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

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Fredric V. Rolando, Administrator

SUMMARY OF MATERIAL MODIFICATIONS FOR YEAR 2021

Dear Participants and Dependents:

This notice summarizes the modifications to the NALC Health Benefit Plan for Employees and Staff (Staff Plan) effective January 1, 2021. This information supplements the information contained in the 2017 NALC Health Benefit Plan for Employees and Staff brochure. 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 2017 Staff Plan brochure and the summaries of material modifications issued each year thereafter for a complete description of your Staff Plan benefits.

General Information

Open Enrollment this year is from December 1, 2020 through December 31, 2020. Any changes in your enrollment will be effective January 1, 2021.

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 888-636-NALC (6252) with any questions concerning mastectomy-related benefits.

Modifications

The modifications, effective as of January 1, 2021, are as follows:

1. We now offer the Accordant Health Management Program for chronic and complex disease management for the following medical conditions:

   - Seizure Disorders (Epilepsy)
   - Rheumatoid Arthritis (RA)

- Multiple Sclerosis (MS)
- Crohn's Disease
- Parkinson's Disease (PD)
- Systemic Lupus Erythematosus (SLE)
- Myasthenia Gravis (MG)
- Sickle Cell Disease (SCD)
- Cystic Fibrosis (CF)
- Hemophilia
- Scleroderma
- Gaucher Disease
- Polymyositis
- Amyotrophic Lateral Sclerosis (ALS- Lou Gehrig's Disease)
- Dermatomyositis
- Chronic inflammatory Demyelinating Polyradiculoneuropathy (CIDP)
- Ulcerative Colitis
- Human Immunodeficiency Virus (HIV)
- Hereditary Angioedema

For more information on the Accordant Health Management programs, please call toll-free 844-923-0805. See Section 5(h). *Wellness and Other Special Features*.

2. We now cover the associated office visit for each covered acupuncture treatment visit. Previously, we only covered the initial office visit. See Section 5(a). *Medical Services and Supplies Provided by Physicians and Other Health Care Professionals.*

3. We now cover 25 acupuncture visits per calendar year. Previously, we covered 15 visits. See Section 5(a). *Medical Services and Supplies Provided by Physicians and Other Health Cere professionals.*

4. We now cover the anesthesia related to a covered vasectomy at 100% when performed 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. See Section 5(b*). Surgical and Anesthesia Services Provided by Physicians and Other Health Care Professionals*.

5. We now cover up to a 90-day supply, per calendar year, of opioid reversal agents at no member cost share. Medication Assisted Treatment (MAT) drugs, including Buprenorphine, Buprenorphine- naloxone, and Naltrexone used for treatment of opioid disorders. See Section 5(f). *Prescription Drug Benefits.*

6. We now cover pulmonary rehabilitation therapy. You pay 15% of the Plan allowance after satisfaction of the $300 calendar year deductible when the 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). *Medical Services and Supplies Provided by Physicians and Other Health Care Professionals.*

7. We now cover gene therapy services at a PPO facility.

- Gene therapy products and services directly related to their administration are covered when medically necessary. Gene therapy is a category of pharmaceutical products approved by the U.S. Food and Drug Administration (FDA) to treat or cure a disease by:
  - Replacing a disease-causing gene with a healthy copy of the gene
  - Inactivating a disease-causing gene that may not be functioning properly
  - Introducing a new or modified gene into the body to help treat a disease

Coverage includes the cost of the gene therapy product, the medical, surgical, and facility services directly related to administration of the gene therapy product, and the professional services. Gene therapy products and their administration are covered when preauthorized to be received at participating PPO facilities specifically contracted for the specific gene therapy service. Gene therapy products and their administration received at other facilities are not covered.

You pay 15% of the Plan allowance after satisfaction of the $300 calendar year deductible when the services are rendered by a PPO provider. When services are rendered by a non-PPO provider, you pay all charges. Call the Nongroup Department at 703-729-4677 for more information and for preauthorization. See Section 5(a). *Medical Services and Supplies Provided by Physicians and Other Health Care Professionals.*

8. We now cover pneumococcal conjugate vaccines (PCV-13) for adults 65 and older. For a complete list of immunizations, go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/ or see our website for details.

9. We now cover Hepatitis A vaccines for individuals diagnosed with human immunodeficiency virus (HIV). For a complete list of immunizations, go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/ or see our website for details.

