The Summary of Benefits and Coverage (SBC) document 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. Please read the Plan brochure that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the Plan brochure**. Benefits may vary if you have other coverage, such as Medicare. 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 get the Plan brochure at http://staff.nalchbp.org. You can call 1-888-636-NALC (6252) to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$300/individual or $600/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 don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers, $3,500 individual / $5,000 family. For out-of-network providers, $7,000 individual and 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, coinsurance for skilled nursing care, and penalties for failure to precertify.	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 1-877-220-6252 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		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20/visit	30% 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	$20/visit	30% coinsurance	
	Preventive care/screening/ immunization	No charges	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.
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 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.
	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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
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	30% 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.
	Urgent care	$20 copayment	30% coinsurance	Professional services of physicians and urgent care center.
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copayment/admission	$350 copayment/admission and 30% coinsurance	Prior approval required. $500 penalty when you fail to obtain prior approval.
	Physician/surgeon fees	15% coinsurance	30% coinsurance	Prior approval for spinal surgery and gender reassignment surgery required. We many deny benefits if you fail to obtain prior approval.
If you need mental health, behavioral health, or substance abuse services	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.
	Inpatient services	$200 copayment/admission	$350 copayment/admission and 30% coinsurance	No deductible. Precertification required. $500 penalty when you fail to percertify.
If you are pregnant	Office visits	No charge	30% 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	30% coinsurance	
	Childbirth/delivery facility services	No charge	$350 copayment/admission and 30% coinsurance	
If you need help recovering or have other special health needs	Home health care	15% coinsurance	30% coinsurance	2 hours/day, up to 50 days/calendar year.
	Rehabilitation services	$20 copay/visit	30% coinsurance	75 visits/year. Includes physical therapy, occupational therapy, and speech therapy.
	Habilitation services	$20 copay/visit	30% coinsurance	
	Skilled nursing care	Not covered	Not covered	Only available to individuals who have Medicare Part A as their primary payor.
	Durable medical equipment	15% coinsurance	30% coinsurance	Prior approval required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
	Hospice services	15% coinsurance	30% coinsurance	30 days/year. Includes inpatient and outpatient hospice services.
If your child needs dental or eye care	Children's eye exam	No charge	30% coinsurance	Limited vision screening as recommended by Bright Futures/AAP
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check the Plan's brochure for more information and a list of any other excluded services.)

- Cosmetic surgery
- Custodial Care
- Dental Care
- Long Term Care
- Private nursing care
- Routine eye care (adult)
- School-based ABA therapy
- Skilled nursing care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see the Plan's brochure.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the US
- 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 NALC Health Benefit Plan for Employees and Staff 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 plan provide Minimum Essential Coverage? **Yes**

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 plan meet the Minimum Value Standards? **Yes**

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 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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$10
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$20**

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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$20
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$720**

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

- **The plan's overall deductible** **$300**
- **Specialist copayment** **$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)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$70
Copayments	$100
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$190**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.