Consumer Driven Option
Advanced Track



APWU HEALTH PLAN
TOGETHER. BETTER HEALTH.®

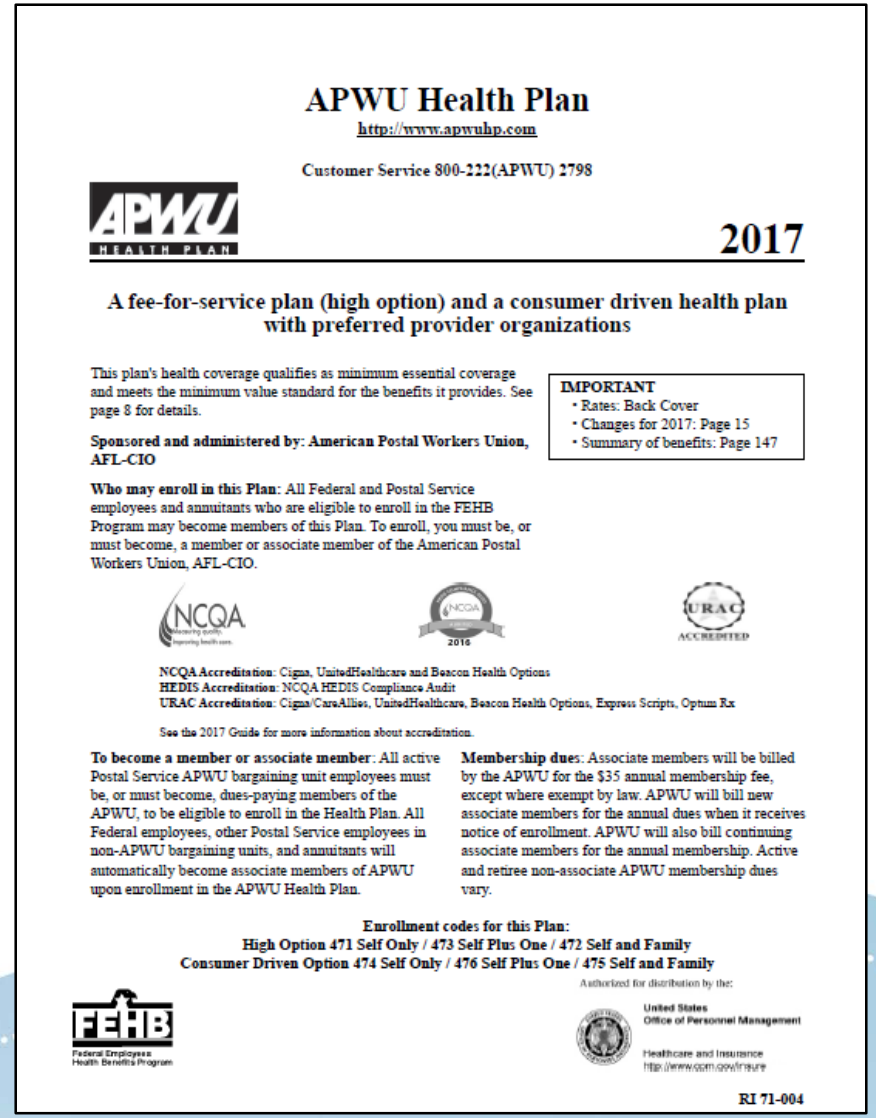
31st Annual Open Season Seminar

Today's Agenda

- Brochure
  - Layout
  - Sections
  - Changes
- Review benefits
  - Examples
  - Live scenarios

If this…

Then that…



APWU Health Plan
http://www.apwuhp.com

Customer Service 800-222(APWU) 2798

APWU HEALTH PLAN

2017

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.

IMPORTANT
- Rates: Back Cover
- Changes for 2017: Page 15
- Summary of benefits: Page 147

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 may become members of this Plan. To enroll, you must be, or must become, a member or associate member of the American Postal Workers Union, AFL-CIO.

NCQA 2016 URAC ACCREDITED

NCQA Accreditation: Cigna, UnitedHealthcare and Beacon Health Options
HEDIS Accreditation: NCQA HEDIS Compliance Audit
URAC Accreditation: Cigna/CareAllies, UnitedHealthcare, Beacon Health Options, Express Scripts, Optum Rx

See the 2017 Guide for more information about accreditation.

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 employees, other Postal Service employees in non-APWU bargaining units, and annuitants will automatically become associate members of APWU upon enrollment in the APWU Health Plan.

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. 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

Authorized for distribution by the:

FEHB Federal Employees Health Benefits Program

United States Office of Personnel Management
Healthcare and Insurance

RI 71-004

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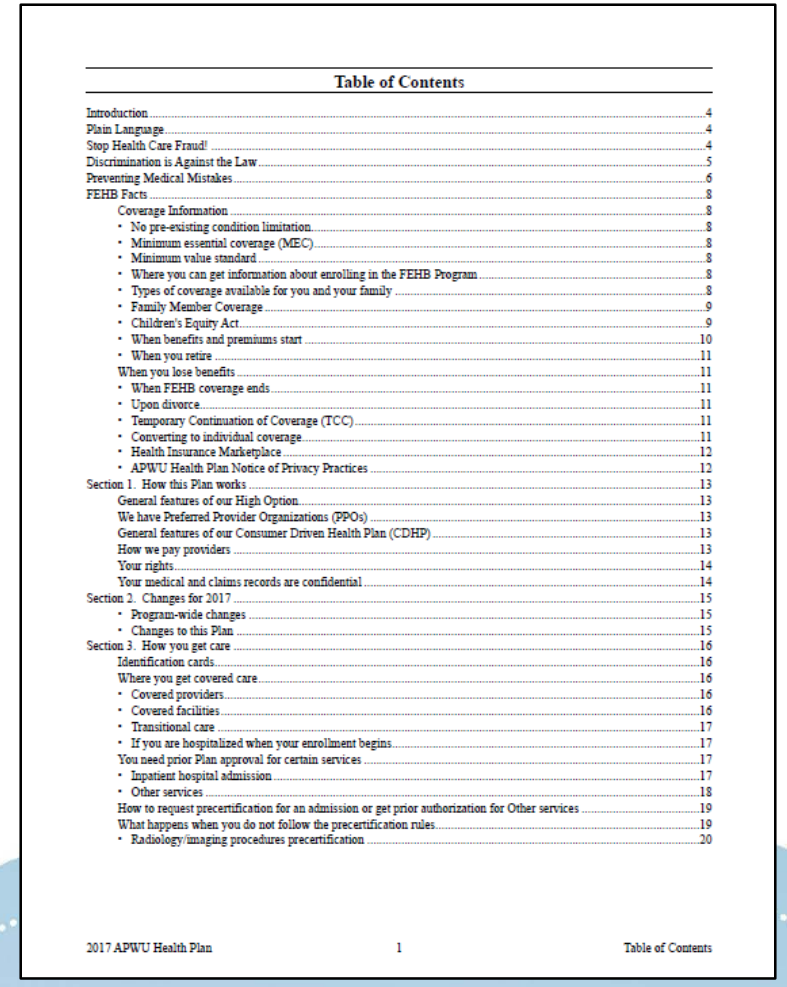
- Section 2: Changes for 2016
- Section 3: How to get care
- Section 4: Your Costs for covered services
- Section 5: Benefits



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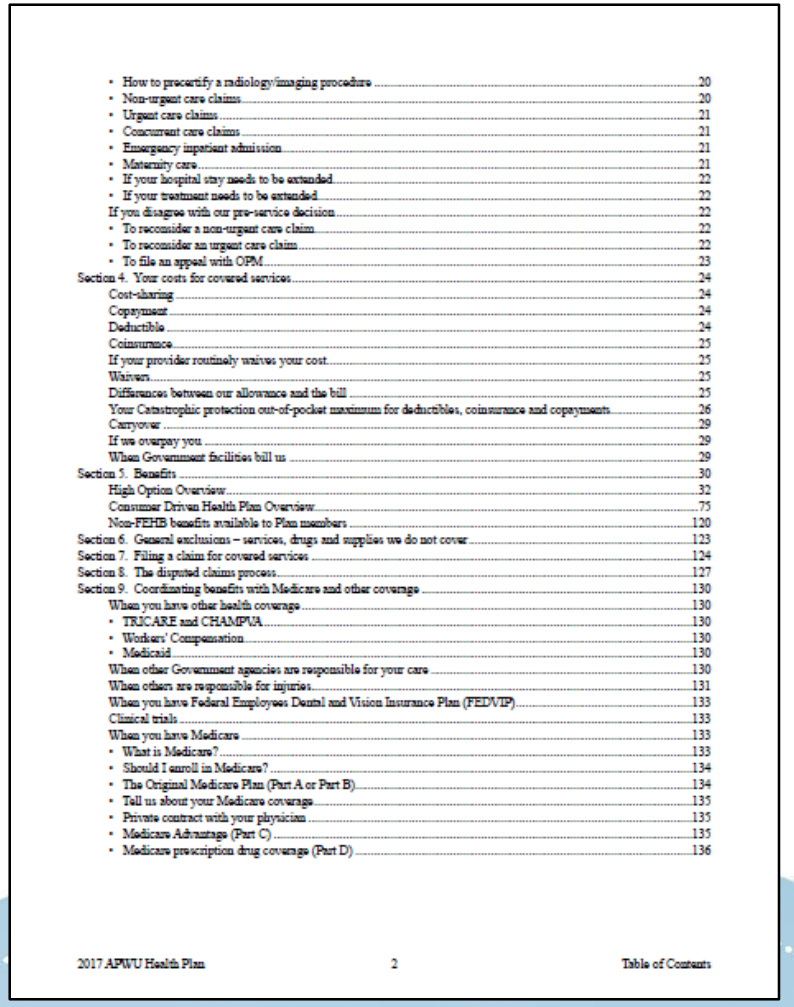

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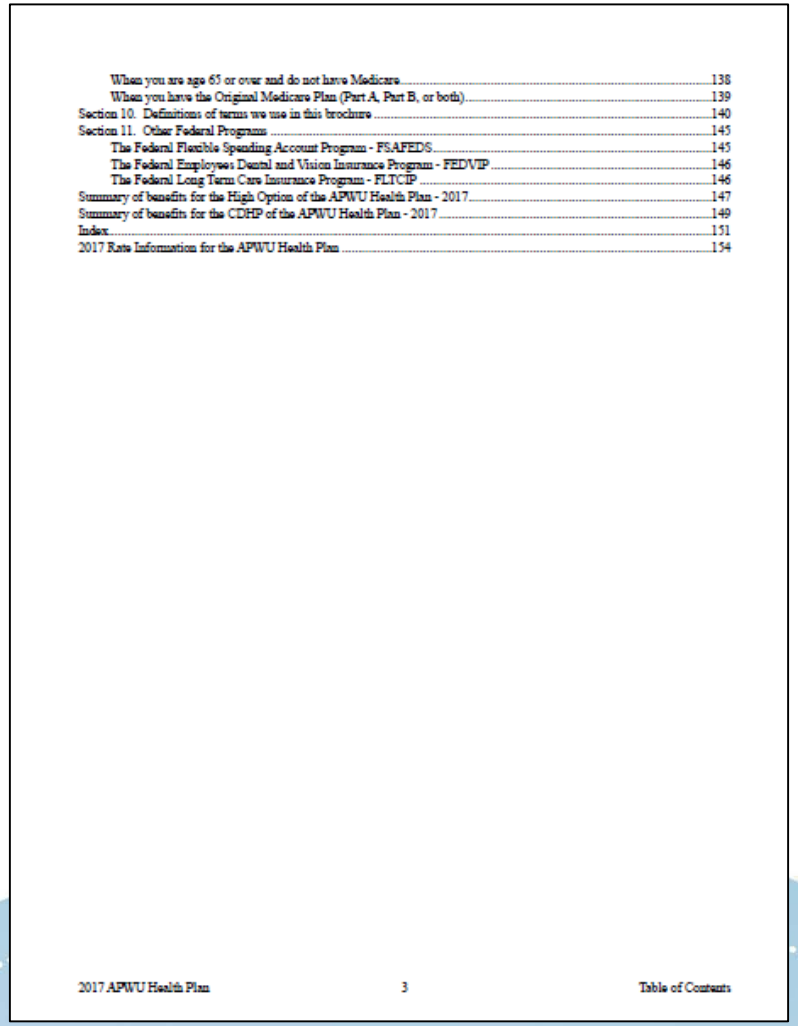

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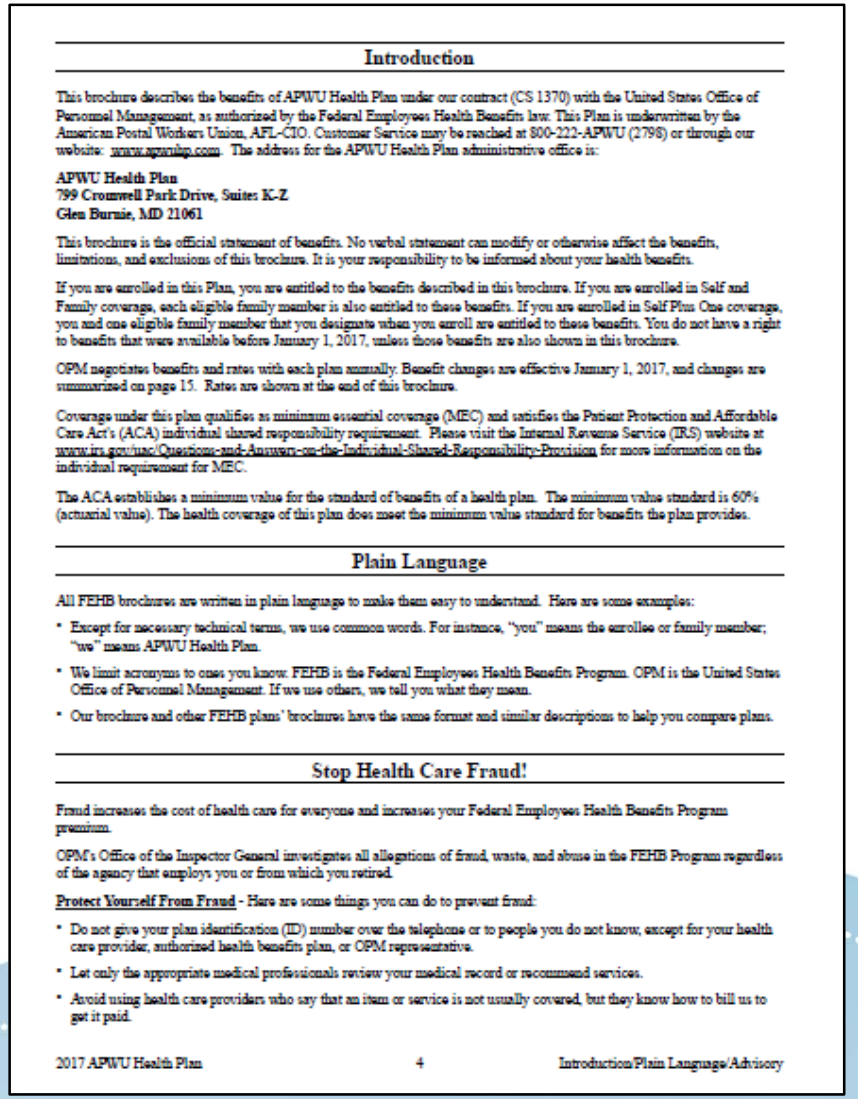


Introduction

This brochure describes the benefits of APWU Health Plan under our contract (CS 1370) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. This Plan is underwritten by the American Postal Workers Union, AFL-CIO. Customer Service may be reached at 800-222-APWU (2798) or through our website: www.apwuhp.com. The address for the APWU Health Plan administrative office is:

APWU Health Plan
799 Cromwell Park Drive, Suites K-Z
Glen Burnie, MD 21061

This brochure is the official statement of benefits. No verbal statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. If you are enrolled in Self Plus One coverage, you and one eligible family member that you designate when you enroll are entitled to these benefits. You do not have a right to benefits that were available before January 1, 2017, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2017, and changes are summarized on page 15. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for benefits the plan provides.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member; "we" means APWU Health Plan.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premiums.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

