

# CHI Health Employee Assistance Program

Coverage Period: 01/01/2017 – 12/31/2017

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

Coverage for: Employee + spouse + dependents  
Plan Type: Employee Assistance Program (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 by calling 402-398-5566 or 1-888-847-4975.

Important Questions	Answers	Why this Matters:
What is the overall <b>deductible</b> ?	<b>\$ 0</b>	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 <b>deductibles</b> for specific services?	<b>\$0</b>	The EAP is provided by our employer to assist you with any personal concern that may affect your job performance. There are no deductibles.
Is there an <b>out-of-pocket limit</b> on my expenses?	No	There are no charges to you for EAP services, so there is no need for a limit on your expenses to them. When services outside the scope of the EAP are required to address your concern, you will be referred for those outside services.
What is not included in the <b>out-of-pocket limit</b> ?	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 <b>network of providers</b> ?	Yes	The EAP has a defined process for accessing services. For information on this process, call 402-398-5566 or 1-888-847-4975.
Do I need a referral to see a <b>specialist</b> ?	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 the community.
Are there services this plan doesn't cover?	Yes	See the chart on page 2 for information about excluded services.

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If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or call 1-866-333-EBSA (3272) to request a copy.

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

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- **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		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
<b>If you visit a health care provider's office or clinic</b>	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	Not Covered	EAP provides services, including assessment, screening, referral and brief counseling. Please contact EAP at 1-888-847-4975 or your Human Resources Department for the number of sessions covered.
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	Not covered	Not covered	None
	Imaging (CT/PET scans, MRIs)	Not covered	Not covered	None
<b>If you need drugs to treat your illness or condition</b>	Generic drugs	Not covered	Not covered	None
	Preferred brand drugs	Not covered	Not covered	None
	Non-preferred brand drugs	Not covered	Not covered	None

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		In-network Provider	Out-of-network Provider	
More information about <b>prescription drug coverage</b> is available at <a href="http://www.[insert]">www.[insert]</a> .	Specialty drugs	Not covered	Not covered	None
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	None
	Physician/surgeon fees	Not covered	Not covered	None
<b>If you need immediate medical attention</b>	Emergency room services	Not covered	Not covered	None
	Emergency medical transportation	Not covered	Not covered	None
	Urgent care	Not covered	Not covered	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Not covered	Not covered	None
	Physician/surgeon fee	Not covered	Not covered	None
<b>If you have mental health, behavioral health, or substance abuse needs</b>	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
<b>If you are pregnant</b>	Prenatal and postnatal care	Not covered	Not covered	None
	Delivery and all inpatient services	Not covered	Not covered	None

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Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
<b>If you need help recovering or have other special health needs</b>	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
<b>If your child needs dental or eye care</b>	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](#).)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Dental Care
- Hearing aids
- Infertility treatment
- Inpatient care
- Long-term care
- Non-emergency care when traveling outside of the United States
- Physicians / psychiatrists
- Private-duty nursing
- Psychological testing
- Routine eye care
- Routine foot care
- Weight loss programs

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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.)

- For a complete description of EAP services call 1-888-847-4975.

### 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 402-398-5566 or 1-888-847-4975. 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](http://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](http://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: EAP at 1-888-847-4975 or contact Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

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

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# CHI Health Employee Assistance Program

Coverage Period: Beginning on or after 01/01/2015

Coverage for: Employee + spouse + dependents

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Plan Type:** Employee Assistance Program (EAP)

## Coverage Examples

### 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:** \$7,540
- **Plan pays** \$
- **Patient pays** \$

##### 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
<b>Total</b>	<b>\$7,540</b>

##### Patient pays:

Deductibles	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
<b>Total</b>	<b>\$</b>

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

- **Amount owed to providers:** \$4,100
- **Plan pays** \$
- **Patient pays** \$

##### 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
<b>Total</b>	<b>\$4,100</b>

##### Patient pays:

Deductibles	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
<b>Total</b>	<b>\$</b>

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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**, **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

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## Coverage Examples

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**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.

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