APWU HEALTH PLAN

35th Annual Open Season Seminar

TOGETHER. BETTER HEALTH.®

BROCHURE REVIEW HIGH OPTION AND CONSUMER DRIVEN OPTION

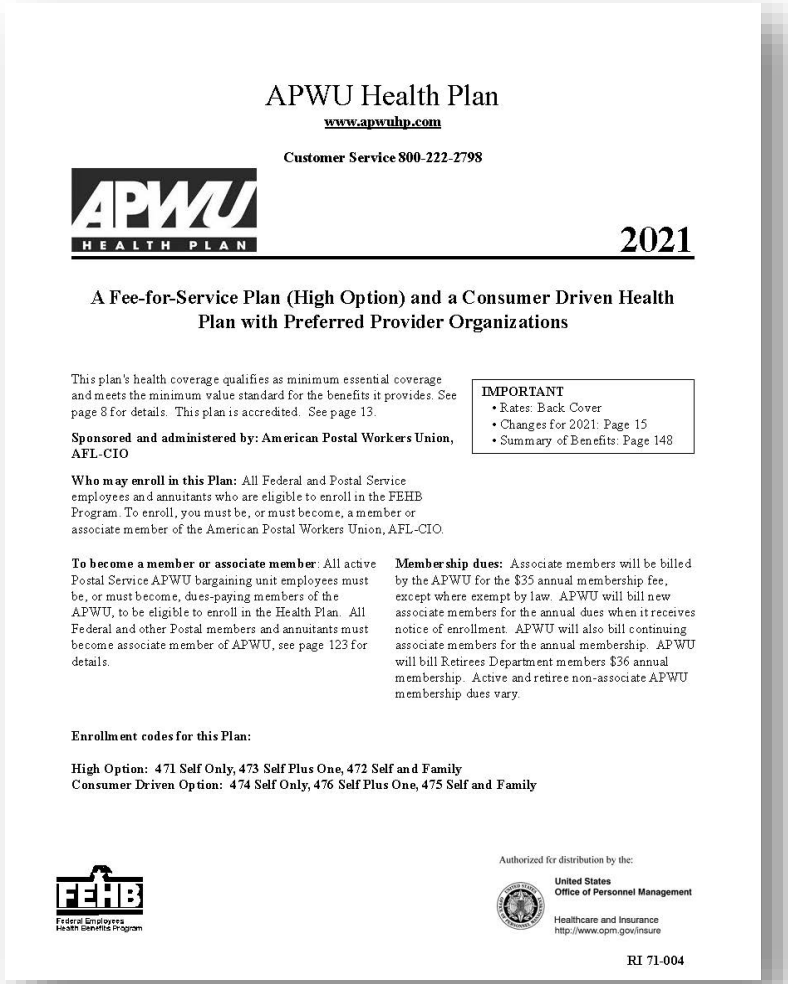
PRESENTED BY

ERIK FENTON AND SHARON MOREHEAD



Today's Agenda

- Brochure
  - Layout
  - Sections
  - Changes
- Review Benefits
  - Changes for 2021



APWU Health Plan

www.apwuhp.com

Customer Service 800-222-2798

APWU HEALTH PLAN

2021

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

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.

IMPORTANT
- Rates: Back Cover
- Changes for 2021: Page 15
- Summary of Benefits: Page 148

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 123 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

Brochure Layout

- Introduction/FEHB Facts (Pgs 4-12)
- **Section 1:** How This Plan Works (Pgs 13-14)
- **Section 2:** Changes for 2021 (Pgs 15)
- **Section 3:** How You Get Care (Pgs 16-24)
- **Section 4:** Your Costs for Covered Services (Pgs 25-30)
- **Section 5:** Benefits
  - High Option (Pgs 33-75)
  - Consumer Driven Option (Pgs 76-123)
- **Section 6:** General Exclusions (Pgs 124-125)
- **Section 7:** Filing a Claim for Covered Services (Pgs 126-128)
- **Section 8:** The Disputed Claims Process (Pgs 129-131)
- **Section 9:** Coordinating Benefits with Medicare and Other Coverage (Pgs 132-142)
- **Section 10:** Definitions (Pgs 143-147)



Brochure Layout (cont.)

- Summary of High Option (Pgs 148-149)
- Summary of Consumer Driven Option (Pgs 150-151)
- Index (Pgs 152-153)
- 2021 Rate Information (Pg 158)



Introduction

- Health Plan Address
- Health Care Fraud
- Never Event
- Patient Safety
- FEHB Facts
- Who’s covered and when?



Section 1: How This Plan Works
High Option

- PPO Network (Cigna OAP)
  - PPO Directory online at: www.apwuhp.com
    - The Health Plan will no longer provide paper directories.
  - Prompts to filter your search results
    - Provider Type
    - Specialty
    - Facility Type
    - Distance from home/work



Section 1: How This Plan Works
Consumer Driven Option

- PPO Network (UnitedHealthcare)
  - PPO Directory online at: www.welcometouhc.com/apwu
  - Prompts to filter your search results
    - Provider Type
    - Specialty
    - Facility Type
    - Distance from home/work
  - Call UnitedHealthcare at: 800-718-1299



Section 2: Changes for 2021
High Option

- Routine mammograms for women age 65 and older every calendar year covered at 100%
- Members who purchase outpatient specialty drug are now required to use Accredo or will be responsible for the full cost of the medication.
- Diabetes Management:
    - A new Patient Assurance Program (PAP) will provide fixed copays for certain insulins to treat Diabetes: $25 copay for 30 days, $75 copay for 90 days.
    - The Diabetes Management Program has been removed, however, the Plan will continue to cover Formulary generic oral medications, Formulary blood glucose test strips and lancets for a $0 copay.



Section 2: Changes for 2021
High Option

- Gene therapy covered at 15% coinsurance, preauthorization is required.
- Change from Beacon Health Options to Cigna Behavioral Health as Mental Health/Substance Use Disorder vendor.
    - Re-issue of ID Cards for all existing Health Plan members
- A new Medicare Advantage Plan, UnitedHealthcare Retiree Advantage plan will be offered.



