HelpNet: Employee Assistance Program

Coverage Period: 01/01/2014 – 12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** employees and their spouses, legal dependents and household members | **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 at www.helpneteap.com or by calling 1-800-969-6162

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$ 0**	The EAP is provided by your employer to assist you with any personal concern that may affect your job performance. There is no deductible because there is no cost to you.
Are there other deductibles for specific services?	**No**	The EAP is provided by your employer to assist you with any personal concern that may affect your job performance. There are not deductibles.
Is there an out–of–pocket limit on my expenses?	**No**	There are no charges to you for EAP services, so there is no need for a limit on your expenses for them. When services outside the scope of the EAP are required to address your concern, you will be referred to those outside services.
What is not included in the out–of–pocket limit?	**Not applicable**	Not applicable because there is no out-of-pocket limit on your expenses.
Is there an overall annual limit on what the plan pays?	**No**	The chart on page 2 describes any limits that may be applicable.
Does this plan use a network of providers?	**Yes**	The EAP has a defined process for accessing services. For information on this process, call 800-969-6162 or go to www.helpneteap.com.
Do I need a referral to see a specialist?	**No**	The EAP does not cover specialists. If the EAP provider determines that you need treatment from a specialist, he/she will refer you to your group health plan or appropriate treatment resources in your community.
Are there services this plan doesn't cover?	**Yes**	See the chart on page 2 for information about excluded services.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

- **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**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

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	$0 for EAP sessions	Not covered	EAP provides services, including assessment, screening, referral & brief counseling up to 5 sessions per concern.
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	Generic drugs	Not covered	Not covered	None
	Preferred brand drugs	Not covered	Not covered	None
	Non-preferred brand drugs	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
drug coverage is available at www.[insert].	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
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	Not covered	Not covered	EAP services are not considered mental / behavioral health treatment. Upon assessment, EAP will refer you to such treatment when appropriate.
	Mental/Behavioral health inpatient services	Not covered	Not covered	None
	Substance use disorder outpatient services	Not covered	Not covered	EAP services are not considered substance use disorder treatment. Upon assessment, EAP will refer you to such treatment when appropriate.
	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 coverd	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 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.)**

- Emergency Care when traveling outside the United States
- Non-Emergency care when traveling outside the United States

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.)**

- For a complete description of EAP services, go to www.helpneteap.com or call 800-969-6162

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 continue access to the EAP for a period of time. Any such rights may be limited in duration. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact your Human Resources Department or the EAP at 800-969-6162. 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 1-877-267-2323 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 EAP at 800-969-6162, or the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) www.dol.gov/ebsa/health reform.

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.

- **Amount owed to providers:** $7,540
- **Plan pays** $ not applicable
- **Patient pays** $ not applicable

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:

Deductibles	$
Co-pays	$
Co-insurance	$
Limits or exclusions	$
Total	**$**

- **Amount owed to providers:** $4,100
- **Plan pays** $ not applicable
- **Patient pays** $ not applicable

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:

Deductibles	$
Co-pays	$
Co-insurance	$
Limits or exclusions	$
Total	**$**

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.