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

P.O. Box 678, Ashburn, Virginia 20146 • (703) 729-4677
Fredric V. Rolando, Administrator

Lawrence Brown, Jr., Chairman
Board of Trustees

Randall L. Keller
Board of Trustees

Michael J. Gill
Board of Trustees

SUMMARY OF MATERIAL MODIFICATIONS FOR YEAR 2016

Dear Participants and Dependents:

This notice summarizes the modifications to the NALC Health Benefit Plan for Employees and Staff (Staff Plan) effective January 1, 2016. This information 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 benefit changes. Please share this summary with your family and keep it with your Staff Plan documents for future reference.

Please refer to the 2012 Staff Plan brochure and the 2013, 2014 and 2015 addendums/summaries for a complete description of your Staff Plan benefits.

General Information

Open Enrollment this year is from December 1, 2015 through December 31, 2015. Any changes in your enrollment made during Open Enrollment will be effective January 1, 2016.

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, 2016, are as follows:

1. We expanded the Family planning benefit to include coverage of a routine office visit associated with a covered family planning service such as:

   - Voluntary female sterilization
   - Surgical placement of implanted contraceptives
   - Insertion of intrauterine devices (IUDs)
   - Administration of an injectable contraceptive drug (such as Depo-Provera)
   - Removal of a birth control device

- Management of side effects of birth control
- Services related to follow-up of services listed above

You pay nothing when services for the routine office visit 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). *Family planning*.

2. We now cover an annual routine Pap test for females age 21 through age 65. Previously, we covered one routine Pap test every three years. 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* and Section 5(a). *Preventive care, children.*

3. We now cover an annual routine Prostate Specific Antigen (PSA) test for men age 40 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*.

4. We now cover routine Hepatitis B virus infection screening for adults and adolescents 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* and Section 5(a). *Preventive care, children.*

5. We now cover routine gonorrhea screening for women age 24 and younger. Previously, the age limit was 25 or younger. 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 application of fluoride varnish to primary teeth by a covered primary care provider for children age 5 and younger. 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.*

7. We now cover an annual set of spinal x-rays associated with chiropractic treatment. Previously, we covered the initial set only. You pay 15% of the Plan allowance if services are rendered by a PPO provider after satisfaction of the $300 calendar year deductible. 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). *Chiropractic*.

8. We now cover educational classes and nutritional therapy for overweight individuals with risk factors for cardiovascular disease. 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). *Educational classes and programs.*

9. We updated our criteria for bariatric surgery. Surgical treatment of morbid obesity (bariatric surgery) is covered when:

    - Clinical records support a body mass index (BMI) of 40 or greater, or 35 or greater with at least one clinically significant obesity-related co-morbidity including but not limited to type 2 diabetes, cardiovascular disease, hypertension, obstructive sleep apnea, hyperlipidemia, or debilitating arthritis.
    - Diagnosis of morbid obesity for a period of one year prior to surgery.
    - The patient has participated in a supervised weight-loss program, of at least six months duration, that includes dietary therapy, physical activity and behavior modification.
    - Evidence in the medical record that attempts at weight loss in the one year period prior to surgery have been ineffective.
    - The patient is age 18 or older.
    - Medical and psychological evaluations have been completed and the patient has been recommended for bariatric surgery.
    - A repeat or revised bariatric surgical procedure is covered only when determined to be medically necessary or a complication has occurred.

    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). *Surgical procedures*.

10. We now exclude weight loss surgery for implantable devices such as Maestro Rechargeable System. You are liable for all charges related to such surgery, and no coverage is available under the Plan. See Section 5(b). *Surgical procedures.*

11. We now utilize the NALC's Advanced Control Specialty Formulary for specialty medications. See Section 5(f). *Prescription drug benefits*.

    All specialty drugs require preauthorization and may include step therapy, call CVS/caremark Specialty Pharmacy at 1-800-237-2767. Our benefit includes the Advanced Control Specialty Formulary that includes a step therapy program and uses evidence-based protocols that require the use of a preferred drug(s) before non-preferred specialty drugs are covered. The Advanced Control Specialty Formulary is designed as a specialty drug formulary that includes generics and clinically effective brands as determined through clinical evidence. The therapy classes chosen for Advanced Control Specialty Formulary have multiple specialty drugs available that are considered therapeutically equivalent (similar safety and efficacy), thus providing the opportunity to utilize the lowest cost drug(s). In addition, categories, therapies and tiering changes could be updated every quarter and added to the formulary. Please refer to the Advanced Control Specialty formulary drug list for more information about the drugs and classes.

    All specialty drugs must be purchased through the CVS/caremark Specialty Pharmacy Services.

    Note: Decisions about prior approval are based on evidence-based guidelines developed by CVS/caremark's pharmacy clinical team and include, but are not limited to, FDA approved indications and/or independent expert panels.

12. We now require prior authorization for all compound drugs. Call CVS/caremark at 1-800-933-NALC (6252) to obtain authorization. See Section 5(f). *Prescription drug benefits*.

