APWU HEALTH PLAN
TOGETHER. BETTER HEALTH.

Brochure Review



Presented by

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and

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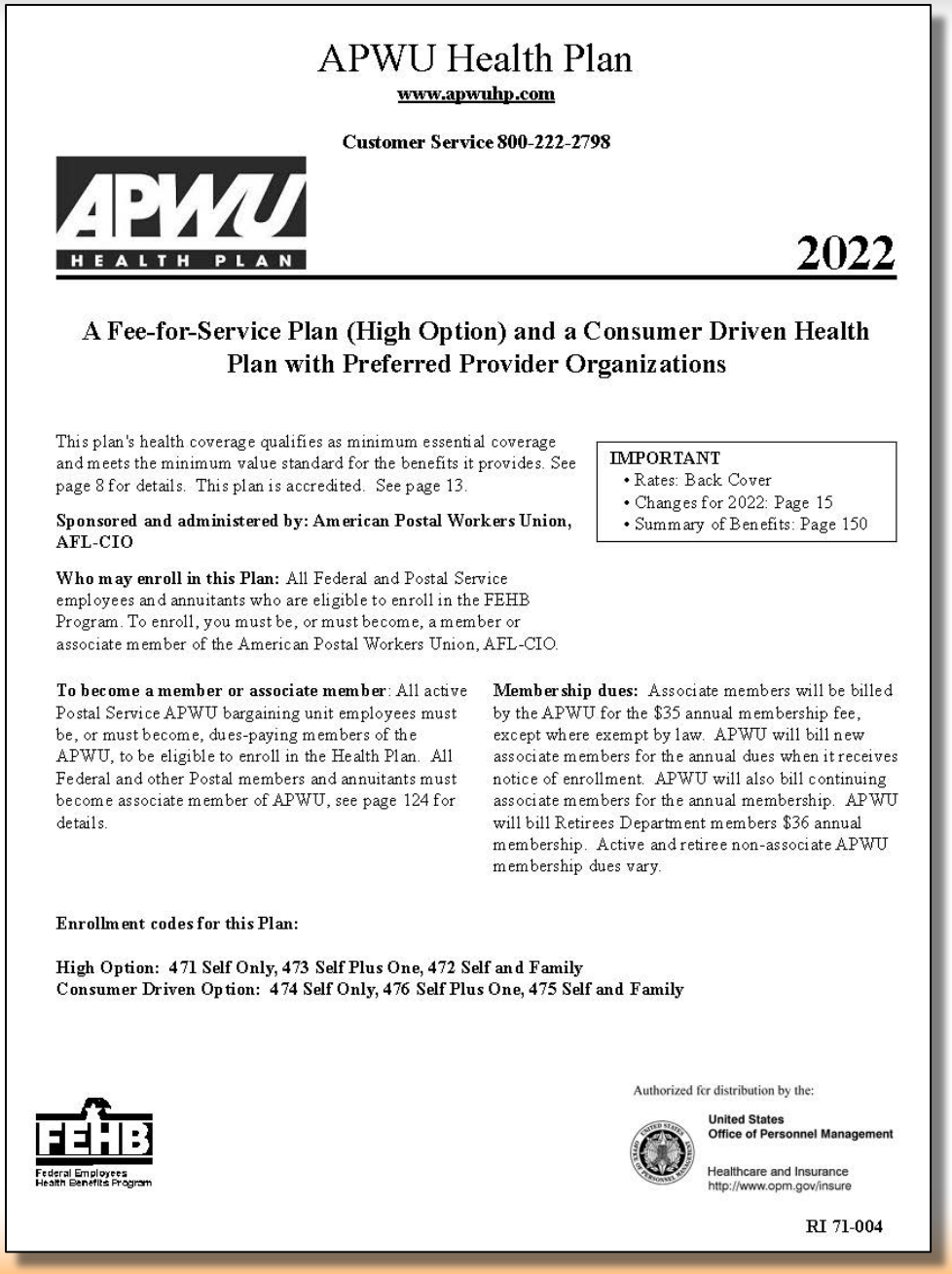
Introduction

- Brochure
  - Layout
  - Sections
  - Changes
- Review Benefits
  - Changes for 2022



