

APWU Health Plan

CONVERSION PLAN

Terms & Conditions Brochure

American Postal Workers Union Health Plan Conversion Plan

This brochure is intended to be a complete statement of benefits available to individuals covered by the APWU Health Plan Conversion Plan, hereafter referred to as the APWU Conversion Plan or the Plan. It describes the benefits, exclusions, limitations, and maximums of the APWU Conversion Plan which are effective as of January 01, 2019, and until amended. It also describes procedures for obtaining benefits. A covered individual should use this brochure to determine his/her entitlements of benefits. Oral statements cannot modify the benefits described in this brochure.

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ENROLLMENT INFORMATION

When coverage as an employee or family member ends with any Plan in the Federal Employees Health Benefits Program (FEHB), or when Temporary Continuation of Coverage (TCC) ends (except by cancellation or nonpayment of premium), you may be eligible to convert to the APWU Conversion Plan.

An employee must apply in writing within 31 days after receiving notice of the conversion right from your employing agency. A family member must convert within the 31-day free extension of coverage that follows the event that terminates eligibility for coverage. Extensions are provided only if applicable through Federal law or Federal regulations (see 5 U.S.C. §8901 et seq. and 5 CFR Part 890.) Enrollment in the plan must be accompanied with a Certificate of Credible Coverage from any FEHB Plan.

Any member of the Conversion Plan may make application to the Plan to enroll or discontinue the enrollment of his or her spouse and/or dependent children. Spouse and/or dependent children must be added within 31 days of becoming a dependent of the member. The requested change in enrollment becomes effective on the first day of the quarter following the receipt and acceptance of the additional premium.

There is no waiting period, no limitation of coverage for preexisting conditions, and no evidence of good health is necessary.

PLAN OPTIONS

There is one plan option available to members.

ENROLLMENT CODES AND QUARTERLY PREMIUMS

The following enrollment codes and premiums are in effect as of January 01, 201~~9~~.

Group	Enrollment Code	Quarterly Premium
Self	CONV1	$810.00
Self Plus one	CONV2	~~$~~1,611.00
Family	CONV3	~~$~~2,682.00

PREMIUM DUE DATES

Members, spouses and dependent children transferring from the FEHB Program or being added to the Conversion Plan must pay the full quarterly premium for the quarter in which the transfer/addition is made in order to be covered for the balance of that quarter.

Premiums are payable in advance. The initial premium payment is due on or before the effective date. Subsequent premiums are due on the first day of each calendar quarter. Those dates are:

January 1

April 1

July 1

October 1

If a member's premium payment is not received in the Conversion Plan office by the first day of the calendar quarter when due, his/her premium payment is considered to be in arrears. A member who is in arrears, as specified in the following paragraph, is ineligible for benefits until overdue premiums are paid.

A member will be canceled from enrollment in the APWU Conversion Plan if his/her premium is not paid for a period of sixty (60) days following the due date. No benefits will accrue or be payable and the member will not be allowed to reinstate the enrollment.

GETTING A CERTIFICATE OF GROUP HEALTH PLAN COVERAGE

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the Conversion Plan Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage.

APWU HEALTH PLAN NOTICE OF PRIVACY PRACTICES

The APWU Health Plan's Notice of Privacy Practices describes how medical information about you may be used by the Health Plan, your rights concerning your health information and how to exercise them, and APWU Health Plan's responsibilities in protecting your health information. The Notice is posted on the Health Plan's website. If you need to obtain a copy of the Health Plan's Notice of Privacy Practices, you may either contact the Health Plan via e-mail through the website, www.apwuhp.com, or by calling 800-222-2798.

PLAN DESIGN AND BENEFITS

All benefits are per covered individual and are subject to the definitions, limitations and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by your Plan; do not rely on these charts alone.

Currently this plan does not utilize a medical provider or pharmacy network.

PLAN FEATURES	
Deductible (per calendar year)	$ 5,200 Self $10,400 Self Plus One $10,400 Family
All covered, and Plan allowable, expenses including prescription drugs accumulate toward the Calendar Year Deductible. Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year. There is no Individual Deductible to satisfy within the Family Deductible.	
Member Coinsurance	50%

Coinsurance is applied to the allowed amount

Maximum-Out-of-Pocket (per calendar year)	$ 6,350 Self $12,700 Self Plus One $12,700 Family

Only those covered, and Plan allowable, Out-of-Pocket expenses resulting from the application of coinsurance percentage and Deductibles may be used to satisfy the Maximum-Out-of-Pocket.

