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**/self & family. Does not apply to prescription drugs, preventive care, surgery, outpatient observation room & inpatient hospital stay when rendered by a participating provider.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for certain 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 **deductibles** 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. $3500 per person or $5000 per family for PPO providers. $3100 per person or $4000 per family for prescription drugs purchased at a network pharmacy or our mail order pharmacy.	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 doesn't cover, 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 participating providers see our online directory at 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, your 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 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-NALC (6252) to request a copy.

- **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 participating **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 provider's office or clinic	Primary care visit to treat an injury or illness	$20 /visit	30% coinsurance	No deductible when services are rendered by a participating provider.
	Specialist visit	$20 /visit	30% coinsurance	
	Other practitioner office visit	$20 /visit	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	You pay nothing when LabCorp or Quest Diagnostics performs your covered lab services.
	Imaging (CT/PET scans, MRIs)	15% coinsurance	30% coinsurance	Prior approval required. We may deny benefits for failure to obtain prior approval.

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 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. Mail order: $12/90-day supply	45% 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 copayment. All compound drugs and certain anti-narcolepsy and analgesic/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.
	Preferred brand drugs	Network retail: 30% coinsurance. Mail order: $65/90-day supply	45% coinsurance	
	Non-preferred brand drugs	Network retail: 45% coinsurance. Mail order: $80/90-day supply	45% coinsurance	
	Specialty drugs	$150/30-day supply $250/60-day supply $350/90-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	30% coinsurance	Prior approval for spinal surgery and gender reassignment surgery required. We may deny benefits if you fail to obtain prior approval.
If you need immediate medical attention	Emergency room services	15% coinsurance	35% coinsurance	Coinsurance does not apply to care received within 72 hours of an "accidental" injury as defined by the Plan.
	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 copayment per admission	$350 copayment per admission and 30% coinsurance	No deductible. Prior approval required. $500 penalty when you fail to obtain prior approval.

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
	Physician/surgeon fee	15% coinsurance	30% coinsurance	Prior approval for spinal surgery and gender reassignment surgery required. We may deny benefits if you fail to obtain prior approval.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	15% coinsurance	30% coinsurance	Prior approval required for certain non-routine outpatient services, including applied behavioral analysis (ABA) therapy. Benefits may be reduced or denied for failure to obtain prior approval. ABA therapy subject to limits based on the age of the child.
	Mental/Behavioral health inpatient services	$200 copayment per admission	$350 copayment per admission and 30% coinsurance	No deductible. Precertification required. $500 penalty when you fail to precertify.
	Substance use disorder outpatient services	15% coinsurance	30% coinsurance	Prior approval required for certain non-routine outpatient services. Benefits may be reduced or denied for failure to obtain prior approval.
	Substance use disorder inpatient services	$200 copayment per admission	$350 copayment per admission and 30% coinsurance	No deductible. Prior approval required. $500 penalty when you fail to obtain prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	30% coinsurance	No deductible when services are rendered by a participating provider/facility.
	Delivery and all inpatient services	No charge	Delivery - 30% coinsurance. Inpatient - $350 copayment per admission and 30% coinsurance	

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 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/visit	30% coinsurance	Limited to combined 75 visits per year. No deductible when services are rendered by a participating provider.
	Habilitation services	$20/visit	30% coinsurance	
	Skilled nursing care	Not covered	Not covered	Limited benefit – only available to individuals who have Medicare Part A as their primary payor.
	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 – up to 30 days annually for a combination of inpatient and outpatient hospice services
If your child needs dental or eye care	Eye exam	$20/visit	30% coinsurance	No deductible when services are rendered by a participating provider.
	Glasses	15% coinsurance	30% coinsurance	Limit – one pair after ocular accident or intraocular surgery.
	Dental check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or Staff Plan brochure 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 Staff Plan brochure for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric Surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the US
- Private duty nursing
- Routine foot care
- Weight loss program

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).

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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** $7,524
- **Patient pays** $16

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	$16
Coinsurance	$0
Limits or exclusions	$0
Total	**$16**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,440
- **Patient pays** $960

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	$272
Coinsurance	$162
Limits or exclusions	$0
Total	**$734**

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.