NATIONAL ASSOCIATION OF LETTER CARRIERS
HEALTH BENEFIT PLAN FOR EMPLOYEES AND STAFF

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SUMMARY OF MATERIAL MODIFICATIONS FOR YEAR 2015

This notice summarizes the modifications to the NALC Health Benefit Plan for Employees and Staff (Staff Plan) effective January 1, 2015. This information supplements the information contained in the 2012 NALC Health Benefit Plan for Employees and Staff brochure and subsequent or summaries of material modifications. Refer to the appropriate sections in the brochure as specified below for our benefit changes. Please share this summary with your family and keep it with your Staff Plan documents for future reference.

Enclosed with this notice is the NALC Health Benefit Plan for Employees and Staff's Summary of Benefits and Coverage (SBC) for the period January 1, 2015 through December 31, 2015, as required by the Affordable Care Act. This document summarizes the benefits under the Staff Plan and is intended to help you compare this Plan's benefits to those of other plans. Please note that we are required to use certain uniform terms and other language prescribed by the Affordable Care Act and applicable regulations in the SBC, and some of the terms, definitions and other language may differ from what is set forth in the Staff Plan brochure. Please refer to the 2012 Staff Plan brochure and the 2013, 2014 addendum for a complete description of your Staff Plan benefits.

General Information

Open Enrollment this year is from December 1, 2014 through December 31, 2014. Any changes in your enrollment will be effective January 1, 2015.

Our Plan meets the requirements under the Women's Health and Cancer Rights Act of 1998 (WHCRA) by providing benefits for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

Please contact the Nongroup Department at 703-729-4677 or 1-888-636-NALC (6252) with any questions concerning mastectomy-related benefits.

Modifications

The modifications, effective as of January 1, 2015, are as follows:

1. This Plan provides benefits for the services of covered professional providers, as required by Section 2706(a) of the Public Health Service Act (PHSA). Covered professional providers are medical practitioners who perform covered services when acting within the scope of their license or certification under applicable state law and who furnish, bill, or are paid for their health care

services in the normal course of business. Covered services must be provided in the state in which the practitioner is licensed or certified.

2. We now require prior authorization for spinal surgeries performed in an inpatient or outpatient setting. You must call 1-877-220-6252 for prior authorization. See Section 3. *How you get care*.

3. We now cover three doses of Haemophilus influenza type b (Hib) vaccine for adults age 19 and older with medical indications as recommended by the Center for Disease Control and Prevention (CDC). Previously, we covered one dose. You pay nothing if services are rendered by a PPO provider. When services are rendered by a non-PPO provider, you pay 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount after satisfaction of the $300 calendar year deductible. See Section 5(a). *Preventive care, adult*.

4. We now cover routine alcohol and drug abuse screening for adults age 22 and older. You pay nothing if services are rendered by a PPO provider. When services are rendered by a non-PPO provider, you pay 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount after satisfaction of the $300 calendar year deductible. See Section 5(a). *Preventive care, adult*.

5. We now cover routine Hepatitis C virus infection screening for adults born between 1945 and 1965 and adults at high risk for infection as recommended by the U.S. Preventive Services Task Force (USPSTF). You pay nothing if services are rendered by a PPO provider. When services are rendered by a non-PPO provider, you pay 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount after satisfaction of the $300 calendar year deductible. See Section 5(a). *Preventive care, adult*.

6. We now cover an annual routine lung cancer screening with low-dose Computerized Tomography (LDCT scan) for adults age 55 through age 80 who have smoking history as recommended by the U.S. Preventive Services Task Force (USPSTF). You pay nothing if services are rendered by a PPO provider. When services are rendered by a non-PPO provider, you pay 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount after satisfaction of the $300 calendar year deductible. See Section 5(a). *Preventive care, adult*.

7. We no longer cover routine double contrast barium enema (DCBE) for adults. Previously, we covered one every five years. See Section 5(a). *Preventive care, adult*.