Certain member cost sharing elements may not apply toward the Maximum-Out-of-Pocket. Charges in excess of the Plan allowable do not count towards the Maximum-Out-of-Pocket.

Once the Family Maximum-Out-of-Pocket is met, all family members will be considered as having met their Maximum-Out-of-Pocket for the remainder of the calendar year. There is no individual Maximum-Out-of-Pocket to satisfy within the Family Payment Limit.

Annual Maximum Benefit	None
Lifetime Maximum	None
Primary Care Physician Selection	None
Certification Requirements	None
Referral Requirement	None

PREVENTIVE CARE ADULT	PLAN PAYS
A routine physical exam-one per person each calendar year over the age of 18.	100% of Plan Allowance (no Deductible)

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").
Routine screenings:
• One non-fasting total blood cholesterol test - every year
• Chlamydial infection
• Prostate Specific Antigen (PSA) test - every year for men starting at age 40
• Osteoporosis screening – every year starting at age 60
• Abdominal aortic aneurysm screening (limited to one per lifetime) for males ages 65 to 75 who have ever smoked
• Colorectal Cancer Screening, including:
  ○ Fecal occult blood test – every year starting at age 40
  ○ Sigmoidoscopy, screening – every five years starting at age 50
  ○ Colonoscopy – every 10 years starting at age 50
• Adult routine immunizations endorsed by the Centers of Disease Control and Prevention (CDC) including, but not limited to:
  ○ Zostavax (shingles) vaccine, no age limit
  ○ Human Papilloma Virus (HPV) vaccine for cervical cancer, no age limit
  ○ Adacel vaccine (adult booster for tetanus, diphtheria and pertussis)
	100% of Plan Allowance (no Deductible)

Well Woman • One annual routine gynecological visit for a pap test for women • Routine mammograms covered annually for women age 35 and older • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at high risk • HPV testing for women • Counseling for sexually transmitted infections for women	100% of Plan Allowance (no Deductible)

• Counseling and screening for HIV for women • Contraceptives, such as surgically implanted contraceptives, injectable contraceptive drugs, intrauterine devices, and diaphragms • Contraceptive counseling for women • Sterilization procedures for women • Patient education and counseling for all women with reproductive capacity • Breastfeeding support, supplies (including rental of breast feeding equipment) and counseling for women for each birth • Screening and counseling for women for interpersonal and domestic violence • BRCA counseling and genetic testing for women at higher risk **(MUST RECEIVE PRIOR APPROVAL FOR BRCA GENETIC TESTING – SEE PAGE 9)** • Generic prescription drugs approved by the FDA for contraception for women.	
PREVENTIVE CARE CHILDREN	**PLAN PAYS**
We provide benefits for a comprehensive range of preventive care services for children, including the preventive services recommended under the Patient Protection and Affordable Care Act (the "Affordable Care Act"), and the American Academy of Pediatrics.	
Childhood immunizations including office visit recommended by the American Academy of Pediatrics for dependent children under age 18.	100% of Plan Allowance (no Deductible)
Rotavirus vaccine for infants less than 1 year old	100% of Plan Allowance (no Deductible)
Vision screening for all children	100% of Plan Allowance (no Deductible)
Hearing screening exam testing and diagnosis and treatment (excluding hearing aids) for hearing loss	100% of Plan Allowance (no Deductible)
Body Mass Index (BMI) Testing for children under age 18	100% of Plan Allowance (no Deductible)
PHYSICIAN SERVICES	**PLAN PAYS**
Office Visits to Covered Providers (non-surgical) Includes services of an internist, general physician, family practitioner or pediatrician	50% of Plan Allowance after Deductible
Allergy Testing and/or Injections	50% of Plan Allowance after Deductible
Occupational, Physical, and Speech Therapy up to a combined 60 visits per calendar year	50% of Plan Allowance after Deductible

Chiropractic Coverage up to 12 visits per calendar year	50% of Plan Allowance after Deductible
Nursing Home Visits by a Covered Provider	50% of Plan Allowance after Deductible
Hospital Visits by a Covered Provider	50% of Plan Allowance after Deductible
Surgeon/Assistant Surgeon/Anesthesiologist	50% of Plan Allowance after Deductible
DIAGNOSTIC PROCEDURES	**PLAN PAYS**
Diagnostic Laboratory and X-ray	50% of Plan Allowance after Deductible
Emergency Medical Care	**PLAN PAYS**
Urgent Care Provider	50% of Plan Allowance after Deductible
Emergency Room	50% of Plan Allowance after Deductible
Non-Emergency Care in an Emergency Room	50% of Plan Allowance after Deductible
Ambulance	50% of Plan Allowance after Deductible
Hospital Care	**PLAN PAYS**
Inpatient Coverage	50% of Plan Allowance after Deductible
Outpatient Hospital Expenses (including surgery)	50% of Plan Allowance after Deductible
Mental Health/Substance Abuse Services	**PLAN PAYS**
Office Visits to Covered Providers	50% of Plan Allowance after Deductible
Inpatient	50% of Plan Allowance after Deductible
Partial Hospitalization	50% of Plan Allowance after Deductible
Outpatient	50% of Plan Allowance after Deductible
Pharmacy	**PLAN PAYS**
Retail	50% after Deductible

Generic prescription drugs approved by the FDA for contraception for women Over-the-counter emergency contraceptive drugs, the "morning after pill" Over-the-counter FDA-approved female birth control methods	100% of Plan Allowance (no Deductible)
Drugs, vitamins and minerals, and nutritional supplements that by Federal Law of the United States require a prescription for their purchase. Medicines to promote better health as recommended under the Patient Protection and Affordable Care Act (the "Affordable Care Act"), including: • Aspirin for men age 45 through 79 and women age 55 through 79 • Vitamin D Supplements for adults age 65 and older • Folic Acid Supplements, 0.4 to 0.8 mg, for women who may become pregnant • Bowel Prep for Colonoscopies • Iron Supplements, for children from age 6 months through 12 months • Fluoride Supplements, for children up to age 6 without fluoride in their water source	100% of Plan Allowance (no Deductible)

Prescriptions and any covered medically necessary supplies must be paid for up front and then submitted to the Health Plan for reimbursement at the level listed above. Any over-the-counter, covered prescriptions must be submitted with pharmacy prescription receipt and/or pharmacy print-out.

GENERAL EXCLUSIONS

The following is a list of services and supplies that are generally not covered:

- All medical and hospital services not specifically covered in, or which are limited or excluded by the plan documents
- Any portion of a provider's fee or charge ordinarily due from the enrollee that has been waived
- Any service or supply not shown as covered
- Charges that we determine to be in excess of the Plan allowance
- Cosmetic surgery, including breast reduction
- Custodial Care
- Drugs and supplies for cosmetic purposes; vitamins, minerals, nutritional supplements and external formulas (except as listed under the Pharmacy benefit); over the counter medical supplies such as dressings and antiseptics
- Dental services, oral surgery, refraction, eye exercises and visual training
- Donor egg retrieval
- Durable medical equipment

- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial
- Hearing aids
- Home births
- Immunizations for travel or work except where medically necessary or indicated
- Implantable drugs and certain injectable drugs including injectable infertility drugs
- Infertility services, including artificial insemination and advanced reproductive technologies, unless specifically listed as covered in the plan documents
- Long term rehabilitation therapy
- "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 falls under these policies. For additional information, please visit www.cms.gov, and enter "Never Events" into SEARCH box
- Non-medically necessary services or supplies
- Over-the-counter medications (except as provided in a hospital or listed under the Pharmacy benefit) and supplies
- Private nurse services
- Radial keratotomy or related procedures
- Reversal of sterilization
- Routine foot care
- Services and supplies furnished or billed by a non-covered facility
- Services, drugs and supplies for which no charge would be made if the covered individual had no health insurance coverage
- Services, drugs and supplies furnished by immediate relatives or household members, such as spouse, parent, child, brother, or sister by blood, marriage, or adoption
- Services, drugs or supplies not required according to accepted standards of medical, dental, or psychiatric practice
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest
- Services, drugs, or supplies you receive while you are not enrolled in this Plan
- Services, drugs, or supplies you receive without charge while in active military service
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies or counseling or prescription drugs
- Sterilization procedures for men
- Telephone, television, radio and all other personal comfort items
- Therapy or rehabilitation other than those listed as covered
- Treatment or services for an illness or injury are payable under any workers' compensation law, occupational disease law or similar legislation
- Weight control services including surgical procedures, medical treatments, weight control/loss problems, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of morbid conditions.
- Claims submitted after timely filing deadline (see page 10)

COORDINATION OF BENEFITS

Coordination of benefits applies when a person covered by the APWU Conversion Plan also has, or is entitled to, benefits from Medicare or any other group health coverage, or is entitled to the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to the APWU Conversion Plan.

When there are multiple plans, one normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. As secondary payer, the APWU Conversion Plan will pay the lesser of: (1) its benefits in full, or (2) a reduced amount that, when added to the benefits payable by the other coverage, will not exceed 100% of covered expenses.

