Carebridge Corporation: Employee Assistance Program

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 11/01/2020 – 10/31/2021

Coverage for: Employee & Family | **Plan Type:** EAP

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 complete terms of coverage, [insert contact information]. 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/ or call 1-800-437-0911 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$ 0	See the chart starting on page 2 for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	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.
Are there other deductibles for specific services?	No.	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.
What is the out-of-pocket limit for this plan?	N/A	There is 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?	N/A	Not applicable because there is no out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	No.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, provider, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services, but only with written approval.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
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——————
	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 by calling 1-800-437-0911	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——————
If you need immediate medical attention	Emergency room care	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 fees	Not Covered	Not Covered	——————none——————

[* For more information about limitations and exceptions, see the plan or policy document at www.myliferesource.com.]

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$0	Not Covered	You are limited to (5) face-to-face counseling sessions per issue.
	Inpatient services	Not Covered	Not Covered	——————none——————
If you are pregnant	Office visits	Not Covered	Not Covered	——————none——————
	Childbirth/delivery professional services	Not Covered	Not Covered	——————none——————
	Childbirth/delivery facility 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 services	Not Covered	Not Covered	——————none——————
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	——————none——————
	Children's glasses	Not Covered	Not Covered	——————none——————
	Children's dental check-up	Not Covered	Not Covered	——————none——————

[* For more information about limitations and exceptions, see the plan or policy document at www.myliferesource.com.]

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
)	)	)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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.

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 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: [insert applicable contact information from instructions].

Does this plan provide Minimum Essential Coverage? [No]
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? [No]
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number].]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 [insert telephone number].]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

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

[* For more information about limitations and exceptions, see the plan or policy document at www.myliferesource.com.]

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	$0
Specialist [cost sharing]	$0
Hospital (facility) [cost sharing]	0%
Other [cost sharing]	0%

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	$7,540

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$7,540
The total Peg would pay is	$7,540

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

The plan's overall deductible	$0
Specialist [cost sharing]	$0
Hospital (facility) [cost sharing]	0%
Other [cost sharing]	0%

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	$5,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$5,400
The total Joe would pay is	$5,400

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

The plan's overall deductible	$0
Specialist [cost sharing]	$0
Hospital (facility) [cost sharing]	0%
Other [cost sharing]	0%

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	$1,925

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,925
The total Mia would pay is	$1,925