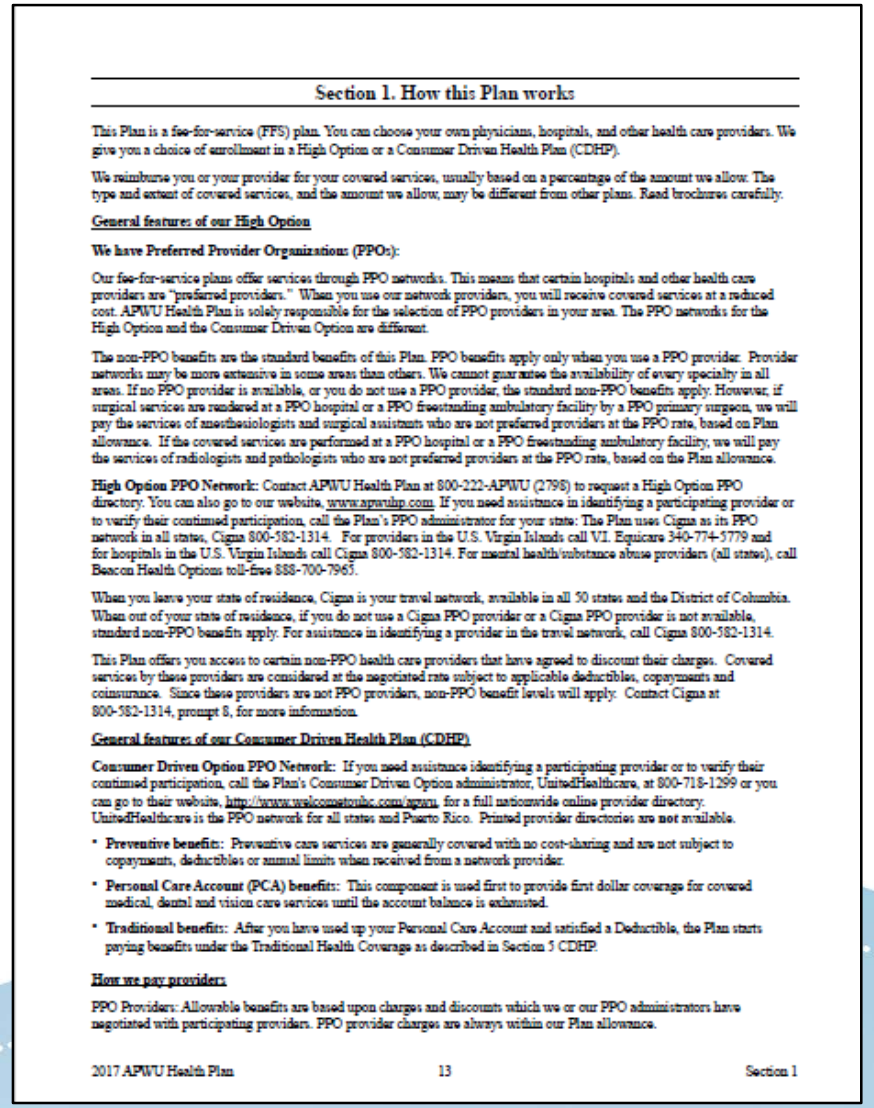
Protect Yourself From Fraud - Here are some things you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care provider, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.

2017 APWU Health Plan 4 Introduction/Plain Language/Advisory

Section 1: How This Plan Works

- PPO Network
  - Directory:
    http://www.welcometouhc.com/apwu
  - Call UnitedHealthcare



Section 1. How this Plan works

This Plan is a fee-for-service (FFS) plan. You can choose your own physicians, hospitals, and other health care providers. We give you a choice of enrollment in a High Option or a Consumer Driven Health Plan (CDHP).

We reimburse you or your provider for your covered services, usually based on a percentage of the amount we allow. The type and extent of covered services, and the amount we allow, may be different from other plans. Read brochures carefully.

General features of our High Option

We have Preferred Provider Organizations (PPOs):

Our fee-for-service plans offer services through PPO networks. This means that certain hospitals and other health care providers are "preferred providers." When you use our network providers, you will receive covered services at a reduced cost. APWU Health Plan is solely responsible for the selection of PPO providers in your area. The PPO networks for the High Option and the Consumer Driven Option are different.

The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas. If no PPO provider is available, or you do not use a PPO provider, the standard non-PPO benefits apply. However, if surgical services are rendered at a PPO hospital or a PPO freestanding ambulatory facility by a PPO primary surgeon, we will pay the services of anesthesiologists and surgical assistants who are not preferred providers at the PPO rate, based on Plan allowance. If the covered services are performed at a PPO hospital or a PPO freestanding ambulatory facility, we will pay the services of radiologists and pathologists who are not preferred providers at the PPO rate, based on the Plan allowance.

High Option PPO Network: Contact APWU Health Plan at 800-222-APWU (2798) to request a High Option PPO directory. You can also go to our website, www.apwuhp.com. If you need assistance in identifying a participating provider or to verify their continued participation, call the Plan's PPO administrator for your state: The Plan uses Cigna as its PPO network in all states, Cigna 800-582-1314. For providers in the U.S. Virgin Islands call VI. Equicare 340-774-5779 and for hospitals in the U.S. Virgin Islands call Cigna 800-582-1314. For mental health/substance abuse providers (all states), call Beacon Health Options toll-free 888-700-7965.

When you leave your state of residence, Cigna is your travel network, available in all 50 states and the District of Columbia. When out of your state of residence, if you do not use a Cigna PPO provider or a Cigna PPO provider is not available, standard non-PPO benefits apply. For assistance in identifying a provider in the travel network, call Cigna 800-582-1314.

This Plan offers you access to certain non-PPO health care providers that have agreed to discount their charges. Covered services by these providers are considered at the negotiated rate subject to applicable deductibles, copayments and coinsurance. Since these providers are not PPO providers, non-PPO benefit levels will apply. Contact Cigna at 800-582-1314, prompt 8, for more information.

General features of our Consumer Driven Health Plan (CDHP)

Consumer Driven Option PPO Network: If you need assistance identifying a participating provider or to verify their continued participation, call the Plan's Consumer Driven Option administrator, UnitedHealthcare, at 800-718-1299 or you can go to their website, http://www.welcometouhc.com/apwu, for a full nationwide online provider directory. UnitedHealthcare is the PPO network for all states and Puerto Rico. Printed provider directories are not available.

- **Preventive benefits:** Preventive care services are generally covered with no cost-sharing and are not subject to copayments, deductibles or annual limits when received from a network provider.
- **Personal Care Account (PCA) benefits:** This component is used first to provide first dollar coverage for covered medical, dental and vision care services until the account balance is exhausted.
- **Traditional benefits:** After you have used up your Personal Care Account and satisfied a Deductible, the Plan starts paying benefits under the Traditional Health Coverage as described in Section 5 CDHP.

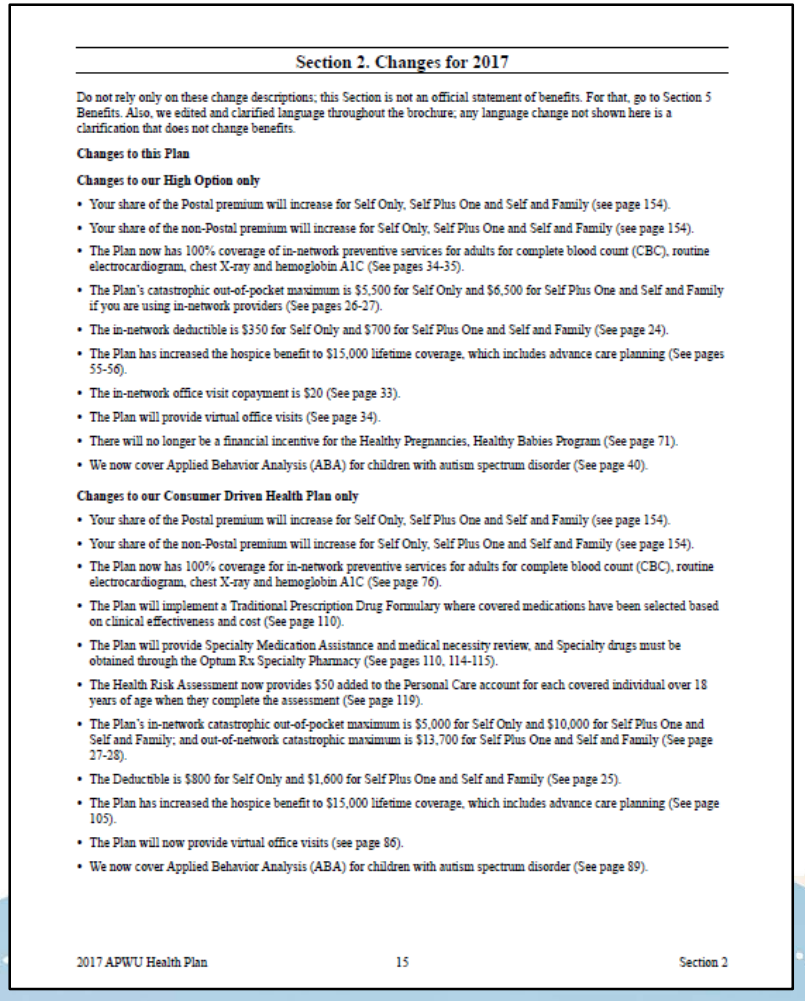
How we pay providers

PPO Providers: Allowable benefits are based upon charges and discounts which we or our PPO administrators have negotiated with participating providers. PPO provider charges are always within our Plan allowance.

2017 APWU Health Plan 13 Section 1

Section 2: Changes for 2017

- In-network Preventive Care Services
  - CBC, EKG, Chest X-ray, Hemoglobin A1C
- ABA for Autism Spectrum Disorder
- Hospice benefit increased to $15,000 (inpatient/outpatient and advanced care planning)
- Virtual Office Visits
- Pharmacy
  - Formulary Exclusions
  - Specialty drugs – 1st fill must be through OptumRx Specialty pharmacy
  - Medical Necessity Review added to Prior Auth
- Health Risk Assessment
  - $50 into the PCA for each person 18 years and older that completes the HRA
- Deductible Changes
  - $800 Self Only
  - $1600 Self Plus One; Self and Family
- Out-of-pocket Catastrophic
  - In-network $5000 Self Only; $10,000 Self Plus One; Self and Family
  - Out-of-network $13,700 Self Plus One; Self and Family



Section 2. Changes for 2017

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Changes to this Plan

Changes to our High Option only

- Your share of the Postal premium will increase for Self Only, Self Plus One and Self and Family (see page 154).
- Your share of the non-Postal premium will increase for Self Only, Self Plus One and Self and Family (see page 154).
- The Plan now has 100% coverage of in-network preventive services for adults for complete blood count (CBC), routine electrocardiogram, chest X-ray and hemoglobin A1C (See pages 34-35).
- The Plan's catastrophic out-of-pocket maximum is $5,500 for Self Only and $6,500 for Self Plus One and Self and Family if you are using in-network providers (See pages 26-27).
- The in-network deductible is $350 for Self Only and $700 for Self Plus One and Self and Family (See page 24).
- The Plan has increased the hospice benefit to $15,000 lifetime coverage, which includes advance care planning (See pages 55-56).
- The in-network office visit copayment is $20 (See page 33).
- The Plan will provide virtual office visits (See page 34).
- There will no longer be a financial incentive for the Healthy Pregnancies, Healthy Babies Program (See page 71).
- We now cover Applied Behavior Analysis (ABA) for children with autism spectrum disorder (See page 40).

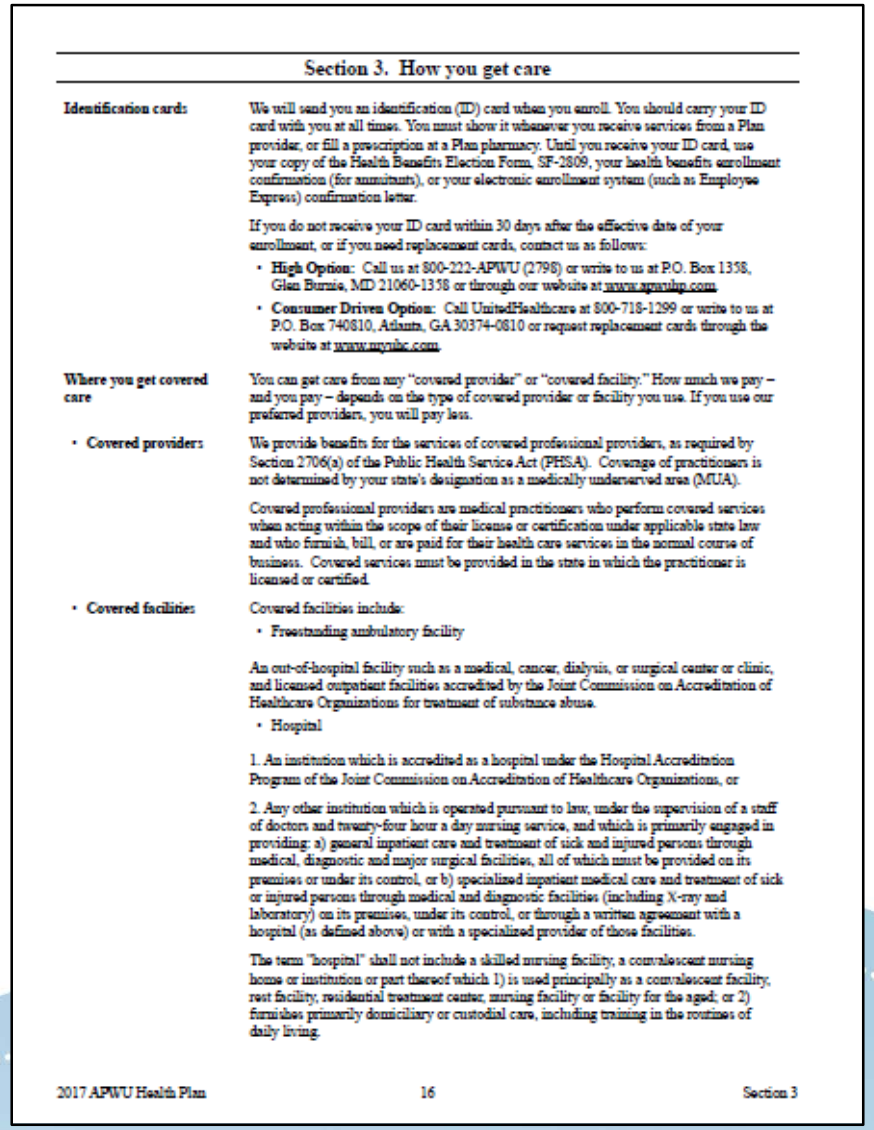
Changes to our Consumer Driven Health Plan only

- Your share of the Postal premium will increase for Self Only, Self Plus One and Self and Family (see page 154).
- Your share of the non-Postal premium will increase for Self Only, Self Plus One and Self and Family (see page 154).
- The Plan now has 100% coverage for in-network preventive services for adults for complete blood count (CBC), routine electrocardiogram, chest X-ray and hemoglobin A1C (See page 76).
- The Plan will implement a Traditional Prescription Drug Formulary where covered medications have been selected based on clinical effectiveness and cost (See page 110).
- The Plan will provide Specialty Medication Assistance and medical necessity review, and Specialty drugs must be obtained through the Optum Rx Specialty Pharmacy (See pages 110, 114-115).
- The Health Risk Assessment now provides $50 added to the Personal Care account for each covered individual over 18 years of age when they complete the assessment (See page 119).
- The Plan's in-network catastrophic out-of-pocket maximum is $5,000 for Self Only and $10,000 for Self Plus One and Self and Family; and out-of-network catastrophic maximum is $13,700 for Self Plus One and Self and Family (See page 27-28).
- The Deductible is $800 for Self Only and $1,600 for Self Plus One and Self and Family (See page 25).
- The Plan has increased the hospice benefit to $15,000 lifetime coverage, which includes advance care planning (See page 105).
- The Plan will now provide virtual office visits (see page 86).
- We now cover Applied Behavior Analysis (ABA) for children with autism spectrum disorder (See page 89).

2017 APWU Health Plan 15 Section 2

Section 3: How to get care

- ID Cards
- Precertification Process
- Services that need precertification
- How do request
- Penalty
- Urgent care



Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, contact us as follows:

- **High Option:** Call us at 800-222-APWU (2798) or write to us at P.O. Box 1358, Glen Burnie, MD 21060-1358 or through our website at www.apwuhp.com.
- **Consumer Driven Option:** Call UnitedHealthcare at 800-718-1299 or write to us at P.O. Box 740810, Atlanta, GA 30374-0810 or request replacement cards through the website at www.myuhc.com.

Where you get covered care

You can get care from any "covered provider" or "covered facility." How much we pay – and you pay – depends on the type of covered provider or facility you use. If you use our preferred providers, you will pay less.

- **Covered providers**

We provide benefits for the services of covered professional providers, as required by Section 2706(a) of the Public Health Service Act (PHSA). Coverage of practitioners is not determined by your state's designation as a medically underserved area (MUA).

Covered professional providers are medical practitioners who perform covered services when acting within the scope of their license or certification under applicable state law and who furnish, bill, or are paid for their health care services in the normal course of business. Covered services must be provided in the state in which the practitioner is licensed or certified.

- **Covered facilities**

Covered facilities include:

- Freestanding ambulatory facility

An out-of-hospital facility such as a medical, cancer, dialysis, or surgical center or clinic, and licensed outpatient facilities accredited by the Joint Commission on Accreditation of Healthcare Organizations for treatment of substance abuse.

- Hospital

1. An institution which is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations, or

2. Any other institution which is operated pursuant to law, under the supervision of a staff of doctors and twenty-four hour a day nursing service, and which is primarily engaged in providing: a) general inpatient care and treatment of sick and injured persons through medical, diagnostic and major surgical facilities, all of which must be provided on its premises or under its control, or b) specialized inpatient medical care and treatment of sick or injured persons through medical and diagnostic facilities (including X-ray and laboratory) on its premises, under its control, or through a written agreement with a hospital (as defined above) or with a specialized provider of those facilities.

The term "hospital" shall not include a skilled nursing facility, a convalescent nursing home or institution or part thereof which 1) is used principally as a convalescent facility, rest facility, residential treatment center, nursing facility or facility for the aged; or 2) furnishes primarily domiciliary or custodial care, including training in the routines of daily living.

2017 APWU Health Plan 16 Section 3

Do I need a pre-notification?

Yes

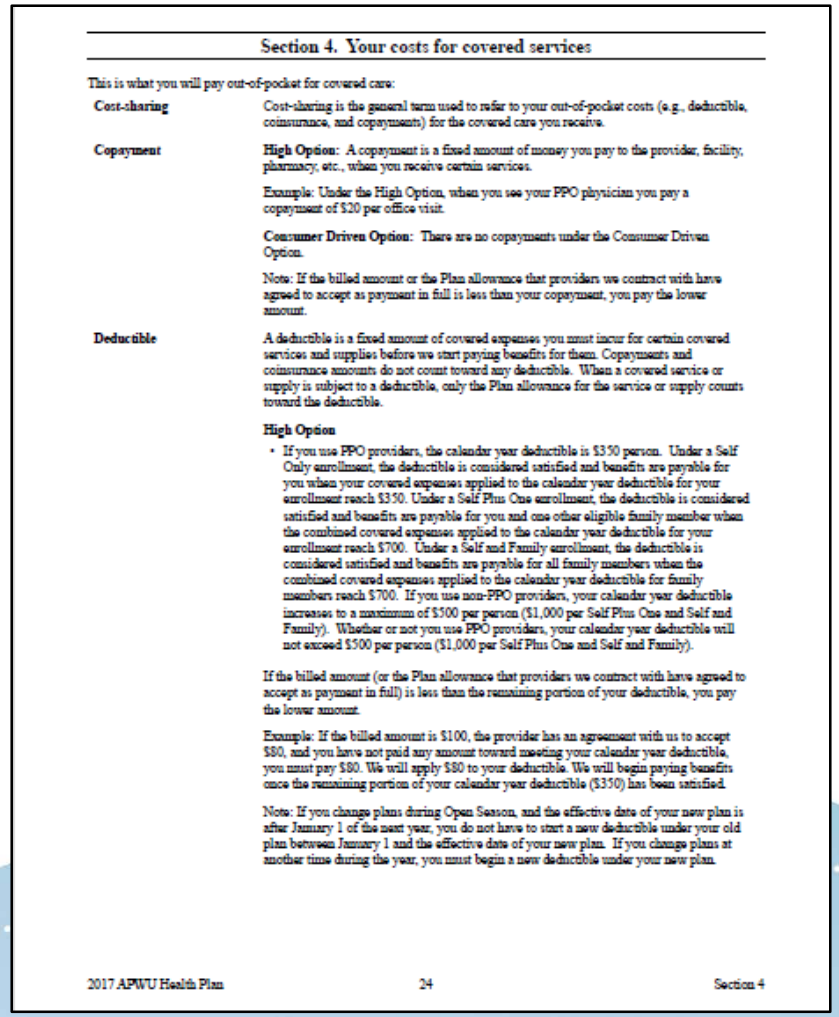
- ✓ In-patient Admission
- ✓ DME
- ✓ Treatment Back/Neck Pain
- ✓ Bariatric Surgery
- ✓ Mental Health Treatment (In-patient)
- ✓ Genetic testing

No

- ✓ Outpatient Services at VA
- ✓ Maternity Care/Admissions
- ✓ Chiropractic Care
- ✓ Acupuncture Treatment

Section 4: Your Costs for Covered Services

- Out-of-Pocket Cost
  - Copay (none)
  - Deductible
  - Coinsurance
- PPO vs. Non PPO
  - Balance billing
- Catastrophic Costs



Section 4. Your costs for covered services

This is what you will pay out-of-pocket for covered care:

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Copayment

High Option: A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: Under the High Option, when you see your PPO physician you pay a copayment of $20 per office visit.

Consumer Driven Option: There are no copayments under the Consumer Driven Option.

Note: If the billed amount or the Plan allowance that providers we contract with have agreed to accept as payment in full is less than your copayment, you pay the lower amount.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for them. Copayments and coinsurance amounts do not count toward any deductible. When a covered service or supply is subject to a deductible, only the Plan allowance for the service or supply counts toward the deductible.

High Option

- If you use PPO providers, the calendar year deductible is $350 person. Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach $350. Under a Self Plus One enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered expenses applied to the calendar year deductible for your enrollment reach $700. Under a Self and Family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $700. If you use non-PPO providers, your calendar year deductible increases to a maximum of $500 per person ($1,000 per Self Plus One and Self and Family). Whether or not you use PPO providers, your calendar year deductible will not exceed $500 per person ($1,000 per Self Plus One and Self and Family).

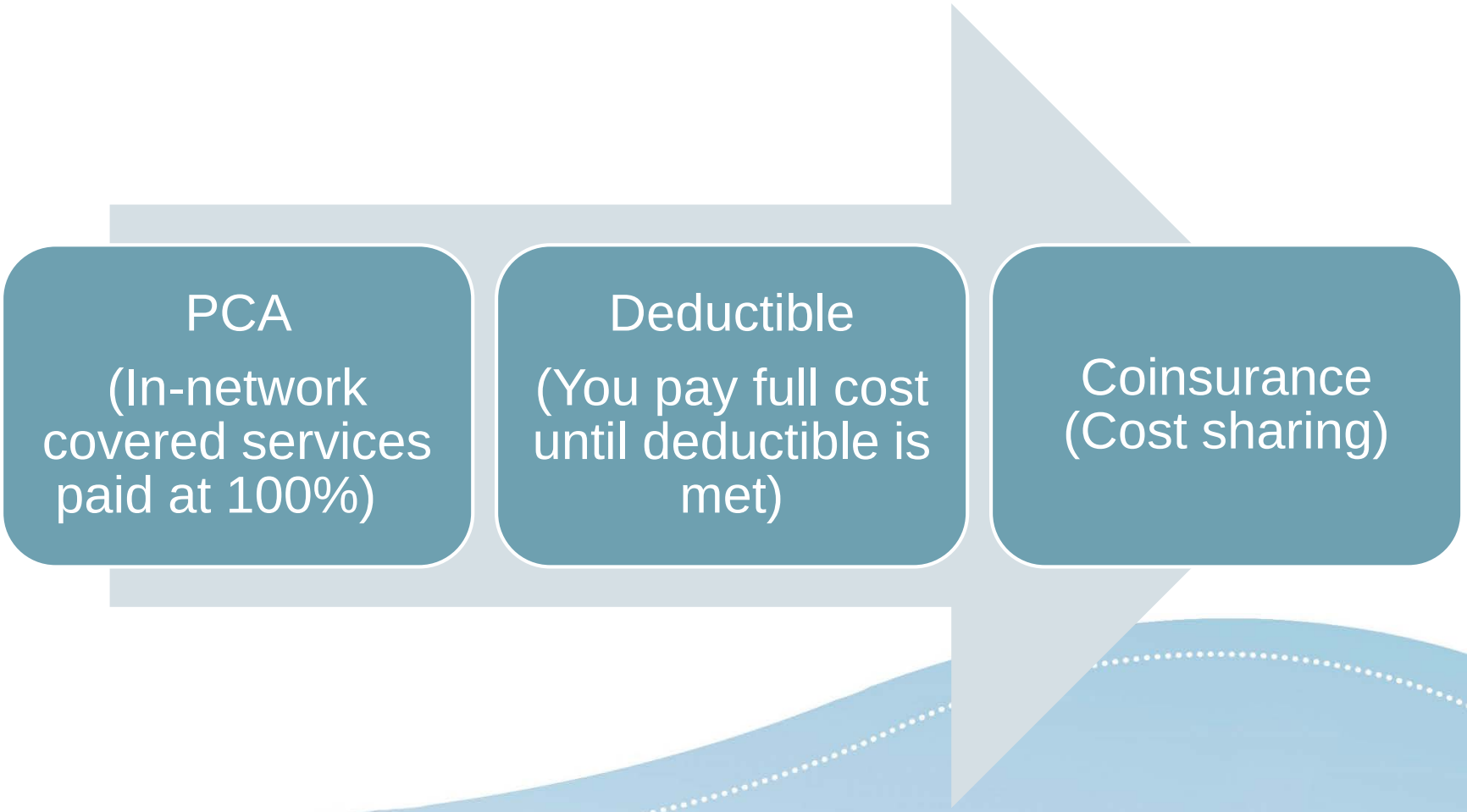
If the billed amount (or the Plan allowance that providers we contract with have agreed to accept as payment in full) is less than the remaining portion of your deductible, you pay the lower amount.

Example: If the billed amount is $100, the provider has an agreement with us to accept $80, and you have not paid any amount toward meeting your calendar year deductible, you must pay $80. We will apply $80 to your deductible. We will begin paying benefits once the remaining portion of your calendar year deductible ($350) has been satisfied.

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

2017 APWU Health Plan 24 Section 4

Deductible - Bridge Between PCA and Traditional Insurance



Personal Care Account (PCA)

Self Only	Self Plus One	Self and Family
• $1200	• $2400	• $2400

- Members are given an account on day one of coverage
- 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

Self Only	Self Plus One	Self and Family
• $5000	• $10,000	• $10,000

PCA/Family Deductible

- Self Plus One or Self and Family: Once one individual meets the Self Only Deductible of $800, Traditional Health Coverage begins for that individual. Once the other covered members meet the additional $800 Deductible, Traditional Health Coverage begins for them.
- Self Only: When an individual meets the out-of-pocket maximum, they pay no coinsurance for covered service for the remainder of the calendar year. Once the other covered members in the family meet the remaining out-of-pocket family maximum, then they pay no coinsurance for covered services for the remainder of the calendar year.

(Next slide shows example)

PCA/Family Deductible

- Self Plus One or Self and Family:

  $2,400 PCA plus $1,600 deductible =

  $4,000 "Total Deductible"

  - Once member one meets an additional out-of-pocket of $1,000 for a total of $5,000, *(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 $5,000 *(for a total of $10,000 for the family),* that persons claims will be paid at 100%.

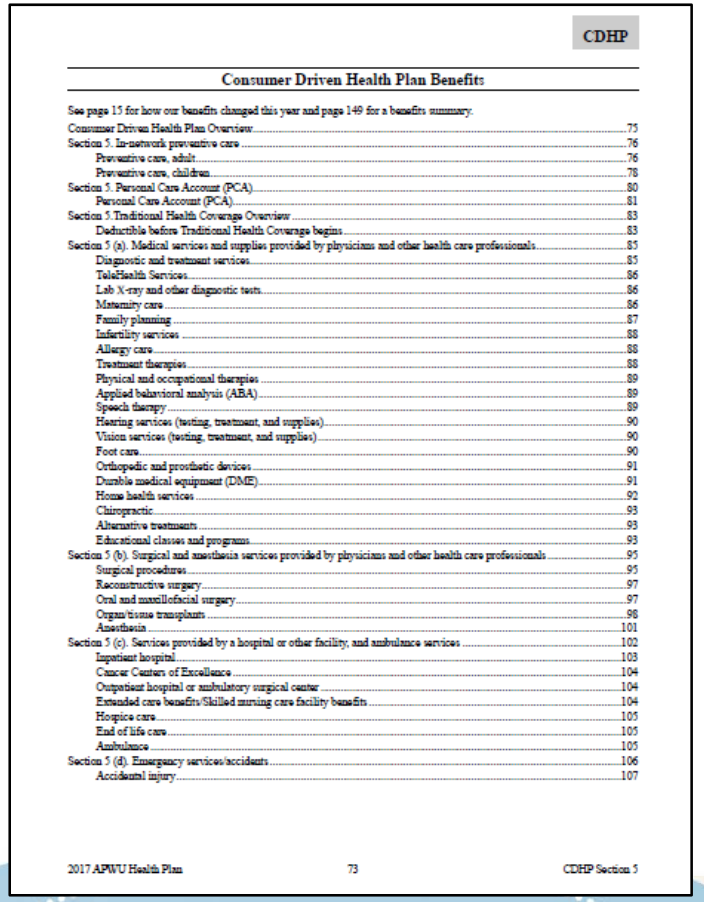
Coinsurance

Definition: The percentage of covered allowances for which the patient is responsible.

- 15% of allowance for in-network care
- 40% of allowance for out-of-network care
- 10% of allowance for treatment of cancer at a Cancer Center of Excellence
- 25% of prescription formulary allowance

Section 5 (a)-(h): Benefits

- In-network Preventive Care
- Medical and supplies
- Surgical and anesthesia services
- Services provided by hospital or other facility
- Emergency services
- Mental health and substance abuse
- Prescription drugs
- Dental benefits
- Special features
- Health education resources and account management tools



CDHP

Consumer Driven Health Plan Benefits

See page 15 for how our benefits changed this year and page 149 for a benefits summary.