8. We now cover routine Human Immunodeficiency Virus (HIV) screening for adults age 65 and younger and for children age 15 and older as recommended by the U.S. Preventive Services Task Force (USPSTF). Previously, we covered one annually. See Section 5(a). *Preventive care, adult* and Section 5(a). *Preventive care, children.*

9. We now cover routine pap tests for females age 21 through age 65, one every three years as recommended by the U.S. Preventive Services Task Force (USPSTF). Previously, we covered an annual routine pap test without an age limitation. See Section 5(a). *Preventive care, adult*.

10. We now cover a routine Human papillomavirus test for women age 30 through age 65, one every three years as recommended by the U.S. Preventive Services Task Force (USPSTF). Previously, we covered one annually for women age 30 and older. See Section 5(a). *Preventive care, adult*.

11. We no longer cover routine prostate specific antigen (PSA) test for adult men. Previously, we covered one annually. See Section 5(a). *Preventive care, adult*.

12. We now cover one routine fasting lipoprotein profile screening for children age 9 through age 11. You pay nothing if services are rendered by a PPO provider. When services are rendered by a non-PPO provider, you pay 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount after satisfaction of the $300 calendar year deductible. See Section 5(a). *Preventive care, children*.

13. We now cover alcohol abuse preventive medicine counseling for children age 18 through age 21. You pay nothing if services are rendered by a PPO provider. When services are rendered by a non-PPO provider, you pay 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount after satisfaction of the $300 calendar year deductible. See Section 5(a). *Preventive care, children*.

14. We now cover routine Human Immunodeficiency Virus (HIV) screening for pregnant women. You pay nothing if services are rendered by a PPO provider. When services are rendered by a non-PPO provider, you pay 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount after satisfaction of the $300 calendar year deductible. See Section 5(a). *Maternity care*.

15. We now cover autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis. You pay 15% of the Plan allowance for services obtained through the Cigna LifeSOURCE Transplant Network®. You pay 15% of the Plan allowance if services are rendered by a PPO provider. When services are rendered by a non-PPO provider, you pay 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount after satisfaction of the $300 calendar year deductible. See Section 5(b). *Organ/tissue transplants*.

16. We now cover isolated small intestine transplant. You pay 15% of the Plan allowance for services obtained through the Cigna LifeSOURCE Transplant Network®. You pay 15% of the Plan allowance if services are rendered by a PPO provider. When services are rendered by a non-PPO provider, you pay 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount after satisfaction of the $300 calendar year deductible. See Section 5(b). *Organ/tissue transplants*.

17. We now pay the Plan allowance for non-PPO ambulance transportation to the nearest PPO facility at the PPO benefit level. See Section 5(c). *Services provided by a hospital or other facility, and ambulance services*.

18. We now utilize a step therapy program for certain specialty medications. See Section 5(f). *Prescription drug benefits*.

    The Plan's Specialty Preferred Drug Program utilizes step therapy for certain specialty medications. We require preferred specialty drugs be used before non-preferred specialty drugs are covered. Our Specialty Preferred Drug Program focuses on biologic therapy classes that have multiple products with prescribing interchangeability based on safety and clinical efficacy. The only classes included in the step therapy program are: human growth hormone, Crohn's disease, multiple sclerosis, rheumatoid arthritis, and psoriasis.

    Step therapy uses evidence-based protocols that require first line preferred specialty drugs to be used before non-preferred specialty drugs are covered.

Call Caremark Specialty Pharmacy Services at 1-800-237-2767 to obtain prior approval.

19. We now cover Tamoxifen and Raloxifene for risk reduction of primary breast cancer for women who are at increased risk for breast cancer as recommended by the U.S. Preventive Services Task Force (USPSTF). You pay nothing when you purchase at a Preferred Network, Network retail pharmacy or mail order pharmacy. See Section 5(f). *Prescription drug benefits*.

    Note: Call us at (703) 729-4677 or 1-888-636-NALC (6252) prior to purchasing this medication at a local NALC Preferred network, Network retail or mail order pharmacy.

20. All mail order copayments now count toward your prescription drug out-of-pocket maximum amount. Previously, only specialty drug copayments counted toward your prescription drug out-of-pocket maximum amount. See Section 4. *Your costs for covered services*.

