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 2020

Dear Participants and Dependents:

This notice summarizes the modifications to the NALC Health Benefit Plan for Employees and Staff (Staff Plan) effective January 1, 2020. 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, 2019 through December 31, 2019. Any changes in your enrollment will be effective January 1, 2020.

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, 2020, are as follows:

1. We now cover medical virtual doctor visits for minor acute conditions through NALCHBP Telehealth. You pay a $10 copayment per visit if a PPO provider is used. When services are rendered by a non-PPO provider, you pay all charges. See Section 5(a). *Diagnostic and treatment services.*

    - Download the NALCHBP Telehealth mobile app, visit http://www.nalchbptelehealth.org, or call 888-541-7706 to access high quality, affordable care, when you need it, where you need it. Care is provided by U.S. board licensed and credentialed physicians and nurse practitioners who can write a prescription for medication, if appropriate. Virtual visits can be used for adults or children with minor acute, non-emergency medical conditions such as flu, sinus problems, allergies, abrasions, or minor wounds. See Section 5(h). *Wellness and Other Special Features.*

- Definition of “minor acute conditions” - Common, non-emergent medical conditions. Examples of common conditions include allergies, cold and flu symptoms, sinus problems, skin disturbances, and minor wounds and abrasions. See Section 12. *Definitions of terms we use in this brochure.*

2. We decreased the copayment for outpatient telemental/virtual visits to $10 when you use an In-Network provider. Previously, you paid $20. 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). *In-Network and Out-of-Network benefits.*

3. You will now pay a $350 copayment per admission to or observation stay in a PPO hospital. Previously, you paid $200. See Section 5(c). *Inpatient hospital* and Section 5(e). *In-Network and Out-of-Network benefits.*

4. You will now pay a $450 copayment and 35% of the Plan allowance plus the difference between our allowance and the billed amount per admission to a non-PPO facility. Previously, you paid $350 and 30%. See Section 5(c). *Inpatient hospital* and Section 5(e). *In-Network and Out-of-Network benefits.*

5. We now cover charges for a non-PPO assistant surgeon at the PPO benefit level when services are performed at a PPO hospital or ambulatory surgical center, and the primary surgeon is PPO. You pay 15% of the Plan allowance. 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.*

6. We now cover vasectomies at 100% when performed by a PPO provider. 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). *Family planning* and Section 5(b). *Surgical procedures.*

7. We now cover osteoporosis screenings for women age 65 and older and all postmenopausal women younger than age 65 who are at increased risk 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 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 now cover up to four (4) outpatient visits at 100% to treat postpartum depression or depression during pregnancy when you use an In-Network mental health provider. This includes individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers. When services are rendered by an Out-of-Network mental health 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. After four (4) visits have been paid at 100%, regular mental health benefits apply. See Section 5(a). *Maternity care* and Section 5(e). *In-Network and Out-of-Network benefits.*

9. We increased the Plan payment for hearing aids and related examination to $1,000 per ear with replacements covered every 3 years when a PPO provider is used. Previously, we paid $500 per ear with replacements covered every 3 years. When services are rendered by a non-PPO provider, you pay all charges after we pay $1,000 per ear. See Section 5(a). *Hearing services (testing, treatment, and supplies).*

10. We increased the Plan payment for one pair of custom functional foot orthotics, including casting, to $500 with replacements every 2 years when prescribed by a physician. Previously, we paid $400 with replacements every 5 years. When services are rendered by a non-PPO provider, you pay 30% of the Plan allowance and all charges after we pay $500. See Section 5(a). *Orthopedic and prosthetic devices.*

11. We now cover eating disorders under our Educational classes and nutritional therapy benefit. You pay nothing if services are prescribed by the attending physician and administered by a covered PPO provider, such as a registered nurse or a licensed or registered dietician/nutritionist. 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*.

