Brochure Review

Presented by

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37th Annual Open Season Seminar

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Introduction

- Brochure
  - Layout
  - Sections
  - Changes
- Review Benefits
  - Changes for 2023

Pop Quiz

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What is the in-network copay for a standard office visit under the High Option Plan?

ⓘ Start presenting to display the poll results on this slide.

POP QUIZ

What is the in-network copay for a standard office visit under the High Option Plan?

- $10
- $20
- ✓ $25
- $30

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What is the in-network copay for a standard office visit under the Consumer Driven Plan?

ⓘ Start presenting to display the poll results on this slide.

POP QUIZ

What is the in-network copay for a standard office visit under the Consumer Driven Plan?

- $10
- $20
- $25
- ✓ N/A

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Do inpatient hospital services under the High Option Plan require prior authorization?

ⓘ Start presenting to display the poll results on this slide.

POP QUIZ

Do inpatient hospital services under the High Option Plan require prior authorization?

- ✔ Yes
- No

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Do inpatient hospital services under the Consumer Driven Plan require prior authorization?

ⓘ Start presenting to display the poll results on this slide.

POP QUIZ

Do inpatient hospital services under the Consumer Driven plan require prior authorization?

- ✔ Yes
- No

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What is the member coinsurance for in-network services when using a Cigna provider under the High Option plan?

ⓘ Start presenting to display the poll results on this slide.

POP QUIZ

What is the member coinsurance for in-network services when using a Cigna provider under the High Option plan?

10%

✓15%

20%

25%

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What is the member coinsurance for out-of-network services under the Consumer Driven Plan?

ⓘ Start presenting to display the poll results on this slide.

POP QUIZ

What is the member coinsurance for out-of-network services under the Consumer Driven Plan?

30%

40%

45%

✓50%

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Does the High Option Plan include dental services?

ⓘ Start presenting to display the poll results on this slide.

POP QUIZ

Does the High Option Plan include dental services?

- ✔ Yes
- No

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Does the Consumer Driven Plan include dental services?

ⓘ Start presenting to display the poll results on this slide.

POP QUIZ

Does the Consumer Driven Plan include dental services?

- Yes
- ✓ No

Brochure Layout

- **Introduction/FEHB Facts** (pgs.4-12)
- **Section 1:** How This Plan Works (pgs.13-14)
- **Section 2:** Changes for 2023 (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)

Brochure Layout

- **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)
- **Section 9:** Coordinating Benefits with Medicare and Other Coverage (pgs.134-144)
- **Section 10:** Definitions (pgs.145-149)
- **Summary of High Option** (pgs.150-151)

Brochure Layout

- **Summary of Consumer Driven Option** (pgs.152-153)
- **Index** (pgs.154-155)
- **2023 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

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 2023

Changes for 2023 - High Option

- Cologuard Colorectal Cancer Screening Kit provided every 3 years starting at age 45 (pg.37)
- Repetitive Transcranial Magnetic Stimulation (TMS) performed in a physician's office will be subject to coinsurance. Enrollee cost sharing will be 15% PPO and 40% Non-PPO (subject to the deductible) (pg.64)
- Preauthorization will not be required for facility based intensive outpatient treatment under the Mental Health and Substance Use Disorder benefit (pg.65)

Changes for 2023 - High Option

- Copay for virtual visits through AmWell will be a $10 copay (pgs.36 & 64)
- Decrease the out-of-network reasonable and customary (R&C) allowance from the 70th percentile to the 60th percentile (pg.14)
- The Medicare Part B monthly reimbursement has increased to $85 for members with the Medicare Advantage enhanced benefits (pg.139 and www.uhcvirtualretiree.com/apwuhp)