21. Your catastrophic protection out-of-pocket maximum for PPO providers/facilities is $3,500 per person or $5,000 per family. Your out-of-pocket maximum for prescriptions drugs dispensed by an NALC Preferred network pharmacy, NALC CareSelect network pharmacy and Caremark mail order pharmacy is $3,100 per person or $4,000 per family. Previously, your PPO out-of-pocket maximum amount was $5,000 per person or family and the prescription drug out-of-pocket maximum was $4,000 per person or family. See Section 4. *Your costs for covered services*.

22. We now pay the Plan allowance for covered laboratory services billed by non-PPO providers at the PPO benefit level when the services are rendered at a PPO hospital or PPO ambulatory surgical center. Previously, you paid 30%. See Section 5(a). *Important things you should keep in mind about these benefits*.

23. You now pay $200 copayment for outpatient observation room and related services in a PPO hospital. Previously, you paid 15% of the Plan allowance after satisfaction of the $300 calendar year deductible. When services are rendered at a non-PPO hospital, you pay 35% of the Plan allowance and the difference, if any, between our allowance and the billed amount after satisfaction of the $300 calendar year deductible. See Section 5(c). *Outpatient hospital or ambulatory surgical center*.

24. We clarified that other “non-routine” services require prior authorization and that you do not need to obtain an approved treatment plan for the mental health and substance abuse services. See Section 5(e). *Mental health and substance abuse benefits*.

    YOU MUST GET PREAUTHORIZATION FOR THE FOLLOWING OUTPATIENT SERVICES: Intensive outpatient program treatment, outpatient electro-convulsive treatment, psychological testing, methadone maintenance, and outpatient treatment visits beyond 45-50 minutes in duration with or without medication management. Benefits are payable only when we determine the care is clinically appropriate to treat your condition. To be eligible to receive full benefits, you must follow the preauthorization process.

25. We clarified that claims for overseas services must include an English translation and the charges must be converted to U.S. dollars using the exchange rate at the time the expenses were incurred. See Section 7. *Filing a claim for covered services*.

26. We clarified our subrogation/reimbursement guidelines. See Section 9. *Coordinating benefits with other coverage*.

Subrogation/Reimbursement guidelines: If we pay benefits for an illness or injury for which you or your dependent are compensated or reimbursed by a third party, or if your illness is otherwise caused by the act or omission of a third party, the Plan has the right to reimbursement of benefits paid by the Plan on your behalf from any recovery made to you by a third party or third party's insurer. "Third party" means another person or entity. Our right to reimbursement is limited to the benefits we have paid or will pay to you or on your behalf related to the illness or injury. You must notify us promptly if you are seeking a recovery from a third party (whether in court or otherwise) because of an illness or injury you or your dependent suffered related to the act or omission of another person. Further, you or your legal representative must keep the Plan advised of developments in your claim and promptly notify us of any recovery you receive, whether in or out of court. You must reimburse us to the full extent the Plan paid benefits, unless we agree to a reduction in writing. If you receive any recovery, you or your legal representative agree to hold any funds you receive in trust until you have confirmed the amount that we are owed and make arrangements to reimburse us. You have the right to retain any recovery that exceeds the amount of the Plan's subrogation/reimbursement claim.

All benefits paid by the Plan related to an illness or injury caused by the act or omission of a third party, or otherwise covered by this provision, are paid on the condition that you comply with the requirements of this provision, and payment of benefits is limited by this provision. By accepting Plan benefits, you agree to the terms of this provision. We will pay benefits for your illness or injury provided you do not interfere with or take any action to prejudice our attempts to recover the amounts we have paid in benefits, and that you cooperate with us in obtaining reimbursement. You must include all benefits paid by the Plan related to the injury or illness in your claim for recovery. You can contact us to find out the amount of benefits paid.

If you do not seek damages from the third party, you must agree to let us seek damages on your behalf. This is referred to as "subrogation". We may require you to assign the proceeds of your claim or the right to take action against the third party in your name, and we may withhold payment of benefits until the assignment is provided. You must sign our subrogation/reimbursement agreement and provide us with any other relevant information about the claim if we ask you to do so. However, a subrogation/reimbursement agreement is not necessary to enforce the Plan's rights.

