Health Plan Representative Manual

2020 Benefit Year

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2020 Premium Rates

		Non-Postal Premium				Postal Premium		
		Biweekly		Monthly		Biweekly		
Type of Enrollment	Enrollment Code	Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share	APWU Your Share
High Option Self Only	471	$235.77	$99.41	$510.84	$215.38	$96.13	$86.31	$96.13
High Option Self Plus One	473	$504.12	$199.74	$1,092.26	$432.77	$192.74	$171.73	$192.74
High Option Self and Family	472	$546.47	$257.95	$1,184.02	$558.89	$250.36	$227.60	$250.36
CDHP Option Self Only	474	$206.89	$68.96	$448.26	$149.42	$66.20	$57.24	$17.16
CDHP Option Self Plus One	476	$449.66	$149.88	$974.25	$324.75	$143.89	$124.40	$46.41
CDHP Option Self and Family	475	$490.53	$163.51	$1,062.82	$354.27	$156.97	$135.71	$54.45

FEHB Benefits for this Plan are described in Brochure RI 71-004.

Non-Postal Rates

Non-postal rates apply to most non-Postal employees. If you are in a special enrollment category, contact the agency that maintains your health benefits enrollment.

Postal Rates

Postal rates apply to United States Postal Service Employees.

Postal Category 1 Rates

Postal Category 1 rates apply to career bargaining unit employees who are represented by the following agreements: APWU, IT/AS, NALC and NPMHU.

Postal Category 2 Rates

Postal Category 2 rates apply to career bargaining unit employees who are represented by the following agreement: PPOA.

APWU rates apply to career Postal employees represented by APWU.

Other Rates

For further assistance, Postal Service employees should call:
USPS Human Resources Shared Service Center: 877-477-3273, Option 5, Federal Relay Service 800-877-8339

Postal rates do not apply to non-career Postal employees, Postal retirees, and associate members of any Postal employee organization, who are not career Postal employees.

The Role of the Health Plan Representative

Health Plan Representatives make a very important difference for the APWU Health Plan, distinguishing us from the hundreds of other plans in the Federal Employees Health Benefits Program (FEHBP). You are a visible face to our members. You are an advocate and resource who can help members locate a Preferred Provider, or understand a section of the Federal Brochure; are available and proactive for questions and information about the Health Plan; and are a point of contact for information about the Health Plan.

You are a source of promotional material and information about the Health Plan, making literature available and visible, promoting the Health Plan's website, and making sure the Union's Local office/post office has Plan materials.

You also are the coordinator of the Local's promotion of this Plan, as the face-to-face representative of the APWU Health Plan across the country and who can talk to coworkers about the advantages of joining or remaining with the Health Plan. During Open Season, at New Hire Orientations, and all year long, HPRs need to let co-workers know about the Health Plan.

- Open Season: Prospective enrollees may only join a health plan in FEHBP during one month each year unless they are new employees. This month is called Open Season, and is usually the second week in November through the second week in December. This is the time when Health Plan Representatives play a key role in marketing the Health Plan. The HPR role during Open Season is to heighten the visibility of the Health Plan by such activities as attending health fairs, using walk-around lists to promote the Health Plan to co-workers, and making yourself and literature about the Health Plan visible and available.
- New Hire Orientations: Making presentations to new hires, and being available to answer questions and provide assistance, is a key role of the HPR. New hires make decisions about their health care coverage during the first 60 days of hiring. Orientations are a perfect opportunity to create enrollment prospects for the Health Plan. APWU provides an Orientation kit for new hires. Your presence is especially important. By being a part of New Hire Orientations, you heighten the visibility of the Health Plan and put a face on the Health Plan for new members.
- Local Organizing Drives: This is the time to let potential new APWU members know that the Health Plan is part of the APWU, is a Union product for Union members, and goes hand-in-hand with membership in the APWU.

- State and Local Publications: Articles on the Health Plan all year long keep both the Plan and you as the HPR visible.
- Federal Brochure: Keep Health Plan Federal Brochures available, understand the Health Plan benefit offerings, and let your co-workers know that as a Health Plan Representative, you can answer their questions and provide help.
- Know the Competition: Although direct comparisons between plans are not permissible, make sure you know where the APWU Health Plan has advantages over other plans. Brochures from other FEHBP plans are available on the Office of Personnel Management website at www.opm.gov/healthcare-insurance/healthcare and at Local health fairs. Become familiar with nationwide competitors, such as Blue Cross, and Local HMO plans in your area.
- Local and State websites: If your Local or State organization has a website, encourage them to create a link to the Health Plan's website, and to include material about the Health Plan on their website.

In the Marketing section of this manual, there is more information on how to market and promote the Health Plan. Tips and techniques are provided to help you "on the front line," marketing the Health Plan. Marketing support material is also available from the Health Plan. Call the HPR Hotline at 800-635-8476, or the Health Plan at 800-222-APWU, or Jasmine Parker, 410-424-1648, to receive Health Plan material any time during the year.

Expense Reimbursement and Leave Without Pay (LWOP) Program

It is the Health Plan's policy to reimburse Health Plan Representatives and other designated individuals on authorized assignments, such as postal and federal health fairs, for the entire amount of their actual expenses, within given limitations.

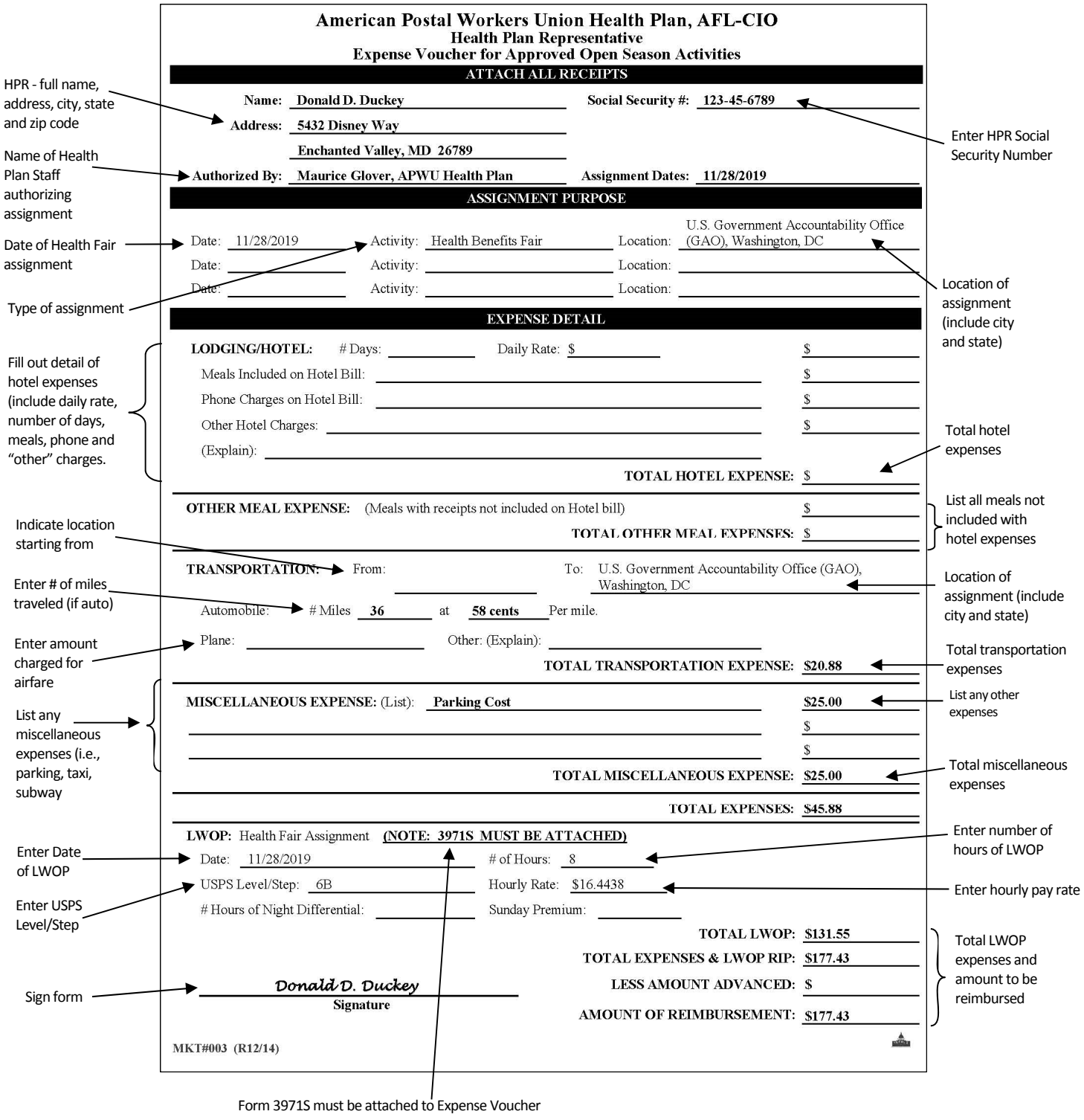
To receive the maximum reimbursement allowable, it is essential that accurate records and receipts for all expenses are kept.

HPRs are reimbursed if the assignment is authorized in advance by the Plan and the expenses are not being reimbursed by another source.

The HPR Expense Voucher is used to summarize your expenses for each assignment. An example of the correct way to fill out an Expense Voucher is shown on the following page.

Please review the following information carefully prior to beginning your assignment. If you have any questions regarding completion of the Expense Voucher, or our reimbursement policy, please contact Jasmine Parker at jparker@apwuhp.com or 410-424-1648.

Expense Voucher



General LWOP Expense Reimbursement

The HPR Expense Voucher must be completed and submitted to the Health Plan as soon as possible after completion of an assignment. Please be sure to also attach a copy of the approved postal or federal health fair invitation/e-mail that you received from APWU Health Plan, with submission of your HPR Expense Voucher. If you would like payment made to you through Electronic Funds Transfer (EF), you will need to complete the form found on our website on the HPR page. Print a copy and attach the form after your initial assignment. Any payments will be direct deposited to your account. Complete the Expense Voucher in its entirety and be sure all original receipts are attached. A copy of the Expense Voucher and copies of any receipts/attachments should also be kept for your files.

Reimbursements of expenses are only made when original receipts are provided. Charge card receipts/statements, travel agency invoices, etc. are not considered sufficient documentation for hotel and transportation expenses. Photocopies of receipts are not acceptable for reimbursement purposes.

Contact Information:

Jasmine Parker
Marketing Programs Coordinator
410-424-1648
410-424-1572
E-Mail: jparker@apwuhp.com

Mail Expense Voucher to:

APWU Health Plan
Attn: Marketing Programs Coordinator
799 Cromwell Park Drive, Suites K-Z
Glen Burnie, MD 21061

Local LWOP Expense Reimbursement

Upon prior approval by the Health Plan, a Local will be reimbursed for the lost time of an APWU Local officer for Health Plan activities. Complete documentation must be received for payment.

Meal Expenses Reimbursement

Reimbursement for meal expenses is allowed for out-of-town health fairs requiring an overnight stay.

Transportation Reimbursement

Full reimbursement is allowed for all reasonable transportation expenses incurred as a result of your assignment. The Health Plan will reimburse the going IRS rate per mile for actual mileage driven. Currently, the rate is 58 cents ($0.58) per mile. Reimbursement will not exceed what the cost for airfare would have been.

List transportation expenses under the appropriate section of the Expense Voucher and make sure the starting location and assignment destination "From/To" lines are complete.

Taxi or public transportation expenses are reimbursed in full and should be listed under Miscellaneous Expenses on the Expense Voucher. Other Miscellaneous Expenses include tips, parking or other valid expenses. Always include a complete explanation of the charge and attach original receipts. In some instances (i.e., subway expenses, tips, etc.) where original receipts cannot be obtained, provide detailed justification of the expense.

USPS LWOP (Salary) Expense Reimbursement

LWOP is reimbursed for federal and postal health fairs HPRs attend when they are approved in advance by the Health Plan. LWOP will not be approved to attend the Health Plan's Annual Open Season Seminar held each October.

The Health Plan is obligated to withhold federal, state and FICA taxes (if applicable) from the LWOP portion of your expenses. Withholding forms can be obtained from your payroll office and must be submitted along with your Expense Voucher. In the absence of a completed W-4 form, the Health Plan will withhold taxes at the "single with no exemptions" rate.

Include LWOP hours for your regularly scheduled work day. Submit a copy of your completed 3971 form to receive payment. Complete the entire LWOP section on the Expense Voucher so correct wage computation can be made. List your correct pay level and step to ensure proper rate of payment. Include your address, Social Security number and reason for assignment on the Expense Voucher.

Ordering Health Plan Supplies

The Health Plan automatically sends a shipment of materials to all Locals prior to the start of Open Season. The materials are marked "APWU Health Plan Open Season Materials - Open Immediately."

- APWU Local Union offices will receive a reduced supply of informational flyers and brochures
- APWU Locals planning a health fair can fill out a previously sent order form

Open Season materials will arrive at your Local approximately two weeks prior to the commencement of Open Season. If the shipment isn't received by that time, contact the Health Plan. All Open Season materials are mailed to the Local. Before additional supplies are ordered, first check the supply of materials at the Local. If additional materials are needed, allow up to one week to receive the shipment, after requested.

Supplies Non-Open Season

When ordering supplies during non-Open Season periods, consider the items and quantities you ordered in the past. Track the time it takes to exhaust your supplies to determine the quantities you need for each item.

Supplies Open Season

When ordering supplies for a health fair at a postal or federal facility, the supply order should not exceed 10% of the total number of employees at the facility:

- Submit to the Health Plan the date, time, health fair location and number of Postal Sales Kits needed for each fair three weeks prior to the event

To order supplies in writing, address your request to:

APWU Health Plan
Attn: Jasmine Parker, Marketing Programs Coordinator
799 Cromwell Park Drive; Suites K-Z
Glen Burnie, MD 21061

When writing to the Health Plan regarding supplies, use the Supply Order Form provided in this section.

To order supplies by telephone call:

■ The HPR Hotline	800-635-8476 between 8:30 a.m. and 4:00 p.m., EST
■ The Toll-Free Number	800-222-2798 between 8:30 a.m. and 7:00 p.m., EST
■ The TDD Line (for Hearing Impaired)	800-622-2511 between 8:30 a.m. and 4:00 p.m., EST
■ Marketing Programs Coordinator	410-424-1567 between 8:30 a.m. and 4:00 p.m. EST or leave a voice mail message

To order claim forms and Federal Brochure by Internet:

Visit the Plan's website at www.apwuhp.com; for shipments of Claim Forms, click APWU Health Plan Members, and then under For All Members, click Order Claim Forms. For shipment of Brochures, click Request a Brochure at the bottom of the Home Page. Fill out the appropriate information and click "Submit".

Access to ordering claim forms and Federal Brochure via our website is available 24 hours a day, seven days a week.

Supply Order Form

Open Season and Non-Open Season Supplies

Items:	*Quantity*
Federal Brochure	_____
Benefits-at-a-Glance:	
High Option	_____
Consumer Driven Option	_____
Both	_____
Information Flyer	_____

Please send supplies to:

Name: _____

Title: _____

Local: _____

Address: _____

City, State, Zip: _____

Daytime Phone #: _____

E-Mail Address: _____

***For Health Fairs** (Please attach copy of Health Fair invitation, if available):*

Agency Name	Date of Health Fair	Number of Expected Attendees

Mail completed form to:
Marketing Programs Coordinator
APWU Health Plan
799 Cromwell Park Drive, Suites K-Z
Glen Burnie, MD 21061

Or, Fax this completed form to Maurice Glover : 410-424-1593

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HPR Quick Reference Section

This section contains a quick reference to important telephone numbers, addresses and hours of operations for the Health Plan. Addresses and telephone numbers are also listed for our PPO (Preferred Provider Organization) vendors, mental health and substance use disorder vendor, precertification vendor, and prescription drug vendor.

APWU Health Plan Information

Claims Address	High Option: Refer to Member ID Card for correct mailing address Consumer Driven Option: UnitedHealthcare P.O. Box 740810 Atlanta, GA 30374-0810 Mental Health and Substance Use Disorders Beacon Health Options P.O. Box 1854 Hicksville, NY 11802-1854
Disputed Claims Address	High Option: APWU Health Plan P.O. Box 1358 Glen Burnie, MD 21060-1358 Consumer Driven Option: UnitedHealthcare Appeals P.O. Box 30573 Salt Lake City, UT 84130-0573
Fax Numbers	Fax machines are operational 24 hours a day; however, do not fax claims unless directed to do so. 410-424-1668 – Customer Service Department 410-424-1589 – Office of the Director Fax number
E-Mail	custser@apwuhp.com
Website	Health Plan: www.apwuhp.com UnitedHealthcare: www.welcometouhc.com/apwu

Telephone Numbers

Type of Phone Service	Telephone Number	Hours of Operation
High Option Members' toll-free line (to speak to a Customer Service Representative) Consumer Driven Option	800-222-2798 800-718-1299	8:30 a.m. to 7:00 p.m., EST Monday - Friday
High Option Automated Voice Response System	800-222-2798 Follow prompts to access categories	Available 24/7
High Option TDD line for the hearing impaired (special equipment is needed for this service)	800-622-2511	8:30 a.m. to 4:00 p.m., EST Monday - Friday
HPR Toll-Free Line	800-635-8476	8:30 a.m. to 4:00 p.m., EST Monday - Friday
Health Plan Administrative Offices	410-424-1500	8:30 a.m. to 4:00 p.m., EST Monday - Friday

High Option PPO Vendors' Addresses and Telephone Numbers

PPO Network Name	Telephone Number	Submit Claims To:
Cigna All states except Virgin Islands Providers Virgin Islands Hospitals	800-582-1314	Cigna HealthCare (Refer to the back of the Member ID Card)
Beacon Health Options (Mental Health and Substance Use Disorders)	888-700-7965	Beacon Health Options (Refer to the back of the Member ID Card)
VI Equicare Virgin Islands Providers	340-774-5779	APWU Health Plan (Refer to the Member ID Card)

Other Health Plan High Option Vendors' Telephone Numbers

Vendor Name	Telephone Number	Other Information
Cigna Nurse Advisory Line	800-582-1314	Available 24 hours a day, 7 days a week.
Express Scripts	800-841-2734 TDD line for hearing impaired: 800-877-8044	Call for information about the Plan's Retail Pharmacy network or to locate a pharmacy near you. website: express-scripts.com
Cigna Precertification	800-582-1314	Cigna CareAllies performs in-patient hospital precertification and radiology/imaging procedures precertification for all states. See Section 3 of the Official Federal Brochure for full details.
UnitedHealthcare	800-718-1299	Call for information about the Consumer Driven Option
OptumRx	800-718-1299	Consumer Driven Option network retail and Mail order pharmacy

Claims Workflow - High Option

The information detailed in this chapter will give you an inside look at the different units within the Health Plan and how the units work together as a team to ensure quick and accurate adjudication of all claims and related documents received at the Health Plan. The flowchart showing the Health Plan's organization by department and unit in the claim's area, and the flowchart showing how a claim is handled through the units for processing, are found at the end of this section.

Claims and Service Department Units

A brief description of each unit at the Health Plan is provided along with the flowcharts to give you an understanding of how the Health Plan handles claims and related documents.

Data Entry Unit

This unit keys claim related data into the Data Entry system. If a scanned image has poor quality, they reject it back to the Scanning Unit. Member information, provider information, dates-of-service, charges and other information necessary for claims payment is keyed.

Enrollment Unit

This unit tracks records received from the Office of Personnel Management (OPM) regarding enrollment and disenrollment, handles membership reconciliation with employer services and retirement systems, and corresponds with various agencies and departments to clarify documented information. The Enrollment Unit verifies coverage for dependents and survivor annuitants. This unit also establishes benefit determination in the case of Other Insurance Coverage (OIC).

Mail Sort Unit

This unit receives all incoming U.S. mail that is sent to our P.O. Box. The unit sorts and preps the documents to ensure direct delivery of items requiring immediate attention. The mail is opened and counted. All documents go through a verification process to make sure all necessary information is included so payment can be made timely and accurately.

Customer Service Unit

This unit receives telephone inquiries from members and providers through the Health Plan's toll free number of 800-222-2798. The unit is trained to thoroughly respond to benefits, eligibility, claim status and explanation of claims processing. Each call received is recorded and documented. The hours of operation are 8:30 a.m. to 7:00 p.m., EST.

Multiple Coverage Unit

This unit has the highest level of processing expertise in the Claims Department. The unit reviews and adjudicates documents involving complex interaction of various eligibility, liability and coverage determination, such as, other insurance coverage, foreign claims, prescription copays, Medicare exhausted claims, tertiary coverage, claims from the Plan's designated organ/ tissue transplant facilities and claims referred by our Utilization Review/Case Management Vendor.

This unit also identifies discrepancies such as possible fraud, underpayments, and corrections to claims history.

Pend Unit

This unit handles review and adjudication of claims related documents for all Health Plan members when a document requires additional investigation before adjudication can occur. The unit performs in-depth analysis of claims related submissions when the claim pends from another unit or the claims system and coordination of benefits from Medicare.

Provider File Unit

This unit is responsible for maintaining our internal provider records. This includes additions, updates and verification of providers. The information kept includes the provider name, address, tax identification number, degree or accreditation, profit/non-profit status and the provider type (i.e., lab, group, individual, etc.). The unit handles Internal Revenue Service reconciliation's to confirm that the information held on the Health Plan's database is accurate and ensures correct tracking of payments to providers.

Public Relations Unit

This unit responds to written inquiries (including emails) from members, providers and various agencies. The unit is trained on all aspects of Claims and Customer Service, which allows them to accurately respond in writing to each inquiry. The unit also works closely with the Office of Personnel Management concerning settlement of appeals and disputed claims.

Review & Recovery Unit

This unit identifies and adjusts over or under payments forwarded from another unit or as a result of a phone call or letter. This unit has telephone and written contact with members, providers and other insurance carriers. The unit tracks cases such as Workers' Compensation due to job related injuries. This unit processes refund checks from members and providers.

Scanning Unit

This unit scans all claims and related documents by claim type and date received, into a system called FormWorks that works with the Health Plan's imaging and claims processing systems. Claims documents are stored, disposed of or delivered to the appropriate unit as designated after rejected and exported documents have been retrieved and returned.

Life of a Claim

Claims are received at the Health Plan through the U.S. Mail or through electronic submission of claims (ESC).

The Claims Department receives claims related mail on a daily basis. The correct mailing address for claims is located on the APWU Health Plan Member ID Card.

