance, copayment or deductible applied to this benefit.

WellSense Signature (HMO) Summary of Benefits

Services that are covered for you	What you must pay when you get these services
Medicare Part B Drugs (including Insulin Drugs) Some drugs are covered by Medicare Part B and some are covered by Medicare Part D. Part B drugs do not count toward your out-of-pocket costs. This plan offers step therapy from one Part B drug to another Part B drug. *Prior authorization may be required for some drugs, including Insulin drugs.*	20% coinsurance Part B insulin drugs are subject to a $35 copayment for a 30 day supply.
Prescription Drug Benefits	
Deductible There is no Part D prescription drug deductible on this plan.	$0
Initial Coverage You pay the copayment or coinsurance listed until you have spent a total of $2,000 in out-of-pocket costs within the calendar year.	Copayments or coinsurance
Retail – 30 day supply	
Tier 1: Preferred Generic	Tier 1: $0 copay
Tier 2: Generic	Tier 2: $5 copay
Tier 3: Preferred Brand	Tier 3: $47 copay
Tier 4: Non-Preferred Drug	Tier 4: $100 copay
Tier 5: Specialty Tier	Tier 5: 33% coinsurance
Retail – 90 day supply	
Tier 1: Preferred Generic	Tier 1: $0 copay
Tier 2: Generic	Tier 2: $12 copay
Tier 3: Preferred Brand	Tier 3: $132 copay
Tier 4: Non-Preferred Drug	Tier 4: $280 copay
Tier 5: Specialty Tier	Tier 5: Not Covered

WellSense Signature (HMO) Summary of Benefits

Services that are covered for you	What you must pay when you get these services
Mail Order – 30 day supply	
Tier 1: Preferred Generic	Tier 1: $0 copay
Tier 2: Generic	Tier 2: $0 copay
Tier 3: Preferred Brand	Tier 3: $45 copay
Tier 4: Non-Preferred Drug	Tier 4: $97 copay
Tier 5: Specialty Tier	Tier 5: 33% coinsurance
Mail Order – 90 day supply	
Tier 1: Preferred Generic	Tier 1: $0 copay
Tier 2: Generic	Tier 2: $0 copay
Tier 3: Preferred Brand	Tier 3: $130 copay
Tier 4: Non-Preferred Drug	Tier 4: $275 copay
Tier 5: Specialty Tier	Tier 5: Not Covered
Insulin Drugs, retail and mail order	
Tier 1 Retail:	
30 day supply	$0 copay
90 day supply	$0 copay
Tier 1 Mail order:	
30 day supply	$0 copay
90 day supply	$0 copay
Tier 2 Retail:	
30 day supply	$5 copay
90 day supply	$12 copay
Tier 2 Mail order:	
30 day supply	$0 copay
90 day supply	$0 copay
Tier 3/4 Retail:	
30 day supply	$35 copay
90 day supply	$105 copay
Tier 3/4 Mail order:	
30 day supply	$35 copay
90 day supply	$105 copay

WellSense Signature (HMO) Summary of Benefits

Services that are covered for you	What you must pay when you get these services
Catastrophic Coverage After your yearly out-of-pocket drug costs reach $2,000, you will pay the amount(s) listed.	$0

Pre-Enrollment Checklist

WellSense HEALTH PLAN

Before making an enrollment decision it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 800-967-4497 (TTY: 711) Monday through Friday 8 a.m. to 8 p.m. We are open daily Oct. 1 through March 31.

Understanding the Benefits

- ◯ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It's important to review plan coverage, cost and benefits before you enroll. Visit wellsense.org/medicare or call 800-967-4497 (TTY: 711) to view a copy of the EOC.
- ◯ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ◯ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ◯ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ◯ **Effect on current coverage:** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- ◯ In addition to your monthly premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month. If you enroll in a plan with a Part B buy-down, you may pay less for your Medicare Part B premium each month.
- ◯ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2026.
- ◯ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ◯ **PPO plans** - Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers.