High Option
Advanced Track



APWU HEALTH PLAN
TOGETHER. BETTER HEALTH.®

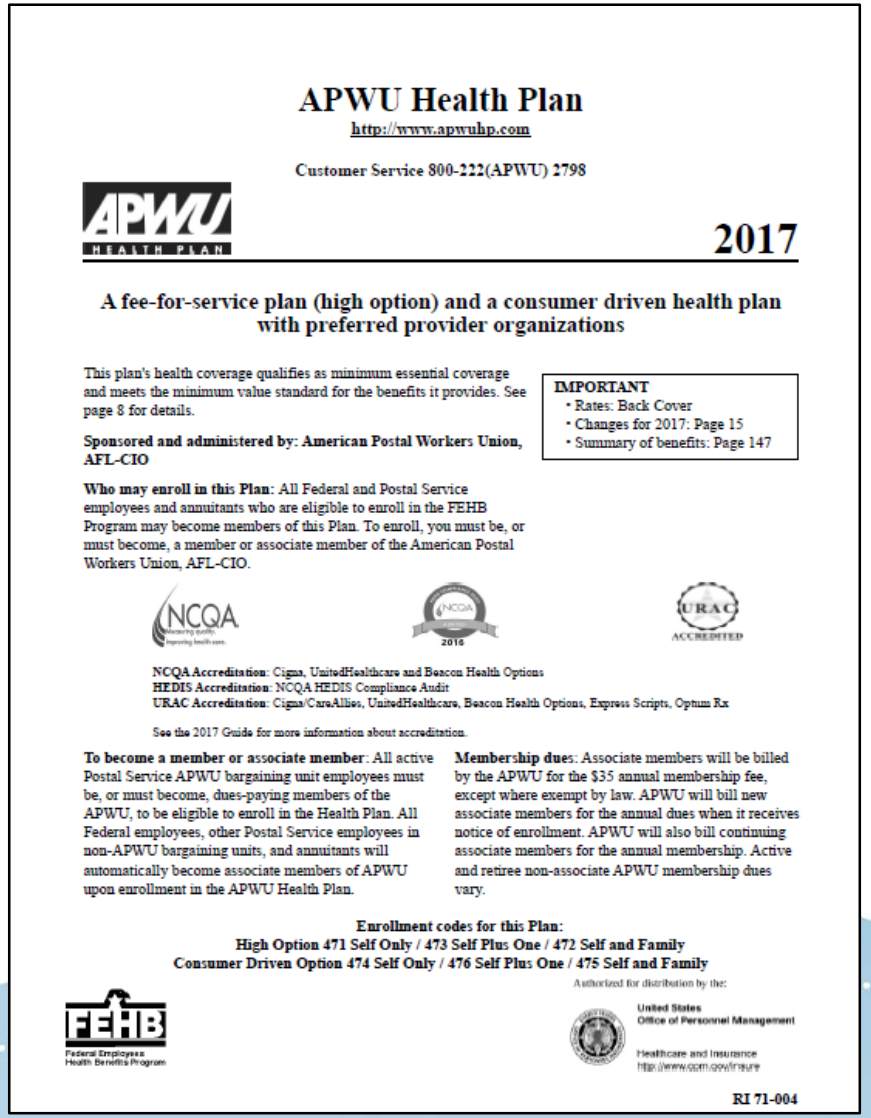
31st Annual Open Season Seminar

Today's Agenda

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

If this…

Then that…



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

Customer Service 800-222(APWU) 2798

APWU HEALTH PLAN

2017

A fee-for-service plan (high option) and a consumer driven health plan with preferred provider organizations

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 8 for details.

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

Sponsored and administered by: American Postal Workers Union, AFL-CIO

Who may enroll in this Plan: All Federal and Postal Service employees and annuitants who are eligible to enroll in the FEHB Program may become members of this Plan. To enroll, you must be, or must become, a member or associate member of the American Postal Workers Union, AFL-CIO.

NCQA 2016 URAC ACCREDITED

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

See the 2017 Guide for more information about accreditation.

To become a member or associate member: All active Postal Service APWU bargaining unit employees must be, or must become, dues-paying members of the APWU, to be eligible to enroll in the Health Plan. All Federal employees, other Postal Service employees in non-APWU bargaining units, and annuitants will automatically become associate members of APWU upon enrollment in the APWU Health Plan.

Membership dues: Associate members will be billed by the APWU for the $35 annual membership fee, except where exempt by law. APWU will bill new associate members for the annual dues when it receives notice of enrollment. APWU will also bill continuing associate members for the annual membership. Active and retiree non-associate APWU membership dues vary.

Enrollment codes for this Plan:
High Option 471 Self Only / 473 Self Plus One / 472 Self and Family
Consumer Driven Option 474 Self Only / 476 Self Plus One / 475 Self and Family

Authorized for distribution by the:

FEHB Federal Employees Health Benefits Program

United States Office of Personnel Management
Healthcare and Insurance
http://www.opm.gov/insure

RI 71-004

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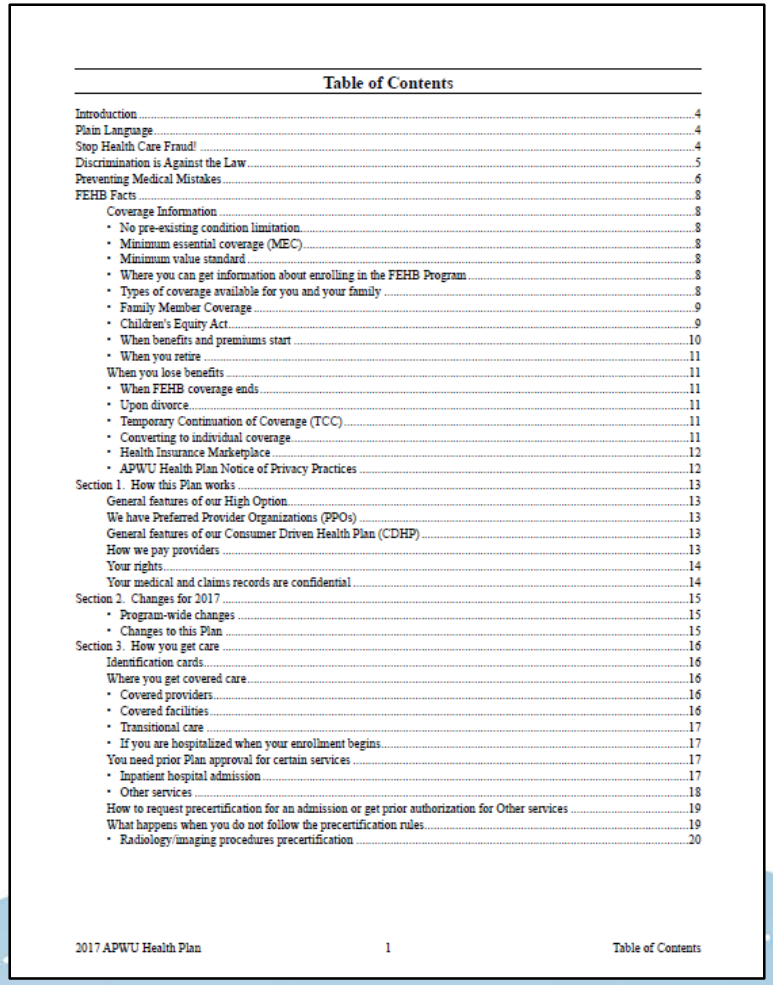
- Introduction/FEHB Facts
- Section 1: How this Plan works
- Section 2: Changes for 2017
- Section 3: How to get care
- Section 4: Your Costs for covered services
- Section 5: Benefits



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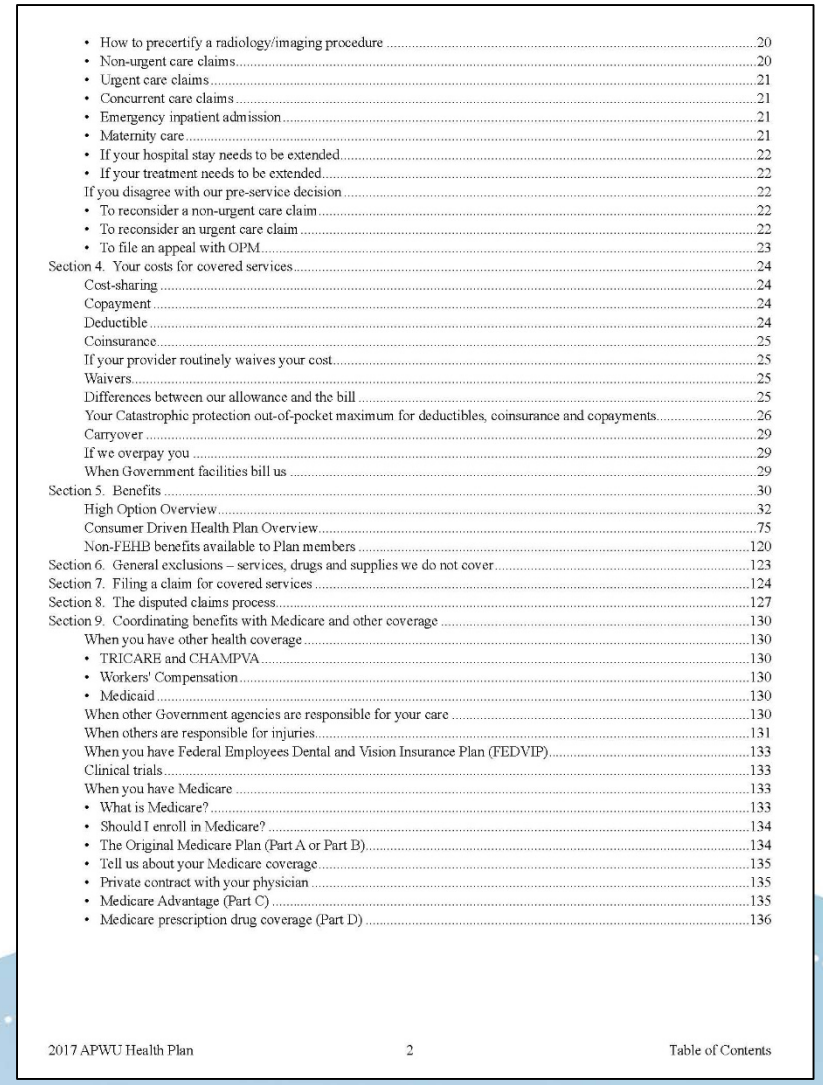

