APWU HEALTH PLAN
TOGETHER. BETTER HEALTH.

Basic and Refresher



Presented by

Wendy Abraham

and

Erik Fenton

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Agenda

Objective: At the end of this presentation, you will understand the following:

- Health Plan Terminology
- 2022 Brochure
  - Table of Contents and Sections
  - Sections 1-2
    - 2022 Changes
  - Sections 3 & 4
- Review APWU Health Plan benefits for 2022
  - Section 5
    - High Option
    - CDHP
  - Sections 6-10

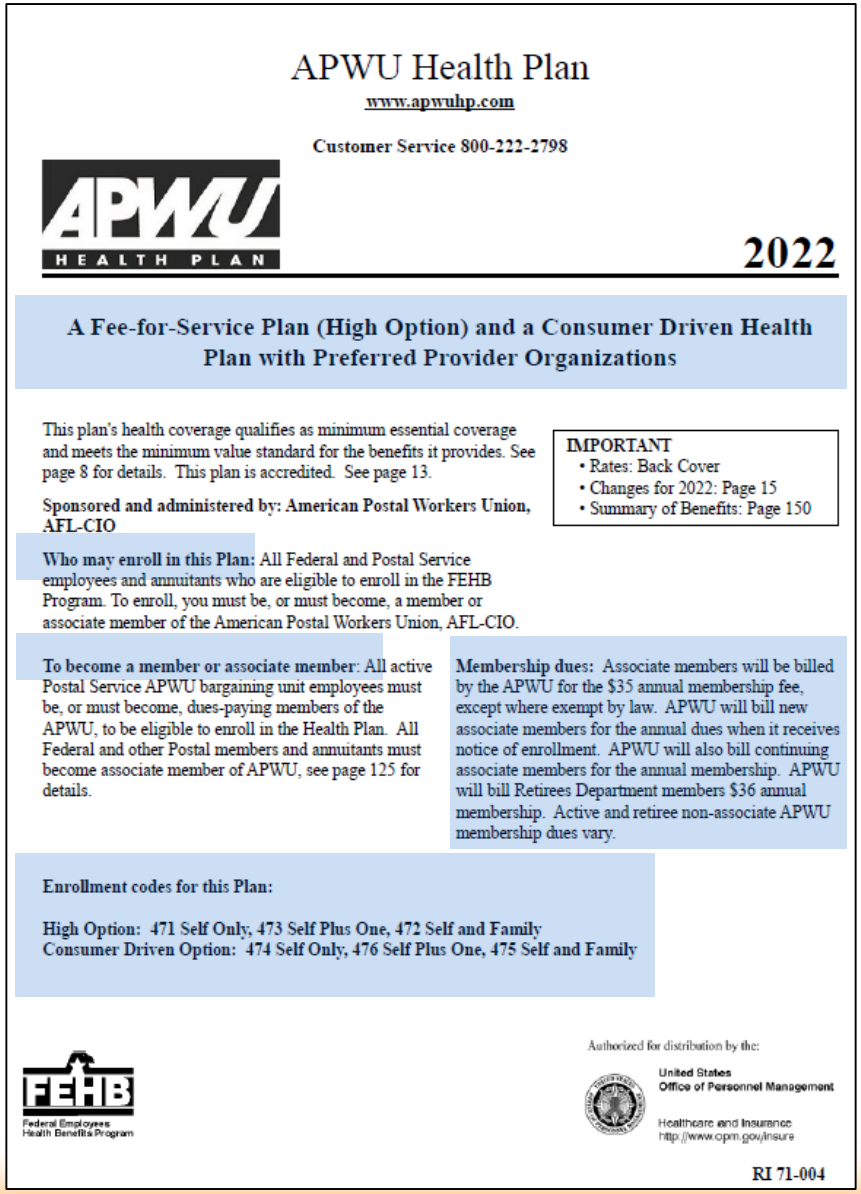
Brochure Tour

Type of Plan

Who can join

How to join

Enrollment Codes



APWU Health Plan

www.apwuhp.com

Customer Service 800-222-2798

APWU HEALTH PLAN

2022

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. This plan is accredited. See page 13.

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

IMPORTANT
- Rates: Back Cover
- Changes for 2022: Page 15
- Summary of Benefits: Page 150

Who may enroll in this Plan: All Federal and Postal Service employees and annuitants who are eligible to enroll in the FEHB 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 must be, or must become, dues-paying members of the APWU, to be eligible to enroll in the Health Plan. All Federal and other Postal members and annuitants must become associate member of APWU, see page 125 for details.

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.

Enrollment codes for this Plan:

High Option: 471 Self Only, 473 Self Plus One, 472 Self and Family
Consumer Driven Option: 474 Self Only, 476 Self Plus One, 475 Self and Family

FEHB Federal Employees Health Benefits Program

Authorized for distribution by the:

United States Office of Personnel Management

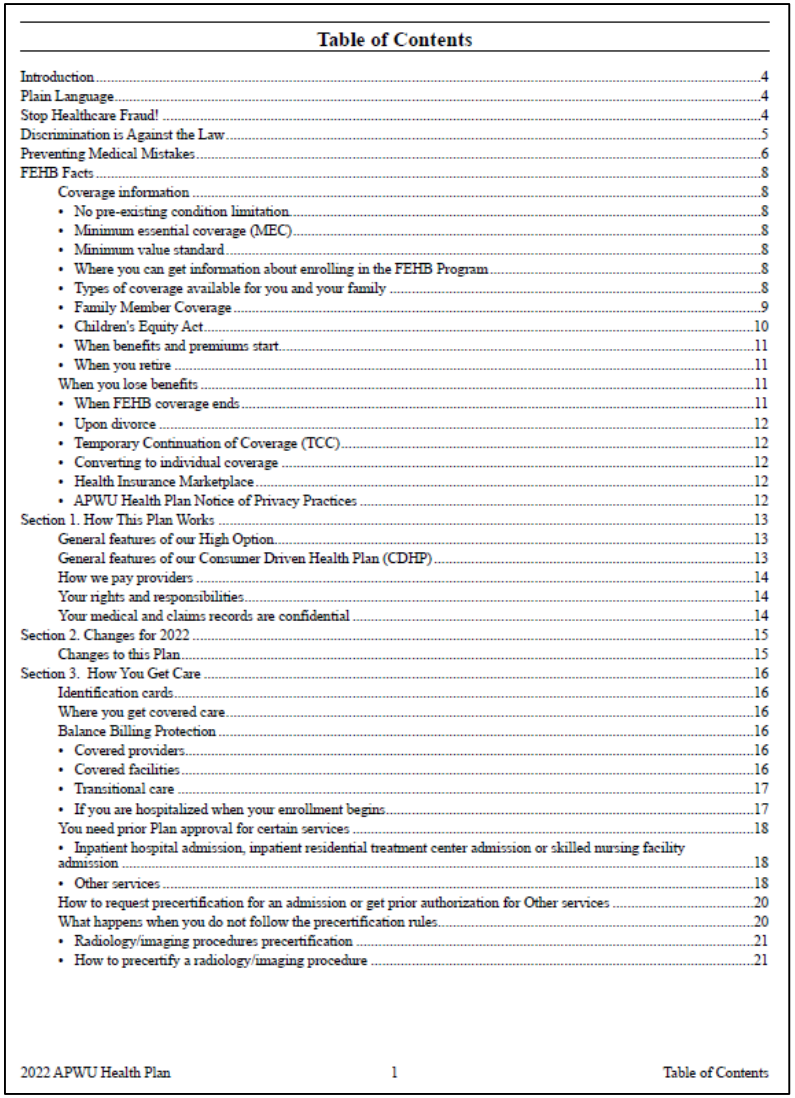
Healthcare and Insurance http://www.opm.gov/insure

RI 71-004

Who is an Associate member…

Brochure: Table of Contents

- Introduction/FEHB Facts
  - Section 1: How This Plan Works
  - Section 2: Changes for 2022
  - Section 3: How You Get Care
  - Section 4: Your Costs for covered services
  - Section 5: Benefits
  - Section 6: General Exclusions
  - Section 7: Filing a claim for covered services
  - Section 8: The disputed claims process
  - Section 9: Coordinating benefits with Medicare and other coverage
  - Section 10: Definitions of Terms We Use in this Brochure



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Introduction (Pgs. 4-12)

- Health Plan Address
- Fraud

Introduction

This brochure describes the benefits of APWU Health Plan under contract (CS 1370) between APWU Health Plan and 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 800-222-2798 or through our website: 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 verbal 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 Plus One or 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, 2022, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2022, and changes are summarized on page 15. Rates are shown at the end of this brochure.

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 and each covered 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.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

Stop Healthcare Fraud!

Fraud increases the cost of healthcare 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 phone or to people you do not know, except for your healthcare provider, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using healthcare 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 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 the APWU Health Plan Fraud Hotline at 410-424-1515.
  - If we do not resolve the issue:

CALL - THE HEALTHCARE FRAUD HOTLINE
877-499-7295
OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form

The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

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 they were disabled and incapable of self-support prior to age 26).
  - A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.
- 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 (TCC).
- 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.

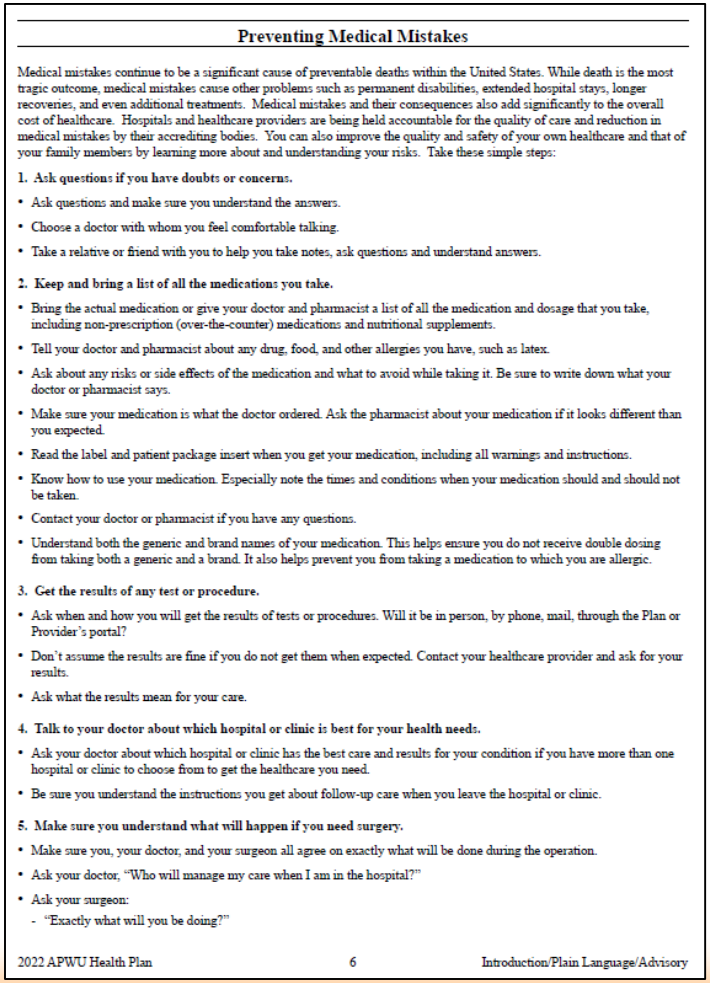
Discrimination is Against the Law

The APWU Health Plan complies with all applicable Federal civil rights laws, including Title VII of the Civil Rights Act of 1964.

You can also file a civil rights complaint with the Office of Personnel Management by mail at: Office of Personnel Management Healthcare and Insurance Federal Employee Insurance Operations, Attention: Assistant Director FEIO, 1900 E Street NW, Suite 3400 S, Washington, DC 20415-3610.

Introduction (Pgs. 4-12)

- Patient Safety
- Never Events



Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. 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. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks. 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 take notes, ask questions and understand answers.

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

- Bring the actual medication or give your doctor and pharmacist a list of all the medication and dosage that you take, including non-prescription (over-the-counter) medications 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 medication is what the doctor ordered. Ask the pharmacist about your medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

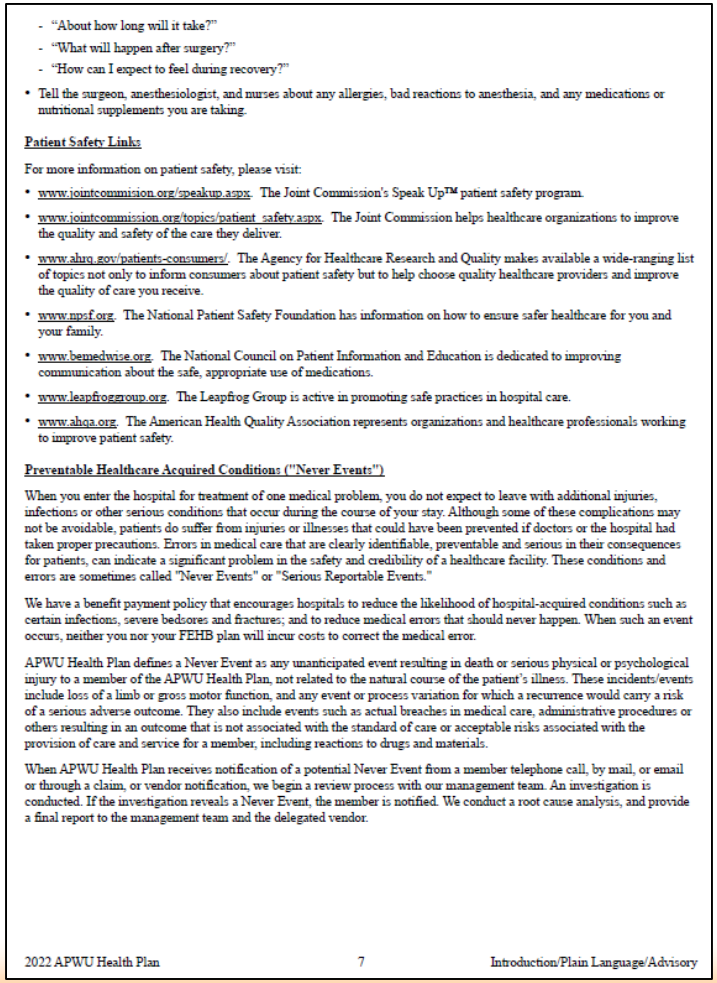
- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Don't assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

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

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

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 reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.
- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers/. 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 healthcare providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.
- www.bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medications.
- 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 healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you do not 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, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

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 to reduce medical errors that should never happen. When such an event occurs, neither you nor your FEHB plan will incur costs to correct the medical error.

APWU Health Plan defines a Never Event as any unanticipated event resulting in death or serious physical or psychological injury to a member of the APWU Health Plan, not related to the natural course of the patient's illness. These incidents/events include loss of a limb or gross motor function, and any event or process variation for which a recurrence would carry a risk of a serious adverse outcome. They also include events such as actual breaches in medical care, administrative procedures or others resulting in an outcome that is not associated with the standard of care or acceptable risks associated with the provision of care and service for a member, including reactions to drugs and materials.

When APWU Health Plan receives notification of a potential Never Event from a member telephone call, by mail, or email or through a claim, or vendor notification, we begin a review process with our management team. An investigation is conducted. If the investigation reveals a Never Event, the member is notified. We conduct a root cause analysis, and provide a final report to the management team and the delegated vendor.

Introduction (Pgs. 4-12)

- FEHB Facts

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** — Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.
- **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 that 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 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 do not 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.

  Once enrolled in your FEHB Program Plan, you should contact your carrier directly for updates and questions about your benefit coverage.
- **Types of coverage available for you and your family** — Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee and one or more eligible family members. Family members include 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 Plus One or 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 Plus One or 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 Plus One or 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 are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Contact your carrier to obtain a Certificate of Creditable Coverage (COCC) or to add a dependent when there is already family Coverage.

Contact your employing or retirement office if you are changing from Self to Self Plus One or Self and Family or to add a newborn if you currently have a Self Only plan.

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, you or they cannot be enrolled in or covered as a family member by another enrollee in 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 website at http://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 your spouse by a valid common-law marriage from a state that recognizes common-law marriages) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described in the chart below.

  Natural children, adopted children, and stepchildren
  Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

  Foster children
  Coverage: 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
  Coverage: 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
  Coverage: Married children (but NOT their spouse or their own children) are covered until their 26th birthday.

Introduction (Pgs. 4-12)

- Who's covered and when?

Children with or eligible for employer-provided health insurance
Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

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 Plus One or 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 in Self Plus One or 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 Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM;
- 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 Plus One or Self and Family, as appropriate, 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 Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.

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 does not 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 does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. 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 processed according to the 2022 benefits of your prior plan or option. If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option.** 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 2022 but any unused PCA benefits from 2021 will be available to you. However, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan's 2021 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 receive 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 or 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).

Introduction (Pgs. 4-12)

• **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 additional information about your coverage choices, www.opm.gov/healthcare-insurance/healthcare/plan-information/guides. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.
• **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). The Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. 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, 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. Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.
• **Converting to individual coverage**	If you leave Federal or Tribal service, your employing office will notify you of your right to convert. You must contact us in writing 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 contact us in writing 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, a waiting period will not be imposed and your coverage will not be limited due to pre-existing conditions. When you contact us, we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 800-222-2798 or visit our website at www.apwuhp.com.
• **Health Insurance Marketplace**	If you would like to purchase health insurance through the ACA'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 Health 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 website. If you need to obtain a copy of the Health Plan's Notice of Privacy Practices, you may either contact the Health Plan via email through the website, www.apwuhp.com, or by calling 800-222-2798.

Section 1: How This Plan Works (Pgs.13-14)

We are a FFS plan

We offer PPO

Non-PPO is standard

High Option

Consumer Driven Option

Section 1. How This Plan Works

This Plan is a fee-for-service (FFS) plan. OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet or exceed nationally recognized standards. APWU Health Plan holds the following accreditations: Accreditation Association for Ambulatory Health Care (www.aaahc.org); National Committee for Quality Assurance (www.ncqa.org); URAC (www.urac.org). To learn more about this plan's accreditation(s), please visit the following website: www.apwuhp.com.

You can choose your own physicians, hospitals, and other healthcare 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 healthcare 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.

High Option PPO Network: You can go to our website, www.apwuhp.com to download a High Option PPO directory. 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 and the U.S. Virgin Islands, Cigna 800-582-1314. For mental health/substance use disorder treatment providers (all states), call Cigna Behavioral Health, 800-582-1314.

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 800-582-1314.

General features of our Consumer Driven Health Plan (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 800-718-1299 or you can go to their website, www.welcometouhc.com/apwu, for a full nationwide online provider directory. UnitedHealthcare is the PPO network for all states and Puerto Rico, and the U.S. Virgin Islands. Printed provider directories are not available.

- **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.
- For mental health/substance use disorder treatment providers (all states), call UHC Behavioral Health Solutions toll-free 800-718-1299.
- **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.

You can choose your own physicians, hospitals and other health care providers

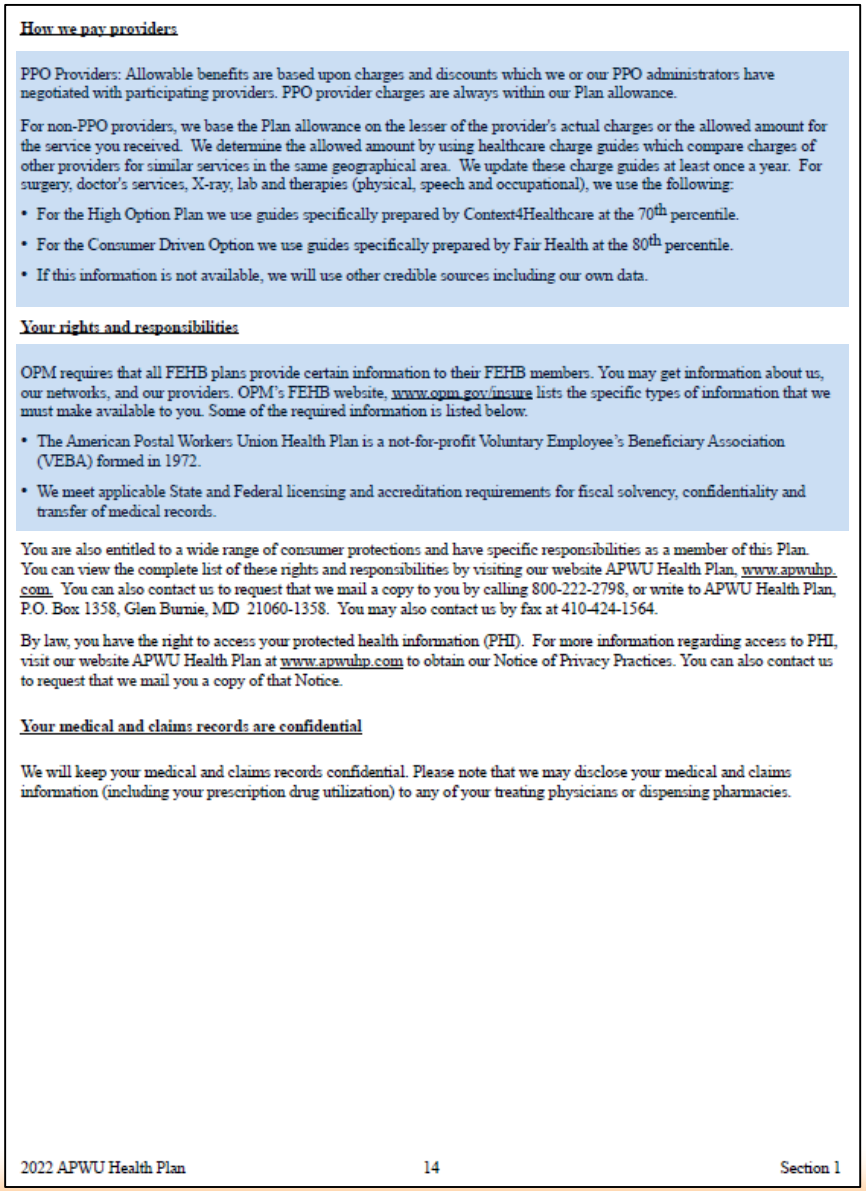
High Option PPO Vendors:
Cigna
Cigna Behavioral Health

Consumer Driven Option PPO Vendors:
UnitedHealthcare
United Behavioral Health

Section 1: How This Plan Works (Pgs.13-14)

Provider payments

Member rights



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.