All payments from the third party must be used to reimburse the Plan for benefits paid, regardless of whether the recovery is by court order or by settlement, and regardless of how the recovery is characterized (i.e., pain and suffering). The Plan has the right of first reimbursement for the full amount of our claim from any recovery you receive, even if your total recovery does not fully compensate you for the full amount of damages claimed. In other words, unless we agree in writing to a reduction, you are required to reimburse the Plan in full for its claim even if you are not "made whole" for your loss. In addition, the Plan's claim is not subject to reduction for attorney's fees or costs under the "common fund" doctrine or otherwise. Any reduction of the Plan's claim for attorney's fees or costs related to the claim is subject to prior written approval by the Plan.

We may reduce subsequent benefit payments to you or your dependents if we are not reimbursed for the benefits we paid pursuant to these subrogation/reimbursement guidelines.

27. We clarified that we will exclude and request an itemized bill when a non-PPO hospital bills a flat rate. See Section 5(c). *Services provided by a hospital or other facility, and ambulance services.*

28. We updated the phone number for our disease management program through Alere Health Management. The phone number is 1-866-956-6252. See Section 5(h*). Special features.*

29. We updated the name of Solutions for Caregivers program. Previously, the program was called Enhanced Eldercare Services. See Section 5(h). *Special features*.

30. We clarified the hours a dedicated coach is available for our Weight Talk Program. A personal dedicated coach is available Sunday through Friday 8:00 a.m. through 3:00 a.m. and Saturday 9:00 a.m. through 12:00 a.m. Eastern time. See Section 5(h). *Special features*.

31. The COBRA Continuation Coverage information contained in pages 98-102 of Section 11. *COBRA Continuation Coverage* is replaced with the following:

    This section has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

    The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator. The Plan Administrator is Fredric V. Rolando, National Association of Letter Carriers, 100 Indiana Avenue, N.W., Washington, DC 20001, phone number (202) 393-4695. COBRA continuation coverage for the Plan is administered by the Assistant Administrator, NALC Health Benefit Plan for Employees and Staff, P.O. Box 678, Ashburn, VA 20146, phone number (703) 729-4677 or 1-888-636-NALC (6252).

    You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

    What is COBRA continuation coverage?

    COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're a participant, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- your hours of employment are reduced, or
- your employment ends for any reason other than your gross misconduct.

If you're the spouse of a participant, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- your spouse dies;**
- your spouse's hours of employment are reduced;
- your spouse's employment ends for any reason other than his or her gross misconduct;
- your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- you become divorced from your spouse.

**Supplemental continued coverage may be available in lieu of COBRA for a surviving spouse and/or dependent(s) upon the employee's death. See Section 10. *Eligibility – What happens if my enrollment in this Plan or my spouse's and/or dependent's eligibility ends?*

Your children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- the parent-participant dies;
- the parent-participant's hours of employment are reduced;
- the parent-participant's employment ends for any reason other than his or her gross misconduct;
- the parent-participant becomes entitled to Medicare benefits (Part A, Part B, or both);
- the parents become divorced; or
- the child ceases to be an eligible dependent (e.g., due to reaching the age limitation) See Section 10. *Eligibility*.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- the end of your employment or reduction of your hours of employment resulting in a loss of coverage;
- your death; or
- You becoming entitled to Medicare benefits (under Part A, Part B, or both)

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Assistant Administrator within 60 days after the qualifying event occurs. You must provide this notice in writing to the Assistant Administrator, NALC Health Benefit Plan for Employees and Staff, P.O. Box 678, Ashburn, VA 20146. The notice must identify the qualifying event, the date on which it occurred and the name(s) of the covered individual(s) whose coverage under the Plan will be lost due to the qualifying event. If the qualifying event is a divorce, you must include with your notice a copy of the divorce decree.