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 124 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 2022 (Pg 15)
- Section 3: How You Get Care (Pgs 16-24)
- Section 4: Your Costs for Covered Services (Pgs 25-31)
- Section 5: Benefits
  - High Option (Pgs 32-76)
  - Consumer Driven Option (Pgs 77-125)
- Section 6: General Exclusions (Pgs 126-127)
- Section 7: Filing a Claim for Covered Services (Pgs 128-130)
- Section 8: The Disputed Claims Process (Pgs 131-133)

Brochure Layout

- Section 9: Coordinating Benefits with Medicare and Other Coverage (Pgs 134-144)
- Section 10: Definitions (Pgs 145-149)
- Summary of High Option (Pgs 150-149)
- Summary of Consumer Driven Option (Pgs 150-151)
- Index (Pgs 152-153)
- 2022 Rate Information (Pg 158)

Introduction

- Health Plan Address
- Healthcare Fraud
- Never Event
- Patient Safety
- FEHB Facts
- Who's Covered and When?



Section 1: How This Plan Works



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
- Call UnitedHealthcare at: 800-718-1299

Section 2: Changes for 2022



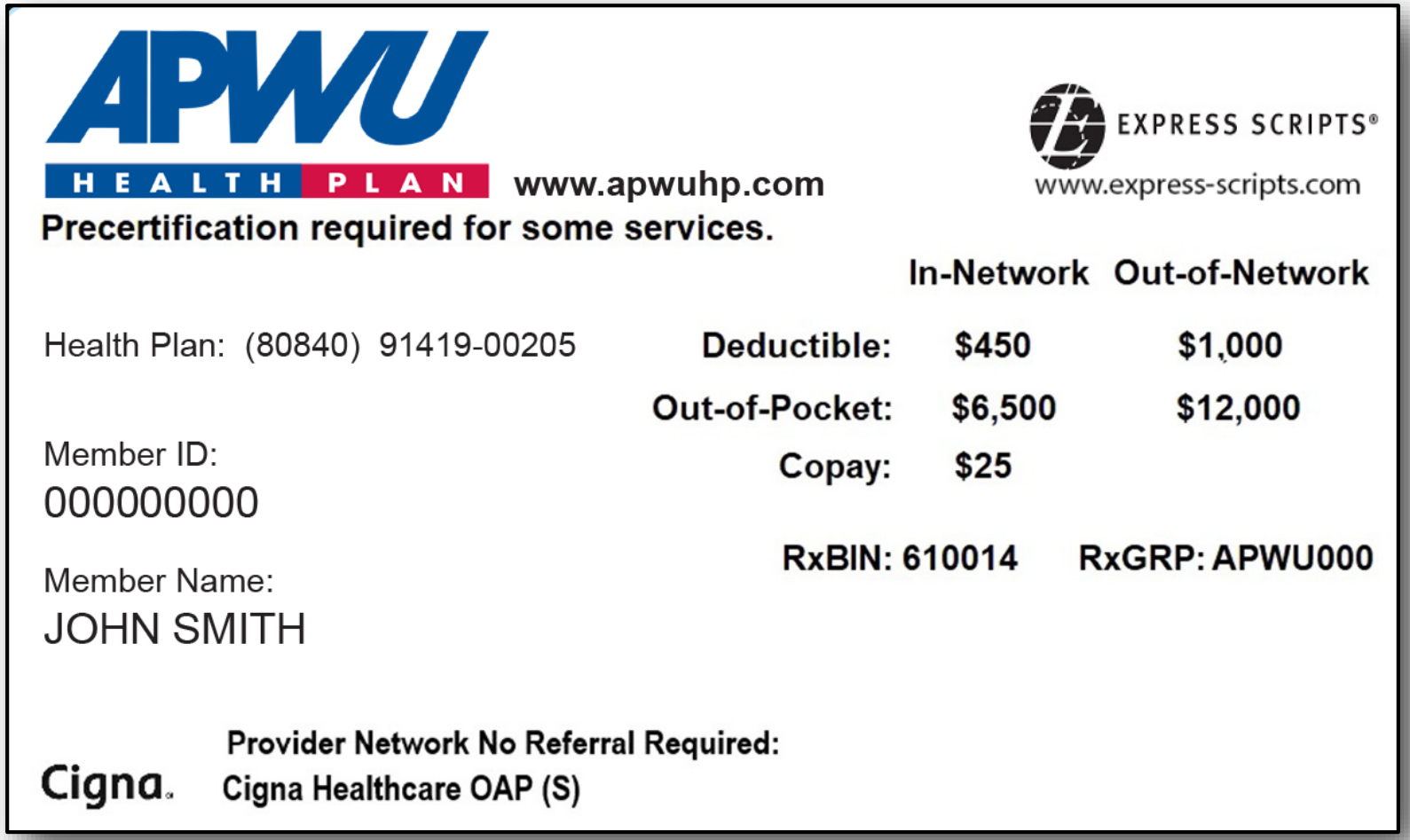
Section 2: Changes for 2022 – High Option

