Employee Assistance Program (EAP) aetna

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 1/01/2013 – 12/31/2013

Coverage for: Employee + Family | **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 by calling 1-800-272-7252.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Not applicable**.	The EAP does not include an overall **deductible.**
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services.
Is there an out–of–pocket limit on my expenses?	No.	The EAP does not include an **out-of-pocket limit,** but see the chart starting on page 2, which describes any limits on what the plan will pay for *specific* covered services, such as visit limits for face-to-face counseling.
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 visit limits for face-to-face counseling.
Does this plan use a network of providers?	Yes. See **www.Aetna.com (docFind) or call 1-800-272-7252** for a list of participating providers.	If you use an in-network health care **provider**, this plan will pay all of the costs of covered services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	**Not applicable**	The EAP does not cover costs to see a **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**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service. The EAP does not include **Co-payments**.

- **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 EAP does not include **Co-insurance**.
- 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**.) Services provided by an out-of-network **provider** are not covered services under EAP.
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts. The EAP does not include **deductibles**, **co-payments** or **co-insurance** amounts. However, use of participating **providers** is required for EAP.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating 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——
	Face-to-Face Counseling Session with an EAP **provider**	No charge	Not Covered	Unlimited (for short-term issues)
	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 www.[insert].	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——

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
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	
	Mental/Behavioral health inpatient services	Not Covered	Not Covered	——none——
	Substance use disorder outpatient services	Not Covered	Not Covered	
	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.)

- Counseling services beyond the number of face-to-face sessions covered by the plan
- Court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation, custody, or visitation evaluations, or paid for by Workers' Compensation
- Fitness for duty evaluations which are used to evaluate whether an employee is safely able to perform his or her duties, such as psychological testing and a written report
- Formal psychological evaluations which normally involve psychological testing and result in a written report
- Inpatient treatment of any kind, or outpatient treatment for any medically treated illness
- Investment advice (nor does plan loan money or pay bills)
- Legal representation in court, preparation of legal documents, or advice in the areas of taxes, patents, or immigration
- Prescription drugs
- Psychiatrist services
- Services by counselors who are not participating **providers**

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.)

- Face-to-Face Counseling Session with an EAP **provider**
- Online Work Life Services
- Unlimited telephonic assessment and referral
- Expenses covered under the EAP plan sponsored by your employer

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 may 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 [contact number]. 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: 1-800-272-7252 or mail to:

Employee Assistance Program
151 Farmington Ave
Hartford, CT 06156
Mail Code: RS32

Language Assistance:

Para obtener asistencia en Español, llame al **1-800-272-7252**.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-800-272-7252**.

如果需要中文的帮助，请拨打这个号码 **1-800-272-7252**.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-800-272-7252**.

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 are not applicable because these are not covered services under the Employee Assistance Program (EAP).

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:** N/A
- **Plan pays** N/A
- **Patient pays** N/A

Sample care costs:

Hospital charges (mother)	
Routine obstetric care	
Hospital charges (baby)	
Anesthesia	
Laboratory tests	
Prescriptions	
Radiology	
Vaccines, other preventive	
Total	**Not Covered**

Patient pays:

Deductibles	
Co-pays	
Co-insurance	
Limits or exclusions	
Total	**Not Covered**

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

- **Amount owed to providers:** N/A
- **Plan pays** N/A
- **Patient pays** N/A

Sample care costs:

Prescriptions	
Medical Equipment and Supplies	
Office Visits and Procedures	
Education	
Laboratory tests	
Vaccines, other preventive	
Total	**Not Covered**

Patient pays:

Deductibles	
Co-pays	
Co-insurance	
Limits or exclusions	
Total	**Not Covered**

Questions and answers about the Coverage Examples:*

***These examples are not applicable because these are not covered services under the (EAP).**

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.