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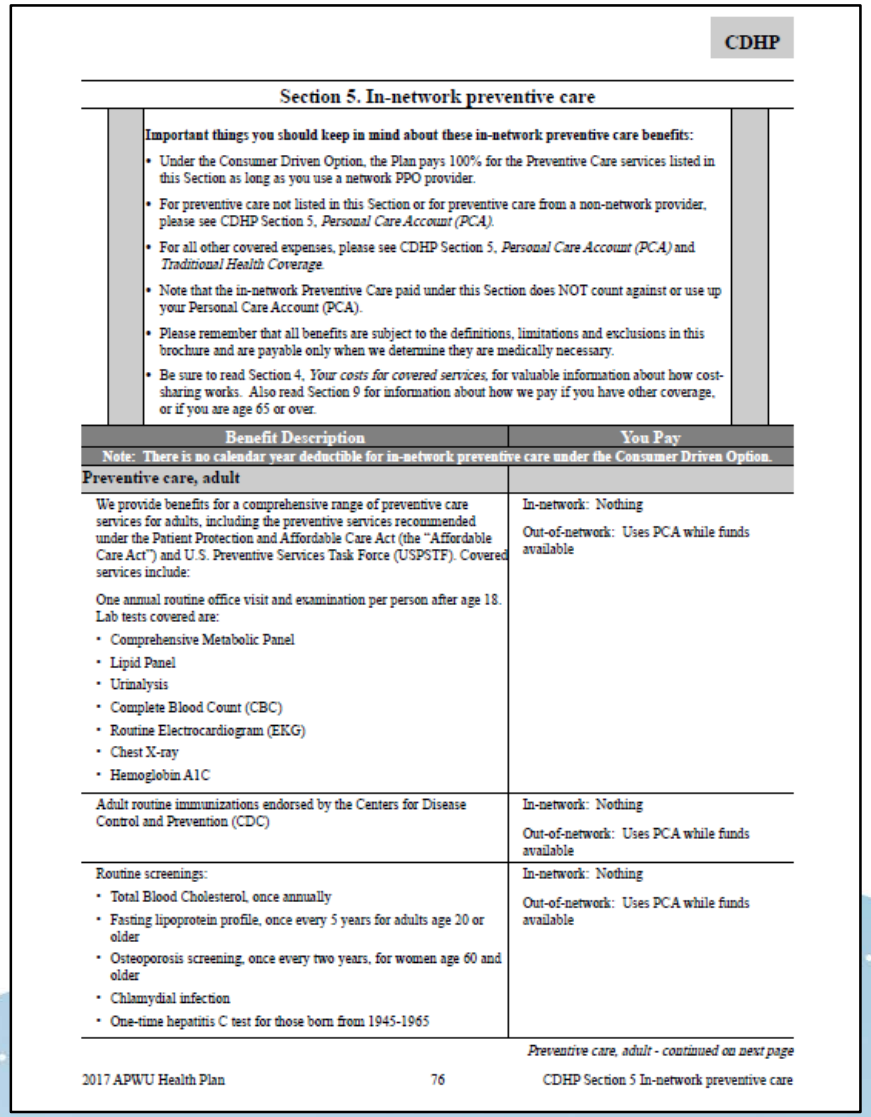
In-network Preventive Care

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



CDHP

Section 5. In-network preventive care

Important things you should keep in mind about these in-network preventive care benefits:

- Under the Consumer Driven Option, the Plan pays 100% for the Preventive Care services listed in this Section as long as you use a network PPO provider.
- For preventive care not listed in this Section or for preventive care from a non-network provider, please see CDHP Section 5, *Personal Care Account (PCA)*.
- For all other covered expenses, please see CDHP Section 5, *Personal Care Account (PCA)* and *Traditional Health Coverage*.
- Note that the in-network Preventive Care paid under this Section does NOT count against or use up your Personal Care Account (PCA).
- 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.

Benefit Description	You Pay
Note: There is no calendar year deductible for in-network preventive care under the Consumer Driven Option.	
Preventive care, adult	
We provide benefits for a comprehensive range of preventive care services for adults, including the preventive services recommended under the Patient Protection and Affordable Care Act (the "Affordable Care Act") and U.S. Preventive Services Task Force (USPSTF). Covered services include: One annual routine office visit and examination per person after age 18. Lab tests covered are: • Comprehensive Metabolic Panel • Lipid Panel • Urinalysis • Complete Blood Count (CBC) • Routine Electrocardiogram (EKG) • Chest X-ray • Hemoglobin A1C	In-network: Nothing Out-of-network: Uses PCA while funds available
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC)	In-network: Nothing Out-of-network: Uses PCA while funds available
Routine screenings: • Total Blood Cholesterol, once annually • Fasting lipoprotein profile, once every 5 years for adults age 20 or older • Osteoporosis screening, once every two years, for women age 60 and older • Chlamydial infection • One-time hepatitis C test for those born from 1945-1965	In-network: Nothing Out-of-network: Uses PCA while funds available

Preventive care, adult - continued on next page

Scenario CDO: Preventive Care

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

All three claims are paid at 100%

Scenario CDO: Preventive Care

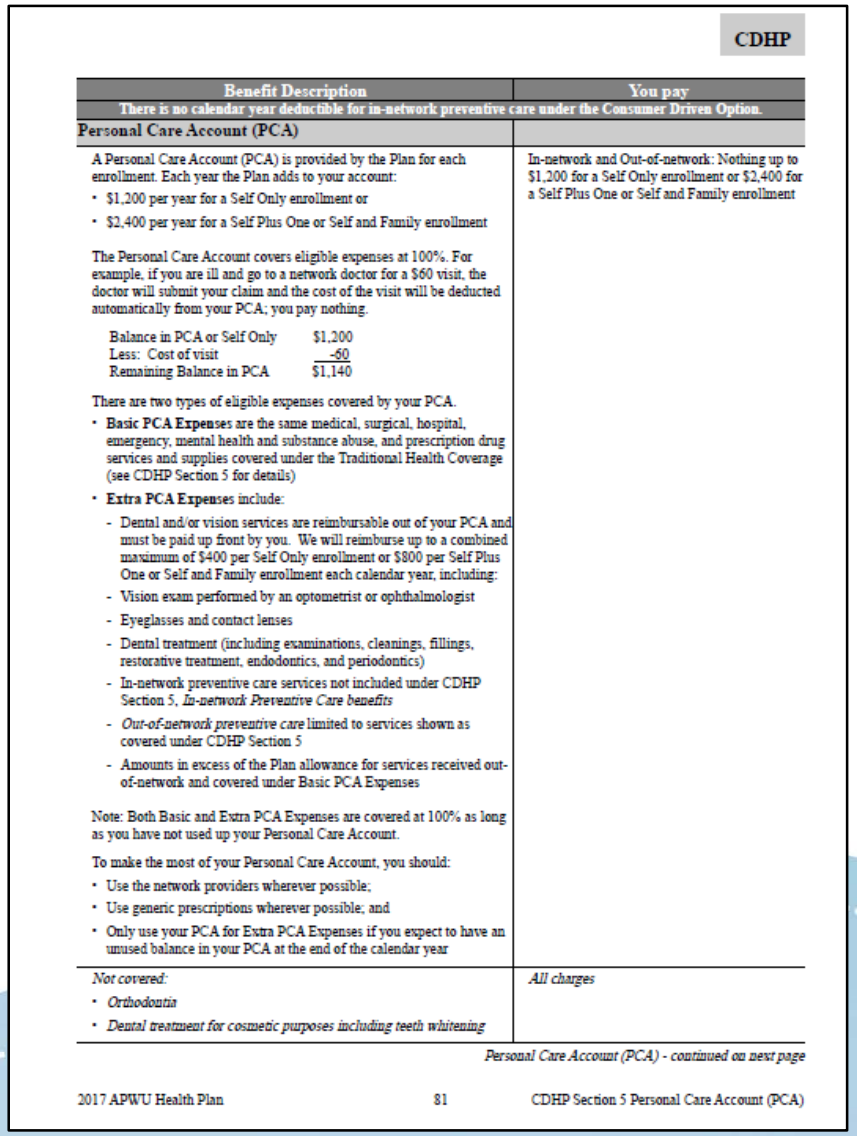
- Member goes for routine colonoscopy
- Member uses in-network providers
- Diagnosis on surgery and anesthesiologist claims is routine
- Diagnosis on in-network lab claim is non-routine (i.e. bleeding)

- Surgery and anesthesia claim are paid at 100%
- Lab claim will pay at 60%; member will be billed for 40% of the plan allowance unless

PCA

- Examples
- Dental
- Vision
- Rollover

$400/$800



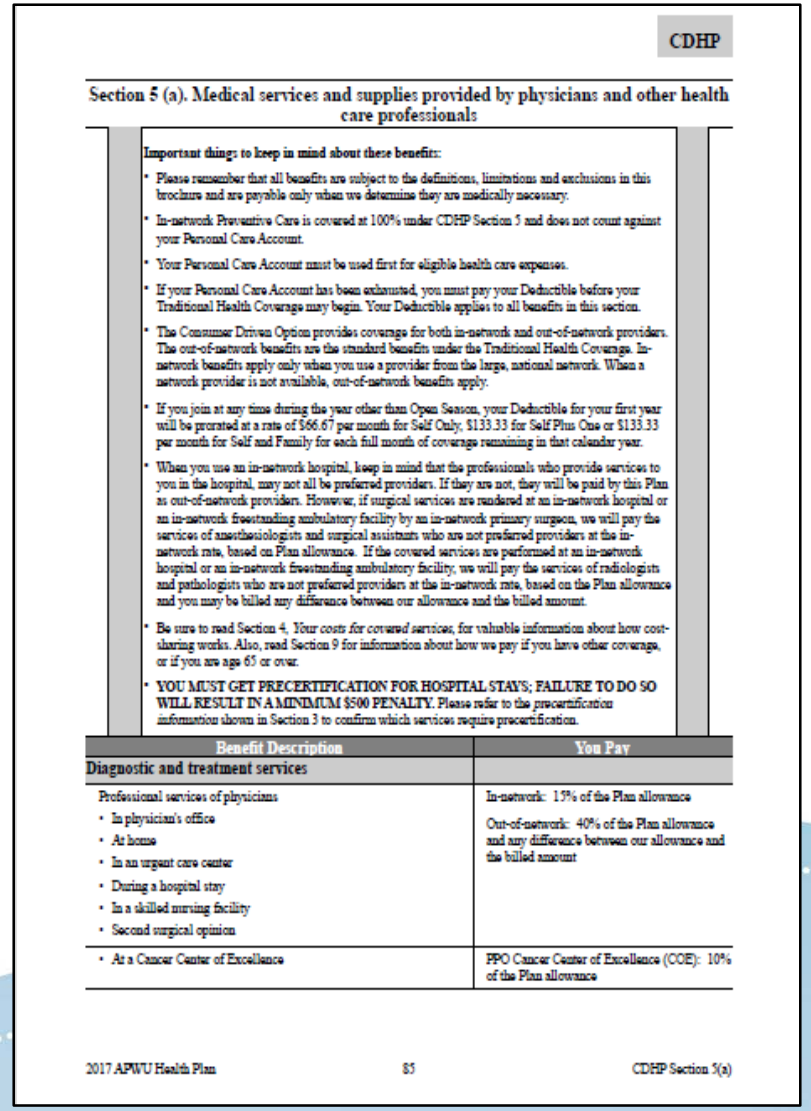
CDHP

Benefit Description	You pay
There is no calendar year deductible for in-network preventive care under the Consumer Driven Option.	
Personal Care Account (PCA)	
A Personal Care Account (PCA) is provided by the Plan for each enrollment. Each year the Plan adds to your account: • $1,200 per year for a Self Only enrollment or • $2,400 per year for a Self Plus One or Self and Family enrollment The Personal Care Account covers eligible expenses at 100%. For example, if you are ill and go to a network doctor for a $60 visit, the doctor will submit your claim and the cost of the visit will be deducted automatically from your PCA; you pay nothing. Balance in PCA or Self Only $1,200 Less: Cost of visit -60 Remaining Balance in PCA $1,140 There are two types of eligible expenses covered by your PCA. • **Basic PCA Expenses** are the same medical, surgical, hospital, emergency, mental health and substance abuse, and prescription drug services and supplies covered under the Traditional Health Coverage (see CDHP Section 5 for details) • **Extra PCA Expenses** include: - Dental and/or vision services are reimbursable out of your PCA and must be paid up front by you. We will reimburse up to a combined maximum of $400 per Self Only enrollment or $800 per Self Plus One or Self and Family enrollment each calendar year, including: - Vision exam performed by an optometrist or ophthalmologist - Eyeglasses and contact lenses - Dental treatment (including examinations, cleanings, fillings, restorative treatment, endodontics, and periodontics) - In-network preventive care services not included under CDHP Section 5, *In-network Preventive Care benefits* - *Out-of-network preventive care* limited to services shown as covered under CDHP Section 5 - Amounts in excess of the Plan allowance for services received out-of-network and covered under Basic PCA Expenses Note: Both Basic and Extra PCA Expenses are covered at 100% as long as you have not used up your Personal Care Account. To make the most of your Personal Care Account, you should: • Use the network providers wherever possible; • Use generic prescriptions wherever possible; and • Only use your PCA for Extra PCA Expenses if you expect to have an unused balance in your PCA at the end of the calendar year	In-network and Out-of-network: Nothing up to $1,200 for a Self Only enrollment or $2,400 for a Self Plus One or Self and Family enrollment
Not covered: • *Orthodontia* • *Dental treatment for cosmetic purposes including teeth whitening*	*All charges*

Personal Care Account (PCA) - continued on next page

Sections 5(a)

- Office visits
- X-rays and diagnostic test
- Maternity
- Family Planning
- Infertility
- Therapies
- Hearing
- DME
- Chiropractic
- Acupuncture



CDHP

Section 5 (a). Medical services and supplies provided by physicians and other health care professionals

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In-network Preventive Care is covered at 100% under CDHP Section 5 and does not count against your Personal Care Account.
- Your Personal Care Account must be used first for eligible health care expenses.
- If your Personal Care Account has been exhausted, you must pay your Deductible before your Traditional Health Coverage may begin. Your Deductible applies to all benefits in this section.
- The Consumer Driven Option provides coverage for both in-network and out-of-network providers. The out-of-network benefits are the standard benefits under the Traditional Health Coverage. In-network benefits apply only when you use a provider from the large, national network. When a network provider is not available, out-of-network benefits apply.
- If you join at any time during the year other than Open Season, your Deductible for your first year will be prorated at a rate of $66.67 per month for Self Only, $133.33 for Self Plus One or $133.33 per month for Self and Family for each full month of coverage remaining in that calendar year.
- When you use an in-network hospital, keep in mind that the professionals who provide services to you in the hospital, may not all be preferred providers. If they are not, they will be paid by this Plan as out-of-network providers. However, if surgical services are rendered at an in-network hospital or an in-network freestanding ambulatory facility by an in-network primary surgeon, we will pay the services of anesthesiologists and surgical assistants who are not preferred providers at the in-network rate, based on Plan allowance. If the covered services are performed at an in-network hospital or an in-network freestanding ambulatory facility, we will pay the services of radiologists and pathologists who are not preferred providers at the in-network rate, based on the Plan allowance and you may be billed any difference between our allowance and the billed amount.
- 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.

