

Brochure Review

Presented by

Sharon Morehead and Erik Fenton

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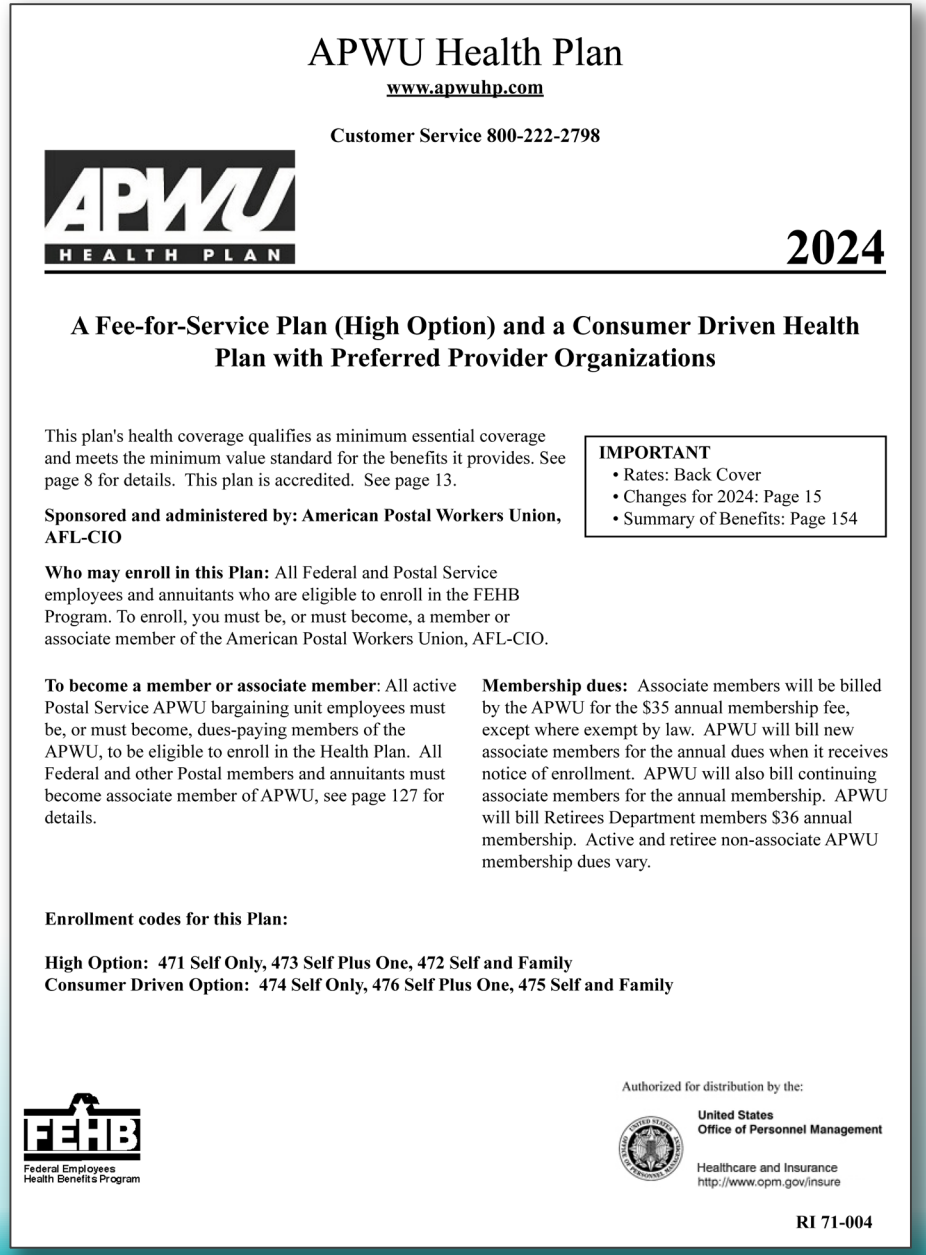
Introduction

- Brochure
  - Layout
  - Sections
  - Changes
- Review Benefits
  - Changes for 2024



APWU Health Plan

www.apwuhp.com

Customer Service 800-222-2798

APWU HEALTH PLAN

2024

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 2024: Page 15
- Summary of Benefits: Page 154

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 127 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

Pop Quiz
Brochure Review

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Join at slido.com
#6998757

ⓘ Start presenting to display the joining instructions on this slide.

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

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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?

