




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: |
|--|--|---|
| <p>What is the overall <u>deductible</u>?</p> | <p>\$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</p> | <p>Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> 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 <u>plan</u>, each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u>.</p> |
| <p>Are there services covered before you meet your <u>deductible</u>?</p> | <p>Yes. Services rendered by an In-Network provider for Preventive Care.</p> | <p>This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. "For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u>. See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/.</p> |
| <p>Are there other <u>deductibles</u> for specific services?</p> | <p>No.</p> | <p>You don't have to meet <u>deductibles</u> for specific services.</p> |
| <p>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</p> | <p>\$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</p> | <p>The <u>out-of-pocket limit</u>, or catastrophic maximum, is the most you could pay in a year for covered services.</p> |
| <p>What is not included in the <u>out-of-pocket limit</u>?</p> | <p>Premiums, balance-billed amounts, health care this Plan does not cover, amounts you pay for</p> | <p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p> |



| | | |
|--|---|---|
| | non-compliance with the Plan's cost containment requirement. | |
| Will you pay less if you use a <u>network provider</u>? | Yes. See www.mycigna.com or call 855-511-1893 for a list of <u>network providers</u> . | This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a provider in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u>? | No. | You can see the <u>specialist</u> you choose without a <u>referral</u> . |

 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 <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | 20% coinsurance | 50% coinsurance | |
| | <u>Specialist</u> visit | 20% coinsurance | 50% coinsurance | The deductible does not apply to Preventive care rendered by an In-Network provider. |
| | <u>Preventive care/screening/immunization</u> | No charge | 50% coinsurance | The deductible does not apply to Preventive care rendered by an In-Network provider. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | 20% coinsurance | 50% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 50% 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.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 certain opioids, 510K dermatological products and artificial saliva require prior authorization. |
| | Preferred brand drugs | Network retail: up to 30-day supply 40* Mail order: 90-day supply \$90 (\$70 for hypertension, diabetes and asthma)* | 50% coinsurance | |
| | Non-preferred brand drugs | Network retail: up to 30-day supply \$60* Mail order: 90-day supply \$125 (\$110 for hypertension, diabetes and asthma)* | 50% coinsurance | |
| | <u>Specialty drugs</u> | 30-day supply \$200* 90-day supply \$400* | Not covered | |
| 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, gender reassignment surgery and organ/tissue transplants. |
| If you need immediate medical attention | Emergency room care | 20% coinsurance | 20% coinsurance | None |
| | <u>Emergency medical transportation</u> | 20% coinsurance | 20% coinsurance | |
| | <u>Urgent care</u> | 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, gender reassignment surgery and organ/tissue transplants.. |

| 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 mental health, behavioral health, or substance abuse services | Outpatient services | 20% coinsurance | 50% coinsurance | Certain outpatient services require prior authorization. |
| | 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 | |
| | Childbirth/delivery facility services | 20% coinsurance | 50% coinsurance | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 20% coinsurance | 50% coinsurance | Limited to 2 hours per day up to 25 days per calendar year. |
| | <u>Rehabilitation services</u> | 20% coinsurance | 50% coinsurance | Limited to combined 50 visits per year. |
| | <u>Habilitation services</u> | 20% coinsurance | 50% coinsurance | |
| | <u>Skilled nursing care</u> | Not Covered | Not Covered | |
| | <u>Durable medical equipment</u> | 20% coinsurance | 50% coinsurance | Prior approval required. |
| | <u>Hospice services</u> | Not Covered | Not Covered | |
| If your child needs dental or eye care | Children's eye exam | No Charge | 50% coinsurance | Limited vision screening as recommended by Bright Futures/AAP |
| | Children's glasses | 20% coinsurance | 50% coinsurance | Limited-one pair after ocular injury or intraocular surgery |
| | Children's dental check-up | Not Covered | Not Covered | None |

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 <u>excluded services</u> .) | | |
|---|---|--|
| <ul style="list-style-type: none"> Cosmetic surgery (except for repair of accidental injury initiated within 6 months of accident, correction of congenital anomaly or breast reconstruction following mastectomy) | <ul style="list-style-type: none"> Dental care Hospice Care Long-term care | <ul style="list-style-type: none"> 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
- Educational classes and programs
- Orthopedic and prosthetic devices
- Routine foot care
- 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 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, kwijigo 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:

| <i>Cost Sharing</i> | |
|-----------------------------------|---------------|
| Deductibles | \$1900 |
| Copayments | \$20 |
| Coinsurance | \$2110 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$10 |
| The total Peg would pay is | \$4040 |

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|---------------|
| Deductibles | \$1900 |
| Copayments | \$1090 |
| Coinsurance | \$80 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$3070 |

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|---------------|
| Deductibles | \$1830 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1830 |