Schedule of Benefits

New Hampshire

WellSense HEALTH PLAN

An Affordable Care Act (ACA) Plan/Qualified Health Plan (QHP)¤

WellSense Clarity NH Bronze 6500

Provider Network: WellSense 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 Services at 855-833-8122.

Deductible (*per calendar year*)	**Amount**
Per Individual *Member*	$6,500 (Medical and Rx)
Per Family	$13,000 (Medical and Rx)
Out-of-Pocket Maximum (*per calendar year*)	**Amount**
Per Individual *Member*	$9,200 (Medical and Rx)
Per Family	$18,400 (Medical 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.	40% *coinsurance* after *deductible*
	Extended care in a chronic disease hospital	40% *coinsurance* after *deductible*
	Extended care in a rehabilitation hospital. *Benefit limit*: limited to 60 calendar days per *calendar year*.	40% *coinsurance* after *deductible*
	Extended care in a skilled nursing facility. *Benefit limit*: limited to 100 calendar days per *calendar year*.	40% *coinsurance* after *deductible*
	Inpatient admission to a general or mental hospital, or substance use disorder facility for mental health acute treatment and substance use disorder treatment	40% *coinsurance* after *deductible*
	Physician, surgeon, and other covered professional *provider* services during *inpatient* care.	40% *coinsurance* after *deductible*
Abortion and Abortion-Related Services Benefits include services for a therapeutic abortion, which is an abortion recommended by a Provider, performed to save the life or health of the mother, or as a result of incest or rape.	*Outpatient surgery*	40% *coinsurance* after *deductible*
Allergy Services	Testing and treatment	$90 *copayment* per visit
	Lab tests	See Lab Tests, below
	Allergy injections	$10 per injection
Ambulance	Covered emergency ambulance	40% *coinsurance* after *deductible*
Treatment of Pervasive Developmental Disorders and 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 • Habilitation services • Applied behavior analysis therapy	You pay the *cost-sharing* applicable to the service(s) rendered.
Cardiac Rehabilitation	Outpatient services	$90 *copayment* per visit
Chemotherapy and Radiation Therapy	Outpatient services	0% coinsurance after *deductible*
Chiropractor Care	Outpatient office visits, including supportive medical treatment services and spinal manipulation up to 12 visits per calendar year	$90 *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
Clinical Trials	The Plan covers services for members enrolled in a qualified clinical trial for the treatment, prevention, or detection of any form of cancer or other life-threatening disease under the terms and conditions provided for under New Hampshire and federal law.	You pay the *cost-sharing* applicable to the service(s) rendered.
Dental procedures	Note: The Plan does not provide most routine and non-routine dental coverage. Coverage is provided for very limited dental services, described below. Members may choose to purchase a stand-alone dental plan on the Exchange for more coverage. **Dental Care for Accidental Injury** Benefits are available for dental work that is Medically Necessary due to an accidental injury to sound natural teeth and gums when the course of treatment for the accidental injury is received or authorized within 3 months of the date of the injury. **Hospital and Anesthesia Charges for dental procedures that must be done in a hospital or outpatient surgery** The Plan will cover the hospital and anesthesia services in a hospital or outpatient surgical setting due to a member having a significant dental condition or a medical condition, behavioral condition, or a developmental disability, that would place the member at serious risk or prohibit the services being done in a dentist's office. **Preparing the Mouth for Medical Treatments** The Plan will cover dental services necessary to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and prepare for transplants. Covered Services include: • Evaluation • Dental x-rays • Extractions, including surgical extractions and, • Anesthesia	40% *coinsurance* after *deductible*
Diabetes Equipment/Supplies and Services and Education	Coverage is provided for: • Self-management training and educational services including medical nutrition therapy services (MNT) for treatment of diabetes, insulin, oral agents, and equipment used to treat diabetes • Insulin drugs shall be capped to not exceed $30 for each 30-day supply, and not be subject to deductible • Diabetes equipment shall be subject to same terms and conditions for DME	You pay the *cost-sharing* applicable to the service(s) rendered.
Dialysis Services	*Outpatient* services	40% *coinsurance* after *deductible*