IF YOU DO NOT PROVIDE TIMELY NOTIFICATION OF QUALIFYING EVENTS AS SET FORTH ABOVE, YOU AND YOUR ELIGIBLE DEPENDENTS WILL NOT BE PERMITTED TO ELECT COBRA CONTINUATION COVERAGE AND YOU WILL BE RESPONSIBLE FOR REIMBURSEMENT TO THE PLAN FOR ANY CLAIMS PAID ON YOU OR YOUR DEPENDENTS' BEHALF DURING THE PERIOD IN WHICH YOUR ELIGIBILITY FOR COVERAGE UNDER THIS PLAN SHOULD HAVE TERMINATED.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each qualified beneficiary who elects COBRA continuation coverage, such coverage will commence as of: (1) the date of the employee's death, when death of the employee is the reason for the qualifying event, or (2) 31 days after the date of the qualifying event, for all other qualifying events.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which the 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Assistant Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must provide the Plan a copy of your determination letter from the Social Security Administration before the 18-month period of COBRA coverage expires. Send the letter to the Assistant Administrator, NALC Health Benefit Plan for Employees and Staff, P.O. Box 678, Ashburn, VA 20146. The extension period will end at the earlier of the end of 29 months or when the disabled person becomes entitled to Medicare.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying

event not occurred. You must notify the Plan in writing within 60 days after a second qualifying event occurs if you want to extend your COBRA continuation coverage. You must provide this notice in writing to the Assistant Administrator, NALC Health Benefit Plan for Employees and Staff, P.O. Box 678, Ashburn, VA 20146. If the second qualifying event is a divorce, you must include a copy of the divorce decree.

Addition of new dependents while enrolled in COBRA

If, while an Employee is enrolled in COBRA continuation coverage, a child is born to or placed for adoption with an Employee, the child may be enrolled for coverage for the balance of the period of your COBRA coverage period available to other Qualified beneficiaries with respect to the same Qualifying event. In order to add a new dependent, you must notify the Plan within 30 days after the birth or placement. You must provide the Plan with documentation supporting addition of the child. Adding a child may cause an increase in the amount you must pay for COBRA coverage if you are not already paying for family coverage. In the case of a birth, adoption, or placement for adoption for your new child, the Plan coverage for your child will be effective on the date of the birth, adoption, or placement for adoption.

Premium Payments

When you, your spouse, or your eligible dependents become eligible to receive COBRA continuation coverage, you will be advised of the premium charge for such coverage.

The COBRA premium charge is 102% of the cost of coverage. Any individual who receives COBRA coverage for an additional eleven (11) months due to a disability as determined by the Social Security Administration (as set forth above) must pay 150% of the cost of coverage during the 11-month disability extension period. The monthly premium is subject to change. You will be notified by the Plan if your premium amount changes.

Once continuation coverage is elected, premium payments must be made on time for the duration of the continuation period in order to keep the coverage in effect. You are required to pay the initial premium within 45 days of returning your Election form, and you must include retroactive payment for all months between your loss of coverage date and your payment. No claims incurred during this period will be processed or paid before the initial premium is received. Once the premium is received, claims incurred from the Qualifying event will be processed. All subsequent payments after the initial payment will be due on the first day of the month for that month's coverage. For example, premiums for the month of November must be paid on or before November 1.

There is a 30-day grace period for all payments after the initial payment (for example, the end of the grace period for payment for coverage in the month of May is May 31). If you have a claim during a month for which you have not paid your premium, the claim will not be paid until after the Plan receives your payment for the month. If COBRA premium payments are not timely made, COBRA continuation coverage will terminate and will not be reinstated.

Please note that the Plan does send bills for COBRA coverage and that it is your responsibility to make COBRA payments on time. You are required to pay your premiums regardless of whether you receive a bill from the Plan. If you do not make your payments on time, your coverage will end and cannot be reinstated.

