APWU Health Plan

http://www.apwuhp.com
Customer Service 1-800-222-(APWU) 2798

APWU HEALTH PLAN

2014

A fee-for-service plan (high option) and a consumer driven health plan with preferred provider organizations

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 8 for details.

Sponsored and administered by: American Postal Workers Union, AFL-CIO

Who may enroll in this Plan: All Federal and Postal Service employees and annuitants who are eligible to enroll in the FEHB Program may become members of this Plan. To enroll, you must be, or must become, a member or associate member of the American Postal Workers Union, AFL-CIO.

IMPORTANT
- Rates: Back Cover
- Changes for 2014: Page 15
- Summary of benefits: Page 138

NCQA Measuring quality. Improving health care.

HEDIS COMPLIANCE AUDIT NCQA AUDITED 2013

URAC ACCREDITED

NCQA Accreditation: Cigna, UnitedHealthcare and ValueOptions
HEDIS Accreditation: NCQA HEDIS Compliance Audit
URAC Accreditation: Cigna/CareAllies, UnitedHealthcare, ValueOptions, Express Scripts, Optum Rx

See the 2014 Guide for more information about accreditation.

To become a member or associate member: All active Postal Service APWU bargaining unit employees must be, or must become, dues-paying members of the APWU, to be eligible to enroll in the Health Plan. All Federal employees, other Postal Service employees in non-APWU bargaining units, and annuitants will automatically become associate members of APWU upon enrollment in the APWU Health Plan.

Membership dues: Associate members will be billed by the APWU for the $35 annual membership fee, except where exempt by law. APWU will bill new associate members for the annual dues when it receives notice of enrollment. APWU will also bill continuing associate members for the annual membership. Active and retiree non-associate APWU membership dues vary.

Enrollment codes for this Plan:

471 - High Option - Self Only / 472 - High Option - Self and Family
474 - Consumer Driven Option - Self Only / 475 - Consumer Driven Option - Self and Family

FEHB Federal Employees Health Benefits Program

Authorized for distribution by the:

United States Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

RI 71-004

Important Notice from APWU Health Plan About

Our Prescription Drug Coverage and Medicare

OPM has determined that the APWU Health Plan prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all Plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15th through December 7th) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048).

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Introduction

This brochure describes the benefits of APWU Health Plan under our contract (CS 1370) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. This Plan is underwritten by the American Postal Workers Union, AFL-CIO. Customer Service may be reached at 1-800-222-APWU (2798) or through our Web site: www.apwuhp.com. The address for the APWU Health Plan administrative office is:

APWU Health Plan
799 Cromwell Park Drive, Suites K-Z
Glen Burnie, MD 21061

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2014, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2014, and changes are summarized on page 15. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for benefits the plan provides.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member; "we" means APWU Health Plan.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud - Here are some things you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care provider, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.

- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services that you did not receive.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 1-800-222-APWU (2798) and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE
877-499-7295
OR go to www.opm.gov/oig
You can also write to:
United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.
- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have such as latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - "Exactly what will you be doing?"
  - "About how long will it take?"
  - "What will happen after surgery?"
  - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

www.ahrq.gov/consumer/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Never Events

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct never events, if you use APWU Health Plan preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen called "Never Events". When a Never Event occurs, neither your FEHB plan nor you will incur costs to correct the medical error.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

  We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

  The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

- **Where you can get information about enrolling in the FEHB Program**

  See www.opm.gov/healthcare-insurance/healthcare for enrollment information as well as:

  - Information on the FEHB Program and plans available to you
  - A health plan comparison tool
  - A list of agencies who participate in Employee Express
  - A link to Employee Express
  - Information on and links to other electronic enrollment systems

  Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Benefits,* brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

  - When you may change your enrollment
  - How you can cover your family members
  - What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire
  - What happens when your enrollment ends
  - When the next Open Season for enrollment begins

  We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

- **Types of coverage available for you and your family**

  Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

  If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB Web site at www.opm.gov/healthcare-insurance/life-event. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/ payroll office, or retirement office.

- **Family Member Coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below...

Children	Coverage
Natural, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster Children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children Incapable of Self-Support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married Children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/healthcare-insurance.

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;

- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2014 benefits of your old plan or option** except when you are enrolled under this Plan's Consumer Driven Option. Under this Plan's Consumer Driven Option, between January 1 and the effective date of your new plan (or change to High Option of this Plan) you will **not** receive a new Personal Care Account (PCA) for 2014 but any unused PCA benefits from 2013 will be available to you. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2013 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

Under the Consumer Driven Option, if you joined this Plan during Open Season, you recieve the full Personal Care Account (PCA) as of your effective date of coverage. If you joined at any other time during the year, your PCA and your Deductible for your first year will be prorated for each full month of coverage remaining in that calendar year.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment; or
- You are a family member no longer eligible for coverage.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy).

- **Upon divorce**

If you are divorced from a Federal employee, or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/healthcare-insurance/healthcare/plan-information/guides.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn age 26, regardless of marital status, etc.

You may not elect TCC if you are fired from your Federal or Tribal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* from your employing or retirement office or from www.opm.gov/healthcare-insurance/healthcare/plan-information/guides. It explains what you have to do to enroll.

We also want to inform you that the Patient Protection and Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules.

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal or Tribal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

- **Getting a Certificate of Group Health Plan Coverage**

  The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

  For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Web site at www.opm.gov/healthcare-insurance/healthcare; refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

- **Health Insurance Market Place**

  If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit **www.HealthCare.gov**. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

- **APWU Health Plan Notice of Privacy Practices**

  The APWU Health Plan's Notice of Privacy Practices describes how medical information about you may be used by the Heatlh Plan, your rights concerning your health information and how to exercise them, and APWU Health Plan's responsibilities in protecting your health information. The Notice is posted on the Health Plan's Web site. If you need to obtain a copy of the Health Plan's Notice of Privacy Practices, you may either contact the Health Plan via e-mail through the Web site, www.apwuhp.com, or by calling 1-800-222-APWU (2798).

Section 1. How this Plan works

This Plan is a fee-for-service (FFS) plan. You can choose your own physicians, hospitals, and other health care providers. We give you a choice of enrollment in a High Option or a Consumer Driven Health Plan (CDHP).

We reimburse you or your provider for your covered services, usually based on a percentage of the amount we allow. The type and extent of covered services, and the amount we allow, may be different from other plans. Read brochures carefully.

General features of our High Option

We have Preferred Provider Organizations (PPOs):

Our fee-for-service plans offer services through PPO networks. This means that certain hospitals and other health care providers are "preferred providers". When you use our network providers, you will receive covered services at a reduced cost. APWU Health Plan is solely responsible for the selection of PPO providers in your area. The PPO networks for the High Option and the Consumer Driven Option are different.

The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas. If no PPO provider is available, or you do not use a PPO provider, the standard non-PPO benefits apply. However, if surgical services are rendered at a PPO hospital or a PPO freestanding ambulatory facility by a PPO primary surgeon, we will pay the services of anesthesiologists who are not preferred providers at the PPO rate, based on Plan allowance. If the covered services are performed at a PPO hospital or a PPO freestanding ambulatory facility, we will pay the services of radiologists and pathologists who are not preferred providers at the PPO rate, based on the Plan allowance.

High Option PPO Network: Contact APWU Health Plan at 1-800-222-APWU (2798) to request a High Option PPO directory. You can also go to our Web page, which you can reach through the FEHB Web site, www.opm.gov/healthcare-insurance/healthcare. If you need assistance in identifying a participating provider or to verify their continued participation, call the Plan's PPO administrator for your state: The Plan uses Cigna as its PPO network in all states, Cigna 1-800-582-1314. For providers in the U.S. Virgin Islands call V.I. Equicare 1-340-774-5779 and for hospitals in the U.S. Virgin Islands call Cigna 1-800-582-1314. For mental health/substance abuse providers (all states), call ValueOptions toll-free 1-888-700-7965.

When you leave your state of residence, Cigna is your travel network, available in all 50 states and the District of Columbia. When out of your state of residence, if you do not use a Cigna PPO provider or a Cigna PPO provider is not available, standard non-PPO benefits apply. For assistance in identifying a provider in the travel network, call Cigna 1-800-582-1314.

This Plan offers you access to certain non-PPO health care providers that have agreed to discount their charges. Covered services by these providers are considered at the negotiated rate subject to applicable deductibles, copayments and coinsurance. Since these providers are not PPO providers, non-PPO benefit levels will apply. Contact Cigna at 1-800-582-1314, prompt 8, for more information.

General features of our Consumer Driven Health Plan (CDHP)

Preventive benefits: Preventive care services are generally covered with no cost-sharing and are not subject to copayments, deductibles or annual limits when received from a network provider.

Personal Care Account (PCA) benefits: This component is used first to provide first dollar coverage for covered medical, dental and vision care services until the account balance is exhausted.

Traditional benefits: After you have used up your Personal Care Account and satisfied a Deductible, the Plan starts paying benefits under the Traditional Health Coverage as described in Section 5 CDHP.

Consumer Driven Option PPO Network: If you need assistance identifying a participating provider or to verify their continued participation, call the Plan's Consumer Driven Option administrator, UnitedHealthcare, at 1-800-718-1299 or you can go to their Web page, http://www.welcometouhc.com/apwu, for a full nationwide online provider directory. UnitedHealthcare is the PPO network for all states and Puerto Rico. Printed provider directories are **not** available.

How we pay providers

PPO Providers: Allowable benefits are based upon charges and discounts which we or our PPO administrators have negotiated with participating providers. PPO provider charges are always within our Plan allowance.

Non-PPO providers: We determine our allowance for covered charges by using health care charge data prepared by Context4Healthcare for the High Option and OptumInsight for the Consumer Driven Health Plan, including our own data, when necessary. We apply this charge data under the High Option at the 70th percentile and under the Consumer Driven Option at the 80th percentile.

Your rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB Web site (www.opm.gov/healthcare-insurance/healthcare) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- CareAllies inpatient precertification and case management services are provided for the High Option in all states. Cigna Health Management, Inc., the company through which the CareAllies program is administered, is fully accredited by URAC for Health Utilization Management and Case Management.
- Cigna performs Disease Management for the High Option. Cigna holds NCQA Health Plan Accreditation for PPO which includes their network.
- Express Scripts, the Health Plan's High Option Pharmacy Benefit Manager (PBM), is accredited by URAC for Mail Service Pharmacy, Specialty Pharmacy (Accredo) and Health Utilization Management.
- ValueOptions performs hospital precertification, continued stay review and outpatient prior authorization for mental health/substance abuse services for the High Option and Consumer Driven Option. They are accredited by URAC for Health Utilization Management and by NCQA for Managed Behavioral HealthCare Organizations.
- UnitedHealthcare (UHC) administers the Consumer Driven Option. They are accredited by URAC for Case Management and by URAC and NCQA for Disease Management. UHC also holds NCQA Health Plan accreditation.
- Optum Rx, the Pharmacy Benefit Manager (PBM) for the Consumer Driven Option is accredited by URAC for Pharmacy Benefit Management and Drug Therapy Management.
- The American Postal Workers Union Health Plan is a not-for-profit Voluntary Employee's Beneficiary Association (VEBA) formed in 1972.
- We meet applicable State and Federal licensing and accreditation requirements for fiscal solvency, confidentiality and transfer of medical records.

If you want more information about us, call 1-800-222-APWU (2798), or write to APWU Health Plan, P.O. Box 1358, Glen Burnie, MD 21060-1358. You may also contact us by fax at 1-410-424-1564 or visit our Web site at www.apwuhp.com.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Section 2. Changes for 2014

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

- Montana and South Dakota were designated as a Medically Underserved Area in 2013, but will not be so designated for 2014.

Changes to this Plan

Changes to our High Option only

- Your share of the Postal premium will increase for Self Only or increase for Self and Family (see page 146).
- Your share of the non-Postal premium will increase for Self Only or increase for Self and Family (see page 146).
- The Plan now offers an out-of-pocket Catastrophic Limit for prescription drugs (see page 27).
- The Plan now offers a Maternity benefit to provide in-network care at no cost (see page 36).
- The Plan now provides Lab services at no cost when LabCorp or Quest Diagnostics performs the covered lab services (see page 33).
- The Health Plan now offers an out-of-pocket catastrophic limit for prescription drugs (see page 27).
- The Plan will now pay all radiologists and pathologists in a PPO hospital as in-network even if they are not preferred providers (see pages 32, 44, 51 and 54).
- When a hospital only has private rooms, the Plan now covers the private room rate (see page 51).
- The Plan now provides in-network HIV screening at no cost (see page 34).
- The Plan now provides one-time hepatitis C test for those born from 1945-1965 at no cost (see page 34).
- The Plan now provides a step therapy program for Osteoporosis, Migraine, Glaucoma and Hypoglycemic medications (see page 60).
- The Plan now covers habilitative services (see page 38 and 39).
- The Plan now offers Diabetes self-management training (see page 43).

Changes to our Consumer Driven Health Plan only

- Your share of the Postal premium will increase for Self Only or increase for Self and Family (see page 146).
- Your share of the non-Postal premium will increase for Self Only or increase for Self and Family (see page146).
- The Plan now offers an out-of-pocket Catastrophic Limit for prescription drugs (see page 27).
- The Plan now offers a Maternity benefit to provide in-network care at no cost (see page 81).
- The Plan will now pay radiologists and pathologists in an in-network hospital as in-network even if they are not preferred providers (see pages 80, 88, 95 and 99).
- The Plan now provides in-network HIV screening at no cost (see page 73).
- The Plan now provides one-time hepatitis C test for those born from 1945-1965 at no cost (see page 72).
- The Plan now offers habilitative services (see pages 83, 84).
- The Plan now offers Diabetes self-management training (see page 87).

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, contact us as follows:

- **High Option:** Call us at 1-800-222-APWU (2798) or write to us at P.O. Box 1358, Glen Burnie, MD 21060-1358 or through our Web site at www.apwuhp.com.
- **Consumer Driven Option:** Call UnitedHealthcare at 1-800-718-1299 or write to us at P.O. Box 740810, Atlanta, GA 30374-0810 or request replacement cards through the Web site at www.myuhc.com.

Where you get covered care

You can get care from any "covered provider" or "covered facility." How much we pay – and you pay – depends on the type of covered provider or facility you use. If you use our preferred providers, you will pay less.

- **Covered providers**

We consider the following to be covered providers when they perform services within the scope of their license or certification:

1. Doctor – A licensed Doctor of Medicine (M.D.), a licensed Doctor of Osteopathy (D.O.), a licensed Doctor of Podiatry (D.P.M.), or, for certain specified services covered by this Plan, a licensed dentist, licensed chiropractor, or licensed clinical psychologist practicing within the scope of the license.
2. Alternate Provider – Alternate providers are covered when performing certain specified services covered by this Plan and when such treatment is within the scope of the provider's license. Alternate providers are limited to licensed physical, occupational and speech therapists; licensed physician's assistants; Registered Nurses (R.N.); Licensed Practical Nurses (L.P.N.); Licensed Vocational Nurses (L.V.N.); Certified Registered Nurse Anesthetists (C.R.N.A.); and licensed acupuncturist (LAc).
3. Other covered providers include a qualified clinical psychologist, clinical social worker, optometrist, audiologist, nurse midwife, nurse practitioner/clinical specialist, and nursing school administered clinic. For purposes of this FEHB brochure, the term "doctor" includes all of these providers when the services are performed within the scope of their license or certification.

Medically underserved areas. We cover any licensed medical practitioner for any covered service performed within the scope of that license in the states OPM determines are "medically underserved." For 2014, the states are: Alabama, Arizona, Idaho, Illinois, Louisiana, Mississippi, Missouri, New Mexico, Oklahoma, South Carolina, South Dakota and Wyoming.

- **Covered facilities**

Covered facilities include:

- Freestanding ambulatory facility

  An out-of-hospital facility such as a medical, cancer, dialysis, or surgical center or clinic, and licensed outpatient facilities accredited by the Joint Commission on Accreditation of Healthcare Organizations for treatment of substance abuse.
- Hospital

1. An institution which is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations, or
2. Any other institution which is operated pursuant to law, under the supervision of a staff of doctors and twenty-four hour a day nursing service, and which is primarily engaged in providing:

   a) general inpatient care and treatment of sick and injured persons through medical, diagnostic and major surgical facilities, all of which must be provided on its premises or under its control, or

   b) specialized inpatient medical care and treatment of sick or injured persons through medical and diagnostic facilities (including X-ray and laboratory) on its premises, under its control, or through a written agreement with a hospital (as defined above) or with a specialized provider of those facilities.

   The term "hospital" shall not include a skilled nursing facility, a convalescent nursing home or institution or part thereof which 1) is used principally as a convalescent facility, rest facility, residential treatment center, nursing facility or facility for the aged; or 2) furnishes primarily domiciliary or custodial care, including training in the routines of daily living.

- **Transitional care**

Specialty care: If you have a chronic or disabling condition and

- lose access to your specialist because we drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB plan, or
- lose access to your PPO specialist because we terminate our contract with your specialist for reasons other than cause,

you may be able to continue seeing your specialist and receiving any PPO benefits for up to 90 days after you recieve notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist and your PPO benefits continue until the end of your postpartum care, even if it is beyond the 90 days.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our High Option begins, call our Customer Service Department immediately at 1-800-222-APWU (2798). For the Consumer Driven Option, please call UnitedHealthcare at 1-800-718-1299. If you are new to the FEHB Program, we will reimburse you for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

The pre-service claim approval processes for inpatient hospital admissions (called precertification) and for other services, are detailed in this Section. A **pre-service** claim is any claim, in whole or in part, that requires approval from us in advance of obtaining medical care or services. In other words, a pre-service claim for benefits (1) requires precertification, prior approval or a referral and (2) will result in a reduction of benefits if you do not obtain precertification, prior approval or a referral.

- **Inpatient hospital admission**

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition. Unless we are misled by the information given to us, we won't change our decision on medical necessity.

In most cases, your physician or hospital will take care of requesting precertification. Because you are still responsible for ensuring that your care is precertified, you should always ask your physician or hospital whether they have contacted us.

Warning

We will reduce our benefits for the inpatient hospital stay by $500 if no one contacts us for precertification. If the stay is not medically necessary, we will only pay for any covered medical services and supplies that are otherwise payable on an outpatient basis.

Exceptions

You do not need precertification in these cases:

- You are admitted to a hospital outside the United States and Puerto Rico.
- You have another group health insurance policy that is the primary payor for the hospital stay.
- Medicare Part A is the primary payor for the hospital stay. Note: If you exhaust your Medicare hospital benefits and do not want to use your Medicare lifetime reserve days, then we will become the primary payor and you **do** need precertification.

- **Other services**

Some services require prior approval **(High Option)** and some require pre-notification **(Consumer Driven Option)**:

- Prior approval/pre-notification is required for organ transplantation. Call before your first evaluation as a potential candidate.
- Prior approval/pre-notification is required for surgical procedures which may be cosmetic in nature such as eyelid surgery (blepharoplasty) or varicose vein surgery (sclerotherapy).
- Prior approval/pre-notification is required for recognized surgery for morbid obesity (bariatric surgery) or for organic impotence.
- Prior approval/pre-notification is required for home health care such as nursing visits, infusion therapy, growth hormone therapy (GHT), rehabilitative and habilitative therapy (physical, occupational or speech therapy - High Option only) and pulmonary rehabilitation programs.
- Prior approval/pre-notification is required for durable medical equipment such as wheelchairs, oxygen equipment and supplies, artificial limbs (prosthetic devices) and braces.
- Prior approval is required for genetic testing (High Option only).
- Prior approval is required for minimally invasive treatment of back and neck pain. This requirement applies to both the physician services and the facility. The following services require prior approval: trigger point injections, epidural steroid injections, facet joint injections, sacroiliac joint injections (High Option only).
- Prior approval for the High Option for outpatient services is not needed at Veterans Administration facilities.

High Option: Call Cigna/CareAllies at 1-800-582-1314 if you need any of the services listed above.

Consumer Driven Option: Call UnitedHealthcare at 1-800-718-1299 if you need any of the services listed above.

- Prior approval/pre-notification is required for certain classes of drugs and coverage authorization is required for some medications. This authorization uses Plan rules based on FDA-approved prescribing and safety information, clinical guidelines, and uses that are considered reasonable, safe, and effective. For example, prescription drugs used for cosmetic purposes such as Retin A or Botox may not be covered. Other medications might be limited to a certain amount (such as quantity or dosage) within a specific time period, or require authorization to confirm clinical use based on FDA labeling.
  - To inquire if your medication requires prior approval or authorization, call Express Scripts Customer Service at 1-800-841-2734 for the High Option (See Section 5(f), page 60) and Optum Rx at 1-800-718-1299 for the Consumer Driven Option (Section 5(f), page 105).
- Prior approval is also required for mental health and substance abuse benefits, inpatient or outpatient, in-network or out-of-network. Under the High Option and the Consumer Driven Option, call ValueOptions at 1-888-700-7965.

How to request precertification for an admission or get prior authorization for Other services

- **High Option:** First you, your representative, your physician, or your hospital must call Cigna/CareAllies at 1-800-582-1314 at least 2 business days before admission or services requiring prior authorization are rendered. For mental health and substance abuse, both inpatient and outpatient, your physician or your hospital must call ValueOptions at 1-888-700-7965 at least 2 business days before admission or services requiring prior authorization. These numbers are available 24 hours every day.
- **Consumer Driven Option:** First you, your representative, your physician, or your hospital must call UnitedHealthcare at 1-800-718-1299 at least 48 hours before admission or services requring prior authorization are rendered. For mental health and substance abuse, both inpatient and outpatient, your doctor or your hospital must call ValueOptions at 1-888-700-7965 at least 48 hours before admission or services requiring prior authorization. These numbers are available 24 hours every day.
- If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone the above number at least 2 business days for the High Option and 48 hours for the Consumer Driven Option following the day of the emergency admission, even if you have been discharged from the hospital.
- Next, provide the following information:
  - enrollee's name and Plan identification number
  - patient's name, birth date, and phone number
  - reason for hospitalization, proposed treatment, or surgery
  - name and phone number of admitting physician
  - name of hospital or facility; and
  - number of planned days of confinement
- We will then tell the physician and/or hospital the number of approved inpatient days and we will send written confirmation of our decision to you, your physician, and the hospital.

What happens when you do not follow the precertification rules

- If no one contacts us, we will decide whether the hospital stay was medically necessary.
- If we determine that the stay was medically necessary, we will pay the inpatient charges, less the $500 penalty.

If we determine that it was not medically necessary for you to be an inpatient, we will not pay inpatient hospital benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.

If we denied the precertification request, we will not pay inpatient hospital benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.

When we precertified the admission but you remained in the hospital beyond the number of days we approved and did not get the additional days precertified, then:

- For the part of the admission that was medically necessary, we will pay inpatient benefits, but
- For the part of the admission that was not medically necessary, we will pay only medical services and supplies otherwise payable on an outpatient basis and will not pay inpatient benefits.

- **Radiology/imaging procedures precertification**

High Option: Radiology precertification is required prior to scheduling specific imaging procedures. We evaluate the medical necessity of your proposed procedure to ensure that the appropriate procedure is being requested for your condition. In most cases your physician will take care of the precertification. Because you are responsible for ensuring that precertification is done, you should ask your doctor to contact us.

