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 HRA Summary Plan Description, contact your Human Resource office at (978) 465-4415. 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 www.healthcare.gov/sbc-glossary.com or call 1-866-444-3272 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$300.00 for each enrolled participant for RX expenses**	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	No	"You will have to meet the deductible before the plan pays for any services."
Are there other deductibles for specific services?	**No**	You don't have to meet deductibles for specific services
What is the out-of-pocket limit for this plan?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses
What is not included in the out-of-pocket limit?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses."
Will you pay less if you use a network provider?	Not Applicable	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	This HRA does not require a referral to see a specialist. Review your group health insurance policy for requirements.

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not covered by this Plan.	Not covered by this Plan.
	Specialist visit	Not covered by this Plan.	Not covered by this Plan.
	Preventive care/screening/ immunization	Not covered by this Plan.	Not covered by this Plan.
If you have a test	Diagnostic test (x-ray, blood work)	Not covered by this Plan.	Not covered by this Plan.
	Imaging (CT/PET scans, MRIs)	Any amount above the max reimbursement allowed	$250.00 per occurrence up to an annual max of $500 single/ $750 family. Reimbursement is based upon funding availability.
If you need drugs to treat your illness or condition	Generic drugs	First $300 in RX costs for each enrolled participant in one of the Qualified Medical Plans.	Reimbursement for RX expenses after the first $300 of RX cost has been paid by the participant. Reimbursement is based upon funding availability.
	Preferred brand drugs		
	Non-preferred brand drugs		
	Specialty drugs		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered by this Plan.	Not covered by this Plan.
	Physician/surgeon fees		
If you need immediate medical attention	Emergency room care	Not covered by this Plan.	Not covered by this Plan.
	Emergency medical transportation	Not covered by this Plan.	Not covered by this Plan.
	Urgent care	Not covered by this Plan.	Not covered by this Plan.
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered by this Plan.	Not covered by this Plan.
	Physician/surgeon fees		
If you need mental	Outpatient services	Not covered by this Plan.	Not covered by this Plan.

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	Limitations, Exceptions, & Other Important Information
health, behavioral health, or substance abuse services	Inpatient services	Not covered by this Plan.	Not covered by this Plan.
If you are pregnant	Office visits	Not covered by this Plan.	Not covered by this Plan.
	Childbirth/delivery professional services	Not covered by this Plan.	Not covered by this Plan.
	Childbirth/delivery facility services		
If you need help recovering or have other special health needs	Home health care	Not covered by this Plan.	Not covered by this Plan.
	Rehabilitation services	Not covered by this Plan.	Not covered by this Plan.
	Habilitation services	Not covered by this Plan.	Not covered by this Plan.
	Skilled nursing care	Not covered by this Plan.	Not covered by this Plan.
	Durable medical equipment		
	Hospice services		
If your child needs dental or eye care	Children's eye exam	Not covered by this Plan.	Not covered by this Plan.
	Children's glasses		
	Children's dental check-up		

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.)		
• Cosmetic Surgery • Dental Care • Infertility Treatment	• Long Term Care • Non-emergency care when traveling outside the U.S. • Private Duty Nursing	• Routine eye care (Adult) • Routine Foot Care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic Care (must be subject to the health plans deductible)	• Infertility treatment (limited to members under the age of 40; subject to State of CT mandate limits) (must be subject to the health plans deductible)	• Weight loss programs (must be subject to the health plans deductible)

Your Rights to Continue Coverage:

If you have Individual health insurance:
There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Massachusetts Division of Insurance at 1-877-563-4467 or www.mass.gov/doi. 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. For more information about possibly buying individual coverage through the state marketplace, please contact the Massachusetts Health Connector at www.mahealthconnector.org.

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: CT Office of the Healthcare Advocate, P.O. Box 1543, Hartford, CT 06144. Phone – 866-466-4446.

Does this plan provide Minimum Essential Coverage? No
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? Not Applicable

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** $
- **Specialist [cost sharing]** $
- **Hospital (facility) [cost sharing]** %
- **Other [cost sharing]** %

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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$
Copayments	$
Coinsurance	$
What isn't covered	
Limits or exclusions	$
The total Peg would pay is	**$**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** $
- **Specialist [cost sharing]** $
- **Hospital (facility) [cost sharing]** %
- **Other [cost sharing]** %

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	**$5,600**

In this example, Joe would pay:

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

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

- **The plan's overall deductible** $
- **Specialist [cost sharing]** $
- **Hospital (facility) [cost sharing]** %
- **Other [cost sharing]** %

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	$
Copayments	$
Coinsurance	$
What isn't covered	
Limits or exclusions	$
The total Mia would pay is	**$**

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