12. We now offer the Real Appeal® weight loss program. Previously, we offered Weight Talk®. The Real Appeal® Program through Optum™ is an online weight loss program that offers group and one-on-one personalized coaching through an online and mobile platform. The program focuses on weight loss through proper nutrition, exercise, sleep and stress management. Members will have access to a Transformation Coach and a suite of online tools to help track food and activity. Members will also receive a Success Kit to support their weight loss journey including a food and weight scale, resistance band, workout DVDs and more!

    Coaching sessions are scheduled online at the members' convenience and educational content is provided throughout the year. Coaches will be able to see the participants' progress throughout the course of the program and be able to offer personalized support. Real Appeal® encourages members to make small changes toward larger long-term health results with sustained support throughout the duration of the program.

    Members can enroll in the Real Appeal® Program online at http://staff.nalchbp.org. You pay nothing for services obtained through the Real Appeal® Program offered by the Plan. See Section 5(a). *Educational classes and programs* and Section 5(h). *Wellness and Other Special features.*

13. We now cover urine drug testing/screening for non-cancerous chronic pain and substance use disorder limited to:

    - 16 definitive (quantitative) drug tests per calendar year
        - Definition of "definitive" - A urine test that measures the quantity of a substance present in a specimen.
    - 32 presumptive (qualitative) drug tests per calendar year
        - Definition of "presumptive" - A urine test that confirms if a substance is present in a specimen.

    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). *Lab, x-ray and other diagnostic tests*, Section 5(e). *In-Network and Out-of-Network benefits*, and Section 12. *Definitions of terms we use in this brochure.*

14. We now offer a standard drug formulary with prior authorization. Previously, we had an open drug formulary. See Section 5(f). *Prescription Drug Benefits.*

15. You will now pay 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount for prescriptions purchased at a non-network retail pharmacy. Previously, you paid 45%. See Section 5(f). *Covered medications and supplies.*

16. You will now pay 50% of the cost for non-formulary brand drugs purchased at a retail pharmacy if NALC Health Benefit Plan for Employees and Staff is primary. Members for whom Medicare is primary will now pay 40% of the cost. Previously, you paid 45% and 30%, respectively. See Section 5(f). *Covered medications and supplies.*

17. You will now pay the following copayments for mail order prescriptions:

    - 60-day supply for NALC Health Benefit Plan for Employees and Staff primary members: $10 generic, $60 Formulary brand, $84 Non-formulary brand
    - 90-day supply for NALC Health Benefit Plan for Employees and Staff primary members: $15 generic, $90 Formulary, $125 Non-formulary brand
    - 60-day supply for Medicare primary members: $7 generic, $50 Formulary brand, $75 Non-formulary brand
    - 90-day supply for Medicare primary members: $10 generic, $75 Formulary brand, $110 Non-formulary brand

    See Section 5(f). *Covered medications and supplies.*

18. We clarified that contraceptive drugs are not limited to the Prescription Drug Benefit. See Section 5(a). *Family planning.*

19. You will now pay $200 for a 30-day supply of a specialty medication, $300 for a 60-day supply, and $400 for a 90-day supply. Previously, you paid $150, $250, and $350, respectively. See Section 5(f). *Covered medications and supplies.*

20. We no longer cover over-the-counter Vitamin D supplements for adults 65 and older. You pay all charges. See Section 5(f). *Preventive care medications.*

21. We now require prior authorization for 510K dermatological products and artificial saliva. Call CVS Caremark® at 800-294-5979 to obtain a list of medications or to obtain prior authorization. See Section 3. *How you get care* and Section 5(f). *Prescription drug benefits.*

22. We clarified that for prescriptions purchased at NALC CareSelect pharmacies, you may obtain up to a 30-day fill plus one refill. If you purchase more than two fills of a maintenance medication at a network pharmacy without prior Plan authorization, you will need to file a paper claim to receive reimbursement at 55% of the Plan allowance. See Section 5(f). *Prescription drug benefits.*