The following outpatient radiology services require precertification:

- CAT/CT – Computerized Axial Tomography
- MRI – Magnetic Resonance Imaging
- MRA – Magnetic Resonance Angiography
- PET – Positron Emission Tomography

- **How to precertify a radiology/imaging procedure**

For these outpatient studies, you, your representative or doctor must call Cigna/CareAllies before scheduling the procedure. The toll free number is 1-800-582-1314.

- Provide the following information:
  - patient's name, Plan identification number, and birth date
  - requested procedure and clinical support for request
  - name and phone number of ordering provider
  - name of requested imaging facility

Warning

We will reduce our benefits for these procedures by $100 if no one contacts us for precertification. If the procedure is not medically necessary, we will not pay any benefits.

Exceptions

You do not need precertification in these cases:

- You have another health insurance policy that is primary including Medicare Parts A&B or Part B Only
- The procedure is performed outside the United States or Puerto Rico
- You are inpatient hospital
- The procedure is performed as an emergency

- **Non-urgent care claims**

For non-urgent care claims, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim.

If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an **urgent care claim** (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 1-800-222-(APWU) 2798. You may also call OPM's Health Insurance at 1-202-606-3818 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 1-800-222-(APWU) 2798. If it is determined that your claim is an urgent are claim, we will expedite our review (if we have not yet responded to your claim).

Concurrent care claims

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital. If you do not telephone the Plan within two business days, penalties may apply - see *Warning* under *Inpatient hospital admissions* earlier in this Section and *If your hospital stay needs to be extended* below.

- **Maternity care**

  You do not need precertification of a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, then your physician or the hospital must contact us for precertification of additional days for your baby.

- **If your hospital stay needs to be extended**

  High Option: If your hospital stay – including for maternity care – needs to be extended, you, your representative, your physician or the hospital must ask us to approve the additional days by calling the precertification vendor Cigna/CareAllies at 1-800-582-1314. If you remain in the hospital beyond the number of days we approved and did not get the additional days precertified, then

  - For the part of the admission that was medically necessary, we will pay inpatient benefits, but
  - For the part of the admission that was not medically necessary, we will pay only medical services and supplies otherwise payable on an outpatient basis and will not pay inpatient benefits.

  Consumer Driven Option: If your hospital stay – including for maternity care – needs to be extended, you, your representative, your doctor or the hospital must ask us to approve the additional days by calling UnitedHealthcare at 1-800-718-1299. If you remain in the hospital beyond the number of days we approved and did not get the additional days precertified, then

  - For the part of the admission that was medically necessary, we will pay inpatient benefits, but
  - For the part of the admission that was not medically necessary, we will pay only medical services and supplies otherwise payable on an outpatient basis and will not pay inpatient benefits.

- **If your treatment needs to be extended**

  If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

If you disagree with our pre-service decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

  Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

  In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to:

  1. Precertify your hospital stay or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or

  2. Ask you or your provider for more information.

  You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

  If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

  In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

  Subject to a request for additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

  After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your costs for covered services

This is what you will pay out-of-pocket for covered care

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Copayment

High Option: A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: Under the High Option, when you see your PPO physician you pay a copayment of $18 per visit.

Consumer Driven Option: There are no copayments under the Consumer Driven Option.

Note: If the billed amount or the Plan allowance that providers we contract with have agreed to accept as payment in full is less than your copayment, you pay the lower amount.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for them. Copayments and coinsurance amounts do not count toward any deductible. When a covered service or supply is subject to a deductible, only the Plan allowance for the service or supply counts toward the deductible.

High Option

- If you use PPO providers, the calendar year deductible is $275 per person. Under a family enrollment, the deductible is satisfied for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $550. If you use non-PPO providers, your calendar year deductible increases to a maximum of $500 per person ($1,000 per family). Whether or not you use PPO providers, your calendar year deductible will not exceed $500 per person ($1,000 per family).

If the billed amount (or the Plan allowance that providers we contract with have agreed to accept as payment in full) is less than the remaining portion of your deductible, you pay the lower amount.

Example: If the billed amount is $100, the provider has an agreement with us to accept $80, and you have not paid any amount toward meeting your calendar year deductible, you must pay $80. We will apply $80 to your deductible. We will begin paying benefits once the remaining portion of your calendar year deductible ($275) has been satisfied.

Note: If you change plans during Open Season, and the effective date of your new plan is after January 1 of the next year, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

If you change from Self and Family to Self Only, or from Self Only to Self and Family during the year, we will credit the amount of covered expenses already applied toward the deductible of your old enrollment to the deductible of your new enrollment. However, if you change from High Option to Consumer Driven Option or from Consumer Driven Option to High Option, during the year, expenses incurred as of the effective date of the option change are subject to the benefit provisions of your new option.

Consumer Driven Option: Your Deductible is your bridge between your Personal Care Account (PCA) and your Traditional Health Coverage. After you have exhausted your PCA, you must pay your Deductible before your Traditional Health Coverage begins. Your Deductible is generally $600 for a Self Only enrollment or $1,200 for a Self and Family enrollment. Your Deductible in subsequent years may be reduced by rolling over any unused portion of your Personal Care Account remaining at the end of the calendar year(s). Also, there is no separate deductible for mental health and substance abuse benefits under the Consumer Driven Option.

Coinsurance

High Option: Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible.

Example: You pay 30% of our allowance for office visits to a non-PPO physician.

Consumer Driven Option: Coinsurance is the percentage of our allowance that you must pay for your care after you have used up your Personal Care Account (PCA) and paid your Deductible.

If your provider routinely waives your cost

If your provider routinely waives (does not require you to pay) your copayments, deductibles, or coinsurance, the provider is misstating the fee and may be violating the law. In this case, when we calculate our share, we will reduce the provider's fee by the amount waived.

For example, if your physician ordinarily charges $100 for a service but routinely waives your 30% coinsurance, the actual charge is $70. We will pay $49 (70% of the actual charge of $70).

Waivers

In some instances, an APWU Health Plan provider may ask you to sign a "waiver" prior to receiving care. This waiver may state that you accept responsibility for the total charge for any care that is not covered by your health plan. If you sign such a waiver, whether you are responsible for the total charge depends on the contracts that the Plan has with its providers. If you are asked to sign this type of waiver, please be aware that, if benefits are denied for the services, you could be legally liable for the related expenses. If you would like more information about waivers, please contact us at 1-800-222-APWU (2798).

Differences between our allowance and the bill

High Option: Our "Plan allowance" is the amount we use to calculate our payment for covered services. Fee-for-service plans arrive at their allowances in different ways, so their allowances vary. For more information about how we determine our Plan allowance, see the definition of Plan allowance in Section 10.

Often, the provider's bill is more than a fee-for-service plan's allowance. Whether or not you have to pay the difference between our allowance and the bill will depend on the provider you use.

- **PPO providers** agree to limit what they will bill you. Because of that, when you use a preferred provider, your share of covered charges consists only of your deductible and coinsurance or copayment. Here is an example about coinsurance: You see a PPO physician who charges $150, but our allowance is $100. If you have met your deductible, you are only responsible for your coinsurance. That is, you pay just -- 10% of our $100 allowance ($10). Because of the agreement, your PPO physician will not bill you for the $50 difference between our allowance and his/her bill.
- **Non-PPO providers**, on the other hand, have no agreement to limit what they will bill you. When you use a non-PPO provider, you will pay your deductible and coinsurance -- **plus** any difference between our allowance and charges on the bill. Here is an example: You see a non-PPO physician who charges $150 and our allowance is again $100. Because you've met your deductible, you are responsible for your coinsurance, so you pay 30% of our $100 allowance ($30). Plus, because there is no agreement between the non-PPO physician and us, the physician can bill you for the $50 difference between our allowance and his/her bill.

The following table illustrates the examples of how much you have to pay out-of-pocket for services from a PPO physician vs. a non-PPO physician. The table uses our example of a service for which the physician charges $150 and our allowance is $100. The table shows the amount you pay if you have met your calendar year deductible.

EXAMPLE	PPO physician	Non-PPO physician
Physician's charge	$150	$150
Our allowance	We set it at: $100	We set it at: $100
We pay	90% of our allowance: $90	70% of our allowance: $70
You owe: Coinsurance	10% of our allowance: $10	30% of our allowance: $30
+Difference up to charge?	No: 0	Yes: $50
TOTAL YOU PAY	**$10**	**$80**

Consumer Driven Option:

In-network providers agree to accept our Plan allowance so if you use an in-network provider, you never have to worry about paying the difference between the Plan allowance and the billed amount for covered services. If your covered expenses are being paid out of your Personal Care Account or if you are receiving in-network covered preventive services, the Plan will pay 100%. If you have exhausted your Personal Care Account, you will be responsible for paying your Deductible and also coinsurance under the Traditional Health Coverage.

Out-of-network Providers - If you use an out-of-network provider, you will have to pay the difference between the Plan allowance and the billed amount only if you use up your Personal Care Account for the year. Note that it usually makes sense to use in-network providers because it will make your Personal Care Account go much further since money left in your Personal Care Account can be rolled over to be used in the next year.

Your Catastrophic protection out-of-pocket maximum for deductibles, coinsurance and copayments

There is a limit to the amount you must pay out-of-pocket for coinsurance for the year for certain charges. When you have reached this limit, you pay no coinsurance for covered services for the remainder of the calendar year.

High Option:

PPO benefit: Your out-of-pocket maximum is $4,000 for either a Self Only or a Self and Family enrollment if you are using PPO providers. Only eligible expenses for PPO providers count toward this limit.

Non-PPO benefit: Your out-of-pocket maximum is $10,000 for either a Self Only or a Self and Family enrollment if you are using non-PPO providers. Eligible expenses for network providers also count toward this limit. Your eligible out-of-pocket expenses will not exceed this amount whether or not you use network providers.

Out-of-pocket expenses for the purposes of this benefit are:

- The 10% you pay (or the 5% you pay for Cancer Centers of Excellence) for PPO; inpatient medical services and supplies, surgical and anesthesia services, services provided by a hospital or other facility and ambulance services, emergency services/ accidents, mental health and substance abuse
- The 30% you pay for non-PPO; medical services and supplies, surgical and anesthesia services, services provided by a hospital or other facility and ambulance services, emergency services/accidents, mental health and substance abuse and dental
- The copayment of $18 for outpatient visits to PPO physicians
- The copayment of $40 for outpatient facility charges in an Urgent Care Center

The following cannot be included in the accumulation of out-of-pocket expenses:

- Expenses in excess of our allowance or maximum benefit limitations
- Any amounts you pay because benefits have been reduced for non-compliance with this Plan's cost containment requirements (see Section 3)
- Covered expenses applied to any deductibles
- The $300 per admission for non-PPO inpatient hospital charges
- Expenses in excess of visit maximums for physical, occupational and speech therapy (see page 38)
- Expenses incurred in excess of the $90 per day provided under home nursing care (see page 42); and
- Expenses in excess of Hospice care and preventive care maximums

Consumer Driven Option:

If you have exceeded your Personal Care Account and met your Deductible the following would apply:

In-network benefit: Your out-of-pocket maximum is $3,000 for a Self Only enrollment or $4,500 for a Self and Family enrollment if you are using in-network providers. Only eligible expenses for network providers count toward this limit.

Out-of-network benefit: Your out-of-pocket maximum is $9,000 for either a Self Only or a Self and Family enrollment if you are using out-of-network providers. Eligible expenses for network providers also count toward this limit. Your eligible out-of-pocket expenses will not exceed this amount whether or not you use network providers.

Out-of-pocket expenses for the purposes of this benefit are:

- The 15% you pay (or the 10% you pay for Cancer Centers of Excellence) for in-network Inpatient and Outpatient hospital charges, Surgical, Medical, Maternity and Emergency services under the Traditional Health Coverage
- The 40% you pay for out-of-network Inpatient and Outpatient hospital charges, Surgical, Medical, Maternity and Emergency services under the Traditional Health Coverage

The following cannot be included in the accumulation of out-of-pocket expenses:

- Any expenses paid by the Plan under your Personal Care Account
- Any expenses paid by the Plan under your in-network Preventive Care benefit
- Any expenses you must pay under your Deductible
- Expenses in excess of our allowance or maximum benefit limitations or expenses not covered under the Traditional Health Coverage
- Covered expenses applied to your Deductible
- Dental care or Vision care expenses above the limitations provided under your Personal Care Account
- Any amounts you pay because benefits have been reduced for non-compliance with this Plan’s cost containment requirements (see Section 3)
- Expenses in excess of Hospice care maximums

Prescription Drug Catastrophic Protection

1. The APWU Health Plan will implement a separate Catastrophic Limit for prescription drugs beginning January 1, 2014.

2. Both the High Option and Consumer Driven Option will have the following Catastrophic Limits:

a. The High Option prescription drug Catastrophic Limit for Self Only will be $4,000 per person and the High Option prescription drug Catastrophic Limit for Self and Family will be $6,500.

b. The Consumer Driven Option prescription drug Catastrophic Limit for Self Only will be $3,000 per person and the Consumer Driven Option prescription drug Catastrophic Limit for Self and Family will be $4,500. PCA dollars and deductible do not count towards the prescription drug Catastrophic Limit.

3. The following cannot be included in the accumulation of out-of-pocket expenses that apply to the prescription drug Catastrophic Limit:

a. Drugs purchased at a non-network pharmacy.

b. The difference in cost when brand name drugs are purchased and a generic is available.

c. Drugs reimbursed at the non-network pharmacy level.

d. 50% coinsurance for retail drugs after the first two fills if mail order is not used.

e. 90% coinsurance for targeted drugs if the Plan's step therapy is not followed.

f. Any associated costs when you purchase medications in excess of the Plan's dispensing limitations.

g. Cost associated with non-covered drugs and supplies.

Carryover

If you changed to this Plan during Open Season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

If we overpay you

We will make diligent efforts to recover benefit payments we made in error but in good faith. We may reduce subsequent benefit payments to offset overpayments. We will generally first seek recovery from the provider if we paid the provider directly, or from the person (covered family member, guardian, custodial parent, etc.) to whom we sent our payment.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. Benefits

See page 15 for how our benefits changed this year. Page 138 is a benefits summary of the High Option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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High Option Overview

The Plan offers a High Option, described in this section. Make sure that you review the benefits that are available under the benefit program in which you are enrolled.

The High Option Section 5, is divided into subsections. Please read *Important things you should keep in mind* at the beginning of each subsection. Also read the general exclusions in Section 6. To obtain claim forms, claims filing advice, or more information about the High Option benefits, contact us at 1-800-222-APWU (2798) or on our Web site at www.apwuhp.com.

The APWU Health Plan's High Option provides a wide range of comprehensive benefits for preventive services, doctors' visits and services, care in a hospital, laboratory tests and procedures, accidental and emergency services, mental health and substance abuse treatment and prescription drugs. We have extensive networks of preferred providers for both medical and mental health services to help lower your costs, but you may use any provider you wish, in or out of our networks.

The High Option includes:

Preventive care

The Plan emphasizes prevention by providing an extensive range of preventive benefits to help members stay well. We include 100% coverage for an array of in-network preventive tests and screenings, routine physical exams, and a Tobacco Cessation Program to stop smoking. To keep children well, we have 100% coverage for recommended immunizations, physical exams and laboratory tests for children. We provide a Wellness benefit that offers a reward for staying well. If you use little or no benefits in a calendar year, our Wellness benefit reimburses you so that you can tailor benefits to your individual needs. We emphasize women's wellness with our Well Woman benefit that provides 100% coverage for a full range of in-network preventive services, preventive tests and screenings, counseling services, breastfeeding support and supplies, and contraceptives, including prescription drug contraceptives.

Medical and Surgical services

The Plan provides coverage for doctors' visits and surgical services and supplies. You pay only a flat copayment for office visits to a network physician, including visits for chiropractic and acupuncture treatment. Maternity care is covered 100%. Mental health and substance abuse has the same comprehensive coverage as is provided for medical care.

Hospitalization and Emergency care

We offer extensive benefits for hospital and other inpatient healthcare services. There is no deductible or per admission charge for in-network hospital care. You also receive 100% coverage for unexpected outpatient care when you need it most with the Plan's Accidental Injury benefit.

Prescription drugs

Our prescription drug program offers prescription savings with no deductible and low copayments for generic drugs. The prescription drug program is easy to use, with a huge network of pharmacies and a Mail Order service where medications are delivered right to your door. The Plan's prescription drug program provides savings and convenience for generic and brand name drugs, and you never have to file a claim.

Special features

Obtaining help from a medical professional is quick, confidential, and free with the Plan's voluntary Nurse Advisory Line, available 24/7 anywhere in the country. Our voluntary Diabetes, Hypertension and Weight Management Programs offer $0 copays and coinsurance for members with these conditions. Online access to claims information and customer service is available through eHealthRecord. We help members navigate the healthcare system with an online Preferred Provider Organization (PPO) directory, Hospital Quality Ratings Guide, Treatment Cost Estimator, and prescription drug information. We also offer online consumer health information and non-FEHB savings on health and wellness products.

Section 5 (a). Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: PPO - $275 per person ($550 per family); Non-PPO - $500 per person ($1,000 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- When you use a PPO hospital, keep in mind that the professionals who provide services to you in the hospital, may not all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers. However, if surgical services are rendered at a PPO hospital or a PPO freestanding ambulatory facility by a PPO primary surgeon, we will pay the services of anesthesiologists who are not preferred providers at the PPO rate, based on Plan allowance. If the covered services are performed at a PPO hospital or a PPO freestanding ambulatory facility, we will pay the services of radiologists and pathologists who are not preferred providers at the PPO rate, based on the Plan allowance.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOU MUST GET PRECERTIFICATION FOR CERTAIN OUTPATIENT IMAGING PROCEDURES.** FAILURE TO DO SO WILL RESULT IN A MINIMUM OF $100 PENALTY. Please refer to precertification information in Section 3 to be sure which procedures require precertification.

Benefit Description	You Pay After the calendar year deductible...
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Diagnostic and treatment services	
Professional services of physicians • In physician's office	PPO: $18 copayment (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Professional services of physicians • During a hospital stay • In a skilled nursing facility • Second surgical opinion • At home	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

Benefit Description	You Pay After the calendar year deductible...
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • CT Scans/MRI/MRA/NC/PET (Outpatient requires precertification – see Section 3, except for NC) • Ultrasound • Electrocardiogram and EEG	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Note: If your PPO provider uses a non-PPO lab or radiologist, we will pay non-PPO benefits for lab and X-ray charges billed by these non-PPO providers.
If LabCorp or Quest Diagnostics performs your covered lab services, you will have no out-of-pocket expense and you will not have to file a claim. To find a location near you, in all states, call Cigna at 1-800-582-1314; or visit our Web site at www.apwuhp.com. Note: Not available in the U.S. Virgin Islands.	Nothing (No deductible)
Not covered: • *Professional fees for automated lab tests* • *Genetic screening*	*All charges*
Pharmacogenomic testing to optimize prescription drug therapies for certain conditions: • Plavix (antiplatelet) • Warfarin (anticoagulant)	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Preventive care, adult	
We provide benefits for a comprehensive range of preventive care services for adults, including the preventive services recommended under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). Covered services include: One routine examination per person per calendar year after age 12. Lab tests covered are: • Comprehensive Metabolic Panel • Lipid Panel • Urinalysis (other laboratory work, X-rays and other diagnostic tests performed, when medically necessary, during a routine exam are subject to the benefits under *Diagnostic and treatment services*)	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Routine screenings, such as: • Total Blood Cholesterol– once annually	PPO: Nothing (No deductible)

Preventive care, adult - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Preventive care, adult (cont.)	
• Fasting lipoprotein profile, once every 5 years for adults age 20 or over • Osteoporosis screening, once every two years, for women age 60 and older • Chlamydial infection • Colorectal Cancer Screening, including - Fecal occult blood test, once annually, ages 40 and older - Sigmoidoscopy screening – starting at age 50 - Colonoscopy, starting at age 50 • Shingles vaccine, starting at age 60 • HIV screening • One-time hepatitis C test for those born from 1945-1965 • Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older • Routine pap test (lab charge), one annually, women age 18 and older • Abdominal Aortic Aneurysm screening, once for men between the ages of 65 and 75 with a smoking history • Biometric screening, once annually Note: Biometric screening includes Body Mass Index (BMI), lipid panel, Total Blood Cholesterol, blood pressure, and Comprehensive Metabolic Panel, as listed above in *Preventive care, adult.*	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC) Note: For immunizations for influenza and pneumonia at a network pharmacy, see Section 5(f), *Prescription drug benefits.* For immunizations for shingles at a network pharmacy, age 60 or older pay nothing; age 59 or younger, see Section 5(f), *Prescription drug benefits.*	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Well woman care, including but not limited to: • One annual routine gynecological visit for pap test for women • Routine mammograms - covered for women age 35 and older; as follows: - From age 35 through 39, one during this five year period - From age 40 through 64, one every calendar year - At age 65 and older, one every two consecutive calendar years • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at high risk • HPV testing for women • Annual counseling for sexually transmitted infections for women • Annual counseling and screening for HIV for women	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

Preventive care, adult - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Preventive care, adult (cont.)	
• Contraceptives, such as surgically implanted contraceptives, injectable contraceptive drugs, intrauterine devices, and diaphragms (See *Family planning*, Section 5(a)) • Contraceptive counseling for women • Sterilization procedures (See *Surgical* procedures, Section 5(b)) • Patient education and counseling for all women with reproductive capacity • Breastfeeding support, supplies (including rental of breast feeding equipment) and counseling for women for each birth • Annual screening and counseling for women for interpersonal and domestic violence Note: In-network prescription drugs and devices approved by the FDA for contraception can be found in Section 5(f), *Prescription drug benefits*.	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Note: A complete list of preventive care services recommended under the USPSTF is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.	
Not covered: • *Adult immunizations not endorsed by the CDC* • *Routine diagnostic tests associated with preventive care other than those specified as covered*	*All charges*
Preventive care, children	
We provide benefits for a comprehensive range of preventive care services for children, including the preventive services recommended under the Patient Protection and Affordable Care Act (the "Affordable Care Act"), and the American Academy of Pediatrics. Covered services include: • Childhood immunizations recommended by the American Academy of Pediatrics • HIV screening	PPO: Nothing (No deductible) Non-PPO: Any difference between the Plan allowance and the billed charge (No deductible)
• Examinations, limited to: - Well-child care charges for physical examinations and laboratory tests through age 12 - Examination for amblyopia and strabismus-limited to one screening examination (age 2 through 6) - One Screening Examination of Premature Infants for Retinopathy of Prematurity or infants with low birth weight or gestational age of 32 weeks or less Note: Children above the age of 12, see Section 5(a), *Preventive care, adults.*	PPO: Nothing (No deductible) Non-PPO: Any difference between the Plan allowance and the billed charge and any amount above $250 per child (ages 0 through 3) each year and any amount above $150 per child (ages 4 through 12) each year (No deductible)

Preventive care, children - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Preventive care, children (cont.)	
Note: A complete list of preventive care services recommended under the USPSTF is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.	
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care • Initial examination of a newborn child covered under a family enrollment Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 22 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. • We pay hospitalization and surgeon services for non-maternity care, as well as covering an extended stay, if medically necessary, the same as for illness and injury.	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Note: For inpatient hospital care related to maternity, we pay for covered services in full when you use preferred providers.
• We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision of a covered newborn	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
• Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk • Breastfeeding support, supplies (including rental of breastfeeding equipment) and counseling for women for each birth	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: Amniocentesis if for diagnosing multiple births	*All charges*
Family planning	
A range of voluntary family planning services, limited to: • Contraceptive counseling for women • Voluntary sterilization for women (See *Surgical* procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives and devices under Section 5(f), *Prescription drug benefits*.	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