- The Plan added a $2,500 maximum per calendar year for infertility drugs (Pg 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 (Pg 69).
- Prior authorization is no longer required for psychological and neuropsychological testing, electroconvulsive therapy, and professional services for intensive outpatient treatment (Pg 63).
- Hypercholesterolemia drugs will no longer be treated as specialty drugs (Section (f)).

Section 2: Changes for 2022 – High Option

- The Plan has increased the number of conditions that require authorization and step therapy for prescription drugs (see Pg 71 for details on these conditions).
- Preventive migraine medications no longer need to be obtained through Network Mail Order (Section 5(f)).
- 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.

Section 2: Changes for 2022 – High Option



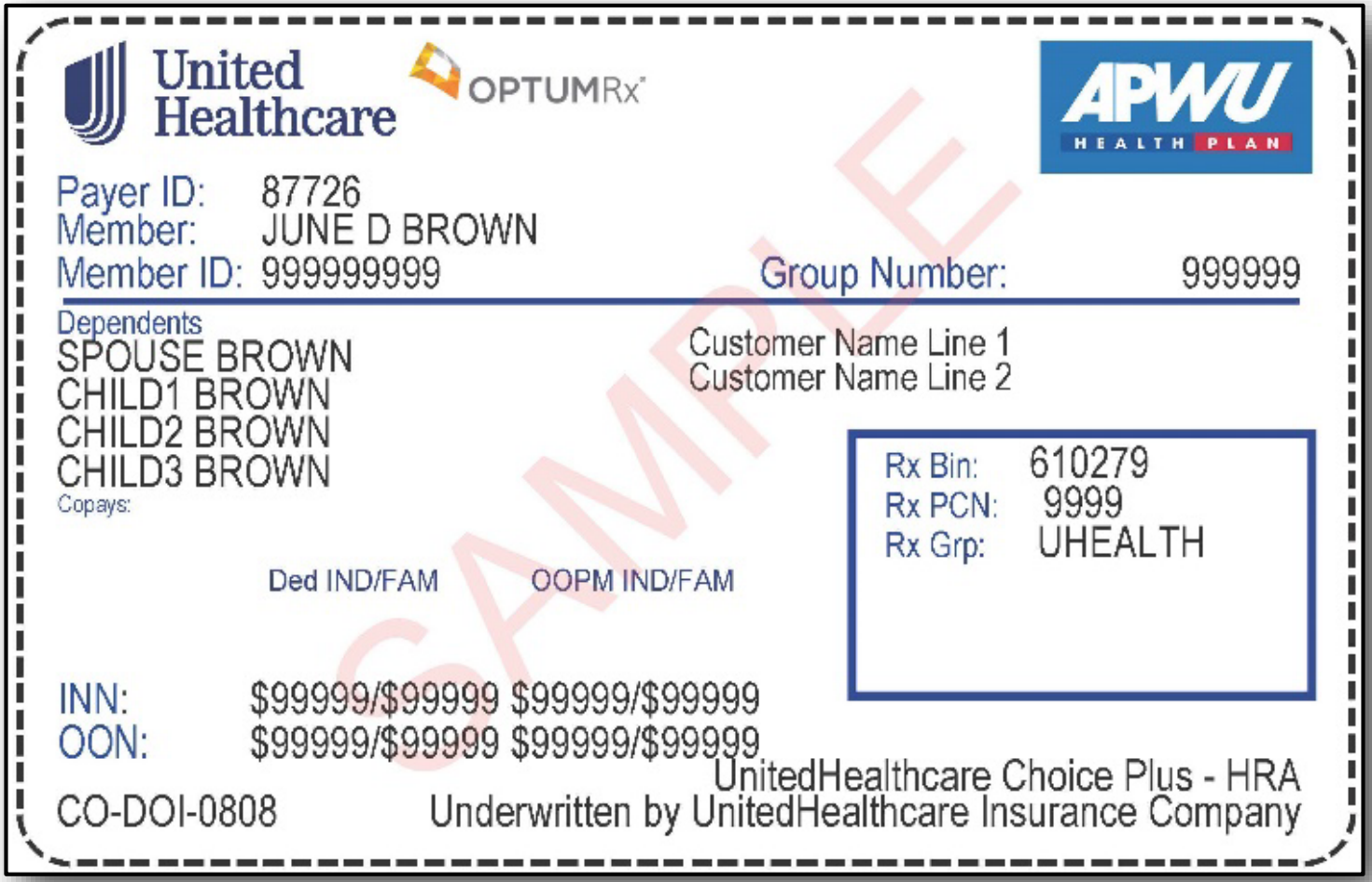
Section 2: Changes for 2022 – Consumer Driven Option

