Canopy: Employee Assistance Program Coverage Period: 01/01/2024 -12/31/2024

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Employee & Household | **Plan Type:** EAP

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document by calling 1-800-433-2320.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0.00**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No. There are no other specific **deductibles**.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	No.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out–of–pocket limit?	This plan has no **out-of-pocket limit.**	Not applicable because there's no **out-of-pocket limit** on your expenses.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	No.	This plan treats **providers** the same in determining payment for the same services.
Do I need a referral to see a specialist?	Yes. A referral from Canopy is required to see a specialist.	This plan will pay some or all of the cost to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

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- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- Your cost sharing does not depend on whether a provider is in a network.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not Covered	Not Covered	----------none----------
	Specialist visit	Not Covered	Not Covered	----------none----------
	Other practitioner office visit	Not Covered	Not Covered	----------none----------
	Preventive care/screening/immunization	Not Covered	Not Covered	----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	Not Covered	Not Covered	----------none----------
	Imaging (CT/PET scans, MRIs)	Not Covered	Not Covered	----------none----------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at – Not Covered	Generic drugs	Not Covered	Not Covered	----------none----------
	Preferred brand drugs	Not Covered	Not Covered	----------none----------
	Non-preferred brand drugs	Not Covered	Not Covered	----------none----------
	Specialty drugs	Not Covered	Not Covered	----------none----------
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered	Not Covered	----------none----------
	Physician/surgeon fees	Not Covered	Not Covered	----------none----------

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	Not Covered	Not Covered	----------none----------
	Emergency medical transportation	Not Covered	Not Covered	----------none----------
	Urgent care	Not Covered	Not Covered	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Covered	Not Covered	----------none----------
	Physician/surgeon fee	Not Covered	Not Covered	----------none----------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No Charge	No Charge	Coverage is limited to 6 face-to face, confidential counseling sessions per primary issue, per employee or household member, per year.
	Mental/Behavioral health inpatient services	Not Covered	Not Covered	----------none----------
	Substance use disorder outpatient services	No Charge	No Charge	Coverage is limited to 6 face-to face, confidential counseling sessions per primary issue, per employee or household member, per year.
	Substance use disorder inpatient services	Not Covered	Not Covered	----------none----------
If you are pregnant	Prenatal and postnatal care	Not Covered	Not Covered	----------none----------
	Delivery and all inpatient services	Not Covered	Not Covered	----------none----------
If you need help recovering or have other special health needs	Home health care	Not Covered	Not Covered	----------none----------
	Rehabilitation services	Not Covered	Not Covered	----------none----------
	Habilitation services	Not Covered	Not Covered	----------none----------
	Skilled nursing care	Not Covered	Not Covered	----------none----------
	Durable medical equipment	Not Covered	Not Covered	----------none----------
	Hospice service	Not Covered	Not Covered	----------none----------
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	----------none----------
	Glasses	Not Covered	Not Covered	----------none----------
	Dental check-up	Not Covered	Not Covered	----------none----------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Dental Care
- Hearing aids
- Infertility treatment
- Long-term care
- Non- emergency care when traveling outside the U.S.
- Private –duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-433-2320. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: The Massachusetts Executive Office of Health and Human Services at 617-573-1600.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $0.00
- **Patient pays:** This condition is not covered, so patient pays 100%.

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays: This condition is not covered, so patient pays 100%.

Deductibles	$
Co-pays	$
Co-insurance	$
Limits or exclusions	$
Total	**$7,540**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $4,100
- **Plan pays** $0.00
- **Patient pays:** This condition is not covered, so patient pays 100%.

Sample care costs:

Prescriptions	$1,500
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$4,100**

Patient pays: This condition is not covered, so patient pays 100%.

Deductibles	$
Co-pays	$
Co-insurance	$
Limits or exclusions	$
Total	**$4,100**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.