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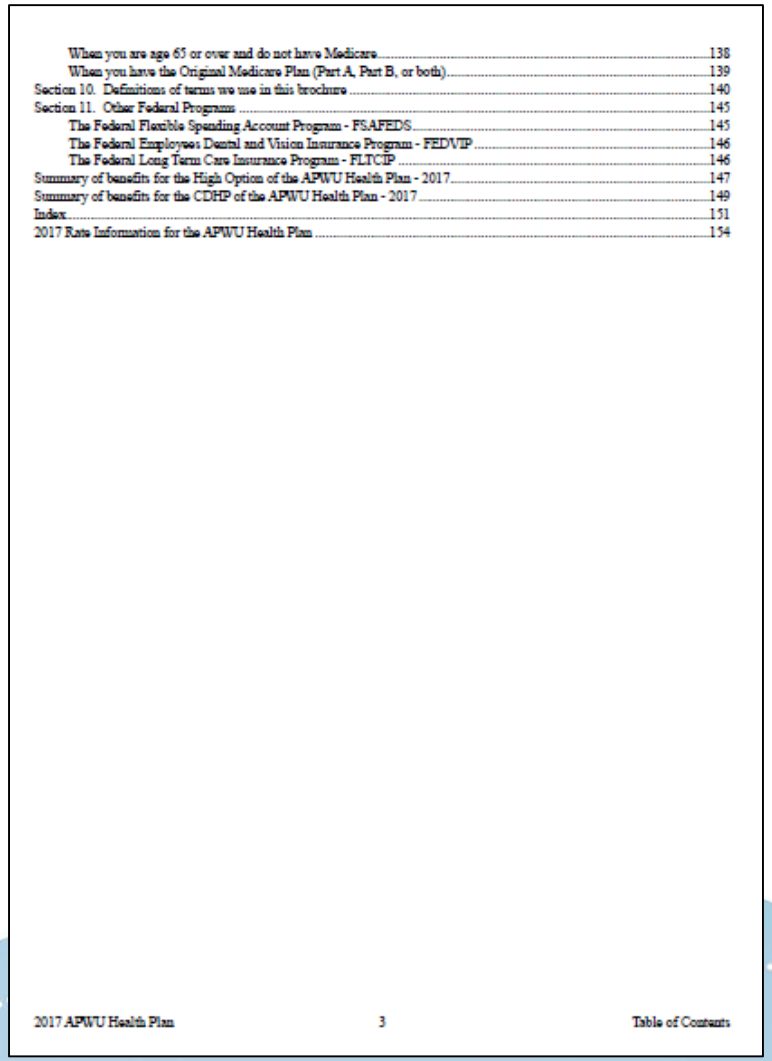

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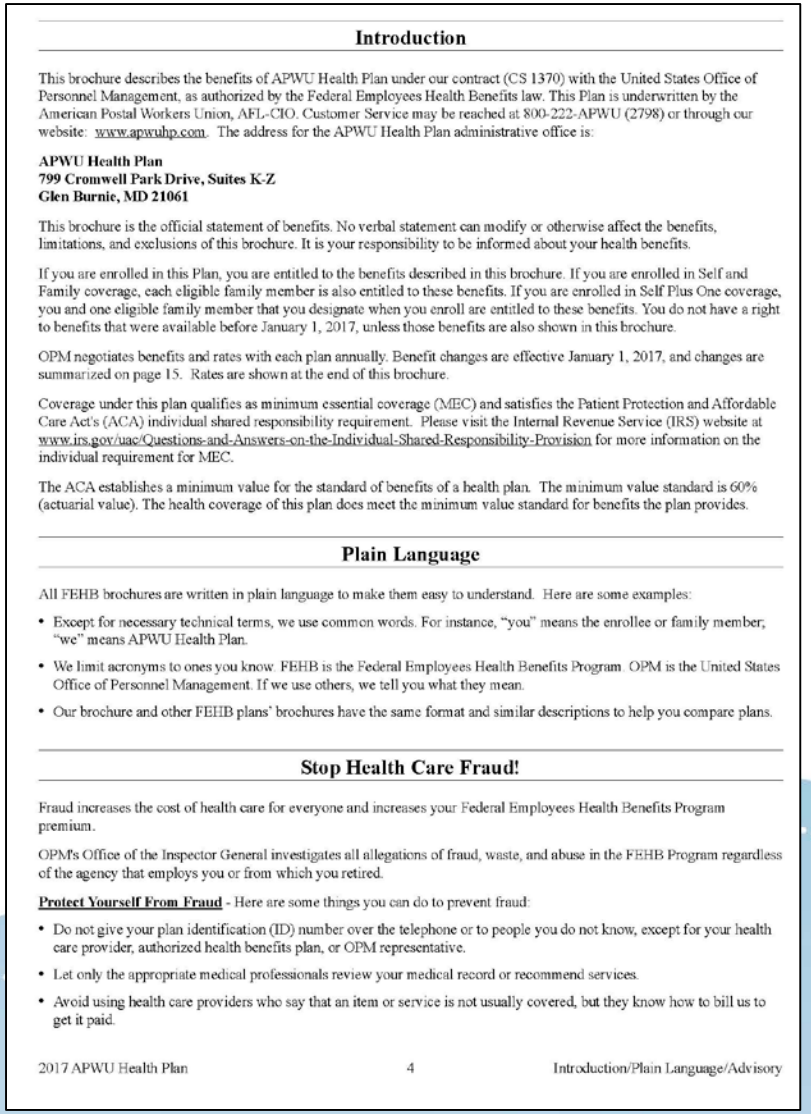
Introduction/Health Care Fraud

(Pgs 4-12)

- Health Plan Address
- Fraud
- Never Events
- Patient Safety
- FEHB Facts
- Who's covered and when?



Introduction

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

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

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

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

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

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

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

Plain Language

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

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

Stop Health Care Fraud!

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

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

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

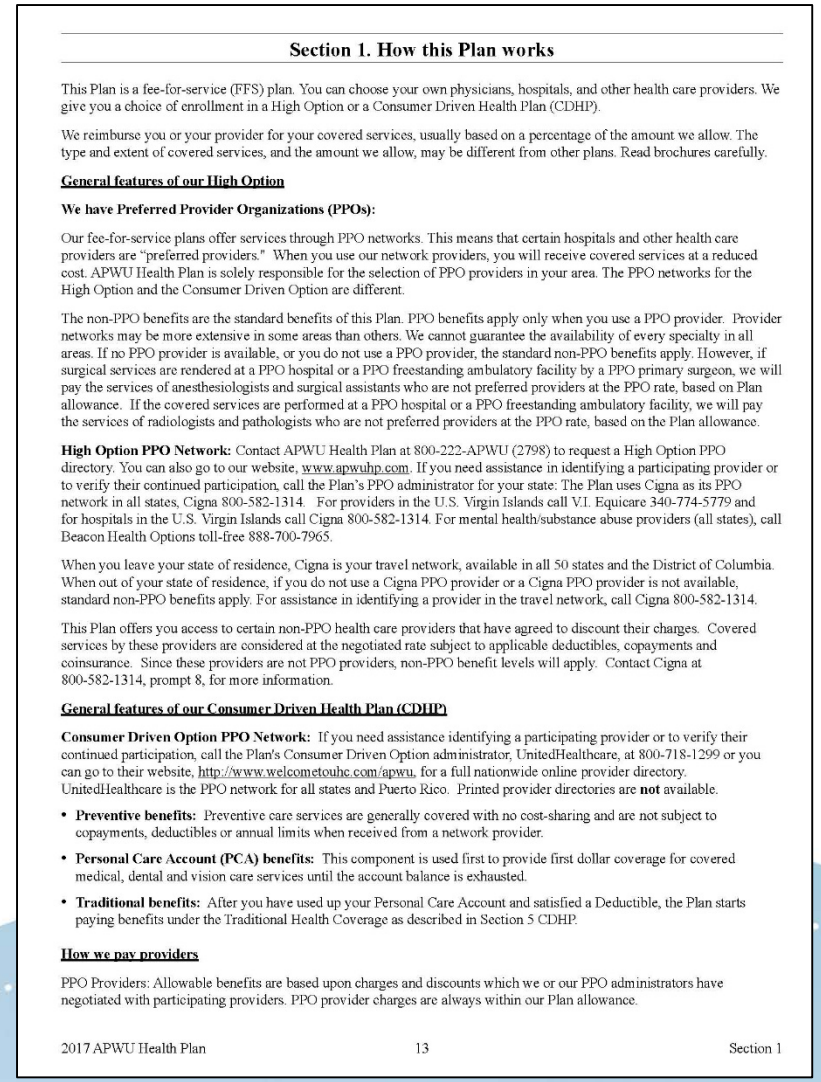
- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care provider, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid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

2017 APWU Health Plan 4 Introduction/Plain Language/Advisory

Section 1: How this Plan works (Pg 13)

PPO Network

- High Option:
  - Directory online at: **www.apwuhp.com**
  - Prompts to filter your search results
    - Provider Type
    - Specialty
    - Facility Type
    - Distance from home/work
  - Call APWU Health Plan to request directory



Section 1. How this Plan works

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

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

General features of our High Option

We have Preferred Provider Organizations (PPOs):

