SUMMARY OF MATERIAL
MODIFICATIONS FOR YEAR 2024

Dear Participants and Dependents:

This notice summarizes the modifications to the NALC Health Benefit Plan for Employees and Staff (Staff Plan) effective January 1, 2024. This information supplements the information contained in the 2022 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 2022 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, 2023 through December 31, 2023. Any changes in your enrollment will be effective January 1, 2024.

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.

Modifications

The modifications, effective as of January 1, 2024, are as follows:

1) We have increased your portion of the out-of-network benefits to 35% of the Plan allowance. Previously you paid 30% of the Plan allowance. See section(s) 5(a). *Medical Services and Supplies Provided by Physicians and Other Health Care Professionals,* 5(b). *Surgical and Anesthesia Services Provided by Physicians and other Healthcare Professionals and* 5(c). *Services Provided by a Hospital or Other Facility, and Ambulance Services*.
2) We now cover certain assisted reproductive technology (ART) procedures for up to three cycles.

The Plan covers diagnosis and treatment of infertility as well as treatment needed to conceive, including covered artificial insemination procedures. Infertility may be established through an evaluation based on medical history and diagnostic testing.

- Diagnostic services
- Laboratory Tests
- Fertility drugs
- Artificial Insemination (up to 3 cycles)
  - Intravaginal insemination (IVI)
  - Intracervical insemination (ICI)
  - Intrauterine insemination (IUI)

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 35% of the Plan allowance and any difference between our allowance and the billed amount after satisfaction of the $300 calendar year deductible. Note: Prescription drugs (Up to 3 cycles of IVF-related drugs) are covered for the treatment of infertility. See section 5(a). *Medical Services and Supplies Provided by Physicians and Other Health Care Professionals.*

3) We now cover up to three cycles of IVF- related prescription drugs. Previously we covered infertility drugs up to $2,500.00 maximum payment per person. See section 5(a). *Medical Services and Supplies Provided by Physicians and Other Health Care Professionals.*

4) We now cover gender affirmation facial feminization/masculinization surgeries.

Gender affirming chest, genital, and facial feminization/masculinization surgeries are covered when medically necessary and meet the following criteria:

- **The patient must meet all requirements:**

  - prior approval must be obtained.

  - patient must be at least 18 years of age at the time prior approval is requested and the treatment plan is submitted.

  - Diagnosis of gender dysphoria is made by a qualified healthcare professional.

    - Patient's gender dysphoria is not a symptom of another mental disorder.

    - Gender dysphoria causes clinical distress or impairment in social, occupational, or other important areas of functioning.

  - 6 months of continuous hormone therapy appropriate to the patient's gender identity.

  - One referral letter of support from a qualified mental health professional who has competencies in the assessment of transgender and gender diverse people is needed.

If medical or mental health concerns are present, they are being optimally managed and are reasonably well-controlled. You pay 15% of the Plan allowance when the services are rendered by a PPO provider. When services are rendered by a non-PPO provider, you pay 35% of the Plan allowance and the

difference, if any, between our allowance and the billed amount after the $300 calendar year deductible is satisfied. See section 5(a). *Medical Services and Supplies Provided by Physicians and Other Health Care Professionals.*

5) We now allow all FDA approved vaccines to be administered at CVS Caremark pharmacies through our NALC Health Benefit Plan Broad Vaccine Administration Network. FDA approved Vaccines administered at a Broad Vaccine Administration Pharmacy are covered at 100%. Previously, we only covered the Herpes Zoster (shingles), flu and pneumococcal vaccines when administered at a CVS Caremark pharmacy. See section 5(a). *Medical Services and Supplies Provided by Physicians and Other Health Care Professionals.*

6) We now count spinal and extra spinal manipulations on the same day as one manipulation towards the yearly maximum. When services are rendered by a PPO provider, you pay a $25.00 copayment per visit (no deductible), services provided by a non-PPO provider you pay 35% of the Plan allowance and any difference between our allowance and the billed amount per visit after a $300 calendar year deductible has been satisfied. We previously counted spinal and extra spinal manipulations on the same day as two separate manipulations. See section 5(a). *Medical Services and Supplies Provided by Physicians and Other Health Care Professionals.*

