



This is only a summary. For more details about this plan visit www.profileeap.com or by calling 1-719-634-1825

Username: city Password:2000

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0	There is no deductible for services covered under your Employee Assistance Program (“EAP”).
Are there other deductibles for specific services?	No	There are no deductibles for services covered under your EAP.
Is there an out-of-pocket limit on my expenses?	N/A	There are no out-of-pocket expenses for services covered under your EAP.
What is not included in the out-of-pocket limit?	N/A	There are no out-of-pocket expenses for services covered under your EAP.
Is there an overall annual limit on what the plan pays?	Yes	Your EAP covers up to 6 sessions per issue per year, up to 3 issues per year.
Does this plan use a network of providers?	Yes. For a list of EAP providers, see www.profileeap.com or call 1-719-634-1825 or 1-800-645-6571	Only in-network providers are covered (at 100%). Your EAP does not cover out-of-network providers.
Do I need a referral to see a specialist?	Yes	You do not need a referral from your employer or your medical provider to get EAP services. In order to receive EAP sessions, you must contact Profile EAP at 719-634-1825 or 1-800-645-6571. Referrals are required for other mental health providers outside of EAP.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 3.

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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. There are no **co-payments** under your EAP.
- **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**. There is no **co-insurance** under your EAP.
- 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**.) There is no **balance billing** under your EAP.
- This plan requires that you use in-network **providers**. There are no **deductibles**, **co-payments** or **co-insurance** amounts under your EAP.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you visit a health care provider's 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	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	

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Employee Assistance Program (EAP): City of Colorado Springs

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

Coverage Period: 01/01/2014-12/31/2014

Coverage for: Employee and Family | Plan Type: EAP

If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	
	Physician/surgeon fees	Not covered	Not covered	
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	No charge	Not covered	Coverage is limited to 6 sessions per issue per year, combined Mental Health and Substance Abuse. Coverage is available to employees and family members at no charge to them. Some examples include relationship and family issues, stress, situational depression, and job performance issues.
	Mental/Behavioral health inpatient services	Not covered	Not covered	
	Substance use disorder outpatient services	No charge	Not covered	Coverage is limited to 6 sessions per issue per year, combined Mental Health and Substance Abuse. Coverage is available to employees and family members at no charge to them.
	Substance use disorder inpatient services	Not covered	Not covered	

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

Coverage Period: 01/01/2014-12/31/2014

Coverage for: Employee and Family | Plan Type: EAP

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	

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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 (Adult)
- Hearing Aids
- Infertility treatment
- Inpatient care
- Long-term care
- Non- emergency care when traveling outside the U.S.
- Coverage provided outside of the U.S.
- Physicians/psychiatrists, psychological testing, chronic mental health issues or any inpatient services.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs, and

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.)

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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 continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-719-634-1825. 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: **1-719-634-1825**.

SPANISH (Español): Para obtener asistencia en Español, llame al 1-719-634-1825.

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

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About these Coverage Examples:

These examples are not applicable because these are not covered services under the Employee Assistance Program (EAP).



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** \$0
- **Patient pays** This condition is not covered, so patient pays 100%.

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
Total	\$7,540

Patient pays:

Deductibles	N/A
Co-pays	N/A
Co-insurance	N/A
Limits or exclusions	\$7,540
Total	\$7,540

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

- **Amount owed to providers:** \$5,400
- **Plan pays** \$0
- **Patient pays** This condition is not covered, so patient pays 100%.

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	N/A
Co-pays	N/A
Co-insurance	N/A
Limits or exclusions	\$5,400
Total	\$5,400

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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 **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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