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

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

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

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

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

General features of our Consumer Driven Health Plan (CDHP)

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

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

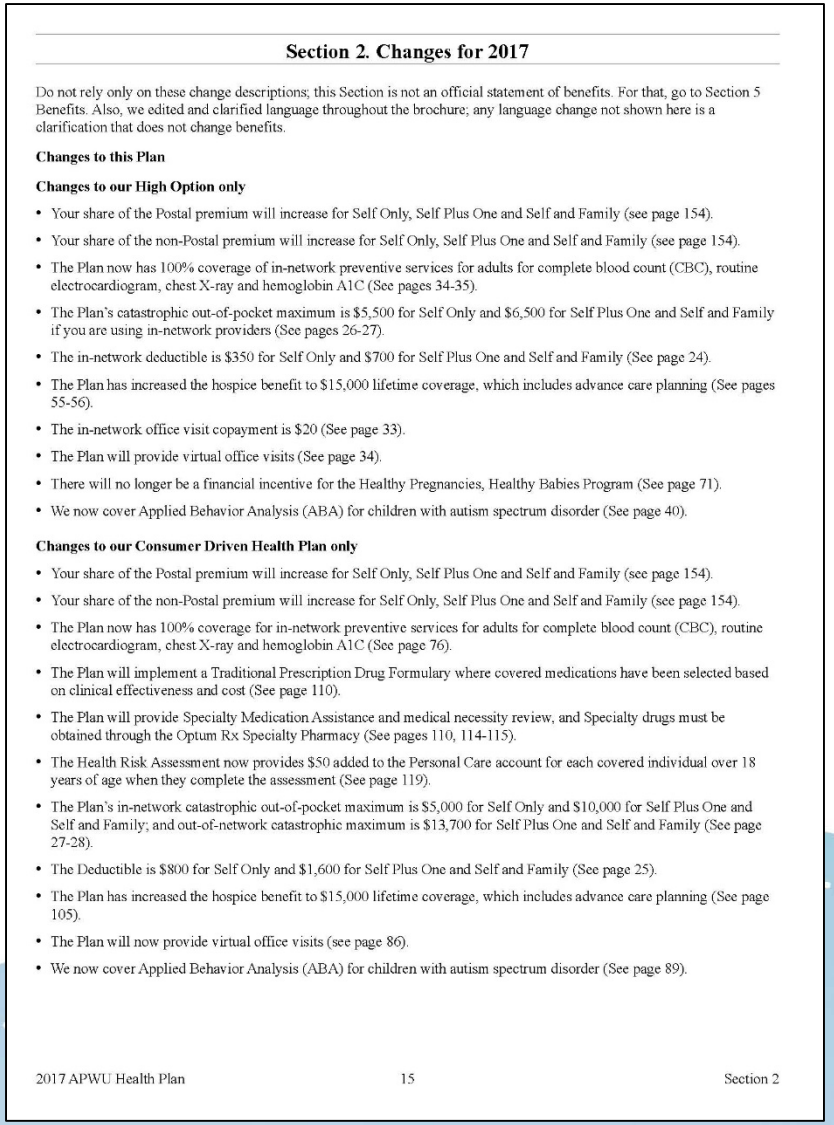
How we pay providers

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

2017 APWU Health Plan 13 Section 1

Section 2: Changes for 2017 (Pg 15)

- **High Option Changes**
  - Applied Behavioral Analysis (ABA)
  - Additional preventive services at 100%
  - In-network office visit copay is $20
  - Virtual office visits; $20 copay



Section 2. Changes for 2017

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

Changes to this Plan

Changes to our High Option only

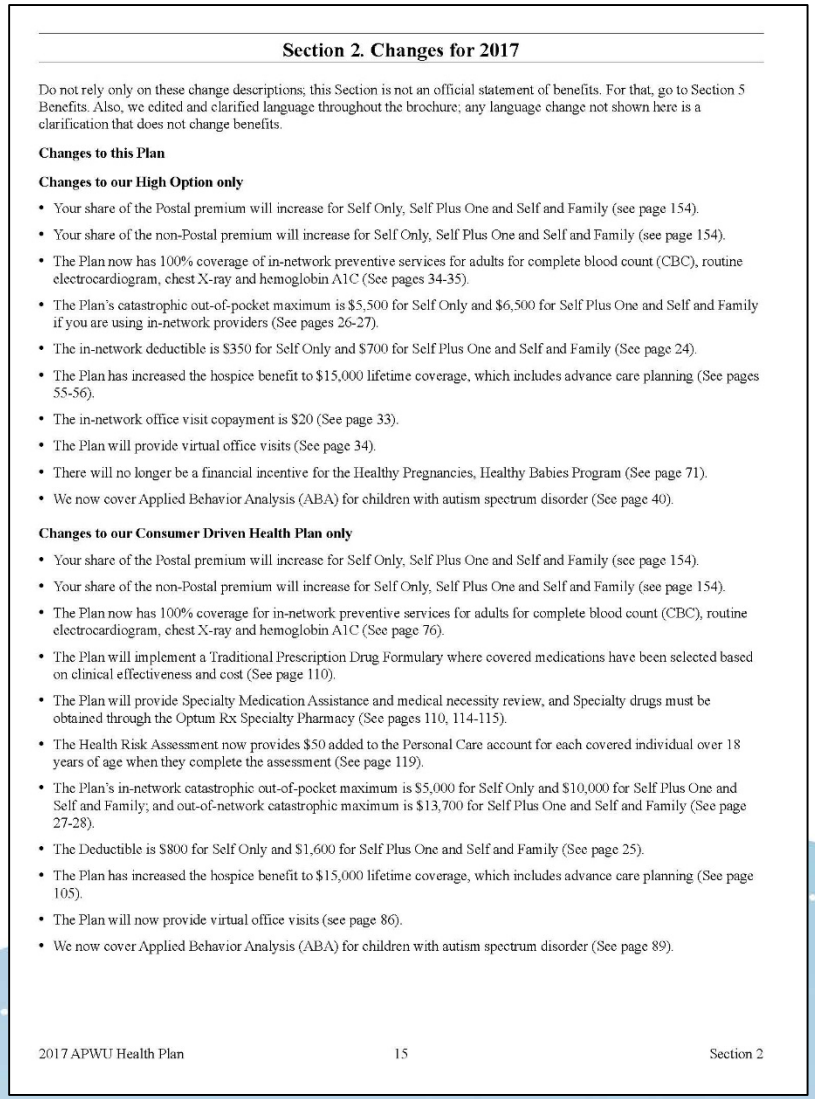
- Your share of the Postal premium will increase for Self Only, Self Plus One and Self and Family (see page 154).
- Your share of the non-Postal premium will increase for Self Only, Self Plus One and Self and Family (see page 154).
- The Plan now has 100% coverage of in-network preventive services for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

Changes to our Consumer Driven Health Plan only

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

Section 2: Changes for 2017 *(cont.)*

- **High Option Changes**
  - In-network deductible increase:
    - $350 Self Only
    - $700 Self Plus One/Self and Family
  - In-network maximum out-of-pocket increase:
    - $5,500 Self Only
    - $6,500 Self Plus One/Family
  - Hospice coverage increase to $15,000 lifetime



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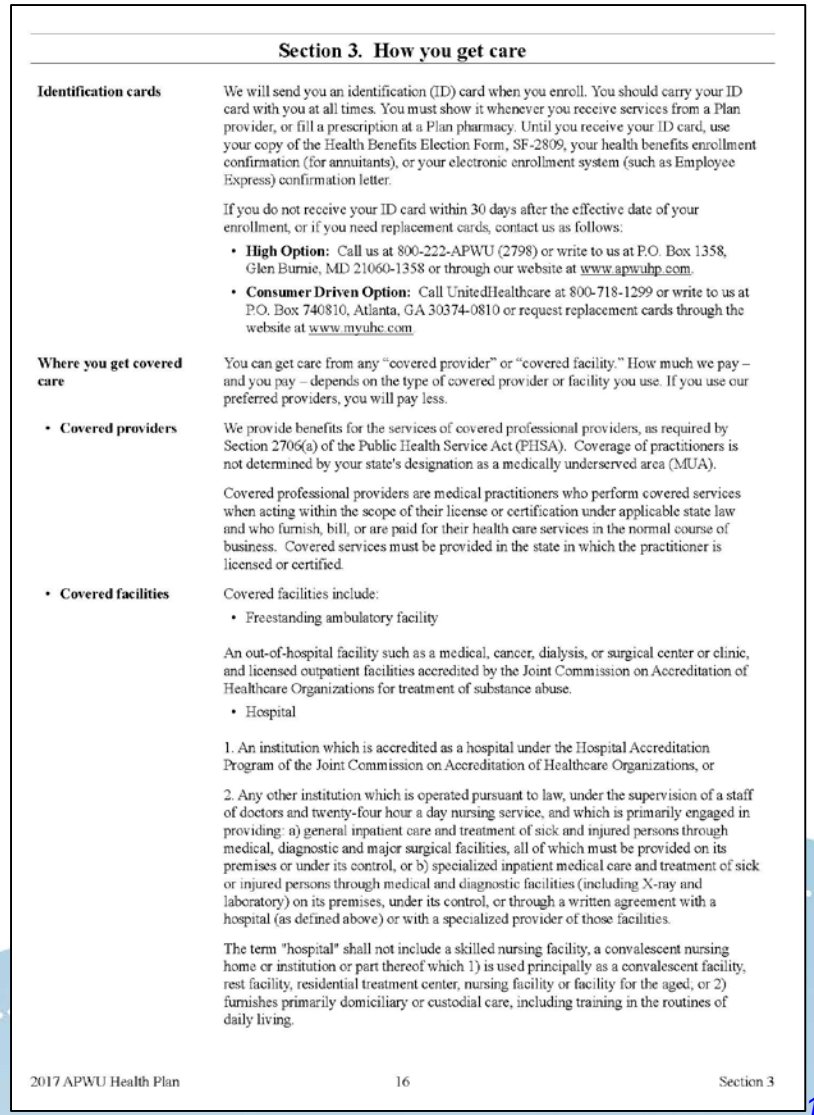
2017 APWU Health Plan 15 Section 2