7) We will now cover genetic counseling with or without authorized genetic testing. You pay 15% of the Plan allowance when the services are rendered by a PPO provider after a $300 calendar year deductible has been satisfied. When services are rendered by a non-PPO provider, you pay 35% of the Plan allowance and any difference 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.*

8) We now cover non-surgical strapping treatment for immobilization of a joint. You pay 15% of the Plan allowance when the services are rendered by a PPO provider after a $300 calendar year deductible has been satisfied. When services are rendered by a non-PPO provider, you pay 35% of the Plan allowance and any difference 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.*

9) We removed the diagnosis limitation for nutritional therapy. Previously, we covered nutritional therapy for diabetes, eating disorders, obesity, and overweight individuals with risk factors for cardiovascular disease. You pay nothing when a PPO provider is used. When services are provided by a non-PPO provider, you pay all charges. See section 5(a). *Medical Services and Supplies Provided by Physicians and Other Health Care Professionals.*

10) We will now cover an annual A1C test for ages 18 and older. Previously, we covered an A1C test for ages 35 through 70. You pay nothing when services are rendered by a PPO provider and 35% of the Plan allowance and any difference between our allowance and the billed amount after satisfaction of the $300 calendar year deductible for services rendered by a non-PPO provider. See section 5(a). *Medical Services and Supplies Provided by Physicians and Other Health Care Professionals.*

11) We now cover an annual skin cancer screening. You pay 15% of the Plan allowance when services are rendered by a PPO provider. When services are rendered by a non-PPO provider, you pay 35% of the Plan allowance and any difference between our allowance and the billed amount after satisfaction of a $300 calendar year deductible. See section 5(a). *Medical Services and Supplies Provided by Physicians and Other Health Care Professionals, Lab, X-ray, and other diagnostic tests.*

12) We now cover screening for anger, depression, and suicide risk in children as recommended by the U. S. Preventive Services Task force (USPSTF). You pay nothing when services are rendered by a PPO provider. When services are rendered by a non-PPO provider, you pay 35% of the Plan allowance and any difference between our allowance and the billed amount after satisfaction of a $300 calendar year

deductible. See section 5(a). *Medical Services and Supplies Provided by Physicians and Other Health Care Professionals.*

13) We now cover Partial Hospitalization (PHP) and Intensive Outpatient Program (IOP) under outpatient benefits. Previously, this was covered under inpatient benefits. For an In-Network facility, you pay 15% of the Plan allowance after a $300 calendar year deductible has been satisfied. For an Out-of-Network facility, you pay 35% of the Plan allowance and any difference between our allowance and the billed a mount after a $300 calendar year deductible is satisfied. See section 5(e). *Mental Health and Substance Use Disorder Benefits*.

14) We have updated our criteria for coverage of bariatric surgeries. We now cover bariatric surgeries for those with a body mass index (BMI) of 35 or greater, or 30 or greater with at least one clinically significant obesity-related comorbidity including but not limited to diabetes mellitus, cardiovascular disease, hypertension, obstructive sleep apnea, hyperlipidemia, or debilitating arthritis for those 13 or older. Previously, we covered bariatric surgery for those 18 years or older with a body mass index (BMI) of 40 or greater, or 35 or greater with at least one clinically significant obesity-related comorbidity including but not limited to diabetes mellitus, cardiovascular disease, hypertension, obstructive sleep apnea, hyperlipidemia, or debilitating arthritis. See section 5(b). *Surgical and Anesthesia Services Provided by Physicians and other Healthcare Professionals.*

15) We no longer offer NALCSelect, NALCPreferred, and NALCSenior Antibiotic generic drug lists. See section 5(f). *Prescription Drug Benefits.*

16) We now cover two pairs of custom functional foot orthotics annually. Previously, we only covered one pair every two years with a maximum Plan payment of $500. When services are provided by a PPO provider, you will now pay 15% of the Plan allowance and all charges after the 2-pair annual limit after a $300 calendar year deductible is satisfied. When services are provided by non-PPO providers, you will pay 35% of the Plan allowance and any difference between the Plan allowance and the charge amount and all charges after the 2-pair annual limit after a $300 calendar year deductible is met. See section 5(a). *Medical Services and Supplies Provided by Physicians and Other Health Care Professionals, Orthopedic and prosthetic devices.*