Changes for 2023 - High Option

- Coverage for standard fertility preservation (retrieval and freezing of eggs or sperm) procedures for iatrogenic infertility caused by chemo, pelvic radiotherapy, ovary or testicle removal and other gonadotoxic therapies for treatment of disease and gender reassignment surgery (pg.40)
  - Fertility preservation procedures require prior authorization approval
  - Lifetime Max: $12,000
  - PPO: 15% of Plan Allowance
  - Non-PPO: 40% of Plan Allowance
  - Subject to the deductible

Changes for 2023 - High Option

- Coverage for medical food formulas as a treatment therapy for people who have Inborn Errors for Metabolism (IEM). In order to be eligible, the medical food formula must be ordered by a health care provider and medically necessary to treat specific nutritional risks, including Phenylketonuria (PKU) and other IEM (pg.41)
  - PPO: 15% of the Plan Allowance ($2,500 Max per calendar year)
  - Non-PPO: 40% of Plan Allowance ($2,500 Max per calendar year)
  - Subject to the deductible

Changes for 2023 - Consumer Driven Option

- Cologuard Colorectal Cancer Screening Kit provided every 3 years starting at age 45 (pg.81)
- Deductible and coinsurance no longer applies to bereavement benefits (pg.110)
- Prescription drugs have moved from a 3-tier traditional Prescription Drug List to a 3-tier advantage Prescription Drug List (pg.117)
- Maven – a Maternity Support Program – has been added to the Health Education Resources (pg.124)
- Real Appeal program, under Special Programs, has been eliminated

Changes for 2023 - Consumer Driven Option

- Coverage for standard fertility preservation (retrieval and freezing of eggs or sperm) procedures for iatrogenic infertility caused by chemo, pelvic radiotherapy, ovary or testicle removal and other gonadotoxic therapies for treatment of disease and gender reassignment surgery (pg.92)
  - Fertility preservation procedures require prior authorization approval
  - Lifetime Max: $12,000
  - PPO: 15% of Plan Allowance
  - Non-PPO: 50% of Plan Allowance
  - Subject to PCA & Deductible

Changes for 2023 - Consumer Driven Option

- Coverage for medical food formulas as a treatment therapy for people who have Inborn Errors for Metabolism (IEM). In order to be eligible, the medical food formula must be ordered by a health care provider and medically necessary to treat specific nutritional risks, including Phenylketonuria (PKU) and other IEM (pg.93)
  - PPO: 15% of the Plan Allowance ($2,500 Max per calendar year)
  - Non-PPO: 40% of Plan Allowance ($2,500 Max per calendar year)
  - Subject to PCA & Deductible

Section 3
How You Get Care

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 a 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 Affirming Surgery
- Iatrogenic Fertility Preservation Procedures
- 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.
- 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
- Clinical Trials
- Chemotherapy – outpatient
- Functional endoscopic sinus surgery
- Hospice – inpatient
- Hysterectomy
- Potential cosmetic procedures
- Sinuplasty
- Sleep apnea procedures and surgery
- Therapeutics (outpatient) dialysis, IV infusion, radiation oncology, intensity modulated radiation therapy, MR-guided focused ultrasound

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
- Intensive Outpatient Therapy

Section 4

Your Costs for Covered Services

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
$10, $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	$10
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

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)

(continued)

- 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

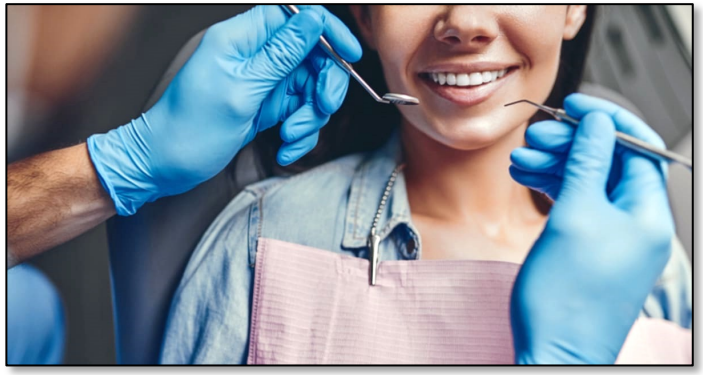
Consumer Driven Option

- 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

Benefits 5(a) – 5(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 and Education Resources & Account Management Tools