Section 3: How you get care (Pgs 16-23)

- ID Cards
- Precertification Process
  - Services that need precertification
  - How to request precertification
  - Penalties for non-compliance/late requests
- Steps to request reconsideration of pre-service decision
- Steps to appeal a decision



Section 3. How you get care

Identification cards

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

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

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

Where you get covered care

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

- **Covered providers**

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

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

- **Covered facilities**

Covered facilities include:

- Freestanding ambulatory facility

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

- Hospital

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

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

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

2017 APWU Health Plan 16 Section 3

Do I Need a Precertification? High Option

Yes

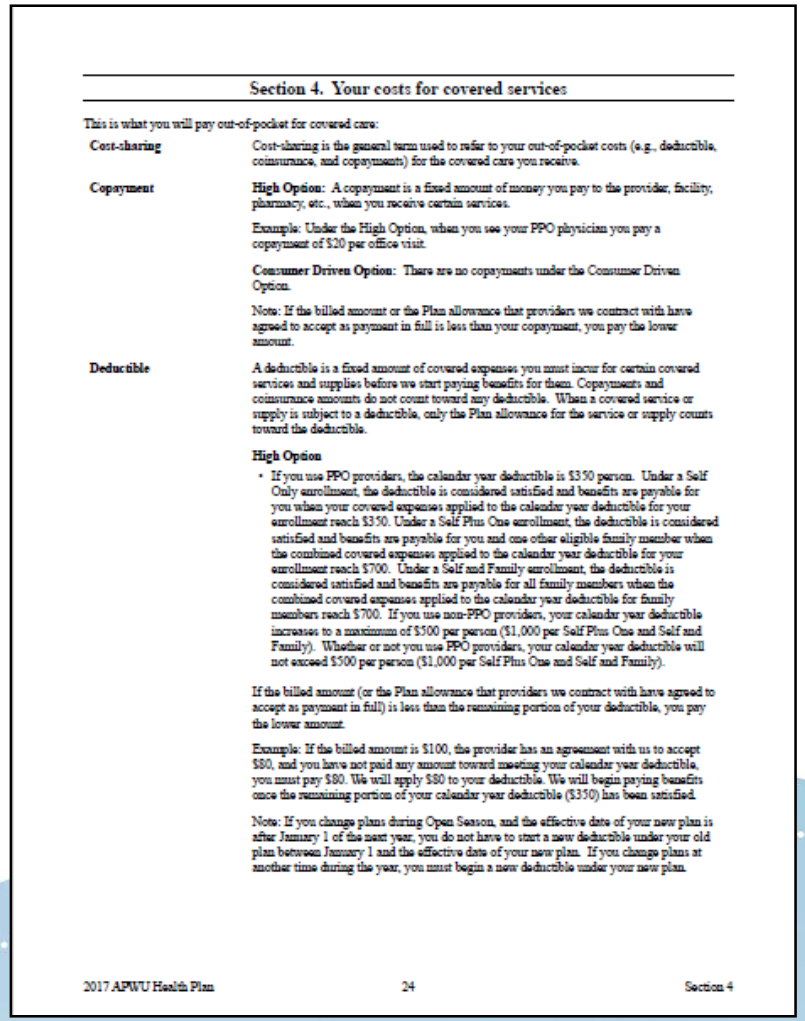
- ✓ High Tech Radiology
- ✓ Physical, Speech, Occupational Therapy
- ✓ Applied Behavioral Analysis
- ✓ In-patient Admission
- ✓ DME
- ✓ Treatment Back/Neck Pain
- ✓ Bariatric Surgery
- ✓ Mental Health Treatment
- ✓ Genetic Testing (BRCA)

No

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

Section 4: Your Costs for Covered Services (Pgs 24-29)

- Out-of-pocket Costs
  - Copay
  - Deductible
  - Coinsurance
- PPO vs. Non PPO
  - Balance billing
- Catastrophic Costs
  - Inclusions/Exclusions
  - PPO Max out-of-pocket
    - $5,500 Self
    - $6,500 Self Plus One/Family
  - Non-PPO out-of-pocket
    - $10,000 Self/Self Plus One/Family



Section 4. Your costs for covered services

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

Cost-sharing

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

Copayment

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

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

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

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

Deductible

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

High Option

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

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

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

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

2017 APWU Health Plan 24 Section 4

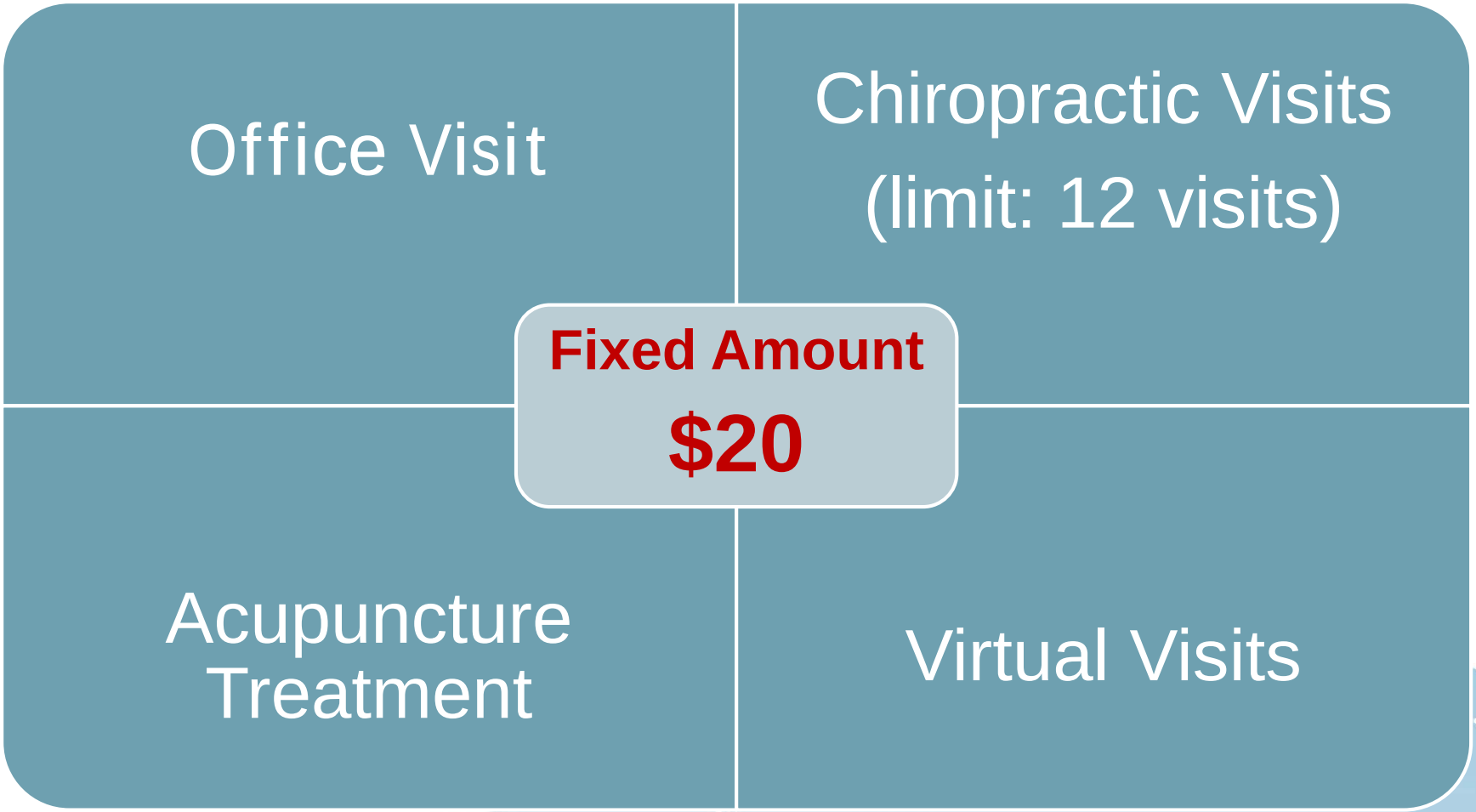
High Option Deductible

Define	When deductible applies	When deductible does not apply
• A fixed amount of covered expenses a member must incur before benefits can be paid	• Covered diagnostic services • Covered therapy services • Covered in-patient professional services	• In-network office visit • Covered in-network preventive care • Services related to an accidental injury • Prescription Rx

High Option Deductible

- In-network
  - $350 Self Only
  - $700 Self Plus One, Self and Family
- Out-of-network
  - $500 Self Only
  - $1,000 Self Plus One, Self and Family
- Eligible deductible amounts for all family members are applied toward the max
- Once combined deductible amounts reach the maximum, the family deductible is considered satisfied
  - A family of five could have amounts applied to their individual deductible(s) that do not meet/exceed the individual one. But when the combined sum of the individual amounts meets the Family Deductible, no further deductible will be taken for any covered family member.