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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

slido



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 UHC 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 UHC 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 2024 (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.32-77)
  - Consumer Driven Option (pgs.78-126)
  - Non-FEHB Benefits (pg.127)

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Brochure Layout

- **Section 6:** General Exclusions (pgs.128-129)
- **Section 7:** Filing a Claim for Covered Services (pgs.130-132)
- **Section 8:** The Disputed Claims Process (pgs.133-135)
- **Section 9:** Coordinating Benefits with Medicare and Other Coverage (pgs.136-147)
- **Section 10:** Definitions (pgs.148-153)
- **Summary of High Option** (pgs.154-155)

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Brochure Layout

- **Summary of Consumer Driven Option** (pgs.156-157)
- **Index** (pgs.158-159)
- **2024 Rate Information** (pg.162)

Introduction

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



Section 1
How This Plan Works

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How This Plan Works – High Option

- PPO Network (UnitedHealthcare PPO)
  - PPO Directory online at: www.apwuhp.com
- Prompts to filter your search results
  - Provider Type
  - Specialty
  - Facility Type
  - Distance from home/work
- Call APWU Health Plan at: 800-222-2798

How This Plan Works – Consumer Driven Option

- PPO Network (UnitedHealthcare PPO)
  - PPO Directory online at: www.whyuhc.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 2024

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Changes for 2024 - High Option

- The Preferred Provider Network (PPO) will change to the UnitedHealthcare (UHC) network of over 1.7 million providers (pg.13)
- Preauthorization requirements for some services have changed (pg.18)
- Telehealth services will now be covered under Teladoc (pg.36)
- Members can now access breastfeeding supplies from any in-network provider (pg.39)

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Changes for 2024 - High Option

- Artificial Insemination (AI) is now covered as well as coverage for infertility medications, including IVF related drugs (pg.40)
- Skilled nursing visits have increased from 25 visits per calendar year to 50 visits per calendar year (pg.45)
- Reduced requirements for gender affirming care (pg.50)

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Changes for 2024 - High Option

- Special Programs have changed under Section 5(h) to include a pregnancy support program, Maven Maternity (new mother program), cancer support program, kidney resources program, a One Pass Select gym discount program and UnitedHealthcare Hearing program (pg.77)
- The APWU Health Plan will participate in a Medicare Part D Plan administered by Express Scripts called Express Scripts Medicare (PDP) (pg.143)

Changes for 2024 - Consumer Driven Option

- Artificial Insemination (AI) is now covered as well as coverage for infertility medications, including IVF related drugs (pg.93)
- Skilled nursing visits have increased from 25 visits per calendar year to 50 visits per calendar year (pg.98)
- Reduced requirements for gender affirming care (pg.102)
- One Pass Select gym discount program, NEW for 2024, has been added to our Special Programs in Section 5(h) (pg.125)

Section 3
How You Get Care

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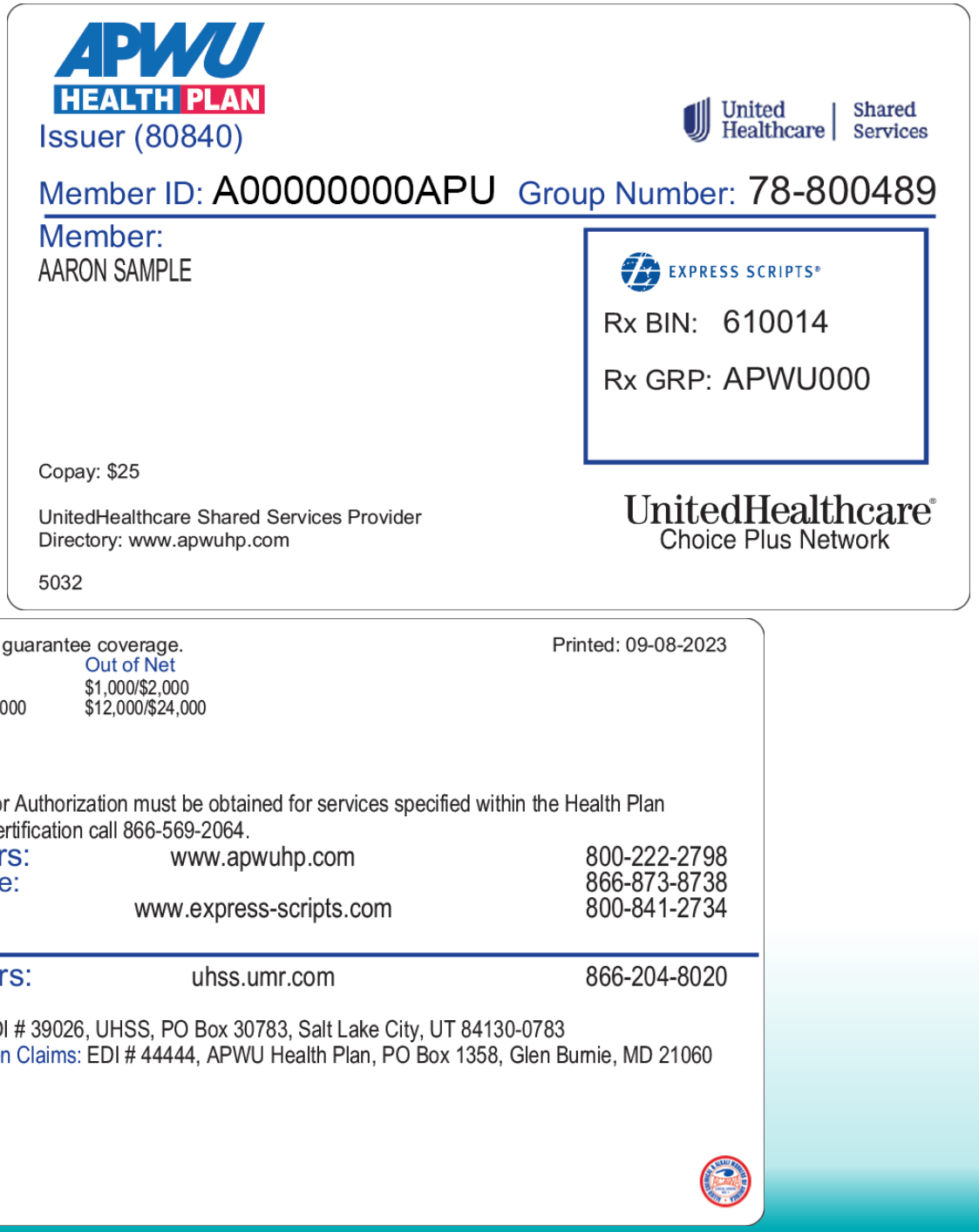
How You Get Care