Once in the Mail Sort Unit, each tray of mail goes through an initial sort to identify non-claims related letters. The mail is then opened and counted. A Mail Sort Clerk checks each document for all information required to process the claim. At this point, the claims may be returned to the member or provider with an appropriate form letter stating the problem with the claim. New procedures have been put in place to ensure that the Mail Sort Clerk makes every effort to obtain missing information prior to returning to the member or provider, which would cause a delay in processing the claim. After the mail is checked, it is sorted and prepped for scanning into our claims system.

The Scanning Unit uses two Kodak scanners with software called Formworks to create an image or picture of each document. This system includes Optical Character Recognition (OCR) and works with the Health Plan's imaging system software that archives images of all documents received at the Health Plan. Once the documents have been scanned, the Data Entry Unit takes over.

The Data Entry Clerk verifies the image quality, that the claim was scanned into the correct claim type and that the document is complete. The Data Entry Clerk keys the claims related data into the system (i.e., member, patient, date of service, charges, etc.). Once this task is performed, the computer system takes over and the image of the document is systematically archived into Macess EXP.

The data that was entered then goes through an initial system edit to verify enrollment and provider information. After that, it goes to the claims system where validation edits are made; and then through the claims editing software called ClaimCheck. ClaimCheck ensures claims are billed according to standard medical guidelines. It checks for proper utilization (e.g., multiple office visits on the same day for the same diagnosis). It also checks provider-billing practices and verifies the diagnosis against professional services to ensure that the two codes are compatible. Further, the

system checks patient history to determine if the claim is a duplicate and ensures the correct payment rate is applied to the benefit. The charge is then compared with the Health Plan's reasonable and customary allowance. After all of these checks, if the claim passes all of them, it is automatically processed that night. A check is generated and mailed the following day. If the claim fails to pass one or more of the verification checks, it is sent to the Pend Unit, or Multiple Coverage Unit to investigate why the claim was not paid, and to rectify the situation.

The Pend Unit performs an in-depth analysis of any claims that have pended from Data Entry, a system edit, electronic submission claims, review of resubmitted charges and coordination of benefits with Medicare claims in order to adjudicate the claim (make payment). When a document requires additional investigation before adjudication can occur, the Pend Analyst forwards the document to the appropriate unit for review.

The Multiple Coverage Unit has the highest level of processing expertise in the Claims Entry Department. The analysts are responsible for review and adjudication of documents involving complex interaction of various eligibility, liability and coverage determination. This includes:

- Other Insurance Claims (OIC)
- Auto Accident Claims
- Plan-designated organ/tissue transplant facilities claims
- Foreign/Out-of-country claims

The Multiple Coverage Unit also identifies discrepancies such as possible fraud, underpayments, claims history corrections and special payable charges.

Requirements for Claim Payment – Medical

The claim must have correct billing information and be complete. This includes:

- Member's Full Name and Street Address
- Member's ID Number
- Patient's Full Name and Street Address
- Patient's Birth Date and Relationship to Member
- Other Insurance Coverage Information
- Release of Information Signature
- Payment Authorization Signature
- Diagnosis (in coded format – ICD 9 Coding)
- Service Date(s)
- Type of Service (in coded format – CPT or HCPCS or Revenue Coding)
- Charges for Each Separate Service
- Provider's Name

- Provider's Degree
- Provider's Street Address
- Name and Street Address Where Service Performed
- Provider's Tax Identification Number
- If another insurer is the primary payer, the payment statement from that carrier is needed
- Provider's NPI

Requirements for Claim Payment – Retail Drugs

- Member's Full Name and Street Address
- Member's ID Number
- Patient's Full Name and Street Address
- Patient's Birth Date and Relationship to Member
- Other Insurance Coverage Information
- Release of Information Signature
- Payment Authorization Signature
- Date of Purchase
- RX Number
- NDC (National Drug Code) Number
- Name of Drug
- Days' supply and quantity per day
- Name of Doctor Prescribing the Drug
- Charge Per Drug
- Supplier's Tax Identification Number
- Pharmacist's Signature
- Pharmacy Name and Street Address
- Member Signature of Authenticity

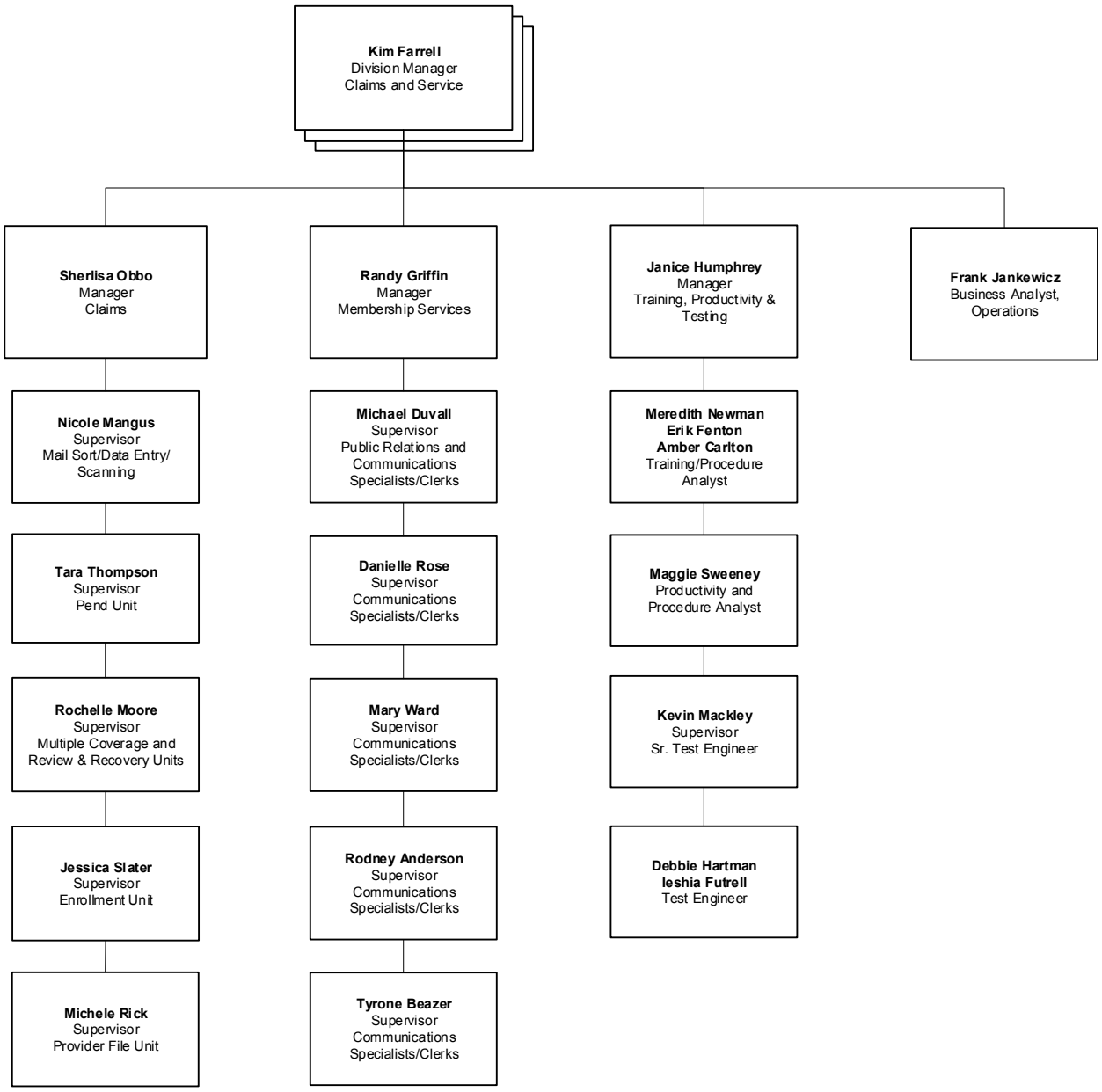
Receipts or pharmacy computer printout is required for reimbursement of drug purchases.

Requirements for Claim Payment – Dental

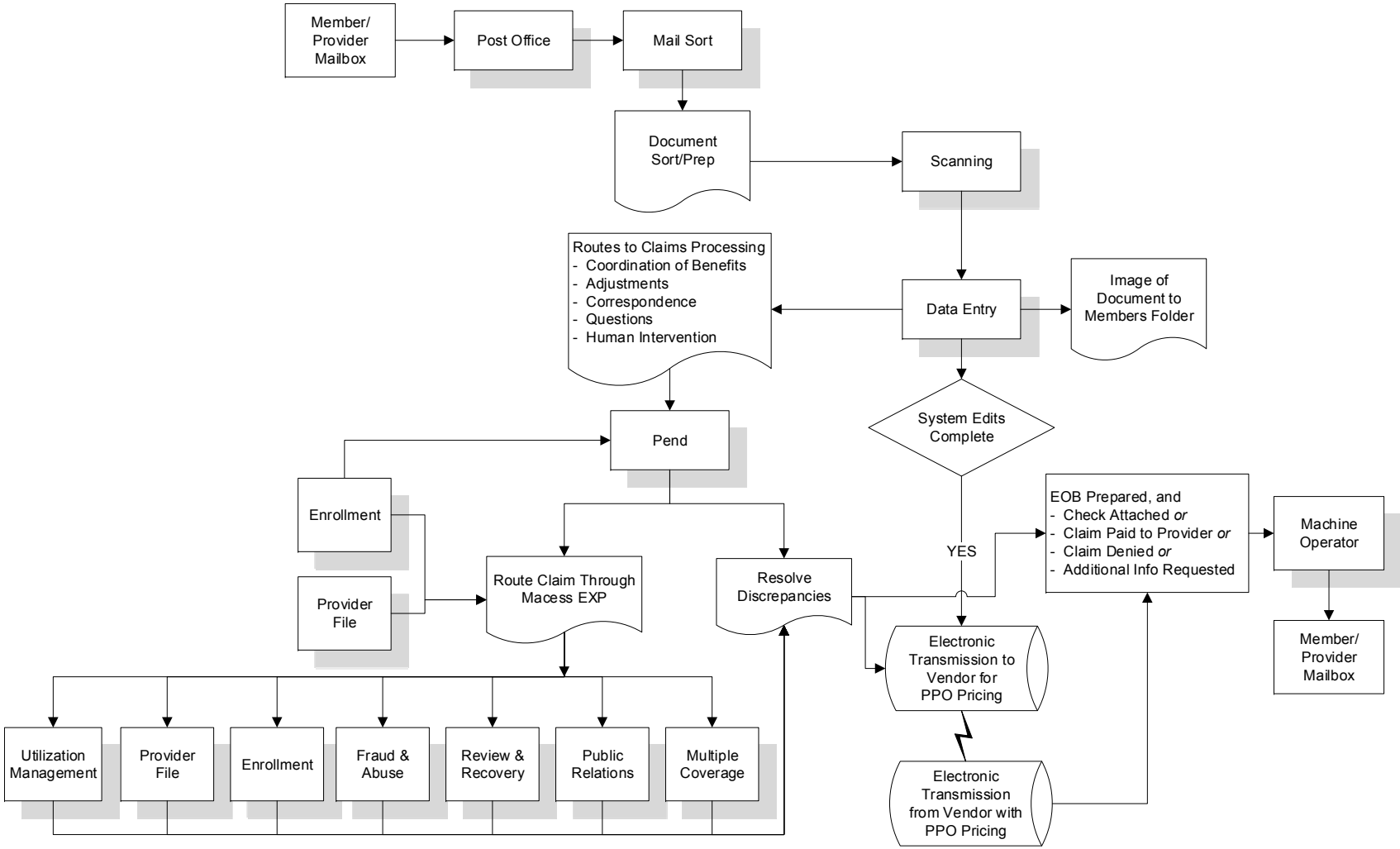
- Member's Full Name and Street Address
- Member's ID Number
- Patient's Full Name and Street Address
- Patient's Birth date and Relationship to Member
- Other Insurance Coverage Information
- Release of Information Signature
- Payment Authorization Signature
- Tooth Number or Letter
- Surfaces Requiring Treatment
- Description of Services
- Date of Service

- Procedure Code (American Dental Association ADA Number)
- Fee Per Service
- Total Charge
- Amount Paid – if any
- Balance Due – if any
- Patient's Account Number
- Provider Name and Street Address
- Tax Identification Number
- State License Number
- Signature – Including Degree
- Name and Street Address Where Services Performed

Claims and Service Division



Claim/Document Flowchart



Costs for Covered Services

Copayments

High Option: A copayment is a fixed amount of money you pay to the provider when you receive services. Example: When you see your PPO physician, you pay a copayment of $18 per visit.

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

Deductibles

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 do not count toward any deductible.

High Option

For PPO providers, the calendar year deductible is $450 per person. Under a Self Plus One or Self and Family enrollment, the deductible is satisfied for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $800.

For non-PPO providers, the calendar year deductible is $1,000 per person and $2,000 Self Plus One or Self and Family.

Medical/Surgical & Mental Health/ Substance Use Disorders	PPO:	$450 per person, ($800 Self Plus One or Self and Family maximum)
	Non-PPO:	$1,000 per person, ($2,000 Self Plus One or Self and Family maximum)
Inpatient Hospital	Non-PPO:	$300 per admission

Note: If you change plans during Open Season, 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.

Consumer Driven Option

There is no upfront calendar year deductible or separate deductible for Mental Health and Substance Use Disorder benefit under the Consumer Driven Option. The Consumer Driven Option deductible is your bridge between your Personal Care Account (PCA) and your Traditional Health Coverage. After you have exhausted your PCA, you must pay your Deductible before Traditional Health Coverage begins ($800 for Self Only; $1,600 for Self Plus One and Self and Family). Your

Deductible in subsequent years may be reduced by the rolling over of any unused part of your PCA at the end of the year.

Coinsurance

High Option: Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance doesn't begin until you meet your deductible (High Option) or your Deductible (Consumer Driven Option).

Example: You pay 30% of our allowance for office visits to a non-PPO physician with the High Option.

Consumer Driven Option: Coinsurance is the percentage of Health Plan's allowance that you must pay for your care after you have used up your Personal Care Account (PCA) and paid your Deductible.

Plan Allowance

High Option: Our Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Fee-for-service plans determine their allowances in different ways. We determine our allowance as follows:

> **PPO Providers:** Our allowance is based on negotiated rates. PPO providers always accept the Plan's allowance as their charge for covered services.
>
> **Non-PPO Providers:** We base the Plan allowance on the reasonable and customary charge for the service you received. We determine the reasonable and customary allowance 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 the Health Insurance Association of America (HIAA) and apply these guides under the High Option at the 70th percentile and under the Consumer Driven Option at the 80th percentile. We update these charges guides at least once each year. If HIAA information is not available, we will use other credible sources including our own data.

Often, the provider's bill is more than a fee-for-service plan's allowance. Whether or not you have to pay the difference between our allowance and the bill will depend on the provider you use.

> **PPO Providers:** Agree to limit what they will bill you. Because of that, when you use a preferred provider, your share of covered charges consists only of your deductible and coinsurance.

Here is an example: You see a PPO physician who charges $150 for services, but our allowance is $100. If you have met your deductible, you are only responsible for your coinsurance. That is, you pay just -- 10% of our $100 allowance ($10). Because of the agreement, your PPO physician will not bill you for the $50 difference between our allowance and his bill.

Non-PPO Providers: Have no agreement to limit what they bill you. When you use a non-PPO provider, you will pay your deductible and coinsurance—**plus** any difference between our allowance and charges on the bill.

Here is an example: You see a non-PPO physician who charges $150 and our allowance is again $100. Because you have met your deductible, you are responsible for your coinsurance, so you pay 30% of our $100 allowance ($30). Plus, because there is no agreement between the non-PPO physician and us, he can bill you for the $50 difference between our allowance and his bill.

The following table illustrates an example of how much you have to pay out-of-pocket for services from a PPO physician vs. a non-PPO physician. The table uses our example of a service for which the physician charges $150 and our allowance is $100. The table shows the amount you pay if you have met your calendar year deductible.

Example: Out-of-pocket expenses for PPO Physician vs. Non-PPO Physician:

Example	PPO Physician		Non-PPO Physician	
Physician's Charge		$150		$150
Our Allowance	We set it at:	$100	We set it at:	$100
We Pay	90% of our allowance	$90	70% of our allowance:	$70
You Owe:	10% of our allowance:	$10	30% of our allowance:	$30
+Difference up to charge?	No:	$0	Yes:	$50
Total You Pay		**$10**		**$80**

If the charge is deemed to be over the Plan's allowance, that amount is the member's responsibility. In order to not pay amounts over the Plan allowance, Preferred Providers are recommended because PPO providers always accept the Plan's allowance as their charge for covered services.

The provider can be asked to call the Health Plan's toll-free number prior to service to see if their charges fall within the Plan allowance. The Customer Service Representatives will only tell the provider if the proposed charges fall within our allowance. They will not tell a provider what our allowance is.

- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- When you use a PPO hospital, keep in mind that the professionals who provide services to you in the hospital, such as radiologists, emergency room physicians, and pathologists, may not all be preferred providers. If they are not, they will be paid by this Plan at the PPO rate when you use a PPO hospital.

Consumer Driven Option: If your covered expenses are being paid out of your Personal Care Account (PCA) or if you are receiving in-network covered preventive services, the Plan will pay 100%. If you have exhausted your Personal Care Account (PCA), you will be responsible for paying your Deductible and also the coinsurance under the Traditional Health Coverage. PPO providers agree to accept our Plan allowance so if you use a PPO Provider, you never have to worry about paying the difference between the Plan allowance and the billed amount for covered services.

- Non-PPO Providers: If you use a non-PPO provider, you will have to pay the difference between the plan allowance and the billed amount only if you use up your Personal Care Account (PCA) for the year. Note that it usually makes sense to use PPO providers because it will make your Personal Care Account (PCA) go much further since money left in your Personal Care Account (PCA) can be rolled over to be used in the next year.

Coordinated Care - High Option

What Does Coordinated Care Mean?

Coordinated Care is medical care that is coordinated by the Health Plan member, the provider of the medical service and the Health Plan. Having all participants assist in health care management ensures that members receive the best available care, in the most appropriate setting in a cost-effective manner.

Members are key partners in coordinating care. By including the expertise of providers and the Health Plan, members have guidance in learning of medical alternatives they may not have known about that will help with their care. Coordinated Care also offers the advantage of having the Health Plan negotiate discounts with providers to help manage costs.

Coordinated Care includes many options. Coordinated Care includes the Health Plan's popular Preferred Provider Organizations, the Mail order Prescription Drug Program and generic drugs, and cost negotiations that the Health Plan undertakes on behalf of members for complex cases. All of these, and many more, fall under the umbrella of "Coordinated Care."

Examples of How Coordinated Care Works for Members

High Option Preferred Provider Organization

The Health Plan's Preferred Provider Organization (PPO) networks are designed to give members a wide choice of qualified doctors and facilities, at the lowest cost possible.

The Health Plan works with the PPO to discount charges for providers in their network, and pays a higher percent of the cost for Preferred Provider services. The end result for members is a wide choice of doctors and facilities, at the lowest cost, anywhere in the nation. To find PPO providers, members can consult the online PPO directory at www.apwuhp.com or contact their PPO at the telephone number listed in the HPR Quick Reference Section.

Quality of the PPO networks is also important to members. In order to participate in the Health Plan's PPO network, a doctor or hospital must be credentialed every two or three years to meet certain standards. When members use the Plan's PPO network, they are assured of using providers that are among the best in the country.

As a fee-for-service health plan, the Plan gives members choices to select any provider they wish.

The Health Plan's PPO network adds cost saving often associated with Health Maintenance Organizations (HMO) to these choices. The Health Plan is constantly looking for ways to coordinate care to give members the best health care options available. The Preferred Provider Organization is one way the Health Plan does this.

Disease Management Program

APWU Health Plan's Coordinated Care organizations offer High Option members with certain chronic conditions a voluntary Disease Management Program. A variety of services are provided to help manage chronic conditions such as diabetes, coronary artery disease and heart failure. Medical and/or pharmacy claims data, as well as interactions with the member and their physicians, are used to help members better manage their care, find outpatient treatment and avoid unnecessary emergency care or outpatient admissions.

Prescription Drugs

The Health Plan also provides a program to assist in identifying patient safety and healthcare issues with prescription drugs. With partner Express Scripts (High Option) and OptumRx (Consumer Driven Option), the Health Plan examines prescription claims and records that may create patient safety problems or undesirable drug reactions for members, and alerts physicians to potential problems.

Radiology/Imaging Precertification

A Health Plan partnership with Cigna provides High Option members with radiology management of outpatient radiological procedures, specifically for Computed Tomography (CAT/CT), Magnetic Resonance Angiography (MRA) and Positron Emission Tomography (PET) scans. The High Option enlists the special expertise of Cigna to aid physicians and enrollees in determining needed procedures and where to receive them. The goal of imaging is to minimize patient exposure to only what is necessary, and to aid in a diagnosis. By adding specialized expertise in radiology, APWU Health Plan's High Option assures patient safety so that members receive tests that offer the best help with their diagnosis.

Hospital Quality Information

The High Option provides an online site where enrollees can find healthcare quality ratings and comparison information on hospitals. Hospitals can be compared for quality and patient safety for certain procedures, or overall quality/safety. The High Option Hospital Quality Ratings Guide is at www.apwuhp.com.

Expansive PPO Networks for Access and Quality

Many of the Health Plan's PPO networks and vendors are accredited with URAC or the National Committee for Quality Assurance (NCQA). Accreditation and certification promotes healthcare quality by establishing standards that PPO's must meet to ensure continuous improvement of quality and efficiency in their networks.

Nurse Advisory Line

The High Option and Consumer Driven Option provide a free 24/7 Nurse Advisory Line. Registered nurses give answers to questions about conditions and treatment options, and provide support and tools to help members make sound healthcare decisions.

Online Health Library

The High Option provides an online health library from the Mayo Clinic where enrollees can find information about illnesses, symptoms, first-aid and wellness. The Consumer Driven Option also provides a health library. Up-to-date information is provided to help members make informed decisions and understand conditions.

Healthcare Pricing

The High Option provides online pricing information so that members can make good cost decisions about their healthcare. By entering their zip code, enrollees can find the cost of certain medical conditions or prescription drugs.

Transition from a Hospital

Another example of Coordinated Care is assistance to members in helping them manage such things as the details and choices needed after surgery has taken place. Having all participants assist in health care management ensures that members receive the best available care, in the most appropriate setting in a cost-effective manner.

In a transition after a hospital stay, Health Plan members and their doctor may agree that more care is needed at home. Before the member leaves the hospital, the hospital's discharge planner and the Health Plan coordinate with them and their doctor. The Health Plan helps find medical equipment that may be needed at home, and assists in locating skilled nursing care if needed.