Medical Service and Supplies

Section 5(a)

- Office, hospital visits
- X-ray 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 recommend 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
- Bloodwork
- Immunizations
- Screenings



Member Scenario

- I got this plan because my coworker said all of their lab work is free. Why did I receive a bill for my lab work?
  - **High Option:** When you have your covered lab services performed at a Quest or LabCorp facility, those test will be covered at 100%. If your lab services are performed in your physician's office, you must specify that you want those tests sent to Quest or LabCorp in order to have them covered at 100%. Otherwise you may be billed.
  - **Consumer Driven:** Preventive lab services performed at an in-network lab will be covered at 100%. For all other covered lab tests, services will be subject to PCA, deductible and coinsurance.

Member Scenario

- How often can I get a colonoscopy?
  - **High Option:** We follow the USPSTF guidelines. USPSTF recommends routine colonoscopies for individuals from at 45-75 which would be covered at 100%. If you have to get a second colonoscopy within the same year, it's likely a medical procedure instead of routine. This would be subject to the deductible and coinsurance.
  - **Consumer Driven:** Routine colonoscopy covered at 100%. Medical procedure subject to PCA, deductible and coinsurance.

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 $10 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 **www.myuhc.com** for information on virtual visits.
  - Subject to 15% of the Plan allowance

Family Planning/Infertility - NEW

- Coverage for standard fertility preservation (retrieval and freezing of eggs or sperm) procedures for iatrogenic infertility caused by chemo, pelvic radiotherapy, ovary or testicle removal and other gonadotoxic therapies for treatment of disease and gender reassignment surgery.
  - Fertility preservation procedures require prior authorization approval
  - Lifetime Max: $12,000
  - PPO: 15% of Plan Allowance
  - Non-PPO: 40% of Plan Allowance
  - Subject to the deductible

Member Scenario

- My partner and I have been having trouble conceiving for over a year. Our doctor advised us to pursue infertility treatment. What does the plan cover?
  - **High Option:** Up to $2500 per calendar year, for the treatment and diagnosis of infertility (subject to the deductible and coinsurance) and an additional $2500 for prescription drugs. This $5000 benefit is per person, not per couple.
  - **Consumer Driven:** Up to $2500 per calendar year, for the treatment and diagnosis of infertility (subject to the PCA, deductible and coinsurance) and an additional $2500 for prescription drugs. This $5000 benefit is per person, not per couple.

Member Scenario

- How are CPAP machines covered? Do I have to purchase, or can I rent?
  - **High Option:** Most CPAP machines are rent to purchase. They are covered under the DME benefit, subject to the deductible and coinsurance.
  - **Consumer Driven:** DME benefit subject to PCA, deductible and coinsurance.

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

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 (Emergency Room)	
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 (Emergency Room)	
In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
15% of the Plan allowance	50% of the Plan allowance plus any difference between the Plan allowance and the billed amount	15% of the Plan allowance	15% of the Plan allowance

Ambulance

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

High Option		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	$10 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
  - Transcranial Magnetic Stimulation (TMS)
  - Applied Behavioral Analysis (ABA)
  - 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

Member Scenario

- My partner and I are considering seeing a marriage therapist. Is that covered?
  - **High Option:** Marriage and family therapists are covered and the member responsibility is a $25 copay when a Cigna Behavioral Health (CBH) provider is used. If seeing an out-of-network provider, deductible and coinsurance would apply.
  - **Consumer Driven:** Whether seeing and in or out-of-work provider, PCA, deductible and coinsurance would apply.

