

41st Annual Open Season Seminar



Brochure Review

*Presented by
Sharon Morehead and
Danielle Rose*



Confidential property of APWU Health Plan. All rights Reserved.



Introduction

- Brochure
 - Layout
 - Sections
 - Changes
- Review Benefit Changes for 2027
- Member Scenarios and Other Hot Topics

APWU Health Plan
www.apwuhp.com
Customer Service 800-222-2798

APWU
HEALTH PLAN

2027

**A Fee-for-Service Plan (High Option), 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. This Plan is accredited. See page 14.

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

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

To become a member or associate member: All active Postal Service APWU bargaining unit employees and annuitants must be, or must become, dues-paying members of the APWU, to be eligible to enroll in the Health Plan. All Postal members and annuitants must become associate members of APWU, see page 141 for details.

Enrollment codes for this Plan
High Option:
23A Self Only
23C Self Plus One
23B Self and Family

Consumer Driven Option:
23D Self Only
23F Self Plus One
23E Self and Family

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. APWU will bill Retirees Department members \$36 annual membership. Active and retiree non-associate APWU membership dues vary.

IMPORTANT
• Rates: Back Cover
• Changes for 2027: Page 16
• Summary of Benefits: Page 172

Authorized for distribution by the:

United States
Office of Personnel Management

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

PSHB

RI 71-019

41st Annual Open Season Seminar

POP QUIZ

Brochure Review



POP QUIZ

What is the amount that is loaded into the PCA annually for Self Plus One or Family under the Consumer Driven Plan?

- \$1,200
- \$2,000
- \$2,400 ←
- \$5,000

This answer can be found on page 93.

POP QUIZ

What is maximum dollar amount allowed in the PCA for Self Only under the Consumer Driven Plan?

- \$10,000
- \$2,000
- \$2,400
- \$5,000



This answer can be found on page 95.

POP QUIZ

What is the in-network cost for maternity care under the High Option Plan?

- \$25 copay
- 15% coinsurance after deductible
- 15% coinsurance (no deductible)
- Nothing 

This answer can be found on pages 41 – 42.

POP QUIZ

Is air ambulance covered under the High Option Plan?

- Yes ←
- No

This answer can be found on page 64.

POP QUIZ

Who is the Telehealth services provider for the High Option Plan?

- AmWell
- Doctors on Demand
- Teladoc 
- All of the above

This answer can be found on page 37.

POP QUIZ

Who is the Telehealth provider for the Consumer Driven Option Plan?

- AmWell
- Doctors on Demand
- Teladoc
- All of the above ←

This answer can be found on page 99.

POP QUIZ

The cost of in-network preventive care services comes out of the PCA?

- Yes
- No



This answer can be found on pages 89 – 92.

PSHB Brochure Layout

- **Introduction/PSHB Facts** (pgs. 4 - 13)
- **Section 1: How This Plan Works** (pgs. 14 - 15)
- **Section 2: Changes for 2026** (pg. 16)
- **Section 3: How You Get Care** (pgs. 17 - 25)
- **Section 4: Your Costs for Covered Services** (pgs. 26 - 32)
- **Section 5: Benefits**
 - High Option (pgs. 33 - 85)
 - Consumer Driven Option (pgs. 86 - 140)
 - Non-PSHB Benefits (pg. 141)

PSHB Brochure Layout

- **Section 6:** General Exclusions (pgs. 142-143)
- **Section 7:** Filing a Claim for Covered Services (pgs. 144-146)
- **Section 8 & 8(a):** The Disputed Claims Process (pgs. 147-151)
- **Section 9:** Coordinating Benefits with Medicare and Other Coverage (pgs. 152-163)
- **Section 10:** Definitions (pgs. 164-170)
- **Summary of High Option** (pgs. 171-172)
- **Summary of Consumer Driven Option** (pgs. 173-175)
- **Index** (pgs. 176-177)
- **2027 Rate Information** (back cover)

41st Annual Open Season Seminar

Changes for 2027



Changes For 2027 (pg. 16)

- **Weight Management** – The Plan will replace the Omada Program for Weight Loss with Teladoc Health Comprehensive Weight Care under the High Option and add the program under the Consumer Driven Option. This virtual program provides members with strategies to support weight loss and long-term health. See *Section 5(h), Weight Management, pages 87 and 145.*
- **Out-of-Pocket Maximum** – The out-of-pocket maximum for out-of-network is now \$15,000 for Self Only and \$30,000 for Self Plus One and Self & Family. See *Section 4, pages 30 and 31.*

Changes For 2027 (pg. 16)

- **Part D TrOOP** – The Part D True Out-of-Pocket maximum (TrOOP) for retirees has increased from \$2,100 to \$2,400.
See Section 5(f)(a), PDP EGWP True Out-of-Pocket Cost, pages 81 and 138.
- **Hinge Health** – Both plans now offer Hinge Health, a digital program for musculoskeletal pain. Members are selected based on UHC clinical review. Members cannot self-refer.