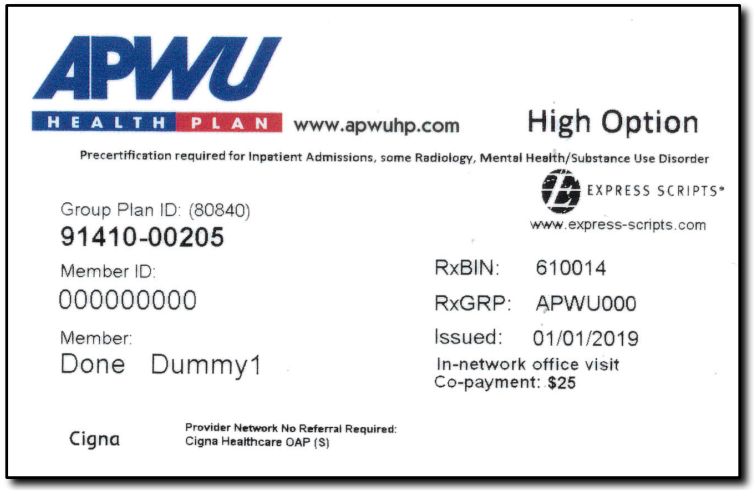
Section 2: Changes for 2021
Consumer Driven Option

- Remove the $25 incentive for completing the Health Risk Assessment and will provide a $25 wellness incentive when the member completes a routine physical each year.
- Cancer Guidance program for providers, where providers will call and receive guidance regarding chemotherapy and site of care for members.



Section 3: How You Get Care

- ID Cards
- Precertification Process
  - Services that need precertification
  - How to request precertification
  - Penalties for non-compliance/late requests
- Steps to request reconsideration of pre-service decision
- Steps to appeal a decision



Do I need Precertification?
High Option and Consumer Driven Option

- Organ transplants
- Procedures which may be cosmetic in nature (eyelid surgery, varicose vein)
- Services and supplies which may be experimental/investigational
- Bariatric Surgery
- Applied Behavioral Analysis (ABA)
- Gender Reassignment Surgery



Do I need Precertification?
High Option and Consumer Driven Option

- Home Health Care such as nursing visits, infusion therapy, growth hormone therapy (GHT), and pulmonary rehabilitation programs
- Durable Medical Equipment (DME) and prosthetic devices
- Genetic testing (BRCA)
- Skilled Nursing Facility (SNF)
- Residential Treatment Center (RTC)



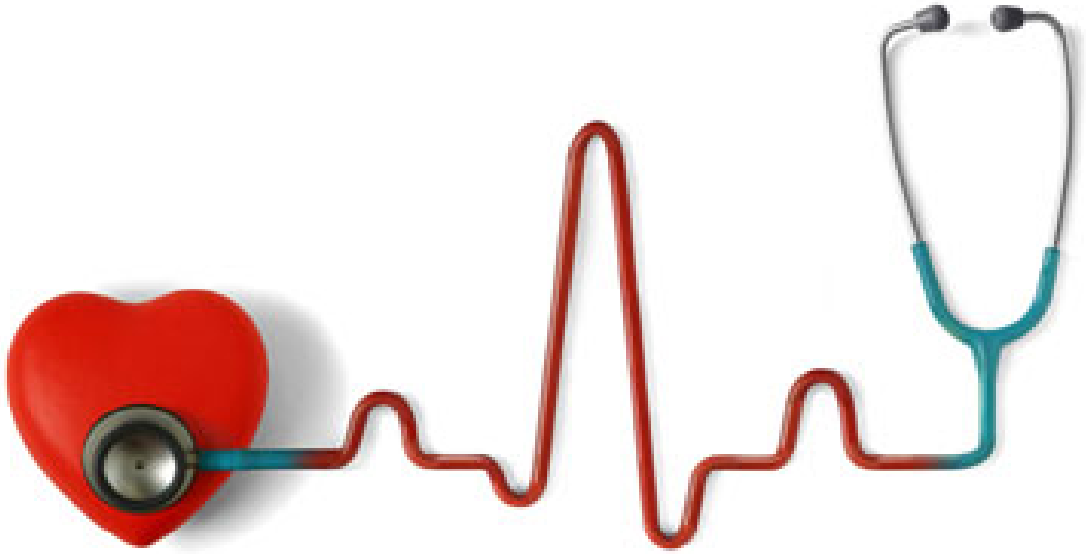
Do I need Precertification?
High Option

- High Tech Radiology
  - MRI
  - CT
  - PET
- Speech Therapy
- Treatment Back / Neck Pain



Do I need Precertification?
Consumer Driven Option

- Treatment of Congenital Heart Disease
- Non-emergent ambulance
- Orthognathic surgery



No Precertification Needed
High Option and Consumer Driven Option

- Outpatient Services at VA
- Maternity Care/Admissions
- Chiropractic Care
- Acupuncture Treatment
- Physical, Occupational Therapy
- Trigger Point Injections



Section 4: Your Costs for Covered Services
High Option

- Out-of-pocket Costs
  - Copay
  - Deductible
  - Coinsurance
- PPO vs. Non-PPO
  - Balance Billing
- Catastrophic Costs / Maximum Out of Pocket



Accumulations to Max Out-of-Pocket* High Option

Applied	Not Applied
5%, 15%, 30%, 40% coinsurance	Amounts exceeding Plan allowance
$15, $25, $30 copay	Amounts over max limits, accumulations
Medical deductible(s)	Precertification penalties
25%, 45% Rx coinsurance	$300 copay for admission to out-of-network facility
$10, $20 Rx copay	50% Rx coinsurance
	Non-Covered Charges

*** Catastrophic Costs**



High Option Deductible

- A fixed amount of covered expenses a member must incur before benefits can be paid

When Deductible Applies	When Deductible Does Not Apply
Covered diagnostic services	In-network office visit
Covered therapy services	Covered in-network preventive care
Covered in-patient professional services	Services related to an accidental injury within 72 hours
Covered surgery/anesthesia services	Prescription Rx



High Option Deductible (cont.)