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 2023: Consumer Driven Only

- Move from a tradition 3-tier Rx Drug list to a 3-tier Advantage Rx Drug list
  - Guides members to more efficient drugs at a lower cost



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



Specialty Drugs
(continued)

- 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

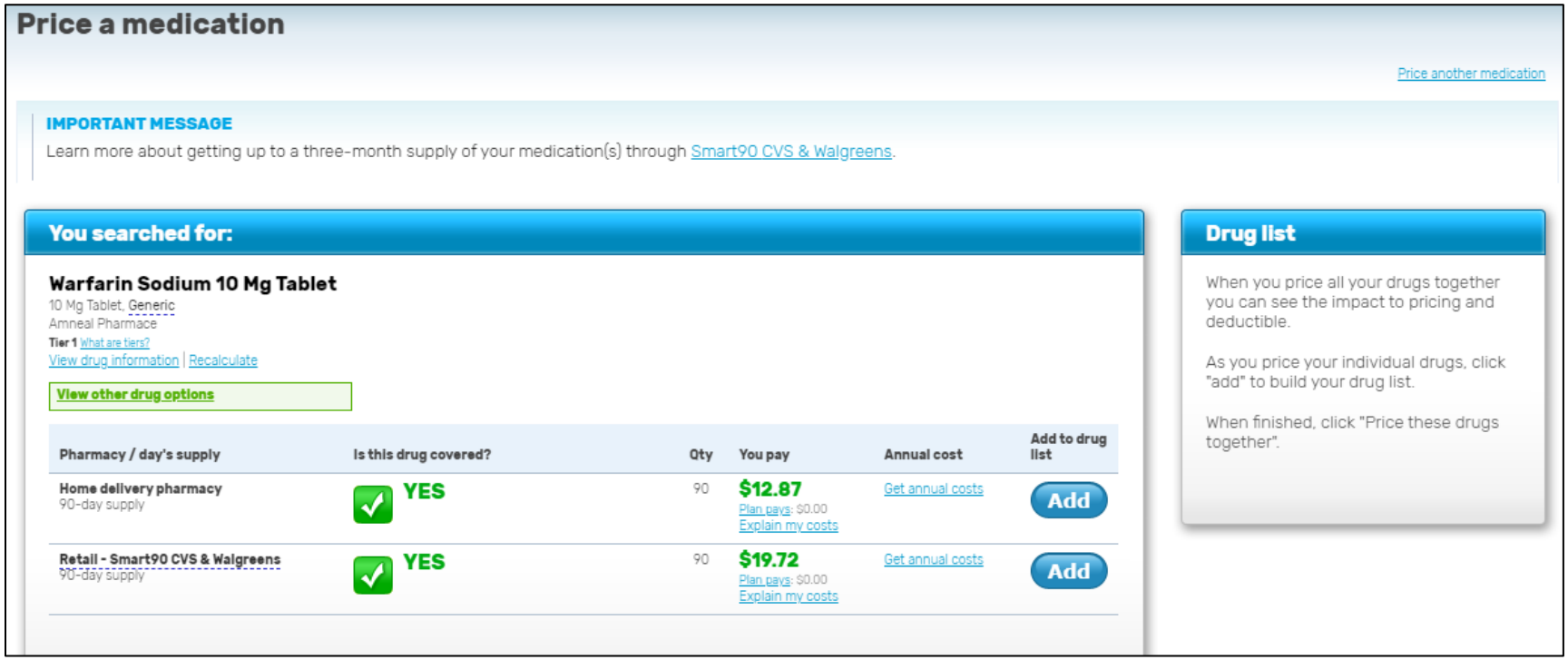
Prescription Coverage Definitions

- 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.72)
    - Consumer Driven Option (Pg.120)