The transition from the hospital is facilitated because a number of health care experts work together to understand the member's needs, find where the care is best provided, determine who can help meet the needs, and negotiate with providers on the costs. Instead of the worry of managing all

health care arrangements, Health Plan members have access to partners working as their advocate and coordinating their care.

Pharmacy Benefit Management

The cost of prescription drugs is skyrocketing. Through Coordinated Care, the Health Plan works with members to help them save on prescription medications by:

- Choosing generic drugs whenever appropriate. Generic medications are sold under a generic name, which may be unfamiliar, but by law, generic medications must have the **same** active ingredients and are subject to the **same** rigid U.S. Food and Drug Administration (FDA) standards for quality, strength and purity as their brand name counterparts. Generic drugs usually cost considerably less than brand name drugs.
- Using the Health Plan's Mail order Prescription Drug program. For long-term prescriptions, the Mail order program gives the greatest savings. There are no deductibles, no saving receipts and the medication is delivered right to your door.
- Over 58,767 pharmacies participate in the Health Plan's Retail Network, including pharmacy giants such as Rite Aid, CVS and Costco. For short-term medications, for example antibiotics to treat infection, using the Retail Network is a cost savings, because the Health Plan has negotiated with these pharmacies to provide discounts to members. There are no deductibles, and the prescription is processed electronically when an Identification Card is presented. After one 30-day refill, you must obtain a new prescription and submit it to the Mail order program.

Flexible Benefits

- Flexible Benefits Option is described in the Health Plan's Federal Brochure.
- The Health Plan helps members by determining the most effective way to provide services.
- The Plan may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. Alternatives are offered on a case-by-case basis, and are special features to the regular contract benefits.
- This means that the Plan may, at its discretion, allow non-covered benefits, or exceed normal maximums, in order to effectively treat a patient in a less costly setting. As an example, the Plan may increase its allowance of $90 per day for home nursing services instead of keeping a patient in an inpatient hospital setting.

- Alternative benefits may be offered by the Plan, and withdrawn at a time when the Plan (and/or its Coordinated Care vendor) believes that the services are no longer medically appropriate. Allowing alternative benefits does not constitute a guarantee of any future alternative benefits. It is at the Plan's discretion when these services are medically appropriate and save both the member and the Health Plan money.
- The use of, or the withdrawal of alternative benefits is not subject to OPM review under the disputed claims process.
- When large dollar expenditures for long term care resulting from an accident or illness are involved, the Plan will often employ its managed care vendors to participate in the management of the patient's care. This is done to coordinate the patient's care in a cost-effective manner. One way that this is done is by contacting the provider of care and directly asking for a discount for service.

Precertification

- Precertification is the process by which, before a hospital stay, the Health Plan evaluates the medical necessity of the stay and the number of days needed to treat the condition.
- This helps ensure that members receive hospital care in the most appropriate setting in the most cost efficient manner.
- If members fail to precertify hospital stays, benefits are reduced by $500.
- Precertification is required for certain outpatient radiological procedures, specifically CT scans, Magnetic Resonance Imaging, Magnetic Resonance Angiography and PET scans.

Prior Approval (High Option) and Pre-Notification (Consumer Driven Option)

- Prior approval is required for outpatient services such as organ transplantation and surgical procedures that may be cosmetic in nature.
- Prior approval is required for inpatient Mental Health and Substance Use Disorder benefits.
- Seeking prior approval ensures that you gain agreement on how the Health Plan will cover the charges.

Ways the Health Plan Helps Keep Members' Costs Low

Fraud and Abuse

The Office of Personnel Management has mandated that all FEHBP plans become more aware of the potential for fraud and abuse. They have also directed plans to take steps in combating this.

Estimates are that as much as 10% of all claims dollars paid in the health insurance industry are paid for fraudulent charges. The Plan fights fraud and abuse in a number of ways:

- A system that examines all claims for patterns of fraud and abuse. It edits claims for frequency of services, service-coding irregularities.
- Rigorous quality assurance programs. Claims processing, and all other operations with the Plan, go through continuous routine quality audits.
- Quarterly audits that are re-audited by an outside actuarial firm.
- Our members - When the Plan considers charges, we send our members a Personal Health Summary. If the provider of service does not supply the member with an itemized billing, members should check the Personal Health Summary. If a member believes that the PHS contains charges the member did not receive, they should call the provider's office and question the charge. If not satisfied with the answer, call the Health Plan, and we will investigate.
- If PHS is received for services when no medical services were performed, the Health Plan should be contacted and will investigate.
- Members can also help fight fraud by never giving their health identification number to someone not known, or over the telephone except to a valid medical provider when you have initiated the contact. Also, asking questions can eliminate unnecessary services.
- The Health Plan's Nurse Advisory Line helps by giving members access to professional registered nurses who can provide answers.
- ClaimCheck - This is a software package that the Health Plan uses to help detect fraudulent or inappropriate billing practices on claims.

Coordinated Care benefits members by bringing together all the health care professionals who can assist in the care. Additionally, by helping members contain health care costs, Coordinated Care helps lower members' out-of-pocket expenses and keeps Health Plan premiums low.

HIPAA

Protecting Member's Personal Health Information

- As a Health Plan Representative for your Local, it is important for you to be aware of the federal privacy law about protecting member's personal health and medical information, the **Health Insurance Portability and Accountability Act** or **HIPAA**.

- Generally, HIPAA prohibits the Health Plan from discussing or disclosing a Health Plan member's personal health information to anyone other than the member unless the Health Plan is using or disclosing the information related to core issues such as the member's medical treatment or payment for his or her health care.

- For Health Plan Representatives, this prohibition means that if a member asks for your help with his or her Health Plan benefits, the Health Plan cannot and will not discuss the member's medical information with you until the member has signed the appropriate form for giving the Health Plan permission to communicate with you about the member and his or her personal health information.

- Even when authorized by a member, remember that health information you receive from the Health Plan is private and confidential. You should handle it with appropriate care and not discuss it with anyone other than the member or the Health Plan.

- There are two forms a member might use to allow you, as a Health Plan Representative, to access his or her personal health information. The *Authorization for Release of Protected Health Information* form allows a member to give you access to his or her health information at the Health Plan. With this access, you can communicate with and receive from the Health Plan designated personal health information about the member. The *Designation of a Personal Representative* form gives you broad access to a member's health information, and also authorizes you to act on the member's behalf with regard to any business the member has with the Health Plan.

- In the following section you will find the Health Plan's Notice of Privacy Practices explaining when and how the Health Plan may use or disclose a member's personal health information. You will also find Health Plan HIPAA forms and an explanation of how to use the forms to access or control access to personal health information. The Notice of Privacy Practices and the forms are also available on the Health Plan's website at www.apwuhp.com. Please remember that a member must submit signed copies of

these forms directly to the Health Plan to authorize access to the information covered by the forms, including your access to a member's personal health information.

- If you have any questions regarding HIPAA or the Health Plan's commitment to protecting personal health information, please contact customer service at 800-222-2798.

APWU Health Plan
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR PERSONAL HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the APWU Health Plan is required to protect the privacy of your personal health information. The APWU Health Plan is also required to give you this Notice to tell you how the APWU Health Plan may use or share your personal health information. If you have questions about this Notice, please contact the APWU Health Plan's HIPAA Privacy/Security Specialist by calling 800- 222-(APWU) 2798.

The APWU Health Plan appreciates that your health information is confidential. We want you to conduct business with us knowing that we respect your privacy, and that we take care to protect your personal health information. When the APWU Health Plan must use or share your personal health information, we make every reasonable effort to use or share only what is needed.

This Notice tells you:

- How the APWU Health Plan may use or share your health information.
- Your rights concerning your health information and how to exercise them.
- The APWU Health Plan's responsibilities in protecting your health information.

How The APWU Health Plan May Use Or Share Your Health Information

In order for the APWU Health Plan to conduct business, your personal health information must be used within the APWU Health Plan and shared with some of our Business Associates. Business Associates include companies and consultants who perform a wide variety of functions on behalf of the APWU Health Plan. For example, we work with companies to provide prescription benefits management, Preferred Provider Organizations, a 24-hour nurse line, precertification for hospital stays, authorization for treatment, case management, legal services, actuarial services, auditing services, transplant services, fraud and abuse investigations, and other contracted functions. The APWU Health Plan makes reasonable efforts to safeguard the information we send to our Business Associates, and we work with them to assure compliance with federal privacy laws.

The APWU Health Plan will not sell your personal health information or use or disclose your personal health information for paid marketing without your authorization. Additionally, uses and disclosures of psychotherapy notes for purposes other than for claims payment or disputed claims as described in this Notice will be made only with your authorization. The following paragraphs explain the ways the APWU Health Plan may use and share personal health information about you or a member of your family *without* your authorization. Please be aware that other uses and discloses not described in this Notice will be made only with your authorization.

1. Payment (Enrollment, Benefits, Premium Billing, and Claims Processing)

Access to your health information is necessary for the APWU Health Plan and our Business Associates to enroll you as a member of the Health Plan, pay claims to you or your provider, and bill premiums for your coverage. For example, a doctor, hospital or other provider submits claims to the APWU Health Plan with your personal health information related to the services they rendered. The provider may submit your claim through a claims clearinghouse (a Business Associate who collects claims from many providers and submits them to the Health Plan all at one time).

The claim may be sent to our Preferred Provider Organizations (also Business Associates) for pricing. The APWU Health Plan and our Business Associates' staff must obtain and use this information in order to process claims in accordance with your Health Plan benefits.

The APWU Health Plan and some of our Business Associates coordinate benefit coverage with other health insurance plans, for example Medicare A and B, or other insurance coverage you may have. In order to coordinate and process these claims correctly, we may share enrollment, benefit and claim information about you. The APWU Health Plan may also share personal health information if you are involved in a workers' compensation case. If you are involved in an auto accident, the APWU Health Plan will coordinate payment and liability with the responsible party's insurance.

The APWU Health Plan may share enrollment information about you with the American Postal Workers Union, AFL-CIO for associate membership fee billing.

2. Healthcare Operations

The APWU Health Plan shares your personal health information with our Business Associates to enable them to provide services to you such as precertification of hospital stays, 24-hour nurse line, patient safety initiatives, etc.

In order to operate our business effectively, our Customer Service Representatives may review of your personal health information during calls. For example, you may call Customer Service for questions regarding precertification, treatment authorization, claim questions, eligibility, benefits, etc. Providers (doctors, hospitals, etc.) also may call Customer Service to inquire about claim status and eligibility.

The APWU Health Plan and our Business Associates may use or share personal health information about all of our participants to ensure that you receive the best quality care at the lowest possible cost, to keep premiums as low as possible, for internal operations, and to identify opportunities for improving our service. For example, we may use personal health information to review treatment and services, and to evaluate the performance of Preferred Provider Organizations and providers. The APWU Health Plan and our Business Associates may combine personal health information about many APWU Health Plan participants to determine types of services to cover, whether new treatments are effective, and services that are unnecessary.

3. OPM and Employing Agency

The APWU Health Plan receives enrollment information from the U.S. Office of Personnel Management (OPM), the U.S. Postal Service, and federal agency payroll offices, and shares enrollment information with them to reconcile enrollment discrepancies. Additional information is shared between OPM and the APWU Health Plan as part of fraud and abuse investigations, Health Plan financial performance activities, provider debarment and suspension, and other operational activities required by OPM.

4. Disputed Claims

The APWU Health Plan or our Business Associates will disclose your personal health information to OPM as required by the disputed claims process. The disputed claim process is described in the APWU Health Plan's Brochure, OPM Federal Brochure RI 71-004.

5. Newsletters, Health Promotion, and Disease Prevention

The APWU Health Plan uses your name and address to send you our newsletter, *The HealthConnection*. We may use your personal health information for periodic mailings and communications related to your health, benefits and coverage. The APWU Health Plan or our Business Associates may use your personal

health information to contact you regarding health promotion, disease management, and other population-specific health programs.

6. Patient Not the Enrollee or Personal Representative

If you are not the APWU Health Plan enrollee or member, the APWU Health Plan and our Business Associates may give information about you to the enrollee or other individuals involved in your care unless you instruct us not to do so. In most cases, the information shared will be limited to information about payment of claims.

You may authorize someone to be your personal representative and act on your behalf for all aspects of your business with us, including providing and receiving personal health information about you. We will require proper documentation that you have designated and authorized the individual to act on your behalf as your personal representative.

7. Overpayments and Subrogation

The APWU Health Plan may share your personal health information with our Business Associates to collect an overpayment of a claim or pursue a subrogation lien. If there is an overpayment, the APWU Health Plan may provide limited information about your claims to external companies or to providers to assist in recovering the overpayment. If your claims can be subrogated to a third-party payor, the Health Plan may provide limited information about you and your claims to its Business Associates to aid in the Health Plan in recovering the subrogated payments.

8. Judicial and Administrative Proceeding

The APWU Health Plan or our Business Associates may disclose personal health information about you in response to a court or administrative order. The APWU Health Plan or our Business Associates may disclose personal health information about you in response to a subpoena, discovery request, or other lawful processes in a judicial or administrative proceeding.

9. Law Enforcement

The APWU Health Plan and our Business Associates may release personal health information about you to law enforcement officials. The APWU Health Plan will disclose personal health information about you at when required or permitted to do so by law.

10. Enforcement by the Secretary of Health and Human Services

The APWU Health Plan may release personal health information about you to the U.S. Secretary of Health and Human Services as required by law and/or to demonstrate our compliance with the law.

11. Other Disclosures Allowed by Law

As permitted in the Health Insurance Portability and Accountability Act ("HIPAA"), the APWU Health Plan and our Business Associates may release personal health information about you as allowed by law. Examples of this are disaster relief efforts; to public health authorities; health oversight activities; to avert a serious threat to health or safety; for military and veterans activities; national security and intelligence activities; protective services for the President and others; for medical suitability determinations; or for correctional and other law enforcement custodial situations.

Automatic Notice of a Breach of Your Personal Health Information

The APWU Health Plan will automatically notify you if there is a breach of your health information. We will send you a written notice within 60 days of discovering the breach that will detail for you the information involved, the nature and duration of the breach, and what has been done to respond to the breach. A breach for these purposes is the acquisition, access, use or disclosure of personal health

information in a manner that is not permitted by the law or the Health Plan's policies, and which compromises the security or privacy of your protected health information.

Your Rights Regarding Personal Health Information About You

You and your dependents have the following rights regarding personal health information the APWU Health Plan maintains. To exercise these rights, please submit your written request to:

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

Please call Customer Service at 800-222-APWU (2798) or go to www.apwuhp.com for more information.

1. Right to Access.

You have the right to inspect and obtain a copy of your health information maintained by the APWU Health Plan. We do not maintain a central file of all your health information. If you would like access to your health information we will act upon your written request within 30 days of receipt for information maintained on-site, and within 60 days of receipt for information maintained off-site. We may require a 30-day extension, and you will be notified if necessary. Please be advised there may be a fee to cover the costs associated with responding to your request.

The APWU Health Plan has the right to deny you access to all or part of the information we maintain (for example, psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action proceeding). We will provide you with a written statement that describes generally the information at issue, the reason for the denial, and how you may appeal the denial if you are not satisfied with our response.

2. Right to Amend.

If you believe the health information the APWU Health Plan has about you is incorrect or incomplete, you may ask to have that information amended.

To request an amendment, you must submit your request in writing and include the reasons why you believe an amendment is necessary. Your request for an amendment may be denied if it is not in writing or does not include a reason to support the request. The APWU Health Plan will act on your request within 60 days of receipt and provide further information regarding the amendment process requirements. If your request is approved, we may contact you to determine if others need to be notified of the amendment and to obtain your authorization to do so.

We will deny your request if you ask us to amend information that:

- Was not created by the APWU Health Plan (if, for example, your physician created the information, we will advise you to contact your physician);
- Is not part of the information you are permitted to inspect and copy; or
- The APWU Health Plan believes the information to be accurate and complete.

If your request is denied, the APWU Health Plan will provide you with a written statement that describes the basis for the denial and a description of how you can submit a statement disagreeing with the denial to be added to your records or submit a complaint.

3. Right to an Accounting of Disclosures.
You have the right to request an "Accounting of Disclosures." This is a list of external persons or organizations with whom the APWU Health Plan has shared personal health information about you that is not included as part of our payment and healthcare operations described earlier. It is possible there will be no disclosures to report or that, in accordance with law, the APWU Health Plan is required to suspend your right to receive an Accounting of Disclosures.

The APWU Health Plan will provide the accounting within 60 days of receipt of the request or notify you in writing if we are unable to meet that deadline or provide the accounting. You are allowed one (1) free accounting in a 12-month period. Please be advised there may be a fee for additional accountings in the same 12-month period. Any request for an accounting must be made in writing, and must state beginning and end dates for the period in which you seek an accounting, but may not include any dates that are more than six years prior to the date of your request.

4. Right to Request Restrictions.
You have the right to request a restriction or limitation on the use or disclosure of your personal health information. The APWU Health Plan is not required to agree to your request.

Any request for restrictions must be made in writing. Your request must include: (1) what information you want to restrict; (2) how you would like the information restricted; and (3) to whom you want the limits to apply.

5. Right to Request Confidential Communications.
You have the right to request that the APWU Health Plan communicate with you about your personal health information in a certain way or at a certain location, for example, at an alternative address. If you are not the member or enrollee, this may include making payment directly to you for your care as well as mailing of any explanation of benefits. We will accommodate, to the best of our abilities, all requests for such confidential communication.

To request confidential communication changes, submit your request in writing to the APWU Health Plan. We may refuse to accommodate your request if you have not provided specific information about the location at which you wish to be contacted.

Other Disclosures of Your Health Information
Other disclosures of your health information not covered by applicable laws or this Notice will be made only with your written authorization. If you provide the APWU Health Plan authorization to disclose personal health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, the APWU Health Plan will no longer disclose personal health information about you for the reasons stated in your written authorization. Please understand that the APWU Health Plan is unable to rescind any disclosures that have already been made with your permission.

Complaints About Your Privacy
If you believe your privacy rights have been violated by the APWU Health Plan or its Business Associates, you may file a complaint with the APWU Health Plan or the U.S. Secretary of the Department of Health and Human Services. To file a complaint with the APWU Health Plan, submit your complaint in writing to:

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

Complaints should outline why you believe your privacy rights have been violated. All complaints will be addressed and you cannot be penalized for filing a complaint.

Changes to This Notice

The APWU Health Plan reserves the right to change the terms of this Notice. We reserve the right to make the revised Notice effective for personal health information we already maintain, as well as any information we receive in the future. The APWU Health Plan will notify you by mail of material changes to the uses or disclosures of your information, your legal rights, the APWU Health Plan's legal duties, or other privacy practices in this Notice, and will post a revised Notice on our website at www.apwuhp.com. You will be able to download the most current Notice from the website. You may also contact Customer Service during normal business hours, Monday through Friday 8:30 a.m. to 8:00 p.m. eastern time, by calling 800-222-(APWU) 2798 to request a copy of this Notice.

APWU Health Plan
Authorization for Release of Protected Health Information

You may authorize APWU Health Plan in writing to share your protected health information (PHI) with a third party (such as an employer, lawyer or unrelated party). By completing and signing this authorization, you allow another person or organization to have access to your health information. This authorization will become effective once it has been entered into our systems, typically within 15 calendar days of receipt.

Please print neatly to ensure accurate processing and to avoid delays in service.

1. Requestor Information:

Requestor ID #: _____

First Name: _____ MI: _____

Last Name: _____ Date of Birth: ____ / ____ / ____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ - _____ - _____ Work Phone: _____ - _____ - _____

E-mail Address: _____

2. At my request, I authorize my protected health information to be disclosed to:

First Name: _____ MI: _____ Last Name: _____

Company Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ - _____ - _____ Work Phone: _____ - _____ - _____

E-Mail Address: _____

HIPAU01 (R 07/13)

3. I authorize the following disclosures of my protected health information to the person/organization listed above.

Check all that apply:

☐ ALL of my Information, Including Mental Health and Substance Abuse Information

☐ Enrollment and Benefits Information ☐ Premium Payment Information

☐ Any Documents Related to an Appeal ☐ Mental Health and Substance Abuse Information

☐ Claims and Explanation of Benefits (EOB) Information

To further limit the information being shared, please be as specific as possible when selecting the options below:

☐ All services for a specific date (provide dates of service):

From: _____ To: _____

☐ All services from a specific health care provider (list provider's name):

_____

☐ Other (please list specific PHI): _____

_____

4. Expiration:

I would like this authorization to expire

☐ on ___ / ___ / ___ (Check this option if you want the authorization to expire in less than one year)

☐ after a specific event has occurred (e.g. after knee surgery or at end of pregnancy):

_____

_____

This authorization will expire one year from date of signature unless you select one of the options above.

HIPAU01 (R 07/13)

5. Right to Revoke (Cancel):

I understand that I may revoke this authorization in writing at any time by sending a letter to the APWU Health Plan. Revoking this authorization will not affect any action that the APWU Health Plan took prior to receiving the written notice of revocation. The revocation should be sent to the APWU Health Plan, Privacy/Security Specialist, 799 Cromwell Park Drive, Suites K-Z, Glen Burnie, MD 21061.

Please refer to the Notice of Privacy Practices, available at **www.APWUHP.com**, for information pertaining to your opportunity to revoke an authorization, as well as the exceptions to this right. Also in the Notice of Privacy Practices is an explanation of all other available rights under the Privacy Rule.

6. Signature:

I, _____, hereby authorize the use and/or disclosure of my protected health information as described above.

I understand that:

1. this authorization is voluntary and being made at my request;
2. the released information may no longer be protected by federal privacy law once it has been released to the person/organization listed herein;
3. this authorization will not be used for medical underwriting; therefore, my treatment, payment, enrollment or eligibility for benefits will not be conditioned on my signing this authorization.

I understand that by signing this form, I am giving my authorization to my Health Plan to use and/or disclose the protected health information specified in the contents of this authorization to the person and/or organization named.

Signature: _____ **Date:** _____

If the person signing this form is not the member whose information is being authorized for release**, please provide your full name and check the box that best describes your relationship to the member.

_____ _____

Print Your Full Name **Phone Number**

☐ Personal Representative ☐ Power of Attorney ☐ Legal Guardian

***** The proper documentation must be on file before this authorization can be processed.***

7. Please mail this authorization to:

APWU Health Plan
HIPAA Privacy/Security Specialist
799 Cromwell Park Drive; Suites K-Z
Glen Burnie, MD 21061

1-800-222-2798

Please keep a copy of this authorization for your records.
We will provide you with a signed copy of this authorization at your request.