23. We clarified that we periodically review and update the prior authorization (PA) drug list in accordance with the guidelines set by the US Food and Drug Administration (FDA) as a result of new drugs, new generic drugs, new therapies, and other factors. Call CVS Caremark® at 800-933-NALC (6252) to obtain prior authorization. See Section 5(f). *Prescription drug benefits.*

24. We clarified that if you would like to obtain 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), you should visit https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf, or you can visit our website at http://staff.nalchbp.org. See Section 5(a). *Preventive care, adult.*

25. We clarified that if you would like to obtain a complete list of childhood immunizations endorsed by the Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics based on the Advisory Committee on Immunization Practices (ACIP), you should visit https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf, or you can visit our website at http://staff.nalchbp.org. See Section 5(a). *Preventive care, children.*

26. We clarified that prior approval is required for BRCA testing whether performed for preventive or diagnostic reasons. Call 833-801-9264 for prior approval. See Section 3. *How you get care*, Section 5(a). *Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals,* and Section 5(a*). Preventive care, adult.*

27. We clarified that hearing aids are covered for diagnoses other than neurosensory hearing loss. See Section 5(a). *Hearing services (testing, treatment, and supplies).*

28. We clarified that custom-made durable braces are covered every 3 years for legs, arms, neck, and back. See Section 5(a). *Orthopedic and prosthetic devices.*

29. We clarified that total electric hospital beds are not covered. See Section 5(a). *Durable medical equipment (DME).*

30. We clarified that manual and semi-electric hospital beds are covered. See Section 5(a). *Durable medical equipment (DME).*

31. We clarified that furniture, such as adjustable mattresses and recliners, is not covered, even when prescribed by a physician. See Section 5(a). *Durable medical equipment (DME).*

32. We clarified that covered speech generating devices include digitized speech devices using pre-recorded messages and synthesized speech devices requiring multiple methods of message formulation and device access. Also included are software programs, mounting systems, and accessories. See Section 5(a). *Durable medical equipment (DME).*

33. We clarified that when spinal and extraspinal manipulations are performed on the same day, a separate $20 copayment applies to each type of manipulation billed. See Section 5(a). *Chiropractic.*

34. We clarified that dry needling is not covered. See Section 5(a). *Physical, occupational, and speech therapies.*

35. We clarified that Hospice is a coordinated program of maintenance, palliative, and supportive care for the terminally ill provided by a medically supervised team under the direction of a Plan-approved independent hospice administration. See Section 5(c). *Hospice care.*

36. We clarified that your enrollment in the Transform Diabetes Care program 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.*

37. We clarified that CareAllies 24-Hour Nurse Line is now called CareAllies 24-Hour Health Information Line. See Section 5(h). *Wellness and Other Special Features.*

38. We clarified that you pay 15% of the Plan allowance after satisfaction of the $300 calendar year deductible for emergency room physician care if the provider is PPO and the charges aren't due to an accidental injury or medical emergency. 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). *Diagnostic and treatment services* and Section 5(d). *Medical emergency.*

39. We clarified that when Medicare is the primary payor and is not covering a service or supply that is covered by the Plan, we will review the Medicare Summary Notice or Medicare Remittance Advice Statement to see if the charge is a contractual obligation (CO) or if it is the patient's responsibility (PR). When the service or supply is the patient's responsibility, we will pay either the charge or our Plan allowance, whichever is less, at 100%.

    If we believe Medicare may have incorrectly denied a service or supply, we will ask the provider or facility to refile with Medicare. See Section 9. *Coordinating benefits with other coverage.*

40. We clarified that we may seek an independent expert opinion to determine our Plan allowance. In the absence of seeking an expert opinion to determine Plan allowance, our allowance will be based on 80% of the billed amount, including foreign claims. See Section 12. *Definitions of terms we use in this brochure.*

41. We clarified that coverage may extend beyond the diagnoses listed in the brochure for blood or marrow stem cell transplants covered only in a National Cancer Institute (NCI) or National Institutes of Health (NIH) approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. See Section 5(b). *Organ/tissue transplants.*

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.