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.[insert].com or call 1-800-[insert] to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**	EAP is provided by your employer to assist you with any personal or work-related concerns. There is no deductible because there is no cost to you.
Are there services covered before you meet your deductible?	**N/A**	There are no deductibles.
Are there other deductibles for specific services?	**N/A**	There are no deductibles.
What is the out-of-pocket limit for this plan?	**N/A**	There are no out-of-pocket limits because there is no cost to you for services covered by the EAP
What is not included in the out-of-pocket limit?	**N/A**	The chart on page 2 describes any applicable limits on what the plan will pay for specific covered services, such as visit limits for counseling.
Will you pay less if you use a network provider?	**Yes**	To receive EAP services, you must call PAS at (800) 356-0845 for a referral. There is no cost to you for services covered and authorized by the EAP.
Do you need a referral to see a specialist?	**N/A**	Specialist services are not covered by the EAP. If your EAP consultant recommends referrals to specialists outside your EAP benefit, you are financially responsible to pay for those services outside your EAP benefit. Some specialty services (medical care) may be covered under your medical benefit 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	N/A	N/A	N/A
	Specialist visit	N/A	N/A	N/A
	Preventive care/screening/ immunization	N/A	N/A	N/A
If you have a test	Diagnostic test (x-ray, blood work)	N/A	N/A	N/A
	Imaging (CT/PET scans, MRIs)	N/A	N/A	N/A
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].com	Generic drugs	N/A	N/A	N/A
	Preferred brand drugs	N/A	N/A	N/A
	Non-preferred brand drugs	N/A	N/A	N/A
	Specialty drugs	N/A	N/A	N/A
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	N/A	N/A	N/A
	Physician/surgeon fees	N/A	N/A	N/A
If you need immediate medical attention	Emergency room care	N/A	N/A	N/A
	Emergency medical transportation	N/A	N/A	N/A
	Urgent care	N/A	N/A	N/A
If you have a hospital stay	Facility fee (e.g., hospital room)	N/A	N/A	N/A
	Physician/surgeon fees	N/A	N/A	N/A
If you need mental health, behavioral health, or substance	Outpatient services	$0 (covered at 100%)	Not covered by EAP	You must call PAS at (800) 356-0845 to access EAP; limited to assessment, referral and short-term solution-focused counseling

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)	
abuse services	Inpatient services	N/A	N/A	N/A
If you are pregnant	Office visits	N/A	N/A	N/A
	Childbirth/delivery professional services	N/A	N/A	N/A
	Childbirth/delivery facility services	N/A	N/A	N/A
If you need help recovering or have other special health needs	Home health care	N/A	N/A	N/A
	Rehabilitation services	N/A	N/A	N/A
	Habilitation services	N/A	N/A	N/A
	Skilled nursing care	N/A	N/A	N/A
	Durable medical equipment	N/A	N/A	N/A
	Hospice services	N/A	N/A	N/A
If your child needs dental or eye care	Children's eye exam	N/A	N/A	N/A
	Children's glasses	N/A	N/A	N/A
	Children's dental check-up	N/A	N/A	N/A

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.)

- Court mandated counseling
- Educational testing
- Evaluations or assessments to be used in worker's compensation proceedings
- Evaluations or assessments to be used in criminal proceedings or any type of legal action
- Evaluations required by any government entity or official
- Evaluations to be used in child custody proceedings
- Fitness for duty determinations
- Inpatient, residential or facility-based outpatient care
- Legal consultation regarding work-related issues; guidance on workplace issues when the employee sues or threatens to sue the employer
- Legal representation
- Medical care, including psychiatric care, medication and medication management
- Neurological testing
- Preparation of income taxes or consultation on tax audits
- Psychiatric testing
- Preparation of documentation for determination of disability, FMLA documentation, excuses for leave of absence or time off
- Psychological testing
- Remedial or social skills education services (such as treatment or services for cognitive rehabilitation, behavioral training, language disorders, learning disorders, etc.)
- Services by providers who are not in PAS' provider network
- Testimony in legal proceedings

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
• For a complete list of Life Management Services, please refer to your EAP Brochure. Contact your HR Department to request a copy of your EAP Brochure and your Summary Plan Description. You may also go online to www.paseap.com to download an electronic copy of your EAP brochure.

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 on how 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? [Yes/No]
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? [Yes/No/Not Applicable]
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 (800) 356-0845.

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

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

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	**$12,700**

In this example, Peg would pay:

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

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

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

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	**$5,600**

In this example, Joe would pay:

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

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

- **The plan's overall deductible** $
- **Specialist *[cost sharing]*** $
- **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	**$2,800**

In this example, Mia would pay:

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

The **EAP** will not be responsible for the costs of these EXAMPLE services because these are not services covered by the EAP.