Any mental health or substance abuse information disclosed by APWU Health Plan may be protected by federal and/or state laws. If these records are protected, Federal Regulation (42 CFR Part 2) prohibits the recipient of the information from further disclosing the information unless the subject of the information has given his/her written consent, or as otherwise permitted by 42 CFR Part 2. A general authorization for release of protected health information or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information for the intent of criminal investigation or prosecution of any alcohol or drug abuse patient.

HIPAU01 (R 07/13)

APWU Health Plan
Designation of Personal Representative

With this form, you are designating a personal representative to act on your behalf in making health care payment related decisions through APWU Health Plan. The individual you name as your personal representative can be a family member, friend, attorney or unrelated party and will have access to your protected health information (PHI), including diagnoses, medical procedures, medications, treating providers, and information such as your date of birth and address. To designate a personal representative, you must complete, sign, date, and submit this form to APWU Health Plan. This designation will become effective once it has been entered into our systems, typically within 15 calendar days of receipt.

Please print neatly to ensure accurate processing and to avoid delays in service.

1. Requestor Information:

Requestor ID #: _____

First Name: _____ MI: _____

Last Name: _____ Date of Birth: _____ / ____ / ____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ - _____ - _____ Work Phone: _____ - _____ - _____

E-mail Address: _____

2. At my request, I designate the following individual to be my Personal Representative:

First Name: _____ MI: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ - _____ - _____ Work Phone: _____ - _____ - _____

E-Mail Address: _____

HIPPR01 (R 06/13)

3. **This designation will expire two (2) years after your coverage at the APWU Health Plan ends, unless you notify APWU Health Plan otherwise.**

4. **Right to Revoke (Cancel):**

I understand that I may revoke this designation at any time by sending a letter to the APWU Health Plan. Revoking this designation will not affect any action that the APWU Health Plan took prior to receiving the written notice of revocation. The revocation should be sent to the APWU Health Plan, HIPAA Privacy/Security Specialist, 799 Cromwell Park Drive, Suites K-Z, Glen Burnie, MD 21061.

Please refer to the Notice of Privacy Practices, available at **www.APWUHP.com**, for information pertaining to your opportunity to revoke an authorization, as well as the exceptions to this right. Also in the Notice of Privacy Practices is an explanation of all other available rights under the Privacy Rule.

5. **Signature:**

I understand that this designation is voluntary and being made at my request. I have had the full opportunity to read and consider the contents of this designation, and I confirm that the information is consistent with my direction to APWU Health Plan. I understand that by signing this form, I am giving my authorization to APWU Health Plan to communicate with my designated Personal Representative acting on my behalf in making healthcare payment related decisions.

Signature: _____ **Date:** _____

6. **Please mail this Designation of Personal Representative to:**

APWU Health Plan
HIPAA Privacy/Security Specialist
799 Cromwell Park Drive; Suites K-Z
Glen Burnie, MD 21061

1-800-222-2798

Please keep a copy of this designation for your records.
We will provide you with a signed copy of this designation at your request.

HIPPR01 (R 06/13)

EXPLANATION OF HIPAA FORMS

Authorization for Release of Protected Health Information

In order for the APWU Health Plan to disclose information about you that is not for the purposes of treatment, payment or health care operations, you must first authorize a person and/or organization to receive your protected health information. By completing and submitting this Authorization for Release of Protected Health Information Form, you are allowing the designated individual(s) to have access to only the protected health information specified by you on the form.

This form is ideal if you need assistance with handling specific claims or only wish for the designated individual to have limited access to your protected health information that will expire in a timeframe not to exceed one year. It is important to note that this form does not allow the authorized individual(s)/organization(s) to make any health care decisions on your behalf. If you wish to authorize the designated individual to be able to make health care decisions on your behalf, please complete and return a Personal Representative Authorization Form.

Personal Representative Authorization

The Personal Representative Authorization Form allows you to designate a personal representative who will act on your behalf in making decisions related to health care, which includes treatment and payment issues. This individual can be a family member, friend, lawyer or unrelated third party.

This form is ideal if you require ongoing, comprehensive assistance. It is important to understand that the individual you list as your personal representative has the authority to make health care payment related decisions on your behalf.

Request for Access

The Request for Access Form is used to make a request to inspect and/or obtain copies of your protected health information maintained by APWU Health Plan and our Business Associates.

Please note that the APWU Health Plan reserves the right to deny access to psychotherapy notes, information compiled for legal proceedings, on-going research or obtained from a confidential source. We also reserve the right to deny access if we believe it may cause you any harm, but we must grant you a review procedure.

The APWU Health Plan must respond to your written request within 30 days from the date it was received.

Request for Accounting of Disclosures

The Request for an Accounting of Disclosures Form allows you to receive an accounting of the disclosures of your protected health information by the APWU Health Plan or our Business Associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request.

The Privacy Rule does not require accounting for disclosures:

- for treatment, payment, or healthcare operations;
- to you or your personal representative;
- for notification of or to persons involved in your health care or payment for health care, for disaster relief, or for facility directories;
- pursuant to an authorization;
- of a limited data set;
- for national security or intelligence purposes;

- to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or
- incident to otherwise permitted or required uses or disclosures.

Accounting for disclosures to health oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

The APWU Health Plan must respond to your written request within 60 days from the date it was received. However, if we are unable to give the requested accounting to you within the 60-day deadline, we will notify you in writing that we will be utilizing our right to a 30-day extension provided we explain the reason for the delay and when we will act on your request.

Request for Confidential Communications

The Request for Confidential Communications Form allows you to request an alternative means or location for receiving communications of protected health information by means other than those that we typically employ. For example, you may request that the Health Plan communicate with you through a designated address or phone number.

The APWU Health Plan must accommodate reasonable requests if you indicate that the disclosure of all or part of the protected health information could endanger you. The Health Plan may not question your statement of endangerment. However, we may condition compliance with a confidential communication request on you specifying an alternative address or method of contact and explaining how any payment will be handled.

Request for Restriction

The Request for Restriction Form allows you to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

Marketing the Health Plan

Marketing is discovering a potential Health Plan member's needs and trying to fulfill them. It involves a communications process that flows in two directions, and is ultimately about building relationships with Health Plan members and potential members. Marketing includes many functions; attending health fairs at your facility, attending health fairs at local federal agencies, advertising in your facility, promotion, public relations and media relations. As HPRs, you are one of the Health Plan's greatest strengths because you create the personalized, one-at-a-time relationships with your co-workers that are so important to marketing. The Health Plan stands out from other health plans because you, as HPRs, are able to be of service to members in a way that differentiates the Health Plan from its competitors.

Overview of Health Plan in the FEHBP

The APWU Health Plan is available to all federal and postal workers, and retirees, as part of the Federal Employees Health Benefits Program (FEHBP). The APWU Health Plan has been a participant in the FEHBP since 1960. The Plan competes nationally and regionally with other FEHBP plans. By law, plans participating in the FEHBP cannot use money derived from premiums to advertise, either at Open Season or throughout the year. Money for advertising comes from APWU, and due to budget cuts this year, funds are limited. This is where you, the HPR, come in. Since you have direct access to our primary market, postal workers, and also access to federal workers in your area, you have the ability to play a great role in helping to promote the Health Plan.

Marketing Objectives

The Health Plan's objectives for 2019 Open Season and 2020 benefit year are:

- To retain 94% or more of its current membership
- To increase the Plan's total enrollment
- To continue to push the 'Walk-around List" to contact Local members who are not members of APWU Health Plan
- To continue attendance and promotion of the Plan at APWU State Conventions and Union Meetings.

For 2019 the Health Plan will promote its strength's in:

- The Innovative Consumer Driven Option
- The Quality and value of the High Option benefit package
- Our Disease Management Programs
- Benefit Enhancements (lab tests covered at 100% for High Option when performed by LabCorp and Quest Diagnostic) and in-network Maternity at 100% for both options

A Joint Venture Between the Health Plan and HPRs

There are two opportunities to increase membership in the APWU Health Plan, Open Season, and Local meetings. Open Season is a joint venture between the Health Plan and HPRs. HPRs play a key role during Local meetings, because you have direct access to APWU members, and if any, new hires.

Open Season

The Health Plan conducts its annual Open Season Seminar to introduce new benefits for the coming year, to provide Health Plan Representatives with the knowledge and skills to market the Health Plan to Local membership and to serve as a face-to-face resource about the Health Plan. Other ways the Health Plan helps support and works collaboratively with your marketing efforts are:

- Postal Service employees in non-APWU bargaining units (i.e., letter carriers, mail handlers, rural letter carriers) may enroll in the APWU Health Plan as Associate Members and pay only $35 per year Associate Member fee.
- An Open Season Hotline (800-PIC-APWU or 800-742-2798) beginning in October. Health Plan Customer Service Representatives who man this Hotline answer questions, mail copies of the new Federal Brochure, Preferred Provider directories and other Open Season material. The Hotline is available Monday through Friday, 9:00 a.m. to 5:00 p.m., EST, throughout Open Season. Open Season is the weeks of November 11 through December 9.
- Marketing materials are available to HPRs to assist with making the Plan visible at health fairs during Open Season. The marketing materials include:
    - New designed table signs to advertise the Plan
    - Promotional give-away items to attract "foot-traffic"
    - Sales flyer highlighting Consumer Driven Option and High Option as well as other information.
- An annual direct mail campaign, customized to specific target markets, highlighting the Plan's benefits and premiums
- A walk-around list to help you market the Health Plan to your Local members, mailed by the Health Plan at the end of September. All Local members who are not members of APWU Health Plan are listed on the walk-around list. Use the walk-around list to:
    - Make personal contacts with Local members and discuss the advantages of enrolling in the APWU Health Plan in a personalized way. In your personal contacts, discuss how the Health Plan can meet their individual health care needs.
    - Send a letter promoting the Health Plan to members in your Local. Let

members know about the quality and value of the APWU Health Plan, and how to reach you if they have questions or need more information. A sample letter is at the end of this section for your reference.

- A preemptive shipment of Open Season material, sent to all Locals. Locals may request additional materials:
    - Submit to the Health Plan the date, time, health fair location and the number of Postal Sales Kits needed for each fair 3 weeks prior to the event.

Open Season promotion on the Health Plan's website www.apwuhp.com: You can find our section for our HPRs at www.apwuhp.com/hpr.php. In our "HPR" section, you'll find the current HPR Manual, information on expense reimbursements, an Expense Voucher and other information. If your Local or State organization has a website, encourage them to create a link to the Health Plan's site and to include material about the Health Plan on their site.

Local Meetings

Contact the Local President and/or Director of Organization to make presentations at Local meetings. These are an opportunity to introduce the Health Plan to members. Let new hires know about the many attractive benefits the Plan offers to all potential members.

If there is a new hire, a Health Plan New Hire Kit is available through the Director of Organization at Headquarters. The kit includes a new employee return post card to obtain supplemental material and the Health Plan's informational flyer.

Most important at the Local meetings is the HPR presence. You make a difference in representing the Plan to your members.

Targeting Prospective Members

APWU members who do not belong to any health plan: APWU Health Plan has one of the lowest costs of any plan in FEHBP.

Other Federal Government employees: The High Option and Consumer Driven Option are competitively priced for federal workers, and benefits are extremely competitive with other plans in which federal employees may be enrolled.

Retirees with Medicare: The High Option supplements Medicare. If retirees have Medicare A and B as their primary plan most health care costs are entirely covered. Coordination between the Health Plan and Medicare means that there is nothing to file and no paperwork. The High Option waives some out-of-pocket costs for Members who have Medicare as their primary payer.

Selling the APWU Health Plan

Following are some pointers on selling the Health Plan:

- Be familiar with the Health Plan products. Know the current options and benefits, and the changes in the new benefit package.
- Read the HPR Reference Manual and the Federal Brochure.
- Be aware of the Plan's premiums, and the premiums of our competitors.
- You cannot make direct comparisons between the Plan and a competitor, but you can direct people to make comparisons of their own.
- Familiarize yourself with the Office of Personnel Management (OPM) website, www.opm.gov/healthcare-insurance/healthcare. These sites are designed to help postal and federal employees choose and research the various programs offered by FEHBP.
- If you are asked questions you cannot answer, do some research. If you cannot find the answer, call the HPR Hotline (800-635-8476), or refer the person to the Open Season Hotline (800-PIC-APWU or 800-742-2798). Never guess or try to make up an answer, as the Health Plan staff is available to help.

Tips on Promoting the Health Plan

As a Health Plan Representative, you are responsible for keeping the APWU Health Plan's name in the public eye. There are a variety of ways to do this. Take advantage of the following promotional ideas and do as many as possible, all year long. Let us know your success.

- Participate in Local organizing drives and meetings to attract new Union members as well as existing Union members not in the Plan. Use this opportunity to let potential

members know that the APWU Health Plan is your Union Plan, and a department of the APWU. By joining the Health Plan, they support a Union product and provide revenue to the Union.

- Post Health Plan information and newsletters on employee and Union bulletin boards and other designated areas, for Open Season and throughout the year.
- Coordinate a Health Plan day at your Local, or a table at Local picnics.
- Distribute Health Plan materials whenever possible. Printed flyers covering both the High Option and Consumer Driven Option benefits and premium changes are available from the Health Plan. Contact the Health Plan to make certain that you have a supply available for distribution.
- Form a Health Plan committee and train members to help you promote the Plan. Try to get volunteers from all shifts.
- During Open Season, work with your committee, or Shop Stewards to ensure that all shifts receive information regarding the Health Plan.
- Establish and maintain contact with postal and federal Health Benefits Officers in your area. Become the Health Plan liaison with postal Health Benefit Officers in Local area for health fairs, relationship building, education and distribution of Plan materials.
- Participate in health fairs at your post office, other post offices in your area, and federal agencies. If you are uncertain of dates and locations, contact the Health Plan for health fair information.
- Involve yourself with retired members or retiree organizations such as the National Association of Retired Federal Employees (NARFE). The website for NARFE is www.narfe.org. Check to see if your Local has a retirees department and make certain they receive Health Plan information. You can also make presentations on behalf of the Health Plan at retiree meetings throughout the year.
- Share "your" marketing tips with other HPRs at the annual HPR Seminar, via e-mail, phone or newsletter.
- Use the Walk Around Lists mailed to you in September. Contact as many members as you can to sell the Plan to them.
- Keep your name, phone number, and/or e-mail address public so that members and potential members know how to reach you.
- Know about other health plans. Although direct comparisons between plans are not permissible, make sure you know the advantages of the APWU Health Plan. Brochures for other FEHBP plans are available on the OPM website at www.opm.gov/healthcare-insurance/healthcare, or at Local health fairs.

- Publicize the Health Plan's website address www.apwuhp.com. If your State or Local has a website, make certain a link is set up from your site to the Health Plan's webpage.
- Keep APWU Health Plan Brochures available. Make it known that you are the Health Plan's Representative and can answer questions.
- Wear your APWU Health Plan shirt when representing APWU Health Plan.
- Coordinate with Web masters to add Health Plan link and material to Local website.
- Coordinate with Local Editors to promote the Health Plan in Local publications. In the HPR section of the Health Plan's website are a variety of articles for your use. They can be submitted as an article or used as a handout to be distributed at meetings and at the workplace.

Promoting Your Health Plan Is Worth Your Time and Effort!

Information Hot Line

Call Toll-Free: 800-222-2798
TDD Line (for hearing impaired only): 800-622-2511
HPR Toll-Free Hot Line: 800-635-8476
Internet Website Address: http://www.apwuhp.com

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

SAMPLE MARKETING LETTER

October 2019

Dear American Postal Workers Union Member:

Please consider the APWU Health Plan as your partner this Open Season. And, as a postal employee and member of the APWU, the USPS pays 95% of your premium cost for the Consumer Driven Option. No other plan will offer you this discount. Also, your enrollment helps the union. The APWU receives funds from OPM for sponsoring the APWU Health Plan, and this payment is set by the performance level of the APWU Health Plan, which is high, then multiplied by the number of members of the Health Plan. Highlights for 2020 are:

Consumer Driven Option

- No premium cost increase this year, and some of the lowest premium costs available for APWU members (95% is paid by USPS)
- Your Personal Care Account (PCA)
  - Members are given an account on day one of coverage that is fully funded, and provided annually by the Health Plan
  - The PCA provides for $1,200 for Self Only and $2,400 for Self Plus One or Self and Family enrollment
  - The PCA pays for covered medical expenses at 100% as long as there are funds in the account
  - Unused funds will rollover to the next year, provided you remain a Health Plan member
- 100% coverage for in-network preventive care
- Coverage for virtual visits; doctor visits from your phone or tablet
- 100% coverage for in-network maternity care
- 100% coverage for pregnancy and tobacco cessation programs

High Option

- No premium cost increase and great benefits
- No deductible on prescriptions
- Generic drugs at retail pharmacy $10 for 30-day supply, $20 for a 90-day supply
- Members can obtain a 90-day prescription of maintenance medication from Walgreens and CVS **without** penalty for not using mail order
- 100% coverage for in-network preventive care
- 100% coverage for labs when you use Quest Diagnostics or LabCorp
- 100% coverage for in-network maternity care
- 100% coverage for accidental injury within **72 hours**
- $25 copayment to see an in-network doctor, including specialists
- $15 virtual visits in-network through American Well
- Diabetes Management Program that offers 100% coverage for generic drugs, blood glucose test strips and lancets through mail order

- Weight Management Program that provides 100% coverage for visits to an in-network dietician or nutritionist

Open Season is November 11 – December 9, 2019. Call the Health Plan's toll-free Open Season Hotline for more information at 800-PIC-APWU, or check out the Health Plan's website at www.apwuhp.com.

Yours in Union Solidarity,

President
Health Plan Representative
APWU, AFL-CIO

Frequently Asked Questions

Benefit FAQs:

Q: ***Does APWU Health Plan cover preventive services?***

A: Yes, the Health Plan covers a variety of in-network preventive services at 100%, such as Pap tests, Well Woman benefits, prostate and colorectal cancer screenings, cholesterol testing and mammography and in-network routine exams every year at 100%. The Health Plan also covers tetanus booster shots and, in certain instances, flu and pneumonia vaccines.

Q: ***How can a member find out about the status of a claim that has been submitted to the APWU Health Plan?***

A: There are several ways for members to determine the status of a claim that they have submitted to the Plan. First, the member can access eHealthRecord, our online access to membership details and claim history. You may also e-mail a status inquiry form to the Plan requesting claims status. Click APWU Health Plan Members, click High Option Claims status inquiry for e-mail status inquiry. Members may also call the Health Plan at 800-222-2798, 24 hours a day, 7 days a week, and key certain requested data onto your telephone keypad. When this is done, the automated telephone response system will give the status of the claim. Finally, members may call the above number between the hours of 8:30 a.m. and 7:00 p.m., EST, Monday-Friday, and speak to a Customer Service Representative regarding the claim status.

Q: ***I have read about "precertification" of services. What services do I need to have precertified?***

A: The Health Plan's contract requires precertification for inpatient hospital stays. Home nursing care and services of either a physical, speech or occupational therapist, and durable medical equipment require prior approval (High Option). See the Plan's Federal Brochure (RI 71-004) to determine if a service you are about to receive needs precertification or preauthorization.

Unless a hospital stay takes place outside of the United States or Puerto Rico, or unless you have other insurance, including Medicare Part A as your primary health insurer, all inpatient hospital stays must be precertified. If a hospital stay is not precertified, a $500 penalty will be assessed when the claim is paid. Planned admission into the hospital must be precertified at least 2 business days prior to the admission to avoid the precertification penalty. If you have an emergency admission or an unscheduled maternity admission, you must certify the stay within 2 business days of the admission, even if you have already been discharged. For a maternity admission, the newborn's stay does not have to be precertified unless the child

stays in the hospital after the mother has been discharged. At the time of the mother's discharge, the newborn's stay becomes a separate admission.

If home nursing, physical, speech or occupational therapy services are not preauthorized, the Health Plan may deny services, even if they are considered medically necessary and appropriate. These benefits are covered when prescribed by a doctor, and the doctor submits a treatment plan for these services.

Cigna is responsible for precertification of CAT/CT/MRI/PET Scans. Prior approval of these procedures is required. Failure to obtain required precertification can result in a $100 penalty and/or denial of the claim pending review. The toll-free number for Cigna is 800-582-1314, found on the High Option ID Card. Have your provider call prior to these procedures.

Q: What is catastrophic protection out-of-pocket coverage? What is considered a "catastrophic" condition?

A: The catastrophic out-of-pocket maximum or limitation does not indicate any one illness or condition. The catastrophic limitation is the maximum amount of combined medical and prescription drug coinsurance that a member has to pay out of their own pocket before the Health Plan pays covered charges at 100% for the balance of the calendar year. Most conditions that the Health Plan pays on your behalf for the High Option, at a percentage amount, will have your portion of the fee (the coinsurance) apply toward a maximum out-of-pocket amount. Once that maximum amount (the catastrophic limit) has been met by a member, the Plan pays covered charges, for the remainder of the calendar year, at 100% of the Plan allowance, or the PPO negotiated rate if you use a Preferred Provider.

Q: Do charges that are applied to my deductible, or charges over the Plan allowance, apply to the catastrophic amount?

A: No. The amounts that are accrued toward the catastrophic limitation are coinsurance or copayments for covered services.

Q: How do I find out if my provider participates with one of the High Option's Preferred Provider Organizations? How do I find a provider who does participate?

A: There are several ways to determine if your provider--doctor, hospital or other-- participates with the APWU Health Plan. Ask the provider's office if they participate with one of the Plan's PPO's, or call the Health Plan at 800-222-2798 between 8:30 a.m. and 7:00 p.m., EST, Monday through Friday and request a PPO directory from a Customer Service Representative. Or check out the High Option PPO Directory on our website, www.apwuhp.com.

Another way to find out if your provider belongs, or to find a provider who does belong, is to call the PPO itself. PPO numbers are listed in the HPR Quick Reference Section.

Q: How do I get a referral to see a specialist--either a PPO specialist or non-PPO specialist?

A: You do not need a referral to see a specialist when you are a member of the APWU Health Plan. You are free to choose your covered providers without seeking our permission.

Q: What is the Health Plan's High Option prescription drug coverage?

A: The Health Plan offers two comprehensive prescription drug programs to its members. There is no deductible to satisfy for either program. With the Plan's Mail order drug benefit, for Tier 1 (generic) prescriptions, members pay a $20 copayment and a coinsurance of 25% for Tier 2 (preferred brand name drugs), and 45% coinsurance for Tier 3 (non- preferred brand name drugs). For specialty drugs, for Tier 4 (generic), members pay 25% and 25% coinsurance for Tier 5 (preferred brand name drugs) and 40% coinsurance for Tier 6 (non-preferred brand name drugs).