Benefit Description	You Pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office • At home • In an urgent care center • During a hospital stay • In a skilled nursing facility • Second surgical opinion	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
• At a Cancer Center of Excellence	PPO Cancer Center of Excellence (COE): 10% of the Plan allowance

Infertility

- The Plan covers services related to the diagnosis and treatment of infertility
  - Covered services would include visits, surgery, and diagnostic testing
  - Maximum Plan benefit: $2,500
- The Plan does not cover costs to assist in conception
  - See list - page 88

Physical/Occupational/Speech

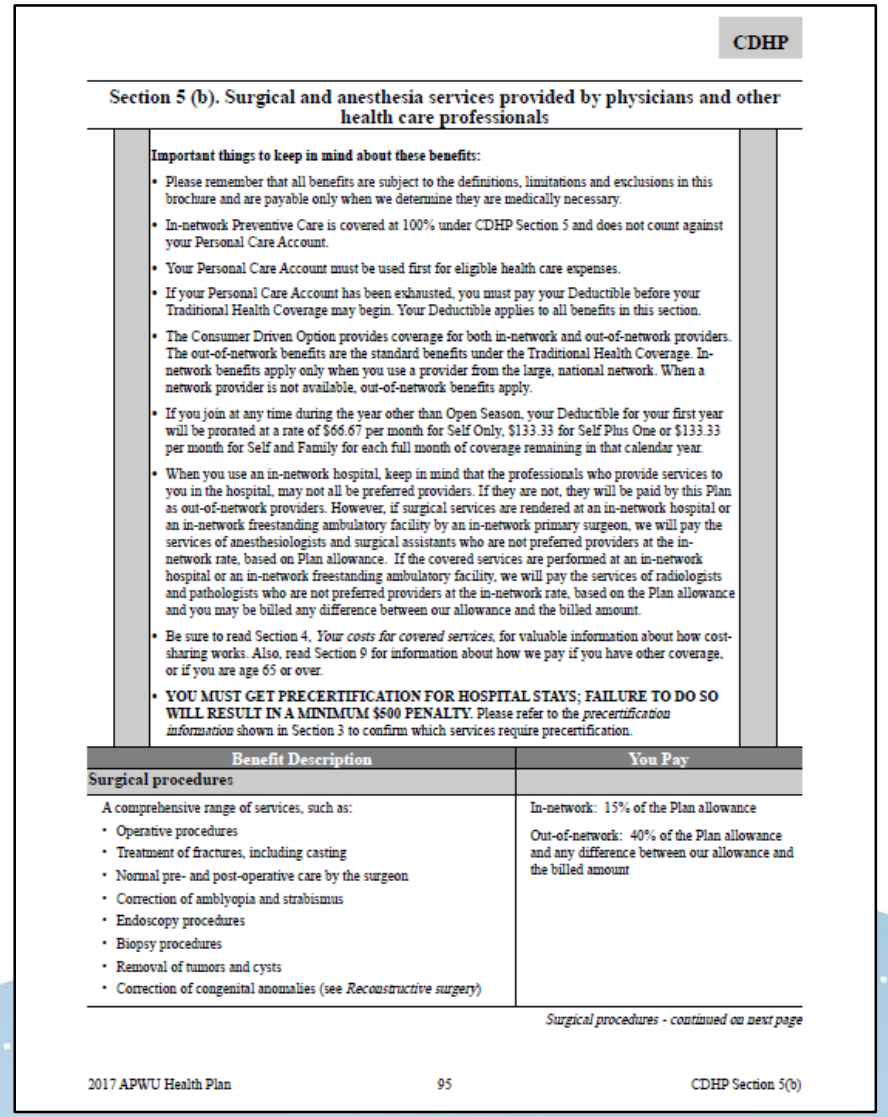
- Covered Treatments
  - Services of a Registered Physical/Occupational Therapist to assist in the recovery of lost, diminished (rehabilitative) or absent (habilitative) functionality
  - Services of a Registered Speech Therapist to assist in restoring lost or diminished functionality
- Benefits are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

Applied Behavioral Analysis (ABA)

- Outpatient ABA for the treatment of Autism Spectrum Disorder
  - **In-network benefit only**
  - Services must be provided under the supervision of a Board Certified Behavior Analyst
  - Provider must be contracted or agree to participate with Beacon Health Options care management activities
  - Services must be preauthorized by Beacon Health Options, call **888-700-7965**
  - Review of ABA services is based on an intensive care management model that monitors treatment plans, objectives and progress milestones
  - Member coinsurance 15% of the Plan allowance

Sections 5(b)

- Surgical procedures
- Anesthesia
- PPO vs. Non-PPO facility



CDHP

Section 5 (b). Surgical and anesthesia services provided by physicians and other health care professionals

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In-network Preventive Care is covered at 100% under CDHP Section 5 and does not count against your Personal Care Account.
- Your Personal Care Account must be used first for eligible health care expenses.
- If your Personal Care Account has been exhausted, you must pay your Deductible before your Traditional Health Coverage may begin. Your Deductible applies to all benefits in this section.
- The Consumer Driven Option provides coverage for both in-network and out-of-network providers. The out-of-network benefits are the standard benefits under the Traditional Health Coverage. In-network benefits apply only when you use a provider from the large, national network. When a network provider is not available, out-of-network benefits apply.
- If you join at any time during the year other than Open Season, your Deductible for your first year will be prorated at a rate of $66.67 per month for Self Only, $133.33 for Self Plus One or $133.33 per month for Self and Family for each full month of coverage remaining in that calendar year.
- When you use an in-network hospital, keep in mind that the professionals who provide services to you in the hospital, may not all be preferred providers. If they are not, they will be paid by this Plan as out-of-network providers. However, if surgical services are rendered at an in-network hospital or an in-network freestanding ambulatory facility by an in-network primary surgeon, we will pay the services of anesthesiologists and surgical assistants who are not preferred providers at the in-network rate, based on Plan allowance. If the covered services are performed at an in-network hospital or an in-network freestanding ambulatory facility, we will pay the services of radiologists and pathologists who are not preferred providers at the in-network rate, based on the Plan allowance and you may be billed any difference between our allowance and the billed amount.
- 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.

Benefit Description	You Pay
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*)	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount

Surgical procedures - continued on next page

Anesthesia

- Services by out-of-network anesthesiologist
  - Where services performed by an in-network surgeon at an in-network facility: Plan will apply in-network benefits to the Plan allowance for the out-of-network anesthesiologist*
  - Where services performed by an in-network surgeon at an **out-of-network facility**: Plan will apply out-of-network benefits to the anesthesiologist*
  - Where services performed by an **out-of-network surgeon** at an in-network facility: Plan will apply out-of-network benefits to the anesthesiologist*

**Anesthesiologist may balance bill the member*

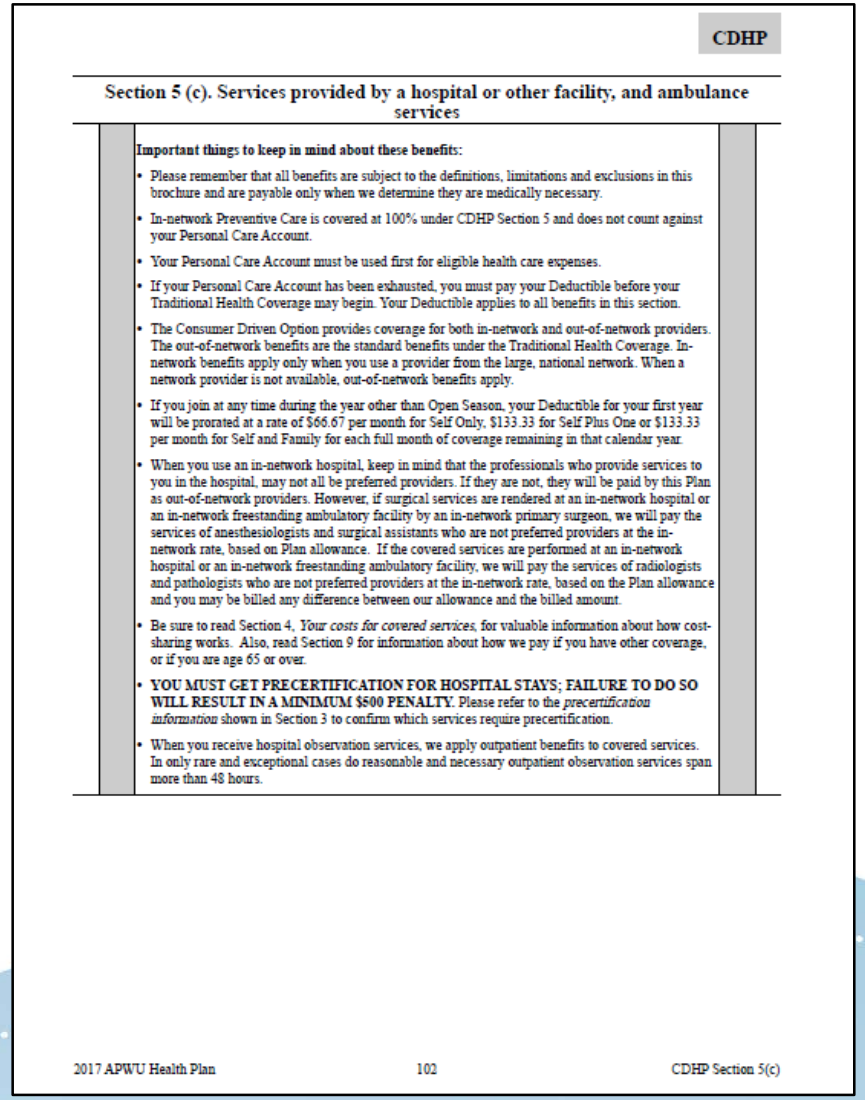
Scenario: Anesthesia

- Member uses in-network hospital and surgeon
- Anesthesiologist is out-of-network

- Surgeon, hospital and anesthesia claim are paid in-network at 85%; member pays 15% of plan allowance
- Anesthesia may balance bill because they are not contracted providers
- Most anesthesiologist are out-of-network
- Bill is $1,000; HP allowance is $600; HP pays $510; anesthesiologist can balance bill member for the $400 difference between billed charge and the allowable, plus the $90 (coinsurance) for a total of $490.

Sections 5(c)

- Room and board
- Cancer Centers of Excellence
- Outpatient
- Hospice
- Extended Care
- Ambulance



CDHP

Section 5 (c). Services provided by a hospital or other facility, and ambulance services

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In-network Preventive Care is covered at 100% under CDHP Section 5 and does not count against your Personal Care Account.
- Your Personal Care Account must be used first for eligible health care expenses.
- If your Personal Care Account has been exhausted, you must pay your Deductible before your Traditional Health Coverage may begin. Your Deductible applies to all benefits in this section.
- The Consumer Driven Option provides coverage for both in-network and out-of-network providers. The out-of-network benefits are the standard benefits under the Traditional Health Coverage. In-network benefits apply only when you use a provider from the large, national network. When a network provider is not available, out-of-network benefits apply.
- If you join at any time during the year other than Open Season, your Deductible for your first year will be prorated at a rate of $66.67 per month for Self Only, $133.33 for Self Plus One or $133.33 per month for Self and Family for each full month of coverage remaining in that calendar year.
- When you use an in-network hospital, keep in mind that the professionals who provide services to you in the hospital, may not all be preferred providers. If they are not, they will be paid by this Plan as out-of-network providers. However, if surgical services are rendered at an in-network hospital or an in-network freestanding ambulatory facility by an in-network primary surgeon, we will pay the services of anesthesiologists and surgical assistants who are not preferred providers at the in-network rate, based on Plan allowance. If the covered services are performed at an in-network hospital or an in-network freestanding ambulatory facility, we will pay the services of radiologists and pathologists who are not preferred providers at the in-network rate, based on the Plan allowance and you may be billed any difference between our allowance and the billed amount.
- 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.
- When you receive hospital observation services, we apply outpatient benefits to covered services. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours.

2017 APWU Health Plan 102 CDHP Section 5(c)

Extended Care

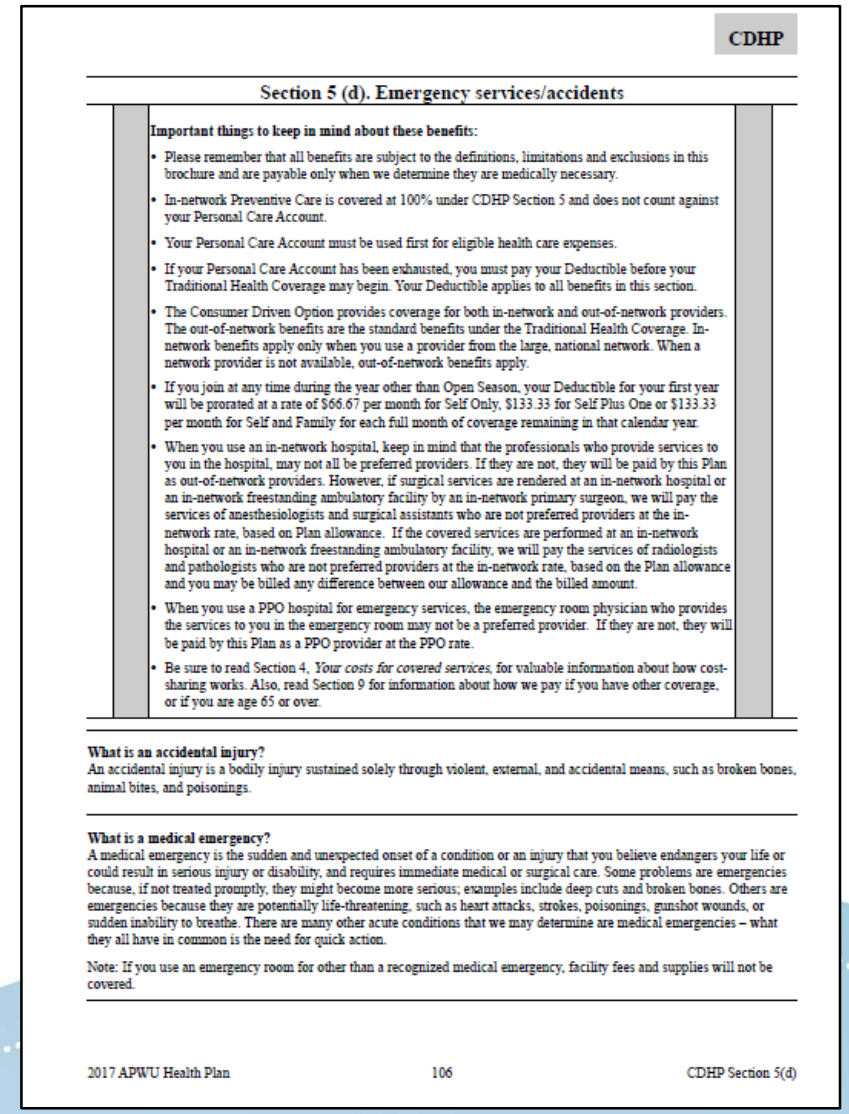
- Plan does not cover care rendered at other than an acute care facility
- Services rendered at a Skilled Nursing Facility (SNF) are specifically excluded from coverage

Hospice

- Inpatient/Outpatient hospice benefit maximum coverage of $15,000.
- Includes advance care planning for end of life issues with your physician.

Sections 5(d)

- Accident
- Medical Emergency
- Urgent Care Center
- Ambulance



CDHP

Section 5 (d). Emergency services/accidents

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In-network Preventive Care is covered at 100% under CDHP Section 5 and does not count against your Personal Care Account.
- Your Personal Care Account must be used first for eligible health care expenses.
- If your Personal Care Account has been exhausted, you must pay your Deductible before your Traditional Health Coverage may begin. Your Deductible applies to all benefits in this section.
- The Consumer Driven Option provides coverage for both in-network and out-of-network providers. The out-of-network benefits are the standard benefits under the Traditional Health Coverage. In-network benefits apply only when you use a provider from the large, national network. When a network provider is not available, out-of-network benefits apply.
- If you join at any time during the year other than Open Season, your Deductible for your first year will be prorated at a rate of $66.67 per month for Self Only, $133.33 for Self Plus One or $133.33 per month for Self and Family for each full month of coverage remaining in that calendar year.
- When you use an in-network hospital, keep in mind that the professionals who provide services to you in the hospital, may not all be preferred providers. If they are not, they will be paid by this Plan as out-of-network providers. However, if surgical services are rendered at an in-network hospital or an in-network freestanding ambulatory facility by an in-network primary surgeon, we will pay the services of anesthesiologists and surgical assistants who are not preferred providers at the in-network rate, based on Plan allowance. If the covered services are performed at an in-network hospital or an in-network freestanding ambulatory facility, we will pay the services of radiologists and pathologists who are not preferred providers at the in-network rate, based on the Plan allowance and you may be billed any difference between our allowance and the billed amount.
- When you use a PPO hospital for emergency services, the emergency room physician who provides the services to you in the emergency room may not be a preferred provider. If they are not, they will be paid by this Plan as a PPO provider at the PPO rate.
- 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.

What is an accidental injury?
An accidental injury is a bodily injury sustained solely through violent, external, and accidental means, such as broken bones, animal bites, and poisonings.

What is a medical emergency?
A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

Note: If you use an emergency room for other than a recognized medical emergency, facility fees and supplies will not be covered.