- Eligible deductible amounts for all family members are applied toward the max

High Option	
DEDUCTIBLES	
PPO	**Non-PPO**
Self Only: $450	Self Only: $1,000
Self Plus One: $800	Self Plus One: $2,000
Self and Family: $800	Self and Family: $2,000
Catastrophic Limit	
Self Only: $6,500	Self Only: $12,000
Self Plus One: $13,000	Self Plus One: $24,000
Self and Family: $13,000	Self and Family: $24,000
Coinsurance	
15%	40%

High Option Deductible (cont.)

- Once combined deductible amounts reach the maximum, the family deductible is considered satisfied.
    - A family of five could have amounts applied to their individual deductible(s) that do not meet/exceed the individual one. But when the combined sum of the individual amounts meets the family deductible, no further deductible will be taken for any covered family member.



High Option Copayments

- A fixed amount of money you pay when you receive covered services.

Service	Copay
Office Visit Chiropractic Visit (24 visit limit) Acupuncture Treatment (26 visit limit)	$25
Virtual Office Visit through American Well	$15
Virtual Office Visit through Cigna	$25
Urgent Care	$30
Admission to **non-participating** hospital	$300
Prescription drugs	$10 Generic - Retail $20 Generic - Mail Order



High Option Coinsurance

- The percentage of covered allowances for which the patient is responsible. Coinsurance does not begin until the deductible has been met.
  - 15% of allowance for PPO care
  - 40% of allowance for non-PPO care
  - 30% of allowance for routine dental services
  - 5% of allowance for treatment of cancer at Cancer Centers of Excellence
  - 25%, 45% Brand named Rx



Section 4: Your Costs for Covered Services
Consumer Driven Option

- Out-of-pocket Cost
  - Copay (none)
  - Deductible
  - Coinsurance
- In-Network vs. Out-of-Network
  - Balance billing



Deductible – Bridge Between PCA and Traditional Insurance

PCA
(Covered services paid at 100%)

Deductible
(You pay full cost until deductible is met)

Coinsurance
(Cost sharing)



Personal Care Account (PCA)

- An established benefit amount which is available to use first to pay for covered hospital, medical, dental and vision expenses.

Self Only	Self Plus One	Self and Family
$1,200	$2,400	$2,400



Personal Care Account (cont.)

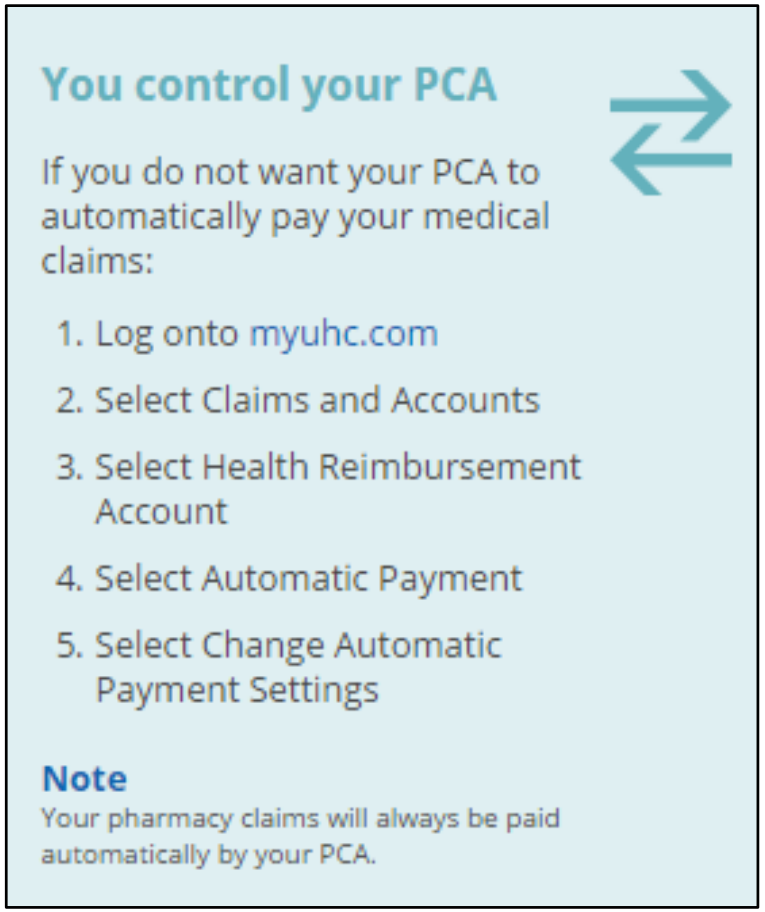
- Members are given an account on day one of coverage.
- PCA is fully funded and provided annually by the Health Plan.
- Pays covered medical expenses at 100% as long as funds are available.
- Any unused funds will roll over to the next year.

PCA Rollover Maximum		
Self Only	**Self Plus One**	**Self and Family**
$5,000	$10,000	$10,000



Controlling Your PCA

- PCA rolls over
- FSA does not roll over
- Member can turn off PCA for a selected period of time
- Member can now use FSA for healthcare expenses
- Except for Rx



Consumer Driven Option Deductible

Consumer Driven Option	
DEDUCTIBLES	
In-Network	**Out-of-Network**
Self Only: $1,000	Self Only: $1,500
Self Plus One: $2,000	Self Plus One: $3,000
Self and Family $2,000	Self and Family: $3,000
Catastrophic Limit	
Self Only: $6,500	Self Only: $12,000
Self Plus One: $13,000	Self Plus One: $24,000
Self and Family: $13,000	Self and Family: $24,000
Coinsurance	
15%	50%



PCA / Family Deductible
Consumer Driven Option

- Self Plus One or Self and Family:

  $2,400 PCA plus $2,000 deductible = $4,400 "Total Deductible"

  - Once member one meets an additional out-of-pocket of $2,100 for a total of $6,500, (*the out-of-pocket max for Self Only*) their claims for covered services will be paid at 100%.
  - Once member two meets the additional Self Plus One out-of-pocket $6,500 (*for a total of $13,000 for the family*), that person's claims will be paid at 100%.