The determination of which health coverage is primary (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners (NAIC). When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the covered individual may have.

This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given to the Conversion Plan to obtain information about benefits or services available from the other coverage or to recover overpayments.

SUBROGATION

If a covered individual suffers an illness or injury through the act or omission of another, the APWU Conversion Plan will pay benefits for the illness or injury, subject to the conditions that the covered individual (1) agrees to the Conversion Plan being reimbursed for benefits paid in an amount not to exceed the amount of the recovery, or that the APWU Conversion Plan be subrogated to the covered individual's rights to the extent of benefits paid, including the right to bring suit; (2) will not take any action which would prejudice the Conversion Plan's subrogation rights; and (3) will cooperate in doing what is reasonably necessary to assist the Conversion Plan in any recovery. All recoveries (whether by lawsuit, settlement or otherwise) must be used to reimburse the Plan for benefits paid. The Conversion Plan's share of the recovery will not be reduced because the covered individual did not receive the full amount of damages claimed or for the covered individual's attorney's fees and costs unless the Conversion Plan agrees in writing to a reduction.

APPLICATION FORMS

The Conversion Plan will prepare and distribute forms to be used by prospective members of the APWU Conversion Plan to complete application for membership.

HOW TO RECEIVE PRIOR APPROVAL

Prior approval is required for BRCA Genetic Testing. You, your representative, or your physician must contact the APWU Health Plan either via e-mail through the website, www.apwuhp.com, or by calling (800) 222-2798 for prior approval and will be required to submit medical records for review to determine eligibility for this benefit.

HOW TO CLAIM BENEFITS

The Conversion Plan will send identification cards to each new member. Your identification card should be presented to a provider of service whenever a covered service is received to ensure that the provider uses the correct enrollment information when billing the APWU Conversion Plan.

Claim forms can be obtained from the Conversion Plan offices. The Conversion Plan will also accept any standard claim form (such as CMS-1500 or UB04) furnished by the provider that includes the information shown below:

- Name of patient and relationship to member
- Member's ID number
- Name, address, degree and taxpayer identification number of person or firm providing the service
- Date(s) of service
- Type(s) of service, including procedure / NDC code(s) and the amount of the charge
- Diagnosis code(s)
- Name, address and policy number for any other insurance coverage
- A copy of the explanation of benefits (EOB) from any primary payer (such as Medicare) must be sent with your claim
- Any over-the-counter, covered prescriptions must be submitted with the pharmacy prescription receipt and/or pharmacy print-out
- Canceled checks, cash register receipts or balance due statements by themselves are not acceptable

The covered individual should always complete the "Patient Information" (top portion) of the claim form and the provider should complete the remainder. Services can be itemized on the claim form or submitted on any standard billing form.

All claim submissions and written inquiries should be sent to:

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

Only when a claim is received and processed can the APWU Conversion Plan determine the dollar amount of eligible expenses. An explanation of benefits (EOB) will be sent to the member with each claim processed to show the amount paid, how payment was calculated, and to whom payment was made.

A claim must be submitted within one year (365 days) of the date the expense was incurred. The Conversion Plan encourages timely submission, because failure to file within the one-year limit will invalidate your claim.

You or your spouse may authorize direct payment to the provider by completing the assignment of benefits payment section of the claim form or the provider's own assignment form. Otherwise, payment will be made to the member. The APWU Conversion Plan reserves the right to pay the member directly for all covered services.

Reply promptly when you are requested to furnish additional information in connection with a claim. If you do not respond, the Plan may delay processing or limit the benefits available.

CLAIMS REVIEW AND APPEAL PROCEDURE

If a covered individual's claim for benefits is denied, or partially denied, a covered individual will be provided with written notice of the denial from the APWU Conversion Plan indicating:

1. The specific reasons for the denial;
2. A reference to the specific plan provision(s) on which the denial was based;
3. A description of any additional material or information necessary to consider the claim for payment and the reason why such material or information is needed; and
4. An explanation of the APWU Conversion Plan's claim review procedures.

Please follow these steps if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization or prior approval required by the Plan Features.

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.

