

The NALC Health Benefit Plan

2008 Benefits At-A-Glance - Certain deductibles, copayments and coinsurance amounts do not apply if Medicare is your primary coverage for medical services (pays first).

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BENEFIT	YOU PAY	
	PPO	Non-PPO
Preventative Care		
Routine Physical Exam, age 22 or older	\$20 copayment	30% after \$300 deductible
Well Child Care (up to age 2)	Nothing	Any amount over Plan allowance
Routine Immunizations (up to age 22)	Nothing	Any amount over Plan allowance
Adult Routine Immunizations	15% after \$250 deductible	30% after \$300 deductible
Inpatient Hospital Care (precertification required)		
Maternity	Nothing	30% after \$100 per admission copay
Medical/Surgery		
Room and Board	Nothing	30% after \$100 per admission copay
Other Services and Supplies	10%	30% after \$100 per admission copay
Mental Health/Substance Abuse		
Room and Board	Nothing	50% after \$500 per admission copay all charges after 50 days maximum
Other Services and Supplies	10%	50% after \$500 per admission copay all charges after 50 days maximum
Outpatient Hospital		
Medical/Surgical	15% after \$250 deductible	30% after \$300 deductible
Emergency (auto accident, acute myocardial infarction & concussion)	15% after \$250 deductible	15% after \$250 deductible
Chiropractic Care		
Initial office visit	\$20 copayment	30% after \$300 deductible
Initial set of spinal x-rays	15% after \$250 deductible	30% after \$300 deductible
Spinal manipulations (12 per calendar year)	15% after \$250 deductible	30% after \$300 deductible
Physician Care		
Office visits	\$20 copayment per visit	30% after \$300 deductible
X-rays, other diagnostic services	15% after \$250 deductible	30% after \$300 deductible
Laboratory Services		
Quest Diagnostics	Nothing	30% after \$300 deductible
Other lab facility	15% after \$250 deductible	30% after \$300 deductible
Maternity Care (complete)	Nothing	30% after \$300 deductible
Accidental Injury (non-surgical care)	Nothing within 72 hours	Any amount over the Plan allowance
Surgery	10%	30% after \$300 deductible
Mental Health and Substance Abuse		
Office visit	\$20 copayment	50% after \$300 deductible
Other diagnostic services	15% after \$250 deductible	All charges after 30 visits
Prescription Drugs		
<i>This is a mandatory generic program with a 30-day limit at local retail</i>		
	Network	Non-Network
Retail Pharmacy	1st and 2nd fill 25% of cost	Full Cost at time of purchase 50% after \$25 deductible
Mail Order Program		
60-day supply	\$8 generic/\$24 brand name	
90-day supply	\$12 generic/\$35 brand name	
Catastrophic Limits		
Medical/Surgical	You pay nothing after coinsurance expenses total: \$4,000 per person or family for services of PPO providers/facilities* \$6,000 per person or family PPO/non-PPO providers/facilities combined*	
Mental Health and Substance Abuse	You pay nothing after coinsurance expenses total: \$4,000 per person or family for Network services/facilities* \$8,000 per person or family for non-network inpatient hospital treatment (to a maximum of 50 days)	

* Your coinsurance expenses for inpatient services billed by a network hospital facility will never exceed \$2,000.