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 2019

Dear Participants and Dependents:

This notice summarizes the modifications to the NALC Health Benefit Plan for Employees and Staff (Staff Plan) effective January 1, 2019. 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, 2018 through December 31, 2018. Any changes in your enrollment will be effective January 1, 2019.

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.

Please note that the Stephanie Stewart is now the Assistant Administrator of the NALC Health Benefit Plan for Employees and Staff, replacing Brian Hellman. Also, please note that Mack Julion has replaced Randall Keller as a Trustee of the Plan.

Modifications

The modifications, effective as of January 1, 2019, are as follows:

1. We require prior authorization (PA) for genetic testing. Benefits are available for diagnostic genetic testing when it is medically necessary to diagnose and/or manage a patient's medical condition. To get prior approval, please call 833-801-9264. You pay 15% of the Plan allowance when the services are rendered by a PPO provider after satisfaction of the $300 calendar year deductible. If the 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). *Lab, x-ray and other diagnostic tests* and Section 3. *How to get care*.

2. We now cover one preventive medicine counseling visit associated with a low-dose Computerized Tomography (LDCT) scan, one annually. 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 preeclampsia screening 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*.

4. We now cover obesity screening for adolescents and children 6 years of age 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, children*.

5. We now cover screening for postpartum diabetes mellitus after pregnancy, for women with a history of gestational diabetes mellitus. 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, adults.*

6. We now cover screening for urinary incontinence under Well-woman care. 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, adults*.

7. We now cover the Shingrix vaccine for the prevention of herpes zoster or shingles for age 50 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*.

8. We have updated the medical requirements to qualify for statin preventive medications; adults at increased risk of cardiovascular disease (CVD), age 40 through 75, with a calculated 10-year CVD event risk of 10% or greater, 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(f). *Preventive care medications*.

9. We now offer lower copayments and coinsurance for medication used to treat asthma, diabetes, and hypertension. For generic, you pay 10% of cost at a network retail pharmacy. Previously, you paid 20% of cost. For a 90-day supply, you pay $8 generic/$50 Formulary brand/$70 Non-formulary brand. Previously, you paid $12 generic/$65 Formulary brand/$80 Non-formulary brand. When you have Medicare, you pay 5% of cost at a network retail pharmacy for generic. Previously, you paid 10% of cost. For a 90-day supply, you pay $4 generic/$40 Formulary brand/$60 Non-formulary brand. Previously, you paid $6 generic/$55 Formulary brand/$70 Non-formulary brand. See Section 5(f). *Covered medications and supplies*.

10. We now cover skin cancer prevention counseling for children age 6 months through 21 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, children.*

11. We now offer the Transform Diabetes Care Program. This program helps deliver better overall care and lower costs for members with diabetes. It includes a connected glucometer, unlimited test strips and lancets, medication therapy counseling from a pharmacist, two annual diabetes screenings at a CVS MinuteClinic® and a suite of digital resources through the CVS mobile App, all at no cost. Please call CVS Caremark® at 800-933-NALC (6252) for more information. See Section 5(h). *Wellness and Other Special features*.

12. We no longer apply manufacturer discounts on Specialty medications to the patient's deductible or out-of-pocket maximum. Some specialty medications may qualify for third party copayment assistance programs which could lower your out-of-pocket costs for those medications. When specialty medication is purchased with a third party copayment assistance coupon, rebate, or card, the Plan will not apply the amount of the discount towards your out-of-pocket maximum. See Section 5(f). *Prescription Drug Benefits*.

13. We no longer require prior authorization for the shingles vaccine. Previously you needed to call 703-729-4677 or 888-636-NALC (6252) prior to purchasing the shingle vaccine at your local pharmacy. See Section 5(a). *Preventive care, adults.*

14. We now cover speech generating devices, limited to $1,250.00 per calendar year. The Plan requires a letter of medical necessity, or a copy of the prescription, from the prescribing physician which details the medical necessity to consider charges for the purchase or rental of DME. You pay 15% of the Plan allowance after satisfaction of the $300 calendar year deductible and all charges after we pay $1,250.00 in a calendar year for a 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 we pay $1,250.00 in a calendar year for a non-PPO provider. See Section 5(a). *Durable medical equipment (DME).*

15. You now pay $20 for a spinal or extraspinal manipulation rendered by a PPO provider. Previously you paid 15% of the Plan allowance 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.*

16. We clarified that the name of Section 5(h). should be Wellness and Other Special Features. See Section 5(h).

17. We clarified medical foods and nutritional supplements when administered by catheter or nasogastric tubes. You pay 15% of the Plan allowance when services are rendered by a PPO provider after 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. If medical foods or nutritional supplements are dispensed by a pharmacy, you will pay the appropriate pharmacy copay/coinsurance. See Section 5(f). *Covered medications and supplies*.

18. We clarified criteria and limitations for gender reassignment surgery benefits.

    - Gender reassignment surgical benefits are limited to the following:
        - For female to male surgery: mastectomy, hysterectomy, vaginectomy, salpingo-oophorectomy, metoidioplasty, phalloplasty, urethroplasty, and placement of an erectile prosthesis
        - For male to female surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, and labiaplasty

    Note: Prior approval required for gender reassignment surgery. For more information about prior approval, please refer to Section 3. *How You Get Care*.