High Option Plan
Office Visit Copay: $20



High Option Plan
Other Copays

- Urgent Care: $40
- Admission to non-participating hospital: $300
- Prescription drugs
  - $10 generic-retail
  - $20 generic-mail order

High Option Coinsurance

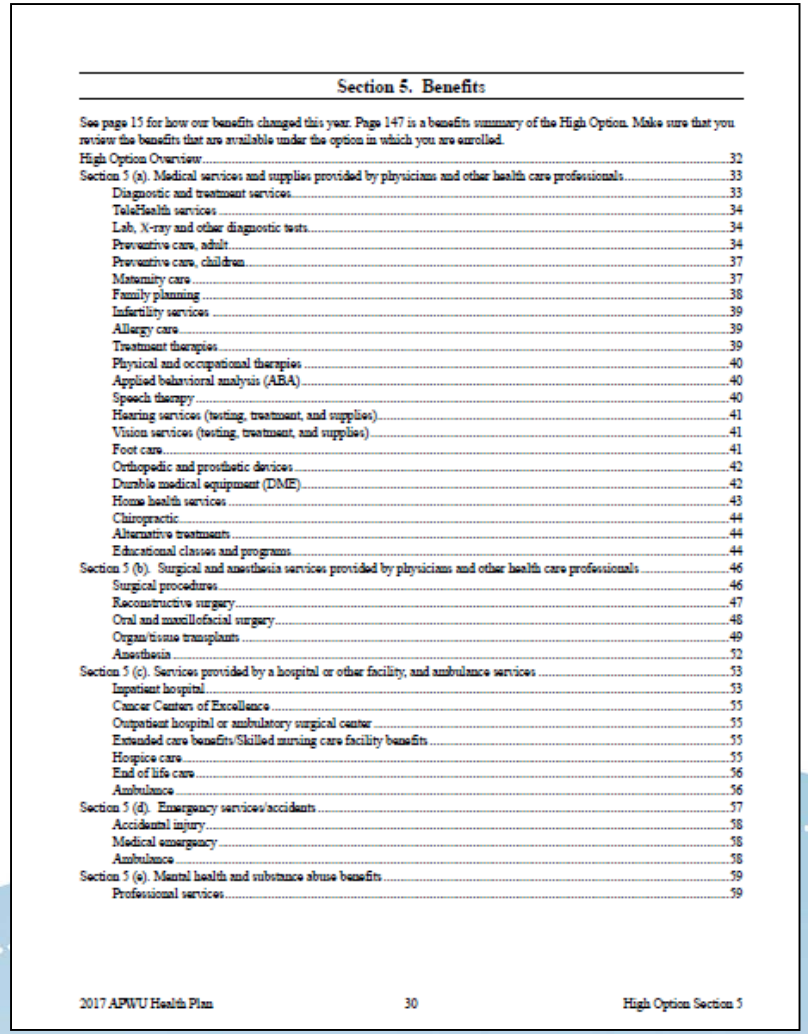
Definition: The percentage of covered allowances for which the patient is responsible. Coinsurance does not begin until the deductible has been met.

- 10% of allowance for in-network care
- 30% of allowance for out-of-network care; covered routine dental services
- 5% of allowance for treatment of cancer at a Cancer Center of Excellence
- 25%, 40% Brand named Rx

Section 5: Benefits

Sections 5 (a)-(h)

a) Medical services and supplies
b) Surgical and anesthesia services
c) Services provided by hospital or other facility
d) Emergency services
e) Mental health and substance abuse
f) Prescription drugs
g) Dental benefits
h) Special features



Section 5. Benefits

See page 15 for how our benefits changed this year. Page 147 is a benefits summary of the High Option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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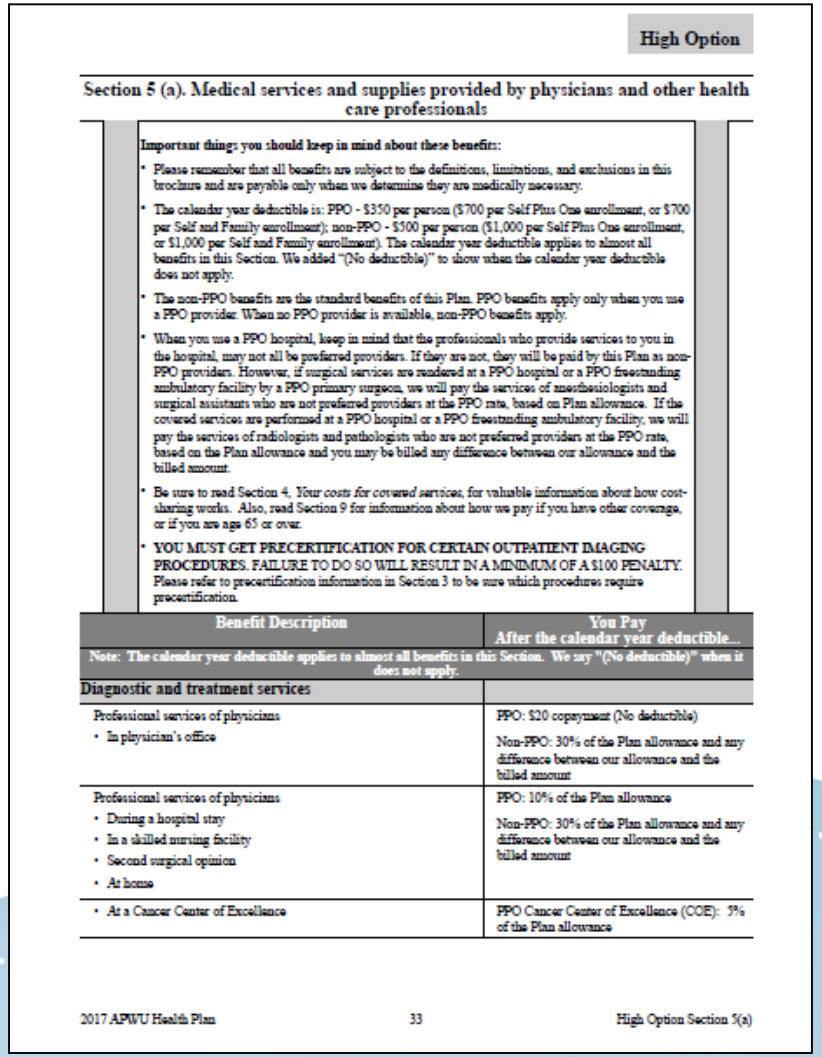
Medical Services and Supplies

Section 5(a) (Pgs 33-45)

- Office, hospital visits
- X-rays and diagnostic tests
- Preventive Care
- Maternity
- Infertility
- Therapies
- Hearing
- Foot Care
- DME
- Home Health Services
- Chiropractic
- Acupuncture



High Option

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: PPO - $350 per person ($700 per Self Plus One enrollment, or $700 per Self and Family enrollment); non-PPO - $500 per person ($1,000 per Self Plus One enrollment, or $1,000 per Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- 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, may not all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers. However, if surgical services are rendered at a PPO hospital or a PPO freestanding ambulatory facility by a PPO primary surgeon, we will pay the services of anesthesiologists and surgical assistants who are not preferred providers at the PPO rate, based on Plan allowance. If the covered services are performed at a PPO hospital or a PPO freestanding ambulatory facility, we will pay the services of radiologists and pathologists who are not preferred providers at the PPO rate, based on the Plan allowance and you may be billed any difference between our allowance and the billed amount.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOU MUST GET PRECERTIFICATION FOR CERTAIN OUTPATIENT IMAGING PROCEDURES. FAILURE TO DO SO WILL RESULT IN A MINIMUM OF A $100 PENALTY.** Please refer to precertification information in Section 3 to be sure which procedures require precertification.

Benefit Description	You Pay After the calendar year deductible...
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Diagnostic and treatment services	
Professional services of physicians • In physician's office	PPO: $20 copayment (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Professional services of physicians • During a hospital stay • In a skilled nursing facility • Second surgical opinion • At home	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
• At a Cancer Center of Excellence	PPO Cancer Center of Excellence (COE): 5% of the Plan allowance

2017 APWU Health Plan 33 High Option Section 5(a)

Virtual Office Visits (Pg 34)

- Lets a patient see and talk to a physician from a computer, tablet, or compatible mobile device.
- A doctor can:
  - Speak to you about minor medical concerns
  - Provide a diagnosis
  - Transmit a prescription to your local network pharmacy
- Call **1-855-818-DOCS** or visit **www.AmWell.com** for information on virtual visits
- In-network benefit only
- Subject to $20 copay

Preventive Care (Pgs 34-37)

- Immunizations recommended by CDC for both children and adults
- Annual routine exam, adults
- Well baby visits
- See pages 34-37 for comprehensive list of covered services
- Note: A service or treatment performed when symptoms of illness are present may not be considered preventive for the purpose of this coverage. Example: A colonoscopy performed when a patient has been experiencing bleeding.

Infertility (Pg 39)

- The Plan covers services related to the *diagnosis* and *treatment* of infertility
  - Covered services would include visits, surgery and diagnostic testing
  - Maximum Plan benefit: $2,500
- The Plan does not cover costs to assist in conception
  - In vitro fertilization
  - Costs of donor sperm/egg

Physical/Occupational/Speech Therapies (Pg 40)

- Covered Treatments
  - Services of a Registered Physical/Occupational Therapist to assist in the recovery of lost, diminished or absent functionality
  - Services of a Registered Speech Therapist to assist in restoring lost or diminished functionality
- Benefits are limited to a combined outpatient visit limit of 60 for physical, occupational and speech therapy
- Services must be ordered by a physician
- Preauthorization is required before services can be considered for payment

Routine Foot Care (Pg 41)

- Routine foot care services are covered only when patient is receiving active treatment for a metabolic or peripheral vascular disease such as Diabetes or Peripheral Neuropathy.
  - Trimming of lesions
  - Trimming of nails