Family planning - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Family planning (cont.)	
• Voluntary sterilization for men (See *Surgical* procedures, Section 5 (b))	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges*
Infertility services	
• Diagnosis and treatment of infertility, except as shown in *Not covered*	PPO: 10% of the Plan allowance and any amount over $2,500 Non-PPO: 30% of the Plan allowance, any difference between our allowance and the billed amount and any amount over $2,500
Not covered: • *Infertility services after voluntary sterilization* • *Assisted reproductive technology (ART) procedures, such as:* - *Artificial insemination (all procedures)* - *In vitro fertilization* - *Embryo transfer and gamete intra-fallopian transfer (GIFT)* - *Intravaginal insemination (IVI)* - *Intracervical insemination (ICI)* - *Intrauterine insemination (IUI)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges*
Allergy care	
• Testing and treatment, including materials (such as allergy serum) • Allergy injections	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*

Benefit Description	You Pay After the calendar year deductible...
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed on pages 47-50. • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: We only cover IV/Infusion therapy and GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See *Other services,* Section 3. Note: Growth hormone and any drugs used for the administration of Home Intravenous (IV) Infusion are covered under the prescription drug benefit. If the drugs are obtained through Accredo Health Group, Express Scripts' specialty pharmacy, they will be paid at the in-network prescription drug benefit. If they are not obtained through Accredo Health Group, Express Scripts' specialty pharmacy, they will be paid at the out-of-network prescription drug benefit. (*Prescription drug benefits*, Section 5(f)). • Respiratory and inhalation therapies	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Physical and occupational therapies	
Physical therapy and occupational therapy provided by a licensed registered therapist up to a combined 60 visits per calendar year Note: Preauthorization of rehabilitative and habilitative therapies is required. See *Other services,* Section 3; a physician must: • Order the care; • Identify the specific professional skills the patient requires and the medical necessity for skilled services; and • Indicate the length of time the services are needed.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Maintenance therapies* • *Exercise programs* • *Physical and occupational therapies without preauthorization*	*All charges*

Benefit Description	You Pay After the calendar year deductible...
Speech therapy	
Speech therapy where medically necessary and provided by a licensed therapist Note: Preauthorization of speech therapy is required. See *Other services*, Section 3. Note: Speech therapy is combined with 60 visits per calendar year for the services of physical therapy and/or occupational therapy (see above). Note: We also have the right to deny any type of therapy, service or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or recurring.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Hearing services (testing, treatment, and supplies)	
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist • One examination and testing for hearing aids every 2 years Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a), *Preventive care, children.*	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
• External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants	Note: For benefits for the devices, see Section 5(a), *Orthopedic and prosthetic devices.*
Not covered: • *Hearing services that are not shown as covered*	*All charges*
Vision services (testing, treatment, and supplies)	
• Internal (implant) ocular lenses and/or the first contact lenses required to correct an impairment caused by accident or illness. The services of an optometrist are limited to the testing, evaluation and fitting of the first contact lenses required to correct an impairment caused by accident or illness Note: See *Preventive care, children* for eye exams for children	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Eyeglasses or contact lenses and examinations for them* • *Eye exercises and visual training* • *Radial keratotomy and other refractive surgery*	*All charges*

Benefit Description	You Pay After the calendar year deductible...
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes	PPO: $18 copayment for the office visit (No deductible) plus 10% of the Plan allowance for other services performed during the visit Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Leg, arm, neck, joint and back braces • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants • Internal prosthetic devices, and surgically implanted breast implant following mastectomy Note: We recommend preauthorization of orthopedic and prosthetic devices. See *Other services*, Section 3. Note: We require preauthorization of artificial limbs. See *Other services*, Section 3. Note: We will pay only for the cost of the standard item. Coverage for specialty items, such as bionics, is limited to the cost of the standard item. Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b), *Surgical procedures*. For information on the hospital and/or ambulatory surgery center benefits, see Section 5 (c), *Services provided by a hospital or other facility, and ambulance services*.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
External hearing aids • Covered every 3 years limited to $1,500 Note: Excluding batteries, benefits for hearing aid dispensing fees, accessories, supplies, and repair service are included in the benefit limit described above.	PPO: All charges in excess of $1,500, up to the PPO allowance (No deductible) Non-PPO: All charges in excess of $1,500 (No deductible)
Not covered:	*All charges*

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Orthopedic and prosthetic devices (cont.)	
• Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups • Lumbosacral supports • Corsets, trusses, elastic stockings, support hose, and other supportive devices	*All charges*
Durable medical equipment (DME)	
Durable medical equipment (DME) is equipment and supplies that: 1. Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury) 2. Are medically necessary 3. Are primarily and customarily used only for a medical purpose 4. Are generally useful only to a person with an illness or injury 5. Are designed for prolonged use; and 6. Serve a specific therapeutic purpose in the treatment of an illness or injury We cover rental or purchase, of durable medical equipment, at our option, including repair and adjustment. Covered items include but are not limited to: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs (standard and electric) • Ostomy supplies (including supplies purchased at a pharmacy) • Crutches • Walkers Note: Preauthorization of durable medical equipment is required. See *Other services*, Section 3. Note: We will pay only for the cost of the standard item. Coverage for specialty equipment, such as all-terrain wheelchairs, is limited to the cost of the standard equipment.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Whirlpool equipment* • *Sun and heat lamps* • *Light boxes* • *Heating pads* • *Exercise devices* • *Stair glides* • *Elevators* • *Air Purifiers*	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Durable medical equipment (DME) (cont.)	
• *Computer "story boards," "light talkers," or other communication aids for communication-impaired individuals*	*All charges*
Home health services	
Services for skilled nursing care up to 25 visits per calendar year, not to exceed a maximum Plan payment of $90 per day, when preauthorized and: • a registered nurse (R.N.), licensed practical nurse (L.P.N.) or licensed vocational nurse (L.V.N.) provides the services; • the attending physician orders the care; • the physician identifies the specific professional skills required by the patient and the medical necessity for skilled services; and • the physician indicates the length of time the services are needed. Note: Skilled nursing care must be preauthorized. See *Other services*, Section 3.	PPO: 10%; all charges after we pay $90 per day Non-PPO: 30%; all charges after we pay $90 per day
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, rehabilitative, or habilitative* • *Nursing services without preauthorization* • *Services of nurses' aides or home health aides*	*All charges*
Chiropractic	
Chiropractic treatment limited to 12 visits and/or manipulations per year Note: X-rays covered under *Diagnostic and treatment services.* Note: Massage therapy not covered.	PPO: $18 copayment (No deductible). Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount.
Alternative treatments	
Acupuncture – by a doctor of medicine or osteopathy or licensed acupuncturist • anesthesia • pain relief	PPO: $18 copayment (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Services of any provider not listed as covered; see Covered providers page 16* Note: Benefits of certain alternative treatment providers may be covered in medically underserved areas; see page 16.	*All charges*

Benefit Description	You Pay After the calendar year deductible...
Educational classes and programs	
If you are an APWU Health Plan member you may enroll in a Tobacco Cessation Program up to two quit attempts per year as follows: • 4 Telephonic counseling sessions with Cigna/CareAllies or; • 4 Group therapy sessions or; • 4 Educational sessions with a physician Note: Enrollment in the Cigna/CareAllies program must be initiated by member after effective date of Health Plan enrollment. For more information contact Cigna/CareAllies at 1-800-582-1314.	PPO: Nothing (No deductible) Non-PPO: All Charges
Prescription drugs (through Express Scripts by Mail only) approved by the FDA to treat tobacco dependence for Tobacco Cessation. Over-the-counter drugs (through Cigna/CareAllies only) approved by the FDA to treat tobacco dependence for Tobacco Cessation.	PPO: Nothing (No deductible) Non-PPO: All Charges
Diabetes self-management training services, up to 10 hours initial training the first year and 2 hours subsequent training annually.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

Section 5 (b). Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: PPO - $275 per person ($550 per family); Non-PPO - $500 per person ($1,000 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- When you use a PPO hospital, keep in mind that the professionals who provide services to you in the hospital, may not all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers. However, if surgical services are rendered at a PPO hospital or a PPO freestanding ambulatory facility by a PPO primary surgeon, we will pay the services of anesthesiologists who are not preferred providers at the PPO rate, based on Plan allowance. If the covered services are performed at a PPO hospital or a PPO freestanding ambulatory facility, we will pay the services of radiologists and pathologists who are not preferred providers at the PPO rate, based on the Plan allowance.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOU MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

Precertification/preauthorization is required for:

- Organ transplantations
- Procedures which might be cosmetic in nature, such as eyelid surgery or varicose vein surgery
- Surgery for morbid obesity; or
- Surgery for organic impotence
- Minimally invasive treatment of back and neck pain, such as trigger point injections, epidural steroid injections, facet joint injections, sacroiliac joint injections.

Benefit Description	You Pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive* surgery) • Surgical treatment of morbid obesity (bariatric surgery) (requires preauthorization. See *Other services*, Section 3) • Insertion of internal prosthetic devices. See Section 5(a), *Orthopedic and prosthetic devices* for device coverage information • Voluntary sterilization for men (e.g., Vasectomy) • Treatment of burns • Assistant surgeons - We cover up to 20% of our allowance for the surgeon's charge	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
• Voluntary sterilization for women (e.g., Tubal ligation) • Surgically implanted contraceptives • Intrauterine devices (IUDs)	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount.
When multiple or bilateral surgical procedures performed during the same operative session add time or complexity to patient care, our benefits are: • For the primary procedure: - PPO: 90% of the Plan allowance; or - Non-PPO: 70% of the Plan allowance • For the secondary procedure(s): - PPO: 90% of one-half of the Plan allowance or - Non-PPO: 70% of one-half of the Plan allowance Note: Multiple or bilateral surgical procedures performed through the same incision are "incidental" to the primary surgery. That is, the procedure would not add time or complexity to patient care. We do not pay extra for incidental procedures.	PPO: 10% of the Plan allowance for the primary procedure and 10% of one-half of the Plan allowance for the secondary procedure(s) Non-PPO: 30% of the Plan allowance for the primary procedure and 30% of one-half of the Plan allowance for the secondary procedure(s); and any difference between our payment and the billed amount
Not covered: • *Cosmetic surgery and other related expenses if not preauthorized* • *Reversal of voluntary sterilization* • *Services of a standby surgeon, except during angioplasty or other high risk procedures when we determine standbys are medically necessary* • *Radial keratotomy and other refractive surgery*	*All charges*

Benefit Description	You Pay After the calendar year deductible…
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - The condition produced a major effect on the member's appearance and - The condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks (including port wine stains); and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - Surgery to produce a symmetrical appearance of breasts - Treatment of any physical complications, such as lymphedema - Breast prostheses; and surgical bras and replacements (see *Prosthetic devices* for coverage) Note: We pay for internal breast prostheses as hospital benefits. Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury if repair is initiated within two years of the accident* • *Surgeries related to sex transformation, sexual dysfunction or sexual inadequacy except if preauthorized for organic impotence*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaw or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures • Extraction of impacted (unerupted) teeth • Alveoplasty, partial ostectomy and radical resection of mandible with bone graft unrelated to tooth structure • Excision of bony cysts of the jaw unrelated to tooth structure	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

Oral and maxillofacial surgery - continued on next page

Benefit Description	You Pay After the calendar year deductible…
Oral and maxillofacial surgery (cont.)	
• Excision of tori, tumors, and premalignant lesions, and biopsy of hard and soft oral tissues • Reduction of dislocations and excision, manipulation, arthrocentesis, aspiration or injection of temporomandibular joints • Removal of foreign body, skin, subcutaneous alveolar tissue, reaction-producing foreign bodies in the musculoskeletal system and salivary stones • Incision/excision of salivary glands and ducts • Repair of traumatic wounds • Sinusotomy, including repair of oroantral and oromaxillary fistula and/or root recovery • Surgical treatment of trigeminal neuralgia • Frenectomy or frenotomy, skin graft or vestibuloplasty-stomatoplasty unrelated to periodontal disease • Incision and drainage of cellulitis unrelated to tooth structure Note: We suggest you call us at 1-800-222-APWU (2798) to determine whether a procedure is covered.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva and alveolar bone)* • *Dental bridges, replacement of natural teeth, dental/orthodontic/ temporomandibular joint dysfunction appliances and any related expenses* • *Treatment of periodontal disease and gingival tissues, and abscesses* • *Charges related to orthodontic treatment*	*All charges*
Organ/tissue transplants	
These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung single/bilateral/lobar	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and any amount over $50,000 for kidney transplants or $100,000 for other listed transplants

Organ/tissue transplants - continued on next page

Benefit Description	You Pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
• Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and any amount over $50,000 for kidney transplants or $100,000 for other listed transplants
These **tandem blood** or **marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and any amount over $50,000 for kidney transplants or $100,000 for other listed transplants
Blood or marrow stem cell transplants limited to the following diagnoses. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin’s lymphoma with recurrence (relapsed) - Aggressive non-Hodgkin's lymphomas - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Amyloidosis - Chronic inflammatory demyelination polyneuropathy (CIDP) - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's PNH, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic Syndromes - Paroxysmal Nocturnal Hemoglobinuria	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and any amount over $50,000 for kidney transplants or $100,000 for other listed transplants

Organ/tissue transplants - continued on next page

Benefit Description	You Pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
- Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia (pediatric only) - X-linked lymphoproliferative syndrome • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast Cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Medulloblastoma - Multiple myeloma - Neuroblastoma - Pineoblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and any amount over $50,000 for kidney transplants or $100,000 for other listed transplants
Mini-transplants (non-myeloablative, reduced intensity conditioning or RIC) are subject to medical necessity review by the Plan.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and any amount over $50,000 for kidney transplants or $100,000 for other listed transplants
Blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and any amount over $50,000 for kidney transplants or $100,000 for other listed transplants

Organ/tissue transplants - continued on next page

Benefit Description	You Pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
Transplant Network The Plan uses specific Plan-designated organ/tissue transplant facilities. Before your initial evaluation as a potential candidate for a transplant procedure, you or your doctor **must** contact the precertification vendor (see *Other services*, Section 3); Cigna at 1-800-668-9682; and ask to speak to a Transplant Case Manager. You will be provided with information about transplant preferred providers. If you choose a Plan-designated transplant facility, you may receive prior approval for travel and lodging costs. Limited Benefits – If you don't use a Plan-designated transplant facility, benefits for pretransplant evaluation, organ procurement, inpatient hospital, surgical and medical expenses for covered transplants, whether incurred by the recipient or donor, are limited to a maximum of $50,000 for kidney transplants or $100,000 for each other listed transplant, including multiple organ transplants.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and any amount over $50,000 for kidney transplants or $100,000 for other listed transplants
Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Transplants not listed as covered*	*All charges*
Anesthesia	
Professional services for administration of anesthesia Note: If surgical services are rendered at a PPO hospital or a PPO freestanding ambulatory facility by a PPO primary surgeon, we will pay the services of non-PPO anesthesiologists at the PPO rate, based on Plan allowance.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

Section 5 (c). Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In this Section, unlike Sections 5(a) and 5(b), the calendar year deductible applies to only a few benefits. We added "(calendar year deductible applies)." The calendar year deductible is: PPO - $275 per person ($550 per family); Non-PPO - $500 per person ($1,000 per family).
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- When you use a PPO hospital, keep in mind that the professionals who provide services to you in the hospital, may not all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers. However, if surgical services are rendered at a PPO hospital or a PPO freestanding ambulatory facility by a PPO primary surgeon, we will pay the services of anesthesiologists who are not preferred providers at the PPO rate, based on Plan allowance. If the covered services are performed at a PPO hospital or a PPO freestanding ambulatory facility, we will pay the services of radiologists and pathologists who are not preferred providers at the PPO rate, based on the Plan allowance.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- The amounts listed below are for the charges billed by the facility (i.e. hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e. physicians, etc.) are in Sections 5(a) or (b).
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

Benefit Description	You Pay
Note: The calendar year deductible applies ONLY when we say below: "(calendar year deductible applies)."	
Inpatient hospital	
Room and board, such as: • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: We only cover a private room when you must be isolated to prevent contagion. Otherwise, we will pay the hospital's average charge for semiprivate accommodations. If the hospital only has private rooms, we will cover the private room rate. Note: When the non-PPO hospital bills a flat rate, we prorate the charges to determine how to pay them, as follows: 30% room and board and 70% other charges.	PPO: 10% of the covered charges Non-PPO: $300 per admission and 30% of the covered charges and any difference between our allowance and the billed amount Note: For inpatient hospital care related to maternity, we pay for covered services in full when you use preferred providers (See Section 5(a), *Maternity care*).
Other hospital services and supplies, such as: • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines	PPO: 10% of the covered charges Non-PPO: $300 per admission and 30% of the covered charges

Inpatient hospital - continued on next page

Benefit Description	You Pay
Inpatient hospital (cont.)	
• Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services Note: We cover appliances, medical equipment and medical supplies provided for take-home use under Section 5(a). We cover prescription drugs and medicines dispensed for take-home use under Section 5(f). Note: We base payment on whether the facility or a health care professional bills for the services or supplies. For example, when the hospital bills for its nurse anesthetists' services, we pay Hospital benefits and when the anesthesiologist bills, we pay Surgery benefits.	PPO: 10% of the covered charges Non-PPO: $300 per admission and 30% of the covered charges Note: For inpatient hospital care related to maternity, we pay for covered services in full when you use preferred providers, (See Section (5a), *Maternity care*).
Not covered: • *Any part of a hospital admission that is not medically necessary (see* Section 10, *Definitions), such as when you do not need acute hospital inpatient (overnight) care, but could receive care in some other setting without adversely affecting your condition or the quality of your medical care. Note: In this event, we pay benefits for services and supplies other than room and board and in-hospital physician care at the level they would have been covered if provided in an alternative setting* • *Custodial care; see* Section 10, *Definitions* • *Non-covered facilities, such as nursing homes, skilled nursing facilities, residential treatment facilities, day and evening care centers, and schools* • *Personal comfort items such as radio, television, air conditioners, beauty and barber services, guest meals and beds* • *Services of a private duty nurse that would normally be provided by hospital nursing staff*	*All charges*
Cancer Centers of Excellence	
The Plan provides access to designated Cancer Centers of Excellence. For information, you must contact Cigna/CareAllies at 1-800-582-1314 prior to obtaining covered services. To receive the higher level of benefits for a cancer related treatment, you are required to visit a designated facility. When you contact Cigna/CareAllies, you will be provided with information about the Cancer Centers of Excellence.	PPO Cancer Centers of Excellence (COE): 5% of the Plan allowance PPO: 10% of the covered charges Non-PPO: $300 per admission and 30% of the covered charges

Benefit Description	You Pay
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by an underlying medical condition. We do not cover the dental procedures. Note: We cover outpatient services and supplies of a hospital or free-standing ambulatory facility the day of a surgical procedure (including change of cast), hemophilia treatment, hyperalimentation, rabies shots, cast or suture removal, oral surgery, foot treatment, chemotherapy for treatment of cancer, and radiation therapy.	PPO: 10% of the Plan allowance (calendar year deductible applies) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Extended care benefits/Skilled nursing care facility benefits	
No benefit	*All charges*
Hospice care	
Hospice is a coordinated program of home and inpatient supportive care for the terminally ill patient and the patient's family provided by a medically supervised specialized team under the direction of a duly licensed or certified Hospice Care Program. • We pay $3,000 annually for outpatient services and $2,000 annually for inpatient services • We pay a $200 annual bereavement benefit per family unit	Any amount over the annual maximums shown
Ambulance	
• Local professional ambulance service when medically appropriate immediately before or after an inpatient admission	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Ambulance service used for routine transport*	*All charges*

Section 5 (d). Emergency services/accidents

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: PPO - $275 per person ($550 per family); Non-PPO - $500 per person ($1,000 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- When you use a PPO hospital, keep in mind that the professionals who provide services to you in the hospital, may not all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers. However, if surgical services are rendered at a PPO hospital or a PPO freestanding ambulatory facility by a PPO primary surgeon, we will pay the services of anesthesiologists who are not preferred providers at the PPO rate, based on Plan allowance. If the covered services are performed at a PPO hospital or a PPO freestanding ambulatory facility, we will pay the services of radiologists and pathologists who are not preferred providers at the PPO rate, based on the Plan allowance.
- When you use a PPO hospital for emergency services, the emergency room physician who provides the services to you in the emergency room may not be a preferred provider. If they are not, they will be paid by this Plan as a PPO provider at the PPO rate, based on the Plan allowance.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.

What is an accidental injury?

An accidental injury is a bodily injury sustained solely through violent, external, and accidental means, such as broken bones, animal bites, and poisonings.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action. If you are unsure of the severity of a condition in terms of this benefit, the Plan recommends that you first call its 24-hour nurse advisory service 1-800-582-1314 or your physician.

Note: If you use an emergency room for other than a recognized medical emergency, facility fees and supplies will not be covered.

Benefit Description	You Pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Accidental injury	
If you receive care for your accidental injury within 24 hours, we cover: • Physician services and supplies • Related outpatient hospital services • Professional ambulance service • Air ambulance if medically necessary for transport to the closest appropriate facility for treatment Note: See Section 5(c) for hospital benefits if you are admitted. Services received after 24 hours are considered the same as any other illness and regular Plan benefits will apply.	PPO: Nothing (No deductible) Non-PPO: Only the difference between our allowance and the billed amount (No deductible)
Medical emergency	
Outpatient facility charges including medical or surgical services and supplies in an Urgent Care Center	PPO: $40 copayment (No deductible) Non-PPO: $40 copayment (No deductible) Note: For Non-PPO benefits, members may be billed the difference between the Plan allowance and the billed amount.
Outpatient medical or surgical services and supplies, other than an Urgent Care Center	PPO: 10% of the Plan allowance Non-PPO: 10% of the Plan allowance Note: For Non-PPO benefits, members may be billed the difference between the Plan allowance and the billed amount.
Ambulance	
• Professional ambulance service within 24 hours of a medical emergency • Air ambulance if medically necessary for transport to the closest appropriate facility for treatment within 24 hours of a medical emergency Note: See Section 5(c) for non-emergency service.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

Section 5 (e). Mental health and substance abuse benefits

You may choose to get care in-network or out-of-network. You need to get Plan approval (preauthorization) for services and follow a treatment plan we approve in order to get benefits. When you receive services as part of an approved treatment plan, cost-sharing and limitations for Plan mental health and substance abuse benefits are no greater than for similar benefits for other illnesses and conditions.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible or, for facility care, the inpatient deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when a deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES**. Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process shown in Section 3 and get Plan approval of your treatment plan.
  - Inpatient care - You must get preauthorization for hospital stays; failure to do so will result in a minimum $500 penalty. To obtain preauthorization of an admission for mental conditions or substance abuse, call ValueOptions at 1-888-700-7965.
  - Outpatient care - You must get preauthorization of outpatient care for mental conditions or substance abuse. Preauthorization must be obtained by calling ValueOptions at 1-888-700-7965.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.
- We do not make available provider directories for mental health or substance abuse providers. ValueOptions will provide you with a choice of network providers when you call to preauthorize your care.

