The NALC Health Benefit Plan High Option

2020 Benefits At-A-Glance - Certain deductibles, copayments and coinsurance amounts do not apply if Medicare is your primary coverage (pays first) for medical services.

BENEFIT	YOU PAY PPO	YOU PAY Non-PPO
Preventive Care		
Annual Routine Physical Exam, age 3 or older	Nothing	30% after $300 deductible*
Adult Routine Immunizations & Tests	Nothing	30% after $300 deductible*
Well Child Care (through age 2)	Nothing	30% after $300 deductible*
Routine Immunizations (through age 21)	Nothing	30% after $300 deductible*
Inpatient Hospital Care (precertification required)		
Maternity	Nothing	35% after $450 per admission copay*
Medical/Surgery		
Room, Board & Other Services & Supplies	$350 copayment per admission	35% after $450 per admission copay*
Mental Health/Substance Use Disorder		
Room, Board & Other Services & Supplies	$350 copayment per admission	35% after $450 per admission copay*
Outpatient Hospital		
Medical/Surgical	15% after $300 deductible	35% after $300 deductible*
Emergency Medical	15% after $300 deductible	15% after $300 deductible*
Observation Room	$350 copayment	35% after $300 deductible*
Chiropractic Care		
Initial office visit and subsequent office visits when rendered same day as a manipulation	$20 copayment	30% after $300 deductible*
Manipulations (24 per calendar year)	$20 copayment	30% after $300 deductible*
One set of spinal x-rays annually	15% after $300 deductible	30% after $300 deductible*
Physician Care		
Office visits	$20 copayment per visit	30% after $300 deductible*
Telehealth virtual vist	$10 copayment per visit	All charges
X-rays, other diagnostic services	15% after $300 deductible	30% after $300 deductible*
Laboratory Services		
LabCorp or Quest Diagnostics	Nothing	
Other lab facility	15% after $300 deductible	30% after $300 deductible*
Maternity Care (complete)	Nothing	30% after $300 deductible*
Accidental Injury	Nothing within 72 hours	Any amount over the Plan allowance within 72 hours
Surgery	15%	30% after $300 deductible*
Mental Health and Substance Use Disorder		
Office visit	$20 copayment per visit	30% after $300 deductible*
Telemental visit	$10 copayment per visit	30% after $300 deductible*
Other diagnostic services	15% after $300 deductible	30% after $300 deductible*
LabCorp or Quest Diagnostics	Nothing	
Other lab facility	15% after $300 deductible	30% after $300 deductible*
Dental		
Accidental dental injury (to a sound natural tooth)	15% within 72 hours	30% after $300 deductible within 72 hours*

Prescription Drugs	**Network**	**Non-Network**
Retail Pharmacy *1st and 2nd fill* *There is a 30-day plus one refill limit at local retail.*	**20%** of generic cost (**10%** of cost for asthma, diabetes, & hypertension) **30%** of Formulary brand cost / **50%** of Non-formulary brand cost	Full cost at time of purchase - **50%***
Mail Order Program		
60-day supply	**$10** generic / **$60** Formulary brand / **$84** Non-formulary brand	
90-day supply	**$5** NALCSelect generic / **$7.99** NALCPreferred generic / **$15** generic / **$90** Formulary brand / **$125** Non-formulary brand (**$8** generic / **$50** Formulary brand / **$70** Non-formulary brand for asthma, diabetes & hypertension)	
Specialty Drugs Mail Order	**$200** 30-day supply / **$300** 60-day supply / **$400** 90-day supply	

A generic equivalent will be dispensed if it is available, unless your physician specifically requires a brand name.
Note: You may purchase up to a 90-day supply (84-day minimum) of covered drugs and supplies at a CVS Caremark® Pharmacy or Longs Drugs through our Maintenance Choice Program. You will pay the applicable mail order copayment for each prescription purchased.

Catastrophic Limits	
Medical/Surgical/Mental Health & Substance Use Disorder	You pay nothing after coinsurance expenses total: $3,500 per person or $5,000 per family for services of PPO providers/facilities $7,000 per person or family for services of PPO/Non-PPO providers/facilities combined
Prescription	After coinsurance amounts for prescription drugs purchased at a network retail pharmacy and mail order copayment amounts including specialty drugs total $3,100 per person or $4,000 per family, network retail coinsurance amounts and specialty drug mail order copayment amounts are waived for the remainder of the calendar year.

**In addition, you are responsible for the difference, if any, between the Plan allowance and the billed amount.*

This is a summary of some of the features of the NALC Health Benefit Plan High Option. Detailed information on the benefits for the 2020 NALC Health Benefit Plan can be found in the official brochure (RI 71-009). All benefits are subject to the definitions, limitations, and exclusions set forth in the official brochure.