Coinsurance
Consumer Driven Option

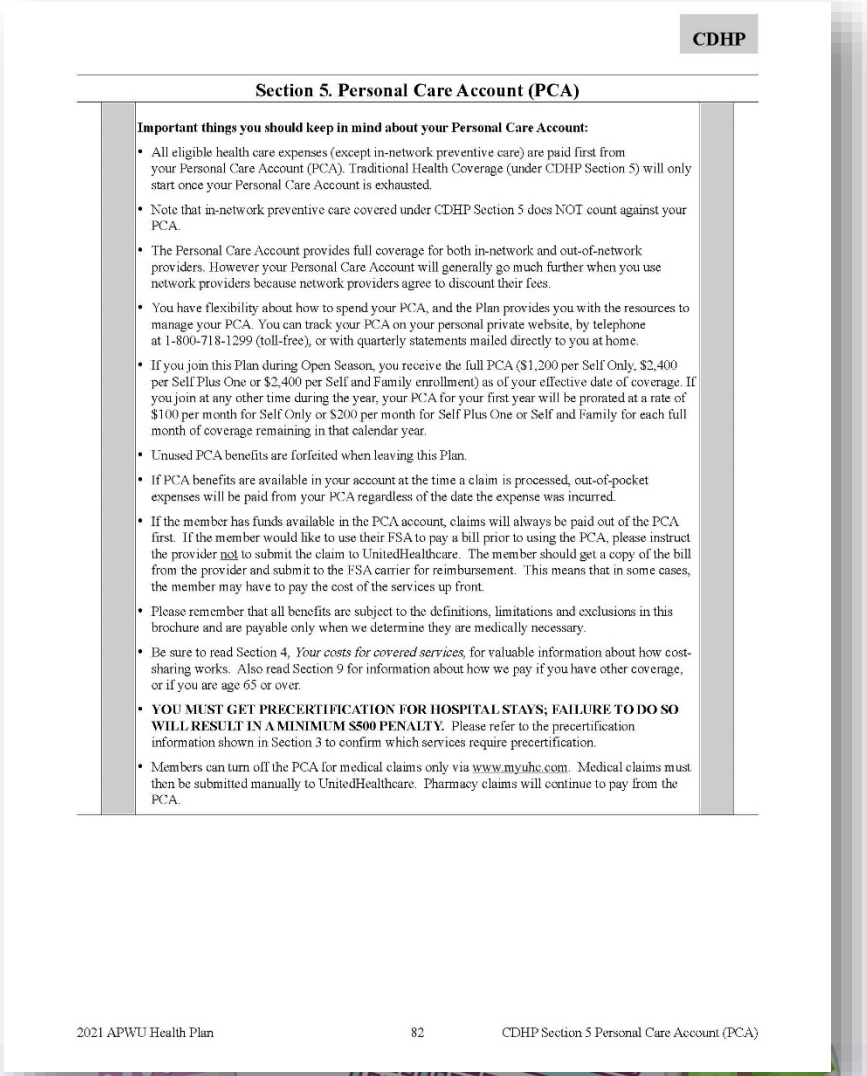
- The percentage of covered allowances for which the patient is responsible.
  - 15% of allowance for in-network care
  - 50% of allowance for out-of-network care
  - 10% of allowance for treatment of cancer at a Cancer Center of Excellence
  - 10% of allowance for transplants performed at a Transplant Center of Excellence
  - 25% of prescription formulary allowance
  - 40% of non-preferred brand name drugs



Personal Care Account (PCA)

- Dental
- Vision
- Rollover

$400/$800



CDHP

Section 5. Personal Care Account (PCA)

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

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

2021 APWU Health Plan 82 CDHP Section 5 Personal Care Account (PCA)

Section 5: Benefits
Sections 5 (a) - (i)

a) Medical Services and Supplies

b) Surgical and Anesthesia Services

c) Services Provided by a Hospital or Other Facility

d) Emergency Services

e) Mental Health and Substance Use Disorder

f) Prescription Drug Benefits

g) Dental Benefits

h) Wellness and other Special Features

i) Health Education Resources and Account Management Tools



Medical Service and Supplies
Section 5(a)

- Office, hospital visits
- X-rays and diagnostic tests
- Preventive Care
- Maternity
- Infertility
- Therapies
- Hearing
- Foot Care
- DME
- Home Health Services
- Chiropractic
- Acupuncture



Preventive Care
In-Network High Option

- **$0.00 Patient responsibility**
  - Immunizations recommended by CDC for both children and adults
  - Annual routine exam, adults
  - Well baby/child visits
  - See brochure for comprehensive list of covered services

Note: *A service or treatment performed when symptoms of illness are present may not be considered preventive for the purpose of this coverage.*

Example: A colonoscopy performed when a patient has been experiencing bleeding.



Preventive Care
In-Network Consumer Driven Option

- Covered services paid at 100%
- PCA is not used
- Annual exam
- Blood work
- Immunizations
- Screenings



Virtual Office Visits

- 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
- In-network benefit only.