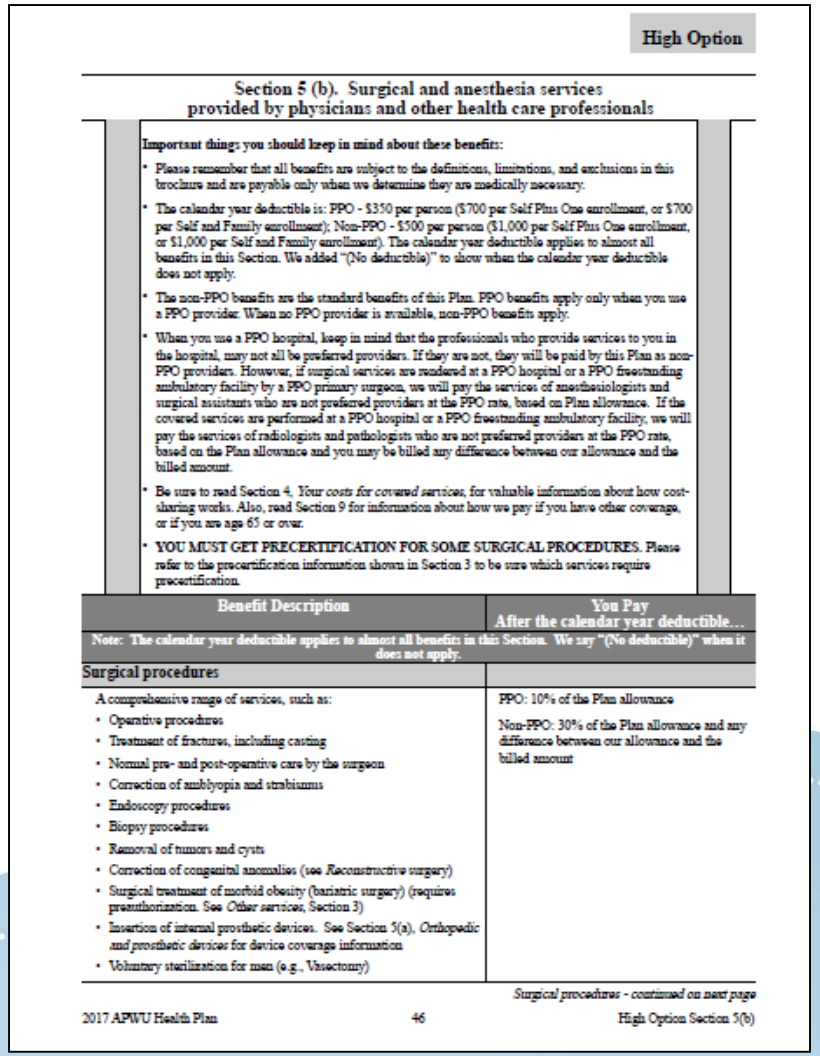
Orthotics

- Definition: Devices (brace, splint, shoes) for supporting, immobilizing or treating muscles, or joints that are weak, ineffective, deformed or injured
  - Shoe and shoe inserts
  - Braces
  - Splints
- The Plan specifically excludes treatment of weak, strained or flat feet, bunions or spurs; and the instability, imbalance or subluxation of the foot *(unless treatment is by open, cutting surgery)*

Surgical and Anesthesia Services

Section 5(b) Pgs 46-53

- Surgical procedures
- Anesthesia
- Organ Transplants
- Oral Surgery
- PPO vs. Non-PPO facility



High Option

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: PPO - $350 per person ($700 per Self Plus One enrollment, or $700 per Self and Family enrollment); Non-PPO - $500 per person ($1,000 per Self Plus One enrollment, or $1,000 per Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- 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, may not all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers. However, if surgical services are rendered at a PPO hospital or a PPO freestanding ambulatory facility by a PPO primary surgeon, we will pay the services of anesthesiologists and surgical assistants who are not preferred providers at the PPO rate, based on Plan allowance. If the covered services are performed at a PPO hospital or a PPO freestanding ambulatory facility, we will pay the services of radiologists and pathologists who are not preferred providers at the PPO rate, based on the Plan allowance and you may be billed any difference between our allowance and the billed amount.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOU MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

Benefit Description	You Pay After the calendar year deductible...
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment of morbid obesity (bariatric surgery) (requires preauthorization. See *Other services*, Section 3) • Insertion of internal prosthetic devices. See Section 5(a), *Orthopedic and prosthetic devices* for device coverage information • Voluntary sterilization for men (e.g., Vasectomy)	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

Surgical procedures - continued on next page

Anesthesia (Pg 52)

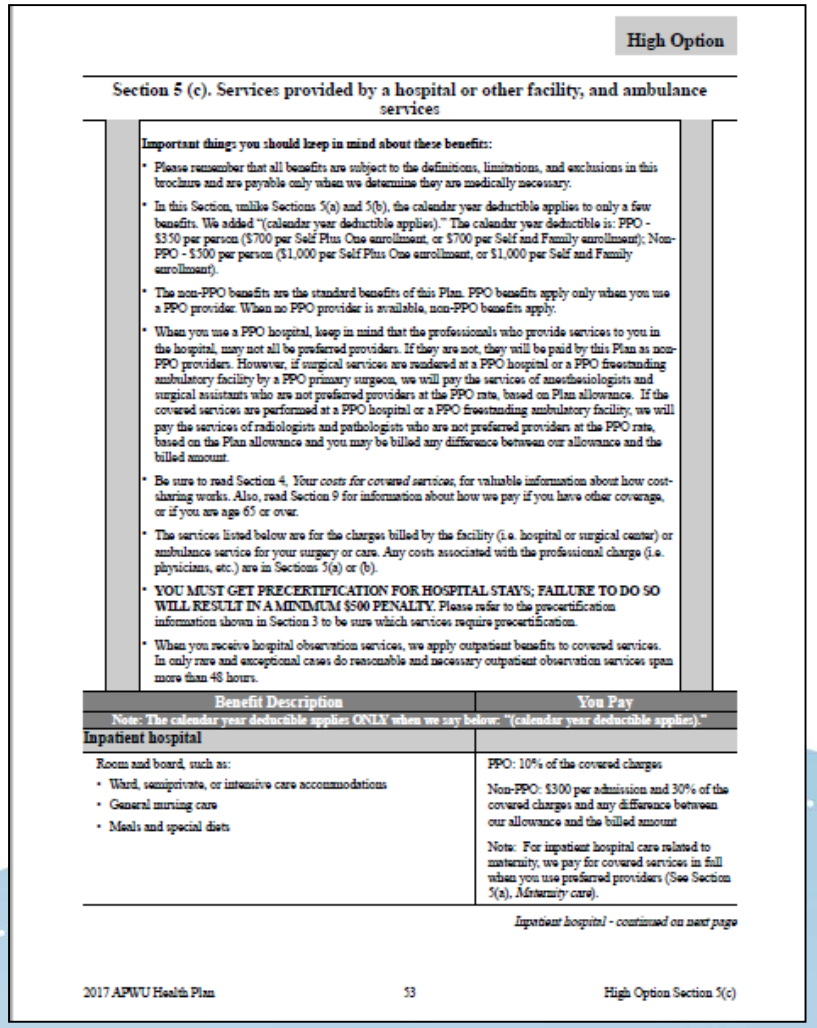
- Services by out-of-network anesthesiologist
  - Plan will apply in-network benefits to the Plan allowance for an out-of-network anesthesiologist where services are performed by an ***in-network surgeon*** at an ***in-network facility***
  - Plan will apply out-of-network benefits to the out-of-network anesthesiologist where services performed by an in-network surgeon at an ***out-of-network facility***
  - Plan will apply out-of-network benefits to the out-of-network anesthesiologist where services performed by an ***out-of-network surgeon*** at an in-network facility
  - In all cases, the out-of-network anesthesiologist may balance bill

Organ and Tissue Transplants

- List of covered transplants on pages 49-51
- All are subject to prior authorization and medical necessity review
- Out-of-network services have benefit payout limitations
- Transplant Network
  - Plan-specific organ/tissue transplant facilities
  - Prior to an initial evaluation, physician or patient must contact Cigna (800-668-9682) and speak to a Transplant Case Manager

Services at Hospital/Facility and Ambulance Services Section 5(c)

- Inpatient Room and board
- Cancer Centers of Excellence
- Outpatient Hospital or Ambulatory Surgical Center
- Hospice
- Extended Care/Skilled Nursing
- Ambulance



High Option

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In this Section, unlike Sections 5(a) and 5(b), the calendar year deductible applies to only a few benefits. We added "(calendar year deductible applies)." The calendar year deductible is: PPO - $350 per person ($700 per Self Plus One enrollment, or $700 per Self and Family enrollment); Non-PPO - $300 per person ($1,000 per Self Plus One enrollment, or $1,000 per Self and Family enrollment).
- 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, may not all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers. However, if surgical services are rendered at a PPO hospital or a PPO freestanding ambulatory facility by a PPO primary surgeon, we will pay the services of anesthesiologists and surgical assistants who are not preferred providers at the PPO rate, based on Plan allowance. If the covered services are performed at a PPO hospital or a PPO freestanding ambulatory facility, we will pay the services of radiologists and pathologists who are not preferred providers at the PPO rate, based on the Plan allowance and you may be billed any difference between our allowance and the billed amount.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- The services listed below are for the charges billed by the facility (i.e. hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e. physicians, etc.) are in Sections 5(a) or (b).
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.
- When you receive hospital observation services, we apply outpatient benefits to covered services. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours.

Benefit Description	You Pay
Note: The calendar year deductible applies ONLY when we say below: "(calendar year deductible applies)."	
Inpatient hospital	
Room and board, such as: • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets	PPO: 10% of the covered charges Non-PPO: $300 per admission and 30% of the covered charges and any difference between our allowance and the billed amount Note: For inpatient hospital care related to maternity, we pay for covered services in full when you use preferred providers (See Section 5(a), *Maternity care*).