- 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

HO ID Card – UHC Mass Re-issue



APWU HEALTH PLAN

Issuer (80840)

United Healthcare | Shared Services

Member ID: A00000000APU Group Number: 78-800489

Member:
AARON SAMPLE

EXPRESS SCRIPTS®

Rx BIN: 610014

Rx GRP: APWU000

Copay: $25

UnitedHealthcare Shared Services Provider
Directory: www.apwuhp.com

5032

UnitedHealthcare®
Choice Plus Network

This card does not guarantee coverage.

Printed: 09-08-2023

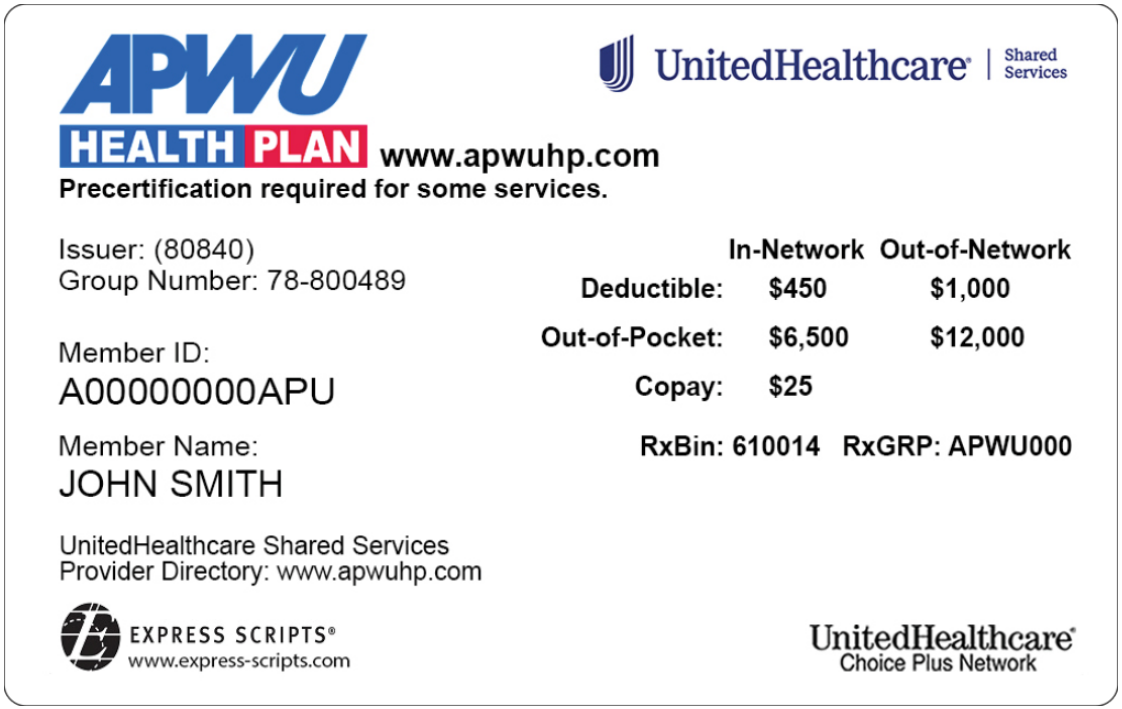
Medical:	In Net	Out of Net
Ded:	$450/$800	$1,000/$2,000
OOPM:	$6,500/$13,000	$12,000/$24,000