Virtual Office Visits
High Option

- Call 1-855-818-DOCS or visit www.AmWell.com for information on virtual visits
  - Subject to a $15 copay through AmWell
- TeleHealth Services through a Cigna provider
  - Subject to a $25 copay



Virtual Office Visits
Consumer Driven Option

- Log into www.myuhc.com for information on virtual office visits
    - Subject to 15% of the Plan allowance
- Mental Health and Substance Use Disorder call 1-800-718-1299 or log into www.myuhc.com for information on virtual visits
    - Subject to 15% of the Plan allowance



Family Planning / Infertility

- The Plan covers services related to the *diagnosis* and *treatment* of infertility:
  - Covered services: Visits, Surgery, Diagnostic testing
  - Maximum Plan benefit: $2,500
- The Plan does not cover costs to assist in conception:
  - In Vitro Fertilization (IVF)
  - Costs of donor sperm/egg



Physical / Occupational / Speech Therapies

- Covered Treatments:
  - Services of a Registered Physical/Occupational Therapist to assist in the recovery of lost, diminished (rehabilitative) or absent (habilitative) functionality.
  - Services of a Registered Speech Therapist to assist in restoring lost or diminished functionality.
- Benefits are limited to a combined outpatient visit count of 60.
- Services must be ordered by a physician.
- Preauthorization is required for speech therapy for High Option only.



Routine Foot Care

- 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



Surgical and Anesthesia Services
Section 5(b)

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



Anesthesia

- Services by an out-of-network anesthesiologist:
  - Plan will apply ***in-network benefits*** to the Plan allowance for an ***out-of-network anesthesiologist*** where services are performed by an ***in-network surgeon*** at an ***in-network facility.***
  - Plan will apply ***out-of-network*** benefits to the ***out-of-network anesthesiologist*** where services performed by an ***in-network surgeon*** at an ***out-of-network facility.***
  - Plan will apply ***out-of-network benefits*** to the ***out-of-network anesthesiologist*** where services performed by an ***out-of-network surgeon*** at an ***in-network facility.***
  - In all cases, the out-of-network anesthesiologist may balance bill.



Organ and Tissue Transplants
High Option

- List of covered transplants (Pgs 50-53).
- All are subject to prior authorization and medical necessity review.
- Out-of-network services have benefit payout limitations.
- Transplant Network
    - Plan-specific organ-tissue transplant facilities.
    - Prior to an initial evaluation, physician or patient must contact Cigna 1-800-668-9682 and speak to a Transplant Case Manager.

Organ and Tissue Transplants
Consumer Driven Option

- List of covered transplants (Pgs 102-105).
- In-Network Transplant Centers of Excellence: 10% of the Plan allowance.
- Out-of-network services have benefit payout limitations.
- Transplant Network
    - Plan-specific organ-tissue transplant facilities.
    - Prior to an initial evaluation, physician or patient must contact UnitedHealthcare at 1-800-718-1299 and speak to a Transplant Case Manager.



Hospital / Facility and Ambulance
Section 5(c)

- Inpatient Room and Board
- Cancer Centers of Excellence
- Outpatient Hospital or Ambulatory Surgical Center
- Hospice
- Extended Care/Skilled Nursing
- Ambulance



Inpatient Room and Board

- Subject to precertification (*Section 3*)
- $500 late precertification penalty
  - Emergency admissions: 2 business days from admission date
  - Scheduled admissions: 2 business days prior to scheduled admissions
  - $300 copay if admitted to an out-of-network facility (High Option Only)



Hospital Observation Services

- Outpatient benefits apply to covered services up to 48 hours.
- Inpatient benefits will apply only when your physician admits you to the hospital as inpatient.



Skilled Nursing Facility

- Services rendered at a Skilled Nursing Facility (SNF) are covered for up to 30 days per person per calendar year when admitted directly from a covered inpatient hospital stay.
    - Prior authorization required

High Option		Consumer Driven Option	
PPO	**Non-PPO**	**In-Network**	**Out-of-Network**
15% of covered charges	$300 per admission and 40% of covered charges and any difference between our allowance and the billed amount	15% of covered charges	50% of covered charges and any difference between allowed and billed amount

Hospice

- 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)

- **Accident:** *An injury resulting from violent external force*
- **Medical Emergency:** *Sudden onset of symptoms that you believe endangers your life or could result in serious disability if not treated promptly*
- Urgent Care Center
- Ambulance



Accidental Injury
High Option

- Outpatient services, including ambulance rendered within **72 hours** of accident
  - No out-of-pocket or cost-sharing (no deductible, coinsurance, copayment)
  - Out-of-network care could result in a patient liability if there is a difference in the fee for the service and the Plan allowance



Accidental Injury
Consumer Driven Option

- Outpatient services, including ambulance rendered within **24 hours** of accident:
  - **In-Network:** PCA, Deductible, 15% of Plan allowance
  - **Out-of-Network:** PCA, Deductible, 15% of Plan allowance plus any difference between the fee for the service and the Plan allowance



Medical Emergency
High Option

Urgent Care Center		Other Facility	
PPO	**Non-PPO**	**PPO**	**Non-PPO**
$30 copayment (No Deductible)	40% of the Plan allowance plus any difference between the Plan allowance and the billed amount	15% of the Plan allowance	15% of the Plan allowance plus any difference between the Plan allowance and the billed amount



Medical Emergency
Consumer Driven Option

- All services subject to the PCA and Deductible

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



Ambulance

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

High Option		Consumer Driven Option	
PPO	**Non-PPO**	**In-Network**	**Out-of-Network**
15% of the Plan allowance (No Deductible)	40% of the Plan allowance plus any difference between the Plan allowance and the billed amount (No Deductible)	PCA, Deductible 15% of the Plan allowance	PCA, Deductible 50% of the Plan allowance plus any difference between the Plan allowance and the billed amount

Mental Health and Substance Use Disorder
Section 5(e)

- Office Visits
    - Virtual Office Visits
- Treatment
- Inpatient
- Outpatient
- Preauthorization



Office Visit and Treatment
High Option

	PPO	Non-PPO
Office Visit	$25 copayment (No Deductible)	40% of the Plan allowance and any difference between our allowance and the billed charges
Virtual Office Visit through Cigna Behavioral Health	$25 copayment (No Deductible)	N/A
Diagnostic Treatment	15% of the Plan allowance	40% of the Plan allowance and any difference between our allowance and the billed charges



