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 2014

Dear Participants and Dependents:

This notice summarizes the modifications to the NALC Health Benefit Plan for Employees and Staff (Staff Plan) effective January 1, 2014. This information supplements the information contained in the 2012 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.

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, 2014 through December 31, 2014, 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 addendum for a complete description of your Staff Plan benefits.

General Information

Open Enrollment this year is from December 1, 2013 through December 31, 2013. Any changes in your enrollment will be effective January 1, 2014.

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, 2014, are as follows:

1. We now cover the PPSV23 pneumococcal vaccine for adults as recommended by the Centers for Disease Control and Prevention (CDC). 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.*

2. We added the Herpes Zoster (shingles) vaccine to the NALC Flu and Pneumococcal Vaccine Administration Network. See Section 5(a). *Preventive Care, adult*

   Note: When the NALC Health Benefit Plan for Employee and Staff is the primary payor for medical expenses, the Herpes Zoster (shingles) vaccine, the seasonal flu vaccine and adult pneumococcal vaccine will be paid in full when administered by a pharmacy that participates in the NALC Flu and Pneumococcal Vaccine Administration Network. A full list of participating pharmacies is available at ww.pharmacyshots.com/vaccine_network_01.pdf or call Caremark Customer Service at 1-800-933-NALC (6252) to locate a local participating pharmacy. (The Herpes Zoster vaccine service will not be available at the NALC Flu and Pneumococcal Vaccine Administration Network until June of 2014.)

   Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at HHS: www.healthcare.gov/prevention.

3. We now cover an annual biometric screening for adults including:

   - calculation of body mass index (BMI)
   - waist circumference measurement
   - total blood cholesterol
   - blood pressure check
   - fasting blood sugar

   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 skin cancer preventive medicine counseling by a covered primary care provider for adults age 24 and younger and for children age 10 and older as recommended by the 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 Children.*

5. We now cover fall prevention preventive medicine counseling by a covered primary care provider for adults age 65 and older as recommended by the 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.*

   Note: A complete list of preventive care services recommended under the USPSTF is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.

6. We now cover a hearing screening for children age 3 through 10. For those at high risk as recommended by Bright Futures/AAP, we cover a hearing screening 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. Previously, we covered a hearing screening for children age 4 through 10. See Section 5(a). *Preventive care, children.*

7. We now cover one dose of tetanus-diphtheria, pertussis (Tdap) vaccine during each pregnancy 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.*

8. You now pay nothing for the removal of a birth control device and for services related to the follow up and management of side effects of birth control when 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. Previously, you paid 15%. See Section 5(a). *Family planning.*

9. We now cover a combined total of 75 rehabilitative and habilitative physical, occupational and speech therapy visits per calendar year. You pay $20.00 copayment per visit and all charges after 75 visit limit 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 and all charges after 75 visit limit. See Section 5(a). *Physical, occupational, and speech therapies.*

   Note: When physical, occupational, and/or speech therapy are performed on the same day, a separate $20 copayment applies to each type of therapy billed.

10. We now cover physical therapy to prevent falls for community-dwelling adults age 65 and older 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). *Physical, occupational, and speech therapies.*

    Therapy is covered when the attending physician:

    - Orders the care;
    - Identifies the specific professional skills the patient requires; and
    - Indicates the length of time the services are needed.

11. We now cover the initial office visit or consultation to assess patient for acupuncture. You pay a $20.00 copayment per visit 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). *Alternative treatments.*

12. You now pay nothing for educational classes and nutritional therapy for self-management of diabetes, hyperlipidemia, hypertension, and obesity when services are rendered by a PPO provider and when:

    - Prescribed by the attending physician, and
    - Administered by a covered provider, such as a registered nurse or a licensed or registered dietician/nutritionist.

    Previously, you paid 15% of the Plan allowance. 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.*

    Note: To join our Weight Management Program, see Section 5(h). *Special features.*

13. We updated our criteria for the coverage of surgical treatment of morbid obesity (bariatric surgery). See Section 5(b). *Surgical procedures.*

    - 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, 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 has 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.

14. We now cover autologous blood or marrow stem cell transplant at a Plan designated center of excellence approved clinical trial in a National Cancer Institute (NCI) or National Institutes of Health (NIH) and if approved by the Plan limited to: aggressive non-Hodgkin's lymphomas (Mantle Cell lymphoma, adult T-cell leukemia/lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms). You pay 15% of the Plan allowance for services obtained through the Cigna *Life*Source Transplant Network®. See Section 5(b). *Organ/tissue transplants.*

15. We now cover over-the-counter vitamin D supplements (600 to 800 IU per day) when purchased at a preferred or network retail pharmacy for adults age 65 and older as recommended by the USPSTF (prescription required). You pay nothing when purchased at a Preferred network or Network retail pharmacy. See Section 5(f). *Covered medications and supplies.*

