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

SUMMARY OF MATERIAL MODIFICATIONS FOR YEAR 2018

Dear Participants and Dependents:

This notice summarizes the modifications to the NALC Health Benefit Plan for Employees and Staff (Staff Plan) effective January 1, 2018. 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 for a complete description of your Staff Plan benefits.

General Information

Open Enrollment this year is from December 1, 2017 through December 31, 2017. Any changes in your enrollment will be effective January 1, 2018.

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.

We are required by law to remind you of the availability of the Staff Plan's Notice of Privacy Practices issued in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A copy of the Notice of Privacy Practices was provided to you previously. If you would like another copy, please contact the Nongroup Department at 703-729-4677 or 1-888-636-NALC (6252).

Modifications

The modifications, effective as of January 1, 2018, are as follows:

1. We require prior authorization (PA) for certain drugs to ensure safety, clinical appropriateness and cost effectiveness. PA criteria is designed to determine coverage and help to promote safe and appropriate use of medications. Medications such as anti-narcolepsy, ADD/ADHD, certain analgesics and certain opioids will require PA. To obtain a list of drugs that require PA, please visit our website, https://staff.nalchbp.org or call 888-636-NALC (6252). Call CVS Caremark® at 800-933-NALC (6252) to obtain prior authorization. See Section 3. *How to get care* and Section 5(f). *Prescription drug benefits*.

2. We now cover breast tomosynthesis (3-D mammogram) as a preventive care screening test when performed in conjunction with a routine screening mammography. You pay nothing 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. See Section 5(a). *Preventive care, adult*.

3. We now cover tuberculosis screening for adults at increased risk, age 18 and older, as recommended by the U.S. Preventive 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*.

4. We now cover additional colorectal cancer screening tests for adults age 50 through 75 as recommended by the U.S. Preventive Task Force (USPSTF).

    - Fecal occult blood test – one annually
    - Fecal immunochemical test (FIT) – one annually
    - Computed tomographic (CT) colonography – one every 5 years
    - Double contrast barium enema (DCBE) – one every 5 years
    - Stool based DNA such as ColoGuard – one every 3 years
    - Sigmoidoscopy screening – one every 5 years
    - Colonoscopy screening (with or without polyp removal) – one every 10 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*.

5. We now cover syphilis screening for children age 11 and older as recommended by the U.S. Preventive 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, children*.

6. We now cover sexually transmitted infections screening for children age 11 and older as recommended by Bright Futures/AAP. 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 one oral health assessment for children ages 12 months and 18 months, then one annually through age 6 as recommended by Bright Futures/AAP. 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.*

8. We now cover breastfeeding support and counseling as recommended by U.S. Preventive Task Force (USPTF). 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*.

9. We clarified that charges for a gestational diabetes screening test for pregnant women after 24 weeks as recommended by the U.S. Preventive Task Force (USPSTF) are payable at 100% 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*.

10. We now cover over-the-counter low-dose aspirin (75 and 81 mg) for the prevention of colorectal cancer and cardiovascular disease for adults age 50-59 as recommended by the U.S. Preventive Task Force (USPSTF) when purchased at a network retail pharmacy (prescription required). You pay nothing. See Section 5(f). *Preventive care medications*.

11. We now cover statin preventive medications for adults at increased risk of cardiovascular disease (CVD), age 40 through 75, as recommended by the U.S. Preventive Task Force (USPSTF) when purchased at a network retail pharmacy or mail order (prescription required). You pay nothing. See Section 5(f). *Preventive care medications*.

12. We review all inpatient surgeries related to bariatric procedures, experimental and investigational procedures, or cosmetic procedures for medical necessity at the time of the inpatient hospital precertification review. See Section 3. *How to get care*.

13. We now pay the Plan allowance for covered electrocardiogram (ECG/EKG) and electroencephalogram (EEG) billed by non-PPO providers at the PPO benefit level when services are rendered at a PPO hospital or PPO ambulatory surgical center. You pay 15% of the Plan allowance after satisfaction of the $300 calendar year deductible. Previously, you paid 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 under *Important things you should keep in mind about these benefits*.

14. We clarified that charges for **routine** sonograms during pregnancy are payable at 100% when services rendered by a PPO provider. If the services 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. **Non-routine** sonograms are payable under diagnostic testing. You pay 15% of the Plan allowance when the services rendered by a PPO provider after satisfaction of the $300 calendar year deductible. If the services 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). *Lab, x-ray and other diagnostic tests* and Section 5(a). *Maternity Care*.

15. We clarified the coverage for Well woman care based on the current recommendations such as:

    - Cervical cancer screening (Pap smear) age 21 through age 65 – one annually
    - Cervical cancer screening (Pap smear) over age 65 – one every 2 years
    - Routine mammogram – age 35 and older, as follows:
        - Age 35 through 39 – one during this 5 years period
        - Age 40 and older – one every calendar year

- Human papillomavirus (HPV) testing age 30 through age 65 – one every 3 years
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus for sexually active women
- Contraception counseling with reproductive capability as prescribed
- Screening and counseling for interpersonal and domestic violence

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*.