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

For Members:	www.apwuhp.com	800-222-2798
24/7 Nurseline:		866-873-8738
RX:	www.express-scripts.com	800-841-2734
For Providers:	uhss.umr.com	866-204-8020

Medical Claims: EDI # 39026, UHSS, PO Box 30783, Salt Lake City, UT 84130-0783
Secondary Med/Den Claims: EDI # 44444, APWU Health Plan, PO Box 1358, Glen Burnie, MD 21060

HO ID Card – UHC - Health Plan Produced



APWU HEALTH PLAN www.apwuhp.com
Precertification required for some services.

UnitedHealthcare | Shared Services

Issuer: (80840)
Group Number: 78-800489

Member ID:
A00000000APU

Member Name:
JOHN SMITH

UnitedHealthcare Shared Services
Provider Directory: www.apwuhp.com

	In-Network	Out-of-Network
Deductible:	$450	$1,000
Out-of-Pocket:	$6,500	$12,000
Copay:	$25	

RxBin: 610014 RxGRP: APWU000

EXPRESS SCRIPTS®
www.express-scripts.com

UnitedHealthcare
Choice Plus Network

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

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

For Members:	**www.apwuhp.com**	**800-222-2798**
24/7 Nurseline:		**866-873-8738**
RX:	**www.express-scripts.com**	**800-841-2734**
For Providers:	**uhss.umr.com**	**866-204-8020**

APWU HP Primary Medical Claims:
EDI # 39026, UHSS, PO Box 30783, Salt Lake City, UT 84130-0783

APWU HP Secondary Medical Claims and Dental Claims:
EDI # 44444, APWU Health Plan, PO Box 1358, Glen Burnie, MD 21060

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

ID Cards - Timing

- UHC Mass Re-issue cards will go out to all current High Option members, based on eligibility file sent to UHC the week of 10/30/2023, and will be mailed the week of 12/4/2023.
- Any new members with an effective date after the eligibility file is sent to UHC and prior to 1/1/2024 will receive 2 cards; a Health Plan issued Cigna card to use through 12/31/2023 and a Health Plan issued UHC card to use after 1/1/2024.
- Any new members with an effective after 1/1/2024 will receive the new Health Plan issued UHC card.

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ID Cards - Timing

- Any members requesting a replacement ID card up to 12/23/2023 will receive a Health Plan Cigna card.
- Any members requesting a replacement ID card after 12/23/2023 will receive a Health Plan issued UHC card.

Do I need Precertification?

High Option (pgs.18-19)

- Applied Behavioral Analysis (ABA)
- Durable Medical Equipment (DME) and prosthetic devices
- Gender Affirming Surgery
- Gene Therapy
- Genetic testing, including BRCA testing
- Hysterectomy
- Functional endoscopic sinus surgery
- Iatrogenic fertility preservation procedures
- Intensive outpatient treatment

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Do I need Precertification?

High Option

- 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 and sacroiliac joint injections.
- Orthognathic surgery (Oral maxillofacial surgery)
- Organ transplantation
- Procedures which may be cosmetic in nature
- Radiation Therapy – Intensive-Modulated Radiation Therapy, Proton Beam Radiation Therapy and Stereotactic Radiation Therapy

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Do I need Precertification?

High Option

- Recognized surgery for severe obesity (bariatric surgery) or for organic impotence
- Residential Treatment Center (RTC)
- Services and Supplies which may be experimental/investigational
- Skilled Nursing Facilities (SNF)
- **Note:** Prior approval for outpatient services at Veterans Administration facilities is not needed.

Do I need Precertification?

Consumer Driven Option (pgs.19-20)

- Air Ambulance – non-emergent
- Applied Behavioral Analysis (ABA)
- Bariatric surgery
- Clinical Trails
- Chemotherapy – outpatient
- Congenital Heart Disease)
- Durable Medical Equipment (DME)
- Functional endoscopic sinus surgery
- Gender affirming surgery
- Genetic testing
- Home healthcare – nursing visits, home infusion therapy
- Hysterectomy

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Do I need Precertification?

Consumer Driven Option (pgs.19-20)

- Iatrogenic fertility preservation procedures
- Organ transplantation
- Orthognathic surgery
- Potential cosmetic procedures
- Residential Treatment Center (RTC)
- Services and supplies which my be experimental/investigational
- Sinuplasty
- Skilled Nursing Facilities (SNF)
- Sleep apnea procedures and surgery
- Therapeutics (outpatient) dialysis, IV infusion, radiation oncology, intensity modulation 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, Speech Therapy
- Trigger Point Injections

Section 4
Your Costs for Covered Services

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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 maximum.