Changes For 2027 (pg. 16)

- **GLP-I Drugs** – The plan now covers GLP-I drugs at 50% per prescription for 30- and 90-day supplies. Members must also participate in the Teladoc Health Comprehensive Weight program. See Section 5(f), *Covered medications and supplies, pages 74 and 131* and Section 5(f)(a), *Covered medications and supplies, pages 83 and 141*.
- **Sex Trait Modification** – The Plan will eliminate the mid-treatment exception process for chemical and hormonal sex trait modification services. See Section 5(b), *Reconstructive surgery, pages 55 and 114*.

Mass Re-issue: Optum Rx



High Option

- ID Card Front Changes:
 - Optum Rx Logo
 - New RxBIN, RxGRP, and RxPCN numbers
- ID Card Back Changes:
 - New Rx website and phone number
- Cards will be mailed the week of December 14th.
- Cut off for sending out 2026 card requests will be December 11, 2026
 - If a replacement card is requested, the member will receive the 2027 card with the Optum Rx information.
 - If a member needs a 2026 card, they can contact Customer Service or print out a temporary card from the member portal until 12/28/26.



UnitedHealthcare

Shared Services

www.apwuhp.com

Precertification required for some services.

Issuer: (80840)
Group Number: 78-800681

Member ID:

Member Name:

In-Network

Out-of-Network

Deductible: \$450 \$1,000

Out-of-Pocket: \$6,500 \$15,000

Copay: \$25

RxBIN: 610011 RxGRP: APWUHP02
RxPCN: APWURX

UnitedHealthcare Shared Services
Provider Directory: www.apwuhp.com



UnitedHealthcare

Choice Plus Network

This card does not guarantee coverage. To verify benefits, view claims, or find a provider, visit the websites or call.

Precertification/Prior Authorization must be obtained for services specified within the Health Plan brochure. For precertification call 866-569-2064.

For Members:

www.apwuhp.com

800-222-2798

24/7 Nurseline:

866-873-8738

RX:

www.optumrx.com

855-593-6185

For Providers:

uhss.umar.com

866-204-8020

APWU HP Primary Medical Claims:

EDI # 39026, UHSS, PO Box 30783, Salt Lake City, UT 84130-0783

APWU HP Secondary Medical Claims and Dental Claims:

EDI # 44444, APWU Health Plan, PO Box 8660, Elkridge, MD 21075

We encourage you to use a family physician as a valuable resource and personal health advocate.



Consumer Driven Option ID Card – Mass Re-issue

- Cards will be mailed the week of December 14th



Member:

Member ID: _____ Group Number: **935443**

Dependents _____

APWU HEALTH PLAN
CONSUMER DRIVEN OPTION

Payer ID 87726

RxBIN: 610279
RxPCN: 9999
RxGrp: UHEALTH

INN: _____ DED IND/FAM \$2200/\$4400 OOPM IND/FAM \$6500/\$13000
OON: _____ \$2700/\$5400 \$15000/\$30000

0502 UnitedHealthcare Choice Plus-HRA
Administered by United HealthCare Services, Inc.

Printed: 08/02/26



This card does not guarantee coverage. To verify benefits, view claims, or find a provider, visit the websites or call.

For Members: myuhc.com 855-808-3003

APWU HP: www.apwuhp.com 800-222-APWU
UnitedHealthcare must be notified 2 business days prior to an elective admission or after an emergency admission. Pre-notification is required for certain procedures, medications and DME.

For Providers: UHCprovider.com
Medical Claims: PO Box 740800, Atlanta GA 30374-0800

Pharmacy Claims: OptumRx PO Box 650540 Dallas, TX 75265-0540
For Pharmacists: 888-290-5416



41st Annual Open Season Seminar

Member Scenarios



Member Scenario

My well-woman visit was covered, but I received an EOB showing cost sharing for the bloodwork my doctor ordered for perimenopause. Why wasn't everything covered as preventive?