16. We now offer Substance Use Disorder (SUD) Care Management Program through Optum ™. This clinical care management outreach program provides ongoing support for those individuals impacted by substance use. Participants are assigned a master's level clinician to provide phone based support and advocacy including, but not limited to:

    - Toxicology screening
    - Meetings with patient's family
    - Referral management and appointment setting
    - Mobile App with patient portal and real-time care plan tracking
    - Unlimited after hour support for both patients and family members
    - Regular reporting

    This program is designed to engage participants in successful recovery by developing the best treatment options and guiding the participants to the right care. See Section 5(h). *Special features*.

17. We now cover wigs for hair loss due to the treatment of cancer. You pay 15% of the Plan allowance and all charges after we pay a maximum of $200 per lifetime 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 all charges after we pay a maximum of $200 per lifetime. The calendar year deductible does not apply. See Section 5(a). *Orthopedic and prosthetic devices*.

18. We clarified what a covered residential treatment facility is and our benefit.

    Residential Treatment Center: Residential treatment centers (RTCs) are accredited by a nationally recognized organization and licensed by the state, district, or territory to provide residential treatment for medical conditions, mental health conditions, and/or substance misuse. Accredited health care facilities (excluding hospitals, skilled nursing facilities, group homes, halfway houses, schools, and similar types of facilities) provide 24-hour residential evaluation, treatment and comprehensive specialized services relating to the individual's medical, physical, mental health, and/or substance misuse therapy needs. RTCs offer programs for persons who need short-term transitional services designed to achieve predicted outcomes focused on fostering improvement or stability in functional, physical and/or mental health, recognizing the individuality, strengths, and needs of the persons served. Benefits are available for services performed and billed by RTCs, as described below. If you have questions about treatment at an RTC, please contact Optum ™ at 866-512-3767.

    Precertification prior to admission to an RTC is required.

    A preliminary treatment plan and discharge plan must be developed and agreed to by the member, provider (residential treatment center (RTC)), and case manager prior to admission.

We cover inpatient care provided and billed by an RTC for members enrolled and participating in an approved plan of care, and when the care is medically necessary for treatment of a medical, mental health, and/or substance misuse condition:

- Room and board, such as semiprivate room, nursing care, meals, special diets, ancillary charges, and covered therapy services when billed by the facility.

Note: RTC benefits are not available for facilities licensed as a skilled nursing facility, group home, halfway house, schools, or similar type facility.

Note: Benefits are not available for non-covered services, including: respite care; outdoor residential programs; wilderness treatment or services provided outside of the provider's scope of practice; recreational therapy; educational therapy; educational classes; bio-feedback; Outward Bound programs; equine therapy provided during the approved stay; personal comfort items, such as guest meals and beds, telephone, television, beauty and barber services; custodial or long term care and domiciliary care provided because care in the home is not available or is unsuitable.

When services are rendered at In-Network facility, you pay $200 copayment per admission. You pay $350 copayment per admission and 30% of the Plan allowance when services are rendered at Out-of-Network facility. The calendar year deductible does not apply. See Section 5(e). *Mental health and substance misuse disorder benefits*.

19. We clarified newborn coverage during or after the mother's confinement. When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. See Section 3. *How to get care*.

20. We clarified coverage for services in conjunction with a routine examination. Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible. See Section 5(a). *Preventive care, adult*.

21. We clarified immunizations, boosters, and medications for travel or work-related exposure are not covered. Also, physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel are not covered. You are responsible for all charges. See Section 5(a). *Preventive care, adult.*

22. We added a reference in Section 5(a). *Preventive care, children* that well-child visits, examinations, and immunizations as described in the Bright Futures Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to http://brightfutures.aap.org/Pages/default.aspx.

23. We updated the term "substance abuse" to "substance misuse disorder" in the brochure. See Section 5(e). *Mental health and substance abuse benefits*.

24. We updated for members in the Commonwealth of Puerto Rico, all non-PPO physicians, hospitals, and facilities contracted through Zelis will be paid at the PPO benefit level. See Section 1. *Facts about the fee-for-service plan*.

25. We added a phone number for Disease management program – Your Health First. You may call 877-220-NALC (6252) to speak to a health advocate. See Section 5(h). Special Features.

26. We updated the toll-free number for Weight Management Program. Call the toll-free number at 844-305-0758. A personal dedicated coach is available 7 days a week 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.

27. We updated the website address for The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines www.bemedwise.org. See *Patient Safety Link.*

28. We updated the term "Privacy Official" to "Privacy Officer" in the brochure. See Section 1. *Notice of NALC Health Benefit Plan for Employees and Staff's Privacy Practices*.

29. We added a website address for Solutions for Caregivers so you may access educational resources and discounted products and services anytime online at www.UHCforCaregivers.com/welcome/nalchbp. Please use code NALCHBP when creating an account. See Section 5(h) *Special features*.

30. Section 8. *Claim and Appeal Procedures; Final review* is amended by adding the following as a last sentence in that subsection:

    The venue for any legal actions against the Plan shall be the U.S. District Court for the Eastern District of Virginia.

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 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.