Covered Services Some services require prior authorization. See your EOC for more information.	**Description**	**Your Cost (*Cost-sharing*)**
Durable Medical Equipment, Prosthetics, Orthotics, Medical Supplies, Medical Formulas and Low Protein Foods++	• Durable medical equipment • Prosthetics • Orthotics • Medical supplies • Medical formulas, including non-prescription enteral formulas • Low protein foods • Ostomy supply • Oxygen and respiratory equipment	40% *coinsurance* after *deductible*
	• Wigs (scalp hair prostheses) for hair loss due to alopecia areata, alopecia totalis, alopecia medicamentosa resulting from the treatment from any form of cancer or leukemia, or permanent loss of scalp hair due to injury • Breast pump and related supplies	0% *coinsurance* after *deductible*
Early Intervention Services	For an eligible *child* through age 2	0%
Emergency Services	Visits to an emergency room If you receive emergency services from a non-network provider, the plan pays up to the allowed amount. 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.	40% *coinsurance* after *deductible*
	Physician, surgeon, and other covered professional *provider* services during *inpatient* care.	40% *coinsurance* after *deductible*
Habilitation Services and Devices	Outpatient physical and occupational therapy as well as medically necessary habilitation devices. *Benefit limit*: limited to 20 visits per calendar year for each type of therapy (physical, occupational and speech). (Benefit limit does not apply to these services when provided to members with autism spectrum disorder or when receiving early intervention services.)	40% *coinsurance* after *deductible*
Hearing Aids	Benefits are available for one hearing aid per ear each time a hearing aid prescription changes.	40% *coinsurance* after *deductible*
	Hearing aid evaluations and exams	$90 *copayment* per visit
	Hearing aid related services and supplies Note: Hearing aid batteries and cleaning fluid are not covered	40% *coinsurance* after *deductible*
Hearing Exams	PCP exams and evaluations	$45 *copayment* per visit

Covered Services Some services require prior authorization. See your EOC for more information.	**Description**	**Your Cost (*Cost-sharing*)**
	Specialist exams and evaluations	$90 *copayment* per visit
Home Health Care	Home care program including home infusion therapy	40% *coinsurance* after *deductible*
Hospice Services	Hospice services for terminally ill	40% *coinsurance* after *deductible*
Infertility Treatment	Covered Services include diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis. Benefits also include services to treat the underlying medical conditions that cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency).	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 coverage for: • Coverage for Perfluoroalkyls (PFAS) and Perfluorinated Compound (PFC) Blood Testing • HLA (bone marrow testing) • blood lead testing	40% *coinsurance* after *deductible*
	X-rays and other imaging tests (for example, fluoroscopic tests)	40% *coinsurance* after *deductible*
	Diagnostic advanced imaging: CT/CTA scan, MRI/MRA, PET scan and NCI/NPI (nuclear cardiac imaging)	40% *coinsurance* after *deductible*
Coverage for Long-Term Antibiotic Therapy for Tick-Borne Illness	Coverage is provided for certain long-term antibiotic therapies for tick-borne illness	40% *coinsurance* after *deductible*
Maternity Services	*Outpatient routine* prenatal office visits including one postpartum visit	0%
	Outpatient non-routine prenatal and postpartum office visits	40% *coinsurance* after *deductible*
Medical Formulas	Non-prescription enteral formulas and low protein food	See Durable Medical Equipment
Medical Supplies	Includes ostomy, tracheostomy and oxygen supplies; and supplies for insulin pumps	See Durable Medical Equipment

Covered Services Some services require prior authorization. See your EOC for more information.	**Description**	**Your Cost (*Cost-sharing*)**
Mental Health and Substance Use Disorder Services	*Inpatient* admission to a general or mental hospital, or substance use disorder facility *Prior Authorization is not required but the facility should notify the plan within 72 hours of admission.*	40% *coinsurance* after *deductible* 40% *coinsurance* after *deductible* for physician and other covered professional provider inpatient services
	Intermediate non-inpatient services that provide more intensive services than outpatient services and less intensive than inpatient services. *Prior Authorization is not required but the facility should notify the plan within 72 hours of admission.*	40% *coinsurance* after *deductible*
	Outpatient office visits	$45 *copayment* per visit
	Medication-Assisted Treatment (MAT) and Associated Services for Opioid Dependence	$45 *copayment* per visit
Medical Nutrition therapy (MNT)/Nutritional Counseling	Services by a registered dietician	40% *coinsurance* after *deductible*
Observation Services		40% *coinsurance* after *deductible*
Outpatient Office Visits for Medical Care (To evaluate and treat illness or injury)	Primary care provider (PCP) office visit	$45 *copayment* per visit
	Specialist office visit	$90 *copayment* per visit
Outpatient Surgery, including Bariatric Surgery	Same day surgery in a hospital or ambulatory surgical center setting. Including diagnostic colonoscopies and endoscopies.	40% *coinsurance* after *deductible*
Pediatric Vision (Ages 18 and under)	• Lenses: One pair every calendar year • Frames: Covered once every calendar year • Contact Lenses: Covered once every calendar year – instead of eyeglasses	40% *coinsurance* after *deductible*