For non-PPO providers, we base the Plan allowance on the lesser of the provider's actual charges or the allowed amount for the service you received. We determine the allowed amount by using healthcare charge guides which compare charges of other providers for similar services in the same geographical area. We update these charge guides at least once a year. For surgery, doctor's services, X-ray, lab and therapies (physical, speech and occupational), we use the following:

- For the High Option Plan we use guides specifically prepared by Context4Healthcare at the 70th percentile.
- For the Consumer Driven Option we use guides specifically prepared by Fair Health at the 80th percentile.
- If this information is not available, we will use other credible sources including our own data.

Your rights and responsibilities

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 website, www.opm.gov/insure lists the specific types of information that we must make available to you. Some of the required information is listed below.

- 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.

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website APWU Health Plan, www.apwuhp.com. You can also contact us to request that we mail a copy to you by calling 800-222-2798, or write to APWU Health Plan, P.O. Box 1358, Glen Burnie, MD 21060-1358. You may also contact us by fax at 410-424-1564.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website APWU Health Plan at www.apwuhp.com to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

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.

2022 APWU Health Plan 14 Section 1

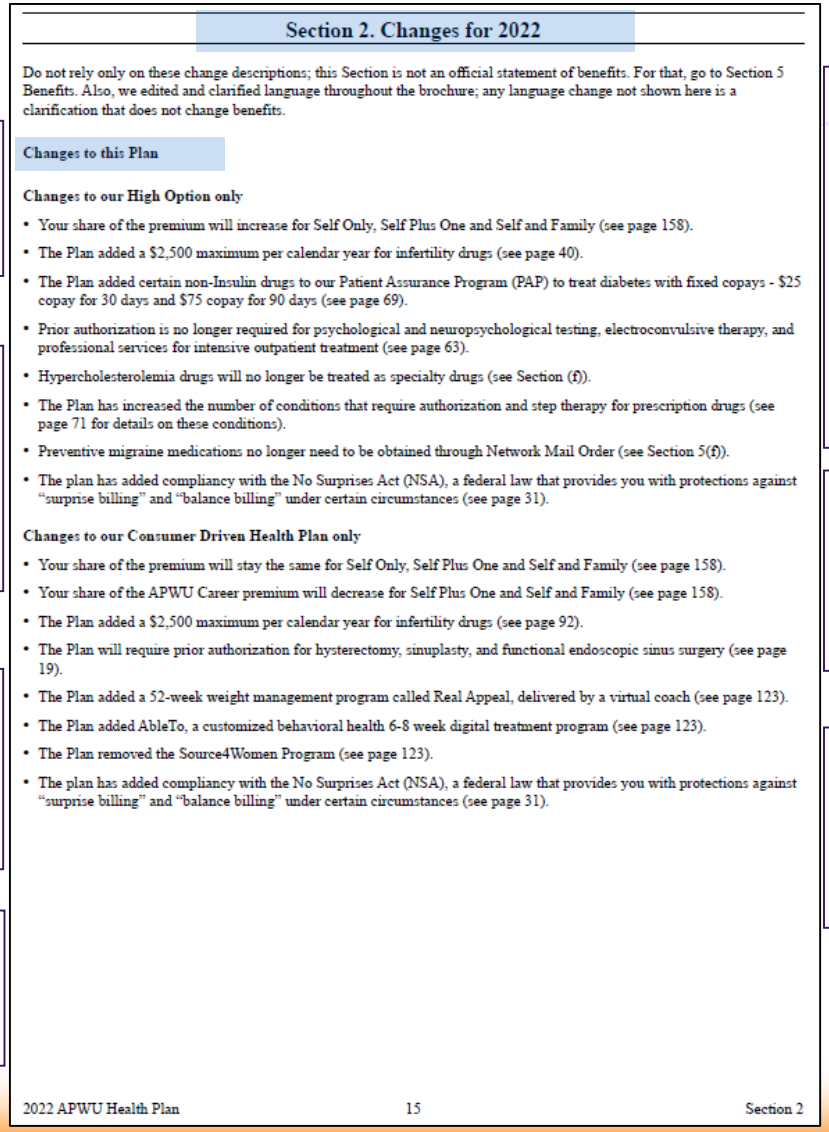
Section 2: Changes for 2022 (Pg. 15)

Real Appeal – weight management program (CDHP)

Fixed Copays for certain insulins & non-insulin drugs for the treatment of Diabetes (PAP) - High Option

Precertification for hysterectomy, sinuplasty, and functional endoscopic sinus surgery (CDHP)

AbleTo – behavioral health digital treatment program (CDHP)



Section 2. Changes for 2022

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.

Changes to this Plan

Changes to our High Option only

- Your share of the premium will increase for Self Only, Self Plus One and Self and Family (see page 158).
- The Plan added a $2,500 maximum per calendar year for infertility drugs (see page 40).
- The Plan added certain non-Insulin drugs to our Patient Assurance Program (PAP) to treat diabetes with fixed copays - $25 copay for 30 days and $75 copay for 90 days (see page 69).
- Prior authorization is no longer required for psychological and neuropsychological testing, electroconvulsive therapy, and professional services for intensive outpatient treatment (see page 63).
- Hypercholesterolemia drugs will no longer be treated as specialty drugs (see Section (f)).
- The Plan has increased the number of conditions that require authorization and step therapy for prescription drugs (see page 71 for details on these conditions).
- Preventive migraine medications no longer need to be obtained through Network Mail Order (see Section 5(f)).
- The plan has added compliancy with the No Surprises Act (NSA), a federal law that provides you with protections against "surprise billing" and "balance billing" under certain circumstances (see page 31).

Changes to our Consumer Driven Health Plan only

- Your share of the premium will stay the same for Self Only, Self Plus One and Self and Family (see page 158).
- Your share of the APWU Career premium will decrease for Self Plus One and Self and Family (see page 158).
- The Plan added a $2,500 maximum per calendar year for infertility drugs (see page 92).
- The Plan will require prior authorization for hysterectomy, sinuplasty, and functional endoscopic sinus surgery (see page 19).
- The Plan added a 52-week weight management program called Real Appeal, delivered by a virtual coach (see page 123).
- The Plan added AbleTo, a customized behavioral health 6-8 week digital treatment program (see page 123).
- The Plan removed the Source4Women Program (see page 123).
- The plan has added compliancy with the No Surprises Act (NSA), a federal law that provides you with protections against "surprise billing" and "balance billing" under certain circumstances (see page 31).

2022 APWU Health Plan 15 Section 2

Precertification no longer required for psychological and neuropsychological testing, electroconvulsive therapy, and professional services for intensive outpatient treatment. (High Option)

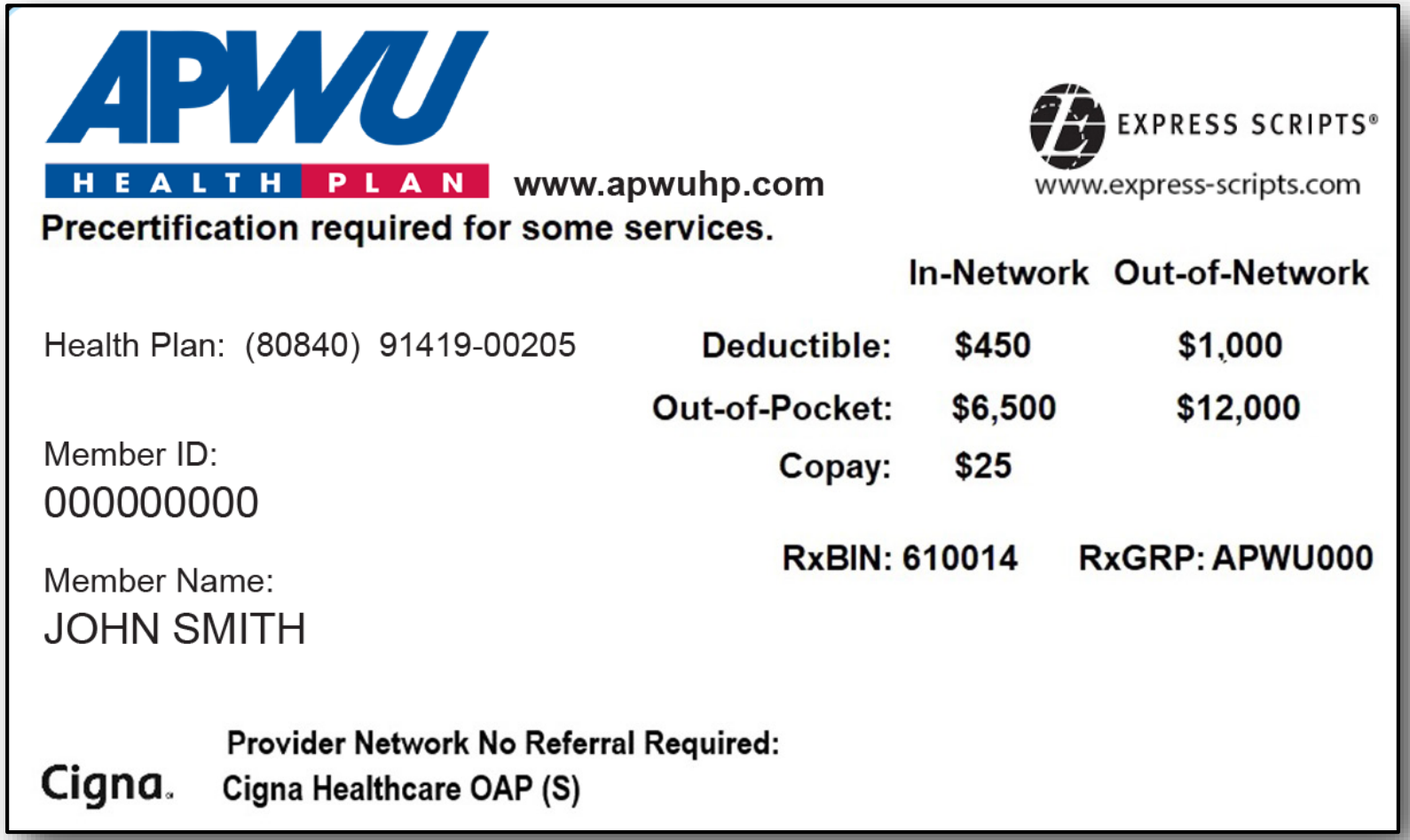
$2500 maximum per calendar year per person for infertility drugs (High Option & CDHP)

New pharmacy precertification requirements for High Option.

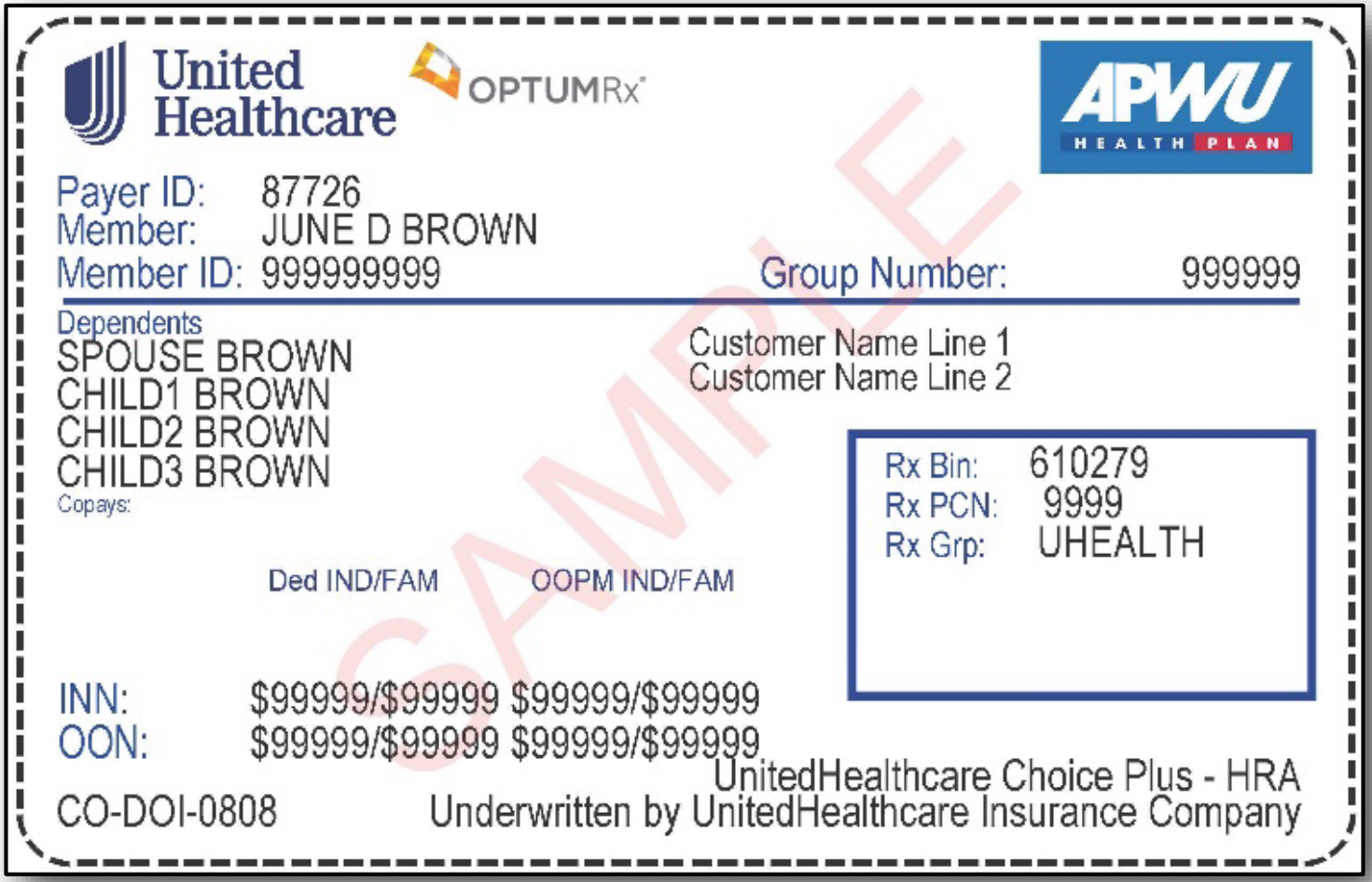
Section 2: Changes for 2022 *(continued)*

- Out-of-Network Air Ambulance covered as In-Network (Pg. 60)
- The Plan has added compliancy with the No Surprises Act (NSA), a federal law that provides you with protections against “surprise billing” and balance billing” under certain circumstances (Pg. 31)
  - Mass re-issue of ID cards for all APWU HP Primary members for January 1, 2022
  - Medicare Primary (A & B) members will not receive new ID cards

Section 2: Changes for 2022
High Option ID card



Section 2: Changes for 2022
Consumer Driven Option ID card



Section 3: How You Get Care (Pgs. 16-24)

- ID Cards (Pg. 16)
- Precertification Process (Pgs. 17-21)
  - Inpatient Hospital Admission
  - $500 Penalty
  - High Option: Call Cigna/CareAllies at 800-582-1314
  - Consumer Driven Option: Call UnitedHealthcare at 800-718-1299
- Other Services (Pgs. 18-19)

Do I need a precertification? High Option

Yes

- ✓ Applied Behavioral Analysis (ABA)
- ✓ Bariatric Surgery
- ✓ Durable Medical Equipment (DME)
- ✓ Gender Reassignment Surgery
- ✓ Gene Therapy
- ✓ Genetic Testing (i.e. BRCA)
- ✓ In-patient Admission–Medical and/or Mental Health
- ✓ Outpatient Radiology Services (CT/MRI/MRA/PET)
- ✓ Potential Cosmetic Surgery
- ✓ Residential Treatment Center (RTC)
- ✓ Skilled Nursing Facility (SNF)
- ✓ Speech Therapy
- ✓ Transcranial Magnetic Stimulation (TMS)
- ✓ Treatment Back/Neck Pain

No

- ✓ Acupuncture Treatment
- ✓ Chiropractic Care
- ✓ Maternity Care/ Admissions
- ✓ Outpatient Services at VA
- ✓ Physical and Occupational Therapy
- ✓ ECT/Psych and Neuropsych testing

Do I need prior approval? CDO

Yes

- ✓ Air Ambulance - Non-emergent
- ✓ Applied Behavioral Analysis (ABA)
- ✓ Bariatric Surgery
- ✓ Chemotherapy-outpatient
- ✓ Clinical Trials
- ✓ Congenital Heart Disease
- ✓ Durable Medical Equipment (DME)
- ✓ Gender Reassignment Surgery
- ✓ Genetic Testing (i.e. BRCA)
- ✓ Home health care – nursing visits and infusion therapy
- ✓ Hospice- Inpatient
- ✓ In-patient Admission – Medical and/or Mental Health
- ✓ Organ Transplantation
- ✓ Orthognathic Surgery
- ✓ Outpatient Radiology Services (CT/MRI/MRA/PET)
- ✓ Potential Cosmetic Surgery
- ✓ Residential Treatment Center (RTC)
- ✓ Skilled Nursing Facility (SNF)
- ✓ Sleep apnea procedures and surgery
- ✓ Therapeutics –outpatient dialysis, IV infusion, radiology oncology, MR focused ultrasound
- ✓ Transcranial Magnetic Stimulation (TMS)
- ✓ Hysterectomy, Sinuplasty, Functional Endoscopic Sinus Surgery

No

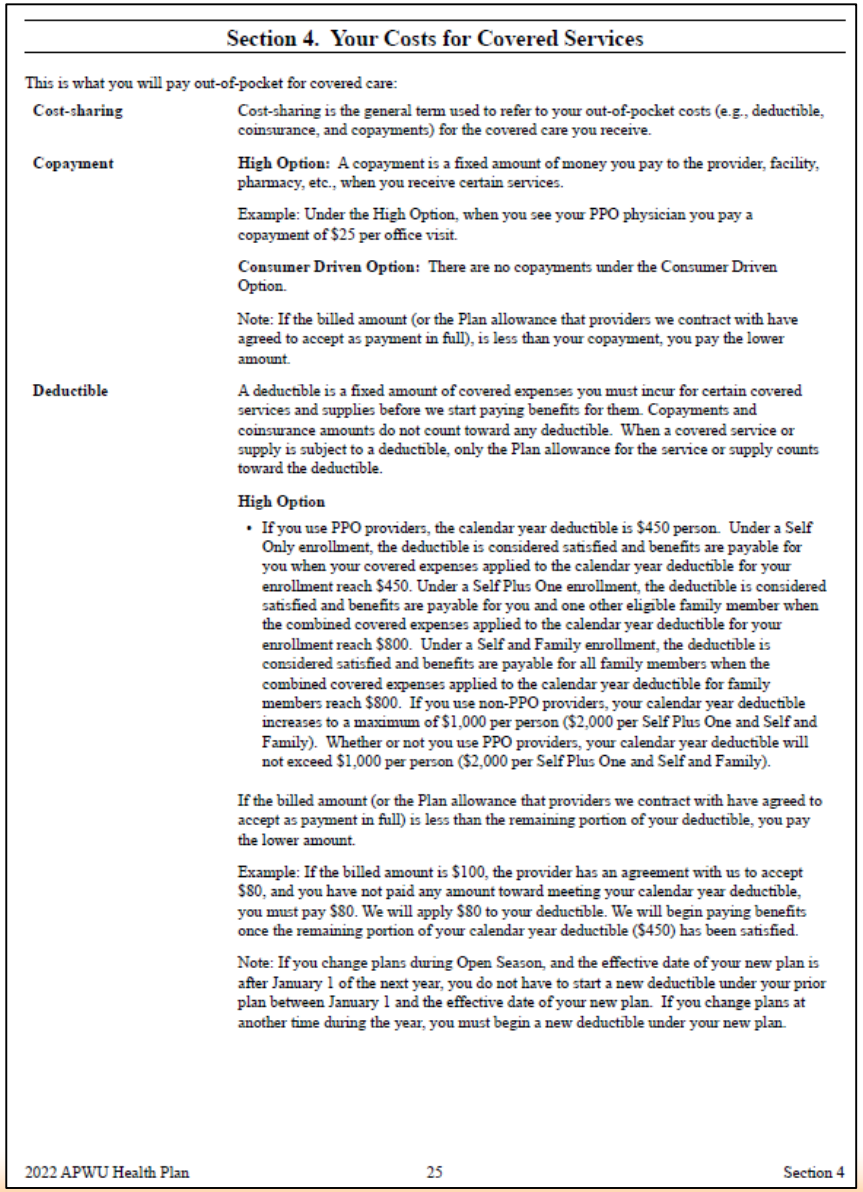
- ✓ Acupuncture Treatment
- ✓ Chiropractic Care
- ✓ Maternity Care/ Admissions
- ✓ Outpatient Services at VA
- ✓ Physical, Occupational and Speech Therapy

Reconsiderations/Appeals (Pg. 24)

- Steps to request reconsideration of pre-service decision
- Steps to appeal a decision (Section 8)
  - Must appeal within 6 months of initial Health Plan decision

Your Costs for Covered Services Section 4 (Pgs. 25-31)

- Out-of-pocket cost
  - Copay
    - CDHP: $0 Copay
  - Deductible
  - Coinsurance
- PPO vs. Non PPO
  - Balance billing
- Catastrophic costs
  - Out-of-pocket max
  - Inclusions/Exclusions
- Surprise Billing – Know Your Rights



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 $25 per office 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 $450 person. Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach $450. Under a Self Plus One enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered expenses applied to the calendar year deductible for your enrollment reach $800. Under a Self and Family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $800. If you use non-PPO providers, your calendar year deductible increases to a maximum of $1,000 per person ($2,000 per Self Plus One and Self and Family). Whether or not you use PPO providers, your calendar year deductible will not exceed $1,000 per person ($2,000 per Self Plus One and Self and 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 ($450) has been satisfied.