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 request to us at: APWU Health Plan Conversion Plan, 799 Cromwell Park Drive, Suites K-Z, Glen Burnie, MD 21061 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) forms. e) Include your email address (optional for member), 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.
2	We have 30 days from the date we receive your request to: a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care) or precertify your hospital stay or grant your request for prior approval for a service, drug, or supply); or b) Write to you and maintain our denial - go to step 4; or c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision. If you have an **urgent care claim** (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine.
4	If you do not agree with our decision, you may ask that we have an independent review organization review our handling of the disputed matter. You must write to us within: a) 90 days after the date of our letter upholding our initial decision; or b) 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or c) 120 days after we asked for additional information. Write to us at: APWU Health Plan Conversion Plan, 799 Cromwell Park Drive, Suites K-Z, Glen Burnie, MD 21061 Send us the following information:

	• A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; • Your daytime phone number and the best time to call; • Your email address, if you would like to receive the decision via email. Please note that by providing your email address, you may receive the decision more quickly. **Note:** If you want an independent review organization to review more than one claim, you must clearly identify which documents apply to which claim. **Note:** You are the only person who has a right to file a disputed claim with an independent review organization. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for **urgent care claims** (see definition under #3 on page 10), a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent. **Note:** The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.
5	An independent review organization will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. The independent review organization will send you a final decision within 60 days. There are no other administrative appeals. **Note:** If you have a serious or life threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, call us at 1-800-222-2798. We will hasten our review (if we have not yet responded to your claim).

CONFIDENTIALITY

Medical and other information provided to the APWU Conversion Plan, including claim files, are kept confidential and will be used: (1) by the APWU Conversion Plan and its subcontractors for internal administration of the Plan, coordination of benefits with other plans, and subrogation of claims; (2) by law enforcement officials with authority to investigate and prosecute alleged civil or criminal actions; (3) by the General Accounting Office when conducting audits; or (4) for bona fide medical research or education. Medical data that does not identify individuals may be disclosed as a result of the bona fide medical research or education.

NOTICE

Any notice required or permitted to be given by the APWU Conversion Plan shall be deemed to have been duly given, if in writing and personally delivered, or if in writing and deposited in the United States mail with postage prepaid, addressed to the member at their last address on record in the office of the APWU Conversion Plan.

DEFINITIONS

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.

Calendar year — January 1 through December 31 of the same year. For new members and covered individuals, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Cosmetic surgery — Any operative procedure or any portion of a procedure performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form.

Coinsurance — Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for the difference between our allowance and billed charges.

Covered providers — For the purposes of this Plan, covered providers include a licensed doctor of medicine (M.D.) or a licensed doctor of osteopathy (D.O.). Within states designated as medically underserved areas, any licensed medical practitioner will be treated as a covered provider for any covered services performed within the scope of their license. States designated as medically underserved are: **Alabama, Arizona, Idaho, Illinois, Louisiana, Mississippi, Missouri, New Mexico, Oklahoma, South Carolina, South Dakota,** and **Wyoming**.

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. The Plan determines which services are custodial care.

Deductible — The amount of expense an individual must incur for covered services before the Plan starts paying benefits for the expense involved. A deductible is not reimbursable by the Plan and benefits paid by the Plan do not count toward the deductible. Only expenses allowable under that benefit count toward the deductible.

Dependent children — Unmarried children who are less than twenty six (26) years of age, and are children of the member, children of the member's spouse or legally adopted children.

Effective date — The date when benefits in the Conversion Plan become effective. The effective date for coverage of dependents subsequently added will be the first day of the next quarter following receipt and acceptance of the additional premium.

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 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 written agreement with a hospital (as defined above) or with a specialized provider of those facilities.

The term "hospital" shall not include 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.

Medically necessary

Services, drugs, supplies or equipment provided by a hospital or covered provider of health care services that the Plan determines:

1. Are appropriate to diagnose or treat the patient's condition, illness or injury;
2. Are consistent with standards of good medical practice in the United States;
3. Are not primarily for the personal comfort or convenience of the patient, the family, or the provider;
4. Are not part of or associated with the scholastic education or vocational training of the patient; and
5. In the case of inpatient care, cannot be provided safely on an outpatient basis.

The fact that a covered provider has prescribed, recommended, or approved a service, supply, drug or equipment does not, in itself, make it medically necessary.

Member

Primary person affiliated with the Conversion Plan (membership will be established with this individual's Social Security number for identification). All other eligible dependents on the member's policy are covered individuals.

Plan allowance

Our Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. We base the Plan allowance on the lesser of the provider's actual charge or the allowed amount for the service you received. We determine the allowed amount by using health care charges guides which compare charges of other providers for similar services in the same geographical area. For surgery, doctor's services, X-ray, lab and therapies (physical, speech and occupational), we use guides prepared by EMC Corporation and Ingenix and apply these guides at the 80th percentile. If this information is not available, we will use other credible sources including our own data.

APWU Health Plan

Conversion Plan

799 Cromwell Park Drive

Suites K-Z

Glen Burnie, MD 21061

1-800-222-2798