Benefit Description	You Pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Professional services	
We cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. • In Physician's office • Professional charges for intensive outpatient treatment in a provider's office or other professional setting	Your cost-sharing responsibilities are no greater than for other illnesses or conditions. PPO: $18 (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed charges.

Professional services - continued on next page

Benefit Description	You Pay After the calendar year deductible…
Professional services (cont.)	
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders, and inpatient professional services. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Electroconvulsive therapy	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed charges
Diagnostics	
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed charges
Inpatient hospital or other covered facility	
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services. • Inpatient diagnostic tests provided and billed by a hospital or other covered facility.	PPO: 10% of the Plan allowance (No deductible) Non-PPO: After $300 per admission, 30% of our allowance and any difference between our allowance and the billed charges (No deductible)
Outpatient hospital or other covered facility	
Outpatient services provided and billed by a hospital or other covered facility • Services such as partial hospitalization, full-day hospitalization, or facility-based intensive outpatient treatment	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed charges
Not covered	
• *Services that are not part of a preauthorized approved treatment plan* • *Services that are not medically necessary*	*All charges*

See these sections of the brochure for more valuable information about these benefits:

- Section 4, *Your costs for covered services*, for information about catastrophic protection for these benefits.
- Section 7, *Filing a claim for covered services*, for information about submitting out-of-network claims.

Section 5 (f). Prescription drug benefits

Important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart on page 61.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible does not apply to prescription drug benefits.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- Prior authorization is required for certain drugs and must be renewed periodically. This review uses Plan rules based on FDA-approved prescribing and safety information, clinical guidelines and uses that are considered reasonable, safe and effective. See the coverage authorization information shown in Section 3, *Other services* and page 60 for more information about this program.

There are important features you should be aware of. These include:

- **Who can write your prescription.** Any covered provider licensed to prescribe drugs may write your prescription.
- **Where can you obtain them.** You can fill the prescription at an Express Scripts network pharmacy, a non-network pharmacy, or by mail. We pay our highest level of benefits for mail order and you should use the mail order program to obtain your maintenance medications.
- **We use a formulary.** Our formulary is open and voluntary. A formulary is a list of medications we have selected based on their clinical effectiveness and lower cost. By asking your doctor to prescribe formulary medications, you can help reduce your costs while maintaining high-quality care. Use of a formulary drug is voluntary; there is no financial penalty if your physician does not prescribe a formulary drug.

Brand/Generic Drugs

- **Why use generic drugs?** A generic drug is a chemical equivalent of a corresponding name brand drug. The US Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand name drugs. Generic drugs are less expensive than brand drugs, therefore, you may reduce your out-of-pocket-expenses by choosing to use a generic drug.
- A generic equivalent will be dispensed if it is available, unless your physician specifically requires a brand name drug. If you receive a brand name drug when a Federally-approved generic drug is available, and your physician has not received a preauthorization, you have to pay the difference in cost between the name brand drug and the generic, in addition to your coinsurance. However, if your doctor obtains preauthorization because it is medically necessary that a brand name drug be dispensed, you will not be required to pay this cost difference. Your doctor may seek preauthorization by calling 1-800-753-2851.
- The Plan may have certain coverage limitations to ensure clinical appropriateness. For example, prescription drugs used for cosmetic purposes may not be covered, a medication might be limited to a certain amount (such as the number of pills or total dosage) within a specific time period, or require authorization to confirm clinical use based on FDA labeling. In these cases, you or your physician can begin the coverage review process by calling Express Scripts Customer Service at 1-800-841-2734.

These are the dispensing limitations:

- The Express Scripts Retail Network – you may obtain up to a 30-day supply plus one 30-day refill for each prescription purchased from an Express Scripts network pharmacy. After one 30-day refill, you must obtain a new prescription and submit it to the mail order program. If you do not, we will pay the non-network pharmacy benefit level. To receive maximum savings you must present your card at the time of each purchase, and your enrollment information must be current and correct. In most cases, you simply present the card together with the prescription to the pharmacist. Refills cannot be obtained until 75% of the drug has been used.
- Exceptions for special circumstances – the Plan will authorize up to a 90-day supply at a network pharmacy for covered persons called to active military service. Also, the Plan will authorize an extra 30-day supply, either at network retail or Home Delivery, for civilian Government employees who are relocated for assignment in the event of a national emergency. Authorization may be obtained from Express Scripts at 1-800-841-2734 or from the Plan at 1-800-222-APWU (2798).
- Non-network pharmacy – if you do not use your identification card, if you elect to use a non-network pharmacy, or if an Express Scripts network pharmacy is not available, you will need to file a claim and we will pay at the non-network retail pharmacy benefit level.
- Mail order – through this program, you may receive up to a 90-day supply of maintenance medications for drugs which require a prescription, diabetic supplies and insulin, syringes and needles for covered injectable medications, and oral contraceptives. Some medications may not be available in a 90-day supply from Express Scripts by Mail even though the prescription is for 90 days.
- Refills for maintenance medications are not considered new prescriptions except when the doctor changes the strength or 180 days has elapsed since the previous purchase. Refill orders submitted too early after the last one was filled are held until the right amount of time has passed. As part of the administration of the prescription drug program, we reserve the right to maximize your quality of care as it relates to the utilization of pharmacies.
- You may fill your prescription at any pharmacy participating in the Express Scripts system. For the names of participating pharmacies, call 1-800-841-2734.

Certain controlled substances and several other prescribed medications may be subject to other dispensing limitations, such as quantities dispensed, and to the judgment of the pharmacist.

Personalized Medicine (voluntary program)

The Personalized Medicine Program combines a Pharmacogenomic test (genetic lab test) with a clinical program to optimize prescription drug therapies for patients taking Warfarin (anticoagulant) and Plavix (antiplatelet). This program focuses on giving physicians information, on an individual level, on patients who have already been diagnosed with a disease or condition.

The benefits of this testing, done with a simple cheek swab are:

- Greater patient safety and efficacy through more precise dosing for Warfarin and Plavix
- Elimination of adverse events since the patient will be taking the appropriate dose of Warfarin or Plavix from the early onset of therapy

Pharmacogenomic testing gives physicians personalized information they can use to make more precise prescribing and dosing decisions to help their patients receive the critical care they need. The Personalized Medicine Program is available to you at no additional cost. If your medication history indicates that the testing could be beneficial for you, a pharmacist will contact your physician to discuss the program. If your doctor agrees that the test results would be helpful, you will be contacted by a pharmacist to let you know that the testing is available. If you agree to participate, you will receive a cheek swab test that you can administer on your own.

The results of your test will be sent to your doctor and to an Express Scripts pharmacist who has received special training in personalized medicine. The pharmacist is available to help your doctor interpret the results of your test. Your participation is voluntary, and your doctor is still solely responsible for deciding which drug and dose is right for you.

Coverage Authorization

- The information below describes a feature of your prescription drug plan known as coverage authorization. Coverage authorization determines how your prescription drug plan will cover certain medications.
- Some medications are not covered unless you receive approval through a coverage review (prior authorization). Examples of drug categories that require a coverage review include but are not limited to, Growth Hormones, Botox, Interferons, Rheumatoid Arthritis agents, Retin A and drugs for organic impotence. This review uses Plan rules based on FDA-approved prescribing and safety information, clinical guidelines and uses that are considered reasonable, safe and effective. There are other medications that may be covered with limits (for example, only for a certain amount or for certain uses) unless you receive approval through a review. During this review, Express Scripts asks your doctor for more information than what is on the prescription before the medication may be covered under your plan. If coverage is approved, you simply pay your normal copayment for the medication. If coverage is not approved, you will be responsible for the full cost of the medication.
- In our ongoing effort to provide a robust yet cost-effective prescription drug benefit, APWU Health Plan participates in programs to encourage the prescribing and use of generics and lower-cost alternative brands when appropriate. In most cases, you save money when the preferred generic or formulary brand is dispensed. One method that has proved effective in saving members money is "preferred drug step therapy." Step therapy ensures that a generic alternative or brand alternative within a therapeutic category is used as a first-line treatment, before the use of a similar but more expensive drug. Specific therapeutic categories are identified as appropriate for preferred drug step therapy. Currently the Plan offers the step therapy programs on Hypnotic, Osteoporosis, Migraine, Glaucoma and Hypoglycemic medications. In these categories, members may pay up to 90 percent coinsurance for the targeted drugs. In situations where the targeted drug is prescribed, doctors are notified of lower-cost generics and preferred brands. If the doctor approves, the cost-effective medication is dispensed. If the doctor disapproves, a coverage review is initiated. If the coverage review is approved, the member is responsible for the normal coinsurance found on page 61. If the coverage review is denied, the member is responsible for 90 percent of the drug cost. If the member does not first obtain the Plan's approval, they will pay the full cost of the drug. If approval is obtained after filling the prescription, the member may be reimbursed for any amount they paid minus their coinsurance. Coverage reviews can be initiated by the member, pharmacist, or doctor by calling Express Scripts at 1-800-841-2734.
- The Plan will participate in other approved managed care programs to ensure patient safety and appropriate therapy in accordance with the Plan rules based on FDA-guidelines referenced above.
- To find out more about your prescription drug plan, please visit Express Scripts online at express-scripts.com or call Express Scripts Member Services at 1-800-841-2734.
- **"Specialty Drugs"** means those covered drugs that are typically high in cost and have one or more of the following characteristics: (1) complex therapy for complex disease; (2) specialized patient training and coordination of care required prior to therapy initiation and/or during therapy; (3) unique patient compliance and safety monitoring requirements; (4) unique requirements for handling, shipping and storage; and (5) potential for significant waste due to the high cost of the drug.

Exceptions to the price threshold may exist based on certain characteristics of the drug or therapy which will still require the drug to be classified as a Specialty Drug. Some examples of the disease categories currently in Express Scripts specialty pharmacy programs include cancer, cystic fibrosis, Gaucher disease, growth hormone deficiency, hemophilia, immune deficiency, hepatitis C, infertility, multiple sclerosis, rheumatoid arthritis and RSV prophylaxis.

In addition, a follow-on-biologic or generic product will be considered a Specialty Drug if the innovator drug is a Specialty Drug.

Many of the Specialty Drugs covered by the Plan fall under the Coverage Authorization program mentioned above.

For Medicare Part B insurance coverage. If Medicare Part B is primary, ask about your options for submitting claims for Medicare-covered medications and supplies, whether you use a Medicare-approved supplier or Express Scripts by Mail. Prescriptions typically covered by Medicare Part B include diabetes supplies (test strips and meters), specific medications used to aid tissue acceptance (such as with organ transplants), certain oral medications used to treat cancer, and ostomy supplies.

- **When you do have to file a claim.** Use a Prescription Drug Claim Form to claim benefits for prescription drugs and supplies purchased from a non-network pharmacy. You may obtain forms by calling 1-800-222-APWU (2798) or from our Web site at www.apwuhp.com. Your claim must include receipts that show the prescription number, the National Drug Code (NDC) number, name of the drug, prescribing physician's name, date of purchase and charge for the drug. Mail the claim form and receipt(s) to:

  APWU Health Plan
  P. O. 1358
  Glen Burnie, MD 21060-1358

Benefit Description	You Pay
Note: The calendar year deductible does not apply to this section.	
Covered medications and supplies	
Each new enrollee will receive a description of our prescription drug program, a combined prescription drug/Plan identification card, a mail order form/patient profile and a pre-addressed reply envelope. You may purchase the following medications and supplies prescribed by a physician from either a pharmacy or by mail: • Drugs and medicines, including those for tobacco cessation, for use at home that are obtainable only upon a doctor's prescription and listed in official formularies • Drugs and medicines (including those administered during a non-covered admission or in a non-covered facility) that by Federal law of the United States require a physician's prescription for their purchase, except those listed as not covered • Insulin and test strips for known diabetics • Needles and syringes for the administration of covered medications • Approved drugs for organic impotence such as Viagra and Levitra are subject to Coverage Authorization, see *Other services,* Section 3 and Section 5(f), page 60 • Drugs that could be used for cosmetic purposes such as: Retin A or Botox	• Network Retail: $8 generic. 25% brand name with an $8 minimum coinsurance up to a maximum of $200 coinsurance per prescription for a 30-day supply • Network Retail Medicare: $8 generic. 25% brand name with an $8 minimum coinsurance up to a maximum of $200 coinsurance per prescription for a 30-day supply • Non-network Retail: 50% of cost with an $8 minimum coinsurance for a 30-day supply • Non-network Retail Medicare: 50% of cost with an $8 minimum coinsurance for a 30-day supply • Network Mail Order: $15 generic. 25% brand name with a $12 minimum coinsurance up to a maximum of $600 coinsurance per prescription for a 90-day supply • Network Mail Order Medicare: $15 generic. 25% brand name with a $12 minimum coinsurance up to a maximum of $600 coinsurance per prescription for a 90-day supply
In-network prescription drugs approved by the FDA for contraception for women Note: If your physician receives preauthorization because it is medically necessary that a brand name contraceptive drug be dispensed, you will pay $0. Your physician may seek preauthorization by calling 1-800-841-2734.	• Network Retail: $0 generic. Brand name 25% with an $8 minimum coinsurance up to a maximum of $200 coinsurance per prescription for a 30-day supply • Network Mail Order: $0 generic. Brand name 25% with a $12 minimum coinsurance up to a maximum of $600 coinsurance per prescription for a 90-day supply

Covered medications and supplies - continued on next page

Benefit Description	You Pay
Covered medications and supplies (cont.)	
	• Non-network Retail: 50% of the cost with an $8 minimum coinsurance for a 30-day supply
In-network generic prescription drugs approved by the FDA for contraception for women In-network devices approved by the FDA for contraception for women	Nothing
Drugs, vitamins and minerals, and nutritional supplements that by Federal law of the United States require a prescription for their purchase Medicines to promote better health as recommended under the Patient Protection and Affordable Care Act (the "Affordable Care Act"), including: • Aspirin for men age 45 through 79 and women age 55 through 79 • Vitamin Supplements are not covered except as stated below: - ACA required coverage for Vitamin D for adults 65 and older - Folic acid supplements, 0.4 to 0.8 mg, for women who may become pregnant - Iron supplements, for children from age 6 months through 12 months	Network Retail: Nothing Network Retail Medicare: Nothing Non-network Retail: 50% of cost with an $8 minimum coinsurance for a 30-day supply Non-network Retail Medicare: 50% of cost with an $8 minimum coinsurance for a 30-day supply
Note: Copay maximum does not apply to out-of-network retail drugs or to brand name drugs when there is a generic available. Note: If you choose a brand name drug when a generic is available and the physician has not received preauthorization, you are responsible for the difference in cost between the brand name drug and the generic, in addition to your coinsurance. Note: The Plan requires a coverage review (prior authorization) of certain prescription drugs based on FDA-approved prescribing and safety information, clinical guidelines, and uses that are considered reasonable, safe and effective. See page 60 for more information. To find out if your prescription requires prior authorization or more about your prescription drug plan, visit Express Scripts online at express-scripts.com or call Express Scripts member services at 1-800-841-2734. Note: Specific covered medications and supplies for patients engaged and compliant with the Plan's Disease Management Programs may have enhanced benefits. See *Disease Management*, Section 5(h), *Special features*.	
Personalized medicine (voluntary program) • Pharmacogenomic testing to optimize prescription drug therapies for certain conditions: - Warfarin (anticoagulant) - Plavix (antiplatelet)	Nothing
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins, minerals, nutritional supplements, and enteral formulas (liquid food supplements)*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You Pay
Covered medications and supplies (cont.)	
• *Medical supplies such as dressings and antiseptics* • *Nonprescription medicines/over-the-counter drugs, except as stated below:* - *Over-the counter emergency contraceptive drugs, the "morning after pill", are covered at no cost if prescribed by a physician and purchased at a network pharmacy* - *Over-the-counter FDA-approved female birth control methods are covered at no cost if prescribed by a physician and purchased at a network pharmacy* Note: Over-the-counter or prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation Program (See Educational classes and programs, page 43).	*All charges*

Section 5 (g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9, *Coordinating benefits* with other coverage.
- The calendar year deductible is: PPO - $275 per person ($550 per family); Non-PPO - $500 per person ($1,000 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 for information abut how we pay if you have other coverage, or if you are age 65 or over.

Note: We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. We do not cover the dental procedure. See Section 5(c), *Inpatient hospital benefits*.

Accidental injury benefit	You Pay
Accidental injury benefit	
We cover restorative services and supplies necessary to repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury (a blow or fall) and must be performed within two years of the accident. See also Section 5(d), *Accidental injury*.	Within 24 hours of accident: PPO: Nothing (No deductible) Non-PPO: Only the difference between our allowance and the billed amount (No deductible) More than 24 hours after accident: PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Dental benefits service	
Office visits (routine limited to 2 visits per year) Restorative care (fillings) X-rays of all types (limited to 2 per year) Prophylaxis (cleanings), (limited to 2 per year) Simple extractions Note: Office visits include examinations and fluoride treatment. Note: Restorative care does not include crowns or in-lay/on-lay restoration.	30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)

Section 5 (h). Special features

Special feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alernative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits under the OPM disputed claims process (see Section 8).
24-hour nurse line	We offer a 24-hour nurse advisory service for your use. This program is strictly voluntary and confidential. You may call toll-free at 1-800-582-1314 and reach registered nurses to discuss an existing medical concern or to receive information about numerous health care issues.
Services for deaf and hearing impaired	We offer a toll-free TDD line for customer service. The number is 1-800-622-2511. TDD equipment is required.
Wellness benefit	We reimburse you up to $250 per Self Only enrollment and $350 per Self and Family enrollment per calendar year for non-covered expenses such as vision and eyeglasses, if received in 2014 and no other benefits for 2014 have been paid. If we paid claims of less than $250 for a Self Only enrollment, the difference up to $250 will be paid. If we paid claims of less than $350 for a Self and Family enrollment, the difference up to $350 will be paid. We will notify you in November if you are eligible for the Wellness benefit. Submit Wellness claims after January 1, 2015. Wellness claims are paid after March 1, 2015. If, after Wellness benefits have been paid, subsequent claims are received for hospital, medical, dental expenses, or pharmacy payments made under the Wellness benefit will be deducted from allowable charges.
Disease Management Program	A voluntary program that provides a variety of services to help you manage a chronic condition with outpatient treatment and avoid unnecessary emergency care or inpatient admissions. Some examples of conditions that can be managed through this program are: diabetes and cardiac conditions. We use medical and/or pharmacy claims data as well as interactions with you and your physician(s). If you have a chronic condition and would like additional information, call Cigna/CareAllies at 1-800-582-1314.

Special feature	Description
Diabetes Management Program	If you are an APWU Health Plan primary member enrolled in the Cigna/CareAllies Diabetes Disease Management Program and participate as required by the program, you may be eligible for the following incentives for in-network services only: • $0 copay for in-network medical office visits for diabetes management (this does not include visits to a Podiatrist or Ophthalmologist) • $0 coinsurance for in-network lab tests related to diabetes management • $0 copay for Generic drugs from Express Scripts by Mail for the specific purpose of lowering your blood sugar • $0 copay for Insulin from Express Scripts by Mail • $0 copay for blood glucose test strips, lancets, syringes, pen needles and Insulin Pump supplies from Express Scripts by Mail • $0 coinsurance for an Insulin Pump (Preauthorization is required) and Insulin Pump supplies purchased in-network If you are an APWU Health Plan member who has other primary insurance (i.e. Medicare primary), you do not have to enroll in the Diabetes Disease Management Program, you may be eligible for the following incentives: • $0 copay for Generic drugs from Express Scripts by Mail for the specific purpose of lowering your blood sugar • $0 copay for Insulin from Express Scripts by Mail • $0 copay for blood glucose test strips, lancets, syringes, pen needles and Insulin Pump supplies from Express Scripts by Mail • $0 coinsurance for in-network lab tests related to diabetes management • $0 coinsurance for an Insulin Pump (Preauthorization is required) and Insulin Pump supplies purchased in-network Note: Enrollment in this program must be initiated by member after effective date of Health Plan enrollment. To enroll contact Cigna/CareAllies at 1-800-582-1314. Note: If you have other primary pharmacy insurance, you must use your primary insurance first and then send the payment information from the primary insurance to APWU Health Plan for coordination of benefits. Note: You must remain in compliance with the program requirements in order to be eligible for the $0 copay incentives. In order to remain compliant with the program, enrollees must complete a call with their health coach at least every 90 days. During these calls, you will discuss such topics as understanding of your disease process, knowledge of your recent lab results, doctor visits and self-care goals.
Review and Reward Program	If you send us a corrected hospital billing, we will credit 20% of any hospital charge over $20 for covered services and supplies that were not actually provided to a covered person. The maximum amount payable under this program is $100 per person per calendar year.
Hypertension (High Blood Pressure) Management Program	If you are an APWU Health Plan primary member enrolled in the Hypertension Education and Coaching Program and participate as required by the program, you may be eligible for the following incentives for in-network services only: • $0 copay for in-network office visits for the treatment of hypertension • $0 coinsurance for in-network lab tests related to the treatment of hypertension • $0 copay for Generic drugs from Express Scripts by Mail for the specific purpose of lowering your blood pressure

	If you are an APWU Health Plan member who has other primary insurance (i.e. Medicare primary), you do not have to enroll in the Hypertension Education and Coaching Program. You will be eligible for the following incentives: • $0 copay for Generic drugs from Express Scripts by Mail for the specific purpose of lowering your blood pressure Note: Enrollment in this program must be initiated by member after effective date of Health Plan enrollment. To enroll contact Cigna/CareAllies at 1-800-582-1314. Note: If you have other primary pharmacy insurance, you must use your primary insurance first and then send the payment information from the primary insurance to APWU Health Plan for coordination of benefits. Note: You must remain in compliance with the program requirements in order to be eligible for the $0 copay incentives. In order to remain compliant with the program, enrollees must complete a call with their health coach at least every 90 days. During these calls, you will discuss such topics as understanding of your disease process, knowledge of your recent lab results, doctor visits and self-care goals.
Weight Management Program	If you are an APWU Health Plan primary member enrolled in the Cigna/CareAllies Weight Management Program and participate as required by the program, you may be eligible for the following incentives for in-network services only: • $0 copay for in-network office visit to a registered Dietician/Nutritionist (see *Special Programs*)
Special Programs	• **Lifestyle Programs** - Wellness Coaches help you develop a personalized plan for tobacco cessation and weight management. For information, call Cigna/CareAllies at 1-800-582-1314, select Hypertension/Weight Management/Tobacco Cessation option. • **Healthy Rewards** - MyCareAllies provides non-FEHB savings on gym memberships, tobacco cessation, weight reduction programs, and more. Visit www.apwuhp.com or call 1-800-558-9443. - **Tobacco cessation** - find discounts on smoking cessation products - **Weight and nutrition** - get help to lose weight with discounts on weight reduction programs from Jenny Craig - **Fitness** - get fit and save on gym memberships - **Vision and hearing care** - receive vision and hearing exams and discounts on hearing aids, discounts on glasses and frames, and discounts on Lasik vision corrections - **Wellness products** - enjoy 40% savings on herbal supplements and vitamins, and 5% at checkout from www.drugstore.com - **Alternative medicine** - find discounts for acupuncture, chiropractor, and massage - **Dental care** - save on dental care with discounts on anti-cavity products and toothbrushes
Online tools and resources	Online tools are available at www.apwuhp.com: • **eHealthRecord** - online information for member services and claims to view claims and find year-to-date information with claim details • **HealthVault** - an online tool to organize important medical information in one secure and central location to share with family and doctors • **HealthAssessment** - answer questions about your health and receive a personalized health program through MyCareAllies

Special feature	Description
Consumer choice information	Access by Internet (www.apwuhp.com) is provided to support your important health and wellness decisions, including: • Online Preferrred Organization (PPO) Directory - nationwide PPO network to find doctors, hospitals and other outpatient providers anywhere in the country • Hospital Quality Ratings Guide - Compare hospitals for quality in your area or anywhere in the country • Treatment Cost Estimator - receive cost estimates for the most common medical conditions, tests and procedures • Prescription drug information, pricing, and network retail pharmacies

Consumer Driven Health Plan Benefits

See page 15 for how our benefits changed this year and page 140 for a benefits summary.

