Employee Assistance Program

Coverage Period: Beginning 4/01/2019

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Employee + Elig.Family | **Plan Type:** EAP

The Summary of Benefits and Coverage (SBC) document shows you how you and the plan would share the cost for covered health care services. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact erc@ercincorp.com. 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 https://www.healthcare.gov or call 1-800-222-8590 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$ 0 Does not apply to EAP	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. "See the chart starting on page 2 for your costs for services this plan covers."
Are there services covered before you meet your deductible?	Yes	"This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply." EAP provides services, including assessment, screening, referral & brief counseling up to **8** sessions per problem issue.
Are there other deductibles for specific services?	No Does not apply to EAP	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?	Does not apply to EAP	"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?	Yes. Call 1-800-222-8590 to access the network of EAP providers.	"This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing)." 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 you need a referral to see a specialist?	Yes. Call 1-800-222-8590 to access the network of EAP providers.	"This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist." The EAP does not cover **specialists**. If the EAP determines that you need treatment from a specialist, you will be referred to your group health plan.

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	$0 for EAP sessions	Not covered	EAP provides services, including assessment, screening, referral & brief counseling up to **8** sessions per problem issue.
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.ercincorp.com	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——————

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	Mental/Behavioral health Outpatient services	$0 for EAP sessions	Not covered	After **8** visits, not covered
	Mental/Behavioral health Inpatient services	Not covered	Not covered	——————none——————
	Substance use disorder outpatient services	$0 for EAP sessions	Not covered	After **8** visits, not covered
	Substance use disorder 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——————

"You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for."

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.)

- Abortion
- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Mental/behavioral health outpatient services beyond 8 visits
- Mental/behavioral health inpatient services
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Substance use disorder outpatient services beyond 8 visits
- Substance use disorder inpatient services
- Weight loss programs

Excluded Services & Other Covered Services:

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

- For a complete description of EAP services, go to www.ERCincorp.com or call 1-800-222-8590.

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: 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. 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: your Client Rights Specialist: Steve Baue at 1-800-222-8590, PO Box 13156, Green Bay, WI 54307. You may also contact the Department of Labor Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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Does this plan provide Minimum Essential Coverage? **No**

This plan or policy does not provide minimum essential coverage, because it provides benefits that are limited to short-term mental health counseling. 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? **Yes**

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 1-800-222-8590
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-222-8590
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-800-222-8590
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-222-8590

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

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Employee + Elig.Family | **Plan Type:** EAP

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	N/A
Specialist *[cost sharing]*	N/A
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	**$2,700**
In this example, Peg would pay: This condition is not covered, so patient pays 100%, unless covered by another applicable health plan.	
Cost Sharing	
Deductibles	$
Copayments	$
Coinsurance	$
What isn't covered	
Limits or exclusions	
The total Peg would pay is	**$2,700**

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

The plan's overall deductible	N/A
Specialist *[cost sharing]*	N/A
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: This condition is not covered, so patient pays 100%, unless covered by another applicable health plan.	
Cost Sharing	
Deductibles	$
Copayments	$
Coinsurance	$
What isn't covered	
Limits or exclusions	
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	N/A
Specialist *[cost sharing]*	N/A
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	**$6,300**
In this example, Mia would pay: This condition is not covered, so patient pays 100%, unless covered by another applicable health plan.	
Cost Sharing	
Deductibles	$
Copayments	$
Coinsurance	$
What isn't covered	
Limits or exclusions	$
The total Mia would pay is	**$6,300**

Questions: Call 1-800-222-8590

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at https://www.healthcare.gov or call 1-800-222-8590 to request a copy.