Members can also receive discounts on FDA-approved prescription drugs not covered in the prescription drug program through the Mail order service.

The Plan also has a contract with over 58,767 pharmacies nationwide, to allow our members to purchase prescriptions at a discount. Our members may purchase covered prescriptions at any Express Scripts network pharmacy. When an Express Scripts network pharmacy is chosen, our members will pay a $10 copayment for Tier 1 (generic drugs) for immediate care prescriptions. For Tier 2 (preferred brand name drugs), members pay a 25% coinsurance and 45% coinsurance for Tier 3 (non-preferred brand name drugs). For specialty drugs, members pay 25% for Tier 4 (generic drugs), 25% for Tier 5 (preferred brand name drugs) and 40% for Tier 6 (non-preferred brand name drugs).

With both the Mail order and the retail drug programs, there is no paperwork for the member to file--the pharmacy does it on your behalf. For more information about either program, or to locate a pharmacy near you, call Express Scripts at 800-841-2734, between 8:00 a.m. and 8:00 p.m., EST, Monday through Friday, or 8:00 a.m. to noon, Saturday.

Q: Am I covered when I am away from my home? Am I covered when I'm outside of the United States?

A: When you select the APWU Health Plan as your insurer, you are always covered, no matter where you are. Your coverage always goes with you, whether you are in another state or another country!

Enrollment FAQs:

Q: Will APWU Health Plan deny coverage if I have a pre-existing condition?

A: There is no denial of coverage for pre-existing conditions with APWU Health Plan. You are covered regardless of any medical condition you had before you enrolled.

Q: Who is eligible to join the APWU Health Plan?

A: The American Postal Workers Union Health Plan is open to all eligible postal and federal employees and retirees. Additionally, it is open to employees of the District of Columbia who were employed by the District prior to October 1, 1987. As a rule of thumb, if an employee, retiree, surviving spouse or child is eligible to enroll in the Federal Employees Health Benefits Program, that person is eligible to join the APWU Health Plan.

Q: What are enrollment categories and who do they cover?

A: APWU Health Plan's **Self-Only** coverage is for you alone. **Self and Family** coverage covers you, your spouse, and your dependent children under age 26, including stepchildren. Self and Family coverage also covers foster children when your employing office authorizes the coverage. **Self Plus One** coverage is for you and one eligible family member.

Q: I am a member of APWU Health Plan. I am thinking of retiring, and want to make sure I am covered when I retire. What are the requirements?

A: If you are thinking of retiring, you must be a member of a health plan in the Federal Employees Health Benefits Program for five-years prior to retiring to continue coverage. These five years can be in any FEHBP health plan or combination of health plans.

Q: If I have Medicare Part A and/or Part B and APWU Health Plan coverage, do you waive any charges?

A: If you are enrolled in the High Option and have Part A of Medicare, the Health Plan waives the deductible, copayment and coinsurance for inpatient hospital services. If you have Part B of Medicare, the Health Plan will waive deductibles and coinsurance for medical services and supplies provided by physicians and other health care professionals. If you are enrolled in the Consumer Driven Option, there is no waiver of out-of-pocket costs.

Q: I have an enrollment issue with the Health Plan. How do I handle it? Can I take care of it through the Internet?

A: Enrollment changes, an add or drop of a covered family member, an addition of or change in Medicare or other insurance coverage are made by sending a letter explaining the situation to the APWU Health Plan at P.O. Box 1358, Glen Burnie, MD 21060-1358, Attention:

Enrollment Department. At this time we do not accept enrollment change requests through the Internet because, for your protection and ours, we want to have the request for change in writing, for verification purposes.

Q: What happens when you are covered by both APWU Health Plan and another plan, such as Medicare?

A: When you are covered by both APWU Health Plan and another plan, such as Medicare, one plan normally pays its benefits in full as the primary payer; the other plan pays next as a secondary payer. If you are an active employee with double coverage, APWU Health Plan usually pays first, and Medicare is secondary. If you are retired with double coverage, Medicare pays first, and the Health Plan is the secondary payer.

Online Security FAQs:

Q: What are APWU Health Plan's Legal and Privacy Policies?

A: The APWU Health Plan is committed to safeguarding your privacy online. In general, you can visit our site without revealing any personal information about yourself. At times, we may ask you for personal information if it is necessary to assist you in selecting appropriate services offered by the APWU Health Plan. All information is provided voluntarily and explicitly by visitors of the site.

The e-mail facilities at our site do not provide a means for completely secure and private communications between us. Your e-mail, like most non-encrypted Internet e-mail communications may be accessed and viewed without your knowledge or permission while in transit to us. If you consider the information you are communicating to be confidential and you wish to keep it private, please do not use e-mail. Instead, you may contact us by telephone at 800-222-2798, or if you are a current member, at the number listed on the back of your identification card. Please note that e-mail sent to us will be shared with our customer service representatives or the staff members who are best able to address your questions or concerns. Once we have responded to your communication, it may be discarded or archived, depending on the nature of the inquiry.

The APWU Health Plan website gathers routine usage information, such as how many people visit the site, the pages visited, and length of time a visitor spends on the site. This information is collected on a random, anonymous basis, which means no personal identifiable information is associated with the data. This data helps us to improve the site content and overall usefulness for visitors.

This site contains hypertext links to other websites. The APWU Health Plan has no control over the content or the availability of these sites, and assumes no responsibility for the

privacy practices of such websites. These links are provided for convenience and reference purposes only, therefore we are not liable for any information or materials contained in them.

The APWU Health Plan reserves the right to modify this legal disclaimer and privacy policy at any time. If you have questions about the privacy statement or the practices of this website, you should contact information@apwuhp.com.

Enrollment

History of FEHBP

The Federal Employees Health Benefits Act of 1959 established the Federal Employees Health Benefits Program (FEHBP), effective July 1, 1960. The FEHBP provides employer-sponsored health benefits to active federal civilian employees and their dependents, including survivors and disabled employees.

Eligibility Requirements

Eligible Employees

1. Active federal, postal and congressional employees
2. Employees of the District of Columbia employed prior to October 1, 1987
3. Retired employees in the above categories with at least five consecutive years of FEHBP coverage immediately preceding retirement on a federal pension
4. Disabled employees in the above categories
5. Survivors of deceased employees and retirees
6. Dependents of active and retired employees in the above categories

Rules and regulations detailing specific eligibility requirements are located in the Federal Personnel Manual (FPM) Section 890.

Opportunities to Enroll or Change Enrollment

Employing agencies are responsible for ensuring that all submitted enrollment actions are permissible and in compliance with federal regulations. See *Table of Permissible Changes* for detailed information at www.opm.gov/healthcare-insurance/healthcare. (Guide to Federal Benefits for APWU Career United States Postal Service Employees)

Types of Health Plans

Fee-for-Service

This is a traditional type of insurance in which the health plan will either pay the medical provider directly or reimburse you once you have paid the bill and filed an insurance claim for each covered medical expense. You select the doctor or hospital of your choice, but you usually must pay a

deductible and coinsurance or copayment. Most fee-for-service plans have preferred provider organizations (PPO). You save money and avoid paperwork when you use preferred providers.

Health Maintenance Organization (HMO)

This type of health plan gives you coordinated care through a network of physicians and hospitals located in particular geographic or service areas. You usually must get all your care from the providers that are part of the plan. You pay copayments for most services and rarely pay a deductible or coinsurance.

Pre-paid Plan

Also known as Comprehensive Medical Plan (CMP), Health Maintenance Organization (HMO) or Individual Practice Association (IPA). These types of plans meet medical needs through specified physicians, hospitals, clinics or other health care delivery systems.

Consumer Driven Plan

A fee-for-service option under the FEHB that offers you greater control over choices of your health care expenditures. You decide what health care services will be reimbursed under the health plan funded Personal Care Account (PCA). Unused benefits from the PCA will roll over at the end of the year. If you spend the entire PCA before the end of the year, then you must satisfy a member responsibility/deductible before benefits are payable under the traditional type of insurance covered by your plan. You decide whether to use in-network or out-of-network providers to reach the maximum benefit allowed under your PCA.

Registration

General

Every eligible employee must choose to either enroll or decline health coverage benefits. Except as stated under Late Registration below, this must be done within 31 days after becoming eligible. An employee making a selection has the right to change his/her mind during this 31 day period.

Late Registration

If an employing office determines that an employee was not able to register within the time limits for reasons beyond his control, they may accept the registration within 31 days after notifying the employee of its determination. The employing officer must decide whether or not the employee's reason for failing to register on a timely basis was for cause beyond his or her control.

Types of Enrollment

Self Only

Covers the enrolled employee only. An employee may enroll for self-only coverage even though the employee has a family.

Self and Family

Covers the enrolled employee and eligible family members. All eligible family members are automatically covered even though they may not be listed on the original enrollment form (SF2809).

If both husband and wife are eligible to enroll as employees, either may enroll for self and family coverage or each may enroll for self-only coverage in the same or different plans. Coverage in more than one plan is prohibited.

Self Plus One

Covers the enrolled employee and one eligible family member.

Dual Coverage

It is illegal for an employee or a family member to be covered by more than one federal health plan at the same time. If a new employee is covered by a self and family enrollment of another employee or annuitant, the employee must, within the first 31 days of eligibility, register but not enroll. This requirement is waived if the original enrollment is canceled or changed to self-only. When an employee finds that he/she or a family member already has coverage under more than one enrollment, the employing office should be notified immediately so the matter can be corrected.

Organizational Rules of Eligibility / Union Dues

Eligible employees enrolling in the APWU Health Plan must be or must become members of the APWU. Membership requirements are as follows:

Postal Employees

Postal employees pay membership fees based on their position and union affiliation.

Employees represented by the APWU, whether or not they are members of the APWU must join the union and pay full dues to belong to the APWU Health Plan. This affects:

- Postal Clerks
- Maintenance Employees
- Motor Vehicle Employees
- PSEs

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 and annuitants will automatically become Associate Members of APWU upon enrollment in the APWU Health Plan. Postal Service employees in non-APWU bargaining units (i.e., letter carriers, mail handlers, rural letter carriers) may now enroll in the APWU Health Plan as Associate Members and pay only a $35 per year Associate Membership fee.

Management employees may join the Plan subject to the bylaws of the Local Constitutions. Some Local Constitutions require full dues, some partial dues and some are silent. When the Local Constitution is silent, the individual may join as a Postal Associate Member (PASM) paying $35 annually.

Employees restricted by federal law from joining the APWU may enroll as an Associate Member (ASM) and pay $35 annually. These employees are:

- Inspectors
- Security Guards

Federal Employees

Any federal employee may enroll in the Plan by becoming an Associate Member (ASM). The annual membership fee billed by the APWU National Office is $35.

Annuitants

A retired federal or postal employee may enroll in the plan. Retired federal employees may enroll as Retired Associate Members (RASM) and pay a $35 annual membership fee.

Retired postal employees (RET) may enroll under several different options offered by the APWU. If a retiree drops the Health Plan and discontinues union membership, he/she can only reenroll as an RASM and pay the $35 annual membership fee.

Note: An annuitant in any category who voluntarily cancels enrollment in FEHBP can **never** re-enroll.

Survivor Annuitant

If an employee set up annuity withholdings for a spouse, health benefits may be transferred to the spouse when the employee dies. The Survivor Annuitant (SA) is not required to pay membership fees. Eligibility is determined by the retirement system (usually OPM) based on the following criteria:

1. Deceased employee enrolled with self and family coverage at time of death
2. At least one family member must be entitled to an annuity

3. Annuity must be sufficient to cover health benefit premiums
4. Survivor Annuitant does not remarry prior to age 55. A SA under 55 loses entitlement to his/her federal annuity if they remarry. Health coverage is dropped when annuity payments are discontinued. If the SA subsequently divorces, the annuity and health benefits may be restored. Children born from the second marriage are not eligible for health benefits under the annuity
5. A spouse over 55 can remarry without losing benefits, but the new spouse is not eligible for coverage

Dependent Annuitant

A dependent annuitant (DA) is a child who survives an employee or the employee's spouse. Coverage continues until age 26. In cases where there is more than one child, health benefits transfer to the youngest child. An employee's spouse may become a dependent of the DA if survivor annuitant requirements are not met or if the employee requested this prior to death.

Retirement Eligibility

Enrollment continues with the same benefits when an employee retires if the employee remains enrolled in a FEHBP plan during retirement. An annuitant who voluntarily cancels his/her enrollment in FEHBP can never re-enroll.

The basic rules of eligibility for continuing health benefits into retirement are:

- The employee must retire on an immediate annuity. If the employee retires on a deferred annuity he/she is not eligible to continue health benefits even when the annuity begins;
- The monthly annuity check must be sufficient to cover the cost of the health insurance premiums;
- The annuitant must have been continuously enrolled in a FEHBP plan for at least 5 years immediately preceding retirement or from the individuals 1st opportunity to enroll.

Note: Enrollment may be as a dependent under a spouse's federal health plan or as the subscriber.

OPM has the right to waive the 5 year requirement at its discretion if exceptional circumstances exist.

In addition to OPM, several agencies maintain their own retirement systems. These agencies include DC employees, the Department of Justice and the Foreign Service. The Social Security System is not considered a federal retirement system for health benefits purposes.

Premiums

The cost of health coverage is shared by the employer and the employee. Premium contributions are determined using a formula based on averaging of the premiums charged by the plans with the highest enrollment. The government share cannot exceed 75% of the total enrollment cost. The employee's share is paid through payroll withholdings. Premium withholdings are made biweekly for active employees and monthly for annuitants.

Pre-tax Withholding of Health Insurance Premiums

A large percentage of postal employees have elected to have their health insurance premiums payroll deducted before income taxes are calculated. This may reduce their income which lowers the amount of income tax that is deducted. However, when premium contributions are withheld on a pre-tax basis, certain Internal Revenue Service (IRS) guidelines restrict withholding changes.

An employee may elect to reduce coverage (i.e., cancel FEHB enrollment or go from Self and Family to Self Only coverage) only during FEHB Open Season, unless one of the following qualified life status changes occurs:

- Marriage or divorce;
- Birth of a child or addition of a qualified dependent;
- Start or end of spouse's employment;
- Change in spouse's employment status (from either full-time to part-time, or the reverse);
- Start or end of spouse's unpaid leave of absence;
- Significant change in health coverage (employee or spouse) because of spouse's employment.

In addition, the Minneapolis Accounting Service Center (formerly PDC) has begun to strictly enforce the time limitations in which permissible changes can be made. For example, if a member divorces, the change to self-only must be requested **within 60 days** of the divorce or the member MUST wait until Open Season.

Since we do not know whether health benefits are deducted before or after income taxes are assessed, we cannot advise members about their options for making changes. These members should always be referred to their personnel offices. If the personnel officer does not know how to handle the situation, the problem should be referred to the personnel officer's supervisor/manager.

Non-pay Status

Federal regulations require an employee to pay for health benefit coverage while in a non-pay status or when salary is insufficient to cover the premium. The employee must make arrangements with the employing office to make payments on a direct pay basis while in a non-pay status. In cases where this creates a hardship, the employee share may be paid when the employee returns to a pay status. The employer should continue to remit their share.

Continuation of Coverage

Upon Transfer

The enrollment of an employee who moves from one employing office to another continues without interruption provided there is not a break in service of more than three calendar days. This applies to all employees, including those enrolled in comprehensive medical plans that transfer to locations outside the service area of the plan. An employee enrolled in an employee organization plan and who transfers to another agency does not have the right to enroll in another plan; the enrollment continues until:

- The employee changes plans when he or she has an opportunity (as during an Open Season) or,
- The plan terminates the enrollment because he or she no longer is a member of the organization.

Upon Retirement

When an employee retires under conditions which entitle him or her to continued enrollment, the enrollment is transferred to the retirement system and is automatically continued.

On Death of Employee

Coverage of family members of an employee who dies in service is automatically continued when title to survivor annuity is established provided the conditions described by law are met.

Termination of Enrollment or Coverage

Cancellation

An employee may cancel an enrollment at any time by completing and submitting to the employing office an SF2809 registering to cancel. The cancellation becomes effective on the last day of the pay period after the one in which the SF2809 is received in the employing office. However, for monthly or four-week pay periods, if an employing office received the SF2809 at least 15 days before the end of the pay period, the cancellation becomes effective at the end of that same pay period. No person

covered by an enrollment that has been voluntarily canceled is entitled to temporary extension of coverage or conversion to a non-group health benefits contract.

Voluntary Cancellation

An employee may voluntarily cancel enrollment at any time. Generally, the cancellation will become effective on the last day of the pay period after the one in which the registration to cancel is received by the employing office. All extensions and conversion rights are waived when coverage is voluntarily canceled. Once the cancellation becomes effective, the employee may not re-enroll until such time as an event occurs which permits enrollment. **See Table of Permissible Changes.**

Termination for Other Reasons

Employees

An employee's enrollment terminates, subject to a 31 day temporary extension of coverage for conversion to a non-group contract, on the earliest of the following dates:

- The last day of the pay period in which the employee is furloughed by reason of reduction-in-force (RIF);
- The last day of the pay period in which he or she is separated other than for transfer or retirement or because of a compensable disability under conditions entitling the employee to continue the enrollment;
- The last day of the pay period in which employment status changes so as to exclude employee from coverage;
- The last day of the pay period in which he or she dies, if a survivor annuitant is not eligible to continue the enrollment;
- The 365th day of non-pay status or, if not entitled to any further continuation because he or she has not had four consecutive months of pay status since exhausting the 365 days continuation of coverage in non-pay status, the last day of the last pay period in pay status;
- The day he or she is separated, furloughed or placed on leave of absence for the purpose of performing military service for a period not limited to thirty days or less;
- The Health Plan cannot terminate a member when notified of their death without a death certificate or paperwork from the employee's payroll office/OPM.

Family Members

The coverage of a member of the family of an employee terminates on the earlier of the following dates:

- The day on which the enrollment is canceled, changed to self only or terminates (unless the employee dies and there is a survivor annuitant eligible to continue the enrollment), or
- The day on which he/she ceases to be a member of the family.

Example: An employee's spouse coverage terminates on the day a final divorce decree is effective; coverage of an employee's child terminates the day the child reaches age 26.

Temporary Extension of Coverage and Conversion

Extension of Coverage

Coverage of an enrolled employee continues temporarily for 31 days after the enrollment terminates for any reason except voluntary cancellation.

In addition, if the employee is confined in a hospital on the 31st day of the temporary extension of coverage, benefits will continue during confinement up to a maximum of 60 more days.

These temporary extensions of coverage are without cost to the employee and apply also to any family member who loses coverage other than by the employee's voluntary cancellation or by the employee's enrollment change from Self and Family to Self only.

How to Continue Coverage

If a member or covered dependent(s) becomes ineligible for coverage under the Federal Employee Health Benefits Program (FEHB) because of divorce, termination of employment for reasons other than gross misconduct or a child reaches age 26, he/she has 2 options to continue coverage.

Conversion Plan

Any person losing federal coverage may convert to an individual contract with the APWU Health Plan. The plan will be different from what the member has currently under the FEHB Program. Premiums are paid directly to the APWU Health Plan on a quarterly basis. (See Terms and Conditions of the Conversion Plan.)

Application for conversion must be made in writing **within 31 days** after federal coverage ends.

Temporary Continuation of Coverage (TCC)

Members and/or dependents that lose coverage may be eligible to continue federal coverage (same benefits) for 18 to 36 months. Under TCC, the insured pays the full cost of the premium (employee and employer shares) plus an administrative charge. An eligible employee covered under a self-only

enrollment may convert to a family enrollment during the 31 day temporary extension if the employee or the employee's spouse is pregnant.

Individuals who are **eligible** include:

- Employees who resign or are terminated for other than gross misconduct (may continue coverage for up to 18 months);
- Dependents and former spouses (may continue for up to 36 months).

Individuals who are **not eligible** include:

- Family members who lose coverage when an employee changes to Self Only or cancels coverage;
- Employees who lost coverage after 12 months in a non-pay status;
- CSRS annuitants and survivor annuitants who lost coverage because their annuities are insufficient to cover premiums;
- Annuitants whose annuities terminate. Applies primarily to disability annuitants whose annuities end due to recovery or restoration to earning capacity;
- Compensationers who lost coverage because their compensation terminates;
- Survivor annuitants whose annuities terminate unless the terminating event is one that allows temporary continuation of FEHB coverage. Example: a surviving spouse loses both the survivor annuity and FEHB coverage because of remarriage before age 55 is not eligible for temporary continuation of coverage because remarriage is not a qualifying event for a surviving spouse. However, a child who loses both a survivor annuity and FEHB coverage because of marriage is eligible for temporary continuation of coverage because marriage is a qualifying event for a child;
- Employees who transfer to a position that is excluded from FEHB coverage by law;
- Widow(er) and children who lose coverage because of the death of an employee or annuitant and who are not eligible for survivor benefits;
- Children whose survivor annuities stop because they are no longer students.

Applicants have up to **60 days** from the date of the qualifying event to notify their employing office that they want to exercise this option. Employing offices notify eligible employees, accept registration forms and transfer information to the appropriate agency. The TCC agency collects premiums and oversees all enrollment changes. An administrative charge of 2% is charged by the agency.

TCC/Conversion Regulations

Reason for Loss of Health Plan Coverage	31 Day Extension Allowed	Eligible for TCC of FEHB Coverage	Eligible for Conversion Plan
Loss of Employment			
Fired	Yes	Yes	Yes
Laid Off	Yes	Yes	Yes
Fired for Gross Misconduct	Yes	No	Yes
Loss of Benefits			
Spouse due to divorce	Yes	Yes	Yes
Dependent due to marriage	Yes	Yes	Yes
Child turning age 26	Yes	Yes	Yes
Employee dies - no annuity established for survivors	Yes	No	Yes
Voluntary Cancellation			
Employee drops coverage	No	No	No
Option Change			
Member changes from Self and Family to Self Only	Yes	No	Yes

Military Service

If an employee enters on active duty in one of the uniformed services for a period limited to 30 days or less, the enrollment will continue and if for a period of more than 30 days, the enrollment will be terminated.

If terminated, the enrollment will not be reinstated until the employee returns to their job in exercise of their reemployment rights. The enrollment will then be reinstated immediately.

There will be no delay of benefits if the employee is confined to a hospital on the effective date of coverage. The employee will also have the chance to change their enrollment as shown on the **Table of Permissible Changes.**

During the time the employee is in military service, he/she and their family will be entitled to medical care offered to members of the uniformed services and their dependents under a different program.