2017 APWU Health Plan 106 CDHP Section 5(d)

Accident

- "Accident" is defined as resulting from a violent external force
- Outpatient services, including ambulance rendered within 24 hours of accident
  - In-network: PCA, Deductible, 15% of Plan allowance
  - Out-of-network: PCA, Deductible, 15% of Plan allowance plus any difference between Plan allowance and billed amount

Medical Emergency

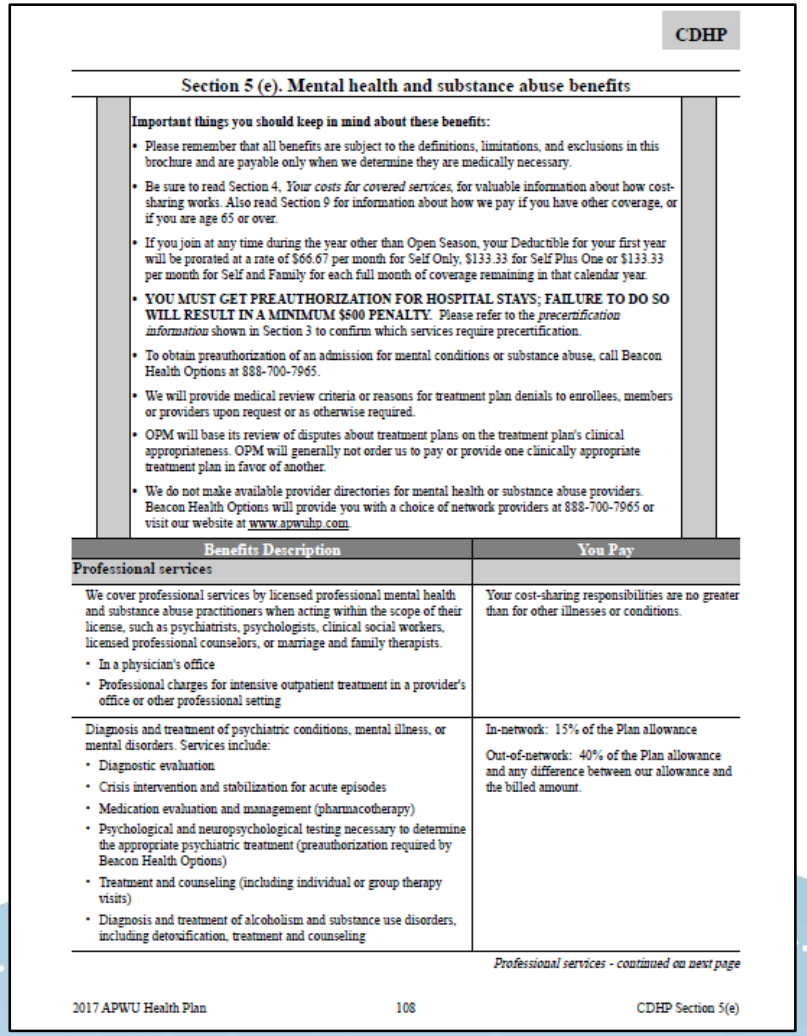
- Sudden onset of symptoms that you believe endangers your life or could result in serious disability if not treated promptly
- Treatment
  - In-network: PCA, Deductible, 15% of Plan allowance
  - Out-of-network: PCA, Deductible, 15% of Plan allowance plus any difference between Plan allowance and billed amount

Ambulance

- Medically necessary professional ambulance transport of a patient within 24 hours of a medical emergency
  - In-network: PCA, Deductible, 15% of Plan allowance
  - Out-of-network: PCA, Deductible, 15% of Plan allowance plus any difference between Plan allowance and billed amount

Sections 5(e)

- Beacon Health Options
- Office Visit
- Treatment
- Inpatient
- Outpatient



CDHP

Section 5 (e). Mental health and substance abuse benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- If you join at any time during the year other than Open Season, your Deductible for your first year will be prorated at a rate of $66.67 per month for Self Only, $133.33 for Self Plus One or $133.33 per month for Self and Family for each full month of coverage remaining in that calendar year.
- **YOU MUST GET PREAUTHORIZATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY.** Please refer to the *precertification information* shown in Section 3 to confirm which services require precertification.
- To obtain preauthorization of an admission for mental conditions or substance abuse, call Beacon Health Options at 888-700-7965.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.
- We do not make available provider directories for mental health or substance abuse providers. Beacon Health Options will provide you with a choice of network providers at 888-700-7965 or visit our website at www.apwuhp.com.

Benefits Description	You Pay
Professional services	
We cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. • In a physician's office • Professional charges for intensive outpatient treatment in a provider's office or other professional setting	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment (preauthorization required by Beacon Health Options) • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and substance use disorders, including detoxification, treatment and counseling	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount.

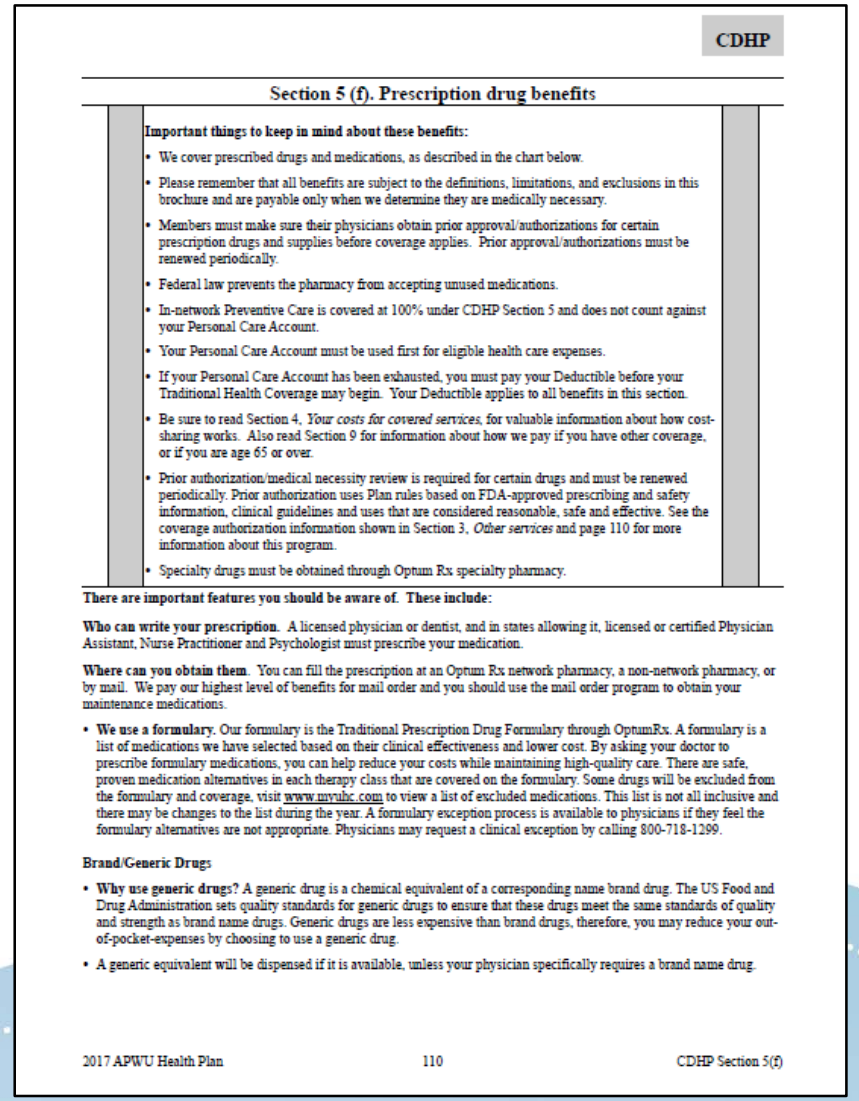
Professional services - continued on next page

Behavioral and Substance Abuse Office Visit and Treatment

- In-network: PCA, Deductible, 15% of Plan allowance
- Out-of-network: PCA, Deductible, 40% of Plan allowance plus any difference between Plan allowance and billed amount

Sections 5(f)

- OptumRx
- Formulary (new)
- FDA approved
- Brand vs. Generic
- Coverage review
- Step Therapy
- 25% of formulary charge



CDHP

Section 5 (f). Prescription drug benefits

Important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart below.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- In-network Preventive Care is covered at 100% under CDHP Section 5 and does not count against your Personal Care Account.
- Your Personal Care Account must be used first for eligible health care expenses.
- If your Personal Care Account has been exhausted, you must pay your Deductible before your Traditional Health Coverage may begin. Your Deductible applies to all benefits in this section.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- Prior authorization/medical necessity review is required for certain drugs and must be renewed periodically. Prior authorization uses Plan rules based on FDA-approved prescribing and safety information, clinical guidelines and uses that are considered reasonable, safe and effective. See the coverage authorization information shown in Section 3, *Other services* and page 110 for more information about this program.
- Specialty drugs must be obtained through Optum Rx specialty pharmacy.

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

Who can write your prescription. A licensed physician or dentist, and in states allowing it, licensed or certified Physician Assistant, Nurse Practitioner and Psychologist must prescribe your medication.

Where can you obtain them. You can fill the prescription at an Optum Rx network pharmacy, a non-network pharmacy, or by mail. We pay our highest level of benefits for mail order and you should use the mail order program to obtain your maintenance medications.

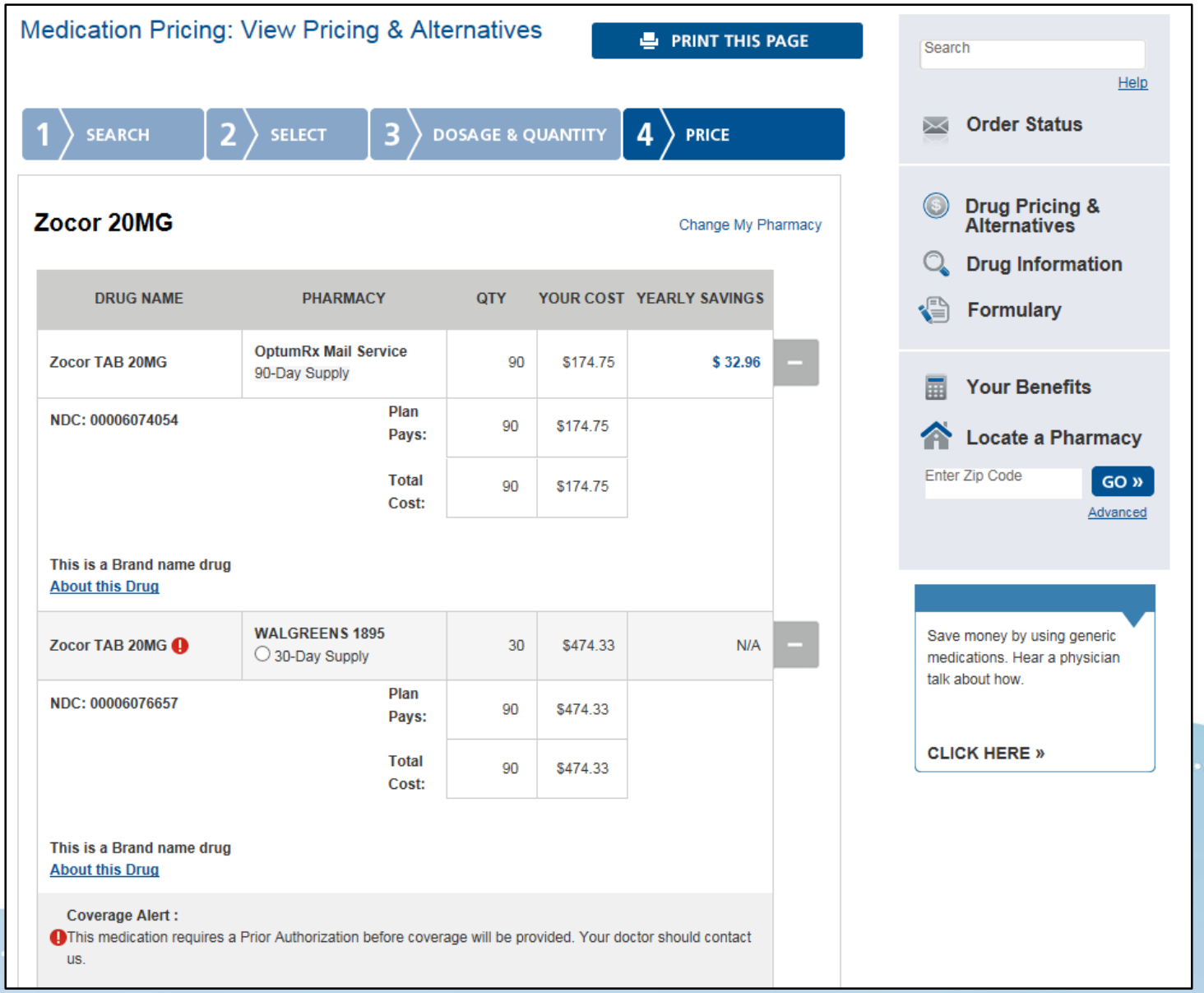
- **We use a formulary.** Our formulary is the Traditional Prescription Drug Formulary through OptumRx. A formulary is a list of medications we have selected based on their clinical effectiveness and lower cost. By asking your doctor to prescribe formulary medications, you can help reduce your costs while maintaining high-quality care. There are safe, proven medication alternatives in each therapy class that are covered on the formulary. Some drugs will be excluded from the formulary and coverage, visit www.myuhc.com to view a list of excluded medications. This list is not all inclusive and there may be changes to the list during the year. A formulary exception process is available to physicians if they feel the formulary alternatives are not appropriate. Physicians may request a clinical exception by calling 800-718-1299.

Brand/Generic Drugs

- **Why use generic drugs?** A generic drug is a chemical equivalent of a corresponding name brand drug. The US Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand name drugs. Generic drugs are less expensive than brand drugs, therefore, you may reduce your out-of-pocket-expenses by choosing to use a generic drug.
- A generic equivalent will be dispensed if it is available, unless your physician specifically requires a brand name drug.

2017 APWU Health Plan 110 CDHP Section 5(f)

Prescription Drug Calculator



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					

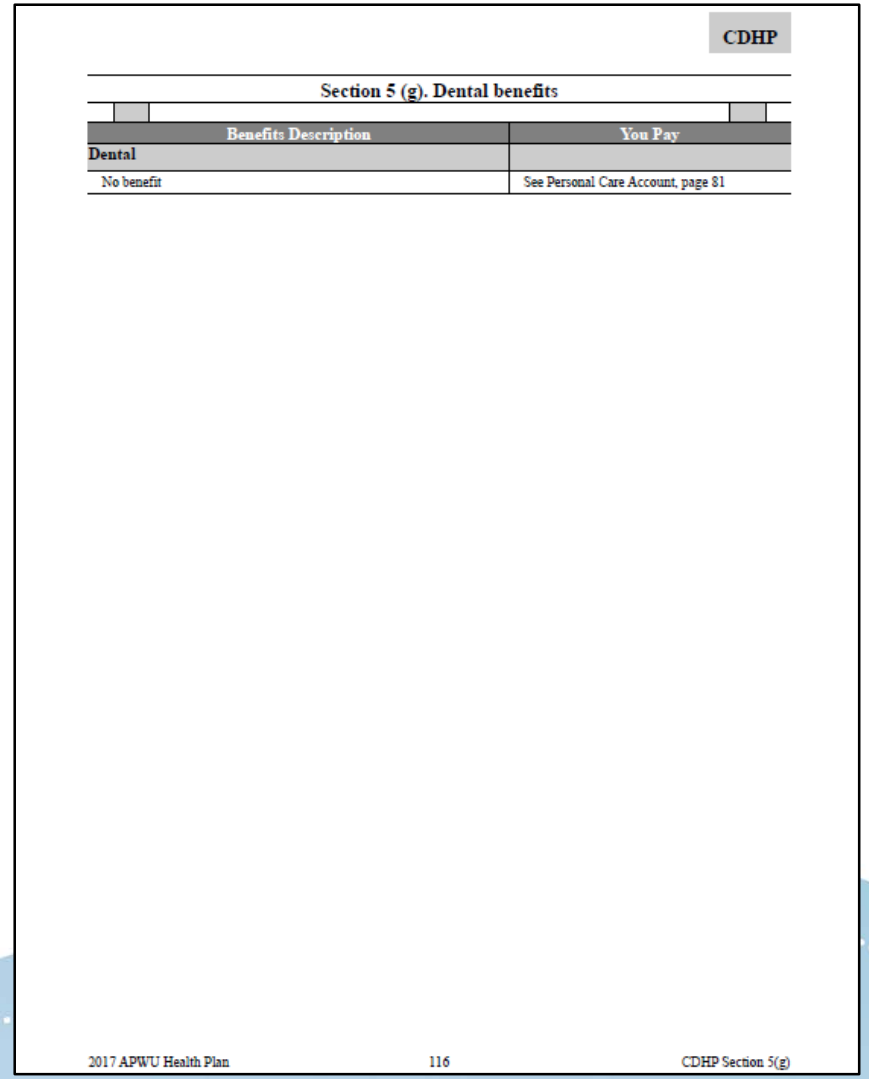
Coverage Alert :
! This medication requires a Prior Authorization before coverage will be provided. Your doctor should contact us.