Inpatient hospital - continued on next page

Inpatient Room and Board

- Subject to pre-authorization *(Section 3)*
- $500 late pre-authorization penalty
  - Emergency admissions: 2 business days from admission date
  - Scheduled admissions: 2 business days prior to scheduled admission
- $300 deductible if confined in an out-of-network facility

Hospice (Pg 55)

- 2017 Benefits
  - Up to $15,000 lifetime maximum including:
    - Inpatient hospice
    - Outpatient hospice
    - Advanced care planning
  - $200 annual bereavement benefit per family
- 2016 Benefits
  - $3,000 annual limit for outpatient hospice
  - $2,000 annual limit for inpatient hospice
  - $200 annual bereavement benefit per family

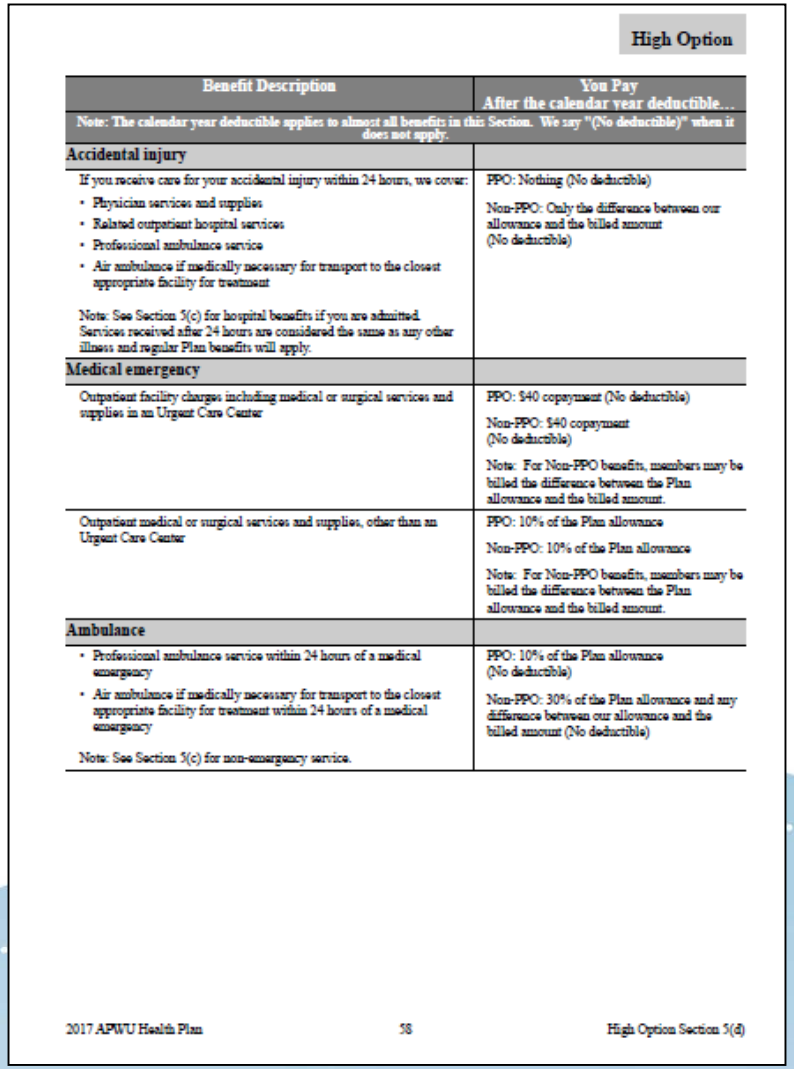
Extended Care/Skilled Nursing Facility

- Plan does not generally cover care rendered at other than an acute care facility
- Services rendered at a Skilled Nursing Facility (SNF) are specifically excluded from coverage
  - Step-down care provided after an acute care confinement but prior to returning home
  - Services typically include rehabilitative therapy and room and board

Emergency Services/Accidents

Section 5(d) Pgs 57-58

- Accident
- Medical Emergency
- Urgent Care Center
- Ambulance



High Option

Benefit Description	You Pay After the calendar year deductible...
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Accidental injury	
If you receive care for your accidental injury within 24 hours, we cover: • Physician services and supplies • Related outpatient hospital services • Professional ambulance service • Air ambulance if medically necessary for transport to the closest appropriate facility for treatment Note: See Section 5(c) for hospital benefits if you are admitted. Services received after 24 hours are considered the same as any other illness and regular Plan benefits will apply.	PPO: Nothing (No deductible) Non-PPO: Only the difference between our allowance and the billed amount (No deductible)
Medical emergency	
Outpatient facility charges including medical or surgical services and supplies in an Urgent Care Center	PPO: $40 copayment (No deductible) Non-PPO: $40 copayment (No deductible) Note: For Non-PPO benefits, members may be billed the difference between the Plan allowance and the billed amount.
Outpatient medical or surgical services and supplies, other than an Urgent Care Center	PPO: 10% of the Plan allowance Non-PPO: 10% of the Plan allowance Note: For Non-PPO benefits, members may be billed the difference between the Plan allowance and the billed amount.
Ambulance	
• Professional ambulance service within 24 hours of a medical emergency • Air ambulance if medically necessary for transport to the closest appropriate facility for treatment within 24 hours of a medical emergency Note: See Section 5(c) for non-emergency service.	PPO: 10% of the Plan allowance (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)

2017 APWU Health Plan 58 High Option Section 5(d)

Accident (Pg 58)

- "Accident" is defined as resulting from a violent, external force
- Outpatient services, including ambulance rendered within 24 hours of accident
  - No out-of-pocket expense or cost-sharing (no deductible, coinsurance, copayment)
  - Out-of-network care could result in a patient liability if there is a difference in the fee for the service and the Plan allowance for it

Medical Emergency (Pg 58)

- Sudden onset of symptoms that you believe endangers your life or could result in serious disability if not treated promptly
- Treatment at an Urgent Care Center
  - Cost share = $40 copayment
- Treatment at other than an Urgent Care Center
  - Cost share = Deductible, 10% coinsurance
- Out-of-network care could result in additional patient liability if there is a difference in the fee for the service and the Plan allowance for it

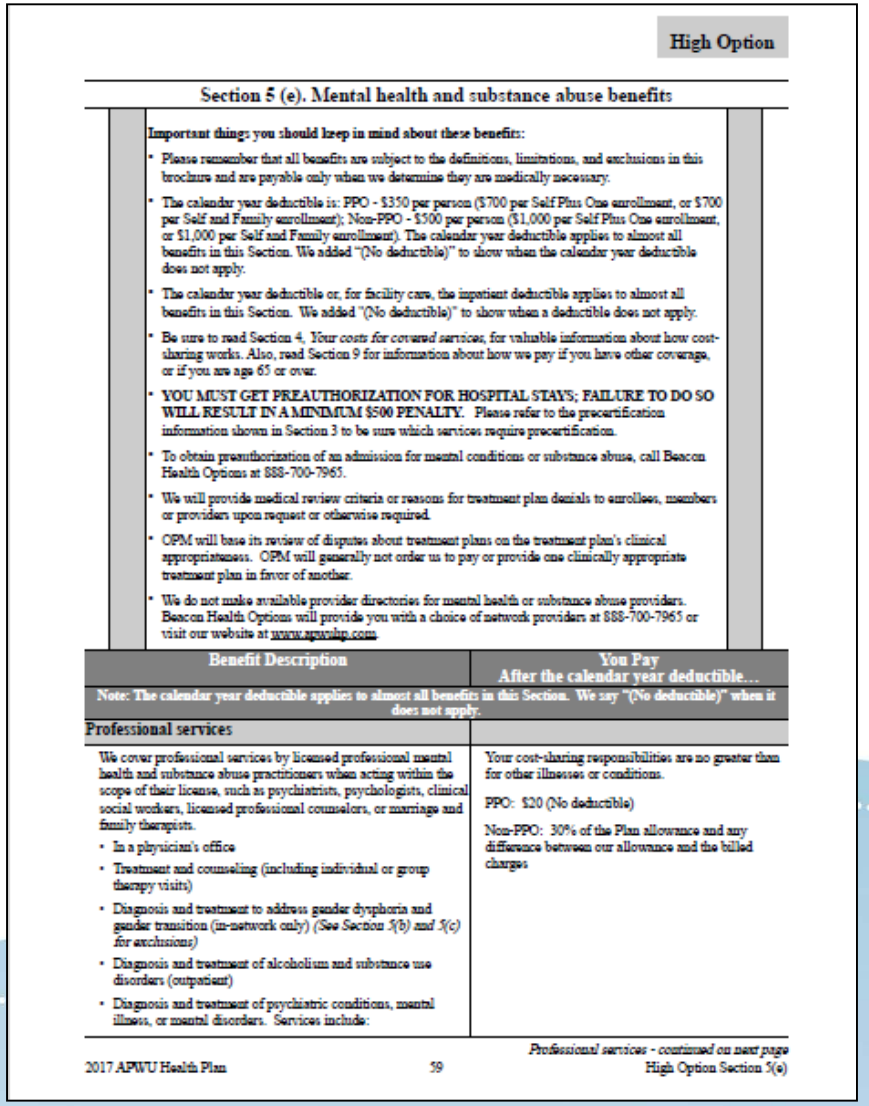
Ambulance (Pg 58)

- Medically necessary professional ambulance transport of a patient within 24 hours of a medical emergency
- In-network provider: Cost share = 10% coinsurance
- Out-of-network provider: Cost share = 30% coinsurance
- Out-of-network transport could result in additional patient liability if there is a difference in the fee for the service and the Plan allowance for the service

Mental Health and Substance Abuse

Section 5(e) Pgs 59-60

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



High Option

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: PPO - $350 per person ($700 per Self Plus One enrollment, or $700 per Self and Family enrollment); Non-PPO - $500 per person ($1,000 per Self Plus One enrollment, or $1,000 per Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The calendar year deductible or, for facility care, the inpatient deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when a deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOU MUST GET PREAUTHORIZATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.
- To obtain preauthorization of an admission for mental conditions or substance abuse, call Beacon Health Options at 888-700-7965.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.
- We do not make available provider directories for mental health or substance abuse providers. Beacon Health Options will provide you with a choice of network providers at 888-700-7965 or visit our website at www.apwuhp.com.

