The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.wellsense.org or by calling 1-855-833-8122. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-855-833-8122 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 Individual / $0 Family	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 an overall deductible.
Are there other deductibles for specific services?	No	
What is the out-of-pocket limit for this plan?	$9,200 Individual / $18,400 Family (Medical and RX)	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.wellsense.org or call 1-855-833-8122 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the network specialist you chose without a referral.

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	$50 / Visit	Not Covered	Specialist visits may require a pre-authorization.
	Specialist visit	$100 / Visit	Not Covered	
	Preventive care/screening/ immunization	No Charge	Not Covered	Gynecological (GYN) exam limited to once per calendar year. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Visit https://www.healthcare.gov/coverage/preventive-care-benefits/ for info on services that are considered preventive.
If you have a test	Diagnostic test (x-ray, blood work, ultrasound)	$25 copayment	Not Covered	
	Imaging (CT/PET scans, MRIs)	$300 copayment	Not Covered	Pre-authorization is required; if pre-authorization is not obtained payment for services could be denied.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.wellsense.org**	Generic drugs	40% coinsurance / Retail and Mail order prescription	Not Covered	Covers up to a 30-day retail (90-day mail order); prescription contraceptives and certain oral anti-cancer drugs are covered in full; step therapy and pre-authorization may be required for certain drugs and supplies.
	Preferred brand drugs	40% coinsurance / Retail and Mail order prescription	Not Covered	
	Non-preferred brand drugs	55% coinsurance / Retail and Mail order prescription	Not Covered	
	Specialty drugs	55% coinsurance /Retail Mail order prescription not applicable	Not Covered	Covers up to a 30-day supply from participating specialty pharmacies; 90-day mail order not available; pre-authorization may be required.

*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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$1,500 copayment	Not Covered	Includes diagnostic colonoscopies and endoscopies; pre-authorization may be required.
	Physician/surgeon fees	$500 copayment	Not Covered	
If you need immediate medical attention	Emergency room care	$2,000 / Visit	$2,000 / Visit	If you receive emergency services from a non-network provider, the plan pays up to the allowed amount.
	Emergency medical transportation	$2,000 copayment	$2,000 copay	None
	Urgent care	$60 / Visit	$60 / Visit	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)	$2,500 / Day	Not Covered	Inpatient hospital copayment applies for only days 1-3 per admission. Pre-authorization is required; if pre-authorization is not obtained, payment for services may be denied.
	Physician/surgeon fees	$2,500 / Day	Not Covered	
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	$50 / Visit	Not Covered	Pre-authorization may be required from our 3rd party contractor, Carelon Behavioral Health. Inpatient hospital copayment applies for only days 1-3 per admission
	Inpatient services	$2,500 / Day	Not Covered	
If you are pregnant	Office visits	$100 / Day	Not Covered	Cost-sharing does not apply to routine prenatal and postpartum services. Inpatient hospital copayment applies for only days 1-3 per admission
	Childbirth/delivery professional services	$2,500 / Day	Not Covered	
	Childbirth/delivery facility services	$2,500 / Day	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	$80 / Visit	Not Covered	Pre-authorization is required; if pre-authorization is not obtained payment for services could be denied.
	Rehabilitation services	$70 / Visit $2,500 / Day for Inpatient services	Not Covered	Limited to 20 visits per therapy per calendar year (except for early intervention services, and members with Autism Spectrum Disorders); limited to 60 calendar days per calendar year for inpatient admissions; Pre-authorization required for certain services. Inpatient hospital copayment applies for only days 1-3 per admission
	Habilitation services	$70 / Visit	Not Covered	Limited to 20 visits per therapy per calendar year (except for early intervention services, and members with Autism Spectrum Disorders); Pre-authorization may be required after initial evaluation.
	Skilled nursing care	$2,500 / Day	Not Covered	Inpatient copayment applies for only days 1-3 per admission. Limited to 100 calendar days per calendar year; Pre-authorization is required; If pre-authorization is not obtained, payment for services could be denied.
	Durable medical equipment	50% coinsurance	Not Covered	Coinsurance does not apply to wigs and breast pumps and related supplies; Pre-authorization may be required from our 3rd party vendor, Northwood, Inc.
	Hospice services	50% coinsurance	Not Covered	Pre-authorization is required. If you do not get pre-authorization, 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 / Preventive exam; $100 / Visit for non-routine and routine exams.	Not Covered	Preventive eye exams are limited to one every 12 months until the end of the calendar month in which they turn age 19.
	Children's glasses	50% coinsurance	Not Covered	Limited to one set of prescription lenses and frames or contact lenses per calendar year until the end of the calendar month in which they turn age 19.
	Children's dental check-up	Not covered	Not Covered	Members may purchase a separate stand-alone dental plan.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental care except as described in EOC
- Early Intervention services for children age 3 and older.
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Services beyond any listed benefit or monetary limit

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

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

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

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: New Hampshire Insurance Department - Consumer, Health Insurance www.nh.gov 1-800-852-3416, or The U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the Department of Health and Human Service's Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- WellSense Health Plan Member Service at 1-855-833-8122
- The U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-833-8122.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-833-8122.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-833-8122.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-833-8122.

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

*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 copayment** $100
- **Hospital (facility)** $2,500 / day

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*
Prescription drugs

Total Example Cost	**$12,970**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$8,000
Coinsurance	$400
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	**$8,500**

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 copayment** $100
- **Primary care visit copayment** $50
- **Durable medical equipment** 50% 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	**$5,720**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,000
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,200**

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

- **The plan's overall deductible** $0
- **Specialist copayment** $100
- **Emergency room** $2,000
- **Durable medical equipment** 50% 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	$2,100
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,300**

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