

## SupportLinc Employee Assistance Program:

Gulf Coast Regional Blood Center

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

**Coverage Period:** Beginning on or after 01/01/2025

**Coverage for:** Employee + spouse and 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 at supportlinc.com (group code: gcrbc) or by calling 888-881-5462.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$0	There is no <u>deductible</u> for services covered under your Employee Assistance Program (“EAP”).
Are there other <u>deductibles</u> for specific services?	No.	You don’t have to meet <u>deductibles</u> for services covered under your EAP.
Is there an <u>out-of-pocket limit</u> on my expenses?	N/A. This plan has no out-of-pocket expenses.	Not applicable because there are no out-of-pocket expenses for services covered under your EAP.
What is not included in the <u>out-of-pocket limit</u> ?	N/A. This plan has no out-of-pocket expenses.	Not applicable because 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.	The chart starting on page 2 describes specific coverage limits, such as limits on the number of sessions.
Does this plan use a <u>network</u> of <u>providers</u> ?	Yes. For a list of EAP providers, call SupportLinc at 888-881-5462	If you use a <u>network</u> EAP <u>provider</u> , this plan will cover all costs for covered services. Your EAP does not cover out-of-network <u>providers</u> ( <b>non-preferred providers</b> ).
Do I need a referral to see a <u>specialist</u> ?	N/A. This plan does not cover <u>specialists</u> .	Not applicable because your EAP does not cover <u>specialists</u> .
Are there services this plan doesn’t cover?	Yes.	Some of the services that your EAP doesn’t cover are listed on pages 2-4. See your plan document for additional information about <u>excluded services</u> .

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If you aren’t clear about any of the underlined 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 [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-866-444-EBSA (3272) to request a copy.

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

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** 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 **coinsurance** 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 in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** 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 <b>provider's</b> office or clinic	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	Not covered	Not covered	-----None-----
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 <b>prescription drug coverage</b> is available at N/A.	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-----

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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 services	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 fee	Not covered	Not covered	-----None-----
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No Charge	Not Covered	Limited to 5 sessions per issue per year.
	Mental/Behavioral health inpatient services	Not Covered	Not Covered	-----None-----
	Substance use disorder outpatient services	No Charge	Not Covered	Limited to 5 sessions per issue per year.
	Substance use disorder inpatient services	Not Covered	Not Covered	-----None-----
If you are pregnant	Prenatal and postnatal care	Not Covered	Not Covered	-----None-----
	Delivery and all inpatient 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 service	Not covered	Not covered	-----None-----
If your child needs dental or eye care	Eye exam	Not covered	Not covered	-----None-----
	Glasses	Not covered	Not covered	-----None-----
	Dental check-up	Not covered	Not covered	-----None-----

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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         | • Hearing Aids                                       | • Physicians/psychiatrists |
| • Bariatric surgery   | • Infertility treatment                              | • Private-duty nursing     |
| • Chiropractic care   | • Inpatient care                                     | • Psychological testing    |
| • Cosmetic surgery    | • Long-term care                                     | • Routine eye care (Adult) |
| • Dental care (Adult) | • Non-emergency care when traveling outside the U.S. | • Routine foot care        |
|                       |  | • Weight loss programs     |

**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:

EAP services will remain available to any employee or dependent who loses coverage due to a qualifying event, for the COBRA period.

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 888-881-5462. 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 SupportLinc at 888-881-5462 or contact Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

### Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al **1-855-836-4924**.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-800-272-7255**.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 **1-800-272-7255**.]

[Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwijigo holne' **1-800-272-7255**.]

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

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## 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** N/A
- **Patient pays** N/A

#### 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	N/A
Copays	N/A
Coinsurance	N/A
Limits or exclusions	N/A
<b>Total</b>	<b>N/A</b>

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

- **Amount owed to providers:** \$5,400
- **Plan pays** N/A
- **Patient pays** N/A

#### 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
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	N/A
Copays	N/A
Coinsurance	N/A
Limits or exclusions	N/A
<b>Total</b>	<b>N/A</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, copayments, and coinsurance 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 copayments, deductibles, and coinsurance. 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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