- The Plan added a $2,500 maximum per calendar year for infertility drugs (Pg 92).
- The Plan will require prior authorization for hysterectomy, sinuplasty, and functional endoscopic sinus surgery (Pg 19).
- The Plan added a 52-week weight management program called Real Appeal, delivered by a virtual coach (Pg 122).
- The Plan added AbleTo, a customized behavioral health 6-8 week digital treatment program (Pg 122).
- The Plan removed the Source4Woman Program (Pg 122).

Section 2: Changes for 2022: Consumer Driven Option

- Out-of-Network Air Ambulance covered as in-network (Pg 112).
- 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.

Section 2: Changes for 2022: Consumer Driven Option



Section 3: How You Get Care



Section 3: How You Get Care

- ID Cards
- Precertification
  - 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
- Services and supplies which may be experimental/investigational
- Bariatric Surgery
- Applied Behavioral Analysis (ABA)
- Gender Reassignment Surgery
- Home Healthcare 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

- Gene Therapy
- Minimally invasive treatment of back and neck pain. This requirement applies to both the physician services and the facility. The following services require prior approval: epidural steroid injections, facet joint injections, sacroiliac joint injections.
- Procedures which may be cosmetic in nature such as eyelid surgery, varicose vein surgery, or Botox injections for medical diagnosis.
- Recognized surgery for morbid obesity (bariatric surgery)

Note: Prior approval for outpatient services at Veterans Administration facilities is not needed.

Do I need Precertification? Consumer Driven Option

- Treatment of Congenital Heart Disease
- Air Ambulance – non-emergent
- Orthognathic surgery
- Bariatric surgery
- Clinical Trials
- Chemotherapy – outpatient
- Functional endoscopic sinus surgery
- Hospice – inpatient
- Hysterectomy
- Potential cosmetic procedures

Do I need Precertification? Consumer Driven Option

- Sinuplasty
- Sleep apnea procedures and surgery
- Therapeutics (outpatient) dialysis, IV infusion, radiation oncology, intensity modulated radiation therapy, MR-guided focused ultrasound
- Prior approval is required for certain classes of drugs and coverage authorization is required for some medications
- Prior approval is also required for some mental health and substance use disorder benefits, inpatient, in-network or out-of-network

No Precertification Needed - High Option and Consumer Driven Option

- Outpatient Services at the Veterans Administration (VA)
- Maternity Care/Admissions
- Chiropractic Care
- Acupuncture Treatment
- Physical, Occupational Therapy
- Trigger Point Injections

Section 4: Your Costs for Covered Services



Section 4: Your Costs for Covered Services High Option

- Out-of-Pocket Costs
  - Copay
  - Deductible
  - Coinsurance
- PPO vs. Non-PPO
  - Balance Billing (services not otherwise addressed by the No Surprises Act (NSA))
- 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

High Option Deductible

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

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 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 AmWell	$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 (services not otherwise addressed by the No Surprises Act (NSA))