- **High Option (pgs. 37-38):** While the well-woman visit may be covered under the preventive care benefit, laboratory or diagnostic services ordered because of symptoms may process under the diagnostic benefit. In this scenario, in-network preventive services for the well-woman visit would be covered at 100%, however, if the lab services would be covered at 85% coinsurance in-network (\$0 if performed at LabCorp or Quest Diagnostics) if it is deemed a covered benefit.
- **Consumer Driven Option (pgs. 89 & 99):** In-network preventive care services would be covered at 100%. All other covered lab services will be subject to PCA, deductible and coinsurance.

Member Scenario

My doctor prescribed hormone therapy. Will my plan cover it?

- A provider's prescription does not automatically guarantee coverage.
- Claims and medication requests remain subject to medical necessity and benefit requirements.
- **High Option (pg. 75)** – Hormone Therapy does require prior authorization and is then covered under the Specialty Drug benefit.
- **Consumer Driven Option (pgs. 130-131)** – Hormone Therapy does require prior authorization and is then covered under the Specialty Drug benefit subject to PCA, deductible and coinsurance.

Member Scenario

My doctor wants to run genetic tests because my mother had breast cancer. Is that covered?

- Relevant facts include family history, inheritable risk, symptoms, physician documentation, and medical necessity.
- The brochure distinguishes testing used to diagnose or manage disease from screening performed without evidence of disease.
- **High Option (pgs. 37-38)** – Genetic testing, including BRCA testing, requires prior approval. Covered under the Lab, X-ray and other diagnostic test benefit. Subject to plan coinsurance unless performed at a Quest Diagnostics or LabCorp facility where the plan pays 100%.
- **Consumer Driven (pg. 99)** – Genetic testing, including BRCA testing, requires prior approval. Covered under the Lab, X-ray and other diagnostic test benefit. Subject to PCA, deductible and coinsurance.

Member Scenario

I am healthy, but I want a broad genetic panel to see whether I might develop a condition later. Will the Plan pay for it?

- If the member has no symptoms, no documented inheritable risk, and no medical indication, the request may fall under the brochure definition of Genetic Screening rather than Genetic Testing and would therefore not be covered under either plan.

Member Scenario

I paid the provider in full and uploaded my receipt. Why haven't I been reimbursed?

- A receipt alone does not satisfy filing requirements.
- The member may also need: an itemized bill, provider information, diagnosis, date of service, proof of payment, and other carrier's EOB if applicable.

Please refer to Section 7. Filing a claim for covered services (pgs. 144-146)

Member Scenario

I paid \$500 out of pocket. Why did the plan only reimburse me \$200?

- Reimbursement is based on covered benefit provisions, the plan allowance, PPO or Non-PPO status, deductible requirements, and cost-sharing provisions.
- The amount a member pays is not automatically the amount reimbursed by the Plan.

This information can be found throughout Section 5 of the brochure.

Member Scenario

I submitted my claim, but nothing has been processed. I do have Medicare.

- If another carrier is primary, the member must provide the primary carrier EOB before the Plan can complete processing of the claim.
 - Examples include: a Medicare Summary Notice or a commercial carrier EOB.
- Processing cannot be finalized without the primary carrier's determination.

See Section 9. Coordination of benefits with Medicare and other coverage (pgs. 152-163)

Member Scenario

My PCA balance went down. Did someone take money from my account?

- A decrease in the PCA balance means a claim was processed and paid using PCA funds.
- This does not mean the claim was denied, the member owes the provider, or money was removed incorrectly.
- The PCA is designed to pay eligible healthcare expenses first.
- If a member has funds available in the PCA account, claims will always be paid out of the PCA first.

Information regarding the PCA can be found on pgs. 93-95.

Member Scenario

I have the Consumer Driven plan. I've never had to pay before. Why does my newest EOB show that I have to pay coinsurance?

- Once the funds in the PCA have been exhausted, traditional health coverage begins, and applicable deductible and cost-sharing requirement apply.

Information regarding the PCA can be found on pgs. 93-95

Member Scenario

I want to use my FSA and save my PCA. How do I do that?

- If PCA funds are available, claims will be paid from the PCA first.
- Members wishing to use their FSA first should: (1) instruct the provider not to submit the claim to UnitedHealthcare, (2) obtain a copy of the bill, and (3) submit the bill directly to the FSA carrier.
- Or the member can go online to their www.myuhc.com account and discontinue automatic payments from their PCA.