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 Teledoc	$10
Virtual Office Visit through UHC	$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

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Personal Care Account (PCA)

- 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 maximum 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

(Pg.84)



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

High Option, Consumer Driven Option, Non-FEHB Benefits

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Benefits - Section 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 and 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 Consumer Driven Option

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



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.

Member Scenario

- I had my preventive mammogram on 8/15/2023. When will I be able to get my preventive mammogram in 2024.
  - The preventive mammogram benefit runs on a calendar year basis, therefore you are eligible for your preventive mammogram on 8/16/2024.

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 tests 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 800-835-2362 or visit www.teledoc.com for information on virtual visits
  - Subject to a $10 copay through Teledoc
- TeleHealth Services through a UHC provider
  - Subject to a $25 copay

Virtual Office Visits

Consumer Driven Option

- Login to www.myuhc.com for information on virtual office visits:
  - Virtual Visits providers through www.myuhc.com: Teladoc, AmWell, Doctor on Demand, Optumcare 24 and Telehealth at 15% coinsurance
  - Virtual visits are 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.
  - Virtual visits are subject to 15% of the Plan allowance

Infertility Services – *NEW!*

- Covered diagnosis and treatment of infertility (excluding IVF, GIFT and ZIFT procedures):
  - Artificial Insemination (AI):
    - Intravaginal Insemination (IVI)
    - Intracervical Insemination (ICI)
    - Intrauterine Insemination (IUI)
  - Infertility medications, including IVF related drugs
  - PPO: 15% of the Plan allowance, subject to deductible.
  - Non-PPO: 40% of the Plan allowance, subject to deductible.
  - $2500 annual maximums no longer apply for medical or prescription drugs.
- Iatrogenic fertility preservation (retrieval of and freezing of eggs or sperm) still covered at Plan deductible and coinsurance level, subject to a $12,000 lifetime maximum.

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:** Diagnosis and treatment of infertility *(excluding IVF, GIFT and ZIFT procedures)* are covered, subject to Plan deductible and coinsurance, including IVF related drugs.
  - **Consumer Driven:** Diagnosis and treatment of infertility *(excluding IVF, GIFT and ZIFT procedures)* are covered, subject to the PCA, deductible and coinsurance, including IVF related drugs.

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.

Member Scenario

- I purchased my hearing aids on 8/15/2022. When can I purchase new hearing aids under the hearing aid benefit?
  - The hearing aid benefit runs on a 3 year calendar year basis, therefore you are eligible to purchase new hearing aids on 8/16/2025.

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 Teledoc	$10 copayment (No Deductible)	*N/A*
Virtual Office Visit through UnitedHealthcare	$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
  - Intensive Outpatient Services
  - Transcranial Magnetic Stimulation (TMS)
  - Applied Behavioral Analysis (ABA)
  - Services at a Residential Treatment Facility
- Contacts:
  - High Option: UnitedHealthcare 866-569-2064
  - 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 UnitedHealthcare provider is used. If seeing an out-of-network provider, deductible and coinsurance would apply.
  - **Consumer Driven:** Whether seeing and in or out-of-network 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

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

As of 2023:

Consumer Driven Option 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

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

(continued on next slide)

Specialty Drugs

- Targeted conditions include:
  - Cystic Fibrosis
  - Gaucher Disease
  - Growth Hormone Deficiency
  - Hepatitis C
  - Rheumatoid Arthritis