Termination of COBRA continuation coverage

In addition to the expiration of the 18, 29, or 36-month periods, continuation coverage may be terminated for any of the following reasons:

- Timely premium payment has not been made
- You, your spouse, or dependents become covered under another health plan (as an employee or other insurer)
- You, your spouse, or dependent obtained an extension of COBRA coverage based upon a disability determination from Social Security, but are no longer disabled. You must advise the Plan within 30 days of the determination that you are no longer disabled
- The Plan no longer provides group health coverage to any employees
- You, your spouse, or dependent first becomes, after electing COBRA coverage, entitled to Medicare (Part A, Part B, or both) (COBRA coverage will terminate for the Medicare-eligible person only)
- Your Employer withdraws from this Plan but continues to cover a classification of employees under another group health plan (in this case, you may be transferred to such other group health plan)
- Any other reason that would warrant termination of eligibility of an active participant (i.e., fraud)

ONCE COBRA COVERAGE IS TERMINATED, IT CANNOT BE REINSTATED.

Changes in persons covered

Once a Qualified beneficiary (i.e., former covered Employee or former covered dependent) is receiving COBRA continuation coverage, the Qualified beneficiary has the same right to enroll under that COBRA coverage dependents who lose other health insurance coverage or newly acquired dependents under the Plan's Special Enrollment rules (See Section 10. *Eligibility-Special Enrollment*) as if the Qualified beneficiary was an active employee under those rules. The Special Enrollment rules do not apply to a Qualified beneficiary who does not elect to receive COBRA coverage or a Qualified beneficiary whose COBRA continuation coverage period has expired. In addition, Qualified beneficiaries are entitled to request changes in their COBRA enrollment status during the annual Open Enrollment period. See Section 10. *Eligibility-Open Enrollment*. Dependents (other than children born to or adopted by former Employees during the Employee's COBRA period) who are added to a Qualified beneficiary's COBRA enrollment are not themselves considered Qualified beneficiaries.

If the addition of a new family member to a Qualified beneficiary's COBRA enrollment will result in a higher premium (as in an enrollment change from Self Only to Family coverage), the Plan will charge the additional premium for the coverage chosen.

A change in COBRA coverage from Family to Self Only enrollment may be made at any time by written request to the Plan.

Coverage of a dependent child under a COBRA Family enrollment terminates upon the child's marriage or attainment of age 26, whichever occurs first. On termination, the dependent may continue coverage under a new COBRA enrollment.

An enrollee should request a change from Family to Self Only when coverage of all family members under the Family enrollment has terminated.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Assistant Administrator, NALC Health Benefit Plan for Employees and Staff, P.O. Box 678, Ashburn, VA 20146, 703-729-4677 or 1-888-636-NALC (6252). For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

32. The language on pages 103-104 of the 2012 Staff Plan brochure concerning "Certificate of Creditable Coverage" is deleted effective January 1, 2015 as this is no longer required by law.

If you have any questions concerning this summary or the Staff Plan, please contact the Nongroup Department at 703-729-4677 or 1-888-636-NALC (6252).

Please attach this Summary of Material Modifications (SMM) to your 2012 brochure (your summary plan description) and other Staff Plan documents for future reference. If you have any questions regarding the information in this SMM, or if you need another copy of the 2012 brochure or subsequent modifications, please contact the Nongroup Department. While every effort has been made to make this as complete and as accurate as possible, it does not restate the existing terms and provisions of the Staff Plan other than the specific terms and provisions it is modifying. The Administrator of the Staff Plan and the Board of Trustees specifically reserve the right to change, eliminate, or add to the benefits provided to participants and beneficiaries and the rules concerning eligibility for such benefits. They also reserve the right to adopt new rules and regulations, to modify the rules and regulations, and to terminate the existing Plan. No benefits or rules of the Plan are guaranteed (vested) for any participant or eligible dependent. All benefits and rules may be changed, reduced, or eliminated at any time by the Administrator and the Board of Trustees, in their sole discretion.

ADDENDUM TO THE SUMMARY OF MATERIAL MODIFICATIONS FOR YEAR 2015

Dear Participants and Dependents:

This addendum supplements the summary of material modifications to the NALC Health Benefit Plan for Employees and Staff (Staff Plan) effective January 1, 2015 that was distributed earlier this month. This information also supplements the information contained in the 2012 NALC Health Benefit Plan for Employees and Staff brochure and subsequent summaries of material modifications. Refer to the appropriate sections in the brochure as specified below for our clarifications to certain eligibility rules. Please share this addendum with your family and keep it with your Staff Plan documents for future reference.