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Summary of benefits for the CDHP of the APWU Health Plan - 2014 140

Consumer Driven Health Plan Overview

The Plan offers a Consumer Driven Health Plan (CDHP). The CDHP benefit package is described in this section. Make sure that you review the benefits that are available under the benefit product in which you are enrolled.

CDHP Section 5, which describes the CDHP benefits, is divided into subsections. Please read *Important things you should keep in mind about these benefits* at the beginning of each subsection. Also read the general exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about CDHP benefits, contact us at 1-800-718-1299 or on our Web site at www.welcometouhc.com/apwu.

This CDHP focuses on you, the health care consumer, and gives you greater control in how you use your health care benefits. With this Plan, eligible in-network preventive care is covered in full, and you can use the Personal Care Account for any covered care. If you use up your Personal Care Account, the Traditional Health Coverage begins after you satisfy your Deductible. If you don't use up your Personal Care Account for the year, you can roll it over to the next year, up to the maximum rollover balance amount, as long as you continue to be enrolled in this CDHP.

The CDHP includes:

In-network Preventive Care

This component covers 100% for preventive care for adults and children if you use a network provider. The covered services include office visits/exams, immunizations and screenings and are fully described in Section 5, *In-network preventive care*. They are based on recommendations by the American Medical Association. We emphasize women's wellness through a Well woman benefit that includes a broad range of preventive services, preventive tests and screenings, counseling services, breastfeeding support and supplies, and contraceptives, including prescription drug contraceptives.

Personal Care Account (PCA)

The Plan also provides a Personal Care Account (PCA) for each enrollment. Each year, the Plan provides $1,200 for a Self Only enrollment or $2,400 for a Self and Family enrollment. The PCA covers 100% for your covered medical expenses, which include dental and vision care.

If you have an unused PCA balance at the end of the year, you can rollover that balance so you can use it in the future. The Personal Care Account is described in Section 5, *Personal Care Account (PCA).*

Note that the in-network Preventive Care benefits paid under Section 5 do NOT count against your Personal Care Account (PCA).

Traditional Health Coverage

After you have used up your Personal Care Account (PCA) and paid your Deductible, the Plan starts paying benefits under the Traditional Health Coverage described in Section 5, *Traditional Health Coverage*. The Plan generally pays 85% of the cost for in-network care and 60% of the Plan allowance for out-of-network care.

Covered services include:

- Medical services and supplies, Section 5(a)
- Surgical and anesthesia services, Section 5(b)
- Hospital services, other facilities and ambulance, Section 5(c)
- Emergency services/Accidents, Section 5(d)
- Mental health and substance abuse benefits, Section 5(e)
- Prescription drug benefits, Section 5(f)

Health education resources and account management tools

Section 5(i) describes the health tools and resources available to you under the Consumer Driven Option to help you improve the quality of your health care and manage your expenses. There is also care support and a 24-hour nurse advisory service.

Section 5. In-network preventive care

Important things you should keep in mind about these in-network preventive care benefits:

- Under the Consumer Driven Option, the Plan pays 100% for the Preventive Care services listed in this Section as long as you use a network PPO provider.
- For preventive care not listed in this Section or for preventive care from a non-network provider, please see CDHP Section 5, *Personal Care Account (PCA)*.
- For all other covered expenses, please see CDHP Section 5, *Personal Care Account (PCA)* and *Traditional Health Coverage*.
- Note that the in-network Preventive Care paid under this Section does NOT count against or use up your Personal Care Account (PCA).
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.

Benefit Description	You Pay
Note: There is no calendar year deductible for in-network preventive care under the Consumer Driven Option.	
Preventive care, adult	
We provide benefits for a comprehensive range of preventive care services for adults, including the preventive services recommended under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). Covered services include: One annual routine office visit and examination per person after age 18. Lab tests covered are: • Comprehensive Metabolic Panel • Lipid Panel • Urinalysis	In-network: Nothing Out-of-network: Uses PCA while funds available
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC)	In-network: Nothing Out-of-network: Uses PCA while funds available
Routine screenings: • Total Blood Cholesterol, once annually • Fasting lipoprotein profile, once every 5 years for adults age 20 or older • Osteoporosis screening, once every two years, for women age 60 and older • Chlamydial infection • One-time hepatitis C test for those born from 1945-1965 • Colorectal Cancer Screenings, member has the choice of the following: - Fecal occult blood test (FOBT) annually beginning at age 50; or - Flexible sigmoidoscopy beginning at age 50; or	In-network: Nothing Out-of-network: Uses PCA while funds available

Preventive care, adult - continued on next page

Benefit Description	You Pay
Preventive care, adult (cont.)	
- Colonoscopy beginning at age 50 • Digital Rectal Examination (DRE) and Prostate Specific Antigen (PSA) test annually starting at age 45 • Abdominal Aortic Aneurysm screening, once for men between the ages of 65 and 75 with a smoking history • HIV screening • Biometric screening, once annually Note: Biometric screening includes Body Mass Index (BMI), lipid panel, Total Blood Cholesterol, blood pressure, and Comprehensive Metabolic Panel, as listed above in *Preventive care, adult.*	In-network: Nothing Out-of-network: Uses PCA while funds available
Well woman care, including but not limited to: • Pap test and routine pelvic exam annually • Routine mammograms - covered for women age 35 and older, as follows: - From age 35 through 39, one during this five year period - From age 40 through 64, one every calendar year - At age 65 and older, one every two consecutive calendar years • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk • HPV testing for women • Annual counseling for sexually transmitted infections for women • Annual counseling and screening for HIV for women • Generic prescription drugs approved by the FDA for contraception (See Section 5(f), *Prescription drug benefits)* • In-network devices approved by the FDA for contraception (See Section 5(f), *Prescription drug benefits)* • Contraceptives, such as surgically implanted, injectable contraceptive drugs, intrauterine devices, and diaphragms (See *Family planning*, Section 5(a)) • Contraceptive counseling for women • Sterilization procedures (See *Surgical procedures*, Section 5(b)) • Patient education and counseling for all women with reproductive capacity • Breastfeeding support, supplies (including rental of breast feeding equipment) and counseling for each birth • Annual screening and counseling for interpersonal and domestic violence Note: A complete list of preventive care services recommended under the USPSTF is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.	In-network: Nothing Out-of-network: Uses PCA while funds available

Benefit Description	You Pay
Preventive care, children	
We provide benefits for a comprehensive range of preventive care services for children, including the preventive services recommended under the Patient Protection and Affordable Care Act (the "Affordable Care Act"), and the American Academy of Pediatrics. Covered services include: Routine office visits, examinations and laboratory tests as follows: • Six visits the first year (to age 1) • Three visits the second year (age 1-2) • Annual visits from age 2 through age 18	In-network: Nothing Out-of-network: Uses PCA while funds available
Childhood immunizations recommended by the American Academy of Pediatrics through age 18	In-network: Nothing Out-of-network: Uses PCA while funds available
Routine screenings: • One Screening Examination of Premature Infants for Retinopathy of Prematurity or infants with low birth weight or gestational age of 32 weeks or less • Lead level testing, one between ages 9 to 12 months and one between 12 and 24 months • Vision screening at ages 3, 4, 5, 6, 8, 10, 12, 15, and 18 • Hearing screening at ages 4, 5, 6, 8, 10, 12, 15, and 18 • HIV screening • Pap test and routine pelvic exam annually beginning at age 18 or the onset of sexual activity, whichever comes first	In-network: Nothing Out-of-network: Uses PCA while funds available
Note: A complete list of preventive care services recommended under the USPSTF is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.	

Section 5. Personal Care Account (PCA)

Important things you should keep in mind about your Personal Care Account:

- All eligible health care expenses (except in-network preventive care) are paid first from your Personal Care Account (PCA). Traditional Health Coverage (under CDHP Section 5) will only start once your Personal Care Account is exhausted.
- Note that in-network preventive care covered under CDHP Section 5 does NOT count against your PCA.
- The Personal Care Account provides full coverage for both in-network and out-of-network providers. However your Personal Care Account will generally go much further when you use network providers because network providers agree to discount their fees.
- You have flexibility about how to spend your PCA, and the Plan provides you with the resources to manage your PCA. You can track your PCA on your personal private Web site, by telephone at 1-800-718-1299 (toll-free), or with monthly statements mailed directly to you at home.
- If you join this Plan during Open Season, you receive the full PCA ($1,200 per Self Only or $2,400 per Self and Family enrollment) as of your effective date of coverage. If you join at any other time during the year, your PCA for your first year will be prorated at a rate of $100 per month for Self Only or $200 per month for Self and Family for each full month of coverage remaining in that calendar year.
- Unused PCA benefits are forfeited when leaving this Plan.
- If PCA benefits are available in your account at the time a claim is processed, out-of-pocket expenses will be paid from your PCA regardless of the date the expense was incurred.
- If the member has funds available in the PCA account, claims will always be paid out of the PCA first. If the member would like to use their FSA to pay a bill prior to using the PCA, please instruct the provider not to submit the claim to UnitedHealthcare. The member should get a copy of the bill from the provider and submit to the FSA carrier for reimbursement. This means that in some cases, the member may have to pay the cost of the services up front.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY.** Please refer to the precertification information shown in Section 3 to confirm which services require precertification.

Benefit Description	You pay
There is no calendar year deductible for in-network preventive care under the Consumer Driven Option.	
Personal Care Account (PCA)	
A Personal Care Account (PCA) is provided by the Plan for each enrollment. Each year the Plan adds to your account: • $1,200 per year for a Self Only enrollment or • $2,400 per year for a Self and Family enrollment The Personal Care Account covers eligible expenses at 100%. For example, if you are ill and go to a network doctor for a $60 visit, the doctor will submit your claim and the cost of the visit will be deducted automatically from your PCA; you pay nothing. Balance in PCA or Self Only $1,200 Less: Cost of visit -60 Remaining Balance in PCA $1,140 There are two types of eligible expenses covered by your PCA. • **Basic PCA Expenses** are the same medical, surgical, hospital, emergency, mental health and substance abuse, and prescription drug services and supplies covered under the Traditional Health Coverage (see CDHP Section 5 for details) • **Extra PCA Expenses** include: - Dental and/or vision services are reimbursable out of your PCA and must be paid up front by you. We will reimburse up to a combined maximum of $400 per Self Only enrollment or $800 per Self and Family enrollment each calendar year, including: - Vision exam performed by an optometrist or ophthalmologist - Eyeglasses and contact lenses - Dental treatment (including examinations, cleanings, fillings, restorative treatment, endodontics, and periodontics) - In-network preventive care services not included under CDHP Section 5, *In-network Preventive Care benefits* - *Out-of-network preventive care* limited to services shown as covered under CDHP Section 5 - Amounts in excess of the Plan allowance for services received out-of-network and covered under Basic PCA Expenses Note: Both Basic and Extra PCA Expenses are covered at 100% as long as you have not used up your Personal Care Account. To make the most of your Personal Care Account, you should: • Use the network providers wherever possible; • Use generic prescriptions wherever possible; and • Only use your PCA for Extra PCA Expenses if you expect to have an unused balance in your PCA at the end of the calendar year	In-network and Out-of-network: Nothing up to $1,200 for a Self Only enrollment or $2,400 for a Self and Family enrollment
Not covered: • *Orthodontia* • *Dental treatment for cosmetic purposes including teeth whitening*	*All charges*

Personal Care Account (PCA) - continued on next page

Benefit Description	You pay
Personal Care Account (PCA) (cont.)	
• *Out-of-network preventive care services not included under CDHP Section 5* • *Services or supplies shown as not covered under Traditional Health Coverage (see CDHP Section 5) and not included under Extra PCA Expenses above*	*All charges*

PCA Rollover

As long as you remain in this Plan, any unused remaining balance in your PCA at the end of the calendar year may be rolled over to subsequent years. The maximum amount allowed in your PCA in any given year may not exceed $5,000 per Self Only enrollment and $10,000 per Self and Family enrollment.

Section 5. Traditional Health Coverage Overview

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In-network Preventive Care is covered at 100% under CDHP Section 5 and does not count against your Personal Care Account.
- Your Personal Care Account must be used first for eligible health care expenses.
- If your Personal Care Account has been exhausted, you must pay your Deductible before your Traditional Health Coverage may begin. Your Deductible applies to all benefits in this section.
- The Consumer Driven Option provides coverage for both in-network and out-of-network providers. The out-of-network benefits are the standard benefits under the Traditional Health Coverage. In-network benefits apply only when you use a provider from the large, national network. When a network provider is not available, out-of-network benefits apply.
- If you join at any time during the year other than Open Season, your Deductible for your first year will be prorated at a rate of $50 per month for Self Only or $100 per month for Self and Family for each full month of coverage remaining in that calendar year.
- When you use an in-network hospital, keep in mind that the professionals who provide services to you in the hospital, may not all be preferred providers. If they are not, they will be paid by this Plan as out-of-network providers. However, if surgical services are rendered at an in-network hospital or an in-network freestanding ambulatory facility by an in-network primary surgeon, we will pay the services of anesthesiologists who are not preferred providers at the in-network rate, based on Plan allowance. If the covered services are performed at an in-network hospital or an in-network freestanding ambulatory facility, we will pay the services of radiologists and pathologists who are not preferred providers at the in-network rate, based on the Plan allowance.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY.** Please refer to the *precertification information* shown in Section 3 to confirm which services require precertification.

Benefit Description	You Pay
Deductible before Traditional Health Coverage begins	
If your Personal Care Account has been exhausted, you are responsible to pay your Deductible before your Traditional Health Coverage begins. Traditional Health Coverage benefits begin after covered eligible expenses total $1,800 for Self Only or $3,600 for Self and Family (the combination of eligible expenses paid out of your PCA and your Deductible) each calendar year. Note: You must use any available PCA benefits, including any amounts rolled over from previous years, before Traditional Health Coverage begins. In year one, therefore, the Deductible is $600 for Self Only and $1,200 for Self and Family enrollment.	In-network/Out-of-network: $600 per Self Only enrollment or $1,200 per Self and Family enrollment

Deductible before Traditional Health Coverage begins - continued on next page

Benefit Description	You Pay
Deductible before Traditional Health Coverage begins (cont.)	

	Self Only	Self and Family
Basic PCA Expenses paid by PCA	$1,200	$2,400
Deductible paid by you	$600	$1,200
Traditional Health Coverage starts after	$1,800	$3,600

In-network/Out-of-network: $600 per Self Only enrollment or $1,200 per Self and Family enrollment

Any PCA dollars that you rollover at the end of the year will reduce your Deductible next year.

In future years, the amount of your Deductible may be lower if you rollover PCA dollars at the end of the year. For example, if you rollover $300 at the end of the year:

	Self Only	Self and Family
PCA for year 2 Rollover from year 1	$1,200 + 300 $1,500	$2,400 + 300 $2,700
Deductible paid by you	+ 300	+ 900
Traditional Health Coverage starts when eligible expenses total	$1,800	$3,600

If you decide to use your PCA for Extra PCA Expenses for other than covered dental and/or vision services, you may increase your Deductible.

For example, if you have out-of-network preventive care for $150 and **later** have an accident that leads to a hospital stay, you will have to pay your Deductible plus "make up" the $150 dollars you spent on Extra PCA Expenses.

Section 5 (a). Medical services and supplies provided by physicians and other health care professionals

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In-network Preventive Care is covered at 100% under CDHP Section 5 and does not count against your Personal Care Account.
- Your Personal Care Account must be used first for eligible health care expenses.
- If your Personal Care Account has been exhausted, you must pay your Deductible before your Traditional Health Coverage may begin. Your Deductible applies to all benefits in this section.
- The Consumer Driven Option provides coverage for both in-network and out-of-network providers. The out-of-network benefits are the standard benefits under the Traditional Health Coverage. In-network benefits apply only when you use a provider from the large, national network. When a network provider is not available, out-of-network benefits apply.
- If you join at any time during the year other than Open Season, your Deductible for your first year will be prorated at a rate of $50 per month for Self Only or $100 per month for Self and Family for each full month of coverage remaining in that calendar year.
- When you use an in-network hospital, keep in mind that the professionals who provide services to you in the hospital, may not all be preferred providers. If they are not, they will be paid by this Plan as out-of-network providers. However, if surgical services are rendered at an in-network hospital or an in-network freestanding ambulatory facility by an in-network primary surgeon, we will pay the services of anesthesiologists who are not preferred providers at the in-network rate, based on Plan allowance. If the covered services are performed at an in-network hospital or an in-network freestanding ambulatory facility, we will pay the services of radiologists and pathologists who are not preferred providers at the in-network rate, based on the Plan allowance.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY.** Please refer to the *precertification information* shown in Section 3 to confirm which services require precertification.

Benefit Description	You Pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office • At home • In an urgent care center • During a hospital stay • In a skilled facility • Second surgical opinion	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount

Benefit Description	You Pay
Lab X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine mammograms • Pathology • X-rays • Non-routine pap tests • CT Scans/MRI/MRA/NC/PET • Ultrasound • Electrocardiogram and EEG Note: If your network provider uses an out-of-network lab or radiologist, we will pay out-of-network benefits for any lab and X-ray charges.	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Professional fees for automated lab tests*	*All charges*
Pharmacogenomic testing to optimize prescription drug therapies for certain conditions: • Plavix (antiplatelet) • Warfarin (anticoagulant)	In-network: Nothing Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care • Initial examination of a newborn child covered under a family enrollment Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 22 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. • We pay hospitalization and surgeon services for non-maternity care, as well as covering an extended stay, if medically necessary, the same as for illness and injury.	In-network: Nothing Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount Note: For inpatient hospital care related to maternity, we pay for covered services in full when you use preferred providers.
• We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision of a covered newborn	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount

Maternity care - continued on next page

Benefit Description	You Pay
Maternity care (cont.)	
• Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk • Breastfeeding support, supplies (including rental of breast feeding equipment) and counseling for women for each birth	In-network: Nothing Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Amniocentesis if for diagnosing multiple births*	*All charges*
Family planning	
A range of voluntary family services limited to: • Contraceptive counseling for women • Voluntary sterilization for women (See *Surgical* procedures, Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under Section 5(a), *Well woman.*	In-network: Nothing Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
• Voluntary sterilization for men (See *Surgical* procedures, Section 5(b)	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary surgical sterilization and genetic counseling.*	*All charges*
Infertility services	
Diagnosis and treatment of infertility, except as shown in *Not covered*	In-network: 15% of the Plan allowance and any amount over $2,500 Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount and any amount over $2,500
Not covered: • *Infertility services afer voluntary sterilization* • *Assisted reproductive technology (ART) procedures, such as:* - *Artificial insemination (all procedures)* - *In vitro fertilization* - *Embryo transfer and gamete intrafallopian transfer (GIFT)* - *Intravaginal insemination (IVI)* - *Intracervical insemination (ICI)* - *Intrauterine insemination (IUI)* • *Services and supplies related to ART procedures* • *Cost of donor sperm*	*All charges*

Infertility services - continued on next page

Benefit Description	You Pay
Infertility services (cont.)	
• *Cost of donor egg*	*All charges*
Allergy care	
• Testing and treatment, including materials (such as allergy serum) • Allergy injections	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Provocative food testing and sublingual allergy desensitization*	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed on pages 90-92 • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: We only cover IV/Infusion therapy and GHT when we are pre-notified of the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See *Other services* under *You need prior Plan approval for certain services,* Section 3. • Respiratory and inhalation therapies	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Physical and occupational therapies	
Physical therapy and occupational therapy provided by a licensed registered therapist up to a combined 60 visits per calendar year We cover rehabilitative and habilitative therapies; a physician should: • Order the care; • Identify the specific professional skills the patient requires and the medical necessity for skilled services; and • Indicate the length of time services are needed.	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Maintenance therapies* • *Exercise programs* • *Physical and occupational therapies without pre-notification*	*All charges*

Benefit Description	You Pay
Speech therapy	
Speech therapy where medically necessary and provided by a licensed therapist Note: Speech therapy is combined with 60 visits per calendar year for the services of physical therapy and/or occupational therapy (see above). We also have the right to deny any type of therapy, service or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or recurring.	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Hearing services (testing, treatment, and supplies)	
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist • One examination and testing for hearing aids every 2 years Note: For routine hearing screening performed during a child's preventive care visit, see Section 5, *Preventive care, children.*	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
• External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants	Note: For benefits for the devices, see Section 5(a), *Orthopedic and prosthetic devices.*
Not covered: • *Hearing services that are not shown as covered*	*All charges*
Vision services (testing, treatment, and supplies)	
• Internal (implant) ocular lenses and/or the first contact lenses required to correct an impairment caused by accident or illness. The services of an optometrist are limited to the testing, evaluation and fitting of the first contact lenses required to correct an impairment caused by accident or illness. Note: See *Preventive care, children*, for eye exams for children.	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Eyeglasses or contact lenses and examinations for them except under PCA* • *Eye exercises and visual training* • *Radial keratotomy and other refractive surgery*	*All charges*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes Note: See *Orthopedic and prosthetic devices* for information on podiatric shoe inserts.	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above*	*All charges*

Foot care - continued on next page

Benefit Description	You Pay
Foot care (cont.)	
• *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Leg, arm, neck, joint and back braces • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b), *Surgical procedures*. For information on the hospital and/or ambulatory surgery center benefits, see Section 5 (c). Note: We recommend pre-notification of orthopedic and prosthetic devices. Call UnitedHealthcare at 1-800-718-1299 for pre-notification. Note: We will pay only for the cost of the standard item. Coverage for specialty items, such as bionics, is limited to the cost of the standard item.	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
External hearing aids • Covered every 3 years limited to $1,500 Note: Excluding batteries, benefits for hearing aid dispensing fees, accessories, supplies, and repair service are included in the benefit limit described above.	In-network: All charges in excess of $1,500 Out-of-network: All charges in excess of $1,500
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices*	*All charges*
Durable medical equipment (DME)	
Durable medical equipment (DME) is equipment and supplies that: 1) Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury) 2) Are medically necessary 3) Are primarily and customarily used only for a medical purpose 4) Are generally useful only to a person with an illness or injury	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount

Durable medical equipment (DME) - continued on next page

Benefit Description	You Pay
Durable medical equipment (DME) (cont.)	
5) Are designed for prolonged use; and 6) Serve a specific therapeutic purpose in the treatment of an illness or injury We cover rental or purchase, of durable medical equipment, at our option, including repair and adjustment. Covered items include but are not limited to: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs (standard and electric) • Ostomy supplies (including supplies purchased at a pharmacy) • Crutches; and • Walkers Note: Call UnitedHealthcare at 1-800-718-1299 as soon as your physician prescribes this equipment because pre-notification is required. Note: We will pay only for the cost of the standard item. Coverage for specialty equipment, such as all-terrain wheelchairs, is limited to the cost of the standard equipment.	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Whirlpool equipment* • *Sun and heat lamps* • *Light boxes* • *Heating pads* • *Exercise devices* • *Stair glides* • *Elevators* • *Air purifiers* • *Computer "story boards," "light talkers," or other communication aids for communication-impaired individuals*	*All charges*
Home health services	
Services for skilled nursing care up to 25 visits per calendar year, not to exceed a maximum Plan payment of $90 per day, when preauthorized and: • a registered nurse (R.N.), licensed practical nurse (L.P.N.) or licensed vocational nurse (L.V.N.) provides the services; • the attending physician orders the care; • the physician identifies the specific professional skills required by the patient and the medical necessity for skilled services; and • the physician indicates the length of time the services are needed Note: Skilled nursing care must be preauthorized. Call UnitedHealthcare at 1-800-718-1299 for pre-notification.	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount

Home health services - continued on next page

Benefit Description	You Pay
Home health services (cont.)	
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, rehabilitative or habilitative* • *Services of nurses' aides or home health aides*	*All charges*
Chiropractic	
Chiropractic treatment limited to 12 visits and/or manipulations per year Note: X-rays covered under *Diagnostic and treatment services.* Note: Massage therapy not covered.	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Alternative treatments	
Acupuncture - by a doctor of medicine or osteopathy or licensed acupuncturist • anesthesia • pain relief	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Services of any provider not listed as covered; see page 16* Note: Benefits of certain alternative treatment providers may be covered in medically underserved areas; see page 16.	*All charges*
Educational classes and programs	
If you are an APWU Health Plan member you may enroll in a Tobacco Cessation Program up to two quit attempts per year as follows: • 4 Telephonic counseling sessions with UnitedHealthcare or; • 4 Group therapy sessions or; • 4 Educational sessions with a physician Note: Enrollment in the UnitedHealthcare program must be initiated by the member after effective date of Health Plan enrollment. For more information contact UnitedHealthcare at 1-800-718-1299.	In-network: Nothing Out-of-network: All charges
Prescription drugs (through Optum Rx by Mail only) approved by the FDA to treat tobacco dependence for Tobacco Cessation. Over-the-counter drugs (through UnitedHealthcare only) approved by the FDA to treat tobacco dependence for Tobacco Cessation.	In-network: Nothing Out-of-network: All charges
Diabetes self-management training services, up to 10 hours initial training the first year and 2 hours subsequent training annually.	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount

Section 5 (b). Surgical and anesthesia services provided by physicians and other health care professionals

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In-network Preventive Care is covered at 100% under CDHP Section 5 and does not count against your Personal Care Account.
- Your Personal Care Account must be used first for eligible health care expenses.
- If your Personal Care Account has been exhausted, you must pay your Deductible before your Traditional Health Coverage may begin. Your Deductible applies to all benefits in this section.
- The Consumer Driven Option provides coverage for both in-network and out-of-network providers. The out-of-network benefits are the standard benefits under the Traditional Health Coverage. In-network benefits apply only when you use a provider from the large, national network. When a network provider is not available, out-of-network benefits apply.
- If you join at any time during the year other than Open Season, your Deductible for your first year will be prorated at a rate of $50 per month for Self Only or $100 per month for Self and Family for each full month of coverage remaining in that calendar year.
- When you use an in-network hospital, keep in mind that the professionals who provide services to you in the hospital, may not all be preferred providers. If they are not, they will be paid by this Plan as out-of-network providers. However, if surgical services are rendered at an in-network hospital or an in-network freestanding ambulatory facility by an in-network primary surgeon, we will pay the services of anesthesiologists who are not preferred providers at the in-network rate, based on Plan allowance. If the covered services are performed at an in-network hospital or an in-network freestanding ambulatory facility, we will pay the services of radiologists and pathologists who are not preferred providers at the in-network rate, based on the Plan allowance.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY.** Please refer to the *precertification information* shown in Section 3 to confirm which services require precertification.

Benefit Description	You Pay
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment of morbid obesity (bariatric surgery) (requires pre-notification. See *You need prior Plan approval for certain services* in Section 3)	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount

Surgical procedures - continued on next page

Benefit Description	You Pay
Surgical procedures (cont.)	
• Insertion of internal prosthetic devices (see *Orthopedic and prosthetic devices* in Section 5(a) for device coverage information) • Voluntary sterilization for men (e.g., Vasectomy) • Treatment of burns • Assistant surgeons - We cover up to 20% of our allowance for the surgeon's charge	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
• Voluntary sterilization for women (e.g., Tubal ligation) • Surgically implanted contraceptives • Intrauterine devices (IUDs)	In-network: Nothing Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
When multiple or bilateral surgical procedures performed during the same operative session add time or complexity to patient care, our benefits are: • For the primary procedure: - In-network: 85% of the Plan allowance or - Out-of-network: 60% of the Plan allowance • For the secondary procedure(s): - In-network: 85% of one-half of the Plan allowance or - Out-of-network: 60% of one-half of the Plan allowance Note: Multiple or bilateral surgical procedures performed through the same incision are "incidental" to the primary surgery. That is, the procedure would not add time or complexity to patient care. We do not pay extra for incidental procedures.	In-network: 15% of the Plan allowance for the primary procedure and 15% of one-half of the Plan allowance for the secondary procedure(s) Out-of-network: 40% of the Plan allowance for the primary procedure and 40% of one-half of the Plan allowance for the secondary procedure (s); and any difference between our payment and the billed amount
Not covered: • *Cosmetic surgery and other related expenses if not preauthorized* • *Reversal of voluntary sterilization* • *Services of a standby surgeon, except during angioplasty or other high risk procedures when we determine standbys are medically necessary* • *Radial keratotomy and other refractive surgery*	*All charges*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - The condition produced a major effect on the member's appearance and - The condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks (including port wine stains); and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as:	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount

Reconstructive surgery - continued on next page

Benefit Description	You Pay
Reconstructive surgery (cont.)	
- Surgery to produce a symmetrical appearance of breast - Treatment of any physical complications, such as lymphedema - Breast prostheses; and surgical bras and replacements (see Section 5(a), *Prosthetic devices* for coverage) Note: We pay for internal breast prostheses as hospital benefits. Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Cosmetic surgery– any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury if repair is initiated within two years of the accident* • *Surgeries related to sex transformation, sexual dysfunction or sexual inadequacy except if preauthorized for organic impotence*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaw or facial bones • Surgical correction of cleft lip, cleft plate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures • Extraction of impacted (unerupted) teeth • Alveoplasty, partial ostectomy and radical resection of mandible with bone graft unrelated to tooth structure • Excision of bony cysts of the jaw unrelated to tooth structure • Excision of tori, tumors, and premalignant lesions, and biopsy of hard and soft oral tissues • Reduction of dislocations and excision, manipulation, arthrocentesis, aspiration or injection of temporomandibular joints • Removal of foreign body, skin, subcutaneous alveolar tissue, reaction-producing foreign bodies in the musculoskeletal system and salivary stones • Incision/excision of salivary glands and ducts • Repair of traumatic wounds • Sinusotomy, including repair of oroantral and oromaxillary fistula and/or root recovery • Surgical treatment of trigeminal neuralgia	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount

Oral and maxillofacial surgery - continued on next page

Benefit Description	You Pay
Oral and maxillofacial surgery (cont.)	
• Frenectomy or frenotomy, skin graft or vestibuloplasty-stomatoplasty unrelated to periodontal disease • Incision and drainage of cellulitis unrelated to tooth structure Note: We suggest you call UnitedHealthcare at 1-800-718-1299 to determine whether a procedure is covered.	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva and alveolar bone)* • *Dental bridges, replacement of natural teeth, dental/orthodontic/ temporomandibular joint dysfunction appliances and any related expenses* • *Treatment of periodontal disease and gingival tissues, and abscesses* • *Charges related to orthodontic treatment*	*All charges*
Organ/tissue transplants	
These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	In-network Transplant Center of Excellence (COE): 10% of the Plan allowance In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount and any amount over $100,000
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	In-network Transplant Center of Excellence (COE): 10% of the Plan allowance In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount and any amount over $100,000

Organ/tissue transplants - continued on next page

Benefit Description	You Pay
Organ/tissue transplants (cont.)	
Blood or marrow stem cell transplants limited to the following diagnoses. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Aggressive non-Hodgkin's lymphomas - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Amyloidosis - Chronic inflammatory demyelination polyneuropathy (CIDP) - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic Syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia (pediatric only) - X-linked lymphoproliferative syndrome • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast Cancer - Ependymoblastoma - Epithelial ovarian cancer	In-network Transplant Center of Excellence (COE): 10% of the Plan allowance In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount and any amount over $100,000

Organ/tissue transplants - continued on next page

Benefit Description	You Pay
Organ/tissue transplants (cont.)	
- Ewing's sarcoma - Medulloblastoma - Multiple myeloma - Neuroblastoma - Pineoblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	In-network Transplant Center of Excellence (COE): 10% of the Plan allowance In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount and any amount over $100,000
Mini-transplants (non-myeloablative, reduced intensity conditioning or RIC) are subject to medical necessity review by the Plan.	In-network Transplant Center of Excellence (COE): 10% of the Plan allowance In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount and any amount over $100,000
Blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of Health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial.	In-network Transplant Center of Excellence (COE): 10% of the Plan allowance In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount and any amount over $100,000
Transplant Network The Plan uses specific Plan-designated organ/tissue transplant facilities. Before your initial evaluation as a potential candidate for a transplant procedure, you or your doctor **must** contact UnitedHealthcare at 1-800-718-1299 and ask to speak to a Transplant Case Manager. You will be provided with information about transplant preferred providers. If you choose a Plan-designated transplant facility, you may receive prior approval for travel and lodging costs. Limited Benefits – If you don't use a Plan-designated transplant facility, benefits for pretransplant evaluation, organ procurement, inpatient hospital, surgical and medical expenses for covered transplants, whether incurred by the recipient or donor, are limited to a maximum of $100,000 for each listed transplant, including multiple organ transplants.	
Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Transplants not listed as covered* • *Implants of artificial organs*	*All charges*

Benefit Description	You Pay
Anesthesia	
Professional services for administration of anesthesia Note: If surgical services are rendered at an in-network hospital or an in-network freestanding ambulatory facility by an in-network primary surgeon, we will pay the services of out-of-network anesthesiologists at the in-network rate, based on Plan allowance.	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount

Section 5 (c). Services provided by a hospital or other facility, and ambulance services

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In-network Preventive Care is covered at 100% under CDHP Section 5 and does not count against your Personal Care Account.
- Your Personal Care Account must be used first for eligible health care expenses.
- If your Personal Care Account has been exhausted, you must pay your Deductible before your Traditional Health Coverage may begin. Your Deductible applies to all benefits in this section.
- The Consumer Driven Option provides coverage for both in-network and out-of-network providers. The out-of-network benefits are the standard benefits under the Traditional Health Coverage. In-network benefits apply only when you use a provider from the large, national network. When a network provider is not available, out-of-network benefits apply.
- If you join at any time during the year other than Open Season, your Deductible for your first year will be prorated at a rate of $50 per month for Self Only or $100 per month for Self and Family for each full month of coverage remaining in that calendar year.
- When you use an in-network hospital, keep in mind that the professionals who provide services to you in the hospital, may not all be preferred providers. If they are not, they will be paid by this Plan as out-of-network providers. However, if surgical services are rendered at an in-network hospital or an in-network freestanding ambulatory facility by an in-network primary surgeon, we will pay the services of anesthesiologists who are not preferred providers at the in-network rate, based on Plan allowance. If the covered services are performed at an in-network hospital or an in-network freestanding ambulatory facility, we will pay the services of radiologists and pathologists who are not preferred providers at the in-network rate, based on the Plan allowance.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY.** Please refer to the *precertification information* shown in Section 3 to confirm which services require precertification.

Benefit Description	You Pay
Inpatient hospital	
Room and board, such as: • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: We only cover a private room when you must be isolated to prevent contagion. Otherwise, we will pay the hospital's average charge for semiprivate accommodations. If the hospital only has private rooms, we will consider a semiprivate equivalent allowance of up to 90% of the private room charge. Note: When the out-of-network hospital bills a flat rate, we prorate the charges to determine how to pay them, as follows: 30% room and board and 70% other charges.	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount Note: For inpatient hospital care related to maternity, we pay for covered services in full when you use preferred providers (See Section 5(a), *Maternity care*).

Inpatient hospital - continued on next page

Benefit Description	You Pay
Inpatient hospital (cont.)	
Other hospital services and supplies, such as: • Operating, recovery and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services Note: We base payment on whether the facility or a health care professional bills for the services or supplies. For example, when the hospital bills for its nurse anesthetists' services, we pay *Hospital* benefits and when the anesthesiologist bills, we pay *Surgery* benefits.	In-network: 15% of Plan allowance Out-of-network: 40% of the Plan allowance and any difference our allowance and billed amount
Not covered: • *Any part of a hospital admission that is not medically necessary (see Definitions,* Section 10*), such as when you do not need acute hospital inpatient (overnight) care, but could receive care in some other setting without adversely affecting your condition or the quality of your medical care. Note: In this event, we pay benefits for services and supplies other than room and board and in-hospital physician care at the level they would have been covered if provided in an alternative setting* • *Custodial care; see Definitions,* Section 10 • *Non-covered facilities, such as nursing homes, skilled nursing facilities, residential treatment facilities, day and evening care centers, and schools* • *Personal comfort items such as radio, television, air conditioners, beauty and barber services, guest meals and beds* • *Services of a private duty nurse that would normally be provided by hospital nursing staff*	*All charges*
Cancer Centers of Excellence	
The Plan provides access to designated Cancer Centers of Excellence. To locate a Cancer Center of Excellence, contact UnitedHealthcare at 1-800-718-1299 and enroll in the program prior to obtaining covered services. The Plan will only pay the higher level of benefits if UnitedHealthcare provides the proper notification to the designated facility/provider performing the services. To receive the higher level of benefits for a cancer-related treatment, you are required to visit a designated facility. Cancer treatment includes the following: • Physician's office services; • Professional fees for surgical and medical services; • Hospital - inpatient stay; and • Outpatient surgery, diagnostic and therapeutic services.	In-network Cancer Centers of Excellence (COE): 10% of the Plan allowance In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and billed amount

Cancer Centers of Excellence - continued on next page

Benefit Description	You Pay
Cancer Centers of Excellence (cont.)	
If you decide to use a designated Center of Excellence, you may receive prior approval for travel and lodging costs.	In-network Cancer Centers of Excellence (COE): 10% of the Plan allowance In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and billed amount
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by an underlying medical condition. We do not cover the dental procedures. Note: We cover outpatient services and supplies of a hospital or free-standing ambulatory facility the day of a surgical procedure (including change of cast), hemophilia treatment, hyperalimentation, rabies shots, cast or suture removal, oral surgery, foot treatment, chemotherapy for treatment of cancer, and radiation therapy.	In-network: 15% of Plan allowance Out-of-network: 40% of the Plan allowance and any difference our allowance and billed amount Note: For inpatient hospital care related to maternity, we pay for covered services in full when you use preferred providers (See Section 5(a), *Maternity care*).
Extended care benefits/Skilled nursing care facility benefits	
No benefit	All charges
Hospice care	
Hospice is a coordinated program of home and inpatient supportive care for the terminally ill patient and the patient's family provided by a medically supervised specialized team under the direction of a duly licensed or certified Hospice Care Program. • We pay $3,000 annually for outpatient services and $2,000 annually for inpatient services • We pay a $200 annual bereavement benefit per family unit	Any amount over the annual maximums shown

Benefit Description	You Pay
Ambulance	
Local professional ambulance service when medically appropriate immediately before or after an inpatient admission	In-network: 15% of Plan allowance Out-of-network: 40% of the Plan allowance and any difference our allowance and billed amount
Not covered: • *Ambulance service used for routine transport*	*All charges*

Section 5 (d). Emergency services/accidents

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In-network Preventive Care is covered at 100% under CDHP Section 5 and does not count against your Personal Care Account.
- Your Personal Care Account must be used first for eligible health care expenses.
- If your Personal Care Account has been exhausted, you must pay your Deductible before your Traditional Health Coverage may begin. Your Deductible applies to all benefits in this section.
- The Consumer Driven Option provides coverage for both in-network and out-of-network providers. The out-of-network benefits are the standard benefits under the Traditional Health Coverage. In-network benefits apply only when you use a provider from the large, national network. When a network provider is not available, out-of-network benefits apply.
- If you join at any time during the year other than Open Season, your Deductible for your first year will be prorated at a rate of $50 per month for Self Only or $100 per month for Self and Family for each full month of coverage remaining in that calendar year.
- When you use an in-network hospital, keep in mind that the professionals who provide services to you in the hospital, may not all be preferred providers. If they are not, they will be paid by this Plan as out-of-network providers. However, if surgical services are rendered at an in-network hospital or an in-network freestanding ambulatory facility by an in-network primary surgeon, we will pay the services of anesthesiologists who are not preferred providers at the in-network rate, based on Plan allowance. If the covered services are performed at an in-network hospital or an in-network freestanding ambulatory facility, we will pay the services of radiologists and pathologists who are not preferred providers at the in-network rate, based on the Plan allowance.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY.** Please refer to the *precertification information* shown in Section 3 to confirm which services require precertification.

What is an accidental injury?

An accidental injury is a bodily injury sustained solely through violent, external, and accidental means, such as broken bones, animal bites, and poisonings.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

Note: If you use an emergency room for other than a recognized medical emergency, facility fees and supplies will not be covered.

Note: When you use a PPO hospital for emergency services, the emergency room physician who provides the services to you in the emergency room may not be a preferred provider. If they are not, they will be paid by this Plan as a PPO-provider at the PPO rate, based on the Plan allowance.

Benefit Description	You Pay
Accidental injury	
If you receive care for your accidental injury within 24 hours, we cover: • Physician services and supplies • Related outpatient hospital services Note: We pay hospital benefits if you are admitted. If you receive care for your accidental injury after 24 hours, we cover: • Physician services and supplies Note: We pay hospital benefits if you are admitted.	In-network: 15% of the Plan allowance Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount
Medical emergency	
• Outpatient facility charges in an Urgent Care Center • Outpatient medical or surgical services and supplies, other than an Urgent Care Center	In-network: 15% of the Plan allowance Out-of-network: 15% of the Plan allowance Note: For out-of-network benefits, members may be billed the difference between the Plan allowance and the billed amount.
Ambulance	
• Professional ambulance service within 24 hours of an accidental injury or medical emergency • Air ambulance if medically necessary for transport to the closest appropriate facility for treatment within 24 hours of an accidental injury Note: See *Hospital* benefits, Section 5(c) for non-emergency service.	In-network: 15% of the Plan allowance Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount

Section 5 (e). Mental health and substance abuse benefits

You may choose to get care in-network or out-of-network. You need to get Plan approval (preauthorization) for services and follow a treatment plan we approve in order to get benefits. When you receive services as part of an approved treatment plan, cost-sharing and limitations for Plan mental health and substance abuse benefits are no greater than for similar benefits for other illnesses and conditions.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES**. Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process shown in Section 3 and get Plan approval of your treatment plan.
  - Inpatient care - You must get preauthorization for hospital stays; failure to do so will result in a minimum $500 penalty. To obtain preauthorization of an admission for mental conditions or substance abuse, call ValueOptions at 1-888-700-7965.
  - Outpatient care - You must get preauthorization of outpatient care for mental conditions or substance abuse. Preauthorization must be obtained by calling ValueOptions at 1-888-700-7965.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.
- We do not make available provider directories for mental health or substance abuse providers. ValueOptions will provide you with a choice of network providers when you call to preauthorize your care.

Benefits Description	You Pay
Professional services	
We cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits)	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount.

Professional services - continued on next page

Benefits Description	You Pay
Professional services (cont.)	
• Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Electroconvulsive therapy • Professional charges for intensive outpatient treatment in a provider's office or other professional setting	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount.
Diagnostics	
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount.
Inpatient hospital or other covered facility	
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount.
Outpatient hospital or other covered facility	
Outpatient services provided and billed by a hospital or other covered facility • Services such as partial hospitalization, half-way house, residential treatment full-day hospitalization, or facility-based intensive outpatient treatment	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Services that are not part of a preauthorized approved treatment plan* • *Services that are not medically necessary*	*All charges*

See these sections of the brochure for more valuable information about these benefits:

- Section 4, *Your costs for covered services*, for information about catastrophic protection for these benefits.
- Section 7, *Filing a claim for covered services*, for information about submitting out-of-network claims.

Section 5 (f). Prescription drug benefits

Important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart below.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In-network Preventive Care is covered at 100% under CDHP Section 5 and does not count against your Personal Care Account.
- Your Personal Care Account must be used first for eligible health care expenses.
- If your Personal Care Account has been exhausted, you must pay your Deductible before your Traditional Health Coverage may begin. Your Deductible applies to all benefits in this section.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- Prior authorization is required for certain drugs and must be renewed periodically. Prior authorization uses Plan rules based on FDA-approved prescribing and safety information, clinical guidelines and uses that are considered reasonable, safe and effective. See the coverage authorization information shown in Section 3, *Other services* and page 105 for more information about this program.