10. We now cover the Tetanus-diphtheria, pertussis (Tdap) vaccine given as a booster once every 10 years. For a complete list of immunizations, go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/ or see our website for details.

11. We now cover the varicella (chicken pox) vaccine for persons at high risk, such as human immunodeficiency virus (HIV) positive. For a complete list of immunizations, go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/ or see our website for details.

12. We now cover Hepatitis C virus infection screening for adults age 18 to 79. Previously, it was covered for individuals born between 1945 and 1965. For a complete list of preventative screening tests go to the U.S. Preventive Task Force (USPSTF) website at https://www.uspreventiveservicetaskforce.org/ or see our website for details.

13. We now cover asymptomatic bacteriuria at 100% under the Maternity care benefit if a PPO provider is used. 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). *Medical Services and Supplies Provided by Physicians and Other Health Care Professionals.*

14. We now offer a wellness incentive program. You can earn valuable health savings rewards to use towards eligible medical expenses. We will send each eligible member, 18 years of age and older, a debit card to access his or her account. Please keep your card for future use even if you use all your health account dollars; you may be eligible for wellness incentives in subsequent benefit years. We do not send new cards to continuing participants until the card expires. If you leave the NALC Health Benefit Staff Plan, any money remaining in your account will be forfeited. Below is a list of programs, screenings, and preventive services that are eligible for a health savings award.

- Your Health First Disease Management Program

  You can earn $50 in health savings rewards once you achieve a fitness, diet, or health goal with the assistance of a trained health coach. Only one incentive can be earned per calendar year. See Section 5(h). *Wellness and Other Special Features.*

- Healthy Pregnancies Healthy Babies®

  Enroll in your 1st or 2nd trimester and stay engaged with a pregnancy specialist during your pregnancy to complete at least 3 calls, one which includes the post-partum call for closure, in order to be eligible for $50 in health savings rewards. See Section 5(h). *Wellness and Other Special features*.

- Quit for Life Tobacco Cessation Program

  You can earn $50 in health savings rewards for participation in this program. Eligibility will be determined by your Quit for Life Coach and you must have at least 5 telephonic counseling sessions. See Section 5(a). *Educational classes and programs* and 5(h). *Wellness and Other Special Features.*

- Annual Biometric Screening

  You can receive $50 in health savings rewards for having an annual biometric screening. See Section 5(a). *Preventive care, adult* and 5(h). *Wellness and Other Special Features.*

- Health Assessment

  Any eligible member or dependent over the age of 18 can earn $30 in health savings rewards by completing the Health Assessment. See Section 5(h). *Wellness and Other Special Features.*

- Annual influenza vaccine

  You can receive $10 in health savings rewards for having an annual flu vaccine. See Section 5(a). *Preventive care, adult* and 5(h). *Wellness and Other Special Features.*

- Annual pneumococcal vaccine

  You can receive $10 in health savings rewards for having an annual pneumococcal vaccine. See Section 5(a). *Preventive care, adult* and 5(h). *Wellness and Other Special Features.*

An eligible medical expense is defined as those expenses paid for care as described in section 213 (d) of the Internal Revenue Code. Please see our website to help you determine whether an expense is eligible. You are only eligible to receive one (1) reward amount per person per program or wellness activity per calendar year.

15. We now cover additional medications at no member cost share for risk reduction of primary breast cancer for women who are at increased risk for breast cancer as recommended by the United States Preventive Services Task Force (USPSTF), limited to:

- Anastrozole
- Exemestane
- Raloxifene
- Tamoxifen

See Section 5(f). *Prescription Drug Benefits.*

16. We now cover preexposure prophylaxis medications for individuals at high risk for human immunodeficiency virus (HIV) at no member cost share.

-Truvada 200mg-300 mg (emtricitabine/tenofovir)

- Brand, until generic becomes available

-Preventive use only -

-Quantity limit (1 tablet/day)

-No prior authorization is required

-Descovy is available with a $0 cost share through an exceptions process, if medically necessary.

See Section 5(f). *Prescription Drug Benefits.*

17. We removed the visitation limit on Applied Behavioral Analysis (ABA) therapy. Previously, we limited the therapy to 15 hours per week for children age 3 through 11 and 9 hours per week for children age 12 through 18. Prior authorization is required for (ABA) therapy. Call 877-468-1016 to find a covered provider and to obtain prior authorization. See Section 5(a). *Medical Services and Supplies Provided by Physicians and Other Health Care Professionals.*

18. We now allow the coinsurance for skilled nursing care visits to count towards the member's catastrophic out of pocket maximum. See Section 4. *Your Costs for Covered Services*.