The Board of Trustees of the Staff Plan revised two provisions of *Section 10. Eligibility* of the 2012 Staff Plan brochure to clarify those provisions.

First, Page 94, Who is Eligible for Coverage?, is revised by adding the bolded language after the first sentence of the fifth paragraph of that section. This change is to clarify that two Employees may elect to switch from a Self and Family enrollment to two Self Only enrollments once they no longer have eligible dependent children under the Staff Plan.

> In the event that both parents of an eligible dependent child are Employees covered by the Staff Plan, that child may be enrolled as the dependent of one of the Employees, but not both. **In such case, one of the Employees may elect a Self and Family coverage covering the other Employee as well as any dependent children. If the Employees no longer have dependent children (i.e., the dependent children become above the age eligible for coverage), the Employees may switch from a Self and Family enrollment to two Self Only enrollments prior to the next Open enrollment period by submitting a request for enrollment to the Nongroup Department. Such change in enrollment shall be effective as of the first day of the month following the date a completed request for enrollment is received.** See Section 10. *Who is eligible for coverage?*.

Second, Page 85, Special Enrollment, Loss of other Insurance Coverage, is revised by replacing the second paragraph of that section with the following language:

> **If you are an active or retired Employee who is a spouse covered under another active or retired Employee's enrollment in the NALC Health Benefit Plan for Employees and Staff and lose coverage due to death, divorce or legal separation, you may request to enroll yourself in a Self Only enrollment (or, if you have eligible dependents, a Self and Family enrollment) within 30 days of the event. The coverage will be effective on the first day of the month following the date a completed request for enrollment is received. See Section 10.** ***Special enrollment Loss of other health insurance coverage.***

If you have any questions concerning this addendum or the Staff Plan, please contact the Nongroup Department at 703-729-4677 or 1-888-636-NALC (6252).

Please attach this Addendum to the Summary of Material Modifications (SMM) to your 2012 brochure (your summary plan description) and other Staff Plan documents for future reference. If you have any questions regarding the information in this Addendum, or if you need another copy of the 2012 brochure or subsequent modifications, please contact the Nongroup Department. While every effort has been made to make this as complete and as accurate as possible, it does not restate the existing terms and provisions of the Staff Plan other than the specific terms and provisions it is modifying. The Administrator of the Staff Plan and the Board of Trustees specifically reserve the right to change, eliminate, or add to the benefits provided to participants and beneficiaries and the rules concerning eligibility for such benefits. They also reserve the right to adopt new rules and regulations, to modify the rules and regulations, and to terminate the existing Plan. No benefits or rules of the Plan are guaranteed (vested) for any participant or eligible dependent. All benefits and rules may be changed, reduced, or eliminated at any time by the Administrator and the Board of Trustees, in their sole discretion.

ADDENDUM TO THE SUMMARY OF MATERIAL MODIFICATIONS FOR YEAR 2015

33. Eligibility. In the event that both parents of an eligible dependent child are Employees covered by the Staff Plan, that child may be enrolled as the dependent of one of the Employees, but not both. In such case, one of the Employees may elect a Self and Family coverage covering the other Employee as well as any dependent children. If the Employees no longer have dependent children (i.e., the dependent children become above the age eligible for coverage), the Employees may switch from a Self and Family enrollment to two self only enrollments prior to the next Open enrollment period by submitting a request for enrollment to the Nongroup Department. Such change in enrollment shall be effective as of the first day of the month following the date a completed request for enrollment is received. See Section 10. *Who is eligible for coverage.*

34. Eligibility. If you are a retired employee who is a spouse covered under another Employee's enrollment in the NALC Health Benefit Plan for Employees and Staff and lose coverage due to death, divorce or legal separation, you may request to enroll yourself in a Self Only enrollment (or, if you have eligible dependents, a Self and Family enrollment) within 30 days of the event. The coverage will be effective on the first day of the month following the date a completed request for enrollment is received. See Section 10. *Special enrollment Loss of other health insurance coverage.*