Benefits Description	You Pay
Covered medications and supplies	
Each new enrollee will receive a combined prescription drug/Plan identification card. You may purchase the following medications and supplies prescribed by a physician from either a network pharmacy or by mail: • Drugs and medicines, including those for tobacco cessation, for use at home that are obtainable only upon a doctor's prescription • Drugs and medicines (including those administered during a non-covered admission or in a non-covered facility) that by Federal law of the United States require a physician's prescription for their purchase, except those listed as not covered • Insulin and test strips for known diabetics • Needles and syringes for the administration of covered medications • Prior authorization is required for certain drugs and must be renewed periodically. Prior authorization uses Plan rules based on FDA-approved prescribing and safety information, clinical guidelines and uses that are considered reasonable, safe and effective. For example, approved drugs for organic impotence are subject to prior Plan approval and limitations on dosage and quantity. See Section 3, *Other services* and page 104 for more information about this program.	• Network Retail: 25% of charge with a minimum of $15 and a maximum per prescription of $200 for a 30-day supply, $400 for a 60-day supply, $600 for a 90-day supply • Network Retail Medicare: 25% of charge with a minimum of $15 and a maximum per prescription of $200 for a 30-day supply, $400 for a 60-day supply, $600 for a 90-day supply • Network Mail Order: 25% of charge with a minimum of $10 and a maximum per prescription of $200 for a 30-day supply, $400 for a 60-day supply, $600 for a 90-day supply • Network Mail Order Medicare: 25% of charge with a minimum of $10 and a maximum per prescription of $200 for a 30-day supply, $400 for a 60-day supply, $600 for a 90-day supply
• In-network prescription drugs approved by the FDA for contraception for women Note: If your physician receives prior authorization because it is medically necessary that a brand name contraceptive drug be dispensed, you will pay $0. Your physician may seek prior authorization by calling 1-800-718-1299.	Network Retail: $0 generic. Brand name 25% of charge with a minimum of $15 and a maximum per prescription of $200 for a 30-day supply, $400 for a 60-day supply, $600 for a 90-day supply

Covered medications and supplies - continued on next page

Benefits Description	You Pay
Covered medications and supplies (cont.)	
	Network Mail Order: $0 generic. Brand name 25% of charge with a minimum of $10 and a maximum per prescription of $200 for a 30-day supply, $400 for a 60-day supply, $600 for a 90-day supply
In-network generic prescription drugs approved by the FDA for contraception for women In-network devices approved by the FDA for contraception for women	Nothing
Drugs, vitamins and minerals, and nutritional supplements that by Federal law of the United States require a prescription for their purchase Medicines to promote better health as recommended under the Patient Protection and Affordable Care Act (the "Affordable Care Act"), including: • Aspirin for men age 45 through 79 and women age 55 through 79 • Vitamin Supplements are not covered except as stated below: - ACA required coverage for Vitamin D for adults 65 and older - Folic acid supplements, 0.4 to 0.8 mg, for women who may become pregnant - Iron supplements, for children from age 6 months through 12 months	Network Retail: Nothing Network Retail Medicare: Nothing
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins, minerals, nutritional supplements, and enteral formulas (liquid food supplements)* • *Medical supplies such as dressings and antiseptics* • *Nonprescription medicines/over-the-counter drugs, except as stated below:* - *Over-the counter emergency contraceptive drugs, the "morning after pill", are covered at no cost if prescribed by a physician and purchased at a network pharmacy* - *Over-the counter FDA-approved female birth control methods are covered at no cost if prescribed by a physician and purchased at a network pharmacy* • *Non-network retail drugs (unless for a sudden illness while traveling outside the United States or Puerto Rico)* Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation Program (See Educational classes and programs page 87). Note: Prescription drugs approved by the FDA for contraception for women are also noted under *Well woman* (See *In-network preventive care*, Section 5 and for devices for birth control under *Family planning* (see Section 5(a)).	

Personalized Medicine (voluntary program)

The Personalized Medicine Program combines a Pharmacogenomic test (genetic lab test) with a clinical program to optimize prescription drug therapies for patients taking Warfarin (anticoagulant) and Plavix (antiplatelet). This program focuses on giving physicians information, on an individual level, on patients who have already been diagnosed with a disease or condition.

The benefits of this testing, done with a simple cheek swab are:

- Greater patient safety and efficacy through more precise dosing for Warfarin and Plavix
- Elimination of adverse events since the patient will be taking the appropriate dose of Warfarin or Plavix from the early onset of therapy

Pharmacogenomic testing gives physicians personalized information they can use to make more precise prescribing and dosing decisions to help their patients receive the critical care they need. The Personalized Medicine Program is available to you at no additional cost. If your medication history indicates that the testing could be beneficial for you, a pharmacist will contact your physician to discuss the program. If your doctor agrees that the test results would be helpful, you will be contacted by a pharmacist to let you know that the testing is available. If you agree to participate, you will receive a cheek swab test that you can administer on your own.

The results of your test will be sent to your doctor and to an Optum Rx pharmacist who has received special training in personalized medicine. The pharmacist is available to help your doctor interpret the results of your test. Your participation is voluntary, and your doctor is still solely responsible for deciding which drug and dose is right for you.

Benefit Description	You Pay
Personalized medicine (voluntary program)	
• Pharmacogenomic testing to optimize prescription drug therapies for certain conditions • Warfarin (anticoagulant) • Plavix (antiplatelet)	Nothing

Coverage Authorization

- The information below describes a feature of your prescription drug plan known as coverage authorization. Coverage authorization determines how your prescription drug plan will cover certain medications.
- Some medications are not covered unless you receive approval through a coverage review (prior authorization). Examples of drug categories that require a coverage review include but are not limited to, Growth Hormones, Botox, Interferons, Rheumatoid Arthritis agents, Retin A and drugs for organic impotence. This review uses plan rules based on FDA-approved prescribing and safety information, clinical guidelines and uses that are considered reasonable, safe and effective. There are other medications that may be covered with limits (for example, only for a certain amount or for certain uses) unless you receive approval through a review. During this review, Optum Rx asks your doctor for more information than what is on the prescription before the medication may be covered under your plan. If coverage is approved, you simply pay your normal copayment for the medication. If coverage is not approved, you will be responsible for the full cost of the medication.
- The Plan will participate in other approved managed care programs to ensure patient safety and appropriate therapy in accordance with the Plan rules based on FDA-guidelines referenced above.
- To find out more about your prescription drug plan, please visit www.myuhc.com or call Member Services at 1-800-718-1299.
- **"Specialty Drugs"** means those covered drugs that typically cost $500 or more per dose or $6,000 or more per year and have one or more of the following characteristics: (1) complex therapy for complex disease (2) specialized patient training and coordination of care (services, supplies, or devices) required prior to therapy initiation and/or during therapy; (3) unique patient compliance and safety monitoring requirements; (4) unique requirements for handling, shipping and storage; and (5) potential for significant waste due to the high cost of the drug.

Exceptions to the price threshold may exist based on certain characteristics of the drug or therapy which will still require the drug to be classified as a Specialty Drug. Some examples of the disease categories currently in Optum Rx's specialty pharmacy programs include cancer, cystic fibrosis, Gaucher disease, growth hormone deficiency hemophilia, immune deficiency, hepatitis C, infertility, multiple sclerosis, rheumatoid arthritis and RSV prophylaxis.

In addition, a follow-on-biologic or generic product will be considered a Specialty Drug if the innovator drug is a Specialty Drug.

Many of the Specialty Drugs covered by the Plan fall under the Coverage Authorization program mentioned above.

Note: If you do not use your identification card at a network pharmacy, or if you use a non-network pharmacy, the Plan provides no benefit and you must pay the full cost of your purchases. Non-network retail drugs will be covered under the in-network benefit only if necessary and prescribed for sudden illness while traveling outside of the United States (including Puerto Rico).

Section 5 (g). Dental benefits

Benefits Description	You Pay
Dental	
No benefit	See Personal Care Account, page 75

Section 5 (h). Special features

Special features	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).

Section 5 (i). Health education resources and account management tools

Special features	Description
Online tools and resources	Your Personal, private Web site accessible by Internet at www.myuhc.com • Your Personal Care Account balance and activity (also mailed quarterly) • Your complete claims payment history • A consumer health encyclopedia and interactive services • Online health risk assessment to help determine your risk for certain conditions and steps to manage them • Personal Health Record
Consumer choice information	Each member is provided access by Internet (www.myuhc.com) or telephone (1-800-718-1299) to information which you may use to support your important health and wellness decisions, including: • Online provider directory with complete national network and provider information (i.e., address, telephone, specialty, practice hours, languages spoken) • Network provider discounted pricing for comparative shopping • Pricing information for prescription drugs • General cost information for surgical and diagnostic procedures and for comparison of different treatment options • Provider quality information • Health calculators on medical and wellness topics
Care support	A 24-hour nurse advisory service for your use. This program is strictly voluntary and confidential. You may call toll-free at 1-800-718-1299 to discuss an existing medical concern or to receive information about numerous health care and self-care issues. This also includes health coaching with a registered nurse when you want to discuss significant medical decisions. TTY/TDD callers, please call the National Relay Center at 1-800-855-2880 and ask for 1-800-718-1299. Identification and notification of potential patient safety issues (e.g., drug interactions). Individual support with a health care professional for numerous medical conditions including maternity, asthma, diabetes, congestive heart failure, healthy back and more. Cancer Centers of Excellence (See Section 5(c), page 96).
Diabetes Management Program	If you are an APWU Health Plan primary member enrolled in the Consumer Driven Option's Diabetes Disease Management Program and participate as required by the program, you may be eligible for the following incentives payable at 100% for in-network services only: • $0 copay for in-network medical office visits for diabetes management (this does not include visits to a Podiatrist or Ophthalmologist) • $0 copay for in-network lab tests related to diabetes management • $0 copay for Generic drugs from Optum Rx by Mail for the specific purpose of lowering your blood sugar • $0 copay for Insulin from Optum Rx by Mail • $0 copay for blood glucose test strips, lancets, syringes, pen needles and Insulin Pump supplies from Optum Rx by Mail • $0 coinsurance for an Insulin Pump (Preauthorization is required) and Insulin Pump supplies purchased in-network

	If you are an APWU Health Plan member who has other primary insurance (i.e. Medicare primary), you do not have to enroll in the Diabetes Disease Management Program, you may be eligible for the following incentives payable at 100%: • $0 copay for Generic drugs from Optum Rx by Mail for the specific purpose of lowering your blood sugar • $0 copay for Insulin from Optum Rx by Mail • $0 copay for blood glucose test strips, lancets, syringes, pen needles and Insulin Pump supplies from Optum Rx by Mail • $0 coinsurance for in-network lab tests related to diabetes management • $0 coinsurance for an Insulin Pump (Preauthorization is required) and Insulin Pump supplies purchased in-network Note: Enrollment in this program must be initiated by member after effective date of Health Plan enrollment. For more information contact UnitedHealthcare at 1-800-718-1299. Note: If you have other primary pharmacy insurance, you must use your primary insurance first and then send the payment information from the primary insurance to UHC for coordination of benefits. Note: You must remain in compliance with the program requirements in order to be eligible for the $0 copay incentives. In order to remain compliant with the program, enrollees must complete a call with their health coach at least every 90 days. During these calls, you will discuss such topics as understanding of your disease process, knowledge of your recent lab results, doctor visits and self-care goals.
Special Programs	Online programs and services provide extra support and savings, at www.welcometouhc.com/apwu • **Healthy Pregnancy Program** - Mothers-to-be receive support through every stage of pregnancy and delivery. • **Healthy Back Program** - Help for preventing or dealing with back pain before it becomes a recurring or long-term issue. • **Cancer Support Program** - Enroll in the program, and receive enhanced benefits at Cancer Centers of Excellence. • **Source4Women** - Resource designed for women to learn how to keep the entire family healthy.

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file a FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow the Plan's guidelines. For additional information contact the Plan at 1-800-222-APWU (2798) or visit their Web site at www.apwuhp.com.

Conversion Plan Health Insurance

When coverage as an employee or family member ends with any Plan in the Federal Employees Health Benefits Program (FEHB), or when Temporary Continuation of Coverage (TCC) ends (except by cancellation or non-payment of premium), you may be eligible to convert to the APWU Health Plan Conversion Plan.

There is no waiting period, no limitation of coverage for preexisting conditions, and no evidence of good health is necessary.

For additional information, please contact us by calling 1-800-222-APWU (2798) or by going to www.apwuhp.com/upload/Conversion_Plan.

American Hearing Benefits 1-866-925-1287
www.americanhearingbenefits.com

The American Hearing Benefits program is an optional program with no additional premium that supplements the benefits in your APWU Health Plan coverage. All participants of the APWU Health Plan, either High Option or Consumer Driven Option, who enroll in the American Hearing Benefits Plan through this offer will receive a discount on hearing aid devices offered through Starkey. To enroll in the plan you must call American Hearing Benefits toll free at 1-866-925-1287. Please specify that you are an APWU Health Plan participant.

Availability: The American Hearing Benefits Plan is available to all Active, Retired, Associate and Transitional Employees, APWU Members in all States and Territories of the United States.

Coverage Description: With this optional plan you must contact American Hearing Benefits (AHB) to activate the benefit. AHB will locate a local provider in your area and schedule your first member visit. After the first visit with a provider, members may schedule additional appointments with the same provider at will. Discounts are applied at the time services are rendered.

This program is available to Group members and their immediate families without any charge. This program involves the extension of a negotiated discount on certain products and services available from certain hearing aid providers and does not involve the provision of insurance. The program discounts are subject to change. It is your responsibility to determine whether the products and services you elect to purchase are covered by the program by calling AHB toll free at 1-866-925-1287.

Coverage Schedule:

- Free hearing screenings annually for members and their immediate family
- Referrals to local providers
- Discounts up to 40%-60% off suggested MSRP prices on Starkey digital hearing instruments
- A full two-year extended warranty included with every purchase of Starkey hearing aid at no additional cost

Benefits on this page are not part of the FEHB contract

The Supplemental Discount Drug Program 1-800-818-6717
express-scripts.com

The Supplemental Discount Drug Program is a value-added program that provides members with access to discounts on prescription drugs not covered by the prescription drug plan when ordered through Express Scripts Mail Service Pharmacies. Specifically, the Supplemental Discount Drug Program will provide discounts to members on all FDA-approved prescription drugs that are dispensed through Express Scripts Mail Order pharmacies, yet are not covered under the prescription drug plan administered by Express Scripts.

Availability: The Supplemental Discount Drug Program is available to all High Option Plan members only.

Coverage Description: You pay 100% of the discounted price. You cannot file a claim for off-Plan prescriptions.

- Call Express Scripts first at 1-800-818-6717 to find out the price of off-Plan prescriptions.
- Obtain the prescription from your physician.
- Complete an Express Scripts Mail Order envelope and enclose your prescription along with your check or credit card number. You must include full payment with your order for prescriptions.

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file a FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums.

Alliant Insurance Services - The Voluntary Benefits Plan

The Voluntary Benefits Plan Dental program is an optional program with an additional premium that supplements the dental benefits in your APWU Health Plan coverage. All participants of the APWU Health Plan, either High Option or Consumer Driven Option, who enroll in the Voluntary Benefits Plan Dental Plan through this offer will receive a discount in the regular premiums for that program. To enroll in this additional coverage, complete and sign the Voluntary Benefits Plan Dental Plan enrollment form, which you can obtain from your APWU Health Plan representative or by calling the Voluntary Benefits Plan office at the toll-free number listed below. Please specify that you are an APWU Health Plan participant.

Availability: The Voluntary Benefits Plan Dental Plan is available to all Active, Retired, Associate, Transitional Employees and APWU Members.

Coverage Description: This optional dental plan is an indemnity insurance plan underwritten by the United States Life Insurance Company. You may use any dentist you choose. Covered services are reimbursed as a percentage of the "Reasonable and Customary" charges for that service in the state where the charge is incurred. Once you have satisfied the continuous coverage limitations of the program, there are no further waiting periods as long as you remain continuously insured under the plan. Both you and your eligible dependents (spouse and unmarried children to age 19 - full-time students to age 25) can be insured under this plan.

Coverage Schedule:

- Calendar Year Deductible:
  - $100 per person - Type II and Type III benefits, combined
- Calendar Year Maximum:
  - $1,500 per person for all covered services
  - $500 per person for all eligible Orthodontic services, if Optional Orthodontic Coverage is selected
- Lifetime Maximum:
  - $1,000 for Orthodontic services, if Optional Orthodontic Coverage is selected

Benefits on this page are not part of the FEHB contract

	After the Annual Deductible, this plan will pay:	
Benefit Schedule		
Type I Benefits: Preventive Services Exams / X-rays / Cleanings	100% of the Reasonable and Customary charges	100% of the Reasonable and Customary charges
Type II Benefits: Basic Services Fillings / Oral Surgery / Extractions	80% of the Reasonable and Customary charges (no waiting period)	50% of the Reasonable and Customary charges (no waiting period)
Type III Benefits: Major Services Crowns / Bridges / Dentures / Periodontics	50% of the Reasonable and Customary charges (12 month waiting period)	50% of the Reasonable and Customary charges (18 month waiting period)
Type IV Benefits: (Optional Coverage) Orthodontic	50% of the Reasonable and Customary charges (24 month waiting period)	50% of the Reasonable and Customary charges (24 month waiting period)

This is a partial summary of the terms, conditions and limitations of the Dental Plan policy #G-224,540. For more information regarding the coverage, rates or to receive an enrollment form, please contact the Voluntary Benefits Plan office by calling or writing:

The Voluntary Benefits Plan

P.O. Box 12009

Cheshire, CT 06410

1-800-422-4492

www.voluntarybenefitsplan.com

Benefits on this page are not part of the FEHB contract

Section 6. General exclusions - services, drugs and supplies we do not cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, (see Section 3, Y*ou need prior Plan approval for certain services*).

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies that are not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies related to sex transformations, sexual dysfunction or sexual inadequacy except for organic impotence as shown on pages 19, 46, 60, 61, 90, 103, 105
- Services, drugs, or supplies for weight reduction/control or treatment of obesity except as shown under *Surgical* benefits, Section 5 and Weight Management Program as shown under *Special features*, Section 5.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs and supplies for which no charge would be made if the covered individual had no health insurance coverage.
- Computer “story boards,” “light talkers,” or other communication aids for communication-impaired individuals.
- Services, drugs, or supplies you receive without charge while in active military service.
- Services, drugs and supplies furnished by immediate relatives or household members, such as spouse, parent, child, brother, or sister by blood, marriage, or adoption.
- Services and supplies furnished or billed by a non-covered facility, except medically necessary prescription drugs and physical, speech and occupational therapy rendered by a qualified professional therapist on an outpatient basis are covered subject to Plan limits.
- Services, supplies and drugs not specifically listed as covered.
- Services, supplies and drugs furnished or billed by someone other than a covered provider as defined on page 16.
- Any portion of a provider’s fee or charge ordinarily due from the enrollee but that has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible, copay or coinsurance, we will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived.
- Charges which you or we have no legal obligation to pay, such as excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see pages 124-129), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge) (see page 128), or State premium taxes however applied.
- Biofeedback; non-medical self care or self help training, such as recreational, educational, or milieu therapy unless specifically listed; or
- Charges that we determine to be in excess of the Plan allowance.
- "Never Events" are errors in patient care that can and should be prevented. The APWU Health Plan will follow the policy of the Centers for Medicare and Medicaid Services (CMS). The Plan will deny payments for care that fall under these policies. For additional information, please visit www.cms.gov, and enter "Never Events" into SEARCH box.

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received).

See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures.

How to claim benefits

High Option: To obtain claim forms, claims filing advice or answers about our benefits, contact us at 1-800-222-APWU (2798), or at our Web site at www.apwuhp.com.

Mail to:

- Cigna Healthcare, P.O. Box 188004, Chattanooga, TN 37422, or Payor ID 62308

VI Equicare claims to:

- APWU Health Plan, P.O. Box 1358, Glen Burnie, MD 21060-1358, or Payor ID 44444

Consumer Driven Option: Contact UnitedHealthcare at 1-800-718-1299 or visit their Web site at www.myuhc.com

Mail to:

- UnitedHealthcare, P.O. Box 740810, Atlanta, GA 30374-0810

In most cases, providers and facilities file claims for you. Your physician must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, call us at 1-800-222-APWU (2798).

When you must file a claim - such as when you use non-PPO providers, for services you received overseas or when another group health plan is primary - submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Patient's name, date of birth, address, phone number and relationship to enrollee
- Patient's Plan identification number
- Name and address of person or company providing the service or supply
- Dates that services or supplies were furnished
- Diagnosis
- Type of each service or supply
- Charge for each service or supply

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

In addition:

- If another health plan is your primary payor, you must send a copy of the explanation of benefits (EOB) form you received from your primary payor (such as the Medicare Summary Notice (MSN)) with your claim.
- Bills for home nursing care must show that the nurse is a registered or licensed practical nurse.
- If your claim is for the rental or purchase of durable medical equipment; private duty nursing; physical therapy, occupational therapy, or speech therapy, you must provide a written statement from the physician specifying the medical necessity for the service or supply and the length of time needed.

- Claims for prescription drugs and supplies must include receipts that show the prescription number, name of drug or supply, prescribing physician's name, date, and charge.
- We will provide translation and currency conversion services for claims for overseas (foreign) services.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Records

Keep a separate record of the medical expenses of each covered family member as deductibles and maximum allowances apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible. In most instances they will serve as evidence of your claim. We will not provide duplicate or year-end statements.

Deadline for filing your claim

Send us all the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service. If you could not file on time because of Government administrative operations or legal incapacity, you must submit your claim as soon as reasonably possible. Once we pay benefits, there is a three-year limitation on the re-issuance of uncashed checks.

Overseas claims

For covered services you receive in hospitals outside the United States and Puerto Rico and performed by physicians outside the United States, send a completed Claim Form and the itemized bills to the following address. Also, send any written inquiries concerning the processing of overseas claims to:

- **High Option:** APWU Health Plan, P.O. Box 1358, Glen Burnie, MD 21060-1358.
- **Consumer Driven Option:** UnitedHealthcare at the claims address shown on the back of your UnitedHealthcare ID card.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

The Secretary of Health and Human Services has identified counties where at least 10 percent of the population is literate only in certain non-English languages. The non-English languages meeting this threshold in certain counties are Spanish, Chinese, Navajo and Tagalog. If you live in one of these counties, we will provide language assistance in the applicable non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes and its corresponding meaning, and the treatment code and its corresponding meaning).

Section 8. The disputed claims process

You may be able to appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit www.apwuhp.com.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision,* we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing APWU Health Plan, Public Relations Department, P.O. Box 1358, Glen Burnie, MD 21060-1358 or calling 1-800-222-APWU (2798).

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/ investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration decision will not afford deference to the initial decision and will be conducted by a Plan representative who is neither the individual who made the initial decision that is the subject of the reconsideration, nor the subordinate of that individual.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjustor or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Disagreements between you and the CDHP fiduciary regarding the administration of a PCA are not subject to the disputed claims process.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your High Option request to us at: APWU Health Plan, P.O. Box 1358, Glen Burnie, MD 21060-1358 or send your Consumer Driven Option request to: UnitedHealthcare Appeals, P.O. Box 30573, Salt Lake City, UT 84130-0573; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) statements. (e) Include your email address (optional), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

Step	Description
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial or c) Ask you or your provider for more information. You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our intial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 2, 1900 E Street, NW, Washington, DC 20415-3620. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. • Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly. Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim. Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent. Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.
4	OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals. If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then, call us at 1-800-222-APWU (2798). We will hasten our review (if we have not yet responded to your claim): or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Healthcare and Insurance office at 1-202-606-3818 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this Plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit the NAIC Web site at http://www.NAIC.org.

When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. When we are the secondary payor, we will not waive specified visit limits.

Please see Section 4, *Your costs for covered services,* for more information about how we pay claims.

- **TRICARE and CHAMPVA**

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

- **Workers' Compensation**

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

- **Medicaid**

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.

When others are responsible for injuries

If we pay benefits for an injury or illness that you receive monetary compensation for from someone else (referred to as a "third party"), you are required to reimburse the Plan for the total amount of benefits it paid out of the compensation you receive. This is sometimes called "subrogation" and the dollar amount of the benefits paid for by the Plan is oftentimes referred to as its "lien." Reimbursement to the Plan is a requirement and condition on your obtaining benefits under the FEHB Program and from the Plan under this brochure. The Plan credits the net funds it recovers through reimbursement and subrogation to the Employee Health Benefits Fund which ultimately helps lower subscription charges for all enrollees in the FEHB Program. This section explains your basic obligations and procedures about this reimbursement requirement.