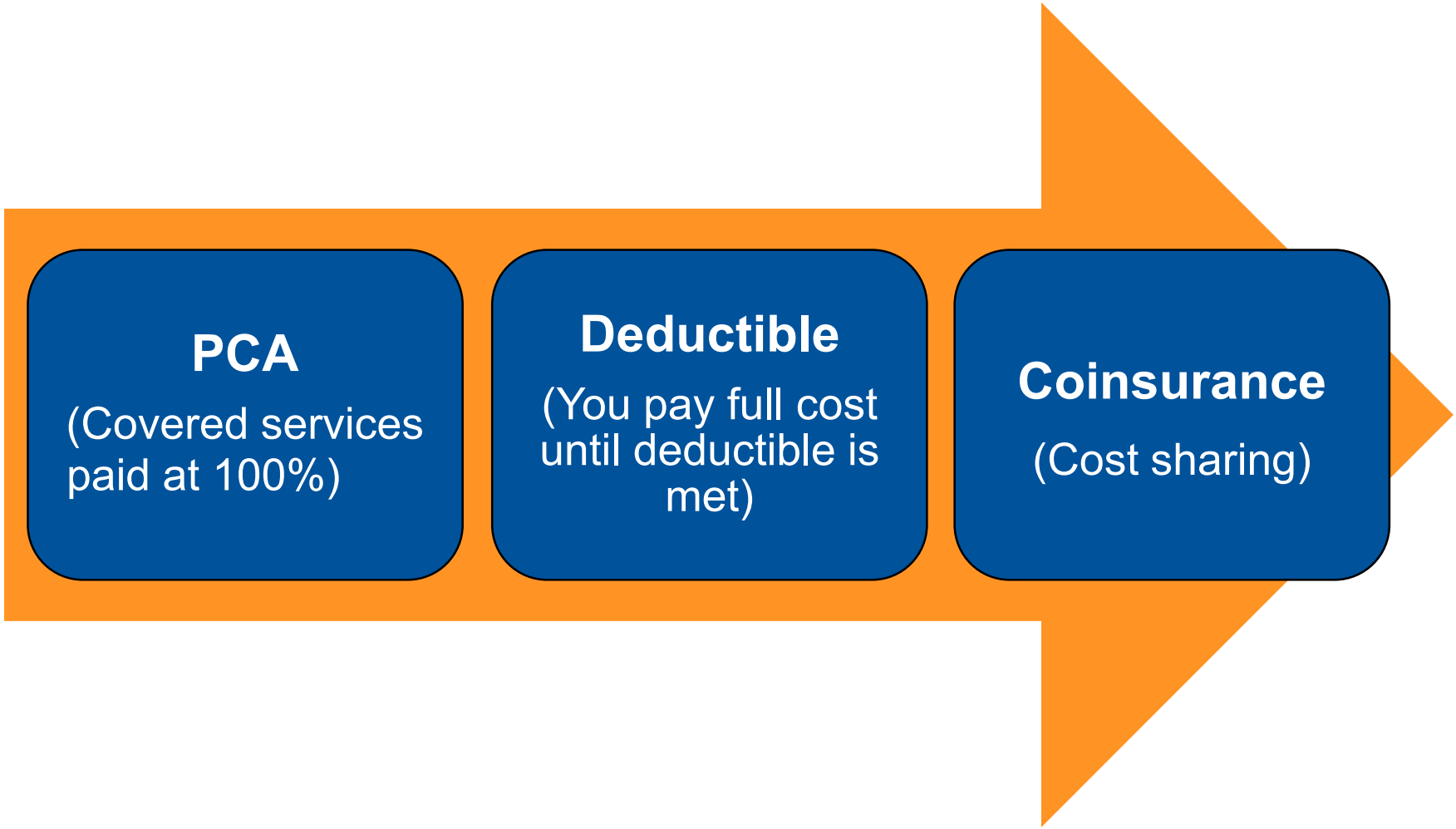
Note: If you change plans during Open Season, and the effective date of your new plan is after January 1 of the next year, you do not have to start a new deductible under your prior plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you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

High Option Deductible (Pg. 25)

Deductible: A fixed dollar amount of covered expenses a member must incur before benefits can be paid.

- In-network
  - $450 Self Only
  - $800 Self Plus One, Self and Family
- Out-of-network
  - $1,000 Self Only
  - $2,000 Self Plus One, Self and Family
- Copays and coinsurance do not count toward deductible amounts

Consumer Driven Option Deductible (Pg. 26)



Consumer Driven Option Deductible (Pg. 26)

Deductible must be met before Traditional Health Coverage Begins.

- **Self Only:** $2,200, but the Health Plan prefunds your Personal Care Account (PCA) with $1,200, so **you pay $1,000**
- **Self Plus One; Self and Family:** $4,400, but the Health Plan prefunds your Personal Account (PCA) with $2,400, so **you pay $2,000**

High Option Coinsurance (Pg. 26)

Definition: The percentage of covered allowances for which the patient is responsible. Coinsurance does not begin until the deductible has been met.

- The percentage that you must pay for your care
  - High Option:
    - 15% (in-network)
    - 40% (out-of-network)

Consumer Driven Option Coinsurance (Pg. 26)

Definition: The percentage of covered allowances for which the patient is responsible. Coinsurance does not begin until the PCA is used and the deductible is met.

- The percentage that you must pay for your care
  - Consumer Driven Option:
    - 15% (in-network)
    - 50% (out-of-network)

PPO vs. Non-PPO (Pg. 27)

- **In-network = PPO**
  - Facilities, providers, and suppliers who contract with a network to provide health services to our members at a discounted rate
    - Member cost share will consist of deductible, coinsurance, or copayment, based on allowable amount
- **Out-of-network = Non-PPO**
  - Facilities, providers, and suppliers who do not contract with a network
    - Member cost share will consist of deductible and coinsurance, PLUS any difference between our allowance and billed charges; this difference is considered 'balanced billing' (services not otherwise addressed by the No Surprises Act (NSA))

High Option
PPO vs. Non-PPO

EXAMPLE	PPO PHYSICIAN	NON-PPO PHYSICIAN
Physician's Charge	$1,500	$1,500
Our Allowance	$1,000	$1,000
We Pay	85% of allowance: $850	60% of allowance: $600
You owe: Coinsurance*	15% of allowance: $150	40% of allowance: $400
+ Difference up to billed charge?	No: $0	Yes: $500
Total You Pay	$150	($500 + $400) $900

****Example assumes deductible has been met***

****Example is not an office visit***

Consumer Driven Option
In-network vs. Out-of-network

EXAMPLE	PPO PHYSICIAN	NON-PPO PHYSICIAN
Physician's Charge	$1,500	$1,500
Our Allowance	$1,000	$1,000
We Pay	85% of allowance: $850	50% of allowance: $500
You owe: Coinsurance*	15% of allowance: $150	50% of allowance: $500
+ Difference up to billed charge?	No: $0	Yes: $500
Total You Pay	$150	($500 + $500) $1,000

****Example assumes PCA has been used and deductible has been met***

Catastrophic Out-of-Pocket Max (Pg. 28)

- When you reach the Catastrophic maximum, you pay no coinsurance for covered services for the remainder of the calendar year
- In-network expenses apply toward out-of-network maximums

HIGH OPTION			CONSUMER DRIVEN OPTION		
	In-network	Out-of-network		In-network	Out-of-network
Self Only	$6,500	$12,000	Self Only	$6,500	$12,000
Self Plus One	$13,000	$24,000	Self Plus One	$13,000	$24,000
Self and Family	$13,000	$24,000	Self and Family	$13,000	$24,000

High Option Catastrophic Costs (Pgs. 28-29)

- Expenses that count toward the out-of-pocket max:
  - 15% coinsurance (or 5% for Cancer Centers of Excellence) for covered PPO services
  - 40% coinsurance for covered Non-PPO services
  - Copayments (i.e. $25 for outpatient PPO office visits, or $15 virtual visits through American Well, or $30 for outpatient facility charges in an Urgent Care Center)
  - Prescription drug costs (i.e. the 25%/45%/$10 or $20 you pay for in-network prescription drugs)

Not included in out-of-pocket max – High Option (Pgs. 28-29)

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, pages 18-20)
- The $300 per admission for non-PPO inpatient hospital charges or skilled nursing facility
- Expenses in excess of visit maximums for physical, occupational and speech therapy, see pages 41-42, and acupuncture, see page 46
- Expenses in excess of Hospice care and preventive care maximums
- The difference in cost when brand name drugs are purchased and a generic is available
- Drugs reimbursed at the non-network pharmacy level
- 50% coinsurance for retail drugs after the first two fills if mail order is not used
- 100% of the cost for targeted drugs if the Plan's step therapy is not followed
- Any associated costs when you purchase medications in excess of the Plan's dispensing limitations
- Cost associated with non-covered drugs and supplies

Consumer Driven Option - Catastrophic Costs (Pgs. 29-30)

- Expenses that count toward the out-of-pocket max:
  - 15% coinsurance (or 10% for Cancer Centers of Excellence) for covered in-network services; and the deductible.
  - 50% coinsurance for covered out-of-network services; and the deductible.
  - 25% or 40% for in-network prescription drug costs.
  - PCA of $1,200 for Self-Only or $2,400 for Self Plus One and Self and Family.

Not included in out-of-pocket max – Consumer Driven Option (Pgs. 29-30)

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

- Any expenses paid by the Plan under your in-network Preventive Care benefit
- Expenses in excess of our allowance or maximum benefit limitations or expenses not covered under the Traditional Health Coverage
- 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, pages 18-20)
- Expenses in excess of Hospice care maximums
- Drugs purchased at a non-network pharmacy
- The difference in cost when brand name drugs are purchased and a generic is available
- Any associated costs when you purchase medications in excess of the Plan's dispensing limitations
- Cost associated with non-covered drugs and supplies

APWU HEALTH PLAN
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2022 High Option Benefits
Section 5

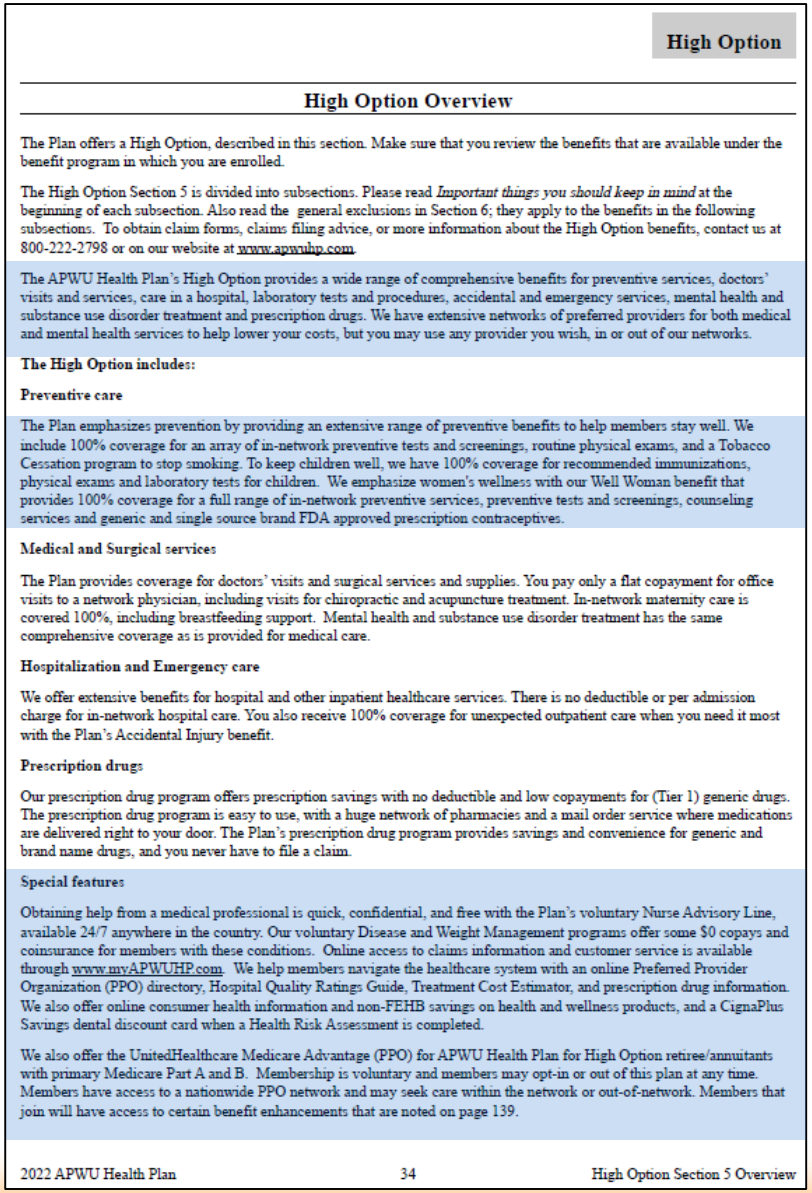


High Option Benefits
Section 5(a)-(h), (Pgs. 32-76)

- Medical Services and Supplies
- Surgical and Anesthesia Services
- Services Provided by Hospital or Other Facility
- Emergency Services/ Accidents
- Mental Health and Substance Use Disorder Benefits
- Prescription Drug Benefits
- Dental Benefits
- Wellness and Other Special Features

High Option Overview (Pg. 34)

We have an extensive network of PPO providers but you may choose any provider in-network or out-of-network



High Option

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; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about the High Option benefits, contact us at 800-222-2798 or on our website 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 use disorder 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 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 and generic and single source brand FDA approved prescription 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. In-network maternity care is covered 100%, including breastfeeding support. Mental health and substance use disorder treatment 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 (Tier 1) 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 Disease and Weight Management programs offer some $0 copays and coinsurance for members with these conditions. Online access to claims information and customer service is available through www.myAPWUHP.com. 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, and a CignaPlus Savings dental discount card when a Health Risk Assessment is completed.

We also offer the UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan for High Option retiree/annuitants with primary Medicare Part A and B. Membership is voluntary and members may opt-in or out of this plan at any time. Members have access to a nationwide PPO network and may seek care within the network or out-of-network. Members that join will have access to certain benefit enhancements that are noted on page 139.

2022 APWU Health Plan 34 High Option Section 5 Overview

Choosing a PPO provider helps to lower your costs

100% coverage on an array of preventive care

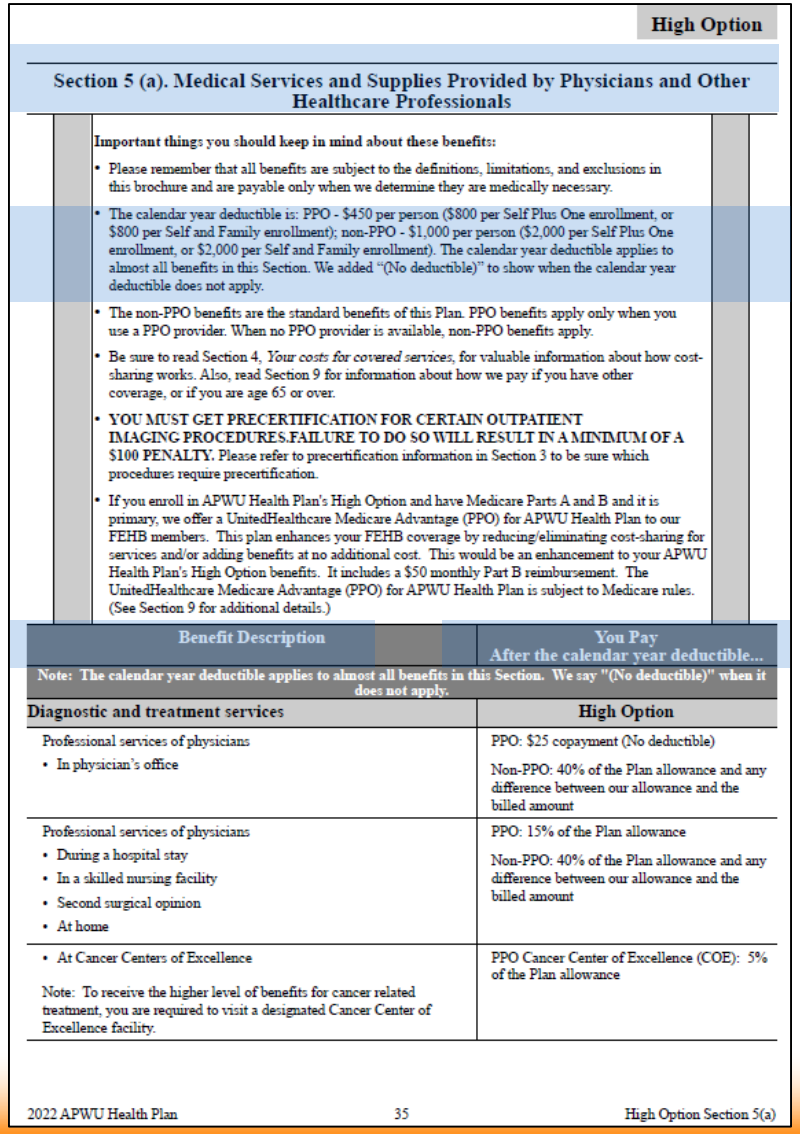
Special features

Medical Services and Supplies Section 5(a), (Pgs. 35-46)

Section Title

Section specific information

Left column provides Benefit Description



High Option

Section 5 (a). Medical Services and Supplies Provided by Physicians and Other Healthcare 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 - $450 per person ($800 per Self Plus One enrollment, or $800 per Self and Family enrollment); non-PPO - $1,000 per person ($2,000 per Self Plus One enrollment, or $2,000 per Self and Family enrollment). 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.
- 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 A $100 PENALTY.** Please refer to precertification information in Section 3 to be sure which procedures require precertification.
- If you enroll in APWU Health Plan's High Option and have Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. This would be an enhancement to your APWU Health Plan's High Option benefits. It includes a $50 monthly Part B reimbursement. The UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan is subject to Medicare rules. (See Section 9 for additional details.)

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	**High Option**
Professional services of physicians • In physician's office	PPO: $25 copayment (No deductible) Non-PPO: 40% 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: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
• At Cancer Centers of Excellence Note: To receive the higher level of benefits for cancer related treatment, you are required to visit a designated Cancer Center of Excellence facility.	PPO Cancer Center of Excellence (COE): 5% of the Plan allowance

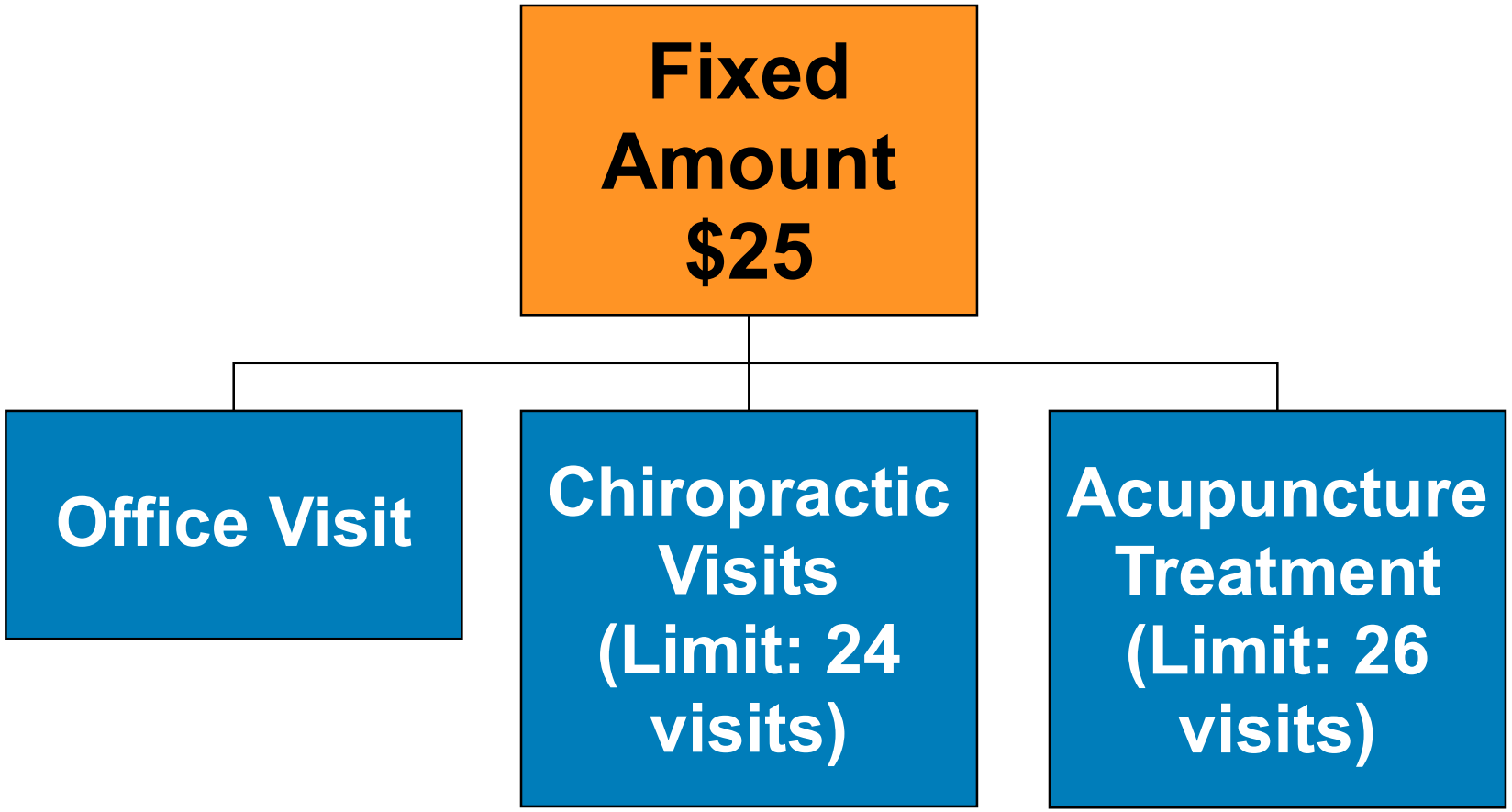
2022 APWU Health Plan 35 High Option Section 5(a)

Deductible

Does the deductible apply

Right column explains $ amount the member is responsible for (You Pay)