Specialty Drug Tiers

High Option

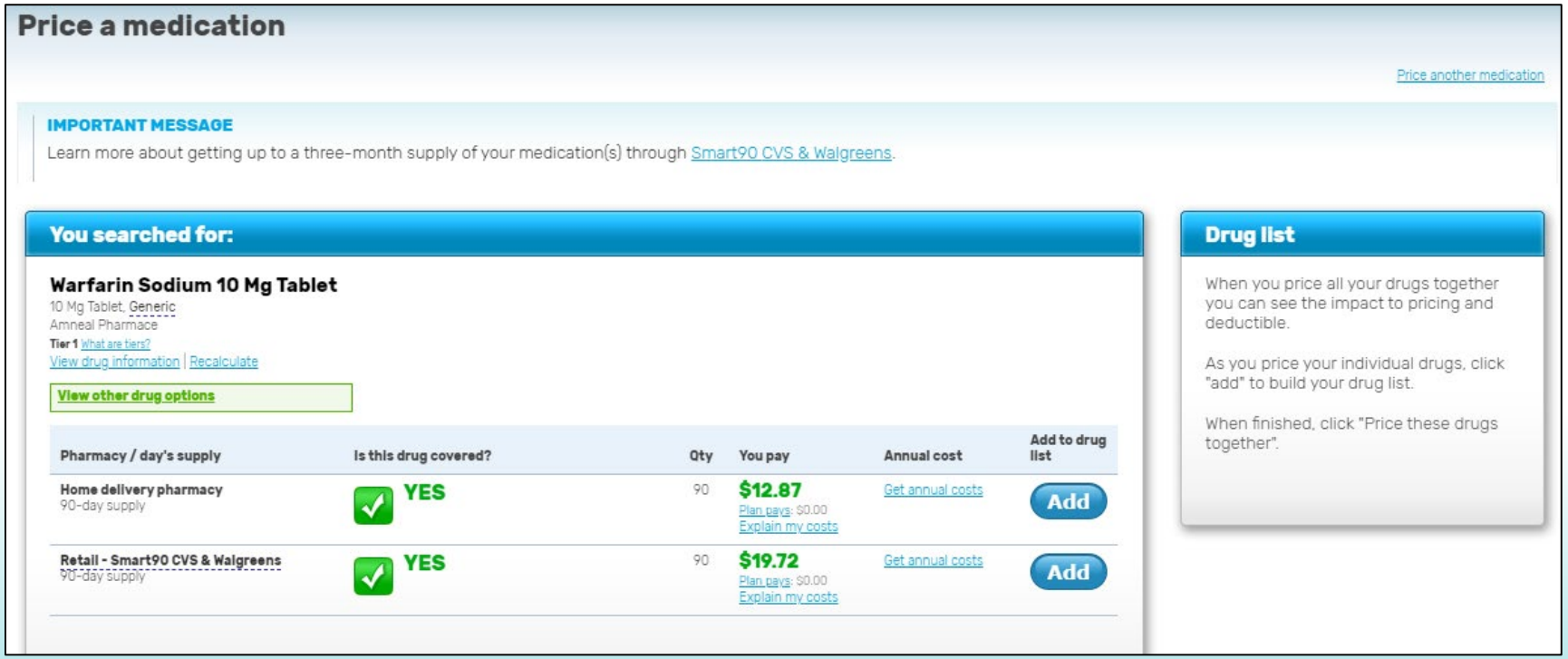
Type of Drug	Network Pharmacy (Retail)	Non-Network Pharmacy (Retail)	Network Mail Order or Smart 90 Pharmacy (CVS/Walgreens)
Generic Drugs **Tier 1**	25% coinsurance; $200 maximum for 30-day supply	50% coinsurance for 30-day supply	25% coinsurance; $300 maximum for 90-day supply
Preferred Brand Drugs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

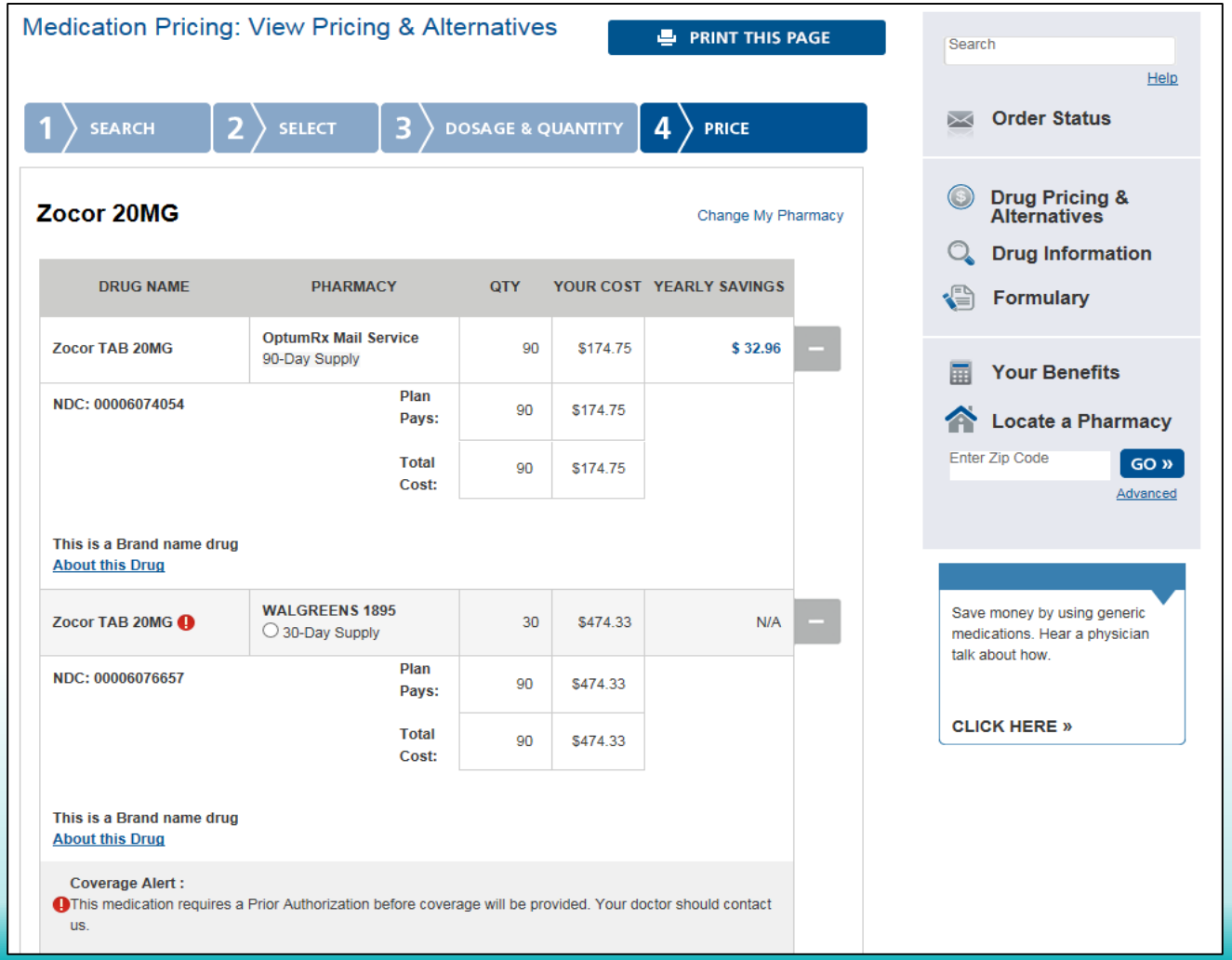
Prescription Coverage Calculator - High Option

