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 http://staff.nalchbp.org/ or by calling 1-888-636-NALC (6252).

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$300** self only/**$600** family. Doesn't apply to preventive care, surgery, or inpatient hospital stay when rendered by a PPO provider, or to prescription drugs. Copayments and coinsurance amounts do not count toward any deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet a **deductible** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For PPO providers **$5,000**; for Non-PPO/PPO providers combined **$7,000**. **$4000** for prescription drugs purchased at a network retail pharmacy or specialty drugs purchased at mail order.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, health care this Plan does not cover, coinsurance for non-network prescriptions or refills at network pharmacies, the difference in cost between brand-name and generic drugs (if your doctor does not specify the brand-name), and penalties for failure to precertify.	Even though you may pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of PPO providers see https://staff.nalchbp.org/ or call 1-877-220-6252.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, the in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-888-636-NALC (6252) or visit us at https://staff.nalchbp.org/. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at https://staff.nalchbp.org/ or call 1-888-636-6252 to request a copy.

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

- **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 **PPO providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	30% coinsurance	Not subject to deductible when services are rendered by a PPO provider. Other practitioners must be covered providers, as defined by the Plan. Acupuncture limited to 15 visits per person per year. Chiropractic limited to an initial set of spinal x-rays and 20 spinal or extraspinal manipulations per calendar year.
	Specialist visit	$20 copay/visit	30% coinsurance	
	Other practitioner office visit	$20 copay/visit for chiropractic; 15% coinsurance for acupuncture	30% coinsurance	
	Preventive care/screening/immunization	No charge	30% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	30% coinsurance	No out-of-pocket expense if LabCorp or Quest Diagnostics performs covered lab services.
	Imaging (CT/PET scans, MRIs)	15% coinsurance	30% coinsurance	Precertification required. We may deny benefits for failure to precertify.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at	Generic drugs	Network retail: 20% coinsurance. Mail order: $8/$12	45% coinsurance	You may obtain up to a 30-day fill plus one refill at network retail. Mail order copayments are for 60/90-day supply. You may purchase a 90-day supply at a CVS Pharmacy and pay the mail order copayment.
	Preferred brand drugs	Network retail: 30% coinsurance. Mail order: $43/$65	45% coinsurance	
	Non-preferred brand drugs	Network retail: 45% coinsurance. Mail order: $58/$80	45% coinsurance	

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
https://staff.nalchbp.org/.	Specialty drugs	$150/30-day supply $250/60-day supply $350/90-day supply	Not Covered	Prior approval required. We may deny benefits if you fail to obtain prior approval.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	35% coinsurance	--none--
	Physician/surgeon fees	15% coinsurance	30% coinsurance	PPO surgeon fee is not subject to the deductible.
If you need immediate medical attention	Emergency room services	15% coinsurance	35% coinsurance	You will not have to pay coinsurance for care received within 72 hours of an accidental injury as defined by the Plan, and such care is not subject to the deductible.
	Emergency medical transportation	15% coinsurance	30% coinsurance	
	Urgent care	15% coinsurance	15% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copay/admission, no copay for newborn delivery	$350 copay/admission and 30% coinsurance	Not subject to deductible. Precertification required. $500 penalty when you fail to precertify.
	Physician/surgeon fee	15% coinsurance	30% coinsurance	PPO surgeon fee is not subject to the deductible.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copay/therapy and 15% coinsurance for other outpatient services	30% coinsurance	Not subject to deductible. Precertification required for certain outpatient services. Benefits may be reduced or denied for failure to precertify.
	Mental/Behavioral health inpatient services	$200 copay/ admission; 15% coinsurance for professional services	$350 copay/admission; 30% coinsurance for professional services	Not subject to deductible. Precertification required. $500 penalty when you fail to precertify.
	Substance use disorder outpatient services	$20 copay/therapy and 15% coinsurance other outpatient services	30% coinsurance	Not subject to deductible. Precertification required for certain outpatient services. Benefits may be reduced or denied for failure to precertify.
	Substance use disorder inpatient services	$200 copay/ admission; 15% coinsurance for professional services	$350 copay/admission; 30% coinsurance for professional services	Not subject to deductible. Precertification required. $500 penalty when you fail to precertify.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	No charge	30% coinsurance	Not subject to deductible when services are rendered by PPO provider/facility.
	Delivery and all inpatient services	No charge	Delivery – 30% coinsurance Inpatient - $350 copayment per admission and 30% coinsurance	
If you need help recovering or have other special health needs	Home health care	15% coinsurance	30% coinsurance	Limited to 2 hours per day up to 50 days per calendar year.
	Rehabilitation services	$20 copay/ visit	30% coinsurance	Limited to combined 75 visits per year. Not subject to deductible when services are rendered by a PPO provider. Habilitation services limited to speech therapy.
	Habilitation services	$20 copay/visit	30% coinsurance	
	Skilled nursing care	No charge	No charge	Limited benefit – only available to individuals who have Medicare Part A as primary payor and subject to payment, admission and supervision conditions in the Plan brochure.
	Durable medical equipment	15% coinsurance	30% coinsurance	Prior approval required. We may deny benefits if you fail to obtain prior approval.
	Hospice service	15% coinsurance	30% coinsurance	Limited benefit – lifetime maximum payment of $3000.
If your child needs dental or eye care	Eye exam	$20 copay/ visit	30% coinsurance	Not subject to deductible when services are rendered by a PPO provider.
	Glasses	15% coinsurance	30% coinsurance	Limited to one pair, and only after ocular accident or intraocular surgery.
	Dental check-up	Not Covered	Not Covered	--none--

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.)

- Cosmetic surgery except for repair of accidental injury initiated within 6 months of accident, correction of congenital anomaly or breast reconstruction following mastectomy
- Dental care (Adult), other than outpatient dental treatment incurred and completed within 72 hours of an accidental injury
- Long-term care
- Routine eye care (Adult)

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.)

- Acupuncture if by a doctor of medicine/osteopathy or licensed/certified acupuncturist; limited to 15 visits per person per calendar year.
- Bariatric Surgery, subject to age, diagnostic and clinical conditions listed in the Plan brochure
- Chiropractic care, limited to an initial set of spinal x-rays and 20 spinal or extraspinal manipulations per calendar year.
- Hearing aids, subject to $500 per ear limit every 3 years.
- Infertility treatment, limited to $2,500 per calendar year per person, and not including assisted reproductive technology procedures or related services or supplies, cost of donor sperm or egg, prescription drugs, or services after voluntary sterilization.
- Non-emergency care when traveling outside the US
- Private duty nursing, limited to 2 hours per day up to 50 days per calendar year and subject to qualification, medical necessity, diagnostic, and time limit conditions in the Plan brochure.
- Routine foot care
- Weight loss programs

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 703-729-4677 or 1-888-636-NALC (6252). 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: NALC Health Benefit Plan for Employees and Staff at 1-888-636-NALC (6252) or you can contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-636-NALC (6252).

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

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** $7,504
- **Patient pays** $36

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	$0
Copays	$36
Coinsurance	$0
Limits or exclusions	$0
Total	**$36**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,777
- **Patient pays** $663

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	$300
Copays	$128
Coinsurance	$195
Limits or exclusions	$40
Total	**$663**

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.