Office Visit and Treatment
Consumer Driven Option

	PPO	Non-PPO
Office Visit	PCA, Deductible 15% of the Plan allowance	PCA, Deductible 50% of the Plan allowance plus any difference between the Plan allowance and the billed charges
Virtual Office Visit through UHC Behavioral Health Solutions	PCA, Deductible 15% of the Plan allowance	N/A
Diagnostic Treatment	PCA, Deductible 15% of the Plan allowance	PCA, Deductible 50% of the Plan allowance plus any difference between the Plan allowance and the billed charges

Mental Health and Substance Use Disorder - Preauthorization

- **Requirements:**
  - Inpatient Services
  - Outpatient Services
  - Applied Behavioral Analysis (ABA)
  - Repetitive Transcranial Magnetic Stimulation (TMS)
  - Services at a Residential Treatment Facility
- **Contacts:**
  - **High Option:** Cigna Behavioral Health 1-800-582-1314
  - **Consumer Driven Option:** UHC Behavioral Health Solutions 1-800-718-1299



Prescription Drugs
Section 5(f)

- Express Scripts / OptumRx
- Formulary
- FDA approved
- Brand vs. Generic
- Network
  - Retail
  - Mail Order
  - Specialty
- Coverage review
- Step Therapy



Prescription Drug Features

- **Vendors**
  - **High Option:** Express Scripts
  - **Consumer Driven Option:** OptumRx
- **National Preferred Formulary**
  - List of medications selected based on clinical effectiveness and lower cost
- **Generic Drugs**
  - Chemical equivalent of a corresponding name brand drug
  - Available at a lower cost
- **New for 2021:** Patient Assurance Program (PAP) will provide fixed copays for certain insulins to treat Diabetes. $25 copay for 30 days, $75 copay for 90 days.



Prescription Drug Tiers
High Option

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



Prescription Drug Tiers
Consumer Driven Option

Type of Drug	Network Pharmacy (Retail)	Non-Network Pharmacy (Retail)	Network Mail Order
Mostly Generic Drugs **Tier 1**	PCA, Deductible 25% of charge with a minimum of $15 and a maximum of $200 for a 30-day supply, $400 for a 60-day supply and $600 for a 90-day supply	N/A	PCA, Deductible 25% of charge with a minimum of $15 and a maximum of $200 for a 30-day supply, $400 for a 60-day supply and $600 for a 90-day supply
Mix of Brand Drugs and Generic **Tier 2**	PCA, Deductible 25% of charge with a minimum of $15 and a maximum of $200 for a 30-day supply, $400 for a 60-day supply and $600 for a 90-day supply	N/A	PCA, Deductible 25% of charge with a minimum of $15 and a maximum of $200 for a 30-day supply, $400 for a 60-day supply and $600 for a 90-day supply
Mostly Brand Drugs **Tier 3**	PCA, Deductible 40% of charge with a minimum of $15 and a maximum of $300 for a 30-day supply, $600 for a 60-day supply and $900 for a 90-day supply	N/A	PCA, Deductible 40% of charge with a minimum of $15 and a maximum of $300 for a 30-day supply, $600 for a 60-day supply and $900 for a 90-day supply

Specialty Drugs

- Must be obtained through:
  - **High Option:** Accredo Specialty Pharmacy
  - **Consumer Driven Option:** OptumRx Specialty Pharmacy
- Injectable, infused, oral or inhaled drugs:
  - Require frequent dosing adjustments
  - Intensive patient training
  - Limited product availability
  - Specialized product handling
- Targeted conditions include:
  - Cystic Fibrosis
  - Gaucher disease
  - Growth hormone deficiency
  - Hepatitis C
  - Rheumatoid Arthritis



Specialty Drug Tiers
High Option

Type of Drug	Network Pharmacy (Retail)	Non-Network Pharmacy (Retail)	Network Mail Order
Generic Drugs **Tier 1**	25% coinsurance; $300 maximum for 30-day supply	50% coinsurance for 30-day supply	25% coinsurance; $150 maximum for 90-day supply
Preferred Brand Drugs **Tier 2**	25% coinsurance; $600 maximum for 30-day supply	50% coinsurance for 30-day supply	25% coinsurance; $300 maximum for 90-day supply
Non-Preferred Brand Drugs **Tier 3**	45% coinsurance; $1,000 maximum for 30-day supply	50% coinsurance for 30-day supply	45% coinsurance; $500 maximum for 90-day supply