NOTE: The full cost of prescription drugs will continue to come out of PCA funds even while the automatic payments are discontinued.

PCA (HRA) Reimbursement

www.myuhc.com

The screenshot displays the United Healthcare website interface. The top navigation bar includes the United Healthcare logo, a Messages icon, a Search bar, and a My Account dropdown. The main navigation menu features links for Home, Find Care & Costs, Claims & Accounts (highlighted with a green arrow), Coverage & Benefits, and Pharmacies & Prescriptions. The 'Claims & Accounts' section is expanded, showing 'Financial Accounts' and 'Spending accounts'. The 'Financial Accounts' section displays a table for the 'Health Reimbursement Account' with the following data:

Employer Contribution	Incentive Earned	Carryover Balance	Total Funds	Year to Date Payments	Balance
\$2,400.00	\$50.00	\$35.52	\$2,450.00	\$1,817.33	\$668.19

Below the table, there are links for 'How it Works', 'Frequently Asked Questions', 'View Claims', and 'Submit a Claim'. At the bottom, there is a section for 'Manage Direct Deposits and Automatic Payments!' with a 'Manage Automatic Payments' button (highlighted with a green arrow) and an 'Add Direct Deposit' button. A 'Chat' button is also visible in the bottom right corner.

PCA (HRA) Reimbursement

www.myuhc.com



Messages

Search

My Account

Home

Find Care & Costs

Claims & Accounts

Coverage & Benefits

Pharmacies & Prescriptions

Automatic Payments

When claims are processed (such as medical, vision, dental or pharmacy) and you're responsible for a portion of the costs, you can choose to have the claim automatically rollover to your Flexible Spending Account for payment.

Current Automatic Payment Settings

Settings for plan year:
1/1/2024 - 12/31/2024

Health Reimbursement Account

Enrolled

Discontinue

Member Scenario

I have \$300 in my PCA. Can you just transfer that money to me?

- No. The PCA is not a cash withdrawal account.
- The PCA is used exclusively to pay eligible healthcare expenses.
- Unused PCA funds are subject to PCA rules and are not member cash assets.

Information regarding the PCA can be found on pgs. 93-95.

Anesthesia

High Option (pg. 57)

Consumer Driven Option (pg. 116)

Services by an out-of-network anesthesiologist:

- If related to emergency services, the anesthesiologist will be paid at the same rate as if they were in-network and can **NOT** balance bill. This is regardless of whether the services were performed at an in-network or out-of-network facility.
- If related to non-emergency services but related to services performed at an in-network facility, the anesthesiologist will be paid at the same rate as if they were in-network and can **NOT** balance bill.
- If related to non-emergency services but related to service performed at an out-of-network facility, the anesthesiologist will be paid at the out-of-network rate and **CAN** balance bill.

How Anesthesia Services are Paid

	In-Network Facility	Out-of-Network Facility	Paid In-Network	Balance Billing Allowed
Emergent	✓	✓	Yes	No
Non-Emergent	✓	⊘	Yes	No
Non-Emergent	⊘	✓	No	Yes

Emergency Service/Accidents

- Accidental Injury: An injury through violent, external and accidental means.
- Medical Emergency: Sudden unexpected onset of a condition or injury that you believe endangers your life or could result in serious disability if not treated promptly.
- Urgent Care Center
- Ambulance



Accidental Injury

High Option (pg. 63)

- Outpatient services rendered within **72** hours of an accident:
 - No out-of-pocket or cost-sharing (no deductible, coinsurance, copayment) in or out-of-network

Consumer Driven Option (pg. 122)

- Outpatient services rendered within **24** hours of an accident:
 - In-network or out-of-network: PCA, Deductible, 15% of Plan allowance



Medical Emergency

High Option (pg. 63)

Urgent Care Center		Other Facility (Emergency Room)	
PPO	Non-PPO	PPO	Non-PPO
\$30 copayment <i>(No Deductible)</i>	40% of the Plan allowance plus any difference between the Plan allowance and the billed amount	15% of the Plan allowance	15% of the Plan allowance

Medical Emergency

Consumer Driven Option - PCA, Deductible (pg. 122)

Urgent Care Center		Other Facility (Emergency Room)	
In-Network	Out-of-Network	In-Network	Out-of-Network
15% of the Plan allowance	50% of the Plan allowance plus any difference between the Plan allowance and the billed amount	15% of the Plan allowance	15% of the Plan allowance

Ambulance

Medically necessary professional ambulance transport of a patient within 24 hours of a medical emergency.