Prescription Coverage Calculator

High Option

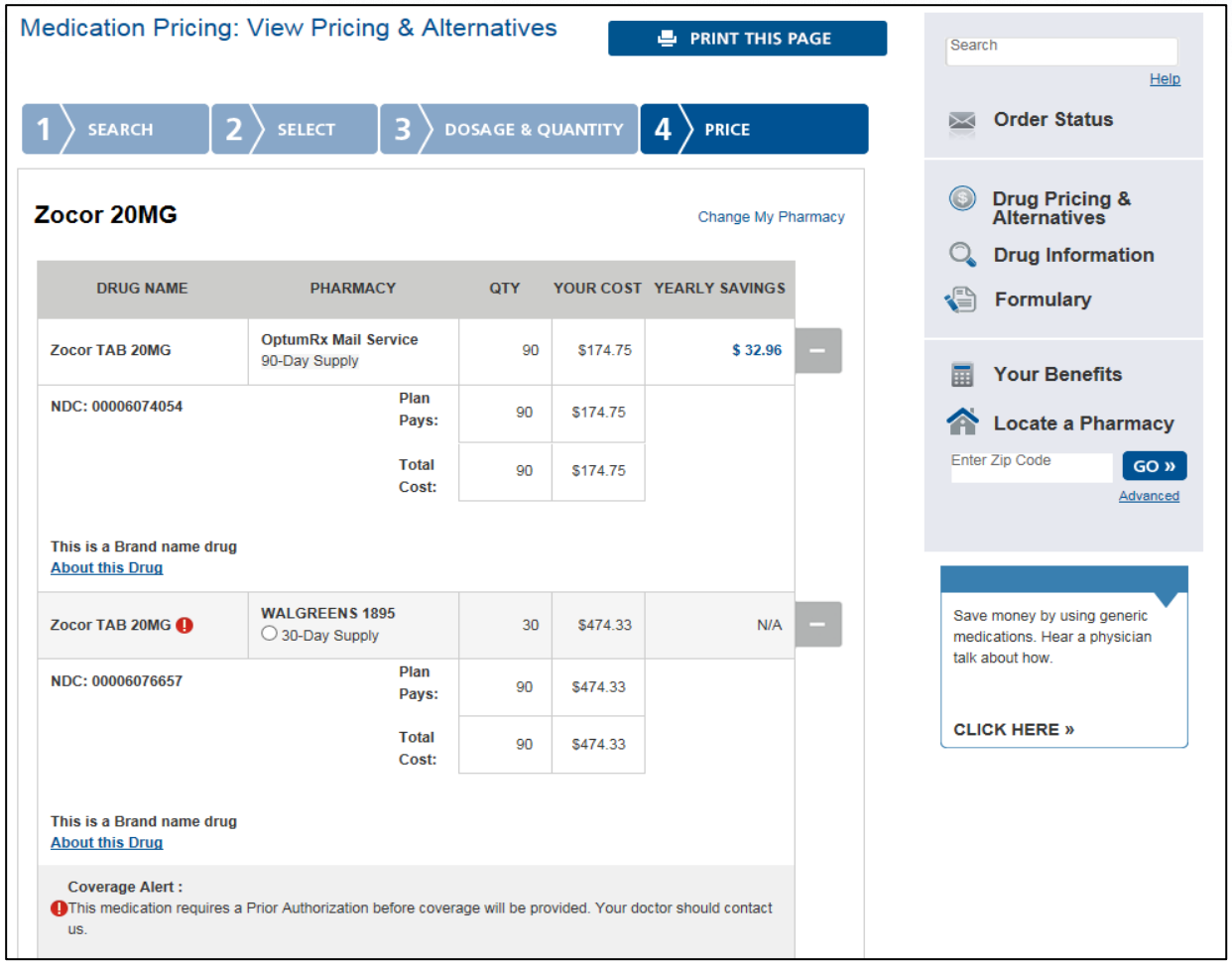
- APWU Health Plan Members
- Under “My Tools” select Pharmacy
- Prescription Cost Calculator “Visit Express Scripts”



Prescription Coverage Calculator

Consumer Driven Option

www.myuhc.com



Dental Benefits - Section 5(g)