High Option Plan
In-network Office Visit Copay: $25



High Option Coinsurance

- 15% of allowance for in-network care
- 40% of allowance for out-of-network care
- 5% of allowance for treatment of cancer at Cancer Centers of Excellence
- 30% of covered routine dental services

TeleHealth Services (Pg. 36)

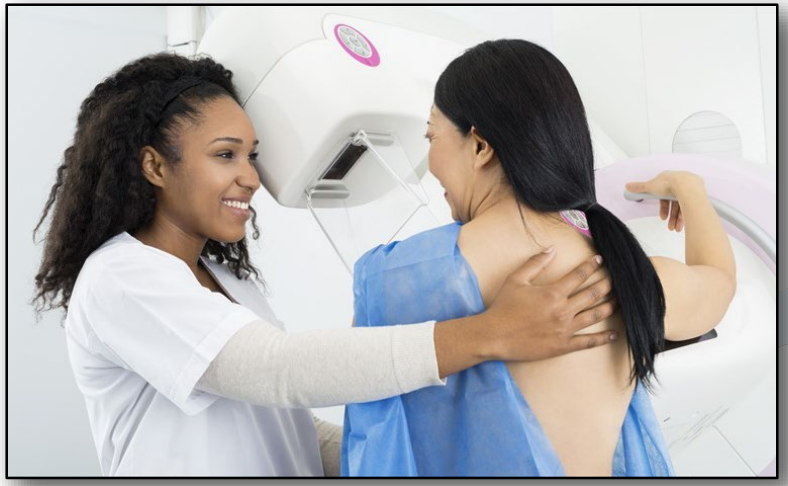
- Allows a patient to see and talk to a physician from a computer, tablet or compatible mobile device
- A doctor can:
  - Speak to you about minor medical concerns
  - Provide a diagnosis
  - Transmit a prescription to your local network pharmacy
- American Well: $15 copay
- In-network (PPO): $25 copay
- No out-of-network benefit

Labs, X-rays and Diagnostic Tests (Pg. 36)

- Diagnostic tests are performed to confirm a medical condition, based on symptoms or suspicions; this is not routine or screening
- Benefit:
  - **PPO:** 15% coinsurance
  - **Non-PPO:** 40% coinsurance and can be billed the difference between allowance and charges
  - Covered lab services performed at Quest or LabCorp: no out-of-pocket expense
- CT/MRI/PET – Require precertification
- **Genetic screening not covered**

Preventive Care (Pgs. 37-38)

- Routine screenings are procedures performed to help keep a member healthy and identify any conditions that may go unnoticed.
- Examples: Immunizations, Colonoscopy, Mammogram, PSA Test and PAP Test





Preventive Care (Pgs. 37-38)

- Annual gynecological visit
- Well-child care
- Immunizations recommended by CDC for adults and American Academy of Pediatrics for children routine screenings
- See pages 37-38 for comprehensive list of covered services
- Benefit:
  - **PPO:** Covered at 100%
  - **Non-PPO:** 40% coinsurance and can be billed the difference between allowance and charges

Scenario – High Option Preventive Care

- **Member goes for routine colonoscopy**
- **Member uses in-network providers**
- **Diagnosis on claim is routine**
- **Claims include surgery; labs; anesthesiologist**

- **All three claims are paid at 100%**

Scenario – High Option Preventive Care

- **Member goes for routine colonoscopy**
- **Member uses in-network providers**
- **Diagnosis on surgery and anesthesiologist claim is routine**
- **Diagnosis on in-network lab claim is non-routine (i.e. bleeding)**

- **Surgery and anesthesia claims are paid at 100%**
- **Lab claim will pay at 85%; member will be billed for 15% of the Plan allowance**

Maternity (Pg. 39)

- Complete maternity care covered at 100% for in-network covered services:
  - Prenatal care, delivery, postnatal care
  - Lab services related to covered, in-network maternity care
  - Breastfeeding support, supplies, equipment rental, and counseling for each birth
- **Genetic screening not covered**

Family Planning (Pg. 40)

Family Planning	High Option
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*, page 69.	PPO: Nothing (No deductible) Non-PPO: 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))	PPO: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic testing and counseling*	*All charges*

Infertility Services (Pg. 40)

Infertility services	High Option
• Diagnosis and treatment of infertility, except as shown in *Not covered* Limited benefits: We pay a maximum of $2,500 for medical and $2,500 for prescription drugs each calendar year per person to diagnose and treat infertility. See Section 5(f) for prescription drugs.	PPO: 15% of the Plan allowance and all charges after we pay $2,500 in a calendar year Non-PPO: 40% of the Plan allowance and all charges after we pay $2,500 in a calendar year
Not covered: • *Infertility services after voluntary sterilization* • *Assisted reproductive technology (ART) procedures, such as:* - *Artificial insemination (all procedures) (AI)* - *In vitro fertilization (IVF)* - *Embryo transfer and gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* - *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*

Physical/Occupational/Speech Therapies (Pgs. 41-42)

- Benefits are limited to a combined outpatient visit limit of 60 for physical, occupational and speech therapy
  - **PPO:** Deductible, then 15% coinsurance
  - **Non-PPO:** Deductible, then 40% coinsurance and can be billed the difference between allowance and charges
- Services must be ordered by a physician
- **Preauthorization is required for Speech Therapy only**

Applied Behavioral Analysis (ABA) (Pg. 42)

- Outpatient Applied Behavioral Analysis (ABA) services for the treatment of Autism Spectrum Disorder:
  - In-network benefit only; deductible, then 15% coinsurance
  - Preauthorization required by Cigna Behavioral Health for High Option
  - Must be provided under the supervision of a Board Certified Behavior Analyst
    - Must be contracted with Cigna Behavioral Health
    - Review of ABA services is based on an intensive care management model that monitors treatment plans, objectives and progress milestones

Hearing and Vision Services (Pgs. 42-43)

- One exam and testing every 2 years for hearing aids
- Internal ocular lenses and/or 1st contact lenses to correct impairment caused by an accident or illness

Routine Foot Care (Pg. 43)

- Routine foot care services are covered only when patient is receiving active treatment for a metabolic or peripheral vascular disease such as Diabetes or Peripheral Neuropathy
  - Trimming of lesions
  - Trimming of nails



Orthopedic and Prosthetic Devices (Pgs. 43-44)

- Not covered:
  - Orthopedic and corrective shoes
  - Arch supports
  - Foot/shoe orthotics
  - Heel pads and heel cups

Durable Medical Equipment (Pgs. 44-45)

- Preauthorization is required
- See page 45 of brochure for list of excluded items
- We limit the Plan allowance to an amount no greater than the purchase price

Home Health Services (Pg. 45)

- Skilled Nursing Care (RN, LPN, LVN)
  - 25 visits per calendar year
  - Maximum 2 hours per day, paid at PPO allowable at:
    - 15% coinsurance PPO
    - 40% coinsurance non-PPO
- Preauthorization required

Chiropractic and Acupuncture (Pg. 46)

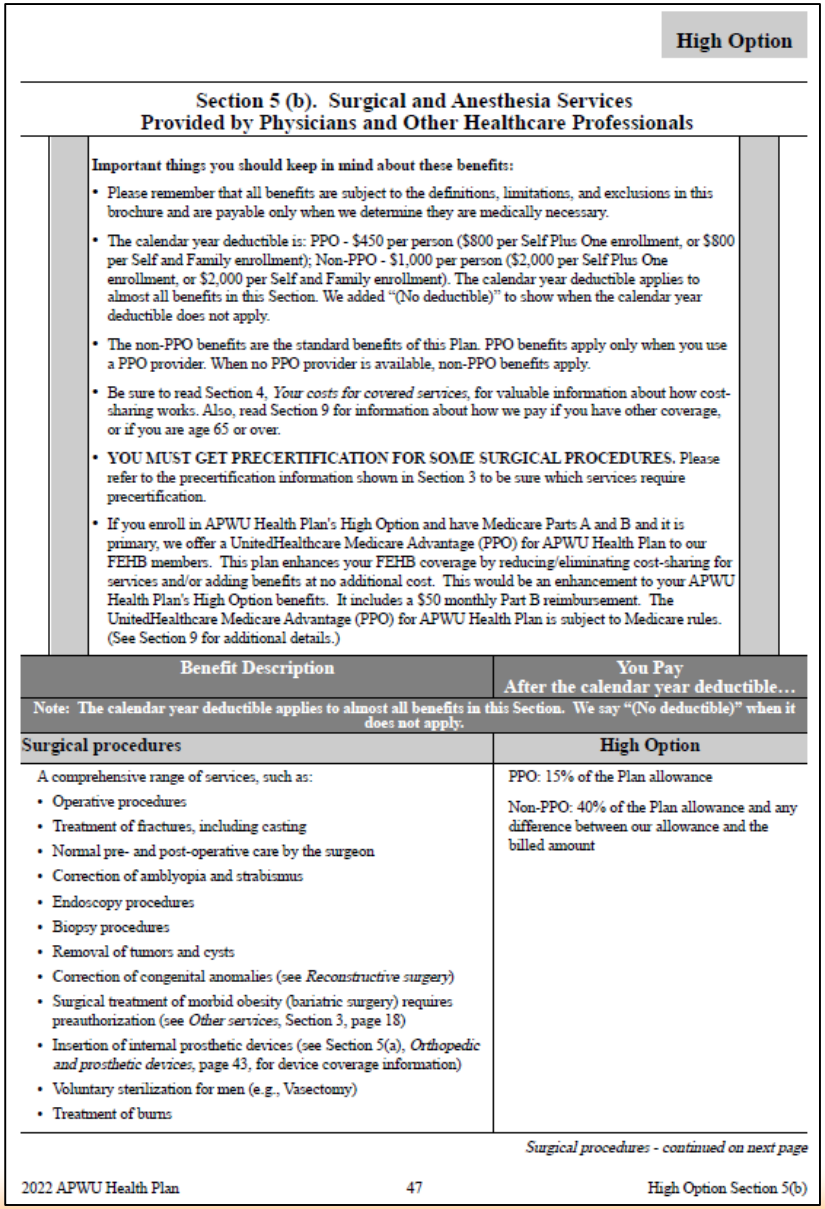
- Chiro treatment is limited to 24 visits and/or manipulations per year
  - Massage therapy and Maintenance therapy is not covered
- Acupuncture limited to 26 visits per year, covered when performed by a doctor of medicine or osteopathy or licensed acupuncturist
- Benefit:
  - **PPO:** $25 copay
  - **Non-PPO:** Deductible, then 40% coinsurance and can be billed the difference between allowance and charges

Educational Classes and Programs (Pg. 46)

- We encourage you to enroll in a Tobacco Cessation Program by contacting Cigna/CareAllies
  - E-cigarette users are eligible for enrollment in smoking cessation programs
  - Telephonic counseling sessions with Cigna/CareAllies
  - Group therapy
  - Educational sessions with a physician
- Diabetes self-management training services

Surgical and Anesthesia Services Section 5(b), (Pgs. 47-54)

- PPO vs. Non-PPO
- Surgical procedures
- Oral Surgery
- Organ and Tissue Transplants
- Anesthesia



High Option

Section 5 (b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare 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 - $450 per person ($800 per Self Plus One enrollment, or $800 per Self and Family enrollment); Non-PPO - $1,000 per person ($2,000 per Self Plus One enrollment, or $2,000 per Self and Family enrollment). 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.
- 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 SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.
- If you enroll in APWU Health Plan's High Option and have Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. This would be an enhancement to your APWU Health Plan's High Option benefits. It includes a $50 monthly Part B reimbursement. The UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan is subject to Medicare rules. (See Section 9 for additional details.)

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	**High Option**
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, page 18) • Insertion of internal prosthetic devices (see Section 5(a), *Orthopedic and prosthetic devices*, page 43, for device coverage information) • Voluntary sterilization for men (e.g., Vasectomy) • Treatment of burns	PPO: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount

Surgical procedures - continued on next page

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

Surgical Procedures (Pgs. 47-54)

- Precertification required for some surgical procedures. Refer to Section 3 of the brochure
- Not covered:

You Pay After the calendar year deductible…
High Option

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* • *Routine treatment of conditions of the foot (see Foot care, Section 5 (a), page 43)*	*All charges*

Oral Surgery (Pgs. 50-51)

- We suggest calling us at 800-222-2798 to determine whether a procedure is covered.



Organ and Tissue Transplants (Pgs. 51-54)

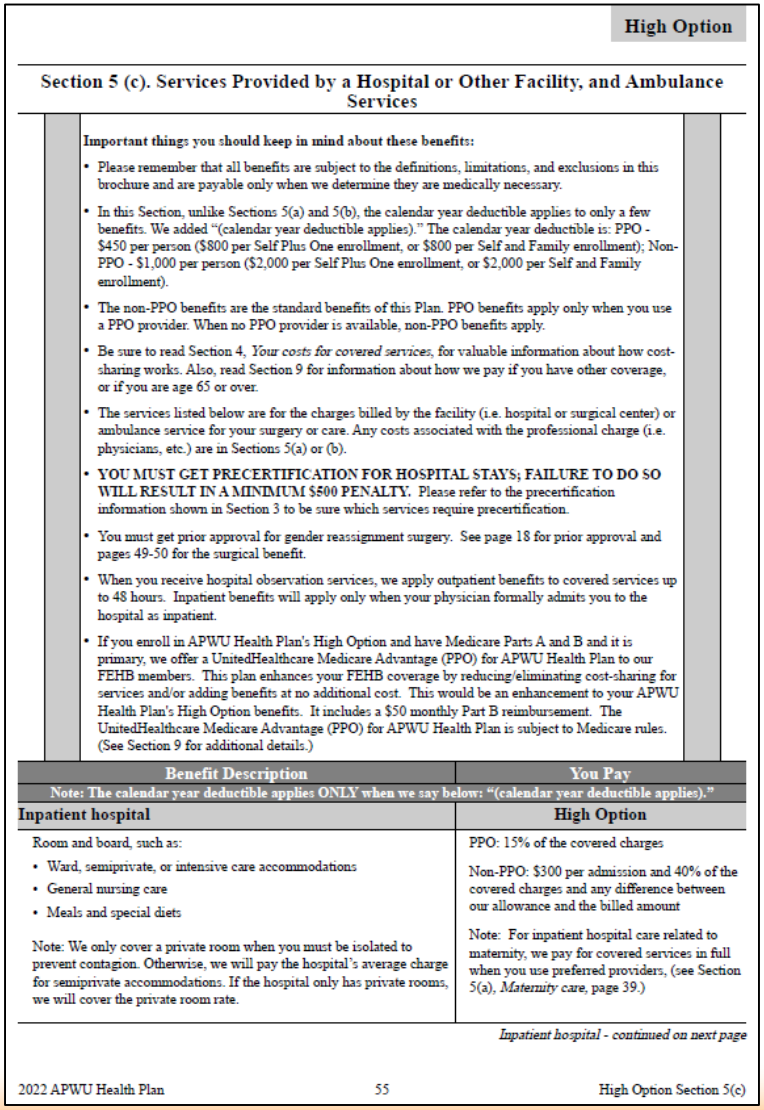
- Complete list of transplants begins on page 51
- All transplants are subject to prior authorization; subject to medical necessity and experimental/investigational review
- Out-of-network services have benefit limitations
- Transplant Network
  - Plan-specific organ/tissue transplant facilities
    - If a Plan-designated transplant facility chosen, travel and lodging costs may be pre-approved
  - Prior to an initial evaluation, physician or patient must contact Cigna to speak with a Transplant Case Manager

Anesthesia (Pg. 54)

- 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.

Services at Hospital/Facility and Ambulance Services Section 5(c), (Pgs. 55-58)

- Inpatient hospital
- Cancer Centers of Excellence
- Outpatient hospital or ambulatory surgical center
- Extended care benefits/ Skilled nursing care facility benefits
- Hospice care
- End of life care
- Ambulance



High Option

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 - $450 per person ($800 per Self Plus One enrollment, or $800 per Self and Family enrollment); Non-PPO - $1,000 per person ($2,000 per Self Plus One enrollment, or $2,000 per Self and Family enrollment).
- 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.
- The services 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.
- You must get prior approval for gender reassignment surgery. See page 18 for prior approval and pages 49-50 for the surgical benefit.
- When you receive hospital observation services, we apply outpatient benefits to covered services up to 48 hours. Inpatient benefits will apply only when your physician formally admits you to the hospital as inpatient.
- If you enroll in APWU Health Plan's High Option and have Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. This would be an enhancement to your APWU Health Plan's High Option benefits. It includes a $50 monthly Part B reimbursement. The UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan is subject to Medicare rules. (See Section 9 for additional details.)

Benefit Description	You Pay
Note: The calendar year deductible applies ONLY when we say below: "(calendar year deductible applies)."	
Inpatient hospital	**High Option**
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.	PPO: 15% of the covered charges Non-PPO: $300 per admission and 40% 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*, page 39.)

Inpatient hospital - continued on next page

Inpatient Hospital (Pgs. 55-56)

- Subject to pre-authorization (See Section 3)
  - Call Cigna/CareAllies
- $500 late pre-authorization penalty
  - **Emergency admissions:** 2 business days from admission date
  - **Scheduled admissions:** 2 business days prior to scheduled admission
- Not subject to deductible
- 15% of the covered charges for PPO facility
- $300 per admission fee and 40% of the covered charges if confined in a Non-PPO facility

Outpatient Hospital or Ambulatory Surgical Center (Pg. 57)

- Subject to deductible
- Coinsurance applies based on provider network affiliation

Hospital Observation

- Is limited to 48 hours
- Outpatient benefits apply



Skilled Nursing Facility (SNF) Benefits (Pgs. 57-58)

- Up to 30 days after approved inpatient confinement
- Medical necessity/prior authorization required



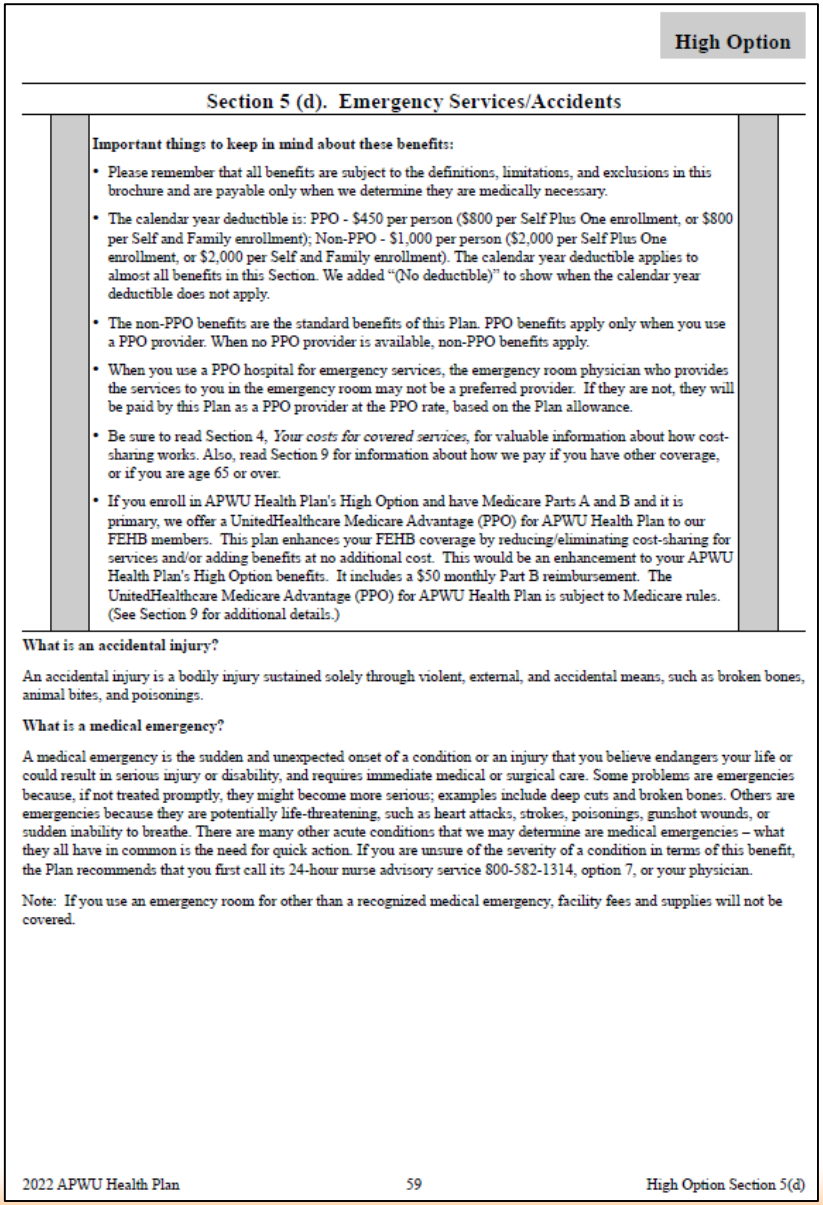
Hospice Care (Pg. 58)

- Up to $15,000 lifetime maximum including:
  - Inpatient hospice
  - Outpatient hospice
  - Advanced care planning
- $200 annual bereavement benefit per family



Emergency Services/Accidents Section 5(d), (Pgs. 59-61)

- Accidental injury
- Medical emergency
- Ambulance



High Option

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 - $450 per person ($800 per Self Plus One enrollment, or $800 per Self and Family enrollment); Non-PPO - $1,000 per person ($2,000 per Self Plus One enrollment, or $2,000 per Self and Family enrollment). 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 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.
- If you enroll in APWU Health Plan's High Option and have Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. This would be an enhancement to your APWU Health Plan's High Option benefits. It includes a $50 monthly Part B reimbursement. The UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan is subject to Medicare rules. (See Section 9 for additional details.)

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 800-582-1314, option 7, 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.