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

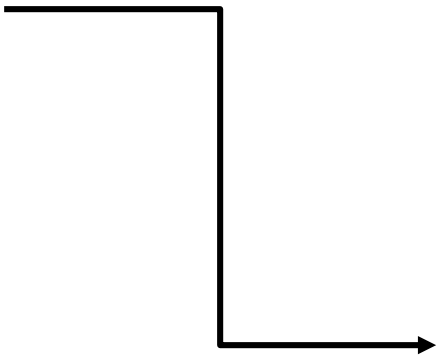
Personal Care Account (PCA) – Cont'd

- 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 rollover 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



You control your PCA
If you do not want your PCA to automatically pay your medical claims:

1. Log onto www.myuhc.com
2. Select Claims and Accounts
3. Select Health Reimbursement Account
4. Select Automatic Payment
5. Select Change Automatic Payment Settings

Note:
Your pharmacy claims will always be paid automatically by your PCA

Consumer Driven Option Deductible

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 healthcare 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.

Section 5: Benefits



Section 5: Benefits 5(a) – 5(i)

5(a) Medical Services and Supplies

5(b) Surgical and Anesthesia Services

5(c) Services Provided by a Hospital or Other Facility

5(d) Emergency Services

5(e) Mental Health and Substance Use Disorder

5(f) Prescription Drug Benefits

5(g) Dental Benefits

5(h) Wellness and Other Special Features

5(i) Health and Education Resources & Account Management Tools

Medical Service and Supplies Section 5(a)

- Office, hospital visits
- X-ray an 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 recommend by CDC for both children and adults
  - Annual route 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
- Bloodwork
- 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

- Login to 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 login to wwww.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 up to a maximum of $2,500 for medical and $2,500 for prescription drug each calendar year:
  - Covered services: Visits, Surgery, Diagnostic testing
- 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 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
- In-network vs. out-of-network facility

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

Organ and Tissue Transplants
High Option

- List of covered transplants (Pgs 51-53)
- 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 at 1-800-668-9682 and speak to a Transplant Case Manager

Organ and Tissue Transplants Consumer Driven Option

- List of covered transplants (Pgs 103-105)
- 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 rendered within 72 hours of an accident:
  - No out-of-pocket or cost-sharing (no deductible, coinsurance, copayment) in or out-of-network

Accidental Injury - Consumer Driven Option

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

Medical Emergency - High Option

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

Medical Emergency - Consumer Driven Option

- PCA, 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

Ambulance

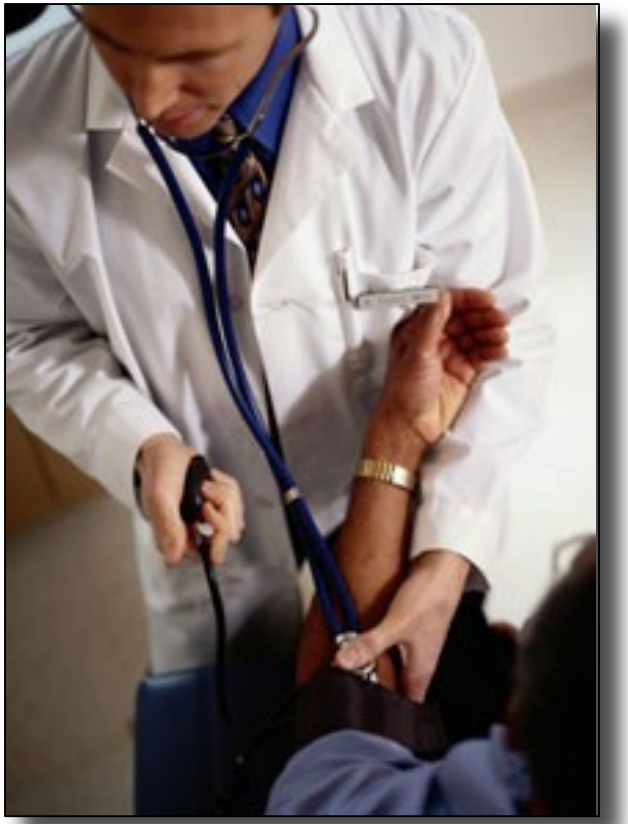
- Medical necessary professional ambulance transport of a patient within **24 hours** of a medical emergency.

