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. Please read the FEHB Plan brochure (RI 71-009) that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB 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 FEHB Plan brochure at www.nalchbp.org, and view the Glossary at www.nalchbp.org. You can call 888-636-6252 to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2000/In-Network self only $4000/In-Network self plus one $4000/In-Network self and family $4000/Out-of-Network self only $8000/Out-of-Network self plus one $8000/Out-of-Network self and family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. Copayments and coinsurance amounts do not count toward your deductible, which generally starts over January 1. When a covered service/supply is subject to a deductible, only the Plan allowance for the service/supply counts toward the deductible. 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	This plan covers some items and services even if you haven't yet met the deductible amount. "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?	$6600/In-Network self only $13200/In-Network self plus one $13200/In-Network self and family $12000/Out-of-Network self only $24000/Out-of-Network self plus one $24000/Out-of-Network self 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 in this 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-billed charges (unless prohibited), health care this plan does not cover, penalties for failure to precert.	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 www.nalchbp.org or call 855-511-1893 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% coinsurance	50% coinsurance	
	Specialist visit	20% coinsurance	50% coinsurance	The deductible does not apply to Preventive care rendered by an In-Network provider.
	Preventive care/screening/ immunization	No charge	50% coinsurance	The deductible does not apply to Preventive care rendered by an In-Network provider.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Precertification required. We may deny benefits if you fail to precertify.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.nalchbp.org	Generic drugs	Network retail: up to 30-day supply $10 ($5 for hypertension, diabetes and asthma)* Mail order: 90-day supply $20 ($13 for hypertension, diabetes and asthma)*	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 copayment. All compound drugs, anti-narcolepsy, ADD/ADHD, certain analgesics, and opioid
	Preferred brand drugs	Network retail: up to 30-day supply 40* Mail order: 90-day supply $80 ($70 for hypertension, diabetes and asthma)*	50% coinsurance	
	Non-preferred brand drugs	Network retail: up to 30-day supply $60*	50% coinsurance	

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)	
		Mail order: 90-day supply $120 ($110 for hypertension, diabetes and asthma)*		medications require authorization.
	Specialty drugs	30-day supply $200* 90-day supply $400*	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)	20% coinsurance	50% coinsurance	None
	Physician/surgeon fees	20% coinsurance	50% coinsurance	Prior authorization is required for spinal surgery, organ/tissue transplants, and gender reassignment surgery.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	20% coinsurance	20% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Precertification required. $500 penalty if you fail to precertify.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	Prior authorization is required for spinal surgery, organ/tissue transplants, and gender reassignment surgery.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance	Precertification required for certain non-routine outpatient services. Benefits may be reduced or denied if you fail to precertify.
	Inpatient services	20% coinsurance	50% coinsurance	Precertification required. $500 penalty if you fail to precertify.
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	None
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	

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)	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Precertification required if stay is more than 48 hours after a vaginal delivery or 96 hours after a cesarean section.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Limited to 2 hours per day up to 25 days per calendar year.
	Rehabilitation services	20% coinsurance	50% coinsurance	Limited to combined 50 visits per year.
	Habilitation services	20% coinsurance	50% coinsurance	
	Skilled nursing care	Not Covered	Not Covered	
	Durable medical equipment	20% coinsurance	50% coinsurance	Prior approval required. We may deny benefits if you fail to obtain prior approval.
	Hospice services	Not Covered	Not Covered	
If your child needs dental or eye care	Children's eye exam	20% coinsurance	50% coinsurance	None
	Children's glasses	20% coinsurance	50% coinsurance	Limit – one pair after ocular injury or intraocular surgery.
	Children's dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your plan's FEHB brochure for more information and a list of any 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
- Hospice Care
- Long-term care
- Routine eye care
- Skilled Nursing Care

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

- Acupuncture
- Bariatric Surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty Nursing
- Routine foot care and
- Weight loss programs

Your Rights to Continue Coverage: You can get help if you want to continue your coverage after it ends. See the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at 855-511-1893 or visit www.opm.gov.insure/health. Generally, if you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, a conversion policy (a non-FEHB individual policy), spouse equity coverage, or receive temporary continuation of coverage (TCC). 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 800-318-2596.

Your Grievance and Appeals Rights: If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal. For information about your appeal rights please see Section 3, "How you get care", and Section 8 "The disputed claims process", in your plan's FEHB brochure. If you need assistance, you can contact: NALC Health Benefit Plan Value Option at 888-636-6252.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 855-511-1893.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 855-511-1893.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 855-511-1893.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 855-511-1893.

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	**$2000**
Specialist *coinsurance*	**20%**
Hospital (facility) *coinsurance*	**20%**
Other *coinsurance*	**20%**

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	$1900
Copayments	$20
Coinsurance	$2050
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$3980**

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

The plan's overall deductible	**$2000**
Specialist *coinsurance*	**20%**
Hospital (facility) *coinsurance*	**20%**
Other *coinsurance*	**20%**

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	$1900
Copayments	$1000
Coinsurance	$80
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2980**

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

The plan's overall deductible	**$2000**
Specialist *coinsurance*	**20%**
Hospital (facility) *coinsurance*	**20%**
Other *coinsurance*	**20%**

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	$1830
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1830**

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