High Option

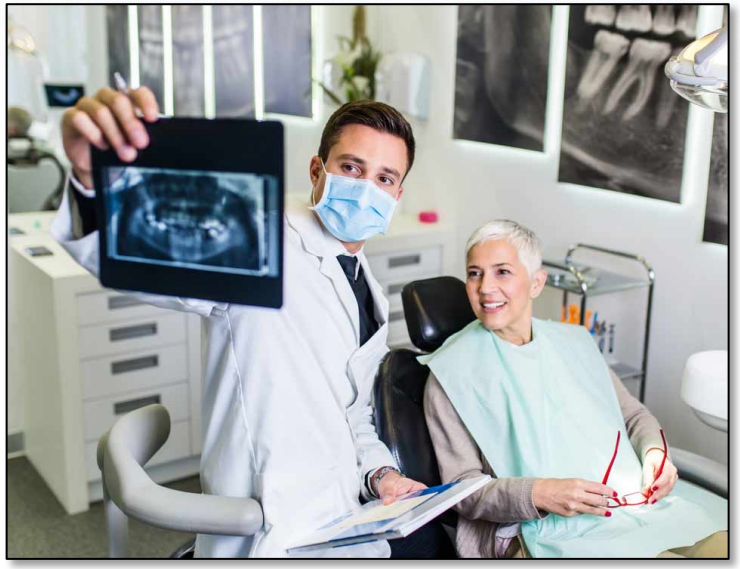
- Preventive care only
  - 2 visits, including fluoride treatments per year
  - 2 cleanings per year
  - 2 X-rays per year
- Other covered dental services
  - Restorative fillings
    - Does not include crowns or in-lay, on-lay restoration
- Cost sharing: 30% of Plan allowance plus any difference in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

Member Scenario

- My dentist says I need to have one of my teeth removed/pulled. How will APWUHP cover that?
  - **High Option:** If the dentist has to cut the gum to remove the teeth, it may be covered under the oral surgery benefit (deductible and coinsurance will apply). If it is a simple extraction (no cutting of the gum), it would be covered under the dental benefit. You would be responsible for 30% coinsurance, no deductible.
  - **Consumer Driven:** Oral surgery benefit (PCA, deductible, coinsurance). Simple extractions, up to $400/$800 of PCA can be used.

Wellness and Other Special Features

Section 5(h) High Option

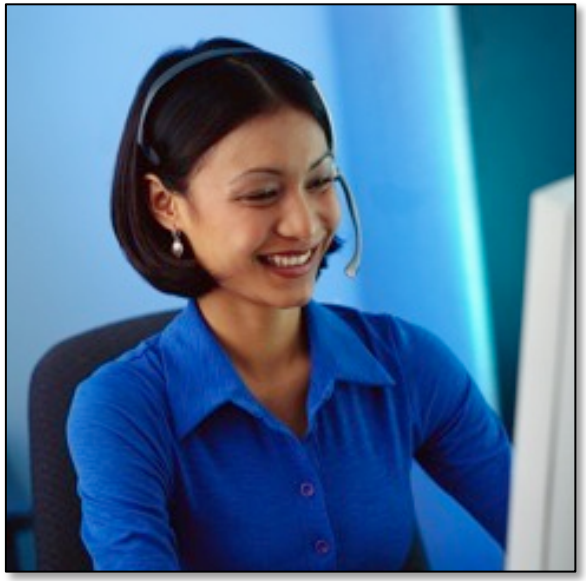
- 24-hour Nurse Line
- Health Management Programs
- Healthy Pregnancies, Healthy Babies
- Health Risk Assessment
  - CignaPlus Savings Dental Program