HIGH OPTION (pg. 64)		CONSUMER DRIVEN OPTION (pg. 122)	
PPO	Non-PPO	In-Network	Out-of-Network
15% of the Plan allowance <i>(No Deductible)</i>	15% of the Plan allowance plus any difference between the Plan allowance and the billed amount <i>(No Deductible)</i>	PCA, Deductible 15% of the Plan allowance	PCA, Deductible 15% of covered charges and any difference between allowed and billed amount

NOTE: Air Ambulance will be covered, at the in-network rate, to the nearest facility, where necessary treatment is available, if no emergency ground transportation is available or suitable, and the patient’s condition warrants immediate evacuation.

Coordinating Benefits

High Option – Medicare Part A and B (pgs. 152-163)

- APWU Health Plan waives deductible, copays and coinsurance
 - Claims submitted electronically by Medicare (Traditional Coverage)
 - Paper claims required when a patient has a Medicare Advantage Plan
 - Minimal, if any, patient out-of-pocket costs
 - Preauthorization requirements waived when APWU Health Plan is secondary
 - **NOTE: If a Postal employee is no longer working and receiving Workers' Compensation, along with Medicare A & B, Workers' Compensation is primary for that condition. If a claim is not injury related, Medicare pays as primary and APWU Health Plan pays secondary.**

Coordinating Benefits

High Option (pgs. 152-153)

- Workers' Compensation
 - We do not cover services where OWCP (or similar agency) assumes liability
- TRICARE/CHAMPVA
 - APWU Health Plan is the primary payor when a patient is also covered by TRICARE or CHAMPVA

Coordinating Benefits

Consumer Driven Option (pg. 152-163)

- Medicare Part A and B
 - APWU Health Plan does not waive deductibles and coinsurance
 - Medicare will pay as primary
 - If there are available funds in the PCA, the Medicare deductible and coinsurance will be paid.
- Other Primary Insurance
 - Primary payor, based on employment status, and relationship to insured, pays first.
 - Deductibles and coinsurance are not waived.
 - If there are funds available in the PCA, Plan pays its normal benefit, or the amount due after the primary carrier pays, whichever is lower.

Updating Demographic Information

The Health Plan can no longer make updates to demographic information. Please make all needed updates through one of the below:

PSHB Support – Contact Information:

- PSHB System (enrollment system) URL: <https://health-benefits.opm.gov>
- Annuitants: Retirement Services 888-767-6738.
- Active Postal Employees: HR Shared Service Center 877-477-3273