    A compound drug is a medication made by combining, mixing, or altering ingredients in response to a prescription, to create a customized drug that is not otherwise commercially available.

Certain compounding chemicals (over-the-counter (OTC) products, bulk powders, bulk chemicals, and proprietary bases) are not covered through the prescription benefit will be determined through preauthorization. Refill limits may apply.

13. We now cover over-the-counter low-dose aspirin for pregnant women at high risk of preeclampsia when purchased at a network retail pharmacy. You pay nothing. See Section 5(f). *Covered medications and supplies*.

14. For members in the state of Alaska, only PPO surgeons contracted through the Cigna OAP network will be paid at the PPO benefit level. Previously, non-PPO surgeons contracted through the MultiPlan network were paid at the PPO benefit level. See Section 1. *Facts about this fee-for-service Plan*.

15. You now pay a $4 copayment for up to a 60-day supply for generic drugs purchased through our mail order program when Medicare Part B is your primary payor. Previously, you paid a $7 copayment. See Section 5(f). *Covered medications and supplies*.

16. You now pay a $6 copayment for up to a 90-day supply for generic drugs purchased through our mail order program when Medicare Part B is your primary payor. Previously, you paid a $10 copayment. See Section 5(f). *Covered medications and supplies*.

17. We now offer Cigna's disease management program – Your Health First. Previously, our disease management program was the Alere™ Health Management. See Section 5(h). *Special features*.

    Through a clinical identification process, individuals are identified who have a chronic medical condition such as asthma, chronic obstructive pulmonary disease (COPD), depression, diabetes, heart disease, and musculoskeletal disorders. Health advocates trained as nurses, coaches, nutritionists, and clinicians use a one-on-one approach to help individuals:

    - Recognize worsening symptoms and know when to see a doctor
    - Establish questions to discuss with their doctor
    - Understand the importance of following doctor's orders
    - Develop health habits related to nutrition, sleep, exercise, weight, tobacco, and stress
    - Prepare for a hospital admission or recover after a hospital stay
    - Make educated decisions about treatment options

18. You may be eligible to receive a CVS gift card or a wearable activity tracking device for completing our Health Risk Assessment. See Section 5(h). *Special features*.

    A free Health Risk Assessment (HRA) is available under the 'Personal Health Record' tab at https://staff.nalchbp.org/. The HRA is an online program that analyzes your health related responses and gives you a personalized plan to achieve specific health goals. Your HRA profile provides information to put you on a path to good physical and mental health.

    When you complete the HRA, you may either choose to be enrolled in the CignaPlus Savings℠ discount dental program and we will pay the CignaPlus Savings discount dental premium for the remainder of the calendar year in which you completed the HRA provided you remain enrolled in our Plan, you may choose to receive a CVS gift card or choose a wearable activity tracking device. See your options below:

    • If one covered member/dependent completes the HRA, you may choose one of the following:
        - Self only enrollment in CignaPlus Savings℠ discount dental program,

- a $40 CVS gift card, or
- a wearable activity tracking device

• If two or more covered family members complete the HRA, you may choose one of the following:

- Family enrollment in CignaPlus Savingssm discount dental program,
- a $40 CVS gift card per person (limit 2 cards per enrollment), or
- a wearable activity tracking device per person (limit 2 devices per enrollment)

Note: You must be 18 years or older to be eligible to complete the HRA. Individuals age 13 and older can access other services offered by CareAllies/Cigna.

19. We removed the general exclusion that stated the Plan did not cover services, supplies or drugs related to sex transformations. See Section 6. *General exclusions – things we don't cover*.

20. We updated the web site address for the U.S. Preventive Services Task Force (USPSTF). See Section 5(a). *Preventive care, adult*.

    Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ and HHS at https://www.healthcare.gov/preventive-care-benefits/.

21. We updated the term "mental retardation" to "intellectual disabilities" in the brochure. See Section 5(e). *Mental health and substance abuse benefits*.

22. We updated the term "autism" to "autism spectrum disorder" in the brochure. See Section 6. *General exclusions – things we don't cover*.

23. We clarified that gender reassignment surgery is not covered. You are liable for all charges. See Section 5(b). *Surgical procedures*.

24. We clarified that our retail network pharmacy is NALC CareSelect Network. Previously, our retail network pharmacies were Preferred network pharmacy and NALC CareSelect Network pharmacy. See Section 5(f). *Prescription drug benefits*.

25. We clarified how to claim benefits and what is considered a clean claim. See Section 7. *Filing a claim for covered services*.

    To obtain claim forms, claims filing advice or answers about our benefits contact us at (703) 729-4677 or 1-888-636-NALC (6252) or at our website at https://staff.nalchbp.org/.

    Note: A clean claim is a claim which contains all necessary information for payment including any substantiating documentation. Clean claims do not require special handling or investigation prior to adjudication. Clean claims must be filed within the timely filing period.