17) We have increased our coverage for wigs for hair loss due to the treatment of cancer to a maximum payment of $350 per lifetime. Previously, the maximum payment was $200. See section 5(a). *Medical Services and Supplies Provided by Physicians and Other Health Care Professionals, Orthopedic and prosthetic devices.*

18) We now cover up to 30 days for confinements in a skilled nursing facility per person annually. Previously, we covered up to 21 days. See section 5(c). *Services Provided by a Hospital or Other Facility, and Ambulance Services.*

19) We removed coverage for readmission to a skilled nursing facility. See section 5(c). *Services Provided by a Hospital or Other Facility, and Ambulance Services.*

20) We have increased our coverage for hearing aids to a maximum payment of $2,500 with replacements covered every three years. Previously, we paid up to a maximum payment of $1,000 an ear. See section 5(a). *Medical Services and Supplies Provided by Physicians and Other Health Care Professionals, Hearing services (testing, treatment, and supplies).*

21) We now cover hearing aids for children up to the age of 18, limited to a maximum payment of $2,500 with replacements covered annually. PPO: you pay nothing up to the Plan limit and all charges after we pay $2,500 (no deductible). Non-PPO: you pay nothing up to the Plan limit and all charges after we pay $2,500 (no deductible). See section 5(a). *Medical Services and Supplies Provided by Physicians and Other Health Care Professionals, Hearing services (testing, treatment, and supplies).*

22) We now cover all hearing aid related exams with a coinsurance. Previously, these services were included in the hearing aid maximum payment. You pay 15% of the Plan allowance when the services are rendered by a PPO provider after a $300 calendar year deductible has been satisfied. When services are rendered by a non-PPO provider, 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(a). *Medical Services and Supplies Provided by Physicians and Other Health Care Professionals, Hearing services (testing, treatment, and supplies).*

23) We now cover a dermatology program through the NALCHBP Telehealth app. Professional services for conditions such as chronic acne, rosacea, or psoriasis. You pay a $10 copayment per visit when the services are rendered by NALCHBP Telehealth providers. There is no non-PPO benefit. See Section 5(a*). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals* and 5(h). *Wellness and Other Special Features.*

24) We now cover the Bend's Behavioral Health Coaching Program through Optum Behavioral Solutions.

    Bend's behavioral Health Coaching Program through Optum is a live video-based service that supports children and families seeking to modify challenging behavior to achieve their behavioral health goals. Along with age and symptom – specific care programs, the coaching program offers interactive content, recourses, parenting tips, tools, and peer community support (for caregivers) that members can access to support their progress.

    Onboarding and assessment protocols ensure that clinically appropriate care programs are selected and provide ongoing monitoring of progress, risks, and clinical needs. In addition, coaches are supervised by licensed mental health providers at all times to ensure the appropriateness of services and the potential need for a higher level of care. See section 5(h). *Wellness and Other Special Features.*

25) We clarified that services related to miscarriage or stillbirth are covered under maternity care benefits. PPO: you pay nothing (no deductible). Non-PPO: you pay 35% of the Plan allowance and any difference between our allowance and the billed amount after a $300 calendar year deductible is satisfied. See Section 5(a). *Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals, Maternity Care.*

26) We clarified that members should contact the Health Plan to obtain claim forms, obtain answers about our benefits, and for claim filing advice. Members can also find the member claim form on the Staff Plan website. Members that are Medicare primary were advised to submit claims directly to the Health Plan and should include a copy of the Medicare Summary Notice (MSN).

27) We clarified that camp, school, and sports physicals are not covered when rendered at CVS Minute Clinic®. See Section 5(a). *Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals, Preventive care, children.*

28) We clarified that for out of network mental health and substance use disorder benefits, a reduction is applied to the physician level reimbursement for certain licensed health care professionals consistent with the Centers for Medicare and Medicaid service (CMS). This reduction is applied to all out-of-network outpatient professional services.

29) We clarified that we do not cover car seats of any kind. See Section 5(a). *Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals, Durable medical equipment (DME).*

30) We clarified that certain other services require precertification and that we may deny benefits if you fail to pre-certify or obtain prior approval for these services.

Please attach this Summary of Material Modifications (SMM) to your 2022 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 a copy of the 2022 brochure, 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.