Family Members Eligible for Coverage

Eligible family members consist of:

- The employee's spouse (including a valid common law marriage where recognized by state law - see list of states in this section);
- Dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office;
- A child over age 26 who is incapable of self-support.

Note: The employing office is initially responsible for making any decisions about a family member's eligibility. The carrier is granted the right to request evidence to certify the eligibility of a family member when a claim is received.

Adopted Children

Applicable state law governs whether or not a child has been adopted. A pre-adoption agreement is not qualifying unless state provides the same rights as for adopted child. A child can be covered as a foster child until the adoption becomes final.

Stepchildren and Recognized Natural Children

If not contrary to state law the illegitimate or adopted child of the employee's spouse is considered a stepchild. However, the stepchild of the employee's spouse (by a previous marriage) is not the employee's stepchild. Stepchildren must live with the employee to be eligible for FEHB coverage.

Foster Children

The following factors establish the eligibility of a foster child for FEHB coverage:

- The child must live with the employee in a regular parent-child relationship;
- The employee must be rearing the child as his/her own;
- The employee need not be related to or have taken steps to legally adopt the child but, there must be an expectation that the employee will continue to rear the child indefinitely into adulthood;
- The employee will be the primary source of financial support for the child.

Common examples of a foster parent/child relationship are:

- A child whose parents have died;
- A child living with the employee under a pre adoption agreement;
- A child in the legal custody of the employee.

The fact that a child's natural parents are alive does not preclude the existence of a foster parent/child relationship between the child and the employee provided the employee is rearing the child as his/her own and expects to continue to rear the child into adulthood. If one or both of the child's natural parents live with him/her and the employee, the parent-child relationship must be with the enrollee not the biological parents.

A child who has been placed in the employee's home by a welfare or Social Service agency under an agreement whereby the agency retains control of the child or pays for maintenance would not qualify as a foster child because there is no regular parent-child relationship. Similarly, an arrangement under which a child is living temporarily with an employee as a matter of convenience would not qualify the child as a foster child. For example: a foreign exchange student.

Effect of Child's Temporary Absence on "Living With" Requirement

Periods of temporary absence while attending school for other reasons will not affect the status of stepchildren or foster children otherwise considered to be living with the employee in a regular parent-child relationship. Also, an employee's stepchild or foster child who lives with the employee at least 6 months of a year under a court order directing shared custody may be considered living with the employee in a regular parent-child relationship.

Common Law Marriages

Applicable state law should be consulted to determine whether a common law marriage is valid. A common law marriage continues until it is legally terminated by annulment, a divorce decree issued to either partner, or by death. Unless one of these events occurs, a couple is married even though they may be separated, have been granted an interlocutory or limited divorce or separate maintenance, the whereabouts of one is unknown to the other or one may have attempted to enter into marriage with another partner.

State Laws for Common Law Marriages Source: Martindale-Hubbell Law Digest 1992	
Alabama	**Valid** - but cannot exist if spouse previously married and has not obtained a valid divorce
Alaska	**Invalid**
Arizona	**Invalid** - recognized if valid where created. Marriage contracted by Arizona residents in another state to evade Arizona law is void
Arkansas	**Invalid** - recognized if contracted in a state where they were valid
California	**Valid** - recognized if valid where created
Canal Zone	**Invalid**
Colorado	**Valid**
Connecticut	**Invalid**
Delaware	**Invalid** - recognized if valid where created
District of Columbia	**Valid**
Florida	**Valid** - Common law marriages consummated after January 1, 1968 are invalid
Georgia	**Valid**
Hawaii	**Invalid** - Marriages legal in the country contracted are legal in Hawaii
Idaho	**Valid**
Illinois	**Invalid**
Indiana	**Invalid**
Iowa	**Valid**
Kansas	**Valid**
Kentucky	**Invalid** - recognized if valid where created
Louisiana	**Invalid** - Marriage valid by the law of state where contracted is valid in Louisiana unless parties were domicile in Louisiana at time of marriage and marriage was prohibited by Louisiana law
Maine	**Invalid** – Out-of-state common law marriages would probably be recognized
Maryland	**Invalid** - recognized if valid where created
Massachusetts	**Invalid**
Michigan	**Invalid**

State Laws for Common Law Marriages Source: Martindale-Hubbell Law Digest 1992	
Minnesota	**Valid** - Common law marriages contracted on or before April 26, 1941 recognized, but marriage contracted since that date void unless requirement herein before stated complied with Minnesota State. Validity of marriage normally determined by law of jurisdiction where contracted and if valid there, valid in Minnesota unless it violates strong public policy
Mississippi	**Invalid** - Common law marriages were valid prior to April 5, 1956
Missouri	**Invalid**
Montana	**Valid**
Nebraska	**Invalid** - recognized if contracted in a state where they were valid
Nevada	**Invalid**
New Hampshire	**Invalid** - Out-of-state common law marriages possibly recognized if any marriage by domiciliaries which is legally contracted in another state will be recognized as valid if parties become permanent residents
New Jersey	**Invalid** - Common law marriage valid where contracted is valid in NJ
New Mexico	**Invalid** - All marriages celebrated beyond limits of state which are valid according to law of country where celebrated or contracted shall be valid
New York	**Invalid** - recognized if valid where created
North Carolina	**Invalid** - recognized if valid where created
North Dakota	**Invalid** - recognized if valid where created. This does not apply if a resident of ND contracts a marriage in another state which is prohibited here
Ohio	**Valid** - Validity is determined by law of state where consummated, but marriage invalid under law of state where first consummated may become valid if continued in Ohio under circumstances implying renewal of marriage agreement. Foreign marriages recognized in Ohio if valid where performed
Oklahoma	**Valid** - recognized if valid where created
Oregon	**Invalid** - recognized if valid where created
Pennsylvania	**Valid**
Philippine Republic	**Invalid**
Puerto Rico	**Invalid**

State Laws for Common Law Marriages Source: Martindale-Hubbell Law Digest 1992	
Rhode Island	**Valid**
South Carolina	**Valid**
South Dakota	**Invalid** - but valid when effected before July 1, 1959
Tennessee	**Invalid** - recognized if valid where created
Texas	**Valid**
Utah	**Invalid** - Unsolemnized marriage arising out of a contract is valid if court or administrative order finds two parties: (1) capable of consent; (2) legally capable of solemnized marriage; (3) have cohabited (4) mutually assume marital rights, duties and obligations; and (5) contend and are believed to be husband and wife. Determination must be made during or within one year of termination
Vermont	**Invalid**
Virginia	**Invalid** - recognized if valid where created
Virgin Islands	**Invalid**
Washington	**Invalid** - recognized if contracted in a state where they were valid
West Virginia	**Invalid** - recognized if contracted in a state where they were valid
Wisconsin	**Invalid**
Wyoming	**Invalid** - recognized if valid where created

Relatives Who are Not Family Members

Parents and relatives are not members of the family within the meaning of the law even though they live with and are dependent upon the employee. They are not eligible for FEHB coverage.

New Family Members

If the employee is enrolled for **Self and Family** coverage:

- A new family member, such as a new spouse or newborn, is automatically covered from the date of the qualifying event

If the employee is enrolled for **Self Only** coverage:

- Employee must complete an SF2809 to change to family coverage;

- Employee must be in a pay status to make a change. If a female employee is making the change due to the birth of a child, the employee should notify personnel of the change prior to taking maternity leave to avoid a gap in coverage for the newborn;
- Employees not in a pay status must wait until they return to a pay status to make enrollment changes. (May apply above if the employee does not have sufficient leave.)

Effective Dates for Enrollment Changes

Enrollment and changes in enrollment (except voluntary cancellation and Open Season changes) become effective on the first day of the first pay period after the one in which:

The employing office receives the registration form (SF2809) and that follows a pay period or any part of which the employee was in a pay status. A cancellation becomes effective on the last day of the pay period after the pay period in which the employing office receives the SF2809. If the employee is on a monthly or a four-week pay period and the employing office receives the SF2809 at least 15 days before the end of the pay period, the cancellation will become effective at the end of the pay period in which the form is received.

Who to Notify of Enrollment Changes

Postal and Federal Employees

Action	Who to Notify to Update Health Benefits
Enroll or change health plans	Personnel/OPM
Cancel/Terminate health plans	Personnel/OPM
Apply for Extended Temporary Continuation of Coverage:	
Same coverage you have now	Personnel/OPM
Conversion Plan Member/Dependent	APWU Health Plan
Change from Self Only to Self and Family or vice versa	Personnel/OPM
Change in last name	APWU Health Plan
Add a dependent (Self & Family Option, Self Plus One):	
Newborn	APWU Health Plan
Natural child	APWU Health Plan
Adopted child	APWU Health Plan
Foster child	APWU Health Plan
To continue coverage for dependent incapable of self-support	Personnel/OPM/APWU Health Plan
Drop a dependent	APWU Health Plan/Personnel/OPM
Change in marital status (Self & Family Option, Self Plus One)	APWU Health Plan
Change in marital status (Self Only Option)	Personnel/OPM
Change in address	APWU Health Plan

Retirees and Survivor Annuitants

Although there are situations that are handled by the Enrollment Department of the APWU Health Plan, there are also situations where the personnel office is to be contacted directly. Since retirees and survivors do not have a personnel office to refer to, they must contact the Office of Personnel Management (OPM) for many of their enrollment situations, such as to report the death of an employee or someone who gets benefits from OPM; or to report a missing payment.

When enrollees write to OPM, they will need to include the annuitant's Social Security number and their Civil Service or FERS claim number. The Civil Service or FERS claim numbers begin with either a "CSA" or a "CSF," followed by seven digits. All correspondence must be signed by the annuitant or their legal representative.

There are several ways to contact OPM:

Write: U.S. Office of Personnel Management
Retirement Operations Center
P.O. Box 45
Boyers, PA 16017

E-Mail: Retire@opm.gov

Website: www.opm.gov

Phone: **88USOPMRET (888-767-6738)**
This is a nationwide toll-free number.

In the Washington, DC area, call
202-606-0500

Hearing Impaired: TDD callers can call toll-free
800-878-5707

When you call, have your CSA/CSF claim number available; it will speed up your call. You can speak to a Customer Service Specialists or you can use any of the features of our automated phone system described below.

If you wish to speak with a Customer Service Specialist, you should call during regular business hours from 7:30 a.m. to 5:30 p.m.

You must have a Personal Identification Number (PIN) to use it. If you do not have a Personal Identification Number (PIN), call the above number and request one from a Customer Service Specialist. The PIN is mailed to you to help maintain the security of your records.

A Comparison of the Conversion Plan and Temporary Continuation of Federal Coverage

Type of Coverage	Total Annual Premium	Premium	Premium Paid To	Benefits	Application Deadline	How Long You Can Continue Coverage
Conversion Plan High Option for Each Adult Enrollee	$ to come (Self Only)	$ to come Quarterly	APWU Health Plan by the enrollee	Limited (Call 800-222-APWU for details)	31 days after benefits end under FEHBP	Indefinitely, as long as premiums are paid
	$ to come (Self Plus One)	$ to come Quarterly	APWU Health Plan by the enrollee	Limited (Call 800-222-APWU for details)	31 days after benefits end under FEHBP	Indefinitely, as long as premiums are paid
	$ to come (Self & Family)	$ to come Quarterly	APWU Health Plan by the enrollee	Limited (Call 800-222-APWU for details)	31 days after benefits end under FEHBP	Indefinitely, as long as premiums are paid
APWU Health Plan (TCC) - 2019	$8,715 plus 2% administrative charge (Self Only)	$335.18 Biweekly (plus 2%)	Employing Office by the enrollee	The same benefits as you have now	60 days after benefits end under FEHBP	Former employees - 18 months
	$18,300 plus 2% administrative charge (Self Plus One)	$703.86 Biweekly (plus 2%)	Employing Office by the enrollee	The same benefits as you have now	60 days after benefits end under FEHBP	Children up to age 26
	$20,915 plus 2% administrative charge (Self & Family)	$804.42 Biweekly (plus 2%)	Employing Office by the enrollee	The same benefits as you have now	60 days after benefits end under FEHBP	Children and former spouses- 36 months

Changes Which Do Not Affect Enrollment

Family Members

If a change in family members of an employee does not affect the enrollment, such as 472 to 471 or vice versa, it is not necessary to report the change(s) to personnel. The plan may request this information including evidence of the family relationship.

Examples of changes which do not affect the enrollment are:

- Birth of a child when enrollment is Self and Family (472);
- Death of the employee's spouse where there are surviving children and the enrollment is Self and Family (472);
- Child reaches age 26, there are other children and/or a spouse still covered and the enrollment is Self and Family.

Name Changes

If an employee's name changes for any reason, the employing office should report the change to the carrier.

Incapable of Self-Support

Requirements

The law provides that an employee's Self and Family enrollment includes children age 26 or over who are incapable of self-support because of a physical or mental incapacity which existed before the child's 26th birthday. The disability may be permanent or temporary.

A child over age 26 may be classified incapable of self-support if:

- The incapacity is expected to continue for at least 1 year;
- The child is not capable of working at a self-supporting job due to the disability;
- The onset of the condition and the incapacity existed prior to the 26th birthday. If the onset is prior to age 26 but, the incapacity occurs at a later date, the child would not be eligible for continued coverage under the law.

Determination of Incapacity For Self-Support

There are certain medical conditions that are so severe that there would be no question that they would not abate and that they would cause children to be incapable of self-support during adulthood. If an enrollee has a child with one of these conditions, then either the carrier or the employing office would be able to extend coverage.

List of Medical Conditions That Would Cause Children to be Incapable of Self-Support During Adulthood

- AIDS - CDC classes A3, B3, C1, C2 and C3 (not seropositivity alone)
- Any malignancy with metastases or which is untreatable
- Inborn errors of metabolism with complications such as the following:
  - Phenylketonuria
  - Homocysteinuria
  - Primary hyperoxaluria
  - Adrenoleukodystrophy
  - Tay-Sachs disease
  - Nieman-Pick disease
  - Gaucher disease
  - Glycogen storage diseases
  - Mucopolysaccharide disease
  - Lesch-Nyhan disease
- Xeroderma Pigmentosa
- Ectodermal Dysplasia
- Chronic neurological disease, whatever the reason, with severe mental retardation or neurological impairment; example:
  - Encephalopathies
  - Cerebral Palsy
  - Uncontrollable Seizure Disorder
- Severe acquired or congenital Heart Disease with decompensation which is not correctable
- Severe mental illness requiring prolonged or repeated hospitalization
- Severe Juvenile Rheumatoid Arthritis
- Osteogenesis Imperfecta
- Chronic Hepatic Failure
- Chronic Renal Failure
- Severe Autism
- Severe Organic Mental Disorder
- Mental Retardation with IQ of 70 or less
- Advanced Muscular Dystrophy

The determination must be based on a medical certificate obtained by the employee at his or her own expense and submitted to:

APWU Health Plan
Attention: Enrollment Unit
P.O. Box 1358
Glen Burnie, MD 21060-1358

The medical certificate must contain:

1. Name of the child
2. Nature of the disability
3. Time length of the disability
4. Probable future course and duration of the disability
5. A statement that the child is incapable of self-support because of a physical or mental disability that existed before the child became 26 years of age and that it can be expected to continue for more than 1 year
6. Physician's signature, office name, and address

Time of Submission

Medical certificates should be submitted at least 30 days prior to the child's 26th birthday. Certificates will be accepted at the time of the initial enrollment or at any later time. The employee is not penalized for late submission.

Approval Process

Enrollment Clerks will review the documentation submitted by the enrollee. If the documentation confirms that the child has a medical condition that is on the list of medical conditions above:

1. Approve continuation of coverage
2. Notify the enrollee in writing using form letter #250A
3. Inform enrollee to take a copy of the approval notice to the employing office so that it may be included with his/her FEHB enrollment documents

If the documentation does not confirm child incapable of self-support during adulthood:

1. Notify the enrollee in writing using form letter #250B that the employing office must make the decision
2. Return the documentation to the enrollee

Processing Certain Transactions With OPM by Telephone

OPM has authorized the Health Plan to process certain transactions with OPM by telephone. A paper confirmation of these transactions is not needed.

The following transactions can be accepted by telephone:

- Reinstatement actions
- Changes/corrections of enrollment effective dates

- Transfer-in actions from agency to retirement system
- Other actions when an enrollee is awaiting medical care
- Addition of family members to a family enrollment
- Enrollment confirmations

Authorization to Process Certain Transactions Without Contacting OPM

The Health Plan may complete certain transactions independently. A paper confirmation or telephone call to OPM is not necessary for these transactions. The following transactions can be processed by the Health Plan without contacting OPM:

- Name corrections (spelling, change to married name, etc.)
- Corrections to dates of birth
- Addition of family members to a family enrollment
- Reinstatement of previously listed family members
- Corrections to Social Security Numbers

Renewal of Medical Certificate

If the medical certificate for a child is approved for a limited period of time, the enrollee is responsible for notifying APWU Health Plan and submitting a current medical certificate. The approval process is the same as above.

Benefits Received From Office of Workers' Compensation

Employees receiving Workers' Compensation benefits are eligible for health benefits. The disability may be temporary or permanent. If the disability is temporary, the employee will return to active duty.

To continue health benefits coverage while on workers' compensation the employee must have 5 years of service immediately preceding the start of compensation or all service since the employee's first opportunity to enroll. "Service" means employment during which the employee was eligible to be enrolled in a plan under the FEHB Program.

Coverage under the Uniformed Services Health Benefits Program (includes CHAMPUS) is creditable toward meeting the above requirements.

Regulations Concerning Non-pay Status

OPM issued regulations for the FEHB Program concerning payment of health benefit premiums for employees during periods of non-pay status.

The regulations require that:

- An employee in a non-pay status contribute to the cost of health benefit premiums for each pay period during which the employee's coverage continues;
- The employee make direct payments to the employing agency;
- If payment of premiums presents a financial hardship, arrangements may be made with the agency to repay the premiums upon return to a pay status;
- Enrollment terminates on the 365th day in a non-pay status;
- Employees exhausting the 365 day extension are not eligible for TCC.

An employee placed on a RIF furlough is treated the same as other employees in non-pay status for the purposes of health benefits.

Table of Permissible Changes in Enrollment for SF2809

Enrollment May Be Cancelled or Changed From Family to Self Only at Any Time

Federal Employees Receiving Premium Conversion Tax Benefits

Table of Permissible Changes in FEHB Enrollment and Premium Conversion Election

Premium Conversion allows employees who are eligible for FEHB the opportunity to pay for their share of FEHB premiums with pre-tax dollars. Premium conversion plans are governed by Section 125 of the Internal Revenue Code, and IRS rules govern when a participant may change his or her election outside of the annual Open Season. **All employees who enroll in the FEHB Program automatically receive premium conversion tax benefits**, unless they waive participation. When an employee experiences a qualifying life event (QLE) as described below, changes to the employee's FEHB coverage **(including change to self only and cancellation)** and premium conversion election may be permitted, so long as they are **because of and consistent with** the QLEs. For more information about premium conversion, please visit www.opm.gov/healthcare-insurance/healthcare.

Qualifying Life Events (QLEs) that May Permit Change in FEHB Enrollment or Premium Conversion Election		***FEHB Enrollment Change that May Be Permitted***				***Premium Conversion Election Change that May Be Permitted***		***Time Limits in which Change May Be Permitted***
Event Code	*Event*	*From Not Enrolled to Enrolled*	*From Self Only to Self and Family*	*From One Plan or Option to Another*	*Cancel or Change to Self Only*	*Participate*	*Waive*	*When you Must File Health Benefits Election form With Your Employing Office*
1	**Employee electing to receive or receiving premium conversion tax benefits**							
1A	Initial opportunity to enroll, for example: • New employee • Change from excluded position • Temporary employee who completes 1 year of service and is eligible to enroll under 5 USC 8906a	Yes	N/A	N/A	N/A	***Automatic Unless Waived***	Yes	Within 60 days after becoming eligible
1B	Open Season	Yes	Yes	Yes	Yes	Yes	Yes	As announced by OPM
1C	Change in family status that results in increase or decrease in number of eligible family members, for example: • Marriage, divorce, annulment • Birth, adoption, acquiring foster child or stepchild, issuance of court order requiring employee to provide coverage for child • Last child loses coverage, for example, child reaches age 26, disabled child becomes capable of self-support, child acquires other coverage by court order • Death of spouse of dependent	Yes	Yes	Yes	Yes	Yes	Yes	Within 60 days after change in family status
		Employees may enroll or change beginning 31 days before the event.						
1D	Any change in employee's employment status that could result in entitlement to coverage, for example: • Reemployment after a break in service of more than 3 days • Return to pay status from nonpay status, or return to receiving pay sufficient to cover premium withholdings, if coverage terminated *(If coverage did not terminate, see 1G.)*	Yes	N/A	N/A	N/A	***Automatic Unless Waived***	Yes	Within 60 days after employment status change
1E	Any change in employee's employment status that could affect cost of insurance, including: • Change from temporary appointment with eligibility for coverage under 5 USC 8906a to appointment that permits receipt of government contribution • Change from full time to part-time career or the reverse	Yes	Yes	Yes	Yes	Yes	Yes	Within 60 days after employment status change
1F	Employee restored to civilian position after serving in uniformed services.[2]	Yes	Yes	Yes	Yes	Yes	Yes	Within 60 days after return to civilian position

