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 ([insert brochure number]) 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.[insert].com, and view the Glossary at www.[insert].com. You can call 1-800-[insert] to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$300 /Self Only $600 /Self Plus One $600/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. **[For family coverage, see instructions for additional applicable language.]**
Are there services covered before you meet your deductible?	Yes. Services rendered by a PPO provider for: Office visits, Preventive care, limited Maternity care, Family planning, PT, OT & ST, Surgeries, Inpatient admissions, Accidental injuries, ABA therapy, telehealth, and prescription medications.	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 non-grandfathered plans insert**: "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 must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$3500/PPO Self only $5000/PPO Self plus one $5000/PPO Self and family $7000 per person or family for PPO and non-PPO providers/facilities combined. $3100 for Self only and $4000 for Self plus one and Self and family for prescription drugs purchased	The out-of-pocket limit, or catastrophic maximum, is the most you could pay in a year for covered services. **[For family coverage, see instructions for additional applicable language.]**

	at a network retail pharmacy or by mail order.	
What is not included in the out-of-pocket limit?	Premiums, balance-billed amounts, health care this Plan does not cover, amounts you pay for non-compliance with the Plan's cost containment requirements.	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 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	No deductible when services are rendered by a PPO provider.
	Specialist visit	$20/visit	30% coinsurance	No deductible when services are rendered by a PPO provider.
	Preventive care/screening/ immunization	No Charge	30% coinsurance	No deductible for in-network.
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	Precertification required. Failure to precert may result in denial of benefits.

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 drugs to treat your illness or condition More information about prescription drug coverage is available at www.[insert].com	Generic drugs	Network retail: 20% coinsurance (10% for hypertension, diabetes, asthma) Mail order: $15/90-day supply ($8 for hypertension, diabetes, 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, certain opioids, 510K dermatological products and artificial saliva require prior authorization.
	Preferred brand drugs	Network retail: 30% coinsurance. Mail order: $90/90-day supply ($50 for hypertension, diabetes, asthma).	50% coinsurance	
	Non-preferred brand drugs	Network retail: 50% coinsurance. Mail order: $125/90-day supply ($70 for hypertension, diabetes, asthma).	50% coinsurance	
	Specialty drugs	$200/30-day supply $300/60-day supply $400/90-day supply	Not covered	Prior approval required. Failure to obtain prior approval may result in a denial of benefits.
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 authorization is required for spinal, gender reassignment surgery, and organ/tissue transplants.
If you need immediate medical attention	Emergency room care	15% coinsurance	15% coinsurance	
	Emergency medical transportation	15% coinsurance	30% coinsurance	Coinsurance does not apply to services received within 72 hours of an accidental injury as defined by the brochure.
	Urgent care	$20 copayment	30% 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)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$350 copayment per admission	$450 copayment per admission and 35% coinsurance	No deductible. Precertification required. $500 penalty for failure to precert.
	Physician/surgeon fees	15% coinsurance	30% coinsurance	Prior authorization is required for spinal and gender reassignment surgery and organ/tissue transplants.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% coinsurance	30% coinsurance	Certain outpatient services require prior authorization.
	Inpatient services	$350 copayment per admission	$450 copayment per admission and 35% coinsurance	No deductible. Precertification required. $500 penalty for failure to precert.
If you are pregnant	Office visits	No charge	30% coinsurance	
	Childbirth/delivery professional services	No charge	30% coinsurance	
	Childbirth/delivery facility services	No charge	$450 copayment per admission and 35% 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 per visit	30% coinsurance	Limited to combined 75 visits per year
	Habilitation services	$20 per visit	30% coinsurance	
	Skilled nursing care	Not covered	Not covered	Limited benefit to individuals who have Medicare A as their primary payor
	Durable medical equipment	15% coinsurance	30% coinsurance	Prior approval required
	Hospice services	15% coinsurance	30% coinsurance	Limited to 30 days annually for inpatient/outpatient hospice
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	15% coinsurance	30% 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 FEHB Plan brochure for more information and a list of any other excluded services.)

- Cosmetic surgery (except for repair from an accidental injury, correction of a congenital anomaly or breast reconstruction following mastectomy)
- Dental care
- Long-term care
- Routine eye care

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

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Educational classes and programs
- Gene therapy
- Telehealth
- Orthopedic and prosthetic devices
- Routine foot care
- Weight loss program

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 [contact number] 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 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 1-800-318-2596.

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 FEHB Plan brochure. If you need assistance, you can contact: : NALC Health Benefit Plan at 888-636-6252.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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 888-636-6252.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888-636-6252.
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 888-636-6252.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 888-636-6252.

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 *[cost sharing]*** $20
- **Hospital (facility) *[cost sharing]*** 0%
- **Other *[cost sharing]*** %

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	$4
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$4**

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

- **The plan's overall deductible** $
- **Specialist *[cost sharing]*** $
- **Hospital (facility) *[cost sharing]*** %
- **Other *[cost sharing]*** %

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$430.00
Coinsurance	$424.00
What isn't covered	
Limits or exclusions	$4
The total Joe would pay is	**$860**

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

- **The plan's overall deductible** $
- **Specialist *[cost sharing]*** $
- **Hospital (facility) *[cost sharing]*** %
- **Other *[cost sharing]*** %

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$63
Copayments	$100
Coinsurance	$38
What isn't covered	
Limits or exclusions	$
The total Mia would pay is	**$200**

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