16. We will pay the Self Only premium for the CignaPlus Savings[SM] discount dental program when you are enrolled in a Self Only option with the Plan and you complete the Health Risk Assessment (HRA). We will pay the Self and Family premium for the CignaPlus Savings[SM] discount dental program when you are enrolled in a Self and Family option

with the Plan and an HRA is completed for two family members. Previously, we waived a $20 PPO office visit copayment(s) when an HRA was completed for one or two family members. See Section 5(h). *Special features.*

17. We now offer the Alere Weight Talk® Program. Previously, our weight management program was the Cigna Healthy Steps to Weight Loss. See Section 5(h). *Special features.*

    The Weight Talk® Program through Alere is a personal coaching program designed to achieve measurable, sustainable weight loss. It is delivered through regular phone-based coaching sessions with a dedicated coach. Participants set realistic weight goals and through small multiple behavior changes learn how to achieve and maintain a healthy weight for the rest of their lives.

    Participants receive scheduled telephone coaching sessions with a dedicated coach or registered dietitian. Participants also have lifetime access to weight loss tools, educational resources and community support on the Weight Talk® Web site. Each participant receives a Welcome Kit containing a weight loss workbook, food journal, tape measure and a wireless activity monitor that tracks and uploads steps, calories burned, distance traveled, and activity duration wirelessly to the Weight Talk® Web site. This allows participants to track their activity history on the Web site and allows coaches to see the participants' progress throughout the course of the program.

    Individuals can enroll in the Weight Talk® Program online at www.nalc.org/depart/hbp 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. and Saturday 9:00 a.m. through 12:00 a.m. Eastern Time.

18. We clarified we cover the Measles, Mumps, Rubella (MMR) vaccine for adults age 19 and older as recommended by the CDC. See Section 5(a). *Preventive care, adult.*

19. We clarified charges for **routine** mammograms are payable at 100% when rendered by a PPO provider. See Section 5(a). *Preventive care, adult.*

20. We added a reference in Section 5(a). *Preventive care, children* that we cover educational classes and nutritional therapy for the self-management of diabetes, hyperlipidemia, hypertension and obesity.

    Note: A complete list of preventive care services recommended under the USPSTF is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.

    Note: See Section 5(a). *Educational classes and programs* for more information on educational classes and nutritional therapy for self management of diabetes, hyperlipidemia, hypertension and obesity.

21. We clarified that the deductible applies to charges for voluntary female sterilization, surgical placement of implanted contraceptives, and insertion of intrauterine devices (IUDs) when services are rendered by a non-PPO provider. See Section 5(a). *Family planning.*

22. We clarified the calendar year deductible does not apply to charges for a hearing aid and related examination for neurosensory hearing loss. See Section 5(a). *Hearing services (testing, treatment, and supplies).*

23. We clarified observation room charges are covered under the Outpatient hospital benefit. See Section 5(c). *Inpatient hospital.*

    Note: When room and board charges are billed by a hospital, inpatient benefits apply. For Observation room charges billed, see Outpatient hospital or ambulatory surgical center in this section.

24. We clarified that the Accidental injury benefit does not apply to charges for emergency room treatment when the patient is admitted to a hospital. See Section 5(d). *Accidental injury.*

    Note: We pay inpatient professional and hospital benefits when you are admitted. See Section 5(a). *Diagnostic and treatment services*, Section 5(b). *Surgical and anesthesia services provided by physicians and other health care professionals*, and Section 5(c). *Services provided by a hospital or other facility, and ambulance services.*

25. We clarified that dental night splint/guard is not covered. See Section 5(g). *Accidental dental injury benefit.* Not covered:

    - Dental services not rendered or completed within 72 hours
    - Bridges, oral implants, dentures, crowns
    - Orthodontic treatment
    - Night splint/guard

26. We clarified the Plan allowance for medical emergency services when rendered at a non-PPO facility. See Section 12. *Definitions of terms we use in this brochure.*

    Non-PPO medical emergency services: Our Plan allowance for non-PPO emergency services is determined by taking the greatest of:

    - The median PPO rate;
    - The usual, customary and reasonable rate (or similar rate determined using the Plan's formula for determining payments for non-PPO services);
    - The Medicare rate; or
    - For facility charges (such as hospitals, dialysis facilities, and ambulatory surgical centers), our allowance is based on two and one-half times the Medicare reimbursement rate.

    Note: For other categories of benefits and for certain specific services within each of the above categories, exceptions to the usual method of determining the Plan allowance may exist. At times, we may seek an independent expert opinion to determine our Plan allowance.

27. We have clarified that an employee on an approved leave without pay with coverage under the Staff Plan is responsible for payment of the employee share of the premium during leave. Coverage ends at the completion of an approved leave without pay (if

applicable), subject to the timely payment of premiums during such leave. See Section 10. *Eligibility When is my coverage terminated?*.

28. Coverage of mental health and substance abuse benefits will be self-funded by the Plan and will continue to be administered by OptumHealth Behavioral Services. Section 5(e). *Mental health and substance abuse benefits*.

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.