26. We clarified the claim requirements for a prescription drug purchased outside the United States and Puerto Rico. See Section 7. *Filing a claim for covered services*.

    Claims for prescription drugs and supplies purchased outside the United States and Puerto Rico must include receipts that show the patient's name, prescription number, name of drug or supply, prescribing physician's name, date of fill, total charge, metric quantity, days' supply, name of pharmacy and if available, the currency used and country where purchased. Complete the short-

term prescription claim form, attach the drug receipts and mail to the NALC Prescription Drug Program.

NALC Prescription Drug Program
P.O. Box 52192
Phoenix, AZ 85072-2192

Claims for overseas (foreign) services must include an English translation. Charges will be converted to U.S. dollars using exchange rate at the time the expenses were incurred.

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

Subrogation/Reimbursement guidelines: Our right to pursue and receive subrogation and reimbursement recoveries is a condition of and a limitation on the nature of benefits or benefit payments and on the provision of benefits under our coverage. By accepting Plan benefits, you agree to the terms of this provision.

If you or your dependent have received benefits or benefit payments as a result of an injury or illness and you (or your dependent) or your representatives, heirs, administrators, successors, or assignees (or those of your dependent) receive payment from any party that may be liable or a third party's insurance policies you must reimburse us out of that payment. "Third party" means another person or entity. Our right of reimbursement extends to any payment received by settlement, judgment, or otherwise. 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 or in subrogation.

You must include all benefits paid by the Plan related to the illness or injury in your claim for recovery. We are entitled to reimbursement to the extent of the benefits we have paid or provided or will pay or provide in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned or characterized (i.e., pain and suffering). Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed. You must reimburse us to the full extent we 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 we are owed and make arrangement to reimburse us. You have the right to retain any recovery that exceeds the amount of the Plan's claim.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights. 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. If you do pursue a claim or case related to your injury or illness (whether in court or otherwise), you must promptly notify us and cooperate with our reimbursement or subrogation efforts. 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 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.

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

28. We updated the website address to allow you to enroll in the Weight Talk Program® online and we updated the availability times for a coach in the Program. See Section 5(a). *Educational classes and programs*.

    Individuals can enroll in the Weight Talk Program® online at https://staff.nalchbp.org/ or call the toll-free number at 1-855-948-8255. A personal dedicated coach is available Sunday through Friday 7:00 a.m. through 3:00 a.m. Eastern Time and Saturday 9:00 a.m. through 12:00 a.m. Eastern Time.

29. We clarified how you can obtain precertification, prior authorization or prior approval for other services. See Section 3. *How to get care*.

    Other non-routine services require precertification, preauthorization, or prior approval.
    • All specialty drugs, including biotech, biological, biopharmaceutical, and oral chemotherapy drugs. Call CVS/caremark at 1-800-237-2767 for prior approval. See Section 5(a). *Treatment therapies* and Section 5(f). *Prescription drug benefits*.

    • All compound drugs. Call CVS/caremark at 1-800-933-NALC (6252) for prior approval. See Section 5(f). *Prescription drug benefits*.

    • Spinal surgeries performed in an inpatient or outpatient setting. Call Cigna at 1-877-220-NALC (6252) to obtain prior approval. See Section 5(b). *Surgical procedures*.

    • Organ/tissue transplants and donor expenses. Call Cigna at 1-800-668-9682 for prior approval. See Section 5(b). *Organ/tissue transplants*.

    • Mental health and substance abuse care. Call OptumHealth Behavioral Solutions at 1-866-512-3767 for prior approval. See Section 5(e). *Mental health and substance abuse benefits*.

    • Durable medical equipment (DME). Call us at 1-888-636-NALC (6252) for prior approval. See Section 5(a). *Durable medical equipment*.

30. **Reporting required under the Affordable Care Act (ACA): What to expect from the Plan in 2016:** Under the Affordable Care Act, starting in 2016, the Plan must provide you with a statement with certain information regarding your coverage under the Plan for 2015, and must also report to the IRS regarding all individuals covered under the Plan during 2015. The information provided by the Plan allows you (and the IRS) to verify the number of months, if any, in which you were covered by "minimum essential coverage", as defined under the ACA. This information is necessary for you to show your compliance with the individual responsibility requirement of the ACA. Coverage under the Plan constitutes "minimum essential coverage" under the ACA. The Plan will report this information to you using IRS Form 1095-B, which provides you with the necessary information for you to complete your own personal tax return. The Plan will mail the 1095-B forms to participants for the 2015 calendar year on or before Jan. 31, 2016. This information will be mailed to Plan participants at the address we currently have on file for you. If you have any questions once you receive the Form 1095-B, or if you do not receive a Form 1095-B, please contact the Nongroup Department at 703-729-4677 or 1-888-636-NALC (6252). Note that this is separate from any obligation your employer may have to provide you with an IRS Form 1095-C regarding your health plan coverage. To learn more about the

Form 1095-B, please visit https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Understanding-Your-Form-1095B.

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.