19. We now cover cognitive rehabilitation therapy following a traumatic brain injury. You pay a $20 copayment per visit (no deductible) and all charges after the 75-visit limit when 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 and all charges after the 75-visit limit. See Section 5(a). *Medical Services and Supplies Provided by Physicians and Other Health Care Professionals*.

20. We now cover inpatient and outpatient observation hospital visit charges by a non-PPO provider at the PPO benefit level when services are rendered at a PPO hospital or ambulatory surgical center. Previously, these were covered at 70% after the deductible. See Section 1. *Facts About This Fee-For-Service Plan,* Section 5(a). *Medical Services and Supplies Provided by Physicians and Other Health Care Professionals,* Section 5(b). *Surgical and Anesthesia Services Provided by Physicians and Other Health Care Professionals*, Section 5(c). *Services Provided by a Hospital or Other Facility, and Ambulance Services*, Section 5(d). *Emergency Services/Accidents*, and Section 5(g). *Dental Benefits*.

21. We no longer cover extracorporeal shock wave treatment for routine foot care. You pay all charges. See Section 5(a). *Medical Services and Supplies Provided by Physicians and Other Health Care Professionals*.

22. We clarified that you can request an online print of PPO providers in your area by calling us at 703-729-4677 or 888-636-NALC (6252). See Section 1. *Facts about this fee-for-service plan*.

23. We clarified that in emergent and urgent clinic settings, you may visit a facility that is in the PPO network. However, you may receive bills from multiple ancillary providers involved in your care who are not a part of the network such as radiologists, anesthesiologists, pathologists, and emergency room physicians. See Section 1. *We have a Preferred Provider Organization (PPO)*.

24. We clarified that genetic testing requires prior approval. See Section 5(a). *Lab, X-ray and other diagnostic tests*.

25. We clarified that polarization and scratch resistant coatings are not covered. See Section 5(a). *Vision services (testing, treatment, and supplies)*.

26. We clarified that we cover the rental or purchase of continuous glucose monitors and insulin pumps under the durable medical equipment benefit (DME) and not under the pharmacy benefit. See Section 5(a). *Durable medical equipment (DME)* and Section 5(f). *Covered medications and supplies*.

27. We clarified that provocative food testing and sublingual allergy desensitization, including drops placed under the tongue are not covered. See Section 5(a). *Allergy care*.

28. We clarified that private duty nursing is not covered. See Section 5(a). *Home health services*.

29. We clarified that we cover services related to pregnancy that result in a miscarriage under the maternity care benefit. See Section 5(a). *Maternity care*.

30. We clarified that we pay inpatient professional, outpatient observation room and all related services, and/or hospital benefits when you are admitted for an accidental injury. See Section 5(d). *Accidental injury*.

31. We clarified that for virtual doctor visits through NALCHBP Telehealth, you can download the mobile app for Android or iOS mobile devices by visiting Google Play™ or the Apple App Store. See Section 5(h). *Special Features*.

32. We clarified that the Diabetes care management program is now Transform Care. See Section 5(h). *Special Features*.

33. We clarified that services, drugs or supplies ordered, performed, or furnished by yourself, immediate relatives, or household members are not covered. See Section 6. *General Exclusions-things we don't cover*.

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  - We clarified that services performed outside of the United States are paid at out-of-network rates and are subject to the $300.00 deductible. You are responsible for the difference between the billed amount and our payment. See Section 7. *Filing a Claim for Covered Services*.

  - We clarified that the Plan does not coordinate benefits with Medicaid and will always be the primary payor. Claims processed by Medicaid as the primary payor will require Medicaid to submit a reimbursement request to the Plan. See Section 9. *Coordinating benefits with other coverage*.

  - We clarified that when we are the secondary payer, we usually pay what is left after the primary plan pays, up to our Plan allowance for each claim. If the balance after the primary carrier payment is higher than our Plan allowance, we will not pay more than our Plan allowance. See Section 9. *Coordinating benefits with other coverage*.

  - We clarified that repair to custom functional foot orthotics is not covered. See Section 5(a). *Foot care*.

Please attach this Summary of Material Modifications (SMM) to your 2017 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 2017 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.