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 703-729-4677 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$350/individual or $700/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You do not have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers, $3,500 individual / $7,000 family. For out-of-network providers, $5,000 individual /$10,000 family.	The out-of-pocket limit, or catastrophic maximum, is the most you could pay in a year for covered services. If you have other family members on the plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this Plan does not cover, and penalties for failure to pre-certify.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://staff.nalchbp.org or call 877-220-6252 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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 provider's office or clinic	Primary care visit to treat an injury or illness	$25/visit	35% coinsurance	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.
	Specialist visit	$25/visit	35% coinsurance	
	Preventive care/screening/ immunization	No charges	35%coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	35% coinsurance	You pay nothing when LabCorp or Quest Diagnostics performs your covered lab services. Prior approval required for genetic testing. When required by law, out-of-network diagnostic tests will be treated as in-network.
	Imaging (CT/PET scans, MRIs)	15% coinsurance	35% coinsurance	Prior approval required. We may deny benefits for failure to obtain prior approval. When required by law, out-of-network imaging will be treated as in-network.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://staff.nalchbp.org/.	Generic drugs	Network retail: 20% coinsurance. (10% for asthma, diabetes, and hypertension) Mail order: 20% coinsurance, maximum of $250 per RX /90 day supply	50% coinsurance	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 coinsurance. 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 denied for failure to obtain prior approval.
	Formulary brand drugs (Preferred brand drugs)	Network retail: 30% coinsurance. Mail order: 30% coinsurance, maximum of $350 per RX /90 day supply	50% coinsurance	
	Non-Formulary brand drugs (Non-preferred brand drugs)	Network retail: 50% coinsurance. Mail order: 50% coinsurance and any difference between	50% coinsurance	

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
		Plan allowance and charge amount, maximum $500 per RX /90 day supply		
	Specialty drugs	$200/30 day supply $350/60 day supply $500/90 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% coinsurance	35% coinsurance	None
	Physician/surgeon fees	15% coinsurance	35% coinsurance	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, out-of-network physician/surgeon fees will be treated as in-network.
If you need immediate medical attention	Emergency room care	15% coinsurance	15% coinsurance	Outpatient hospital medical emergency services for a medical emergency condition.
	Emergency medical transportation	15% coinsurance	35% coinsurance	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. Coinsurance for out-of-network air ambulance services is 15%.
	Urgent care	$25 copayment	35% coinsurance	When required by law, out-of-network emergency services provided at urgent care facilities licensed in the state to provide emergency care will be treated as in-network.
If you have a hospital stay	Facility fee (e.g., hospital room)	$350 copayment/admission	$450 copayment/admission and 35% coinsurance	Prior approval required. $500 penalty when you fail to obtain prior approval.
	Physician/surgeon fees	15% coinsurance	35% coinsurance	Prior approval is required for spinal

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
				surgery, gender reassignment surgery, and organ/tissue transplants. When required by law, out-of-network physician/surgeon fees will be treated as in-network.
If you need mental health, behavioral health, or substance use services	Outpatient services	15% coinsurance	35% coinsurance	Certain outpatient services require prior authorization.
	Inpatient services	$350 copayment/admission	$450 copayment/admission and 35% coinsurance	No deductible. Precertification required. $500 penalty for failure to pre-certify.
If you are pregnant	Office visits	No charge	35% coinsurance	No deductible 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	35% coinsurance	
	Childbirth/delivery facility services	No charge	$450 copayment/admission and 35% coinsurance	
If you need help recovering or have other special health needs	Home health care	15% coinsurance	35% coinsurance	2 hours/day, up to 50 days/calendar year.
	Rehabilitation services	15% coinsurance	35% coinsurance	75 visits/year. Includes physical therapy, occupational therapy, cognitive rehabilitation therapy following a traumatic brain injury, and speech therapy.
	Habilitation services	15% coinsurance	35% coinsurance	
	Skilled nursing care	15% coinsurance and all charges after 30-day annual limit	35% coinsurance, and all charges after 30-day annual limit	When this plan is your primary 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 30 days per person, per calendar year.
	Durable medical equipment	15% coinsurance	35% coinsurance	Prior approval required.
	Hospice services	Nothing up to the Plan limit	35% coinsurance	Limited to 30 days annually for inpatient/ outpatient hospice.

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 your child needs dental or eye care	Children's eye exam	No charge	35% coinsurance	Limited vision screening as recommended by Bright Futures/AAP.
	Children's glasses	15% coinsurance	35% coinsurance	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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Custodial Care
- Dental Care
- Private nursing care
- Routine eye care (adult)
- Routine Foot Care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Weight loss programs

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, or the U.S. Department of Health and Human Services at 877-267-2323 x61565 or 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 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).]

[Traditional 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, kwiijigo holne' 888-633-NALC (6252).]

[Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 888-633-NALC (6252) uff.]

[Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 888-633-NALC (6252).]

[Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 888-633-NALC (6252).]

[Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 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** **$350**
- **Specialist copayment** **$25**
- **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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$350
Copayments	$0
Coinsurance	$45
What isn't covered	
Limits or exclusions	$15
The total Peg would pay is	**$410**

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

- **The plan's overall deductible** **$350**
- **Specialist copayment** **$25**
- **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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$150
Coinsurance	$1,096.00
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,266.00**

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

- **The plan's overall deductible** **$350**
- **Specialist copay** **$25**
- **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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$350
Copayments	$50
Coinsurance	$45
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$445**