    Note: Your provider must submit a treatment plan including all surgeries planned and the estimated date each will be performed. A new prior approval must be obtained if the treatment plan is approved and your provider later modifies the plan.

    Note: Benefits for gender reassignment surgery are limited to once per covered procedure, per lifetime. Benefits are not available for repeat or revision procedures when benefits were provided for the initial procedure. Benefits are not available for gender reassignment surgery for any condition other than gender dysphoria.

    - Gender reassignment surgery on an inpatient or outpatient basis is subject to the pre-surgical requirements listed below. **The patient must meet all requirements**.
        - Prior approval is 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 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
        - Patient must meet the following criteria:
            - Documentation the individual has lived for at least 12 continuous months in a gender role that is congruent with their gender identity (including place of employment, family, social and community activities)
            - 12 months of continuous hormone therapy appropriate to the patient's gender identity
            - Two referral letters from mental health professionals (Master's level or more advanced degree from an accredited institution) to include a letter of recommendation for the procedure
            - If medical or mental health concerns are present, they are being optimally managed and are reasonably well-controlled
        - Reversal of a gender reassignment surgery is covered only when determined to be medically necessary or a complication occurs

    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 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.*

19. We added a link from our website to all covered immunizations for adults and children. Visit our website http://staff.nalchbp.org for a complete list of adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC) based on the Advisory Committee on Immunization Practices (ACIP) schedule. Also, see the American Academy of Pediatrics Bright Futures Guideline at http://staff.nalchbp.org for a complete list of childhood immunizations. See Section 5(a). *Preventive care, adult,* and Section 5(a). *Preventive care, children.*

20. We clarified that some local pharmacies have refill limitations that differ from those listed in our brochure. Most prescriptions can be filled after 75% of the drug has been used. However, individual pharmacists may refuse to fill or refill a prescription if there is a question about the order's accuracy, validity, authenticity, or safety to the patient, based on the pharmacists' professional judgement. Network retail pharmacy limitations are waived when you have Medicare Part D as your primary payor and they cover the drug. See Section 5(f). *Prescription Drug Benefits*.

21. We clarified the difference between the USPSTF and the Bright Futures/AAP recommendations for vision screening for children.

    - Vision screening for amblyopia or its risk factors (limited to: strabismus, astigmatism, anisometrophia, and hyperopia) as recommended by the U.S. Preventive Services Task Force (USPSTF) and Bright Futures/AAP – one annually age 3 through 5
    - Vision screening as recommended by Bright Futures/AAP, age 6 through 18

    You pay nothing 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). *Preventive Care, children.*

22. We clarified which accreditations a freestanding ambulatory facility must have to be covered by the Plan. An outpatient facility accredited by the Joint Commission, Accreditation Association of Ambulatory Health Care (AAAHC), American Association for the Accreditation of Ambulatory Surgery Facilities (AAAASF), Health Facilities Accreditation Program (HFAP), or that has Medicare certification. See Section 3. *How You Get Care*.

23. We added a link from our website http://staff.nalchbp.org to a list of all specialty drugs including biotech, biological, biopharmaceutical, and oral chemotherapy drugs requiring prior approval. You may also call CVS Specialty™ at 800-237-2767 to obtain prior approval, for more information, or a complete list. See Section 5(f). *Prescription Drug Benefits*.

24. We clarified how we process claims when the Plan is secondary under the Prescription drug benefit. When you have other prescription drug coverage, and the other carrier is primary, use that carrier's drug benefit first. After the primary carrier has processed the claim and made a payment, we will pay as secondary up to our Plan limit. If no payment is made by the primary payor, complete the short-term prescription claim form, attach the drug receipts and other carrier's reason for denial and mail to the NALC Prescription Drug Program. NALC Prescription Drug Program, P.O. Box 52192, Phoenix, AZ 85072-2192. See Section 5(f). *Prescription Drug Benefits*.

25. We clarified the You pay for non-PPO hospital confinements under Inpatient hospital. When services are provided by a non-PPO hospital, you pay $350 copayment per admission and 30% of the Plan allowance

and the difference, if any, between our allowance and the billed amount. See Section 5(c). *Inpatient Hospital*.

26. We clarified that the waiver of two $20 PPO medical office visit copayments will be applied to claims for services rendered after completion of the Health Assessment. See 5(h). *Wellness and Other Special Features*.

27. We clarified that telemental health visits may also be referred to as virtual visits. We cover outpatient telemental or virtual visits rendered by providers such as psychiatrists, psychologists, or clinical social workers. To find a telemental/virtual visit provider, call Optum at 866-512-3767. You pay $20 copayment when services are rendered by an In-Network provider. When services are rendered by an Out-of-Network 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(e). *Mental Health and Substance Use Disorder Benefits*.

28. We updated the hours of operation for the Weight Management Program. Individuals can enroll in the Weight Talk® Program online at https://staff.nalchbp.org or call the toll-free number at 844-305-0758. A personal dedicated coach is available 7 days a week from 5:00 a.m. to 9:00 p.m. Pacific time. See Section 5(h). *Wellness and Other Special Features*.

If you have any questions concerning this summary or the Staff Plan, please contact the Nongroup Department at 703-729-4677 or 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.