Accidental Injury (Pg. 60)

- "Accident" is defined as resulting from a violent, external force
- Outpatient services rendered within **72** hours of an accident
  - No out-of-pocket expense or cost-sharing (no deductible, coinsurance, copayment) in or out-of-network

Medical Emergency (Pg. 60)

- Sudden onset of symptoms that you believe endangers your life or could result in serious disability if not treated promptly
- Treatment at an Urgent Care Center
  - Cost share = $30 copayment* in-network
  - Cost share = 40% coinsurance out-of-network
    - Out-of-network care could result in additional patient liability if there is a difference in the fee for the service and the Plan allowance for it
- Treatment at other than an Urgent Care Center - in or out-of-network
  - Cost share = Deductible, 15% coinsurance

***High tech imaging (CT, MRI, PET, MRA) at an Urgent Care Center is subject to deductible and coinsurance and requires precertification.**

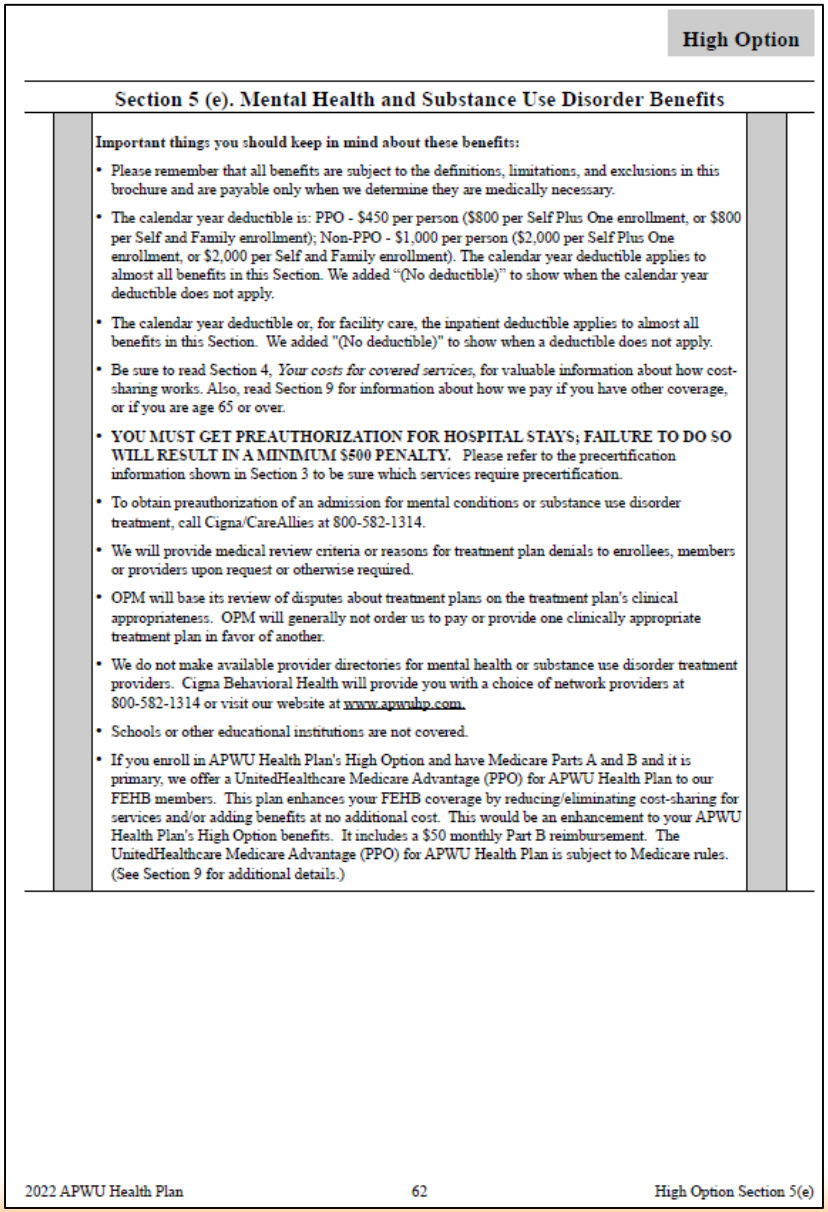
Ambulance (Pgs. 60-61)

- Professional ambulance service within 24 hours of a medical emergency
- Air ambulance* transport to nearest facility where necessary treatment is available
- Ambulance services used for routine transport are not covered
- Out-of-network care could result in additional patient liability if there is a difference in the fee for the service and the Plan allowance for the service

***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.

Mental Health and Substance Use Disorder Section 5(e), (Pgs. 62-65)

- Cigna Behavioral Health
  - 1-800-582-1314
- Professional services
  - Outpatient in a physician's office
  - Inpatient
- Diagnostics
- Inpatient hospital or other covered facility – not subject to deductible
- Outpatient hospital or other covered facility



High Option

Section 5 (e). Mental Health and Substance Use Disorder 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.
- The calendar year deductible is: PPO - $450 per person ($800 per Self Plus One enrollment, or $800 per Self and Family enrollment); Non-PPO - $1,000 per person ($2,000 per Self Plus One enrollment, or $2,000 per Self and Family enrollment). 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 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 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.
- To obtain preauthorization of an admission for mental conditions or substance use disorder treatment, call Cigna/CareAllies at 800-582-1314.
- 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 use disorder treatment providers. Cigna Behavioral Health will provide you with a choice of network providers at 800-582-1314 or visit our website at www.apwuhp.com.
- Schools or other educational institutions are not covered.
- If you enroll in APWU Health Plan's High Option and have Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. This would be an enhancement to your APWU Health Plan's High Option benefits. It includes a $50 monthly Part B reimbursement. The UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan is subject to Medicare rules. (See Section 9 for additional details.)

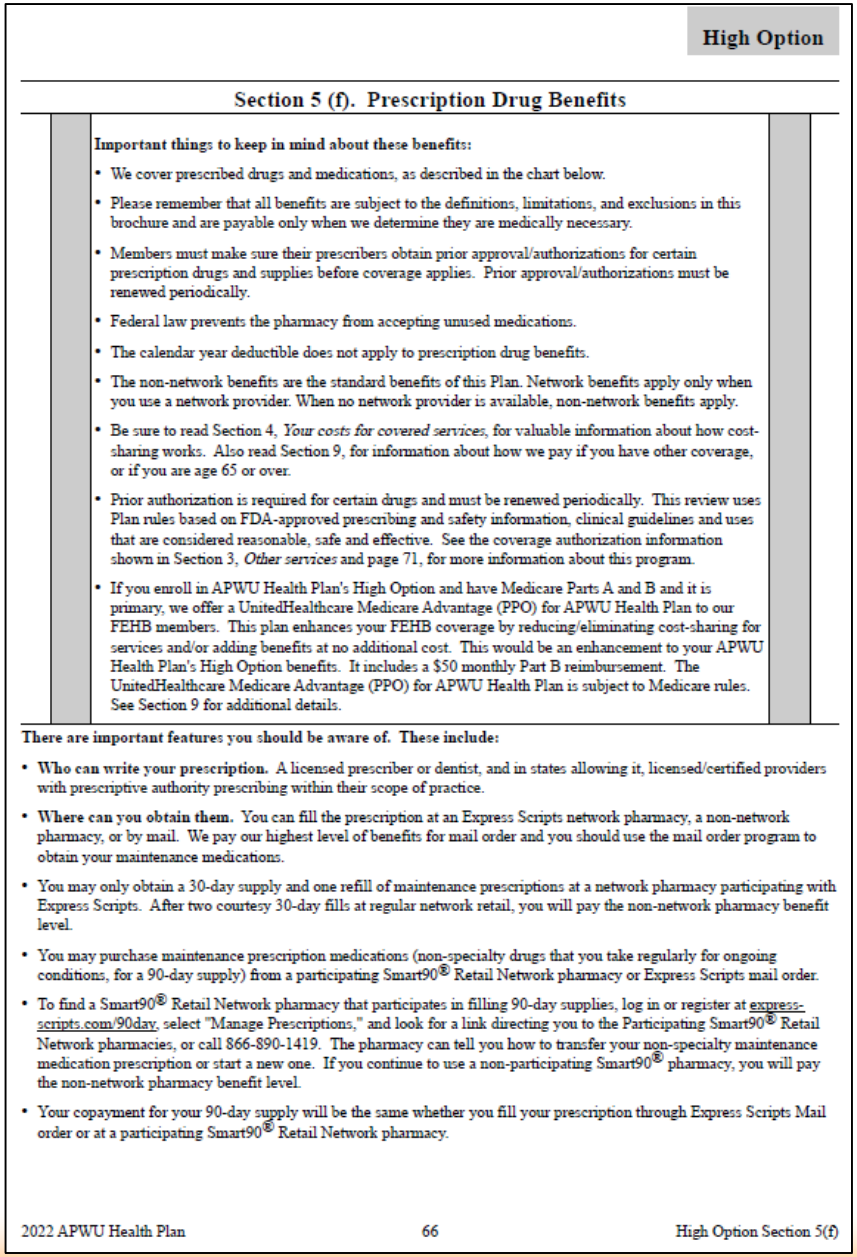
2022 APWU Health Plan 62 High Option Section 5(e)

Cigna Behavioral Health (Pgs. 62-64)

- Must obtain preauthorization for:
  - Inpatient Mental Health or Substance Misuse Disorder Hospital admissions
  - Inpatient treatment and Transcranial Magnetic Stimulation (TMS)
- To obtain preauthorization, call Cigna Behavioral Health
- $500 penalty for failure to obtain precertification
  - 2 business days prior to elective hospital admission
  - 2 business days after an emergency admission

Prescription Drugs Section 5(f), (Pgs. 66-72)

- Express Scripts
- Definitions
  - Preferred Formulary
  - Generic Drugs
- Dispensing Limitations
- Coverage Tiers
- Specialty Drugs
  - Definition
  - Coverage
- Contraceptives
- Step Therapy



High Option

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.
- Members must make sure their prescribers obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- The calendar year deductible does not apply to prescription drug benefits.
- The non-network benefits are the standard benefits of this Plan. Network benefits apply only when you use a network provider. When no network provider is available, non-network 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 71, for more information about this program.
- If you enroll in APWU Health Plan's High Option and have Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan to our FEHB members. This plan enhances your FEHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. This would be an enhancement to your APWU Health Plan's High Option benefits. It includes a $50 monthly Part B reimbursement. The UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan is subject to Medicare rules. See Section 9 for additional details.

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

- **Who can write your prescription.** A licensed prescriber or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice.
- **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.
- You may only obtain a 30-day supply and one refill of maintenance prescriptions at a network pharmacy participating with Express Scripts. After two courtesy 30-day fills at regular network retail, you will pay the non-network pharmacy benefit level.
- You may purchase maintenance prescription medications (non-specialty drugs that you take regularly for ongoing conditions, for a 90-day supply) from a participating Smart90® Retail Network pharmacy or Express Scripts mail order.
- To find a Smart90® Retail Network pharmacy that participates in filling 90-day supplies, log in or register at express-scripts.com/90day, select "Manage Prescriptions," and look for a link directing you to the Participating Smart90® Retail Network pharmacies, or call 866-890-1419. The pharmacy can tell you how to transfer your non-specialty maintenance medication prescription or start a new one. If you continue to use a non-participating Smart90® pharmacy, you will pay the non-network pharmacy benefit level.
- Your copayment for your 90-day supply will be the same whether you fill your prescription through Express Scripts Mail order or at a participating Smart90® Retail Network pharmacy.

Prescription Drug Definitions (Pgs. 66-67)

- Express Scripts is our Network Pharmacy
  - For participating pharmacies, call Express Scripts or go to www.express-scripts.com
- National Preferred Formulary
  - List of medications selected based on clinical effectiveness and lower cost
- Brand Name Drugs – Preferred and Non-preferred
  - Protected by a patent and manufactured and sold only by the company holding the patent

(continued on next slide)

Prescription Drug Definitions (Pgs. 66-67)

- Generic Drugs
  - Chemical equivalent of a corresponding name brand drug, typically available at a lower cost
- To view list of drugs based on payment level, visit: www.apwuhp.com/high_option_pharmacy_program.php

Dispensing Limitations (Pgs. 67-68)

- Express Scripts Retail Pharmacy
  - Up to a 30-day supply plus one 30-day refill
    - After one 30-day refill, you must submit a new prescription to the mail order program, or submit a 90-day prescription to a retail Smart90 Pharmacy (CVS or Walgreens)
    - If not, we will pay the non-network pharmacy benefit
- Mail Order
  - Up to a 90-day supply of maintenance drugs, diabetic supplies and Insulin, syringes and needles for covered injectable medications, and oral contraceptives

Prescription Drug Tiers (Pg. 67)

	Type of Drug	Network Pharmacy (Retail)	Non- Network Pharmacy (Retail)	Network Mail Order/Retail Smart90
Tier 1	Generic Drugs	$10 copay for 30-day supply	50% coinsurance for 30-day supply	$20 copay for 90-day supply
Tier 2	Preferred Brand Drugs	25% coinsurance; $200 max for 30-day supply	50% coinsurance for 30-day supply	25% coinsurance; $300 max for 90-day supply
Tier 3	Non-Preferred Brand Drugs	45% coinsurance; $300 max for 30-day supply	50% coinsurance for 30-day supply	45% coinsurance; $500 max for 90-day supply

Patient Assurance Program (PAP) (Pg. 69)

- Provides fixed copays for certain insulins and non-insulin diabetes drugs to treat Diabetes
  - $25 for 30 days
  - $75 for 90 days

Participating Drugs on the National Preferred Formulary:

- FARXIGA®
- GLYXAMBI®
- HUMALOG®
- HUMALOG MIX®
- HUMULIN®
- JARDIANCE®
- LEVEMIR®
- LEVEMIR® FLEXTOUCH®
- LYUMJEV™
- OZEMPIC®
- RYBELSUS®
- SEMGLEE®
- SYNJARDY®
- SYNJARDY® XR
- TRIJARDY® XR
- TRULICITY®
- XIGDUO® XR

Diabetes Medications and Supplies (Pg. 69)

- $0 copay for generic drugs from Express Scripts by mail for the specific purpose of lowering blood sugar
- $0 copay for preferred formulary test strips and lancets from Express Scripts by mail

Specialty Drugs (Pg. 69)

- Specialty drugs administered at home, physicians office, or any other outpatient setting must be obtained through Accredo Specialty pharmacy
- Injectable, infused, oral or inhaled drugs that:
  - Require frequent dosing adjustments
  - Intensive patient training
  - Limited product availability
  - Specialized product handling

(continued on next slide)

Specialty Drugs (Pg. 69)

- Targeted conditions include:
  - Cystic Fibrosis
  - Gaucher disease
  - Growth hormone deficiency
  - Hepatitis C
  - Rheumatoid Arthritis

Specialty Drug Tiers (Pg. 69)

	Type of Drug	Network Pharmacy (Retail)	Non- Network Pharmacy (Retail)	Network Mail Order/Retail Smart90
Tier 4	Generic Drugs	25% coinsurance; $300 max for 30-day supply	50% coinsurance for 30-day supply	25% coinsurance; $150 max for 90-day supply
Tier 5	Preferred Brand Drugs	25% coinsurance; $600 max for 30-day supply	50% coinsurance for 30-day supply	25% coinsurance; $300 max for 90-day supply
Tier 6	Non-Preferred Brand Drugs	45% coinsurance; $1,000 max for 30-day supply	50% coinsurance for 30-day supply	45% coinsurance; $500 max for 90-day supply

Prescription Drugs
Section 5(f), (Pgs. 69-72)

- $0 out-of-pocket costs
  - Contraceptive Drugs – on the ESI Patient Protection and Affordable Care Act List
  - Prescription drugs to treat tobacco dependence (Mail Order)
  - OTC to treat tobacco dependence (Cigna/CareAllies only)
  - Naloxone and Narcan for prevention of opioid overdose related deaths
- Preventive Care Medications with a USPSTF recommendation of A or B when prescribed by a health care professional and filled at a network pharmacy. For current recommendations go to:

www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations

Prescription Drugs (Pg. 70)

- Prescription drugs with an over-the-counter (OTC) equivalent are not covered.



Step Therapy (Pg. 71)

- Ensures generic/brand alternative within a therapeutic category is the first-line treatment, before the use of a similar but more expensive drug
- See page 71 of brochure for more information on specific therapeutic categories

Dental Benefits
Section 5(g), (Pg. 73)

- Preventive care only
  - 2 visits, including fluoride treatments per year
  - 2 cleanings per year
  - 2 X-rays per year
- Other covered dental services
  - Restorative fillings
    - Does not include crowns or in-lay, on-lay restoration
  - Simple extractions
- Cost sharing: 30% of Plan allowance plus difference in provider's fee and the Plan allowance

Wellness and Other Special Features Section 5(h), (Pgs. 74-76)

- 24-hour Nurse Line
- Disease Management Program
- Healthy Pregnancies, Healthy Babies Program
- Special Programs
  - Weight Management
  - Tobacco Cessation
- Health Risk Assessment
  - Cigna Plus Dental Savings

Section 5 (h). Wellness and Other 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 alternative 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, pages 131-133).
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 800-582-1314 and reach registered nurses to discuss an existing medical concern or to receive information about numerous healthcare issues.
Services for deaf and hearing impaired	We offer a toll-free TDD line for customer service. The number is 800-622-2511. TDD equipment is required.
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. As an example, members with cardiac conditions can participate in this program. 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 800-582-1314.
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.
Weight Management Program	$0 copay for in-network office visit to a registered Dietician/Nutritionist
Healthy Pregnancies, Healthy Babies Program	Enroll in this program and you take the first step toward giving your baby a healthy start in life. Enroll by calling CareAllies at 1-800-582-1314, prompt 8.

24-hour Nurse Line (Pg. 74)

- Speak to a registered nurse by calling Cigna/CareAllies to discuss medical concerns or to receive information about health issues
  - Voluntary and confidential



Healthy Pregnancies, Healthy Babies Program (Pg. 74)

- Dedicated nursing staff is available to answer questions and educate pregnant women
- Enroll by calling Cigna/CareAllies, prompt 8



Special Programs (Pg. 75)

- **Lifestyle Programs** – Wellness coaches will help you develop a personalized plan for tobacco cessation and weight management
  - Call Cigna/CareAllies
- **Healthy Rewards** – MyCareAllies provides non-FEHB savings on gym memberships, tobacco cessation, weight reduction programs, and more
  - Visit www.apwuhp.com or call Cigna/CareAllies

Health Risk Assessment (Pg. 75)

- Complete online Health Risk Assessment to become eligible for the CignaPlus Savings Discount Dental Program*
  - Self Only enrollment, complete online HRA and Plan will pay the premium for Self Only CignaPlus Dental Program
  - Self Plus One and Self and Family enrollment, at least 2 family members must complete the HRA and the Plan will pay the premium for Self and Family CignaPlus Discount Dental Program

* **CignaPlus Savings Discount Dental Program:** Discount dental program providing APWU Health Plan members access to discounted fees with participating dental providers **(for non-routine services not otherwise covered by the Plan)**

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Questions:
2022 High Option Benefits



How much is the in-network office visit copay?

A. $30
✓ B. $25
C. $20
D. No copay

(Answer can be found in the 2022 Brochure pg. 35)

How much is the in-network Deductible, if applicable?

- ✔ A. Self Only: $450; Self Plus One and Self and Family: $800
- B. Self Only: $250; Self Plus One and Self and Family: $500
- C. $0 Deductible
- D. Self Only: $500; Self Plus One and Self and Family: $1,000

(Answer can be found in the 2022 Brochure pg. 25)

What is the limit for infertility drugs?

A. $10,000

✓ B. $2,500

C. $5,000

D. No coverage for infertility drugs

(Answer can be found in the 2022 Brochure pgs. 15 & 40)

What will not accumulate toward your Catastrophic out-of-pocket expenses?

A. $500 pre-cert penalty
B. $300 Non-PPO hospital admission fee
C. Expenses in excess of benefit limitations
✓ D. All of the above

(Answer can be found in the 2022 Brochure pg. 29)

What is the Catastrophic out-of-pocket maximum (in-network)?

A. In-network: Self Only; $6,500; Self Plus One and Self and Family: $13,000
Out-of-network: Self Only $12,000; Self Plus One and Self and Family: $24,000

B. In-network: Self Only; $5,500; Self Plus One and Self and Family: $6,500
Out-of-network: Self Only, Self Plus One and Self and Family: $10,000

C. In-network: Self Only; $5,500; Self Plus One and Self and Family: $5,500
Out-of-network: Self Only, Self Plus One and Self and Family: $5,500

D. $10,000 per membership

(Answer can be found in the 2022 Brochure pg. 28)

Which type of drugs no longer need to be obtained through Network Mail Order?

A. Hypercholesterolemia drugs
B. Non-insulin drugs
✓ C. Preventive migraine drugs
D. Maintenance drugs

(Answer can be found in the 2022 Brochure pg.15)

What is the benefit for Virtual Visits via Telehealth?

A. No benefit; in-network only

B. 30% coinsurance

✓ C. $15 copay for American Well;
$25 copay PPO: No out-of-network benefit

D. $20 copay

(Answer can be found in the 2022 Brochure pg. 36)

Psychological and neuropsychological testing require pre-certification.

A. True

✔ B. False

(Answer can be found in the 2022 Brochure pg. 15)

What is the limit on Home Health Skilled Nursing visits?

A. 90%

B. 15%

✔ C. 2 hours per day, 25 visits

D. No limit

(Answer can be found in the 2022 Brochure pg. 45)

Is genetic screening a covered benefit?

A. Yes

✔ B. No

(Answer can be found in the 2022 Brochure pg. 40)

What is covered under Family Planning?

- ✔ A. Contraceptives, voluntary sterilization
- B. Reversal of sterilization
- C. Diapers and strollers
- D. Gift card to Babies ‘R’ Us

(Answer can be found in the 2022 Brochure pg. 40)

What is covered under the $2,500 maximum medical infertility benefit?

A. Artificial insemination
B. In Vitro Fertilization (IVF)
C. Infertility services after voluntary sterilization
✓ D. Diagnosis and treatment of infertility

(Answer can be found in the 2022 Brochure pg. 40)

What is the copay for a PPO urgent care visit?

- ✔ A. $30
- B. $40
- C. $0
- D. 40%

(Answer can be found in the 2022 Brochure pg. 60)

Does Speech Therapy (ST) require pre-authorization?

- ✔ A. Yes
- B. No

(Answer can be found in the 2022 Brochure pg. 42)

What is the benefit maximum for PT/OT and ST combined?

A. 30 visits

✓ B. 60 visits

C. 40 visits

D. 90 visits

(Answer can be found in the 2022 Brochure pgs. 41 & 42)

What is the maximum limit for acupuncture visits?