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 »

Sections 5(g)

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



CDHP

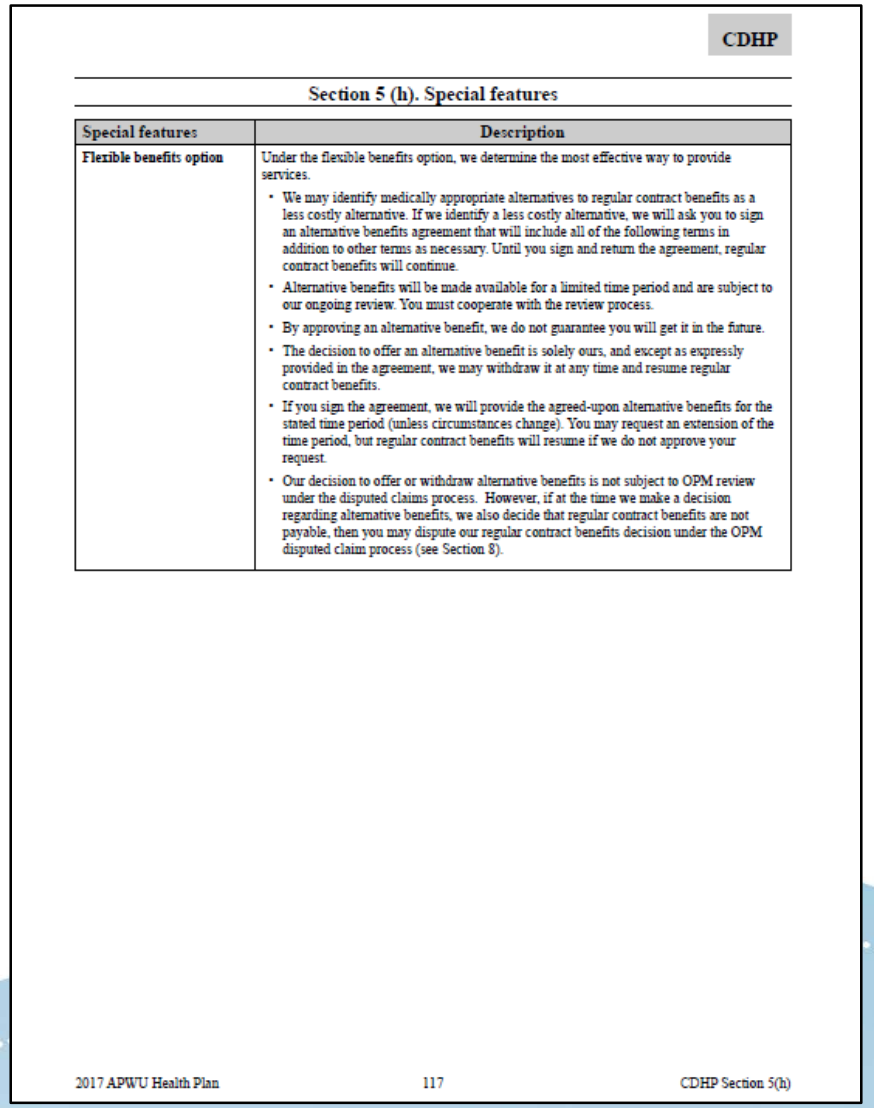
Section 5 (g). Dental benefits

Benefits Description	You Pay
Dental	
No benefit	See Personal Care Account, page 81

2017 APWU Health Plan 116 CDHP Section 5(g)

Sections 5(h)

- Flexible spending
- Turn off PCA



CDHP

Section 5 (h). Special features

Special features	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).

Scenario: Controlling 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

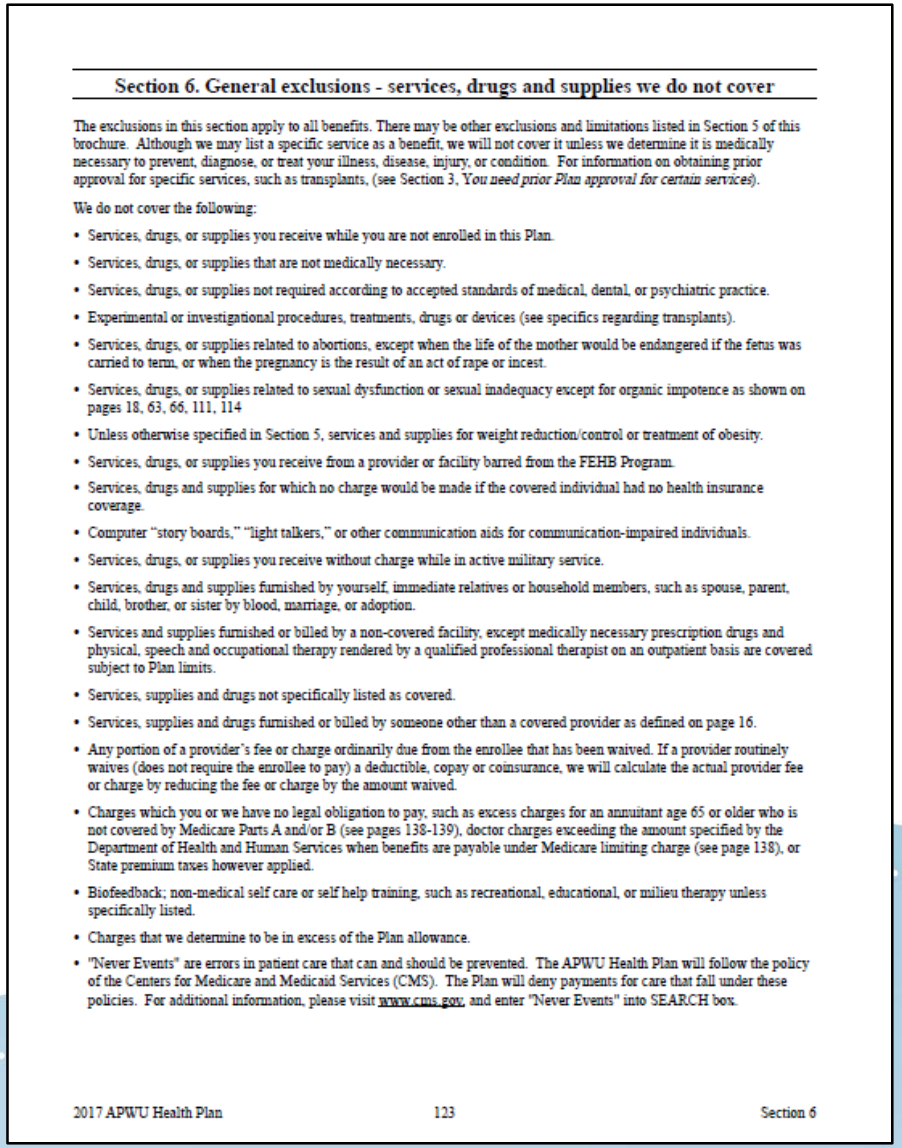


Health Management Programs

- Diabetes Management – You pay nothing (in-network)
  - Office visit for the treatment of your Diabetes
  - Labs
  - Generic medication by mail to specifically lower blood glucose
  - Insulin by mail
  - Certain supplies by mail

Section 6: General Exclusions

- Review list



Section 6. General exclusions - services, drugs and supplies we do not cover

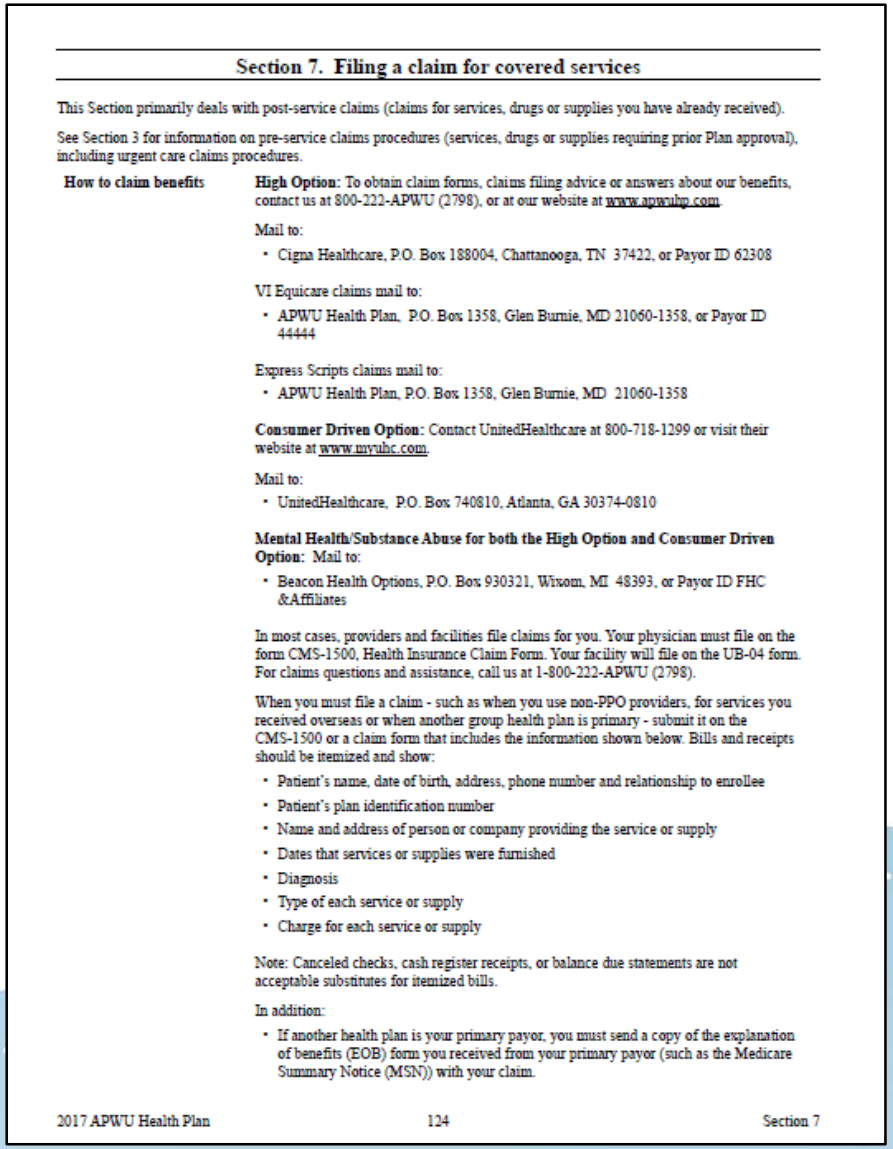
The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, (see Section 3, *You need prior Plan approval for certain services*).

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies that are not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus was carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies related to sexual dysfunction or sexual inadequacy except for organic impotence as shown on pages 18, 63, 66, 111, 114
- Unless otherwise specified in Section 5, services and supplies for weight reduction/control or treatment of obesity.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs and supplies for which no charge would be made if the covered individual had no health insurance coverage.
- Computer "story boards," "light talkers," or other communication aids for communication-impaired individuals.
- Services, drugs, or supplies you receive without charge while in active military service.
- Services, drugs and supplies furnished by yourself, immediate relatives or household members, such as spouse, parent, child, brother, or sister by blood, marriage, or adoption.
- Services and supplies furnished or billed by a non-covered facility, except medically necessary prescription drugs and physical, speech and occupational therapy rendered by a qualified professional therapist on an outpatient basis are covered subject to Plan limits.
- Services, supplies and drugs not specifically listed as covered.
- Services, supplies and drugs furnished or billed by someone other than a covered provider as defined on page 16.
- Any portion of a provider's fee or charge ordinarily due from the enrollee that has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible, copay or coinsurance, we will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived.
- Charges which you or we have no legal obligation to pay, such as excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see pages 138-139), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare limiting charge (see page 138), or State premium taxes however applied.
- Biofeedback; non-medical self care or self help training, such as recreational, educational, or milieu therapy unless specifically listed.
- Charges that we determine to be in excess of the Plan allowance.
- "Never Events" are errors in patient care that can and should be prevented. The APWU Health Plan will follow the policy of the Centers for Medicare and Medicaid Services (CMS). The Plan will deny payments for care that fall under these policies. For additional information, please visit www.cms.gov, and enter "Never Events" into SEARCH box.

Section 7: Filing a claim

- Claims
- Deadlines
- Overseas



Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received).

See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures.

How to claim benefits

High Option: To obtain claim forms, claims filing advice or answers about our benefits, contact us at 800-222-APWU (2798), or at our website at www.apwuhp.com.

Mail to:

- Cigna Healthcare, P.O. Box 188004, Chattanooga, TN 37422, or Payor ID 62308

VI Equicare claims mail to:

- APWU Health Plan, P.O. Box 1358, Glen Burnie, MD 21060-1358, or Payor ID 44444

Express Scripts claims mail to:

- APWU Health Plan, P.O. Box 1358, Glen Burnie, MD 21060-1358

Consumer Driven Option: Contact UnitedHealthcare at 800-718-1299 or visit their website at www.myuhc.com.

Mail to:

- UnitedHealthcare, P.O. Box 740810, Atlanta, GA 30374-0810

Mental Health/Substance Abuse for both the High Option and Consumer Driven Option: Mail to:

- Beacon Health Options, P.O. Box 930321, Wixom, MI 48393, or Payor ID FHC &Affiliates

In most cases, providers and facilities file claims for you. Your physician must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, call us at 1-800-222-APWU (2798).