Table of Permissible Changes in Enrollment for SF2809 – (*continued)*

Qualifying Life Events (QLEs) that May Permit Change in FEHB Enrollment or Premium Conversion Election		***FEHB Enrollment Change that May Be Permitted***				***Premium Conversion Election Change that May Be Permitted***		***Time Limits in which Change May Be Permitted***
Event Code	*Event*	*From Not Enrolled to Enrolled*	*From Self Only to Self and Family*	*From One Plan or Option to Another*	*Cancel or Change to Self Only*	*Participate*	*Waive*	*When you Must File Health Benefits Election form With Your Employing Office*
1G	Employee, spouse or dependent: • Begins nonpay status or insufficient pay[3] or • Ends nonpay status or insufficient pay if coverage continued • *(If employee's coverage terminated, see 1D.)* • *(If spouse's or dependent's coverage terminated, see 1M.)*	No	No	No	Yes	Yes	Yes	Within 60 days after employment status change
1H	Salary of temporary employee insufficient to make withholdings for plan in which enrolled.	N/A	No	Yes	Yes	Yes	Yes	Within 60 days after receiving notice from employing office
1I	Employee (or covered family member) enrolled in FEHB health maintenance organization (HMO) moves or becomes employed outside the geographic area from which the FEHB carrier accepts enrollments or, if already outside the area, moves further from this area.[4]	N/A	Yes	Yes	N/A *(See 1M)*	No *(See 1M)*	No *(See 1M)*	Upon notifying employing office of move
1J	Transfer from post of duty within a State of the United States or the District of Columbia to post of duty outside a State of the United States or District of Columbia, or reverse.	Yes	Yes	Yes	Yes	Yes	Yes	Within 60 days of arriving at new post
		Employees may enroll or change beginning 31 days before leaving the old post of duty.						
1K	Separation from federal employment when the employee or employee's spouse is pregnant.	Yes	Yes	Yes	N/A	N/A	N/A	During employee's final pay period
1L	Employee becomes entitled to Medicare and wants to change another plan or option.[5]	No	No	Yes *(Changes may be made only once)*	N/A *(See 1M)*	N/A *(See 1M)*	N/A *(See 1M)*	Any time beginning on the 30th day before becoming eligible for Medicare
1M	Employee or eligible family member loses coverage under FEHB or another group insurance plan including the following: • Loss of coverage under another FEHB enrollment due to termination, cancellation, or change to Self Only of the covering enrollment • Loss of coverage due to termination of membership in employee organization sponsoring the FEHB plan[6] • Loss of coverage under another federally-sponsored health benefits program, including: TRICARE, Medicare, Indian Health Service • Loss of coverage under Medicaid or similar State-sponsored program of medical assistance for the needy • Loss of coverage under a non-federal health plan, including foreign, state or local government, private sector • Loss of coverage due to change in worksite or residence *(Employees in an FEHB HMO, also see 1I.)*	Yes	Yes	Yes	Yes	Yes	Yes	Within 60 days after loss of coverage
		Employees may enroll or change beginning 31 days before the event.						
1N	Loss of coverage under a non-federal group health plan because an employee moves out of the commuting area to accept another position and the employee's non-federal employed spouse terminates employment to accompany the employee.	Yes	Yes	Yes	Yes	Yes	Yes	From 31 days before the employee leaves the commuting area to 180 days after arriving in the new commuting area
1O	Employee or eligible family member loses coverage due to discontinuance in whole or part of FEHB plan.[7]	Yes	Yes	Yes	Yes	Yes	Yes	During Open Season, unless OPM sets a different time

Table of Permissible Changes in Enrollment for SF2809 – (*continued)*

Qualifying Life Events (QLEs) that May Permit Change in FEHB Enrollment or Premium Conversion Election		***FEHB Enrollment Change that May Be Permitted***				***Premium Conversion Election Change that May Be Permitted***		***Time Limits in which Change May Be Permitted***
Event Code	*Event*	*From Not Enrolled to Enrolled*	*From Self Only to Self and Family*	*From One Plan or Option to Another*	*Cancel or Change to Self Only*	*Participate*	*Waive*	*When you Must File Health Benefits Election form With Your Employing Office*
1P	Enrolled employee or eligible family member gains coverage under FEHB or another group insurance plan, including the following: • Medicare (Employees who become eligible for Medicare and want to change plans or options, see 1L.) • TRICARE for Life, due to enrollment in Medicare. • TRICARE due to change in employment status, including: (1) entry into active military service, (2) retirement form reserve military service under Chapter 67, title 10. • Health insurance acquired due to change of worksite or residence that affects eligibility for coverage • Health insurance acquired due to spouse's or dependent's change in employment status (includes state, local, or foreign government or private sector employment).[8]	No	No	No	Yes[9]	Yes	Yes	Within 60 days after QLE
1Q	Change in spouse's or dependent's coverage options under a non-federal health plan, for example: • Employer starts or stops offering a different type of coverage *(If no other coverage is available, also see 1M.)* • Change in cost of coverage • HMO adds a geographic service area that now makes spouse eligible to enroll in that HMO • HMO removes a geographic area that makes spouse ineligible for coverage under that HMO, but other plans or options are available *(If no other coverage is available, see 1M.)*	No	No	No	Yes[9]	Yes	Yes	Within 60 days after QLE
1R	Employee or eligible family member becomes eligible for assistance under Medicaid or a State Children's Health Insurance Program (CHIP).	Yes	Yes	Yes	Yes[9]	Yes	Yes	Within 60 days after the date the employee or family member becomes eligible for assistance.

(If you are a United States Postal Service Employee, these rules may be different. Consult your employing office or information provided by your agency.)

1. Employees may change to Self Only outside of Open Season only if ***the QLE caused*** the enrollee to be the last eligible family member under the FEHB enrollment. Employees may cancel enrollment outside of Open Season only if ***the QLE caused*** the enrollee and all eligible family members to acquire other health insurance coverage.
2. Employees who enter active military service are given the opportunity to terminate coverage. Termination for this reason does not count against the employee for purposes of meeting the requirements for continuing coverage after retirement. Additional information on the FEHB coverage of employees who return from active military service is available in the Frequently Asked Questions section of the FEHB website at www.opm.gov/healthcare-insurance/healthcare.
3. Employees who begin nonpay status or insufficient pay ***must*** be given an opportunity to elect to continue or terminate coverage. A termination differs from a cancellation as it allows conversion to nongroup coverage and does not count against the employee for purposes of meeting the requirements for continuing coverage after retirement.
4. This code reflects the FEHB regulation that gives employees enrolled in an FEHB HMO who ***change from Self Only to Self and Family or from one plan or option to another*** a different timeframe than that allowed under 1M. For change to Self Only, cancellation, or change in premium conversion status, see 1M.
5. This code reflects the FEHB regulation that gives employees enrolled in FEHB a one-time opportunity to change plans or options under a different timeframe than that allowed by 1P. For change to Self Only, cancellation, or change in premium conversion status, see 1P.
6. If employee's membership terminates (e.g., for failure to pay membership dues), the employee organization will notify the agency to ***terminate*** the enrollment.
7. Employee's failure to select another FEHB plan is deemed a cancellation for purposes of meeting the requirements for continuing coverage after retirement.
8. Under IRS rules, this includes start/stop of employment or nonpay status, strike or lockout, and change in worksite.
9. Employees may change to Self Only outside of Open Season only if the QLE caused all eligible family members to acquire other health insurance coverage. Employees may cancel enrollment outside of Open Season only if the QLE caused the enrollee and all eligible family members to acquire other health insurance coverage.

Table of Permissible Changes in FEHB Enrollment for Individuals Who Are Not Participating in Premium Conversion

Enrollment May Be Cancelled or Changed From Family to Self Only at Any Time

QLE's That Permit Enrollment or Change		***Change Permitted***			***Time Limits***
Event Code	*Event*	*From Not Enrolled to Enrolled*	*From Self Only to Self and Family*	*From One Plan or Option to Another*	*When You Must File Health Benefits Election Form With Your Employing Office*
2	**Annuitant (Includes Compensationers)** ***Note for enrolled survivor annuitants: A change in family status based on additional family members can only occur if the additional eligible family members are family members of the deceased employee or annuitant.***				
2A	Open Season	No	Yes	Yes	As announced by OPM.
2B	Change in family status; for example: marriage, birth or death of family member, adoption, legal separation, or divorce.	No	Yes	Yes	From 31 days before through 60 days after the event.
2C	Reenrollment of annuitant who suspended FEHB enrollment to enroll in a Medicare Advantage plan, Medicaid, a similar State-sponsored program, or to use TRICARE (including Uniformed Services Family Health Plan or TRICARE for Life), Peace Corps, or CHAMPVA, and who later ***involuntarily*** loses this coverage under one of these programs.	May Reenroll	N/A	N/A	From 31 days before through 60 days after involuntary loss of coverage.
2D	Reenrollment of annuitant who suspended FEHB enrollment to enroll in a Medicare Advantage plan, Medicaid, a similar State-sponsored program, or to use TRICARE (including Uniformed Services Family Health Plan or TRICARE for Life), Peace Corps, or CHAMPVA, and who wants to reenroll in the FEHB Program for any reason other than an involuntary loss of coverage.	May Reenroll	N/A	N/A	During Open Season.
2E	Restoration of annuity or compensation (OWCP) payments; For example: • Disability annuitant who was enrolled in FEHB, and whose annuity terminated due to restoration of earning capacity or recovery from disability, and whose annuity is restored; • Compensationer whose compensation terminated because of recovery from injury or disease and whose compensation is restored due to a recurrence of medical condition; • Surviving spouse who was covered by FEHB immediately before survivor annuity terminated because of remarriage and whose annuity is restored; • Surviving child who was covered by FEHB immediately before survivor annuity terminated because student status ended and whose survivor annuity is restored; • Surviving child who was covered by FEHB immediately before survivor annuity terminated because of marriage and whose survivor annuity is restored;	Yes	N/A	N/A	Within 60 days after the retirement system or OWCP mails a notice of insurance eligibility.
2F	Annuitant or eligible family member loses FEHB coverage due to termination, cancellation, or change to Self Only of the covering enrollment.	Yes	Yes	Yes	From 31 days before through 60 days after date of loss of coverage.
2G	Annuitant or eligible family member loses coverage under FEHB or another group insurance plan; for example: • Loss of coverage under another federally-sponsored health benefits program; • Loss of coverage due to termination of membership in the employee organization sponsoring the FEHB plan; • Loss of coverage under Medicaid or similar State-sponsored program (but see events 2C and 2D); • Loss of coverage under a non-federal health plan.	No	Yes	Yes	From 31 days before through 60 days after loss of coverage.
2H	Annuitant or eligible family member loses coverage due to the discontinuance, in whole or part, of an FEHB plan.	N/A	Yes	Yes	During Open Season, unless OPM sets a different time.
2I	Annuitant or covered family member in a Health Maintenance Organization (HMO) moves or becomes employed outside the geographic area from which the carrier accepts enrollments, or if already outside this area, moves or becomes employed further from this area.	N/A	Yes	Yes	Upon notifying the employing office of the move or change of place of employment.
2J	Employee in an overseas post of duty retires or dies.	No	Yes	Yes	Within 60 days after retirement or death.
2K	An enrolled annuitant separates from duty after serving 31 days or more in a uniformed service.	N/A	Yes	Yes	Within 60 days after separation from the uniformed service.
2L	On becoming eligible for Medicare (This change may be made only once in a lifetime.)	N/A	No	Yes	At any time beginning on the 30th day before becoming eligible for Medicare.

2M	Annuitant's annuity is insufficient to make withholding for plan in which enrolled.	N/A	No	Yes	Employing office will advise annuitant of the options.
3	**Former Spouse Under The Spouse Equity Provisions** ***Note: Former spouse may change to Self and Family only if family members are also eligible family members of the employee or annuitant.***				
3A	Initial opportunity to enroll. Former spouse must be eligible to enroll under the authority of the Civil Service Retirement Spouse Equity Act of 1984 (P.L. 98-615), as amended, the Intelligence Authorization Act of 1986 (P.L. 99-569), or the Foreign Relations Authorization Act, Fiscal Years 1988 and 1989 (P.L. 100-204).	Yes	N/A	N/A	Generally, must apply within 60 days after dissolution of marriage. However, if a retiring employee elects to provide a former spouse annuity or insurable interest annuity for the former spouse, the former spouse must apply within 60 days after OPM's notice of eligibility for FEHB. May enroll any time after employing office establishes eligibility.
3B	Open Season	No	Yes	Yes	As announced by OPM.
3C	Change in family status based on addition of family members who are eligible family members of the employee or annuitant.	No	Yes	Yes	From 31 days before through 60 days after change in family status.
3D	Reenrollment of former spouse who suspended FEHB enrollment to enroll in a Medicare Advantage plan, Medicaid, a similar State-sponsored program, or to use TRICARE (including Uniformed Services Family Health Plan or TRICARE for Life), Peace Corps, or CHAMPVA, and who later ***involuntarily*** loses this coverage under one of these programs.	May reenroll	N/A	N/A	From 31 days before through 60 days after involuntary loss of coverage.
3E	Reenrollment of annuitant who suspended FEHB enrollment to enroll in a Medicare Advantage plan, Medicaid, a similar State-sponsored program, or to use TRICARE (including Uniformed Services Family Health Plan or TRICARE for Life), Peace Corps, or CHAMPVA, and who wants to reenroll in the FEHB Program for any reason other than an involuntary loss of coverage.	May reenroll	N/A	N/A	During Open Season.
3F	Former spouse or eligible child loses FEHB coverage due to termination, cancellation, or change to Self Only of the covering enrollment.	Yes	Yes	Yes	From 31 days before through 60 days after loss of coverage.
3G	Enrolled former spouse or eligible child loses coverage under another group insurance plan; for example: • Loss of coverage under another federally-sponsored health benefits program; • Loss of coverage due to termination of membership in the employee organization sponsoring the FEHB plan; • Loss of coverage under Medicaid or similar State-sponsored program (but see 3D and 3E); • Loss of coverage under a non-federal health plan.	N/A	Yes	Yes	From 31 days before through 60 days after loss of coverage.
3H	Former spouse of eligible family member loses coverage due to the discontinuance, in whole or part, of an FEHB plan.	N/A	Yes	Yes	During Open Season, unless OPM sets a different time.
3I	Former spouse or covered family member in a Health Maintenance Organization (HMO) moves or becomes employed outside the geographic area from which the carrier accepts enrollments, or if already outside this area, moves or becomes employed further from this area.	N/A	Yes	Yes	Upon notifying the employing office of the move or change of place of employment.
3J	On becoming eligible for Medicare (This change may be made only once in a lifetime.)	N/A	No	Yes	At any time beginning the 30th day before becoming eligible for Medicare.
3K	Former spouse's annuity is insufficient to make FEHB with-holdings for plan in which enrolled.	No	No	Yes	Retirement system will advise former spouse of options.
4	**Temporary Continuation of Coverage (TCC) for Eligible Former Employees, Former Spouses and Children.** ***Note: Former spouse may change to Self and Family only if family members are also eligible family members of the employee or annuitant.***				
4A	Opportunity to enroll for continued coverage under TCC provisions: • Former employee • Former spouse • Child who ceases to qualify as a family member	Yes Yes Yes	Yes N/A N/A	Yes N/A N/A	Within 60 days after the qualifying event, or receiving notice of eligibility, whichever is later.
4B	Open Season: • Former employee • Former spouse • Child who ceases to qualify as a family member	No No No	Yes Yes Yes	Yes Yes Yes	As announced by OPM.
4C	Change in family status (except former spouse): for example, marriage, birth or death of family member, adoption, legal separation, or divorce.	No	Yes	Yes	From 31 days before through 60 days after event.
4D	Change in family status of former spouse, based on addition of family members who are eligible family members of the employee or annuitant.	No	Yes	Yes	From 31 days before through 60 days after event.
4E	Reenrollment of a former employee, former spouse, or child whose TCC enrollment was terminated because of other FEHB coverage and who lose the other FEHB coverage before the TCC period of eligibility (18 or 36 months) expires.	May reenroll	N/A	N/A	From 31 days before through 60 days after the event. Enrollment is retroactive to the date of the loss of the other FEHB coverage.
4F	Enrollee or eligible family member loses coverage under FEHB or another group insurance plan; for example:	No	Yes	Yes	From 31 days before through 60 days after loss of coverage.

	• Loss of coverage under another FEHB enrollment due to termination, cancellation, or change to Self Only of the covering enrollment (but see event 4E); • Loss of coverage under another federally- sponsored health benefits program; • Loss of coverage due to termination of membership in the employee organization sponsoring the FEHB plan; • Loss of coverage under Medicaid or similar State-sponsored program; • Loss of coverage under a non-federal health plan.				
4G	Enrollee or eligible family member loses coverage due to the discontinuance, in whole or part, of an FEHB plan.	N/A	Yes	Yes	During Open Season, unless OPM sets a different time.
4H	Enrollee or covered family member in a Health Maintenance Organization (HMO) moves or becomes employed outside the geographic area from which the carrier accepts enrollments, or if already outside this area, moves or becomes employed further from this area.	N/A	Yes	Yes	Upon notifying the employing office of the move or change of place of employment.
4I	On becoming eligible for Medicare (This change may be made only once in a life time.)	N/A	No	Yes	At any time beginning on the 30th day before becoming eligible for Medicare.
5	**Employees Who Are Not Participating in Premium Conversion**				
5A	Initial opportunity to enroll.	Yes	N/A	N/A	Within 60 days after becoming eligible.
5B	Open Season	Yes	Yes	Yes	As announced by OPM.
5C	Change in family status; for example: marriage, birth or death of family member, adoption, legal separation, or divorce	Yes	Yes	Yes	From 31 days before through 60 days after event.
5D	Change in employment status; for example: • Reemployment after a break in service of more than 3 days; • Return to pay status following loss of coverage due to expiration of 365 days of LWOP status of termination of coverage during LWOP; • Return to pay sufficient to make withholdings after termination of coverage during a period of insufficient pay; • Restoration to civilian position after serving in uniformed services; • Change from temporary appointment to appointment that entitles employee receipt of Government contribution; • Change to or from part-time career employment.	Yes	Yes	Yes	Within 60 days of employment status change.
5E	Separation from federal employment when the employee is or employee's spouse is pregnant.	Yes	Yes	Yes	Enrollment of change must occur during final pay period of employment.
5F	Transfer from a post of duty within the United States to a post of duty outside the United States, or reverse.	Yes	Yes	Yes	From 31 days before leaving old post through 60 days after arriving at new post.
5G	Employee or eligible family member loses coverage under FEHB or another group insurance plan; for example: • Loss of coverage under another FEHB enrollment due to termination, cancellation, or change to Self Only of the covering enrollment; • Loss of coverage under another federally-sponsored health benefits program; • Loss of coverage due to termination of membership in the employee organization sponsoring the FEHB plan; • Loss of coverage under Medicaid or similar State-sponsored program; • Loss of coverage under a non-federal health plan.	Yes	Yes	Yes	From 31 days before through 60 days after loss of coverage.
5H	Enrollee or eligible family member loses coverage due to the discontinuance, in whole or part, of an FEHB plan.	N/A	Yes	Yes	During Open Season, unless OPM sets a different time.
5I	Loss of coverage under a non-federal group health plan because an employee moves out of the commuting area to accept another position and the employee's non-federally employed spouse terminates employment to accompany the employee.	Yes	Yes	Yes	From 31 days before the employee leaves the commuting area through 180 days after arriving in the new commuting area.
5J	Employee or covered family member in a Health Maintenance Organization (HMO) moves or becomes employed outside the geographic area from which the carrier accepts enrollments, or if already outside the area, moves or becomes employed further from this area.	N/A	Yes	Yes	Upon notifying the employing office of the move or change of place of employment.
5K	On becoming eligible for Medicare (This change may be made only once in a lifetime.)	N/A	No	Yes	At any time beginning on the 30th day before becoming eligible for Medicare.
5L	Temporary employee completes one year of continuous service in accordance with 5 U.S.C. Section 8906a.	Yes	N/A	N/A	Within 60 days after becoming eligible.
5M	Salary of temporary employee insufficient to make withholdings for plan in which enrolled.	N/A	No	Yes	Within 60 days after receiving notice from employing office.
5N	Employee or eligible family member becomes eligible for assistance under Medicaid or a State Children's Health Insurance Program (CHIP).	Yes	Yes	Yes	Within 60 days after the date the employee or family member becomes eligible for assistance.

Glossary

Terms and Definitions

The health insurance industry, like any other industry, has a language of its own. In addition to terms familiar in the insurance industry, the Health Plan also uses standard medical terms and acronyms. This glossary will help familiarize you with terms used in this manual, during training sessions, in correspondence with the Health Plan or when speaking to Customer Service Representatives.

Term	Definition
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.
Annuitant	A person whose health insurance premiums are paid from an annuity – either a retirement annuity or a survivor's annuity.
Assignment	Your authorization for us to pay benefits directly to the provider. We reserve the right to pay you directly for all covered services.
Associate Member	A person eligible to join the Health Plan, but one who is not eligible to become an APWU dues paying member. Examples of this would be federal employees or employees of the USPS who are not eligible to become members of the APWU.
Brand Name Drug	The product name under which a drug is advertised and sold.
Brand Name Versus Generic	Generic drugs usually cost considerably less than brand name drugs even though by law they must have the same active ingredients and are subject to the same U.S. Food and Drug Administration standards for quality, strength and purity.
Brochure (or Federal Brochure or Official Brochure)	The Plan's description of benefits, limitations, exclusions, and definitions under the FEHB Program.

Term	Definition
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.
Childhood Immunization Coverage	The Plan covers immunizations for children to age 26 with no deductible, and 100% payment. The immunizations that are covered include those recommended by the American Academy of Pediatrics.
ClaimCheck	A computer software package utilized by the Health Plan to help detect fraudulent or inappropriate billing practices.
Coinsurance	Is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts.
Consumer Driven Option	A fee-for-service option under the FEHB that offers you greater control over choices of your health care expenditures. You decide what health care services will be reimbursed under the health plan funded Personal Care Account (PCA). Unused benefits from the PCA will roll over at the end of the year. If you spend the entire PCA before the end of the year, then you must satisfy a Deductible before benefits are payable under the traditional type of insurance covered by your plan. You decide whether to use in-network or out-of-network providers to reach the maximum benefit allowed under your PCA.
Coordination of Benefits (COB)	COB is a provision used by insurance companies when dealing with multiple health plans, such as Medicare or other insurance. When a plan coordinates benefits, it ensures that the multiple plans do not duplicate payments, by limiting all payments to no more than 100% of the actual charge.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services.
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 the Official Brochure.

Term	Definition
Current Procedural Terminology Code (CPT Code)	A standardized coding system used by medical providers to describe services rendered. CPT codes cover a wide range of medical services, such as doctors' visits, lab testing, x-rays and scans, surgery and therapy. Insurance companies base their payments on specific CPT codes.
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. The Health Plan determines which services are custodial care. Custodial care that last 90 days or longer is sometimes know as Long term care.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before the Health Plan pays benefits for those services. Under the *Consumer Driven Option*, your Deductible is the amount you must pay, if you have exhausted your Personal Care Account (PCA), before your Traditional Health Coverage begins.
Diagnosis Code	Numeric, or alpha-numeric codes, called ICD 9 codes, are used to specify illness or injury. ICD 9 codes are the industry standard.