A. 12 visits
B. 60 visits
✓ C. 26 visits
D. 90 visits

(Answer can be found in the 2022 Brochure pg. 46)

What statement is true regarding the benefit for Residential Treatment Facility?

A. No authorization needed

✓ B. Pre-auth required through Cigna Behavioral Health; covered both in-network and out-of-network

C. Pre-auth required through Cigna Behavioral Health; in-network only; deductible then 10% coinsurance

D. Only payable for the enrollee

(Answer can be found in the 2022 Brochure pg. 64)

Orthotics are covered under routine foot care for Postal Employees only.

A. True

✔ B. False

(Answer can be found in the 2022 Brochure pg. 44)

What is the annual visit limit for chiropractic visits and/or manipulations?

A. 12

✓ B. 24

C. 60

D. There is no visit/manipulation limit

(Answer can be found in the 2022 Brochure pg. 46)

Pre-authorization is required for medical inpatient confinement, but not if treatment is for behavioral health.

A. True

✔ B. False

(Answer can be found in the 2022 Brochure pg. 18)

After 1 refill at the in-network retail pharmacy, what are your options?

A. Move your prescription to CVS or Walgreens and get a 90-day supply at retail
B. Move your prescription to Mail Order and get a 90-day supply
C. Continue at your current retail pharmacy (not CVS or Walgreens) where benefits will revert to out-of-network; you will be responsible for 50% of the cost of the drug
✓ D. All of the above

(Answer can be found in the 2022 Brochure pg. 68)

Skilled Nursing Facility is covered for a maximum of 30 days following transfer from an acute care hospital. Prior authorization is required.

✔ A. True

B. False

(Answer can be found in the 2022 Brochure pgs. 19 & 57)

What are the fixed copays for the defined insulin and non insulin blood sugar reducing drugs covered under the Patient Assurance Program (PAP)?

- ✔ A. $25 for 30 days; $75 for 90 days
- B. $25 for 30 days; $50 for 90 days
- C. $25 for 30 days; $25 for 90 days
- D. None

(Answer can be found in the 2022 Brochure pg. 69)

What is the incentive if you complete the Health Risk Assessment?

A. Additional PCA dollars will be put into your PCA account

✓ B. Members will have access to the CignaPlus Dental Discount Program

C. You will receive a free gym membership

D. None of the above

(Answer can be found in the 2022 Brochure pg. 75)

If you go to an urgent care center and have a high-tech radiology imaging procedure (CT, MRI, MRA or PET scan), do you need prior authorization?

- ✔ A. Yes
- B. No

(Answer can be found in the 2022 Brochure pg. 60)

Are the high-tech radiology imaging procedures (CT, MRI, MRA or PET scan) covered under the $30 copayment for urgent care centers?

A. Yes

✔ B. No

(Answer can be found in the 2022 Brochure pg. 60)

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2022 Consumer Driven Option Benefits – Section 5



Consumer Driven Option Benefits
Section 5 Overview, (Pg. 77)

- In-Network Preventive Care
- Personal Care Account (PCA)
- Traditional Health Coverage Overview
- 5(a) Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals
- 5(b) Surgical and Anesthesia Services Provided by Physicians and Other Healthcare Professionals
- 5(c) Services Provided by a Hospital or Other Facility, and Ambulance Services
- 5(d) Emergency Services/Accidents

Consumer Driven Option Benefits
Section 5 Overview, (Pg. 78)

- 5(e) Mental Health and Substance Use Disorder Benefits
- 5(f) Prescription Drug Benefits
- 5(g) Dental Benefits
- 5(h) Wellness and Other Special Features
- 5(i) Health Education Resources and Account Management Tools
- Summary of Benefits for the CDHP 2022

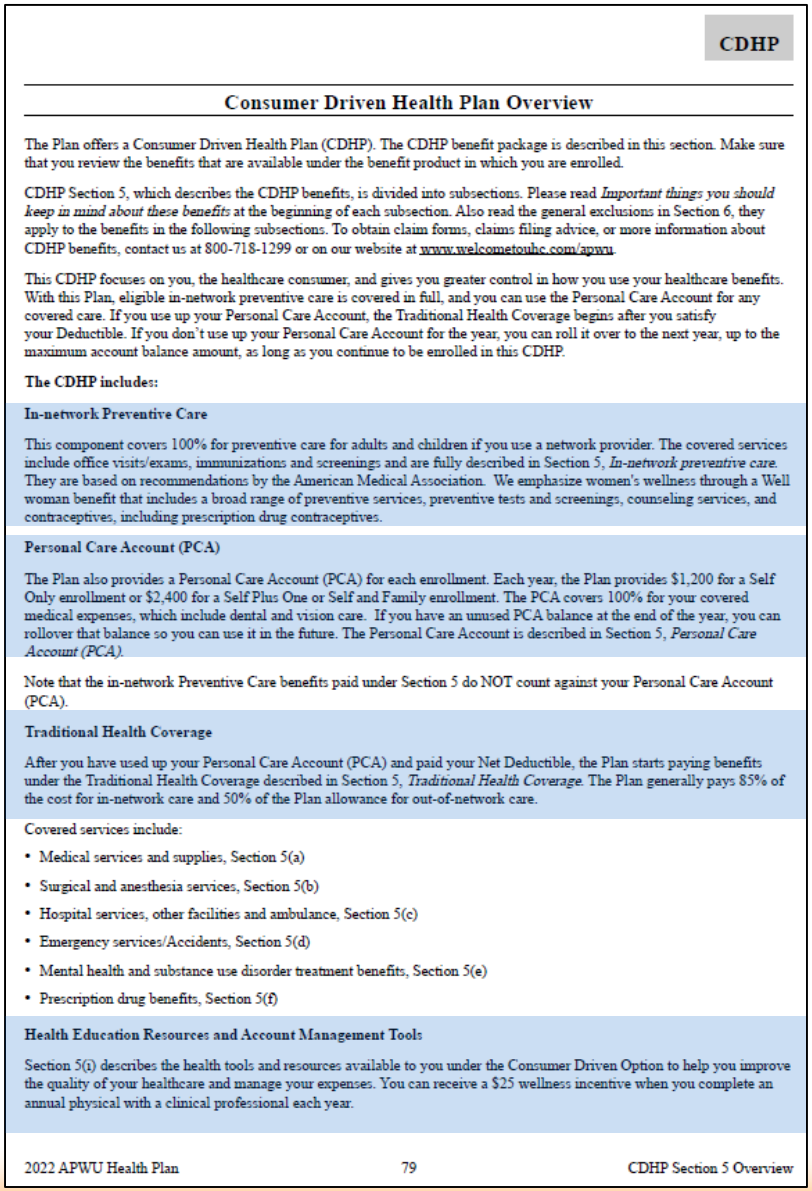
Consumer Driven Health Plan Overview (Pg. 79)

In-network Preventive Care

Personal Care Account

Traditional Health Coverage

Health Education Resources



CDHP

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 800-718-1299 or on our website at www.welcometouhc.com/apwu.

This CDHP focuses on you, the healthcare consumer, and gives you greater control in how you use your healthcare 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 account 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, 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 Plus One or 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 Net 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 50% 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 use disorder treatment 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 healthcare and manage your expenses. You can receive a $25 wellness incentive when you complete an annual physical with a clinical professional each year.

2022 APWU Health Plan 79 CDHP Section 5 Overview

In-network Preventive Care
Section 5, (Pgs. 80-82)

- APWU Health Plan is in compliance with the Affordable Care Act's preventive care guidelines
- When using in-network, participating providers:
  - Covered routine preventive care for adults and children is paid at 100%
  - Periodic routine exams, lab, testing, immunizations
    - No reduction to your PCA
    - No deductible
    - No coinsurance

Preventive Care

- Routine screenings are procedures performed to help keep a member healthy and identify any conditions that may go unnoticed.



In-network Preventive Care – Adult (Pgs. 80-81)

$25 PCA incentive for annual routine physical

Adult Care

- One routine physical
- Adult immunizations recommended by the CDC
- Routine screenings recommended by USPSTF (A or B)
- PSA, Urinalysis, EKG, CXR, Hemoglobin, A1C, Colorectal screening, mammograms
- Well Woman Care, i.e. Pap

In-network Preventive Care – Children (Pgs. 81-82)

Care for Children

- Well-Child visits, exams and other preventive services (Bright Futures and USPSTF)
- Childhood immunizations recommended by the CDC

Note: *Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member coinsurance, and deductible.*

Scenario – CDO Preventive Care

- **Member goes for routine colonoscopy**
- **Member uses in-network providers**
- **Diagnosis on claim is routine**
- **Claims include surgery; labs; anesthesiologist**

- **All three claims are paid at 100%**

Scenario – CDO Preventive Care

- **Member goes for routine colonoscopy**
- **Member uses in-network providers**
- **Diagnosis on surgery and anesthesiologist claim is routine**
- **Diagnosis on in-network lab claim is non-routine (i.e. bleeding)**

- **Surgery and anesthesia claims are paid at 100%**
- **Lab claim will pay at 85%; member will be billed for 15% of the Plan allowance, unless there are funds available in the PCA to cover the coinsurance costs**

Personal Care Account (PCA)
Section 5, (Pgs. 83-85)

- APWU Health Plan funds your PCA each year
  - Self Only: $1,200
  - Self Plus One:
  - Self and Family: $2,400
- PCA is used to reimburse first dollars incurred
  - Coverage for in-network ***and*** out-of-network providers
- A portion of PCA dollars can be used for services not otherwise covered by the CDHP ("Extra PCA Expenses") - examples: Dental and/or Vision
  - Single Enrollment: $400
  - Family Enrollment: $800

Controlling PCA (Pg. 83)

- If a member has an FSA and doesn't want to use PCA funds, they can turn off PCA; must update annually
- Member can now use FSA for healthcare expenses
  - Member should instruct provider to not submit claim to UHC
  - Member may have to pay claim up front
- Except for Rx



PCA Expense Example (Pg. 84)

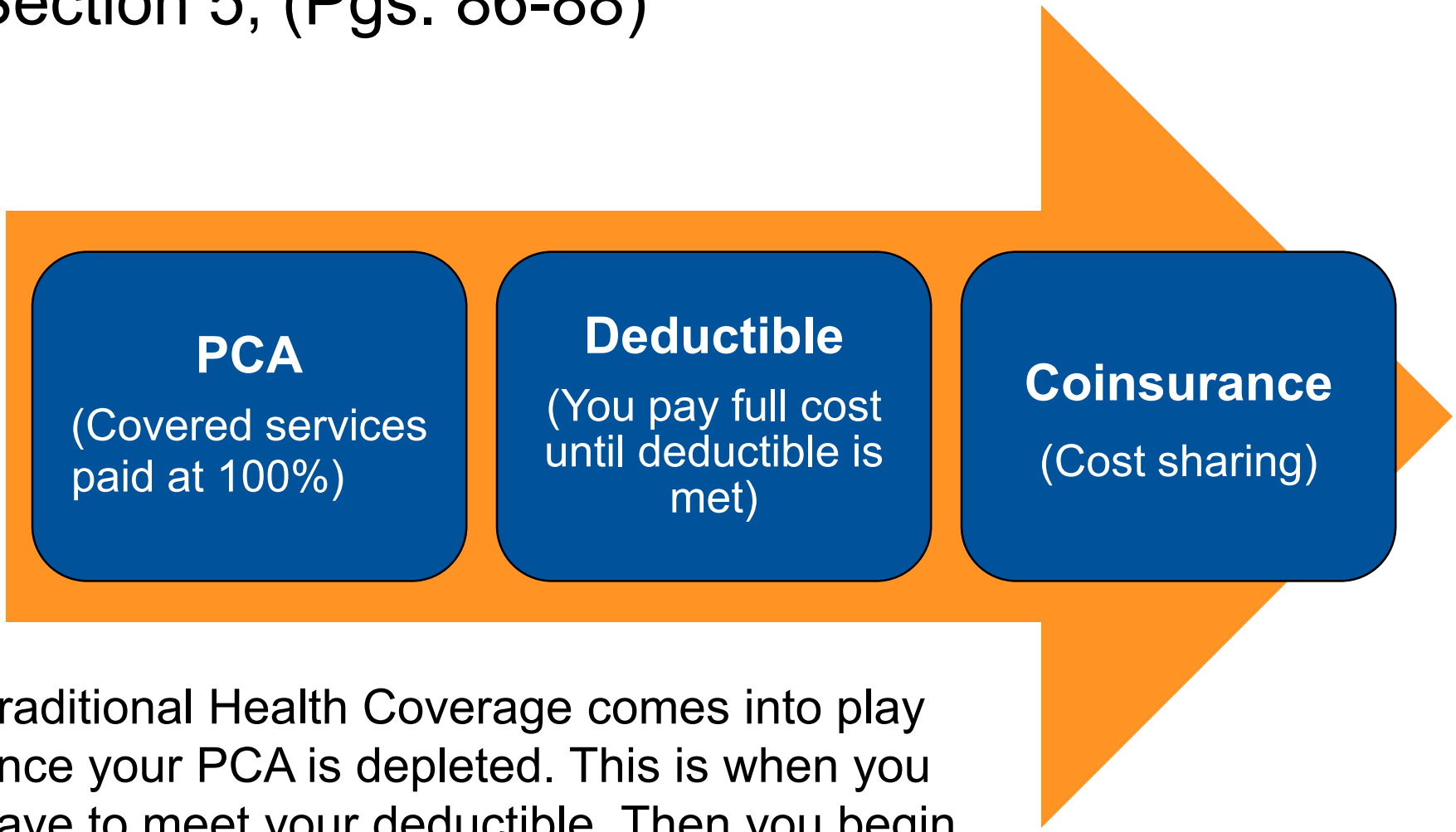
- If you are ill and you go to an in-network doctor, the doctor will submit your claim and the cost of the visit will be deducted automatically from your PCA. You pay nothing for eligible expenses while you still have funds in your PCA!
  - Balance in PCA: $1,200
  - Less provider contracted rate for visit: $60
  - Remaining balance in PCA: $1,140

PCA Rollover (Pg. 85)

- PCA dollars not used during the current calendar year…
  - are rolled over and added to the following year's PCA to a maximum PCA balance of:
    - Self Only: $5,000
    - Self Plus One
    - Self and Family $10,000
    - Maximum PCA account balance can never exceed these dollar limits
  - reduce the following year's deductible by an equal amount



Traditional Health Coverage Overview
Section 5, (Pgs. 86-88)



Traditional Health Coverage comes into play once your PCA is depleted. This is when you have to meet your deductible. Then you begin paying coinsurance.

Consumer Driven Option Deductible (Pg. 87)

Deductible must be met before Traditional Health Coverage begins.

- **Self Only:** $2,200, but the Health Plan prefunds your Personal Care Account (PCA) with $1,200, so **you pay $1,000 (Net Deductible)**
- **Self Plus One; Self and Family:** $4,400, but the Health Plan prefunds your Personal Account (PCA) with $2,400, so **you pay $2,000 (Net Deductible)**

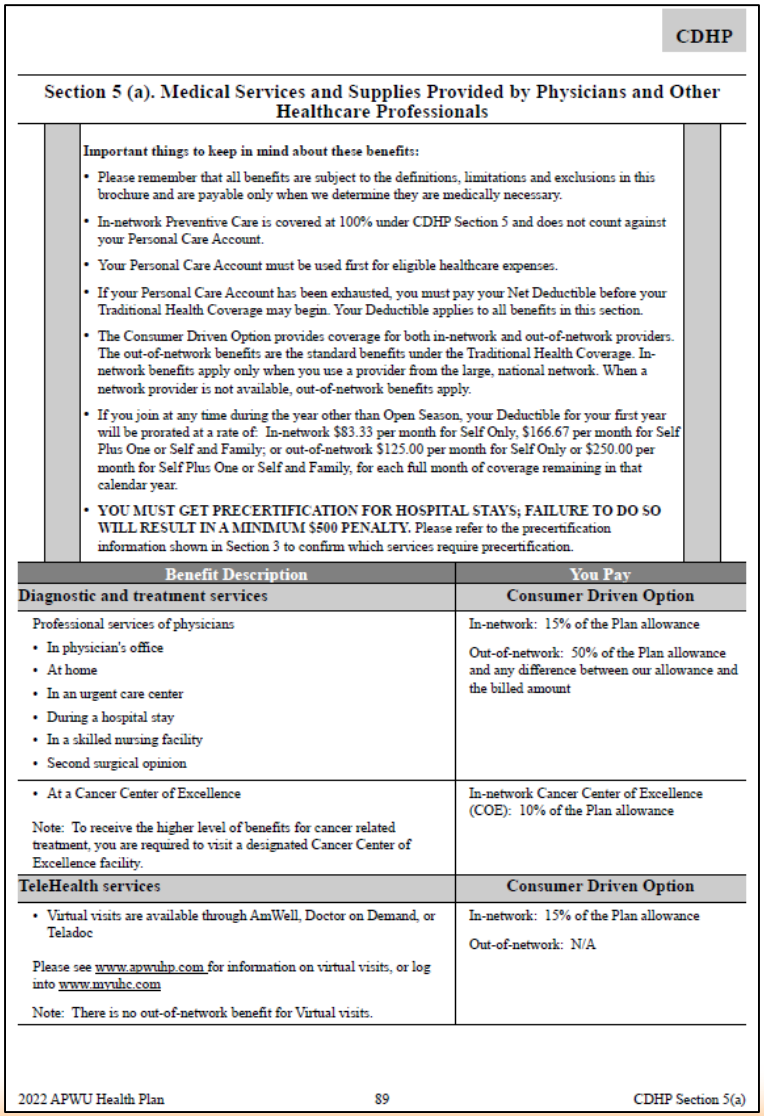
Coinsurance

Definition: The percentage of covered allowances for which the patient is responsible. Coinsurance does not begin until the deductible has been met.

- 10% of allowance for treatment of cancer at Cancer Centers of Excellence
- 15% of allowance for in-network care
- 50% of allowance for out-of-network care
- 25% Tier 1 and Tier 2/40% Tier 3 of prescription formulary allowance

Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals Section 5(a), (Pgs. 89-98)

- Diagnostic and Treatment Services
- TeleHealth Services
- Lab X-ray and Other Diagnostic Tests
- Maternity Care
- Family Planning
- Infertility Services*
- Allergy Care
- Treatment Therapies
- Physical and Occupational Therapy
- Applied Behavioral Analysis (ABA)
- Speech Therapy (ST)
- Hearing Services
- Vision Services
- Foot Care
- Durable Medical Equipment (DME)
- Home Health Services
- Chiropractic
- Alternative Treatments – Acupuncture
- Educational Classes



CDHP

Section 5 (a). Medical Services and Supplies Provided by Physicians and Other Healthcare 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 healthcare expenses.
- If your Personal Care Account has been exhausted, you must pay your Net 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: In-network $83.33 per month for Self Only, $166.67 per month for Self Plus One or Self and Family; or out-of-network $125.00 per month for Self Only or $250.00 per month for Self Plus One or Self and Family, for each full month of coverage remaining in that calendar year.
- **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	**Consumer Driven Option**
Professional services of physicians • In physician's office • At home • In an urgent care center • During a hospital stay • In a skilled nursing facility • Second surgical opinion	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount
• At a Cancer Center of Excellence Note: To receive the higher level of benefits for cancer related treatment, you are required to visit a designated Cancer Center of Excellence facility.	In-network Cancer Center of Excellence (COE): 10% of the Plan allowance
TeleHealth services	**Consumer Driven Option**
• Virtual visits are available through AmWell, Doctor on Demand, or Teladoc Please see www.apwuhp.com for information on virtual visits, or log into www.myuhc.com Note: There is no out-of-network benefit for Virtual visits.	In-network: 15% of the Plan allowance Out-of-network: N/A

2022 APWU Health Plan 89 CDHP Section 5(a)

Diagnostic and Treatment Services Lab, X-ray and Other Diagnostic Tests

- Professional services of physicians
- TeleHealth virtual visits (AmWell, Doctor on Demand, Teladoc and Optum Virtual Care)
- Lab, X-ray and other non-preventive diagnostic tests
  - Blood tests, urinalysis, X-rays, non-routine mammogram or 3D mammogram, CT, MRI, PET, EKG, EEG

Maternity Care
Section 5(a), (Pgs. 90-91)

- Pre and post-natal care, delivery
  - No need to pre-certify normal deliveries
  - Covered at 100% in-network
  - Out-of-Network (OON) inpatient hospital – 50% of Plan Allowance and $300 per admission fee applies
- Nursery charges covered while mother confined
  - When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.
- Not covered: genetic screening

Family Planning
Section 5(a), (Pg. 91)

- Covered Family Planning Services
  - Contraceptives
  - Oral Contraceptives covered as Pharmacy
  - Voluntary sterilization
- Not covered
  - Reversal of sterilization or genetic counseling

Infertility
Section 5(a), (Pg. 92)

- The Plan covers services related to the diagnosis and treatment of *infertility*
  - Maximum Plan benefit of $2,500/year for medical, i.e. diagnosis and treatment
  - Maximum Plan benefit of $2,500/year for prescription drugs to treat infertility
- The Plan does not cover costs to assist in conception, i.e. IVF

Treatment Therapies
Section 5(a), (Pgs. 92-93)

- Chemotherapy and Radiation Therapy
- Dialysis
- IV Infusion Therapy – Home IV and Antibiotic Therapy*
- Growth Hormone Therapy*
- Respiratory and Inhalation Therapy

Therapies require Pre-notification; Drugs used for GHT covered under Prescription Drug Benefit

Physical, Occupational, Speech Therapies Section 5(a), (Pgs. 93-94)

- Rehabilitative therapy to restore function
- Habilitative therapy – to learn or establish function
- Licensed, registered therapist
- 60 visit combined annual maximum
- Not covered:
  - Maintenance therapy
  - Exercise programs

Applied Behavioral Analysis (ABA)
Section 5(a), (Pg. 93)

- Outpatient ABA for the treatment of Autism Spectrum Disorder
  - In-network benefit only
  - Services must be preauthorized by UHC Behavioral Health Solutions
  - Services must be provided under the supervision of a Board Certified Behavior Analyst
  - Provider must be contracted or agree to participate with UHC Behavioral Health Solutions care management activities