When you must file a claim - such as when you use non-PPO providers, for services you received overseas or when another group health plan is primary - submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Patient's name, date of birth, address, phone number and relationship to enrollee
- Patient's plan identification number
- Name and address of person or company providing the service or supply
- Dates that services or supplies were furnished
- Diagnosis
- Type of each service or supply
- Charge for each service or supply

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

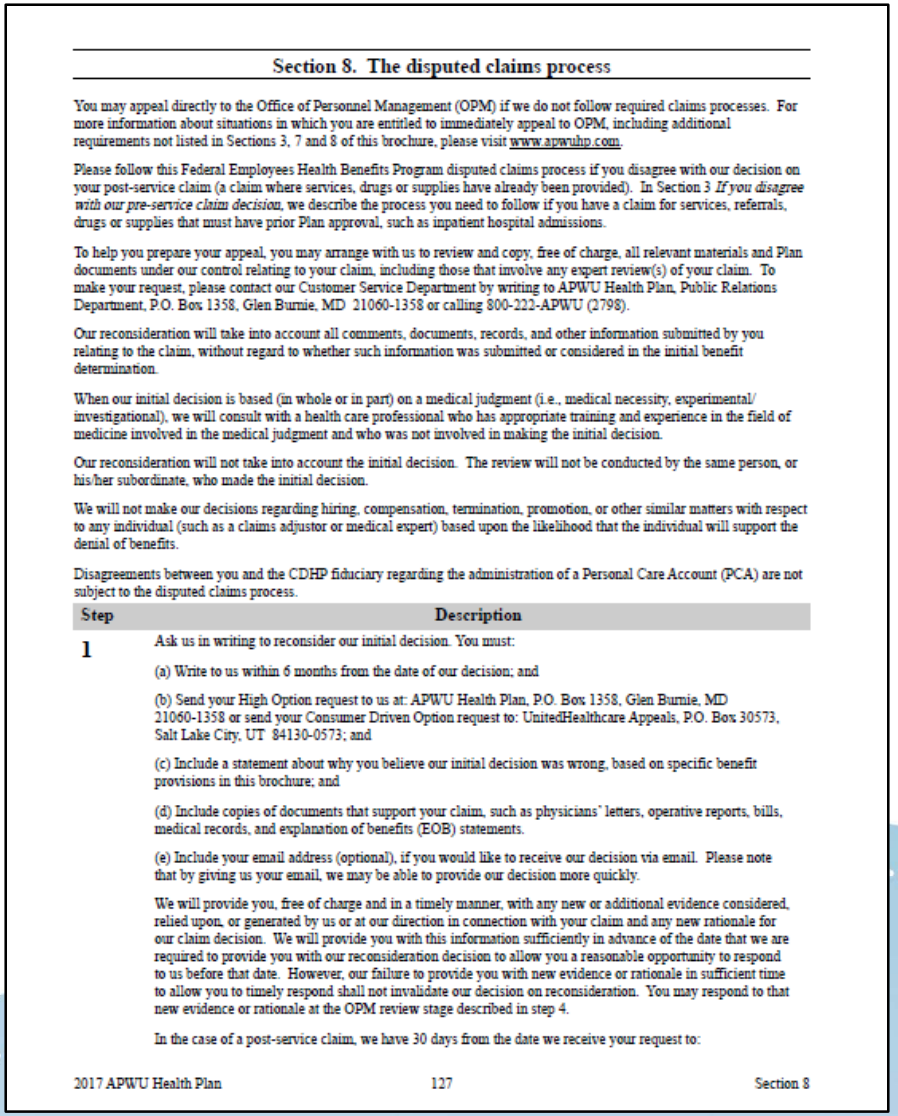
In addition:

- If another health plan is your primary payor, you must send a copy of the explanation of benefits (EOB) form you received from your primary payor (such as the Medicare Summary Notice (MSN)) with your claim.

2017 APWU Health Plan 124 Section 7

Section 8: Disputed Claims

- Review steps



Section 8. The disputed claims process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit www.apwuhp.com.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision*, we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing to APWU Health Plan, Public Relations Department, P.O. Box 1358, Glen Burnie, MD 21060-1358 or calling 800-222-APWU (2798).

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/ investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or his/her subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjustor or medical expert) based upon the likelihood that the individual will support the denial of benefits.

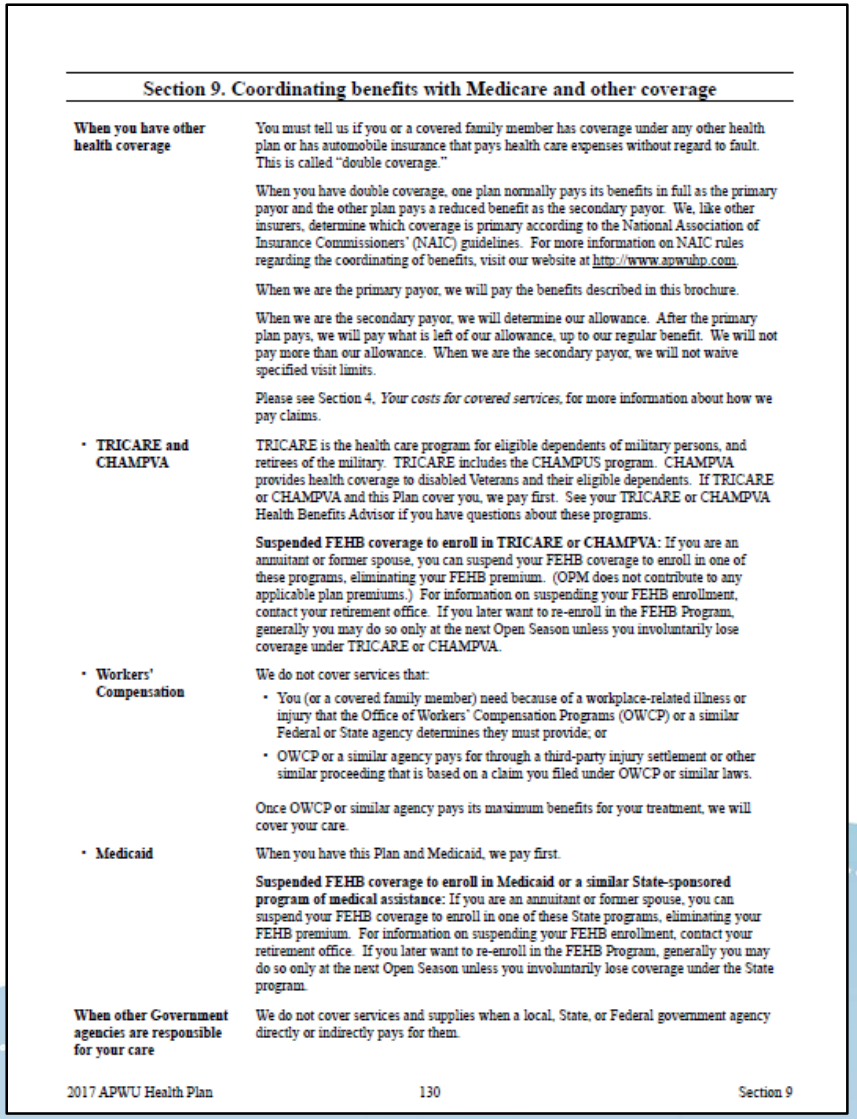
Disagreements between you and the CDHP fiduciary regarding the administration of a Personal Care Account (PCA) are not subject to the disputed claims process.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your High Option request to us at: APWU Health Plan, P.O. Box 1358, Glen Burnie, MD 21060-1358 or send your Consumer Driven Option request to: UnitedHealthcare Appeals, P.O. Box 30573, Salt Lake City, UT 84130-0573; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) statements. (e) Include your email address (optional), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4. In the case of a post-service claim, we have 30 days from the date we receive your request to:

2017 APWU Health Plan 127 Section 8

Section 9: Coordinating Benefits

- Other health coverage
- Primary payor chart



Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit our website at http://www.apwuhp.com.

When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. When we are the secondary payor, we will not waive specified visit limits.

Please see Section 4, *Your costs for covered services*, for more information about how we pay claims.

- **TRICARE and CHAMPVA**

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

- **Workers' Compensation**

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

- **Medicaid**

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.

2017 APWU Health Plan 130 Section 9

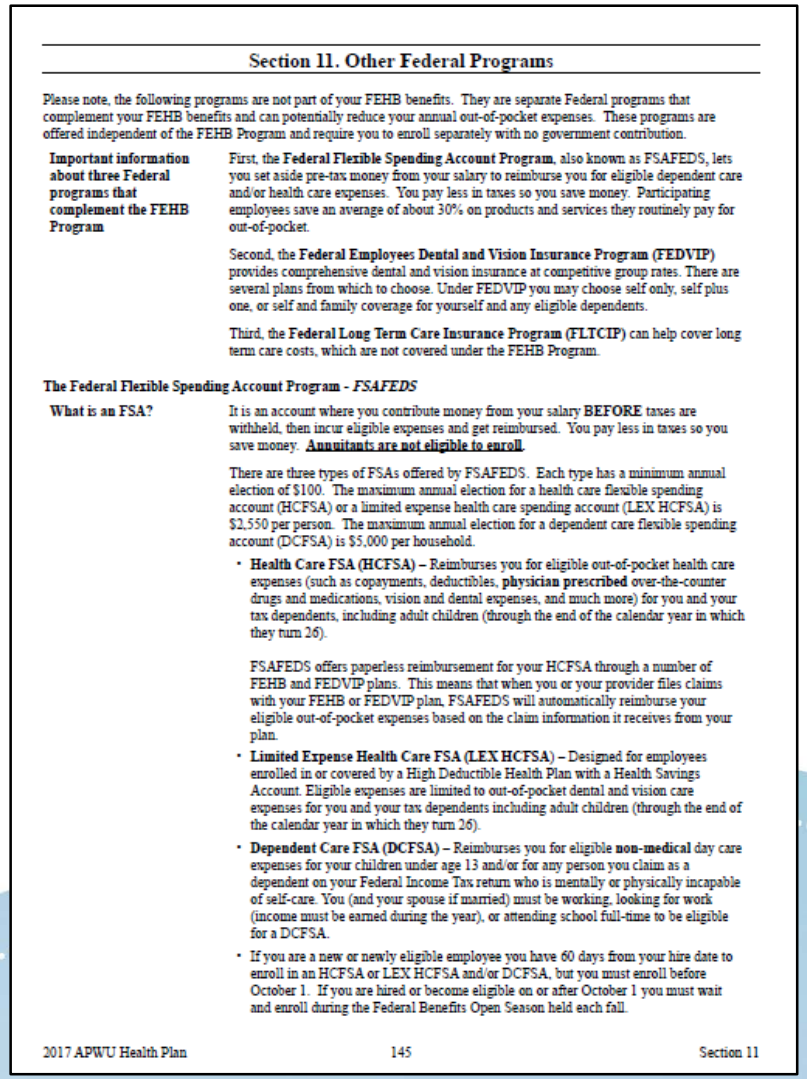
Section 10: Definitions

Section 10. Definitions of terms we use in this brochure

Accidental injury	An injury resulting from a violent external force.
Admission	The period from entry (admission) into a hospital or other covered facility until discharge. In counting days of inpatient care, the date of entry and the date of discharge are counted as the same day.
Assignment	Your authorization for us to pay benefits directly to the provider. We reserve the right to pay you directly for all covered services.
Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Clinical trials	An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either Federally-funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application. If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial: • Routine care costs - costs for routine services such as doctors visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy • Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care • Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis or results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This Plan does not cover these costs.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 25.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 24.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance and copayments) for the covered care you receive.
Covered services	Services we provide benefits for, as described in this brochure.
Custodial care	Treatment or services, regardless of who recommends them or where they are provided, that could be rendered safely and reasonably by a person not medically skilled, or that are designed mainly to help the patient with daily living activities. These activities include, but are not limited to: • Personal care such as help in: walking; getting in and out of bed; bathing; eating by spoon, tube or gastrostomy; exercising; dressing • Homemaking, such as preparing meals or special diets • Moving the patient • Acting as a companion or sitter • Supervising medication that can usually be self administered; or • Treatment or services that any person may be able to perform with minimal instruction, including but not limited to recording temperature, pulse, and respirations, or administration and monitoring of feeding systems

Section 11: Other Federal Programs

- FSA
- Stand alone dental and vision



Section 11. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no government contribution.

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. Participating employees save an average of about 30% on products and services they routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program - *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,550 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA) –** Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).

  FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.
- **Limited Expense Health Care FSA (LEX HCFSA) –** Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to out-of-pocket dental and vision care expenses for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26).
- **Dependent Care FSA (DCFSA) –** Reimburses you for eligible **non-medical** day care expenses for your children under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Summary: Consumer Driven Option

Summary of benefits for the CDHP of the APWU Health Plan - 2017

- **Do not rely on this chart alone.** All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Below, an asterisk (*) means the item is subject to the Deductible, generally $800 per Self Only and $1,600 per Self Plus One or Self and Family, once your Personal Care Account has been spent. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use an out-of-network physician or other health care professional.

CDHP Benefits	You Pay	Page
In-network preventive care:	Nothing	76
Personal Care Account:		
Up to $1,200 for Self Only or $2,400 for Self Plus One or Self and Family for medical, surgical, hospital, mental health and substance abuse services and prescription drugs plus certain dental and vision care	Nothing up to $1,200 for Self Only or $2,400 for Self Plus One or Self and Family	81
Traditional Health Coverage after Personal Care Account is exhausted		83
Medical/Surgical services provided by physicians:		
• Diagnostic and treatment services provided in the office*	In-network: 15% of Plan allowance Out-of-network: 40% of our allowance plus amount over our allowance	85
Services provided by a hospital:		
• Inpatient*	In-network: 15% of Plan allowance Out-of-network: 40% of our allowance plus amount over our allowance	103
• Outpatient*	In-network: 15% of Plan allowance Out-of-network: 40% of our allowance plus amount over our allowance	104
Emergency benefits:		
• Accidental injury*	In-network: 15% of Plan allowance Out-of-network: 15% of Plan allowance plus amount over our allowance	107
• Medical emergency*	In-network: 15% of Plan allowance Out-of-network: 15% of Plan allowance plus amount over our allowance	107
Mental health and substance abuse treatment*:	In-network: 15% of Plan allowance Out-of-network: 40% of our allowance plus amount over our allowance	108
Prescription drugs:		
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- Hearing services
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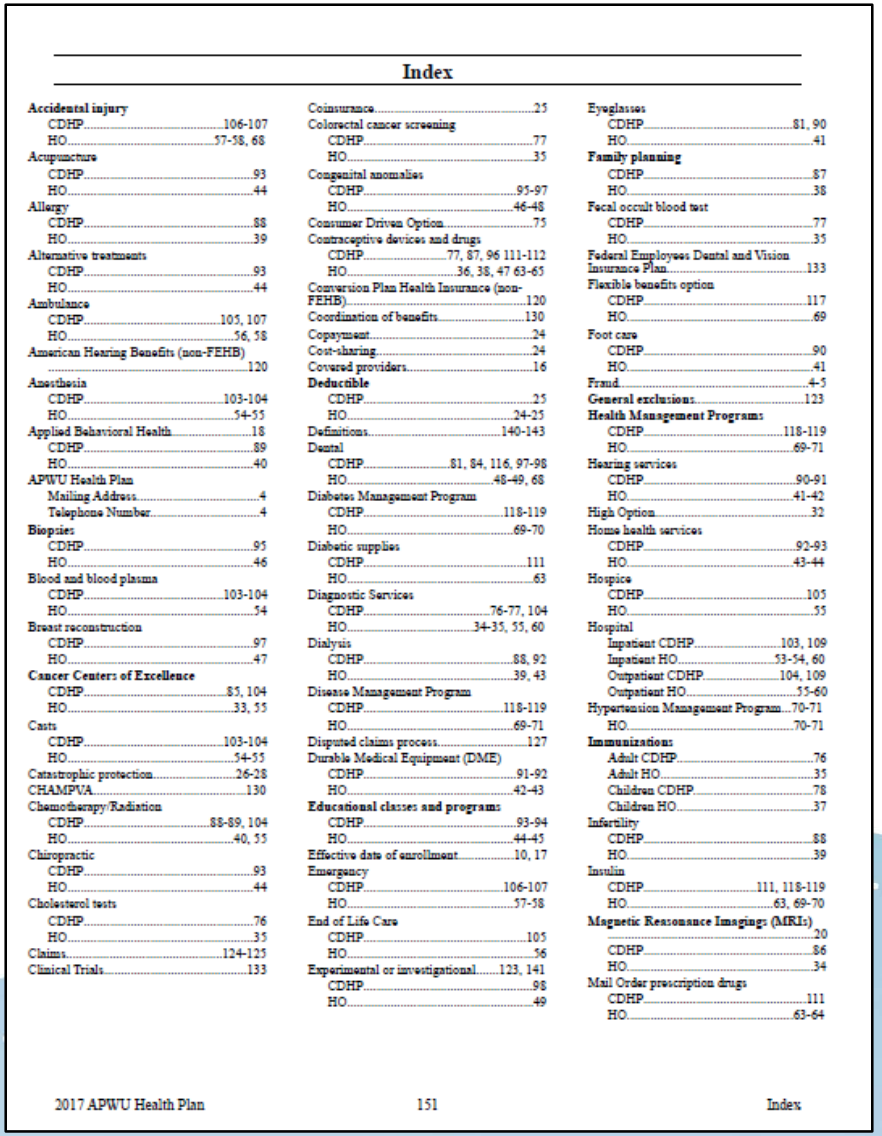

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Thank You!

Please fill out the class evaluation form provided and place it in the collection box.

Please note any questions for the **Roundtable** discussion on the card provided and place in the drop box at the Registration Desk.

The Roundtable discussion will be during Closing Session:

Thursday, October 20, 2016