Term	Definition
Durable Medical Equipment (DME)	Equipment such as a wheelchair, oxygen equipment, crutches, hospital beds or walkers. This equipment is prescribed by a doctor, is medically necessary to treat a condition, is primarily used for a medical purpose, is designed for a long period of use and has a specific therapeutic purpose. The Health Plan's Brochure lists certain items of DME that should be preauthorized prior to purchase.
Electronic Submission of Claims (ESC)	Claims that are sent to the Health Plan via electronic media (i.e., tape or modem) and not paper. The claims are received from various sources, (e.g., Medicare, PPO vendors, and Envoy, which is a claims clearinghouse that provides sign-up to have claims submitted to insurance carriers electronically). The Health Plan continually works to expand ESC capabilities. Claims received electronically are handled quickly and efficiently without human intervention.
Emergency First Aid for Accidental Injury (EFA)	Immediate care for the treatment of an injury caused by a violent, external force. EFA must take place on an outpatient basis (if the patient is admitted to a hospital, all emergency room/first aid charges fall under inpatient benefits). Service must be performed within 24 hours of the date of accident to fall within the Health Plan EFA payment constraints.
Experimental or Investigational Services	A drug, device, or biological product is experimental or investigational if the drug, device, or biological product cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time it is furnished. Approval means all forms of acceptance by the FDA. A medical treatment or procedure, or a drug, device, or biological product is experimental or investigational if 1) reliable evidence shows that it is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or 2) reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or biological product or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or

Term	Definition
	its efficacy as compared with the standard means of treatment or diagnosis. Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure. Determination of experimental/investigational status may require review by a specialty appropriate board-certified health care provider or appropriate government publications such as those of the National Institute of Health, National Cancer Institute, Food and Drug Administration, Agency of Health Care Policy & Research, and the National Library of Medicine.
Explanation of Benefits (EOB)	The Plan's statement, issued to members regarding the disposition of a claim that was submitted to the Health Plan. The EOB identifies the patient, provider of service, type of service and how the Plan handled the charge(s).
Express Scripts	The Health Plan vendor that administers the High Option Mail order drug program and the Retail Pharmacy Network.
Federal Employees Health Benefits Program (FEHBP)	A federal health insurance program that offers federal and postal employees and retirees access to health insurance. The APWU Health Plan is one of hundreds of plans in the FEHB Program.
Flexible Benefits Option	Under the High Option, the Plan's authority to determine the most effective way to provide needed medical services to the member. The Plan has the authority to allow medically appropriate alternatives to traditional medical care and coordinate the provisions of Plan benefits as a less costly alternative benefit. This means that the Plan can allow usually non-covered services and supplies to be paid in lieu of more costly services that would provide the same basic benefit to a member. An example of this would be the Plan allowing a stay in a Skilled Nursing Facility (normally non-covered) in lieu of an inpatient hospital stay. Services under the Flexible Benefits

Term	Definition
	Option are subject to ongoing review and discretion by the Plan, and alternative benefits may be withdrawn at any time. Approval of alternative benefits is not a guarantee of future alternative benefits, and this decision may not be disputed with OPM.
Generic Drug	A non-name brand drug. Generic drugs are less costly than name brand drugs even though, by law, they must have the same active ingredients and are equal in strength, effectiveness, purity and safety.
Generic Equivalent	By law, the active ingredients in generic medications must be the same as in brand medications. Generic drugs, by law, are equal in strength, quality and purity as their brand counterparts.
Genetic Screening	The diagnosis, prognosis, management, and prevention of genetic disease for those patients who have no current evidence or manifestation of a genetic disease and those who have not been determined to have an inheritable risk of genetic disease.
Genetic Testing	The diagnosis and management of genetic disease for those patients with current signs and symptoms and for those who we have determined have an inheritable risk of genetic disease.
Global Fee	A single fee for a total medical service that encompasses multiple services. A well-known example of a global fee is the charge for delivering a child. The single global fee encompasses pre-natal and post-natal care, as well as the delivery charge.
Group Health Coverage	Health care coverage that a member is eligible for because of employment by, membership in, or connection with, a particular organization or group that provides payment for hospital, medical, or other health care services or supplies, or that pays a specific amount for each day or period of hospitalization if that specified amount exceeds $200 per day, including extension of any of these benefits through COBRA.
Habilitative Care	Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy

Term	Definition
	for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.
Health Care Professional	A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.
Health Maintenance Organization (HMO)	A health plan that provides coordinated care through a network of physicians and hospitals located in particular geographic or service areas. You usually must get all your care from the providers that are part of the plan.
Health Plan Representative (HPR)	An elected or appointed official from an APWU State or Local Organization, whose job is to promote the Health Plan. HPRs are resources to Health Plan members. HPRs answer member questions, intervene with the Health Plan on the member's behalf, and interpret or explain benefits and provisions in the Plan's Brochure.
Health Risk Assessment	Health risk assessment is a systematic approach to collecting information from individuals that identifies risk factors, provides individualized feedback, and links the person with at least one intervention to promote health, sustain function and/or prevent disease.
HEALTHsuite	The Health Plan's claims processing system.
High Option	A fee-for-service plan in the FEHB. You can choose your own physicians, hospitals, and other health care providers. The Health Plan reimburses you or your provider for covered services, usually based on a percentage of the amount the Health Plan allows. The High Option offers services through PPO networks. When you use the Health Plan's network providers, you receive covered services at a reduced cost.
HIPAA	The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is legislation passed by Congress to protect the privacy of medical information. It requires all health plans to take measures to protect personal health information about its members (eff. April 14, 2003).

Term	Definition
Home Health Care Agency	An agency which meets all of the following: • is primarily engaged in providing, and is duly licensed or certified to provide, skilled nursing care and therapeutic services; • has policies established by a professional group associated with the agency or organization. This professional group must include at least one registered nurse (R.N.) to direct the services provided and it must provide for full-time supervision of each service by a physician or registered nurse; • maintains a complete medical record on each individual; and • has a full-time administrator.
Hospice Care Program	A coordinated program of home and inpatient palliative and supportive care for the terminally ill patient and the patient's family provided by a medically supervised specialized team under the direction of a duly licensed or certified Hospice Care Program.
ICD-9 Code	See "Diagnosis Code."
Immediate Care Prescription	For Plan purposes, an immediate care prescription is the first filling of a prescription (for up to a 30 day supply), and the initial refill (again, for up to a 30 day supply). After the first filling and the initial refill at a retail pharmacy, any further dispensing of that prescription should be handled through the Mail order pharmacy to receive the maximum Plan benefit.
Incidental Procedure	A surgical procedure that is not medically indicated or necessary, but which is done in conjunction with a medically necessary procedure. An example of this would be a patient having his appendix removed during gall bladder surgery.
Mail order drug	A prescription drug used on a regular basis should be ordered through the Mail order drug program.
Maintenance Therapy	Includes but is not limited to physical, occupational, or speech therapy where continued therapy is not expected to result in

Term	Definition
	significant restoration of a bodily function but is utilized to maintain the current status.
Major Procedure	The primary reason for surgery. May be performed with a lesser, or secondary procedure(s). The major procedure will be considered at a higher percentage of the Plan's reasonable and customary allowance.
Medical Emergency	The sudden and unexpected onset of a serious, possibly life-threatening condition requiring immediate care. Examples of true medical emergencies would include loss of consciousness, difficulty breathing, poisoning, severe bleeding or chest pain. Treatment at an emergency room must take place within 24 hours of the onset of the condition.
Medical Justification	Medical documents and records, such as operative notes, office records, progress notes, etc., that justify the medical necessity of a procedure or treatment.
Medically Necessary	Services, drugs, supplies or equipment provided by a hospital or covered provider of health care services that we determine: • are appropriate to diagnose or treat the patient's condition, illness or injury; • are consistent with standards of good medical practice in the United States; are not primarily for the personal comfort or convenience of the patient, the family, or the provider; • are not a part of or associated with the scholastic education or vocational training of the patient; and • 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.
Medicare	Health insurance for aged and certain disabled individuals. Part A of Medicare (Hospital Insurance) is premium-free to individuals who qualify. It covers hospital services, skilled nursing facilities and other types of charges. Part B (Supplemental Medical Insurance) has a monthly premium, and covers many outpatient charges and professional fees. Medicare Part D covers prescription drugs. Medicare is

Term	Definition
	sponsored by the federal government. The Health Plan coordinates its benefits with Medicare to ensure correct payment of charges.
Medicare Summary Notice (MSN)	Medicare's statement regarding the disposition of a claim. The MSN identifies the patient, provider of service, type of service and how Medicare handled the charge(s).
Modifier	An additional two character code that can be used to further define a medical service. Modifiers are used in conjunction with CPT, or type of service codes.
Non-Preferred Provider (Non-PPO)	A doctor, hospital or other health care professional that **does not** participate with any of the Health Plan's Preferred Provider networks. The benefits that a member sees by going to a Preferred Provider (discount, higher rate of payment, automatic claims filing) would not apply to this type of provider.
Office of Personnel Management (OPM)	The federal agency that oversees the FEHB Program. OPM dictates, to a large extent, what benefits can and cannot be covered. OPM also sets the procedures for establishing premium rates. The Health Plan has to coordinate with OPM regarding its benefits package, premiums and how the benefits are administered. The Health Plan also has to comply with OPM mandates.
OptumRx	The Health Plan vendor that administers the Consumer Driven Option Mail order drug program and the Retail Pharmacy Network.
Out-of-Pocket Maximums (OOP)	The maximum amount of coinsurance, copayments and deductibles a member must pay, prior to the Health Plan paying charges at 100% of allowance for the balance of the calendar year. The Health Plan has separate out-of-pocket maximums for Preferred Providers and out-of-network providers.
Personal Care Account (PCA)	Under the Consumer Driven Option, your Personal Care Account (PCA) is an established benefit amount which is available for you to use first to pay for covered hospital, medical, dental and vision care expenses. You determine how your PCA will be spent and any unused amount at the end of

Term	Definition
	the year may be rolled over to increase your available PCA in the subsequent years.
Personal Health Summary (PHS)	The Plan's statement, issued to members regarding the disposition of claims that were submitted to the Health Plan. The PHS identifies the patient, provider of service, type of service and how the Plan handled the charge(s).
Personal Representative	The individual(s) you name as your personal representative(s) can be a family member, friend, attorney or unrelated party and will have access to your protected health information (PHI), including diagnoses, medical procedures, medications, treating providers, and information such as your date of birth and address.
Plan Allowance	The Plan allowance is the amount used to determine payment and coinsurance for covered services. Fee-for-service plans determine their allowances in different ways. The Health Plan determines our allowance as follows: For PPO providers, our allowance is based on negotiated rates. PPO providers always accept the Plan's allowance as their charge for covered services. For non-PPO providers, we base the Plan allowance on the lesser of the provider's actual charge or the reasonable and customary charge for the service you received. We determine the reasonable and customary allowance 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 the Health Insurance Association of America (HIAA) and apply these guides at the 70th percentile (High Option) or 80th percentile (Consumer Driven Option). We update these charges guides at least once each year. If HIAA information is not available, we will use other credible sources including our own data.
Preferred Provider Organization (PPO)	A group of doctors, hospitals and other health care professionals who have agreed to accept pre-negotiated (discounted) fees for their services on behalf of Health Plan members. When a member selects a Preferred Provider, the Health Plan pays charges at a higher payment rate. Claims are

Term	Definition
	automatically sent to the Health Plan for payment. The use of Preferred Providers is voluntary.
Primary Care Physician	A physician, such as an internist or family practice physician, who helps decide the course of a patient's medical care.
Primary Plan	The health insurance carrier that pays first, when a patient has coverage with multiple health plans.
Rehabilitative Care	Treatment that reasonably can be expected to restore and/or substantially restore a bodily function that was impaired as a result of trauma or disease.
Residential Treatment Center (RTC)	A Residential Treatment Center (RTC), sometimes called a rehab, is a live-in healthcare facility providing therapy for substance abuse, mental illness, or other behavioral problems.
Retail Drug	A prescription drug that you need immediately can be purchased at a participating retail pharmacy.
Revenue Code	A type of service code used on inpatient hospital bills. Revenue codes break down inpatient and outpatient hospital services, such as semiprivate room, laboratory charges, blood services, operating room, etc.
Secondary or Lesser Procedure	A surgical procedure done in conjunction with a major or primary procedure. The secondary procedure is considered at 50% of reasonable and customary.
Secondary Plan	The health insurance carrier that pays second, when a patient has coverage with multiple health plans.
Standard Medical Practice	Procedures and services, for a given condition, endorsed by members of the American Medical Association, and accepted by Medicare.
Subrogation or Subrogation Rights	The right of the Health Plan to seek reimbursement for money paid, on behalf of an enrollee, for which a third party is responsible. For example, if a member falls in a store and breaks a leg, and the store makes a cash settlement with the person that includes restitution for medical treatment, the Health Plan has a right to seek reimbursement for charges that

Term	Definition
	it paid related to the injury. This theory can apply to Workers' Compensation cases and automobile accidents.
Tertiary Plan	The health insurance carrier that pays last, when a patient has coverage with 3 group health plans or when there are 2 group health plans and Medicare.
Traditional Benefit or Traditional Payment Rate	The non-PPO rate of payment for a specific charge. This rate of payment is based on the Health Plan's reasonable and customary allowance.
Urgent Care Claims	A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts: • Waiting could seriously jeopardize your life or health; • Waiting could seriously jeopardize your ability to regain maximum function; or • In the opinion of a physician with knowledge of your medical condition, waiting would subject you to server pain that cannot be adequately managed without the care or treatment that is the subject of the claim. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses and average knowledge of health and medicine. If you believe your claim qualifies as an urgent care claim, you should notify us when you submit the claim. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.
Virtual Visits	A virtual visit lets you see and talk to a doctor from your phone, tablet or computer. A doctor can see and speak to you about minor medical concerns, provide a diagnosis and, if appropriate, a prescription can be sent to your local pharmacy.
Web Page	A term used to describe a particular page on a company's website.
Website	This term describes a company's, user's or organization's Web pages. The Health Plan's Web address is www.apwuhp.com.

Term	Definition
Well Child Benefit	A benefit offered to members of the High Option who have children age 12 or younger. This is a multi-tiered benefit, with the payout based on the age of the child and/or whether a Preferred Provider is used. The PPO benefit has no deductible, charges are paid at 100% and there is no annual maximum payout, up through age 12. If a non-PPO provider is used for services, there is no deductible and charges are paid at 100% of the Plan's allowance. There are annual maximums with a non-PPO provider. For children from birth through age 3, the annual maximum is $250 per child. From age 4 through 12, the annual maximum is $150 per child.

Insurance Abbreviations

Abbreviation	Meaning
A&H	Accident & Health
AD&D	Accidental Death & Dismemberment
AI	Accidental Injury
APS	Attending Physician's Statement (Doctor's Report)
B/MM	Basic & Major Medical (Supplemental)
BI	Bodily Injury
CAP	Common Accident Provision
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CMM	Comprehensive Major Medical
COB	Coordination of Benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act
CPT	Current Procedural Terminology
CRVS	California Relative Value Study
CY	Calendar Year
DC	Double Coverage
DCI	Double Coverage Inquiry
DI	Disability Insurance. Disability Income (U.S.)
DME	Durable Medical Equipment
DOA	Date of Accident

Abbreviation	Meaning
DOB	Date of Birth
DRG	Diagnostic Related Groups
DSM	Diagnostic and Statistical Manual of Mental Disorders
ECF	Extended Care Facility
EE	Enrollee or Employee
EOB	Explanation of Benefits
ERISA	Employee Retirement Income Security Act
FDA	Food and Drug Administration (U.S.)
FEHBA	Federal Employees Health Benefits Act
FEHBP	Federal Employees Health Benefits Program
FFS	Fee for Service
FPM	Federal Personnel Manual
GAO	General Accounting Office (U.S.)
GHAA	Group Health Association of America
GPP	Group Practice Plan
HCF	Health Care Foundation
HCFA	Health Care Financing Administration (U.S.)
HCPCS	HCFA Common Procedural Coding System
HHCA	Home Health Care Agency
HHS	Health and Human Services (Dept. of)
HIAA	Health Insurance Association of America

Abbreviation	Meaning
HIC	Health Insurance Council
HM	Hospital Miscellaneous
HMO	Health Maintenance Organization
ICA	International Claim Association
ICD	International Classification of Diseases
IME	Independent Medical Examination
IOD	Injury on Duty
IPA	Independent Practice Association
IPP	Individual Practice Plan
LOMA	Life Office Management Association
LOS	Length of Stay
LTC	Long Term Care
LTD	Long Term Disability
ME	Medical Examination
MM (E)	Major Medical (Expense)
NAIC	National Association of Insurance Commissioners
NHC	National Health Council
NOC	Notice of Claim
OBD	Order of Benefit Determination
OBRA	Omnibus Budget Reconciliation Act
OOP	Out-of-Pocket

Abbreviation	Meaning
OPM	Office of Personnel Management (U.S.)
OWCP	Office of Workers' Compensation Program
PDN	Private Duty Nursing
PDR	Physicians' Desk Reference
PHS	Public Health Service (U.S.)
PIP	Personal Income Protection (No-Fault Automobile)
POL	Proof of Loss
PPO	Preferred Provider Organization
PSRO	Professional Standards Review Organization
R&B	Room & Board
R&C	Reasonable & Customary
RCAF	Reasonable & Commonly Accepted Fee
RVS	Relative Value Study
SMM	Supplemental Major Medical
SNF	Skilled Nursing Facility
SSA	Social Security Administration (U.S.)
SSN	Social Security Number
STD	Short Term Disability
TEFRA	Tax Equity and Fiscal Responsibility Act
TPA	Third Party Administrator
UB-82	Uniform Billing, 1982 (form)

Abbreviation	Meaning
UCR	Usual, Customary and Reasonable
URC	Utilization Review Committee
USF	Uniform Services Facilities
USHBP	Uniformed Services Health Benefits Program
VA	Veterans Administration (U.S.)
WHO	World Health Organization
WP	Waiting Period

Medical Practitioners

The contract with OPM (Office of Personnel Management) lists several types of medical/dental/mental practitioners that are covered by the Plan (see Definitions - Covered Providers). The fact that a listed practitioner performs a service does not, of itself, make the service covered. To qualify for benefits, the practitioner must (1) be licensed by the state where practicing, (2) perform a service permitted by that license and (3) perform a service covered by the Plan.

Degree	Meaning
A.C.P.	Advanced Clinical Practitioner
A.C. S.W.	Academy of Certified Social Workers
B.S.N.	Bachelor of Science in Nursing
C.C.D.N.	Certified Chemical Dependency Nurse
C.C.D.P.	Certified Chemical Dependency Practitioner
C.C.D.T.	Certified Chemical Dependency Therapist
C.D.N.	Chemical Dependency Nurse
C.D.S.	Chemical Dependency Specialist
C.N.S.	Clinical Nurse Specialist
C.N.T.	Clinical Nurse Therapist
C.R.N.A.	Certified Registered Nurse Anesthetist
C.S.	Clinical Specialist
C.S.P.	Certified School Psychologist
C. S.W.	Certified Social Worker
C. S.W. - A.C.P.	Certified Social Worker - Advanced Clinical Practitioner

Degree	Meaning
D.C.	Doctor of Chiropractic (MUA only)
D.D.S.	Doctor of Dental Surgery
D.Ed.	Doctor of Education (Psychology)
D.M.	Doctor of Mechanotherapy (MUA only)
D.M.D.	Doctor of Medical Dentistry
D.O.	Doctor of Osteopathy
D.P.M.	Doctor of Podiatric Medicine
D.S.C.	Doctor of Surgical Chiropody (Podiatrist)
D.S.W.	Doctor of Social Work
Ed. D.	Doctor of Education (Psychology)
G.N.P.-C	Geriatric Nurse Practitioner - Certified
L.C.S.W.	Licensed Clinical Social Worker
L.I.C.S.W.	Licensed Independent Clinical Social Worker
L.P.N.	Licensed Practical Nurse
L.P.T.	Licensed Physical Therapist
L.S.W.	Licensed Social Worker
L.V.N.	Licensed Vocational Nurse
M.D.	Doctor of Medicine
M.D.S.	Dental Surgeon
M.S.N.	Master of Science in Nursing
M.S.S.W.	Master of Science & Social Work

Degree	Meaning
M.S.W.	Master of Social Work
N.D.	Doctor of Naturopathy (MUA only)
N.M.W.	Nurse Midwife
N.P.	Nurse Practitioner
O.D.	Doctor of Optometry
O.T.	Occupational Therapist
O.T.R.	Registered Occupational Therapist
O.T.R./L.	Licensed Registered Occupational Therapist
P.A.	Physician Assistant
Ph.D	Doctor of Philosophy (Psychology)
Psy.D	Doctor of Psychology
P.T.	Physical Therapist
R.D.H.	Registered Dental Hygienist
R.N.	Registered Nurse
R.N.C.	Certified Registered Nurse
R.N.C.D.	Registered Nurse - Chemical Dependency
R.N.C.S.	Registered Nurse - Certified Specialist
R.P.T.	Registered Physical Therapist
R.S.T.(P.)	Registered Speech Therapist (Pathologist)

Educational degrees which do not necessarily indicate a medical practitioner, are excluded or would only be covered in a Medically Underserved Area when licensed:

Degree	Meaning
A.T.R.	Activities Therapist Registered
B.S.	Bachelor of Science
B.S.W.	Bachelor in Science Work
C.A.C.	Certified Addiction Counselor
C.A.D.A.C.	Certified Alcohol & Drug Abuse Counselor
C.A.D.C.	Certified Alcohol & Drug Counselor
C.A.S.	Certified Alcoholism Specialist
C.C.C.	Certified Christian Counselor
C.C.D.C.	Certified Chemical Dependency Counselor
C.E.D.T.	Certified Eating Disorder Therapist
C.P.C.	Certified Professional Counselor
C.R.P.S.	Certified Relapse Prevention Specialist
C.S.	Certified Specialist
C.S.A.C.	Certified Substance Abuse Counselor
C.T.R.S.	Certified Therapeutic Recreation Specialist
D.Div.	Doctor of Divinity
E.D.S.	Educational Development Specialist
L.D.	Licensed Dietician
L.M.H.C.	Licensed Mental Health Counselor

Degree	Meaning
L.P.C.	Licensed Professional Counselor
M.A.	Master of Arts (Psychology)
M.C.	Master in Counseling
M. Div.	Master of Divinity
M. E(d).	Master of Education (Psychology)
M.F.C.C.	Marriage & Family Child Counselor
M.F.T.	Marriage & Family Therapist
M.H.S.	Marriage of Human Service
M.M.F.T.	Master in Marriage & Family Therapy
M.P.H.	Master of Public Health
M.S.	Master of Science (Psychology)
M. Tr.	Master of Theology
N.N.C.	National Certified Counselor
P.C.	Pastoral Counselor
R.D.	Registered Dietician
R.D.L.D.	Registered Dietician Licensed Dietician
R.T.R.	Recreational Therapist Registered
Sp. Ed.	Special Education (Teacher)
S.W.	Social Worker