Claim Inquiries

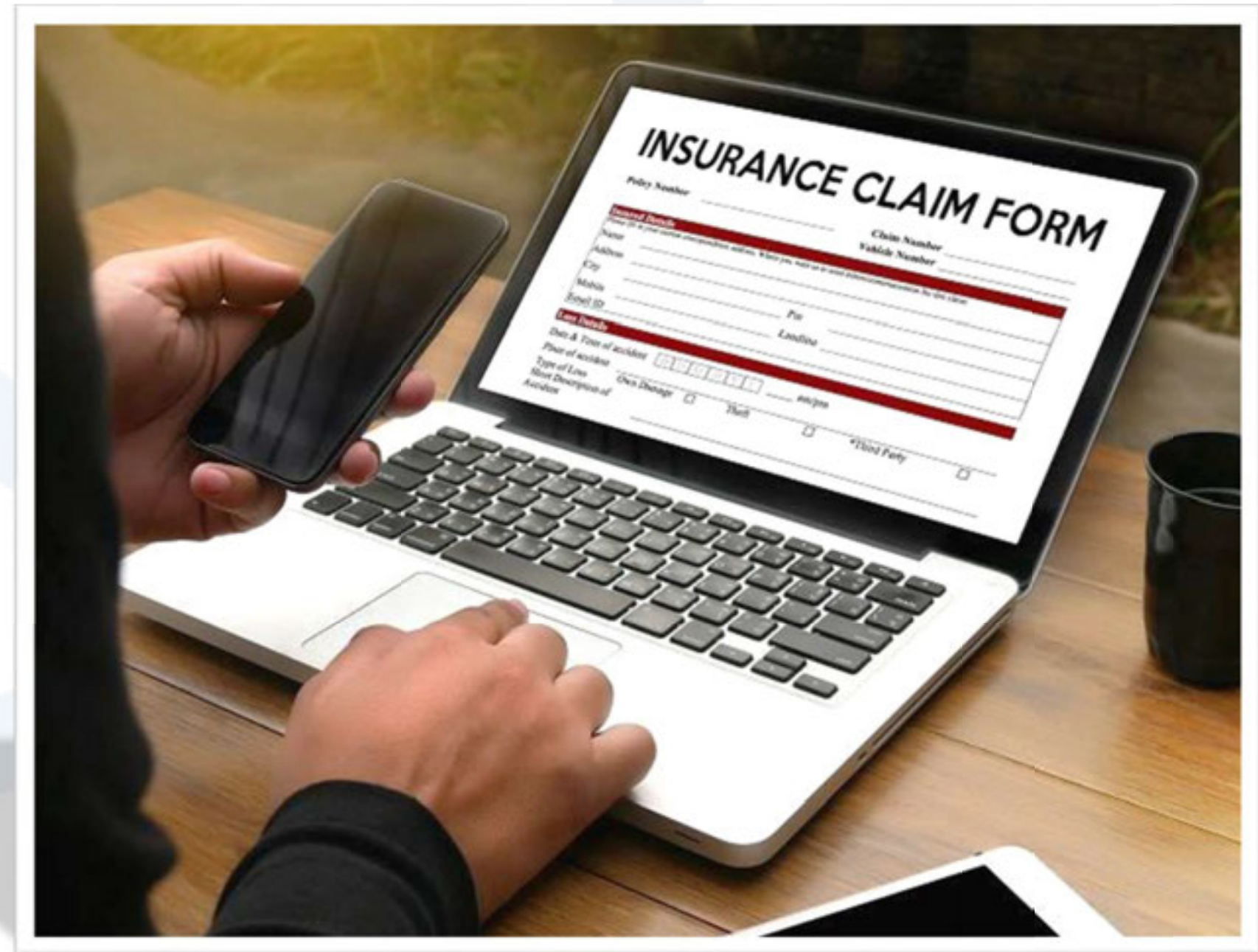
What information do you need?

- HIPAA Personal Representative Form or Authorization to Release Private Health Information (PHI!)
 - Can be found on the website under HIPAA Privacy Forms
 - Individual may also be on the phone to give permission for that call
- Patient Demographics
 - Member ID, Member Name, Date of Birth (DOB), Address

(continued on next slide)

Claim Inquiries

- Claim Information:
 - Date of Service (DOS)
 - Provider Name
 - Claim Outcome
 - Expected Outcome
 - Prior Correspondence



Claim Appeals Process

- Members have the right to appeal a denied claim or request reconsideration of a Health Plan decision.
 - Step 1 – Submit written appeal within 6 months of denial.
 - Step 2 – Plan responds within 30 days; approve, deny, or request more information.
 - Step 3 – If denied again, member may appeal to OPM within 90-120 days.
 - Step 4 – Member may file in federal court if they disagree with OPM's decision.
 - See Section 8 & 8(a) The disputed claims process (pgs. 147-151)



Contact Us

Open Season Hotline

(800) PIC-APWU

High Option

www.apwuhp.com

(800) 222-APWU (2798)

Pharmacy

Optum Rx

www.optumrx.com

PSHB (855) 593-6185

Consumer Driven Option

www.myuhc.com

(800) 718-1299

Health Plan Representative

Phone Line

(800) 635-8476

Let's Talk HIPAA

- What does HIPAA stand for?
 - *Health Insurance Portability and Accountability Act*
- What was HIPAA intended to do?
 - Improve fraud and abuse protections
 - Improve administrative efficiencies
 - Ensure privacy, security and confidentiality of Protected Health Information (PHI)



Protected Health Information (PHI)

- General Definition:
 - Information that identifies an individual and describes his/her medical condition or treatment
- Specifically Includes:
 - Clinical information
 - Information on payment
 - Basic demographic information
 - Name, address, telephone number
- Applies to written, verbal, and electronic information

What does it mean for you?

- Personal Representative
 - A person that can act on behalf of the member
 - Personal Representative Form must be on file in order to discuss a member's information with you.
 - Without proper authorization, we can only provide general information.
- Communications in Public Areas
 - Be aware of your surroundings when discussing sensitive information, including PHI. Do not discuss sensitive information of PHI in public areas.



Thank
You