(continued on next slide)

Applied Behavioral Analysis (ABA)
Section 5(a), (Pg. 93)

- Review of ABA services is based on an intensive care management model that monitors treatment plans, objectives and progress milestones
- Member coinsurance 15% of the Plan allowance

Hearing and Vision Services
Section 5(a), (Pg. 94)

- One exam and testing every 2 years for hearing aids
- Internal ocular lenses and/or 1st contact lenses to correct impairment caused by an accident or illness

Routine Foot Care
Section 5(a), (Pgs. 94-95)

- Routine foot care services are covered only when patient is receiving active treatment for a metabolic or peripheral vascular disease such as Diabetes or Peripheral Neuropathy
  - Trimming of lesions
  - Trimming of nails
- Not covered:
  - Orthopedic and corrective shoes
  - Arch supports
  - Foot/shoe orthotics
  - Heel pads and heel cups



Orthopedic and Prosthetic Devices Section 5(a), (Pg. 95)

- Covered devices include:
  - Artificial limbs* and eyes
  - External and internal breast prostheses; surgical bras following a mastectomy
  - Leg, arm, neck, joint and back braces
  - Internal prosthetics: artificial joints, pacemakers, cochlear implants*
  - Hearing aids every 3 years; maximum payout of $1,500

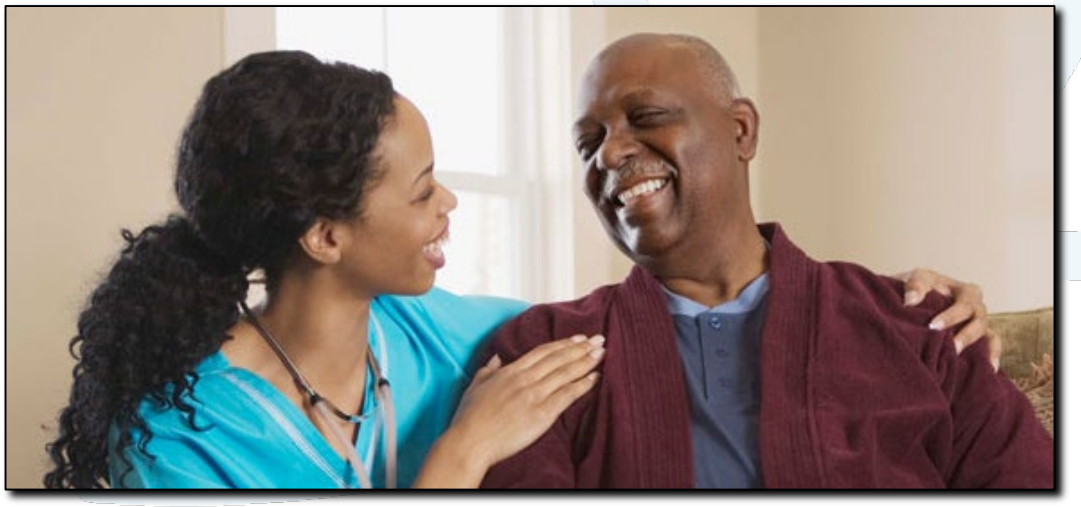
Pre-notification recommended

Durable Medical Equipment
Section 5(a), (Pgs. 95-96)

- Pre-notification is required
- See page 96 of brochure for list of excluded items
- We limit the Plan allowance to an amount no greater than the purchase price

Home Health Services
Section 5(a), (Pgs. 96-97)

- Skilled Nursing Care (RN, LPN, LVN)
  - 25 visits per calendar year (up to 2 hour maximum visit)
  - Uses PPO allowance
  - Pre-authorization required



Chiropractic and Alternative Treatments Section 5(a), (Pg. 97)

- Chiropractic
  - Treatment limited to 24 visits and/or manipulations per calendar year
    - Massage therapy and maintenance therapy are not covered
    - X-rays covered under diagnostics
- Acupuncture
  - Covered if performed by an MD, DO or a licensed acupuncturist

Educational Classes and Programs
Section 5(a), (Pgs. 97-98)

- We encourage you to enroll in the Quit for Life Tobacco Cessation Program by contacting UHC
  - E-cigarette users are eligible for enrollment in smoking cessation programs
  - Telephonic counseling sessions
  - Group therapy
  - Educational sessions with a physician
- Diabetes self-management training services

Surgical and Anesthesia Services Section 5(b), (Pgs. 99-106)

- Surgical Procedures
  - Operative procedures including pre and post-operative care
  - Surgical treatment of morbid obesity* as well as any surgery that could potentially be considered cosmetic
  - Reconstructive surgery
  - Treatment of gender dysphoria*

***Requires pre-notification**

Oral Surgery
Section 5(b), (Pgs. 102-103)

- We suggest calling UHC to determine if a procedure is covered



Organ and Tissue Transplants
Section 5(b), (Pgs. 103-106)

- Complete list of transplants begins on page 103
- All transplants are subject to prior authorization; subject to medical necessity and experimental / investigational review
- Out-of-network services have benefit limitations
- Transplant Network
  - Plan-specific organ/tissue transplant facilities
    - If a Plan-designated transplant facility chosen, travel and lodging costs may be pre-approved
  - Prior to an initial evaluation, physician or patient must contact UHC to speak with a Transplant Case Manager

Anesthesia
Section 5(b), (Pg. 106)

- Professional services for administration of anesthesia
- 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

Services Provided by a Hospital or Other Facility, and Ambulance Services Section 5(c), (Pgs. 107-110)



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 healthcare expenses.
- If your Personal Care Account has been exhausted, you must pay your Net 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: In-network $83.33 per month for Self Only, $166.67 per month for Self Plus One or Self and Family; or out-of-network $125.00 per month for Self Only or $250.00 per month for Self Plus One or Self and Family, for each full month of coverage remaining in that calendar year.
- **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.
- You must get prior approval for gender reassignment surgery. See page 19 for prior approval and page 99 for the surgical benefit.
- When you receive hospital observation services, we apply outpatient benefits to covered services up to 48 hours. Inpatient benefits will apply only when your physician admits you to the hospital as inpatient.

Benefit Description	You Pay
Inpatient hospital	**Consumer Driven Option**
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: 50% 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*, page 90).
Other hospital services and supplies, such as: • Operating, recovery, maternity and other treatment rooms • Prescribed drugs and medications	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount

Inpatient hospital - continued on next page

Precertification
Section 5(c), (Pg. 107)

- Call UnitedHealthcare for precertification
- You may be subject to a **$500 precert penalty** if inpatient precertification is not done:
  - 2 business days prior to an elective admission, or
  - within 2 business days after an emergency admission



Inpatient Hospital
Section 5(c), (Pgs. 107-108)

- Room and Board
- Ancillary/Other Hospital Charges
- Cancer Centers of Excellence
  - Contact UHC to enroll prior to initial treatment for referral
  - Patient pays 10% of Plan allowance
  - May receive pre-approval for travel and lodging expenses
  - Includes in and outpatient services at designated facilities

Outpatient Hospital or Ambulatory Care Facility Section 5(c), (Pg. 109)

- Operating, recovery, treatment rooms
- Pharmacy items and medical supplies
- Diagnostic testing
- Blood and its administration
- Pre-surgical testing
- Anesthetics

Skilled Nursing Facility Benefit
Section 5(c), (Pgs. 109)

- When APWU Health Plan is Primary
  - And you have had a covered inpatient hospital stay;
  - The Health Plan will approve up to a maximum of 30 days in a skilled Nursing Facility (SNF) based on medical necessity
  - Prior approval required. Call UnitedHealthcare at 1-800-718-1299
- Not covered: Custodial Care

Hospice Care
Section 5(c), (Pg. 110)

- Maximum lifetime payout of $15,000 includes outpatient/ inpatient and advance care planning (end of life care)
- Inpatient hospice – contact UHC for prior approval
- $200 bereavement benefit per family unit



Ambulance
Section 5(c), (Pg. 110)

- Local, professional ambulance service
  - Medically appropriate
  - Before or after an inpatient admission
- Ambulance services used for routine transport are not covered
- Prior approval is required for non-emergent air ambulance transport

Emergency Services/Accident Section 5(d), (Pgs. 111-112)

- "Accident" is defined as resulting from a violent, external force
- Outpatient physician, supplies and related outpatient hospital services rendered within 24 hours of accident
  - 15% coinsurance for both in-network and out-of-network care*
- Ground Ambulance15% in-network; 50% out-of-network**
- Air Ambulance to the closest available facility to treat the patient
  - 15% coinsurance for both in-network and out-of-network care*

*Provider cannot balance bill the member.

**Provider can balance bill the member.

Medical Emergency (Pg. 112)

- Sudden onset of symptoms that you believe endangers your life or could result in serious disability if not treated promptly
- Treatment at an Urgent Care Center
  - Cost share = 15% coinsurance in-network
  - Cost share = 50% coinsurance out-of-network*
- Treatment at other than an Urgent Care Center**
  - Cost share = 15% coinsurance in and out-of-network

*For out-of-network care at an urgent care center, members may be billed the difference between the Plan allowance and the billed amount

**Provider cannot balance bill the member.

Mental Health and Substance Use Disorder Section 5(e), (Pgs. 113-115)

- Must obtain preauthorization for:
  - Inpatient Mental Health or Substance Use Disorder Hospital admissions
  - Inpatient treatment, psychological testing, Electroconvulsive Therapy (ECT), Transcranial Magnetic Stimulation (TMS), ABA, Residential Treatment
- To obtain preauthorization, call UHC Behavioral Health Solutions
- $500 penalty for failure to obtain precertification
  - 2 days prior to elective hospital admission
  - 2 days after an emergency admission

Mental Health and Substance Use Disorder Section 5(e), (Pgs. 113-115)

- Virtual Visits/TeleHealth Services, call UHC Behavioral Health Solutions, 800-718-1299
  - 15% in-network
  - No out-of-network benefit

Prescription Drug Benefits
Section 5(f), (Pgs. 116-120)

Administered by OptumRx

- Covered Medication Supplies
  - Rx drugs, diabetic supplies, Insulin





Prescription Drugs (Pgs. 115-116)

- **Traditional Prescription Drug Formulary:** A list of selected covered drugs based on clinical effectiveness and lower cost, (there are certain drugs excluded).
- **Brand Name Drugs:** Protected by a patent and manufactured and sold only by the company holding the patent
- **Generic Drugs:** When the patent for the brand name drug expires, generic versions of the drug can be offered for sale if the FDA agrees; generic drugs are typically less expensive than brand name drugs



Prescription Drug Tiers
Consumer Driven Option – OptumRx

Tier 1	Medications that provide the highest overall value. Mostly generic drugs. Some brand name drugs may also be included.	Use Tier 1 drugs for the lowest out-of-pocket costs.
Tier 2	Medications that provide good overall value. A mix of brand name and generic drugs.	Use Tier 2 drugs, instead of Tier 3, to help reduce your out-of-pocket costs.
Tier 3	Medications that provide the lowest overall value. Mostly brand name drugs, as well as some generics.	Ask your doctor if a Tier 1 or Tier 2 option could work for you.

Covered Medication/Supplies
Section 5(f), (Pg. 117)

- Patient Responsibility
  - **Network Retail:** Tier 1 and Tier 2 - 25% coinsurance; minimum $15, maximum out-of-pocket $200 for each 30-day supply; Tier 3 - 40% coinsurance; minimum $15, maximum out-of-pocket $300 for each 30-day supply
  - **Network Mail Order:** Tier 1 and Tier 2 - 25% coinsurance; minimum $10, maximum out-of-pocket $200 for each 30-day supply; Tier 3 - 40% coinsurance; minimum $10, maximum out-of-pocket $300 for each 30-day supply
- No coverage for prescriptions purchased out-of-network

Prescription Drugs (Pg. 118)

- Zero out-of-pocket costs
  - Contraceptive drugs on the UHC PPACA list at Network Retail or Mail Order
  - Select over-the-counter (OTC) and prescription tobacco cessation medications approved by the FDA to treat tobacco dependence (In-network retail/Mail Order) Preventive Care Medications with a USPSTF recommendation of A or B when prescribed by a health care professional and filled at a network pharmacy; for current recommendations go to: www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations
  - Naloxone & Narcan – opioid reversal agents

Prescription Drugs (Pg. 118)

- Prescription drugs with an over-the-counter (OTC) equivalent are not covered.



Coverage Authorization (Pg. 119)

- Prior approval/medical necessity review needed for some medications

  Examples: Growth Hormone, Botox, Rheumatoid Arthritis agents, specialty cholesterol drugs
- Step Therapy review
- Supply limits
- Compound Medication restrictions
- OptumRx will work w/physician to obtain information needed to give approval *(based on FDA guidelines)*
- If not approved, patient may opt to fill prescription and will assume responsibility for its full cost

Specialty Drugs (Pg. 120)

First Fill of Specialty Drugs must be obtained through OptumRx Specialty Pharmacy.

- Cost ranges from $500 per dose or $6000 or more per year
- Complex treatment, care
- Safety monitoring
- Special requirements for shipping, handling
- Disease categories include:
  - Cancer, cystic fibrosis, growth hormone deficiency, hemophilia, immune deficiency, Hepatitis C
- Visit www.myuhc.com or call UnitedHealthcare

APWU HEALTH PLAN
TOGETHER.
BETTER HEALTH.®

Dental (Pg. 121)

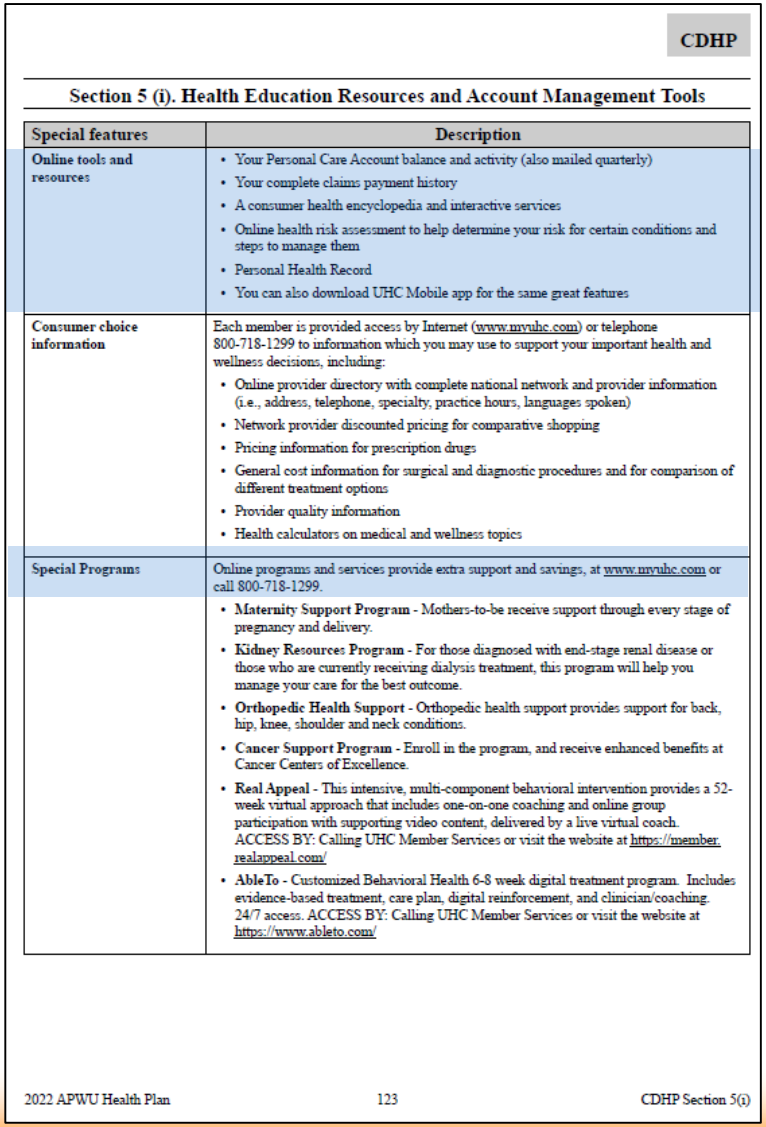
No Benefit Except Under “Extra PCA”



Health Education Resources and Account Management Tools Section 5(i) (Pg. 123)

Online tools

Special Programs



CDHP

Section 5 (i). Health Education Resources and Account Management Tools

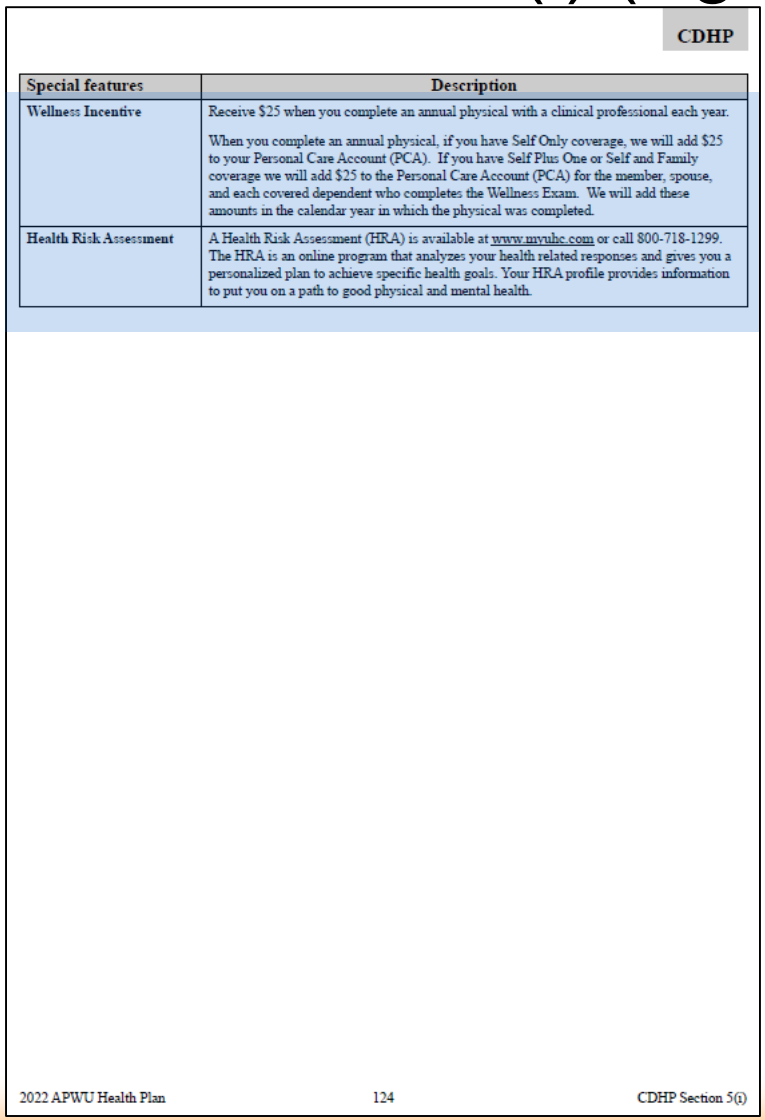
Special features	Description
Online tools and resources	• Your Personal Care Account balance and activity (also mailed quarterly) • Your complete claims payment history • A consumer health encyclopedia and interactive services • Online health risk assessment to help determine your risk for certain conditions and steps to manage them • Personal Health Record • You can also download UHC Mobile app for the same great features
Consumer choice information	Each member is provided access by Internet (www.myuhc.com) or telephone 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
Special Programs	Online programs and services provide extra support and savings, at www.myuhc.com or call 800-718-1299. • **Maternity Support Program** - Mothers-to-be receive support through every stage of pregnancy and delivery. • **Kidney Resources Program** - For those diagnosed with end-stage renal disease or those who are currently receiving dialysis treatment, this program will help you manage your care for the best outcome. • **Orthopedic Health Support** - Orthopedic health support provides support for back, hip, knee, shoulder and neck conditions. • **Cancer Support Program** - Enroll in the program, and receive enhanced benefits at Cancer Centers of Excellence. • **Real Appeal** - This intensive, multi-component behavioral intervention provides a 52-week virtual approach that includes one-on-one coaching and online group participation with supporting video content, delivered by a live virtual coach. ACCESS BY: Calling UHC Member Services or visit the website at https://member.realappeal.com/ • **AbleTo** - Customized Behavioral Health 6-8 week digital treatment program. Includes evidence-based treatment, care plan, digital reinforcement, and clinician/coaching. 24/7 access. ACCESS BY: Calling UHC Member Services or visit the website at https://www.ableto.com/

2022 APWU Health Plan 123 CDHP Section 5(i)

Health Education Resources and Account Management Tools Section 5(i) (Pg. 124)

Wellness Incentive

Health Risk Assessment



CDHP

Special features	Description
Wellness Incentive	Receive $25 when you complete an annual physical with a clinical professional each year. When you complete an annual physical, if you have Self Only coverage, we will add $25 to your Personal Care Account (PCA). If you have Self Plus One or Self and Family coverage we will add $25 to the Personal Care Account (PCA) for the member, spouse, and each covered dependent who completes the Wellness Exam. We will add these amounts in the calendar year in which the physical was completed.
Health Risk Assessment	A Health Risk Assessment (HRA) is available at www.myuhc.com or call 800-718-1299. The HRA is an online program that analyzes your health related responses and gives you a personalized plan to achieve specific health goals. Your HRA profile provides information to put you on a path to good physical and mental health.

2022 APWU Health Plan 124 CDHP Section 5(i)

AbleTo: Personalized Virtual Care and Real Appeal: Weight-loss Program

*There are two **NEW** programs being implemented for the Consumer Driven Option, effective 1/1/2022 and there is no cost to the member:*

- **AbleTo:** An evidence-based and personalized 8-week virtual therapy and coaching program that provides support for depression, anxiety and stress that typically accompanies health issues such as cardiac conditions, diabetes, chronic pain and cancer and may help bring down the total cost of care
- **Real Appeal:** Online weight-loss program that can help improve employee health, prevent disease and decrease medical expenses by up to 16% for members vs. non-members.

Real Appeal: Weight-loss Program

UnitedHealthcare®

Uniting clinically proven science with a Transformation Coach and engaging content.



