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. You can get the FEHB Plan brochure at www.nalc.org/depart/hbp or by calling 1-888-636-6252.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$ 300/self only $ 600/self and family Deductible does not apply to prescription drugs, preventive care, surgery, and inpatient hospital stay when services rendered by a PPO provider.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for certain covered services you use. **Copayments** and **coinsurance** amounts do not count toward your **deductible**, which generally starts over January 1st. When a covered service or supply is subject to a **deductible**, only the Plan allowance for the service or supply counts toward the **deductible**. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible** and for which services are subject to the **deductible**.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. $5000 for PPO providers. $7000 for PPO & non-PPO providers combined. $4000 for prescription drugs purchased at a network retail pharmacy or specialty drugs purchased at mail order.	The **out-of-pocket limit,** or catastrophic maximum**,** is the most you could pay during the 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, penalties for failure to precert.	Even though you 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 our online directory at www.nalc.org/depart/hbp 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 terms 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 4. See this plan's FEHB brochure for additional information about **excluded services**.

- **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 (plus you may be balance billed)	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 PPO provider. Other practitioners must be covered providers, as defined by the Plan.
	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	none
	Imaging (CT/PET scans, MRIs)	15% coinsurance	30% coinsurance	Precertification required. We may deny benefits for failure to precert.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider (plus you may be balance billed)	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.nalc.org/depart/hbp .	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 Pharmacy and pay the mail order copayment.
	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. 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	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. Precertification required. $500 penalty when you fail to precert.
	Physician/surgeon fee	15% coinsurance	30% coinsurance	PPO surgeon fee is not subject to the deductible.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider (plus you may be balance billed)	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	15% coinsurance	30% coinsurance	Precertification required for certain outpatient services. Benefits may be reduced or denied for failure to precert.
	Mental/Behavioral health inpatient services	$200 copayment per admission.	$350 copayment per admission.	No deductible. Precertification required. $500 penalty when you fail to precert.
	Substance use disorder outpatient services	15% coinsurance	30% coinsurance	Precertification required for certain outpatient services. Benefits may be reduced or denied for failure to precert.
	Substance use disorder inpatient services	$200 copayment per admission.	$350 copayment per admission and 30% coinsurance	No deductible. Precertification required. $500 penalty when you fail to precert.
If you are pregnant	Prenatal and postnatal care	No charge	30% coinsurance	No deductible when services are rendered by a 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/visit	30% coinsurance	Limited to combined 75 visits per year. No deductible when services are rendered by a PPO provider.
	Habilitation services	$20/visit	30% coinsurance	
	Skilled nursing care	$0	$0	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 – lifetime maximum payment of $3000.
If your child needs dental or eye care	Eye exam	$20/visit	30% coinsurance	No deductible when services are rendered by a PPO provider.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider (plus you may be balance billed)	Limitations & Exceptions
	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 this plan's FEHB 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
- Long-term care
- Routine eye care

Other Covered Services (This isn't a complete list. Check this plan's FEHB 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 U.S.
- Private duty nursing
- Routine foot care
- Weight loss programs

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, to convert to an individual policy, and to receive temporary continuation of coverage (TCC). Your TCC rights will 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. An individual policy may also provide different benefits than you had 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, see the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at 1-888-636-6252 or visit www.opm.gov/insure/health.

Your Appeal 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 at 1-888-636-6252.

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." **Coverage under this plan qualifies as 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). **The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.**

Language Access Services:

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

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-636-6252.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-888-636-6252.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-636-6252.

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	$660
Coinsurance	$0
Limits or exclusions	$0
Total	**$960**

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.

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