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 covered charges and any difference between allowed and billed amount

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

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 AmWell	$15 copayment (No Deductible)	N/A
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

	In-Network	Out-of-Network
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 2022 – High Option Only

- Certain non-Insulin drugs have been added to the Patient Assurance Program (PAP) to treat diabetes with fixed copays - $25 copay for a 30 day supply and $75 copay for a 90 day supply.
- Hypercholesterolema drugs will no longer be treated as specialty drugs.
- Increased number of conditions that require authorization and step therapy for prescription drugs.
- Preventive migraine medications no longer need to be obtained through Network Mail Order.

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 or Smart 90 Pharmacy (CVS/Walgreens)
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 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

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 or Smart 90 Pharmacy (CVS/Walgreens)
Generic Drugs **Tier 1**	25% coinsurance; $200 maximum for 30-day supply	50% coinsurance for 30-day supply	25% coinsurance; $300 maximum 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 Coverage Definitions

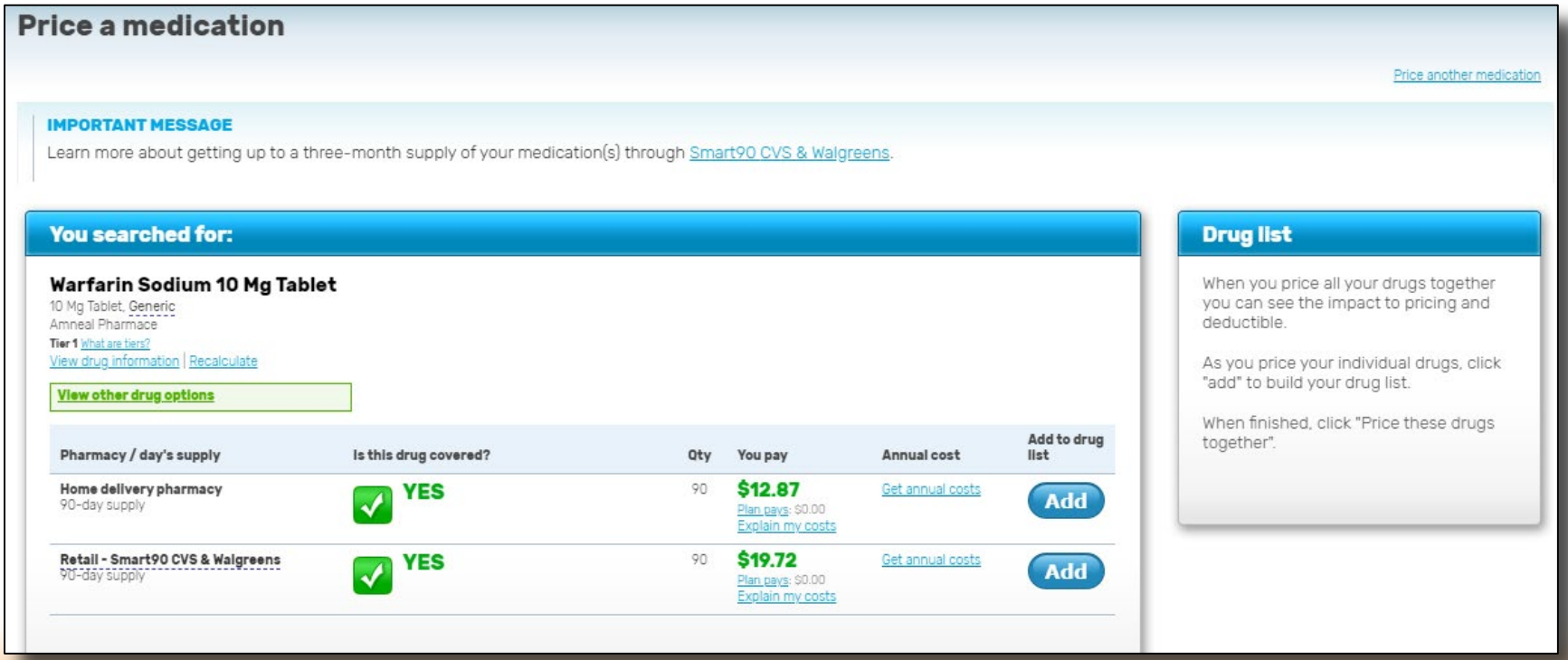
- Drugs covered only with a prior authorization include:
  - Growth Hormones
  - Botox
  - Retin-A
  - Drugs for gender transition



