




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, please read the Plan brochure that contains the complete terms of this plan. 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 <http://staff.nalchbp.org> or call 888- 636 NALC (6252) to request a copy.

Important Questions	Answers	Why This Matters:
<p><b>What is the overall <a href="#">deductible</a>?</b></p>	<p>\$300/individual or \$600/family</p>	<p>Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>
<p><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>	<p>Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a>.</p>	<p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a>. See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a></p>
<p><b>Are there other <a href="#">deductibles</a> for specific services?</b></p>	<p>No.</p>	<p>You do not have to meet <a href="#">deductibles</a> for specific services.</p>
<p><b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b></p>	<p>For <a href="#">in-network providers</a>, \$3,500 individual / \$5,000 family. For <a href="#">out-of-network providers</a>, \$7,000 individual and family.</p>	<p>The <a href="#">out-of-pocket limit</a>, or catastrophic maximum, is the most you could pay in a year for covered services. If you have other family members on the <a href="#">plan</a>, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.</p>
<p><b>What is not included in the <a href="#">out-of-pocket limit</a>?</b></p>	<p><a href="#">Premiums</a>, <a href="#">balance-billing</a> charges, health care this <a href="#">Plan</a> does not cover, and penalties for failure to pre-certify.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>
<p><b>Will you pay less if you use a <a href="#">network provider</a>?</b></p>	<p>Yes. See <a href="https://staff.nalchbp.org">https://staff.nalchbp.org</a> or call 877-220-6252 for a list of <a href="#">network providers</a>.</p>	<p>This <a href="#">plan</a> uses a <a href="#">provider network</a>. You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a>. You will pay the most if you use an <a href="#">out-of-network provider</a>, and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider</a>'s charge and what your plan pays (<a href="#">balance billing</a>). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.</p>
<p><b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b></p>	<p>No.</p>	<p>You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a>.</p>

 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		
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	\$20/visit	30% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
	<a href="#">Specialist</a> visit	\$20/visit	30% <a href="#">coinsurance</a>	
	<a href="#">Preventive care/screening/immunization</a>	No charges	30% <a href="#">coinsurance</a>	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	15% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	You pay nothing when LabCorp or Quest Diagnostics performs your covered lab services. Prior approval required for genetic testing. When required by law, <a href="#">out-of-network</a> diagnostic tests will be treated as <a href="#">in-network</a> .
	Imaging (CT/PET scans, MRIs)	15% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Prior approval required. We may deny benefits for failure to obtain prior approval. When required by law, <a href="#">out-of-network</a> imaging will be treated as <a href="#">in-network</a> .
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://staff.nalchbp.org/">http://staff.nalchbp.org/</a>	Generic drugs	<a href="#">Network</a> retail: 20% <a href="#">coinsurance</a> . (10% for asthma, diabetes, and hypertension) Mail order: \$15/90 day supply (\$8 for asthma, diabetes, and hypertension)	50% <a href="#">coinsurance</a>	You may obtain up to a 30-day fill plus one refill at network retail. You may purchase a 90-day supply at a CVS Caremark® pharmacy and pay the mail order copayment. All compound drugs, 501K dermatological products, artificial saliva, anti-narcolepsy, ADD/ADHD, certain analgesics, and opioid medications require prior approval and are subject to quantity and duration limits. Benefits may be reduced or
	Preferred brand drugs	<a href="#">Network</a> retail: 30% <a href="#">coinsurance</a> . Mail order: \$90/90 day supply (\$50 for asthma,	50% <a href="#">coinsurance</a>	

Common Medical Event	Services You May Need	What You Will Pay		
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		diabetes, and hypertension		denied for failure to obtain prior approval.
	Non-preferred brand drugs	<a href="#">Network</a> retail: 50% <a href="#">coinsurance</a> . Mail order: \$125/90 day supply (\$70 for asthma, diabetes, and hypertension)	50% <a href="#">coinsurance</a>	
	<a href="#">Specialty drugs</a>	\$200/30 day supply \$300/60 day supply \$400/90 day supply	Not covered	Prior approval required. If you fail to obtain prior approval, then we may deny. Step therapy is required for certain specialty drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	15% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Prior approval for spinal surgery and gender reassignment surgery required. We may deny benefits if you fail to obtain prior approval. When required by law, <a href="#">out of -network</a> physician/surgeon fees will be treated as <a href="#">in-network</a> .
If you need immediate medical attention	<a href="#">Emergency room care</a>	15% <a href="#">coinsurance</a>	15% <a href="#">coinsurance</a>	Outpatient hospital medical emergency services for a medical emergency condition.
	<a href="#">Emergency medical transportation</a>	15% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	When ambulance transportation to the nearest PPO facility is provided by a non-PPO provider, we will pay up to the Plan allowance at the PPO benefit level. <a href="#">Coinsurance</a> for <a href="#">out-of-network</a> air ambulance services is 15%.
	<a href="#">Urgent care</a>	\$20 <a href="#">copayment</a>	30% <a href="#">coinsurance</a>	When required by law, <a href="#">out-of-network</a> emergency services provided at urgent