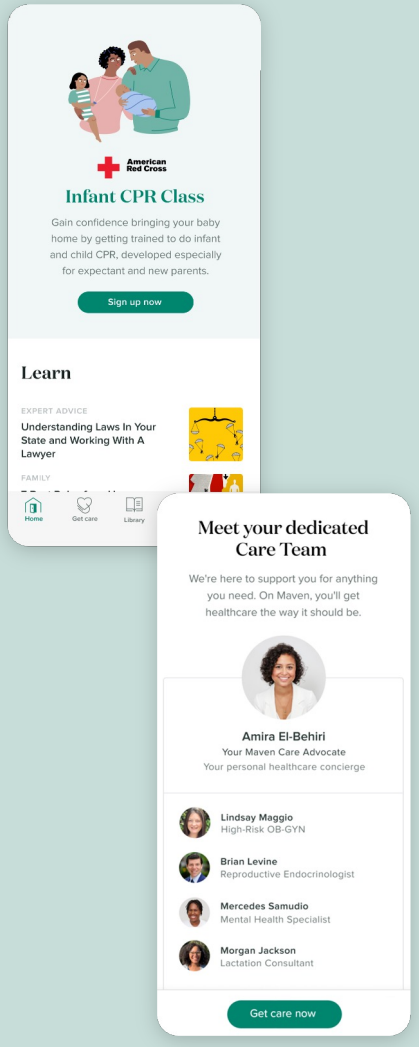
Health Education Resources and Account Management Tools

Section 5(i) Consumer Driven Option

- Online tools and resources
- Consumer choice information
- 24-hour Nurse advisory line
- Special Programs
  - MAVEN - Maternity Support Program
  - Kidney Resources Program
  - Orthopedic Health Support
  - Cancer Support
  - AbleTo



Maven offers complete support for every unique family journey



<u>Care & Benefits Navigation:</u> 24/7 access to personalized and continuous support from our Care Advocates when and where members need it

- *Dedicated Care Advocates provide **holistic support and continuity of care** to each member throughout their journey*
- ***Around-the-clock availability** - supplemental support day or night*

<u>Specialized Support:</u> Diverse providers who deliver inclusive, compassionate support and education

- *Available providers from **30+ specialties and 350+ subspecialties** – OBGYNs, Doulas, Career Coaches, Pediatric Sleep Coaches, and more*
- ***Referrals** to in-person, in-network providers*
- *Committed to **culturally competent support***

<u>Content & Community:</u> Clinician-designed programs that improve health and well-being

- ***On-demand and live member classes** like infant CPR and breastfeeding 101*
- ***Provider-approved**, personalized action plans and community forums*

Who's eligible for Maven?

APWUHP Consumer Driven Plan enrollees and/or their dependents who may be in the following life stages:

- A person who is currently pregnant
- The new parent of a newborn under one year of age
- The spouse or partner of someone who is pregnant / has a child under one year of age
- Someone who recently experienced the loss of a pregnancy or infant

Maternity & Newborn Support

Pregnancy

Postpartum & newborn support

Miscarriage & loss

Return-to-work and career coaching

Partner track

Enrollment begins January 1st, 2023.
Download the Maven Clinic app from the iOS App Store or Google Play Store to get started or go to mavenclinic.com/join/apwuhp to learn more.

APWU HEALTH PLAN | MAVEN | Optum | UnitedHealthcare

Section 6
General Exclusions

General Exclusions

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



See full list on pg.126

Section 7
Filing a Claim

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

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

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 $85.00 of Medicare Part B monthly premium
  - $0 Deductible and Out-of-Pocket Maximums
  - $0 Cost for physician office visits or hospitalization (inpatient or outpatient)

Coordinating Benefits

High Option *(continued)*

- Medicare Advantage Plan, UnitedHealthcare Retiree Advantage Plan
  - Incentive Programs
    - Renew Active
    - Podiatry Benefit
    - Hearing Aid Benefit
    - Nationwide network

Coordinating Benefits

High Option *(continued)*

- 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

High Option *(continued)*

- 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

High Option *(continued)*

- 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

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.