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.hriworld.com or by calling 1-800-952-1245

Important Questions	Answers	Why this Matters:
What is the overall deductible?	N/A	There is no deductible for services covered under your Employee Assistance Program ("EAP").
Are there other deductibles for specific services?	N/A	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?	NO - N/A	Your EAP covers up to 3 sessions per issue per year.
Does this plan use a network of providers?	YES	Only in-network providers are covered (at 100%).
Do I need a referral to see a specialist?	N/A	In order to receive EAP sessions, you must contact HRI at 1-800-952-1245
Are there services this plan doesn't cover?	N/A	Your EAP is a short term counseling program that only covers up to 3 sessions per issue per year.

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

- 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 __N/A_ 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 In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	N/A		
	Specialist visit	N/A		
	Other practitioner office visit	N/A		
	Preventive care/screening/immunization	N/A		
If you have a test	Diagnostic test (x-ray, blood work)	N/A		
	Imaging (CT/PET scans, MRIs)	N/A		
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.[insert].	Generic drugs	N/A		
	Preferred brand drugs	N/A		
	Non-preferred brand drugs	N/A		
	Specialty drugs	N/A		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	N/A		
	Physician/surgeon fees	N/A		

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
If you need immediate medical attention	Emergency room services	N/A		
	Emergency medical transportation	N/A		
	Urgent care	N/A		
If you have a hospital stay	Facility fee (e.g., hospital room)	N/A		
	Physician/surgeon fee	N/A		
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$0 (covered at 100%)	0	Up to 3 face to face outpatient sessions per issue per year for purposes of assessment and referral or short-term counseling
	Mental/Behavioral health inpatient services	N/A		
	Substance use disorder outpatient services	$0 (covered at 100%)	0	Up to 3 face to face outpatient sessions per issue per year for purposes of assessment and referral or short-term counseling
	Substance use disorder inpatient services	N/A		
If you are pregnant	Prenatal and postnatal care	N/A		
	Delivery and all inpatient services	N/A		
If you need help recovering or have other special health needs	Home health care	N/A		
	Rehabilitation services	N/A		
	Habilitation services	N/A		
	Skilled nursing care	N/A		
	Durable medical equipment	N/A		
	Hospice service	N/A		
If your child needs dental or eye care	Eye exam	N/A		
	Glasses	N/A		
	Dental check-up	N/A		

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.)
· Physicians/psychiatrists, psychological testing, chronic mental health issues or any inpatient services.

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.)

Your Rights to Continue Coverage:

The plan does not include rights for continued coverage; if further treatment after the 1-3 sessions is needed, a referral to a specialist within the employee or household member's medical/behavioral health network will be provided.

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: This is not applicable. In the event the employee or household member has a complaint, he/she can call 1-800-952-1245 and speak with an Intake consultant who will initiate a formal complaint process to resolve the matter