- 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 71)
    - Consumer Driven Option (Pg 118)

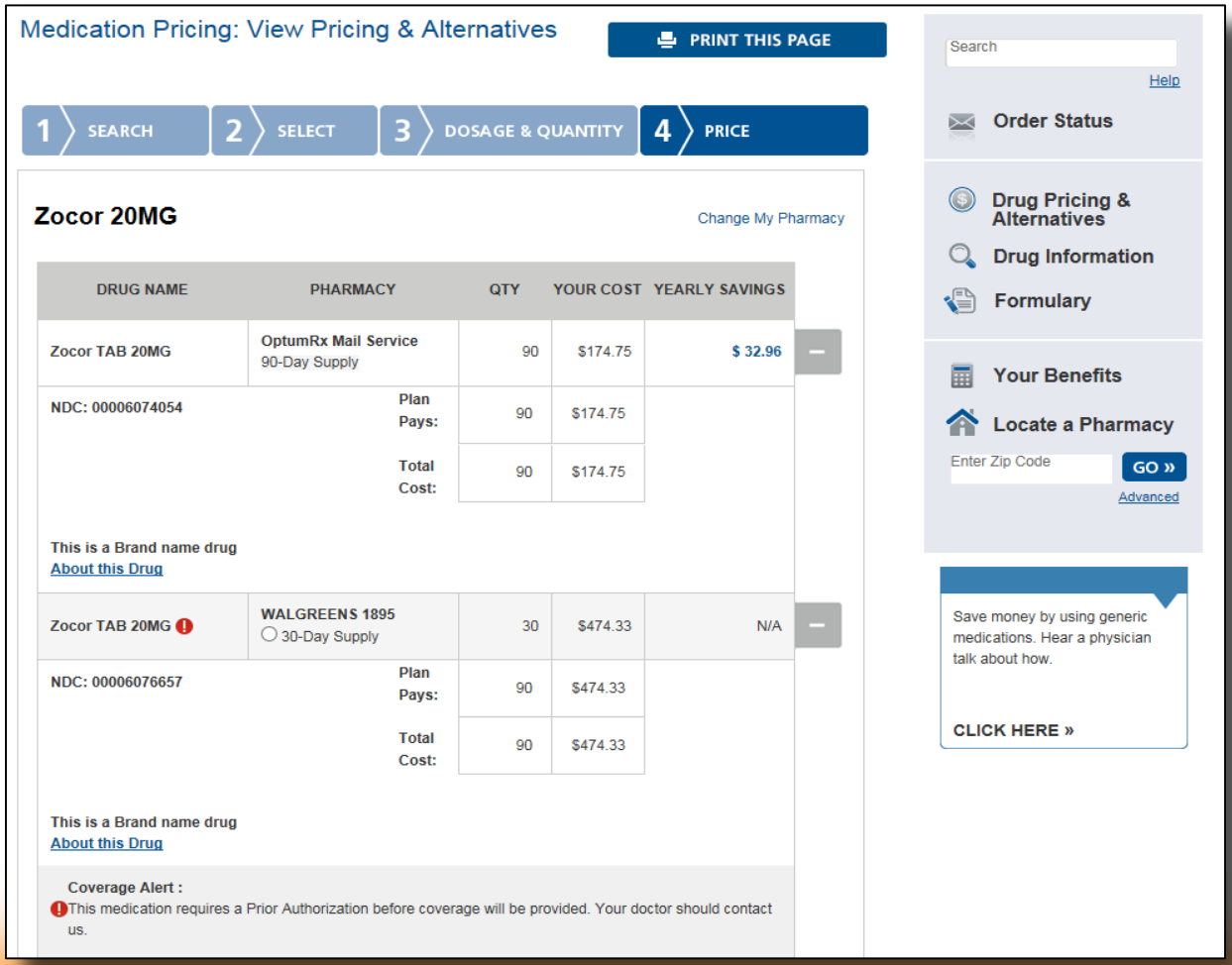
Prescription Coverage Calculator
High Option