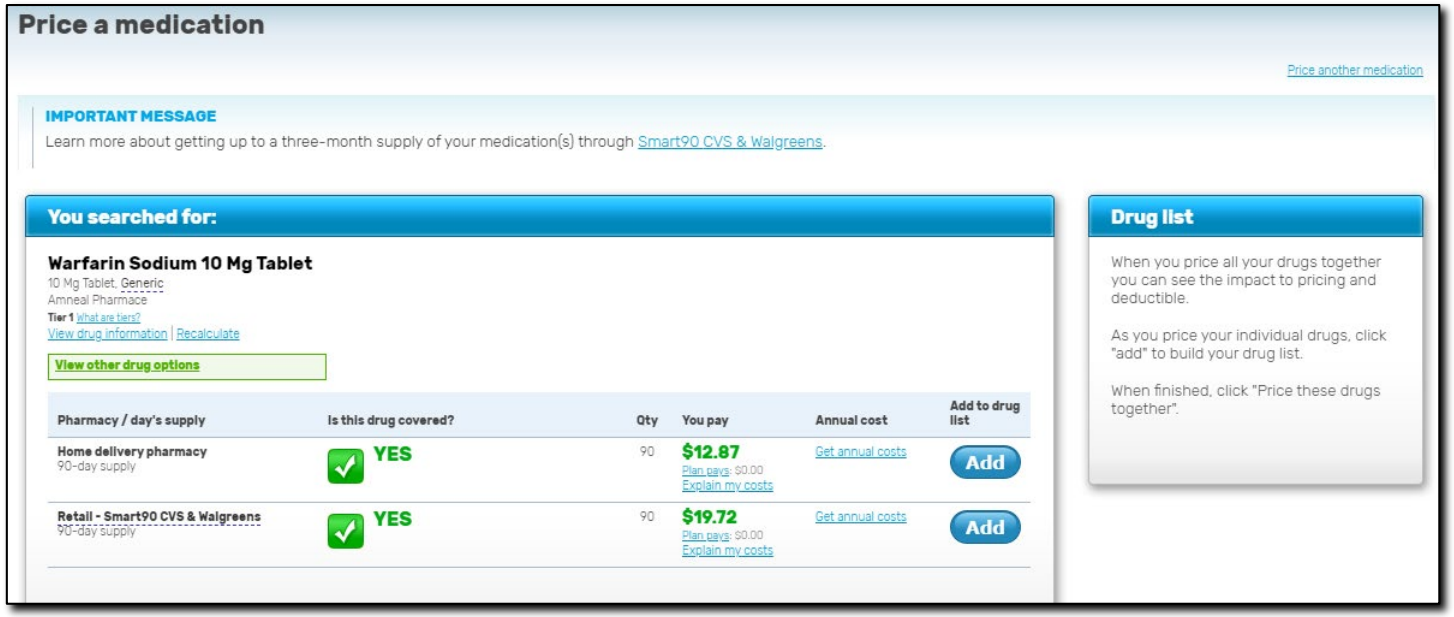
Prescription Coverage Definitions

- Drugs covered only with a prior authorization include:
  - Growth Hormones
  - Botox
  - Retin-A
  - Drugs for gender transition
- Step Therapy/Coverage Review
  - Ensures Generic/Brand alternatives within a therapeutic category is the first-line treatment
  - Full list of affected drug categories:
    - High Option (Pg 69)
    - CDO (Pg 118)



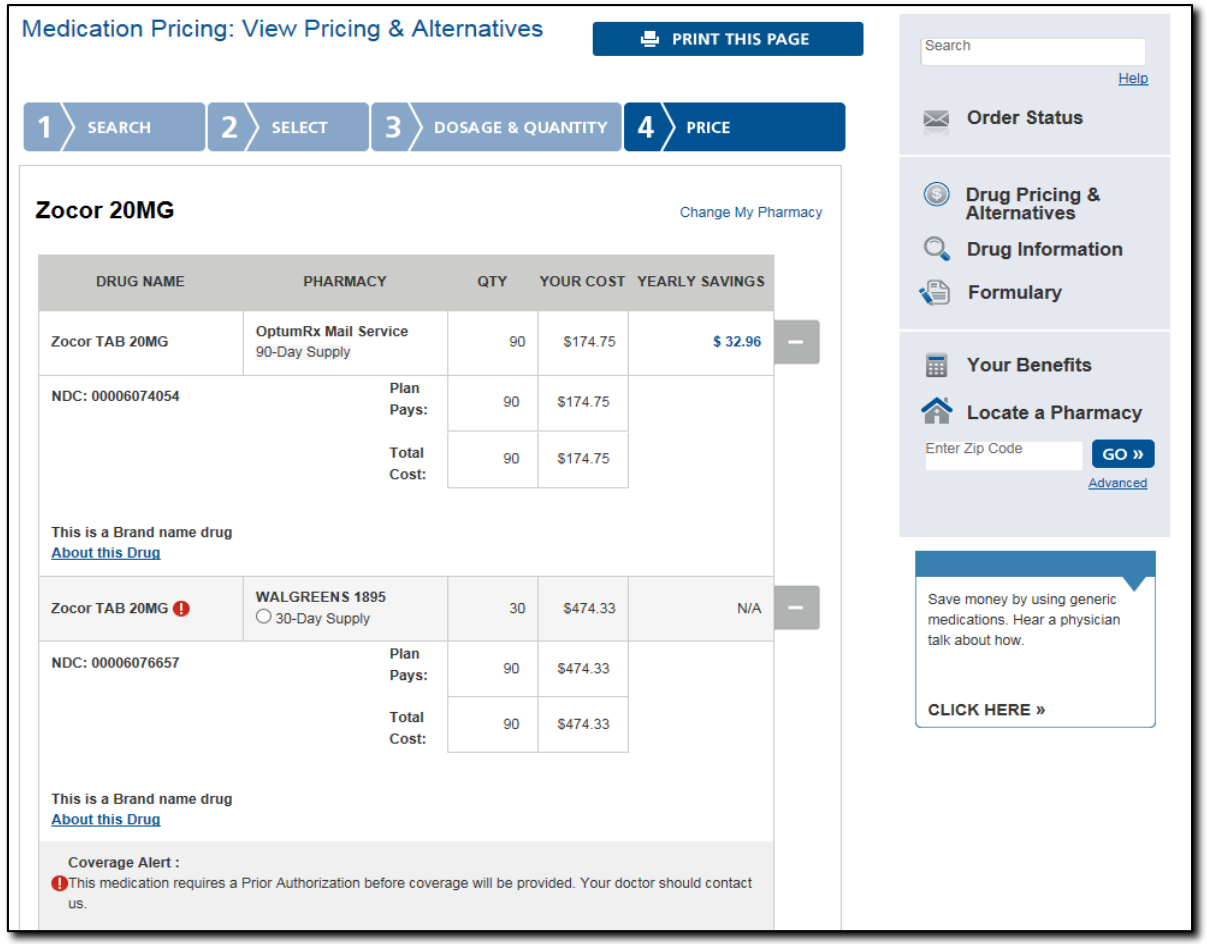
Prescription Drug Calculator
High Option

- www.apwuhp.com
  - APWU Health Plan Members
  - Under “My Tools” select Pharmacy
  - Prescription Cost Calculator “Visit Express Scripts”



Prescription Drug Calculator
Consumer Driven Option

- www.myuhc.com



Dental Benefits
Section 5(g) High Option

- 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 any difference in provider's fee and APWU Health Plan allowance