Common Medical Event	Services You May Need	What You Will Pay		
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
				care facilities licensed in the state to provide emergency care will be treated as <a href="#">in-network</a> .
If you have a hospital stay	Facility fee (e.g., hospital room)	\$350 <a href="#">copayment</a> /admission	\$450 <a href="#">copayment</a> /admission and 35% <a href="#">coinsurance</a>	Prior approval required. \$500 penalty when you fail to obtain prior approval.
	Physician/surgeon fees	15% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Prior approval is required for spinal surgery, gender reassignment surgery, and organ/tissue transplants. When required by law, <a href="#">out of -network</a> physician/surgeon fees will be treated as <a href="#">in-network</a> .
If you need mental health, behavioral health, or substance use services	Outpatient services	15% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Certain outpatient services require prior authorization.
	Inpatient services	\$350 <a href="#">copayment</a> /admission	\$450 <a href="#">copayment</a> /admission and 35% <a href="#">coinsurance</a>	No <a href="#">deductible</a> . Precertification required. \$500 penalty for failure to precertify.
If you are pregnant	Office visits	No charge	30% <a href="#">coinsurance</a>	No <a href="#">deductible</a> when services are rendered by a participating provider/facility. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	30% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	No charge	\$450 <a href="#">copayment</a> /admission and 35% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	15% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	2 hours/day, up to 50 days/calendar year.
	<a href="#">Rehabilitation services</a>	\$20 <a href="#">copay</a> /visit	30% <a href="#">coinsurance</a>	75 visits/year. Includes physical therapy, occupational therapy, cognitive rehabilitation therapy following a traumatic brain injury, and speech therapy.
	<a href="#">Habilitation services</a>	\$20 <a href="#">copay</a> /visit	30% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	15% <a href="#">coinsurance</a> and all	30% <a href="#">coinsurance</a> , and all	When this <a href="#">plan</a> is your primary

Common Medical Event	Services You May Need	What You Will Pay		
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		charges after 21 day annual limit	charges after 21-day annual limit	insurance: Inpatient confinement at a skilled nursing facility is covered following transfer from a covered acute inpatient confinement when skilled care is still required. Benefits are limited to 21 days per person, per calendar year
	<a href="#">Durable medical equipment</a>	15% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Prior approval required.
	<a href="#">Hospice services</a>	15% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Limited to 30 days annually for inpatient/ outpatient hospice.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	30% <a href="#">coinsurance</a>	Limited vision screening as recommended by Bright Futures/AAP.
	Children's glasses	15% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Limited to one pair after ocular injury or intraocular surgery
	Children's dental check-up	Not covered	Not covered	None

**Excluded Services & Other Covered Services:**

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Custodial Care</li> <li>• Dental Care</li> </ul>	<ul style="list-style-type: none"> <li>• Long Term Care</li> <li>• Private nursing care</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (adult)</li> <li>• School-based ABA therapy</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids</li> <li>• Infertility treatment</li> <li>• Non-emergency care when traveling outside the US</li> </ul>	<ul style="list-style-type: none"> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul>

**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: the U.S. Department of Labor, Employee Benefits Security Administration at 866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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](http://www.HealthCare.gov) or call 1800-318- 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: NALC Health Benefit Plan for Employees and Staff at 888-636-NALC (6252) or you can contact the Department of Labor’s Employee Benefits Security Administration at 866-444-EBSA (3272).

**Does this plan provide Minimum Essential Coverage? Yes**

[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**

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 888-633-NALC (6252).]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888-633-NALC (6252).]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 888-633-NALC (6252).]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 888-633-NALC (6252).]

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

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](#) \$300
- [Specialist copayment](#) \$20
- Hospital (facility) coinsurance 15%
- Other coinsurance 15%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$25
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Peg would pay is</b>	<b>\$45</b>

**Managing Joe's Type 2**

**Diabetes** (a year of routine in-network care of a well- controlled condition)

- The [plan's](#) overall [deductible](#) \$300
- [Specialist copayment](#) \$20
- Hospital (facility) coinsurance 15%
- Other coinsurance 15%

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$300
<a href="#">Copayments</a>	\$180
<a href="#">Coinsurance</a>	\$30
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$510</b>

**Mia's Simple Fracture**

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$300
- [Specialist copay](#) \$20
- Hospital (facility) coinsurance 15%
- Other coinsurance 15%

This EXAMPLE event includes services like:

- [Emergency room care](#) (*including medical supplies*)
- [Diagnostic test](#) (*x-ray*)
- [Durable medical equipment](#) (*crutches*)
- [Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$40
<a href="#">Coinsurance</a>	\$72
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$212</b>