Covered Services Some services require prior authorization. See your EOC for more information.	**Description**	**Your Cost (*Cost-sharing*)**
Podiatry Services	*Non-routine* foot care (such as treatment for hammertoe and osteoarthritis)	$90 *copayment* per visit
	Outpatient lab tests and x-rays	See Lab Tests, X-Rays and Other Tests
	Medically Necessary *Routine* foot care for members with diabetes or systemic circulatory disease or peripheral artery disease.	$90 *copayment* per visit
Prescription Drugs¤¤¤ From a network Retail Pharmacy: (up to a 30-day supply)	Generic - Tier 1	25% *coinsurance* after deductible
	Preferred brand - Tier 2	35% *coinsurance* after deductible
	Non-preferred brand - Tier 3	40% *coinsurance* after deductible
	Specialty - Tier 4	40% *coinsurance* after deductible
Prescription Drugs¤¤¤ From Mail Service Pharmacy: (up to a 90-day supply)	Generic - Tier 1	25% *coinsurance* after deductible
	Preferred brand - Tier 2	35% *coinsurance* after deductible
	Non-preferred brand - Tier 3	40% *coinsurance* after deductible
	Specialty - Tier 4	Not Covered
Note: You pay nothing for: and (1) Certain oral anti-cancer drugs (2) statins (3) aspirin (4) Pre-exposure 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, 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 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/ *In some cases we refer to "routine" rather than preventive for our benefits. Preventive care is* defined as services to prevent any disease or injury rather than diagnose or treat a complaint or symptom, *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. In most cases, if your service is determined to be routine or non-routine rather than preventive, cost-sharing will apply to those services.	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, including newborn hearing screening • Preventive vision exams: One exam per member every 12 months until age 19 (see *Vision Services For Members Through Age 18* in this document for more information). Preventive health services for adults: • Annual physical exams • Preventive immunizations • Preventive screening tests and procedures, including screening colonoscopies Preventive health services for women, including pregnant women: • Annual GYN exams, including screening pap smears: One exam per calendar year • Routine prenatal care, including one postpartum visit • Screening mammograms • Voluntary sterilization procedures • Breast pumps and related supplies • Family Planning services with a contracted provider	0%
Prosthetic Devices	Includes wigs (scalp hair prostheses) for hair loss due to alopecia areata, alopecia totalis, alopecia medicamentosa resulting from the treatment from any form of cancer or leukemia, or permanent loss of scalp hair due to injury	See Durable Medical Equipment

Covered Services Some services require prior authorization. See your EOC for more information.	**Description**	**Your Cost (*Cost-sharing*)**
Rehabilitation Therapies	Short term *outpatient* physical, occupational, and speech therapy. *Benefit limit*: limited to 20 visits per calendar year for each type of therapy (physical, occupational and speech). (*Benefit limit* does not apply to these services when provided to *members* with autism spectrum disorder; or when receiving early intervention services.)	40% *coinsurance* after *deductible*
	Aural and pulmonary therapy	40% *coinsurance* after *deductible*
Second Opinions	*Outpatient second and third opinions*	See Outpatient Office Visits for Medical Care
TMJ Disorder Treatment	Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services.	You pay the *cost-sharing* applicable to the service(s) rendered.
Transplant	Coverage includes Medically Necessary human organ, tissue, and stem cell / bone marrow transplants. Transplants are covered like any other surgery, under the regular Inpatient and outpatient benefits.	You pay the *cost-sharing* applicable to the service(s) rendered
Urgent Care		$70 *copayment* per visit
Vision Services for Members	***See Pediatric Vision for details.*** ***There is no Routine Vision care coverage for Adults (members age 19 and older).*** Care is provided for Pediatric *Routine* vision exams to monitor an existing vision condition. Care is provided for all members for Non-routine vision care including services to treat or diagnose a medical condition of the eye. Coverage may include: • Non-routine eye exams to diagnosis a medical condition such as glaucoma or diabetic retinopathy, or to treat an injury to the eye. • Contact lenses or eyeglasses needed for the following conditions: Keratoconus, post cataract surgery with an intraocular lens implant, or post-cataract surgery without a lens implant. • Post-retinal detachment surgery. Note: *Routine care* is defined as services provided routinely to monitor an existing condition. *Non-routine* care is defined as services to evaluate and/or treat a new or worsening condition, illness, or injury.	$90 *copayment* per visit

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.

¤¤¤ 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 855-833-8122.

+ The *plan* contracts with *Carelon Behavioral Health (Carelon)* to manage all mental health and substance use disorder services for *members*. To locate a *network provider* of mental health or substance use disorder 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.

*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 qualifying health 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. If you have any questions, you may reach out to Member Services 855-833-8122.