The Real Appeal weight-loss program helps employees prevent disease, change behavior and save on medical expenses.







AbleTo: Personalized Virtual Care

UnitedHealthcare®

Evidence-based and personalized 8-week virtual therapy program provides convenient access and helps control medical costs

- 10 years delivering remote therapy
- 12 peer-reviewed published studies and research papers
- URAC, NCQA, HI-TRUST Accredited

- Nation-wide network of nearly 1,000 providers
- 800K+ completed sessions
- 25 million covered lives

- 9 health plan partners representing commercial, Medicare Advantage, and Medicaid lines of business
- 97% member satisfaction

PROACTIVE DATA-DRIVEN IDENTIFICATION AND OUTREACH

Mark is overwhelmed managing type 2 Diabetes, experiencing depression and low energy. Based on information from Mark's claims data we predict a need.

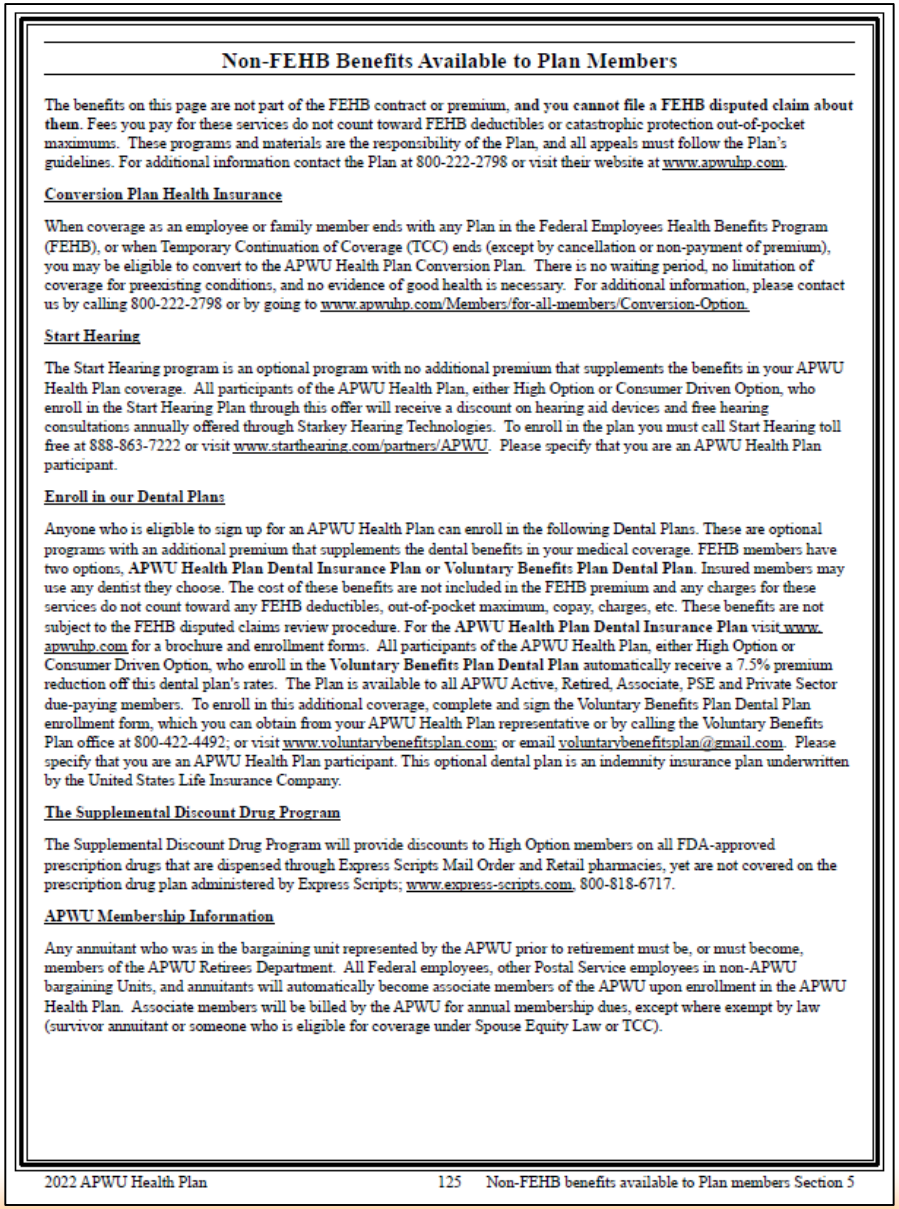


Proactive outreach engages Mark in both behavioral coaching and personalized therapy via phone or video twice a week for up to 8 weeks.

IMPROVED BEHAVIORAL OUTCOMES		IMPROVED MEDICAL OUTCOMES		IMPROVED PRODUCTIVITY	
↓ 55%	↓ 45%	↓ 17%	↓ 46%	↓ 55%	↓ 43%
Depression	Anxiety	Pain severity	Medication Non-Adherence	Absenteeism	Presenteeism

Brochure Tour – Non FEHB Benefits

Our members have access to other benefits that are not part of the FEHB program *(Pg. 125)*



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 800-222-2798 or visit their website 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 800-222-2798 or by going to www.apwuhp.com/Members/for-all-members/Conversion-Option.

Start Hearing

The Start Hearing 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 Start Hearing Plan through this offer will receive a discount on hearing aid devices and free hearing consultations annually offered through Starkey Hearing Technologies. To enroll in the plan you must call Start Hearing toll free at 888-863-7222 or visit www.starthearing.com/partners/APWU. Please specify that you are an APWU Health Plan participant.

Enroll in our Dental Plans

Anyone who is eligible to sign up for an APWU Health Plan can enroll in the following Dental Plans. These are optional programs with an additional premium that supplements the dental benefits in your medical coverage. FEHB members have two options, **APWU Health Plan Dental Insurance Plan or Voluntary Benefits Plan Dental Plan.** Insured members may use any dentist they choose. The cost of these benefits are not included in the FEHB premium and any charges for these services do not count toward any FEHB deductibles, out-of-pocket maximum, copay, charges, etc. These benefits are not subject to the FEHB disputed claims review procedure. For the **APWU Health Plan Dental Insurance Plan** visit www.apwuhp.com for a brochure and enrollment forms. All participants of the APWU Health Plan, either High Option or Consumer Driven Option, who enroll in the **Voluntary Benefits Plan Dental Plan** automatically receive a 7.5% premium reduction off this dental plan's rates. The Plan is available to all APWU Active, Retired, Associate, PSE and Private Sector due-paying members. 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 800-422-4492; or visit www.voluntarybenefitsplan.com; or email voluntarybenefitsplan@gmail.com. Please specify that you are an APWU Health Plan participant. This optional dental plan is an indemnity insurance plan underwritten by the United States Life Insurance Company.

The Supplemental Discount Drug Program

The Supplemental Discount Drug Program will provide discounts to High Option members on all FDA-approved prescription drugs that are dispensed through Express Scripts Mail Order and Retail pharmacies, yet are not covered on the prescription drug plan administered by Express Scripts; www.express-scripts.com, 800-818-6717.

APWU Membership Information

Any annuitant who was in the bargaining unit represented by the APWU prior to retirement must be, or must become, members of the APWU Retirees Department. All Federal employees, other Postal Service employees in non-APWU bargaining Units, and annuitants will automatically become associate members of the APWU upon enrollment in the APWU Health Plan. Associate members will be billed by the APWU for annual membership dues, except where exempt by law (survivor annuitant or someone who is eligible for coverage under Spouse Equity Law or TCC).

Brochure Tour

Things we don't cover Pg. 126-127

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, *You need prior Plan approval for certain services*).

How and when to file a paper claim Pgs. 128-130

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).

How to appeal Pgs. 131-133

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information or to make an inquiry 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 call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website.

What if you have Medicare, Other Insurance, TRICARE, CHAMPA Pgs. 134-144

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 healthcare expenses without regard to fault. This is called "double coverage."

Term definitions Pgs. 145-149

Section 10. Definitions of Terms We Use in This Brochure

Summary of Benefits – High Option (Pgs. 150-151)

Summary of Benefits for the High Option of the APWU Health Plan - 2022

Do not rely on this chart alone. This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB Brochure. You can also obtain a copy of our Summary of Benefits Coverage as required by the Affordable Care Act at www.apwuhp.com. 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, $450 (PPO) or $1,000 (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 healthcare professional.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office*	PPO: $25 copay per visit (No deductible); 15% of Plan allowance Non-PPO: 40% of our allowance plus amount over our allowance	35
Services provided by a hospital:		
• Inpatient	PPO: 15% of Plan allowance Non-PPO: $300 per admission and 40% of our allowance plus amount over our allowance	55
Services provided by a hospital:		
• Outpatient*	PPO: 15% of Plan allowance Non-PPO: 40% of our allowance plus amount over our allowance	57
Emergency benefits:		
• Accidental injury	PPO: Nothing Non-PPO: Nothing	60
• Medical emergency* (other than an Urgent Care Center)	PPO: 15% of Plan allowance Non-PPO: 15% of Plan allowance	60
Mental health and substance use disorder treatment:	PPO: $25 copay per visit (No deductible); 15% of Plan allowance Non-PPO: 40% of our allowance plus amount over our allowance	63
Prescription drugs:		
• Network pharmacy	$10 Tier 1/25% Tier 2/45% Tier 3/Specialty drugs 25% Tier 4/25% Tier 5/45% Tier 6	68
• Non-network pharmacy	50% of cost	68
• Mail order	$20 Tier 1/25% Tier 2/45% Tier 3 Specialty drugs 25% Tier 4/25% Tier 5/45% Tier 6	68

High Option Benefits	You pay	Page
Dental care:	30% of Plan allowance plus amount over our allowance	73
Wellness and other special features: Flexible benefits option, 24-hour nurse line, services for deaf and hearing-impaired, Disease Management Program, Review and Reward program, Diabetes and Weight Management Programs, online access to claims information, online Preferred Provider Organization (PPO) directories, Hospital Quality Ratings Guide, Treatment Cost Estimator, online non-FEHB savings on health and wellness products and Health Risk Assessment (HRA) savings.	See Section 5(h)	74
Protection against catastrophic costs (out-of-pocket maximum):	PPO: Nothing after $6,500 for Self Only or $13,000 for a Self Plus One or Self and Family enrollment per year Non-PPO: Nothing after $12,000 for Self Only, or $24,000 for a Self Plus One or Family enrollment per year Some costs do not count toward this protection	28

Summary of Benefits – Consumer Driven Option (Pgs. 152-153)

Summary of Benefits for the CDHP of the APWU Health Plan - 2022

Do not rely on this chart alone. This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB Brochure. You can also obtain a copy of our Summary of Benefits Coverage as required by the Affordable Care Act at www.apwuhp.com. 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 Net Deductible, $450 (PPO) or $1,000 (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 healthcare professional.

CDHP Benefits	You Pay	Page
In-network preventive care:	Nothing	80
Personal Care Account:		
Up to $1,200 for Self Only or $2,400 for Self Plus One or Self and Family for medical, surgical, hospital, mental health and substance use disorder treatment services and prescription drugs plus certain dental and vision care	Nothing up to $1,200 for Self Only or $2,400 for Self Plus One or Self and Family	84
Traditional Health Coverage after Personal Care Account is exhausted	See Section 5 Traditional Health Overview (Net Deductible before Traditional Health Coverage Begins)	86
Medical/Surgical services provided by physicians:		
• Diagnostic and treatment services provided in the office*	In-network: 15% of Plan allowance Out-of-network: 50% of our allowance plus amount over our allowance	89
Services provided by a hospital:		
• Inpatient*	In-network: 15% of Plan allowance Out-of-network: 50% of our allowance plus amount over our allowance	107
• Outpatient*	In-network: 15% of Plan allowance Out-of-network: 50% of our allowance plus amount over our allowance	109
Emergency benefits:		
• Accidental injury*	In-network: 15% of Plan allowance Out-of-network: 15% of Plan allowance	112
• Medical emergency* (other than an Urgent Care Center)	In-network: 15% of Plan allowance Out-of-network: 15% of Plan allowance	112
Mental health and substance use disorder treatment*:	In-network: 15% of Plan allowance Out-of-network: 50% of our allowance plus amount over our allowance	113-114

CDHP Benefits	You Pay	Page
Prescription drugs:		
• Network Retail*	25% minimum $15 Tier 1 & Tier 2/40% minimum $15 Tier 3	117
• Network Home Delivery*	25% minimum $10 Tier 1 & Tier 2/40% minimum $10 Tier 3	117
Dental Care/Vision Care (covered only under Personal Care Account):	Any amount over $400 per Self Only or $800 per Self Plus One or Self and Family (see Section 5 Extra PCA Expenses).	84
Health education resources and account management tools: Online tools and resources, Consumer choice information, Services for deaf and hearing-impaired, online special programs for extra support savings, $25 wellness incentive when you complete an annual physical, and Health Risk Assessment (HRA).	See Section 5(i)	123
Protection against catastrophic costs (out-of-pocket maximum):	In-network: Nothing after $6,500 Self Only or $13,000 for a Self Plus One or Self and Family enrollment per year Out-of-network: Nothing after $12,000 Self Only or $24,000 for a Self Plus One or Self and Family enrollment per year Some costs do not count toward this protection	29

2022 Rate Information (Pg. 158)

2022 Rate Information for the APWU Health Plan

To compare your FEHB health plan options please go to www.opm.gov/fehbcompare.

To review premium rates for all FEHB health plan options please go to www.opm.gov/FEHBpremiums or www.opm.gov/Tribalpremium.

APWU rates apply to career Postal employees represented by APWU.

Premiums for Tribal employees are shown under the Monthly Premium Rate column. The amount shown under employee contribution is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Premium Rates:

Type of Enrollment	Enrollment Code	Biweekly Gov't Share	Biweekly Your Share	Monthly Gov't Share	Monthly Your Share	Biweekly APWU Your Share
High Option Self Only	471	$244.86	$106.39	$530.53	$230.51	$106.39
High Option Self Plus One	473	$524.63	$212.96	$1,136.70	$461.41	$212.96
High Option Self and Family	472	$574.13	$268.83	$1,243.95	$582.46	$268.83
CDHP Option Self Only	474	$208.96	$69.65	$452.75	$150.91	$13.93
CDHP Option Self Plus One	476	$454.15	$151.38	$983.99	$327.99	$30.28
CDHP Option Self and Family	475	$495.44	$165.14	$1,073.45	$357.81	$33.03

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Questions:
2022 Consumer Driven Option Benefits



How much is the in-network office visit copay?

A. $18
B. $25
C. $20
✓ D. No copay

(Answer can be found in the 2022 Brochure pg. 25)

How much is the in-network Deductible?

- ✓ A. Self Only: $2,200; Self Plus One and Self and Family: $4,400
- B. Self Only: $1,800; Self Plus One and Self and Family: $3,600
- C. $0 Deductible
- D. Self Only: $800; Self Plus One and Self and Family: $1,600

(Answer can be found in the 2022 Brochure pg. 87)

Do covered in-network preventive care costs deduct anything from your PCA?

A. Yes

✔ B. No

(Answer can be found in the 2022 Brochure pg. 80)

The maximum account balance (including rollover) in your PCA can never exceed $5,000 for Self Only or $10,000 for Self Plus One and Self and Family.

- ✔ A. True
- B. False

(Answer can be found in the 2022 Brochure pg. 85)

How much of your PCA account is funded by the Health Plan?

A. Self Only: $1,800; Self Plus One and Self and Family: $3,600

B. $10,000 per membership

✓ C. Self Only: $1,200; Self Plus One and Self and Family: $2,400

D. Nothing

(Answer can be found in the 2022 Brochure pg. 84)

How much of your PCA dollars can be used toward dental/vision services?

A. Dental and vision services are not covered
B. No restriction
C. Self Only: $600; Self Plus One and Self and Family: $1,200
✓ D. Self Only: $400; Self Plus One and Self and Family: $800

(Answer can be found in the 2022 Brochure pg. 84)

If you do not want certain expenses paid from your PCA account, can it be turned off?

- ✔ A. Yes
- B. No

(Answer can be found in the 2022 Brochure pg. 83)

If you are able to “turn off” your PCA for certain expenses, can you turn it off for prescription drugs?

A. Yes

✔ B. No

(Answer can be found in the 2022 Brochure pg. 83)

For in-network diagnostic services, how much is your coinsurance after your PCA is exhausted and your deductible has been met?

- ✔ A. 15%
- B. 40%
- C. 25%
- D. No coinsurance

(Answer can be found in the 2022 Brochure pg. 89)

What will not accumulate toward your Catastrophic out-of-pocket expenses?

A. In-network preventive care
B. Drugs purchased at non-network pharmacy
C. Dental and vision care above limitations of PCA
✓ D. All of the above

(Answer can be found in the 2022 Brochure pg. 30)

What is the Catastrophic out-of-pocket maximum?

A. In-network: Self Only; $6,500; Self Plus One and Self and Family: $13,000
   Out-of-network: Self Only $12,000; Self Plus One and Self and Family: $24,000
B. In-network: Self Only; $5,500; Self Plus One and Self and Family: $6,500
   Out-of-network: Self Only, Self Plus One and Self and Family: $10,000
C. $15,000 per membership
D. In-network: Self Only; $10,000; Self Plus One and Self and Family: $10,000
   Out-of-network: Self Only, Self Plus One and Self and Family: $10,000

(Answer can be found in the 2022 Brochure pg. 29)

How much is the coinsurance for Tier 3 Drugs at Retail and at Mail Order?

A. No coinsurance

✓ B. Retail: 40% of the cost with a $15 minimum up to a max of $300 for a 30-day supply, $600 for a 60-day supply, $900 for a 90-day supply

Mail: 40% of the cost with a $10 minimum up to a max of $300 for a 30-day supply, $600 for a 60-day supply, $900 for a 90-day supply

C. Retail: 25% of the cost with a $15 minimum up to a max of $200 for a 30-day supply, $400 for a 60-day supply, $600 for a 90-day supply

Mail: 25% of the cost with a $10 minimum up to a max of $200 for a 30-day supply, $400 for a 60-day supply, $600 for a 90-day supply

D. $100 copay per prescription

(Answer can be found in the 2022 Brochure pg. 117)

What is covered under Family Planning?

- A. Contraceptives, voluntary sterilization
- B. Reversal of sterilization
- C. Diapers and strollers
- D. Gift card to Babies ‘R’ Us

(Answer can be found in the 2022 Brochure pg. 91)

What TeleHealth services are available to you in-network?

A. Mental health visits
B. Medical visits
✓ C. Both

(Answer can be found in the 2022 Brochure pgs. 89 &114)

What is the benefit for in-network Virtual Visits (TeleHealth)?

- ✔ A. 15% coinsurance
- B. 40% coinsurance
- C. Deductible, then 40% coinsurance
- D. $20 copay

(Answer can be found in the 2022 Brochure pgs. 89 &114)

Up to 2 hours of Home Health Skilled Nursing Care (25 visit limit) is covered in-network at 15% coinsurance and out-of-network at 50% coinsurance.

- ✔ A. True
- B. False

(Answer can be found in the 2022 Brochure pg. 96)

Is genetic screening a covered benefit?

A. Yes

✓ B. No

(Answer can be found in the 2022 Brochure pg. 90)

Are Infertility Drugs Covered?

A. Yes, $10,000 limit per lifetime

✓ B. Yes, $2,500 maximum per year.

C. Yes, no maximum amount

D. No coverage

(Answer can be found in the 2022 Brochure pg. 92)

What is not covered under the $2,500 maximum medical infertility benefit?

A. Artificial insemination
B. In Vitro Fertilization (IVF)
C. Cost of donor sperm/egg
✓ D. All of the above

(Answer can be found in the 2022 Brochure pg. 92)

Do PT/OT/ST require pre-authorization? And what is the benefit maximum?

- ✔ A. No; 60 visits combined
- B. Yes; 60 visits combined
- C. Yes; 20 visits each
- D. No; 20 visits each

(Answer can be found in the 2022 Brochure pgs. 93 & 94)

What statement is true regarding care in a Residential Treatment Facility?

A. No authorization needed

✓ B. Pre-auth required through UHC Behavioral Solutions; covered both in-network and out-of-network

C. Pre-auth required through Beacon Health Options; in-network only

D. Payable only for the enrollee

(Answer can be found in the 2022 Brochure pg. 114)

Is admission to a Skilled Nursing Facility, after an approved hospital confinement, a covered benefit?

- ✔ A. Yes, it has to be precertified and is covered for non-custodial care
- B. No, it is not a covered benefit
- C. Yes, it is covered for long term custodial care and doesn't need to be precertified
- D. Yes, but you don't have to be in the hospital prior to admission

(Answer can be found in the 2022 Brochure pg. 109)

What is the annual visit limit for chiropractic visits and/or manipulations?

A. No limit restriction
B. 12
C. 6
✓ D. 24

(Answer can be found in the 2022 Brochure pg. 97)

Pre-authorization is required for medical inpatient confinement, but not if treatment is for behavioral health.

A. True

✓ B. False

(Answer can be found in the 2022 Brochure pg. 18)

Can specialty drugs be obtained at the retail pharmacy?

A. Yes

✔ B. No

(Answer can be found in the 2022 Brochure pg. 116)

Is there a wellness incentive if you complete an annual physical each year?

A. Yes

B. No

✓ C. Yes, $25 added to the PCA for each family member that has an annual physical

D. Yes, $50 added to the PCA for anyone over age 18

(Answer can be found in the 2022 Brochure pg. 124)

What is the name of new cognitive behavioral health program and do you have to pay anything for it when you are invited to enroll?

A. We don't have a new program.

✓ B. AbleTo, the cost of the program is paid by the Plan. You have no copays, coinsurance or PCA deductions.

C. United Behavioral Health Solutions. Yes, $25 coinsurance for each session.

(Answer can be found in the 2022 Brochure pg. 123)

Do you have access to a new weight loss program called Real Appeal?

✔ A. Yes

B. No

(Answer can be found in the 2022 Brochure pg. 123)

Questions for Closing Session

Email any questions to:
closingsessionquestions@apwuhp.com

You will receive an email following our Seminar with a link to fill out your class evaluations online.

THANK YOU!

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36th Annual Open Season Seminar, October 20 – 22, 2021