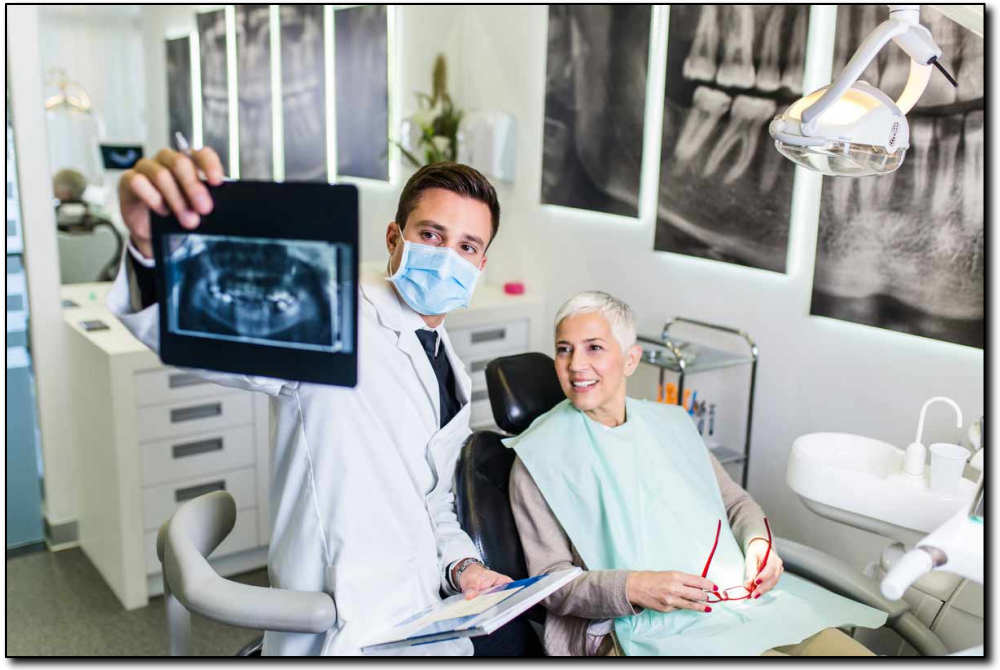
CignaPlus Savings Discount
Dental Program High Option

- 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).*
- Complete online Health Risk Assessment to become eligible for this program.
    - Self-Only enrollment, complete online HRA and Plan will pay the premium for Self Only coverage with 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 coverage with CignaPlus Discount Dental Program.



Dental Benefits
Consumer Driven Option

- Dental services are not covered
- Can use up to $400 from PCA for Self Only enrollment or $800 for Self Plus One or Self and Family enrollment



Wellness and Other Special Features
Section 5(h) High Option

- 24-hour Nurse Line
- Health Management Programs
- Healthy Pregnancies, Healthy Babies
- Health Risk Assessment
    - CignaPlus Savings (Dental Program)



Health Education Resources and Account Management Tools
Section 5(i) Consumer Driven Option

- Online tools and resources
- Consumer choice information
- 24-hour Nurse advisory line
- Special Programs
    - Healthy Pregnancy
    - Kidney Resources Program
    - Orthopedic Health Support
    - Cancer Support
    - Source4Women



Section 6: General Exclusions

- Experimental or investigational procedures, drugs, services
- Biofeedback; non-medical self-help training services
- Services, drugs, supplies that are not medically necessary



Section 7: Filing a Claim

- **Claims**
  - Where to file
  - Addresses, electronic payor numbers, phone numbers
- **Deadlines**
  - Timeframe for filing claims based on when services were rendered
- **Overseas**
  - Documentation needed for reimbursement
  - Address to submit claims



Section 8: Disputed Claims

- Written request for reconsideration
    - Timeframes to appeal
    - Supporting documents needed
- APWU Health Plan response within 30 days
- Member appeals to OPM
- OPM response



Section 9: Coordinating Benefits
High Option

- Medicare Advantage plan, UnitedHealthcare Retiree Advantage Plan
  - Must be enrolled in the High Option
  - Must have Medicare A and B
  - Reimburse $50.00 of Medicare Part B monthly premium
  - $0 Deductible and Out-of-Pocket Maximums
  - $0 Cost for physician office visits or hospitalization (inpatient or outpatient)
  - Incentive Programs
    - Silver Sneakers
    - Podiatry Benefit
    - Hearing Aid Benefit
    - Nationwide Network



Section 9: Coordinating Benefits
High Option

- Medicare A and B
  - APWU Health Plan waives deductible, copays and coinsurance
  - Claims submitted electronically by Medicare (Traditional Coverage)
  - Paper claims required when a patient has a Medicare Advantage Plan
  - Minimal, if any, patient out-of-pocket costs
  - Preauthorization requirements waived when APWU Health Plan is secondary



Coordinating Benefits (cont.)

- Other Primary Medical, Dental, or No Fault Insurance
  - Primary payor based on employment status, and relationship to insured
  - Deductibles, copays and coinsurance are not waived
  - Plan pays its normal benefit or the amount due after the primary carrier pays, whichever is lower
  - Paper claims to include the primary payor's EOB/Remittance Advice to receive reimbursement
  - Preauthorization requirements waived when APWU Health Plan is secondary



Coordinating Benefits (cont.)

- **Medicaid**
  - We do not coordinate with Medicaid; APWU Health Plan is the primary payor when a patient has Medicaid coverage
- **Worker's Compensation**
  - We do not cover services where OWCP (or similar agency) assumes liability
- **TRICARE / CHAMPVA**
  - APWU Health Plan is the primary payor when a patient is also covered by TRICARE or CHAMPVA



Section 10: Definitions

- An alphabetical listing that defines many common terms used in the Brochure
  - Genetic Testing
  - Genetic Screening
  - Medically Necessary
  - Pre-service Claim
  - Post-service Claim
  - Subrogation



Last Pages

- Summary: High Option (Pgs 148-149)
- Summary: Consumer Driven (Pgs 150-151)
- Index (Pgs 152-153)
- Notes Pages (Pgs 154-157)
- Rate Page (Pg 158)



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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!

