



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.concern-eap.com or by calling 1-800-344-4222.

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 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 plans covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	No out-of-pocket payments for covered services	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Additional counseling visits or other services beyond the number covered under your plan	
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 <u>network of providers</u> ?	Yes	For information about network providers , please call 1-800-344-4222.
Do I need a referral to see a <u>specialist</u> ?	Not applicable	
Are there services this plan doesn't cover?	Yes	Some of the services this plan does not cover are listed on page 3. See your policy or plan document for information about excluded services .

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

Corrected on May 11, 2012

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Copayments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.

Coinsurance 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 **coinsurance** 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**, **copayments** and **coinsurance** 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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	Not Covered	Not Covered	
	Specialist visit	Not Covered	Not Covered	
	Other practitioner office visit	Not Covered	Not Covered	
	Preventive care/screening/immunization	Not Covered	Not Covered	
If you have a test	Diagnostic test (x-ray, blood work)	Not Covered	Not Covered	
	Imaging (CT/PET scans, MRIs)	Not Covered	Not Covered	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at (Not Applicable)	Generic drugs	Not Covered	Not Covered	
	Preferred brand drugs	Not Covered	Not Covered	
	Non-preferred brand drugs	Not Covered	Not Covered	
	Specialty drugs	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered	Not Covered	
	Physician/surgeon fees	Not Covered	Not Covered	

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LLNS Employee Assistance Program - CONCERN: EAP

Coverage Period: 01/01/2015 - 12/31/2015

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

Coverage for: Employee & Eligible Dep | Plan Type: EAP

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	
	Emergency medical transportation	Not Covered	Not Covered	
	Urgent care	Not Covered	Not Covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Covered	Not Covered	
	Physician/surgeon fee	Not Covered	Not Covered	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$0 for up to 5 visits	Not Covered	EAP assess/short-term counseling only
	Mental/Behavioral health inpatient services	Not Covered	Not Covered	
	Substance use disorder outpatient services	\$0 for up to 10 visits	Not Covered	EAP assess/short-term counseling only
	Substance use disorder inpatient services	Not Covered	Not Covered	
If you are pregnant	Prenatal and postnatal care	Not Covered	Not Covered	
	Delivery and all inpatient services	Not Covered	Not Covered	
If you need help recovering or have other special health needs	Home health care	Not Covered	Not Covered	
	Rehabilitation services	Not Covered	Not Covered	
	Habilitation services	Not Covered	Not Covered	
	Skilled nursing care	Not Covered	Not Covered	
	Durable medical equipment	Not Covered	Not Covered	
	Hospice service	Not Covered	Not Covered	
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	
	Glasses	Not Covered	Not Covered	
	Dental check-up	Not Covered	Not Covered	

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.)

- Psychiatric consultation/medication management
- Evaluation/treatment of learning disabilities
- Court ordered services

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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.)

- None

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 coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-344-4222. 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: Quality Assurance Manager at 1-800-344-4222 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-344-4222

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-344-4222

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-344-4222

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiiijigo holne' 1-800-344-4222

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

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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: \$
- Plan pays \$
- Patient pays \$

Sample care costs:

Hospital charges (mother)	Not Cvr'd
Routine obstetric care	Not Cvr'd
Hospital charges (baby)	Not Cvr'd
Anesthesia	Not Cvr'd
Laboratory tests	Not Cvr'd
Prescriptions	Not Cvr'd
Radiology	Not Cvr'd
Vaccines, other preventive	Not Cvr'd

Total	
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Patient pays:

Deductibles	\$
Copays	\$
Coinsurance	\$
Limits or exclusions	\$

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

- Amount owed to providers: \$
- Plan pays \$
- Patient pays \$

Sample care costs:

Prescriptions	Not Cvr'd
Medical Equipment and Supplies	Not Cvr'd
Office Visits and Procedures	Not Cvr'd
Education	Not Cvr'd
Laboratory tests	Not Cvr'd
Vaccines, other preventive	Not Cvr'd

Total	
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Patient pays:

Deductibles	\$
Copays	\$
Coinsurance	\$
Limits or exclusions	\$

Total	\$
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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, copayments, and coinsurance 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 copayments, deductibles, and coinsurance. 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.

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