- Select “Members”
- Under “My Tools” select “Pharmacy”
- Prescription Cost Calculator “Visit Express Scripts”



Prescription Coverage Calculator - Consumer Driven Option

www.myuhc.com



Medication Pricing: View Pricing & Alternatives

PRINT THIS PAGE

1 SEARCH | 2 SELECT | 3 DOSAGE & QUANTITY | 4 PRICE

Zocor 20MG

Change My Pharmacy

DRUG NAME	PHARMACY		QTY	YOUR COST	YEARLY SAVINGS
Zocor TAB 20MG	OptumRx Mail Service 90-Day Supply		90	$174.75	$ 32.96
NDC: 00006074054		Plan Pays:	90	$174.75	
		Total Cost:	90	$174.75	
This is a Brand name drug About this Drug					
Zocor TAB 20MG !	WALGREENS 1895 30-Day Supply		30	$474.33	N/A
NDC: 00006076657		Plan Pays:	90	$474.33	
		Total Cost:	90	$474.33	
This is a Brand name drug About this Drug					

Coverage Alert :
! This medication requires a Prior Authorization before coverage will be provided. Your doctor should contact us.

Search
Help
Order Status
Drug Pricing & Alternatives
Drug Information
Formulary
Your Benefits
Locate a Pharmacy
Enter Zip Code
GO »
Advanced

Save money by using generic medications. Hear a physician talk about how.
CLICK HERE »

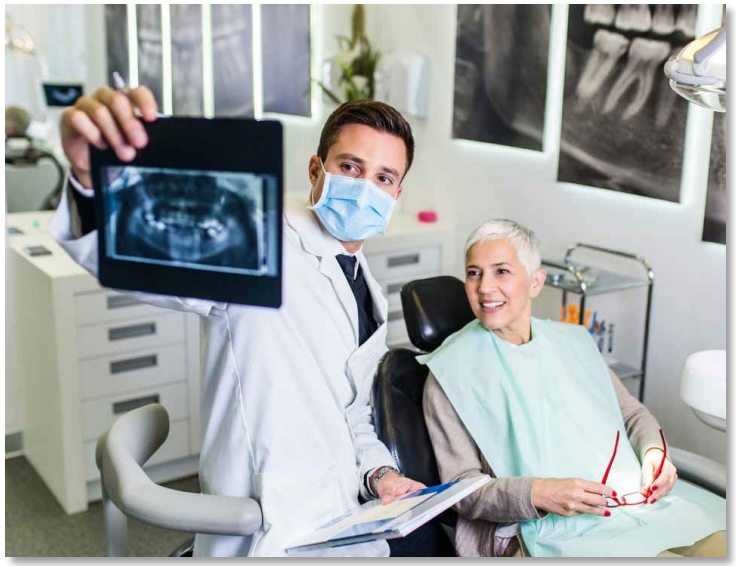
Dental Benefits

High Option, Section 5(g)

- 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

Dental Benefits

Consumer Driven Option, Section 5(g)



- 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

To save on dental today, you can use Careington Dental Network: Save on Dental Today! | Careington & APWU (solutionssimplified.com)

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 Option:** Oral surgery benefit (PCA, deductible, coinsurance). Simple extractions, up to $400/$800 of PCA can be used.