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



Prescription Coverage Calculator Consumer Driven Option

- www.myuhc.com



Dental Benefits
Section 5(g) High Option

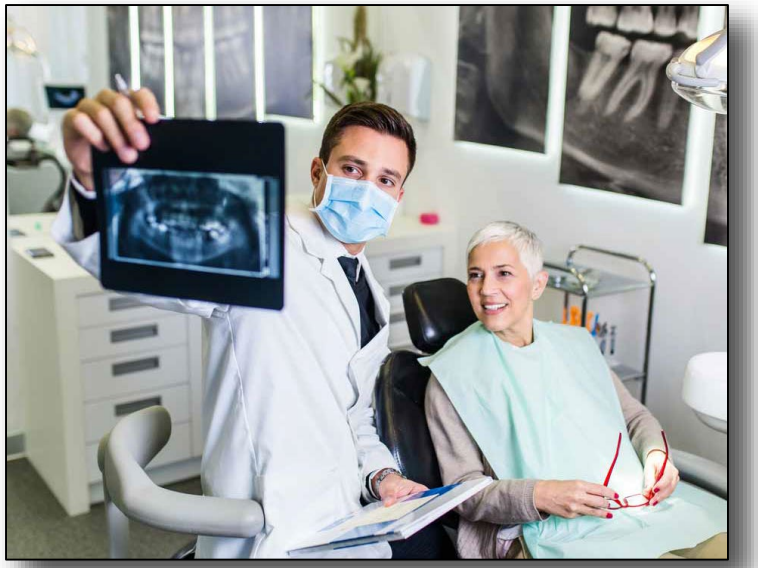
- Preventive care only
  - 2 visits, including fluoride treatments per year
  - 2 cleanings per year
  - 2 X-rays per year
- Other covered dental services
  - Restorative fillings
    - Does not include crowns or in-lay, on-lay restoration
- Cost sharing: 30% of Plan allowance plus any difference in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



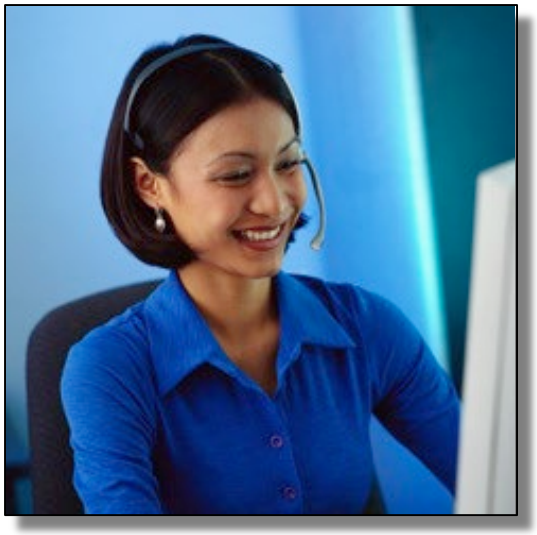
Wellness and Other Special Features Section 5(h) High Option

- 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
  - Maternity Support Program
  - Kidney Resources Program
  - Orthopedic Health Support
  - Cancer Support
  - Real Appeal
  - AbleTo



Section 6: General Exclusions



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



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 cliams

Section 8: Disputed 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



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)

Section 9: Coordinating Benefits
High Option

(continued)

- Medicare Advantage Plan, UnitedHealthcare Retiree Advantage Plan
  - Incentive Programs
    - Silver Sneakers
    - Podiatry Benefit
    - Hearing Aid Benefit
    - Nationwide network

Section 9: Coordinating Benefits
High Option *(cont'd)*

- 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

Section 9: Coordinating Benefits
High Option *(cont'd)*

- 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

Section 9: Coordinating Benefits
High Option *(cont'd)*

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

Section 10: Definitions



Section 10: Definitions

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



Last Pages

- Summary of Benefits High Option: (Pgs 150-151)
- Summary of Benefits Consumer Driven Option: (Pgs 152-153)
- Index (Pgs 154-155)
- Notes Pages (Pgs 156-157)
- Rate Page (Pg 158)



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!

APWU HEALTH PLAN
TOGETHER. BETTER HEALTH.