By enrolling in the Plan and in accordance with the FEHB Program and this brochure, you agree to the following:

- You will reimburse the Plan in any and all situations where you recover money from any source related to an injury or illness for which the Plan has paid benefits. This may include money recovered from a lawsuit, a settlement, administrative claims (such as worker's compensation), a third party's insurance, or your own automobile or homeowner's insurance.
- You will reimburse the Plan up to the total amount of benefits for the care related to the injury or illness that the Plan has paid or reasonably anticipates paying. This reimbursement responsibility covers benefits for you and any other person on your membership. Similarly, you are obligated to reimburse the Plan from any money that is recovered, whether that money is recovered by you directly or by your legal representatives, dependents, heirs, estate, administrators, successors or assignees.
- You will reimburse the Plan on a first priority basis out of any recovery you obtain no matter the source (litigation, settlement, insurance claim or settlement) and no matter how the recovery is characterized (such as your claim against the third party being for "pain and suffering").
- You will not do anything that would prevent us from being fully reimbursed for the benefits we paid, and you will cooperate in assisting us in recovering the cost of the benefits we paid.
- You agree and authorize the Plan to communicate directly with any of your insurance carriers regarding your injury or illness and their reimbursements.

You are obligated to reimburse the Plan even if the amount you receive does not compensate you fully or if you have other liens or expenses. We are entitled to be reimbursed for our benefit payments even if you are not legally "made whole" for all of your damages arising out of the injury or illness. Our right of recovery is also not subject to reductions for attorney's fees or costs in recovering the money under the "common fund" or other legal doctrines. If you wish to discuss the amount of reimbursement to pay to the Plan, please contact Customer Service (High Option, 1-800-222-2798; Consumer Driven Option, 1-800-718-1299) or our subrogation representatives at the contact information at the end of this section.

What to communicate to the Plan

- Promptly inform us if you have an injury or illness for which benefits paid by the Plan might be reimbursed or subrogated as described here. This includes reporting third party cases to Customer Service or responding to any questionnaires or surveys inquiring about benefit claims paid by the Plan. We or our subrogation representatives will communicate with you about whether you owe the Plan any reimbursement. Failure to provide information related to reimbursements may delay the processing of your benefits.

- If you make a claim or demand on a third party for compensation for an injury or illness for which the Plan has paid benefits, notify us immediately. We will communicate with you to keep the status of your claim or demand updated in our systems so that there is no delay in processing your claims. We may seek a first priority lien on the proceeds of your claim in order to ensure that the Plan is reimbursed for the benefits we paid or will pay. We may also require you to assign to us (1) your claim or demand or (2) your right to the proceeds of your claim or demand. In all cases, we may enforce our right of recovery and reimbursement by offsetting any undisputed amount you owe the Plan as a result of recovering money from a third party against future benefit payments on your behalf by the Plan.

If you do not pursue a claim or demand against a third party, we reserve the right to ask you to allow the Plan to sue the third party in your name. The Plan's right to reimbursement applies even if the Plan paid benefits before we knew of the accident or illness. Restrictive endorsements or other statements on checks accepted by the Plan or its agents to reimburse the Plan in a subrogation matter will not bind the Plan.

If you need more information or wish to report or discuss a subrogation or reimbursement matter, please contact Customer Service or our subrogation representatives:

High Option:

ODSA

P.O. Box 34188

Washington, DC 20043-4188

subroinfo@odsalaw.com

1-877-535-1075 or 1-202-898-1075

Consumer Driven Option:

UnitedHealthcare

1-800-718-1299

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP)

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan:

Coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally-funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care

- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials, this Plan does not cover these costs

When you have Medicare

- **What is Medicare?**

Medicare is a health insurance program for:

- People 65 years of age or older
- Some people with disabilities under 65 years of age
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We do not offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on page 124.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call them at 1-800-772-1213, (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213, (TTY 1-800-325-0778) to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**.

When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10 % increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

(Please refer to page 126 for information about how we provide benefits when you are age 65 or older and do not have Medicare.)

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first. In this case, we do not waive any out-of-pocket costs.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 1-800-222-APWU (2798) or see our Web site at www.apwuhp.com.

We waive some costs if the Original Medicare Plan is your primary payor.

Under the High Option, we will waive some out-of-pocket costs as follows:

- Inpatient hospital service. If you are enrolled in Medicare Part A, we will waive the deductible and coinsurance.
- Medical services and supplies provided by physicians and other health care professionals. If you are enrolled in Medicare Part B, we will waive the deductible, coinsurance and copayment.

Under the Consumer Driven Option, when Original Medicare (either Medicare Part A or Medicare Part B) is the primary payer, we will **not** waive any out-of-pocket costs.

Note: We do not waive our deductible, copayments or coinsurance for prescription drugs or for services and supplies that Medicare does not cover. Also, we do not waive benefit limitations, such as the 12-visit limit for chiropractic services or the 60-visit limit for physical, occupational or speech therapy.

You can find more information about how our Plan coordinates benefits with Medicare in APWU Health Plan's Blueprint to Medicare at www.apwuhp.com.

- **Tell us about your Medicare coverage**

  You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Private contract with your physician**

  A physician may ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. Should you sign an agreement, Medicare will not pay any portion of the charges, and we will not increase our payment. We will still limit our payment to the amount we would have paid after Original Medicare's payment. You may be responsible for paying the difference between the billed amount and the amount we paid.

- **Medicare Advantage (Part C)**

  If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

  If you enroll in a Medicare Advantage plan, the following options are available to you:

  This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

  Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

  When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

When you are age 65 or over and do not have Medicare

Under the FEHB law, we must limit our payments for inpatient hospital care and physician care to those payments you would be entitled to if you had Medicare. Your physician and hospital must follow Medicare rules and cannot bill you for more than they could bill you if you had Medicare. You and the FEHB benefit from these payment limits. Outpatient hospital care and non-physician based care are not covered by this law; regular Plan benefits apply. The following chart has more information about the limits.

If you:

- are age 65 or over; and
- do not have Medicare Part A, Part B, or both; and
- have this Plan as an annuitant or as a former spouse, **or** as a family member of an annuitant or former spouse; and
- are not employed in a position that gives FEHB coverage. (Your employing office can tell you if this applies.)

Then, for your inpatient hospital care:

- The law requires us to base our payment on an amount - the "equivalent Medicare amount" - set by Medicare's rules for what Medicare would pay, not on the actual charge.
- You are responsible for your applicable deductibles, coinsurance, or copayments under this Plan.
- You are not responsibile for any charges greater than the equivalent Medicare amount; we will show that amount on the explanation of benefits (EOB) form that we send you.
- The law prohibits a hospital from collecting more than the "equivalent Medicare amount".

And, for your physician care, the law requires us to base our payment and your coinsurance or copayment on:

- an amount set by Medicare and called the "Medicare approved amount," or
- the actual charge if it is lower than the Medicare approved amount.

If your physician:	**Then you are responsible for:**
Participates with Medicare or accepts Medicare assignment for the claim and is a member of our PPO network,	your deductibles, coinsurance, and copayments.
Participates with Medicare and is **not** in our PPO network,	your deductibles, coinsurance, copayments, and any balance up to the Medicare approved amount.
Does not participate with Medicare,	your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount.

It is generally to your financial advantage to use a physician who participates with Medicare. Such physicians are permitted to collect only up to the Medicare approved amount.

Our explanation of benefits (EOB) form will tell you how much the physician or hospital can collect from you. If your physician or hospital tries to collect more than allowed by law, ask the physician or hospital to reduce the charges. If you have paid more than allowed, ask for a refund. If you need further assistance, call us.

When you have the Original Medicare Plan (Part A, Part B, or both)

We limit our payment to an amount that supplements the benefits that Medicare would pay under Medicare Part A (Hospital insurance) and Medicare Part B (Medical insurance), regardless of whether Medicare pays. Note: We pay our regular benefits for emergency services to an institutional provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare.

We use the Department of Veterans Affairs (VA) Medicare-equivalent Remittance Advice (MRA) when the statement is submitted to determine our payment for covered services provided to you if Medicare is primary, when Medicare does not pay the VA facility.

If you are covered by Medicare Part B and it is primary, your out-of-pocket costs for services that both Medicare Part B and we cover depend on whether your physician accepts Medicare assignment for the claim.

High Option: If your physician **accepts** Medicare assignment, then you pay **nothing** for covered charges.

Consumer Driven Option: If your physician **accepts** Medicare assignment, then you pay nothing if you have unused benefits available under your Personal Care Account to pay the difference between the Medicare approved amount and Medicare's payment. If your PCA is exhausted, you must pay either this full difference under your Deductible or the lesser of your coinsurance or the full difference if your Deductible has been met.

If your physician **does not accept** Medicare assignment, then you pay the difference between the "limiting charge" or the physician's charge (whichever is less) and our payment combined with Medicare's payment.

It is important to know that a physician who does not accept Medicare assignment may not bill you for more than 115% of the amount Medicare bases its payment on, called the "limiting charge." The Medicare Summary Notice (MSN) that Medicare will send you will have more information about the limiting charge. If your physician tries to collect more than allowed by law, ask the physician to reduce the charges. If the physician does not, report the physician to the Medicare carrier that sent you the MSN form. Call us if you need further assistance.

Please see Section 9, *Coordinating benefits with other coverage*, for more information about how we coordinate benefits with Medicare.

Section 10. Definitions of terms we use in this brochure

Accidental injury — An injury resulting from a violent external force.

Admission — The period from entry (admission) into a hospital or other covered facility until discharge. In counting days of inpatient care, the date of entry and the date of discharge are counted as the same day.

Assignment — Your authorization for us to pay benefits directly to the provider. We reserve the right to pay you directly for all covered services.

Calendar year — January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Clinical trials — An approved clinical trial includes a phase I, phase II, phase II, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either Federally-funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application. If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs - costs for routine services such as doctors visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy
- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis or results, and clinical tests performed only for research purposes.

Coinsurance — Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 25.

Copayment — A copayment is a fixed amount of money you pay when you receive covered services. See page 24.

Cost-sharing — Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance and copayments) for the covered care your receive.

Covered services — Services we provide benefits for, as described in this brochure.

Custodial care — Treatment or services, regardless of who recommends them or where they are provided, that could be rendered safely and reasonably by a person not medically skilled, or that are designed mainly to help the patient with daily living activities. These activities include, but are not limited to:

- Personal care such as help in: walking; getting in and out of bed; bathing; eating by spoon, tube or gastrostomy; exercising; dressing
- Homemaking, such as preparing meals or special diets
- Moving the patient
- Acting as a companion or sitter
- Supervising medication that can usually be self administered; or
- Treatment or services that any person may be able to perform with minimal instruction, including but not limited to recording temperature, pulse, and respirations, or administration and monitoring of feeding systems

We determine which services are custodial care. Custodial care that lasts 90 days or more is sometimes known as long term care.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 24.

Experimental or investigational service

A drug, device, or biological product is experimental or investigational if the drug, device, or biological product cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time it is furnished. Approval means all forms of acceptance by the FDA.

A medical treatment or procedure, or a drug, device, or biological product is experimental or investigational if 1) reliable evidence shows that it is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or 2) reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or biological product or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

Determination of experimental/investigational status may require review by a specialty appropriate board-certified health care provider or appropriate government publications such as those of the National Institute of Health, National Cancer Institute, Food and Drug Administration, Agency of Health Care Policy & Research, and the National Library of Medicine.

Genetic screening

The diagnosis, prognosis, management, and prevention of genetic disease for those patients who have no current evidence or manifestation of a genetic disease and those who have not been determined to have an inheritable risk of genetic disease.

Genetic testing

The diagnosis and management of genetic disease for those patients with current signs and symptoms and for those who we have determined have an inheritable risk of genetic disease.

Group health coverage

Health care coverage that a member is eligible for because of employment by, membership in, or connection with, a particular organization or group that provides payment for hospital, medical, or other health care services or supplies, or that pays a specific amount for each day or period of hospitalization if that specified amount exceeds $200 per day, including extension of any of these benefits through COBRA.

Habilitative services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health care professional

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Home health care agency

An agency which meets all of the following:

- Is primarily engaged in providing, and is duly licensed or certified to provide, skilled nursing care and therapeutic services

- Has policies established by a professional group associated with the agency or organization. This professional group must include at least one registered nurse (R.N.) to direct the services provided and it must provide for full-time supervision of each service by a physician or registered nurse
- Maintains a complete medical record on each individual; and
- Has a full-time administrator

Hospice care program

A coordinated program of home and inpatient palliative and supportive care for the terminally ill patient and the patient's family provided by a medically supervised specialized team under the direction of a duly licensed or certified Hospice Care Program.

Maintenance therapy

Includes but is not limited to physical, occupational, or speech therapy where continued therapy is not expected to result in significant restoration of a bodily function but is utilized to maintain the current status.

Medically necessary

Services, drugs, supplies or equipment provided by a hospital or covered provider of health care services that we determine:

- Are appropriate to diagnose or treat the patient's condition, illness or injury
- Are consistent with standards of good medical practice in the United States
- Are not primarily for the personal comfort or convenience of the patient, the family, or the provider
- Are not a part of or associated with the scholastic education or vocational training of the patient; and
- In the case of inpatient care, cannot be provided safely on an outpatient basis

The fact that a covered provider has prescribed, recommended, or approved a service, supply, drug or equipment does not, in itself, make it medically necessary.

Pharmacogenomics

The study of a patient's genes to predict response to drugs and hence select the right drug and the right quantity.

Plan allowance

Our Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Fee-for-service plans determine their allowances in different ways. We determine our allowance as follows:

For PPO providers, our allowance is based on negotiated rates. PPO providers always accept the Plan’s allowance as their charge for covered services.

For non-PPO providers, we base the Plan allowance on the lesser of the provider’s actual charge or the allowed amount for the service you received. We determine the allowed amount by using health care charges guides which compare charges of other providers for similar services in the same geographical area. For surgery, doctor’s services, X-ray, lab and therapies (physical, speech and occupational), we use guides prepared by the Context4Healthcare and OptumInsight and apply these guides under the High Option at the 70th percentile and under the Consumer Driven Option at the 80th percentile. We update these charges guides at least once each year. If this information is not available, we will use other credible sources including our own data.

For more information, see *Differences between our allowance and the bill* in Section 4.

Post-service claims

Any claims that are not pre-service. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims

Those claims (1) that require precertification, prior approval or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Rehabilitative care Treatment that reasonably can be expected to restore and/or substantially restore a bodily function that was impaired as a result of trauma or disease.

Us/We Us and We refer to APWU Health Plan.

You You refers to the enrollee and each covered family member.

Urgent care claims A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 1-800-222-APWU (2798). You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Consumer Driven Health Plan Definitions

Consumer Driven Option	A fee-for-service option under the FEHB that offers you greater control over choices of your health care expenditures. You decide what health care services will be reimbursed under the Health Plan funded Personal Care Account (PCA). Unused funds from the PCA will roll over at the end of the year. If you spend the entire PCA fund before the end of the year, then you must satisfy a deductible **before** benefits are payable under the traditional type of insurance covered by your Plan. You decide whether to use in-network or out-of-network providers to reach the maximum fund allowed under your PCA.
Deductible	Under the Consumer Driven Option, your Deductible is the amount you must pay, if you have exhausted your Personal Care Account, before your Traditional Health Coverage begins. See page 27.
Personal Care Account	Under the Consumer Driven Option, your Personal Care Account (PCA) is an established benefit amount which is available for you to use first to pay for covered hospital, medical, dental and vision care expenses. You determine how your PCA will be spent and any unused amount at the end of the year may be rolled over to increase your available PCA in the subsequent year(s).
Rollover	As long as you remain in this Plan, any unused remaining balance in your PCA at the end of the calendar year may be rolled over to subsequent years. The maximum amount allowed in your PCA in any given year may not exceed $5,000 per Self Only enrollment and $10,000 per Family enrollment.

Section 11. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no government contribution.

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS**,** lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. Participating employees save an average of about 30% on products and services they routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program - *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $250. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,500 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, Insulin, products, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.

  FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.
- **Limited Expense Health Care FSA (LEX HCFSA**) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.**

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

All dental plans provide a comprehensive range of services, including:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and X-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 12-month waiting period. Beginning in 2014, most FEDVIP dental plans cover adult orthodontia. Review your FEDVIP dental plan's brochure for information on this benefit.

Vision Insurance

All vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional information

You can find a comparison of the plans available and their premiums on the OPM Web site at www.opm.gov/dental and www.opm.gov/vision. This site also provides links to each plan's Web site, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY 1-877-889-5680).

The Federal Long Term Care Insurance Program - *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337), (TTY 1-800-843-3557), or visit www.ltcfeds.com.

Summary of benefits for the High Option of the APWU Health Plan - 2014

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Below, an asterisk (*) means the item is subject to the calendar year deductible, $275 (PPO) or $500 (Non-PPO). And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a Non-PPO physician or other health care professional.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office*	PPO: $18 copay per visit (No deductible); 10% of Plan allowance Non-PPO: 30% of our allowance plus amount over our allowance	32
Services provided by a hospital:		
• Inpatient	PPO: 10% of Plan allowance Non-PPO: $300 per admission and 30% of our allowance plus amount over our allowance	51
• Outpatient*	PPO: 10% of Plan allowance Non-PPO: 30% of our allowance plus amount over our allowance	53
Emergency benefits:		
• Accidental injury	PPO: Nothing Non-PPO: Any amount over our allowance	55
• Medical emergency*	PPO 10% of Plan allowance Non-PPO: 10% of our allowance plus amount over our allowance	55
Mental health and substance abuse treatment:	PPO: $18 copay per visit (No deductible); 10% of Plan allowance Non-PPO: 30% of our allowance plus amount over our allowance	56
Prescription drugs:		
• Network pharmacy	$8 generic/25% brand name	61
• Network pharmacy Medicare	$8 generic/25% brand name	61
• Non-network pharmacy	50% of cost	61
• Non-network pharmacy Medicare	50% of cost	61
• Mail order	$15 generic/25% brand name	61

High Option Benefits	You pay	Page
• Mail order Medicare	$15 generic/25% brand name	61
Dental care:	30% of Plan allowance plus amount over our allowance	64
Special features:	Flexible benefits option, 24-hour nurse line, services for deaf and hearing-impaired, Wellness benefit, Disease Management Program, Review and reward program, Diabetes, Hypertension and Weight Management Programs, online access to claims information, online Preferred Provider Organization (PPO) directories, Hospital Quality Ratings Guide, Treatment Cost Estimator, and online non-FEHB savings on health and wellness products.	65
Protection against catastrophic costs (out-of-pocket maximum)**:**	PPO: Nothing after $4,000/Self Only or Family enrollment per year Non-PPO: Nothing after $10,000/Self Only or Family enrollment per year Some costs do not count toward this protection	26

Summary of benefits for the CDHP of the APWU Health Plan - 2014

- **Do not rely on this chart alone.** All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

  If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

  Below, an asterisk (*) means the item is subject to the Deductible, generally $600 per Self Only and $1,200 per Self and Family, once your Personal Care Account has been spent. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use an out-of-network physician or other health care professional.

CDHP Benefits	You Pay	Page
In-network preventive care:	Nothing	72
Personal Care Account:		
Up to $1,200 for Self Only or $2,400 for Self and Family for medical, surgical, hospital, mental health and substance abuse services and prescription drugs plus certain dental and vision care	Nothing up to $1,200 for Self Only or $2,400 for Self and Family	75
Traditional Health Coverage after Personal Care Account is exhausted		78
Medical/Surgical services provided by physicians:		
• Diagnostic and treatment services provided in the office*	In-network: 15% of Plan allowance Out-of-network: 40% of our allowance plus amount over our allowance	80
Services provided by a hospital:		
• Inpatient*	In-network: 15% of Plan allowance Out-of-network: 40% of our allowance plus amount over our allowance	95
• Outpatient*	In-network: 15% of Plan allowance Out-of-network: 40% of our allowance plus amount over our allowance	97
Emergency benefits:		
• Accidental injury*	In-network: 15% of Plan Allowance	100
• Medical emergency*	Out-of-network: 15% of Plan Allowance plus amount over our allowance	100
Mental health and substance abuse treatment*:	In-network: 15% of Plan allowance Out-of-network: 40% of our allowance plus amount over our allowance	101
Prescription drugs:		
• Network pharmacy*	25%/minimum $15	103
• Network pharmacy Medicare*	25%/minimum $15	103
• Mail order*	25%/minimum $10	103

CDHP Benefits	You Pay	Page
• Mail order Medicare*	25%/minimum $10	103
Dental Care/Vision Care (covered only under Personal Care Account):	Any amount over $400 per Self Only or $800 per Family (see Section 5) Extra PCA Expenses).	107
Health education resources and account management tools: Online tools and resources, Consumer choice information, Services for deaf and hearing-impaired, 24-hour nurse advisory service and Care support, Diabetes Management Program, online special programs for extra support and savings		109
Protection against catastrophic costs (out-of-pocket maximum):	In-network: Nothing after $3,000 Self Only or $4,500 Family enrollment per year Out-of-network: Nothing after $9,000/Self Only or Family enrollment per year Some costs do not count toward this protection	26

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2014 Rate Information for the APWU Health Plan

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the Guide to Federal Benefits for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to Postal Service employees. They are shown in special Guides published for APWU (including Material Distribution Center and Operating Services) NALC, NPMHU and NRCLA. Career Postal Employees (see RI 70-2A); Information Technology/Accounting Services employees (see RI 70-2IT); Nurses (see RI 70-2N); Postal Service Inspectors and Office Inspector General (OIG) law enforcement employees and Postal Career Executive Service employees (see RI-2IN); and non-career employees (see RI 70-8PS), including a preferred rate for qualified non-career APWU Postal Support Employees (PSEs) who enroll in the APWU CDHP Plan.

Career employees hired before May 23, 2011, will have the same rates as the APWU rates shown below. In the 2014 Guide to Federal Benefits for APWU and NRLCA Career United States Postal Service Employees (RI 70-2A), November 2013) this will be referred to as the "Current" rate; otherwise, "New" rates apply.

Postal Category 1 rates apply to career bargaining unit employees covered by the Postal Police contract.

Postal Category 2 rates apply to career non-bargaining unit, non-executive, non-law enforcement employees, and non-law enforcement Inspection Service and Forensics employees.

APWU rates apply to career postal employees represented by the APWU (including MDC and HQ Operating Services) and the National Postal Professional Nurses Union (NPPN) who meet certain eligibility requirements.

Other rates apply to other postal employees. Employees in these groups should refer to the appropriate Guide as described above for applicable APWU High Option and CDHP rates.

PostalEASE, the employee self-service system used for FEHB enrollment, automatically provides the applicable premium to individual employees.

For further assistance, Postal Service employees should call:

Human Resources Shared Service Center
1-877-477-3273, Option 5
TTY: 1-866-260-7507

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable Guide to Federal Benefits.

Premiums for Tribal employees are shown under the monthly non-postal column. The amount shown under employee contribution is the maximum you will pay. Your Tribal employee may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Office for exact rates.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium		
		Biweekly		Monthly		Biweekly		
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share	APWU Your Share
High Option Self Only	471	$189.29	$63.09	$410.12	$136.70	$41.64	$54.89	$39.31
High Option Self and Family	472	$427.99	$142.66	$927.31	$309.10	$94.16	$124.12	$96.57
CDHP Option Self Only	474	$134.89	$44.96	$292.26	$97.42	$29.68	$39.12	$8.99
CDHP Option Self and Family	475	$303.44	$101.15	$657.46	$219.15	$66.76	$88.00	$20.23