Wellness and Other Special Features

High Option, Section 5(h)

- 24-hour Nurse Line
- Health Management Programs
  - Pregnancy Support Program
    - Maven Maternity
  - Cancer Support Program
  - Kidney Resources Program
  - One Pass Select Gym Discount
  - UnitedHealthcare Hearing



Health Education Resources and Account Management Tools

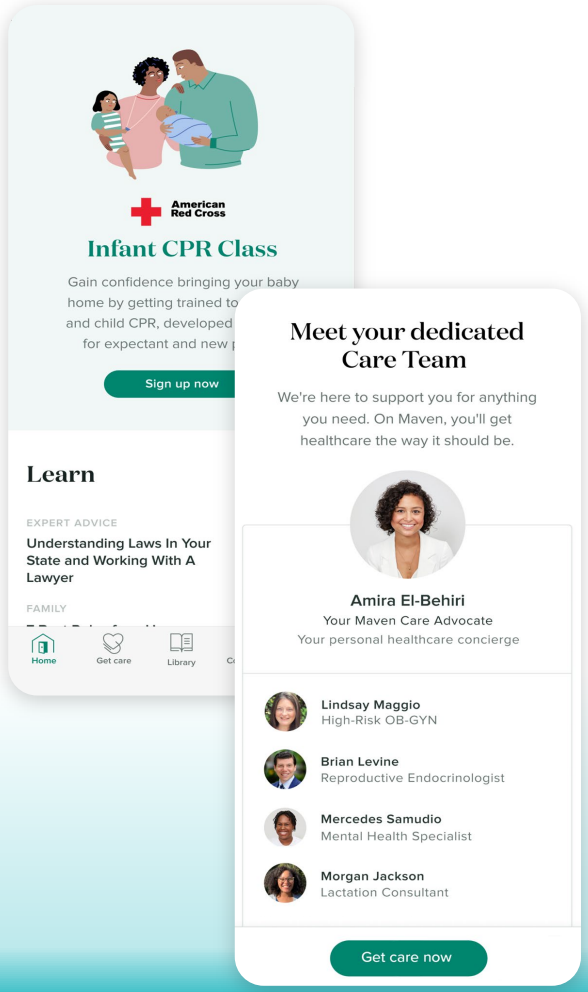
Consumer Driven Option, Section 5(i)

- Online tools and resources
- Consumer choice information
- Special Programs
  - MAVEN - Maternity Support Program
  - Kidney Resources Program
  - Orthopedic Health Support
  - Cancer Support
  - One Pass Select Gym Discount Program



Maven

- Maven offers complete support for every unique family journey.



Care & Benefits Navigation: 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*

Specialized Support: Diverse providers who deliver inclusive, compassionate support and education

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

Content & Community: 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*

Maven

- Who's eligible for Maven?

Both APWUHP Consumer Driven Plan and High Option 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

APWU HEALTH PLAN | MAVEN | Optum | UnitedHealthcare

Maternity & Newborn Support

Pregnancy

Postpartum & Newborn Support

Miscarriage & loss

Return-to-work and career coaching

Partner track

**Available to High Option Plan enrollees beginning January 1, 2024.*
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.

Section 6
General Exclusions

APWU HEALTH PLAN

38th Annual Open Season Seminar



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.128)



Section 7
Filing a Claim

APWU HEALTH PLAN

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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

APWU HEALTH PLAN

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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

APWU HEALTH PLAN

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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)

(continued on next slide)

Coordinating Benefits

High Option

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

(continued on next slide)

Coordinating Benefits

High Option

- Medicare Prescription Drug Plan Employer Group Waiver Plan (PDP EGWP) (pgs.143-144)
  - If you are enrolled in Medicare, and are not enrolled in a Medicare Advantage Plan (Part C), you will be automatically enrolled in the Medicare Prescription Drug Plan (PDP).
    - You will continue to remain enrolled in our FEHB Plan.
    - Participation is voluntary, and you have the choice to opt out of this enrollment at any time.
    - The Plan is called the Express Scripts Medicare (PDP) for APWU Health Plan and is administered by Express Scripts.
    - Members enrolled in the PDP will receive a separate prescription ID card.

(continued on next slide)

Coordinating Benefits

High Option

- Medicare Part 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

(continued on next slide)

Coordinating Benefits

High Option

- 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

(continued on next slide)

Coordinating Benefits

High Option

- 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

APWU HEALTH PLAN

38th Annual Open Season Seminar



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.154-155)
- Summary of Benefits Consumer Driven Option (pgs.156-157)
- Index (pgs.158-159)
- Notes (pgs.160-161)
- Rate Information (pg.162)



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.