Benefit Description	You Pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Professional services	
We cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. • In a physician's office • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment to address gender dysphoria and gender transition (in-network only) *(See Section 5(b) and 5(c) for exclusions)* • Diagnosis and treatment of alcoholism and substance use disorders (outpatient) • Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include:	Your cost-sharing responsibilities are no greater than for other illnesses or conditions. PPO: $20 (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed charges

Professional services - continued on next page

Office Visit vs. Treatment Behavioral and Substance Abuse

- In-network $20 copay
- Out-of-network 30% after deductible
  - Office Visits
  - Treatment/counseling
  - Individual/group therapy
  - Diagnostic evaluation
  - Medication management
- Diagnostic Treatment 10%/30% after deductible
  - Diagnostic tests
  - Partial Hospitalization
  - Facility-based outpatient treatment

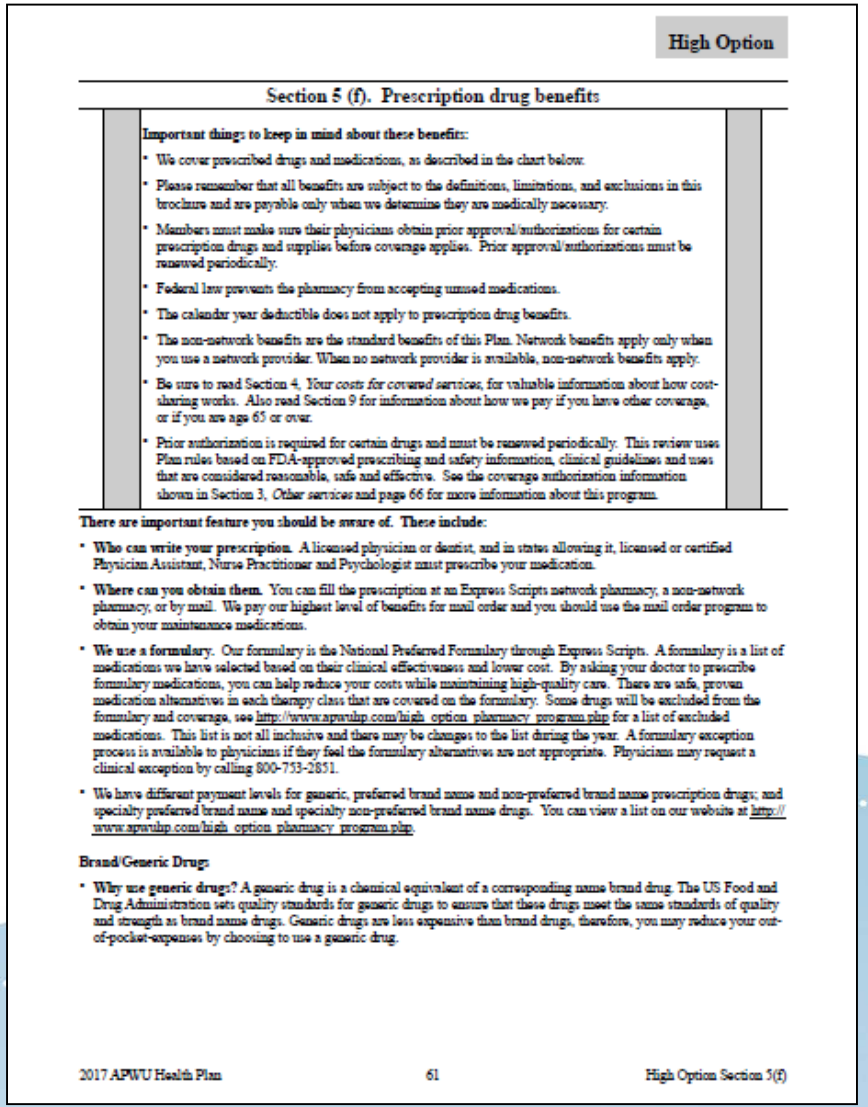
Behavioral Health and Substance Abuse

- Preauthorization Requirements
  - Beacon Health Options **888-700-7965**
  - Inpatient services
  - Outpatient services
  - Applied Behavioral Analysis

Prescription Drugs

Section 5(f) Pgs 61-67

- Express Scripts
- Formulary
- FDA approved
- Brand vs. Generic
- Network
  - Retail
  - Mail Order
  - Specialty
- Coverage review
- Step Therapy



High Option

Section 5 (f). Prescription drug benefits

Important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart below.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- The calendar year deductible does not apply to prescription drug benefits.
- The non-network benefits are the standard benefits of this Plan. Network benefits apply only when you use a network provider. When no network provider is available, non-network benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- Prior authorization is required for certain drugs and must be renewed periodically. This review uses Plan rules based on FDA-approved prescribing and safety information, clinical guidelines and uses that are considered reasonable, safe and effective. See the coverage authorization information shown in Section 3, *Other services* and page 66 for more information about this program.

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

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed or certified Physician Assistant, Nurse Practitioner and Psychologist must prescribe your medication.
- **Where can you obtain them.** You can fill the prescription at an Express Scripts network pharmacy, a non-network pharmacy, or by mail. We pay our highest level of benefits for mail order and you should use the mail order program to obtain your maintenance medications.
- **We use a formulary.** Our formulary is the National Preferred Formulary through Express Scripts. A formulary is a list of medications we have selected based on their clinical effectiveness and lower cost. By asking your doctor to prescribe formulary medications, you can help reduce your costs while maintaining high-quality care. There are safe, proven medication alternatives in each therapy class that are covered on the formulary. Some drugs will be excluded from the formulary and coverage, see http://www.apwuhp.com/high_option_pharmacy_program.php for a list of excluded medications. This list is not all inclusive and there may be changes to the list during the year. A formulary exception process is available to physicians if they feel the formulary alternatives are not appropriate. Physicians may request a clinical exception by calling 800-753-2851.
- We have different payment levels for generic, preferred brand name and non-preferred brand name prescription drugs; and specialty preferred brand name and specialty non-preferred brand name drugs. You can view a list on our website at http://www.apwuhp.com/high_option_pharmacy_program.php.

Brand/Generic Drugs

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

2017 APWU Health Plan 61 High Option Section 5(f)

Prescription Drug Definitions (Pg 61)

- Express Scripts is our Network Pharmacy
- National Preferred Formulary
  - List of medications selected based on clinical effectiveness and lower cost
- Generic Drugs
  - Chemical equivalent of a corresponding name brand drug
  - Available at a lower cost
- To view list of drugs covered by APWU Health Plan, visit: **www.apwuhp.com/high_option_pharmacy_program.php**

Prescription Drug Tiers

Type of Drug	Network Pharmacy (Retail)	Non-Network Pharmacy (Retail)	Network Mail Order
Generic Drugs	$10 copay for 30 day supply	50% coinsurance; $10 min for 30 day supply	$20 copay for 90 day supply
Preferred Brand Drugs	25% coinsurance; $10 min/$200 max for 30 day supply	50% coinsurance; $10 min for 30 day supply	25% coinsurance; $20 min/$300 max for 90 day supply
Non-Preferred Brand Drugs	40% coinsurance; $20 min/$300 max for 30 day supply	50% coinsurance; $10 min for 30 day supply	40% coinsurance; $30 min/$500 max for 90 day supply

Specialty Drugs (Pg 63)

- Injectable, infused, oral or inhaled drugs that:
  - Require frequent dosing adjustments
  - Intensive patient training
  - Limited product availability
  - Specialized product handling
- Targeted conditions include:
  - Cystic Fibrosis
  - Gaucher disease
  - Growth hormone deficiency
  - Hepatitis C
  - Rheumatoid Arthritis

Specialty Drug Tiers

Type of Drug	Network Pharmacy (Retail)	Non-Network Pharmacy (Retail)	Network Mail Order
Generic Drugs	25% coinsurance; max $300 for 30 day supply	50% coinsurance; $10 min for 30 day supply	25% coinsurance; $150 max for 90 day supply
Preferred Brand Drugs	25% coinsurance; $40 min/$600 max for 30 day supply	50% coinsurance; $10 min for 30 day supply	25% coinsurance; $20 min/$300 max for 90 day supply
Non-Preferred Brand Drugs	40% coinsurance; $60 min/$1,000 max for 30 day supply	50% coinsurance; $10 min for 30 day supply	40% coinsurance; $30 min/$500 max for 90 day supply

Prescription Coverage Definitions

- Coverage Review
  - Some drugs are covered only with a prior authorization and include:
    - Growth Hormones
    - Botox
    - Retin-A
    - Drugs for gender transition
- Step Therapy
  - Ensures generic/brand alternative within a therapeutic category is the first-line treatment
  - See page 66 for a list of affected drug categories

Dental Benefits

Section 5(g) Pg 68

High Option

Section 5 (g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9, *Coordinating benefits with other coverage*.
- The calendar year deductible is: PPO - $350 per person ($700 per Self Plus One enrollment, or $700 per Self and Family enrollment); Non-PPO - $500 per person ($1,000 per Self Plus One enrollment, or $1,000 per Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 for information abut how we pay if you have other coverage, or if you are age 65 or over.

Note: We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. We do not cover the dental procedure. See Section 5(c), *Inpatient hospital benefits*.

Accidental injury benefit	You Pay
Accidental injury benefit	
We cover restorative services and supplies necessary to repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury (a blow or fall) and must be performed within two years of the accident. See also Section 5(d), *Accidental injury*.	Within 24 hours of accident: PPO: Nothing (No deductible) Non-PPO: Only the difference between our allowance and the billed amount (No deductible) More than 24 hours after accident: PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Dental benefits service	
Office visits (routine limited to 2 visits per year) Restorative care (fillings) X-rays of all types (limited to 2 per year) Prophylaxis (cleanings), (limited to 2 per year) Simple extractions Note: Office visits include examinations and fluoride treatment. Note: Restorative care does not include crowns or in-lay/on-lay restoration.	30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)

Routine Dental Benefits

Section 5(g) Pg 68

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

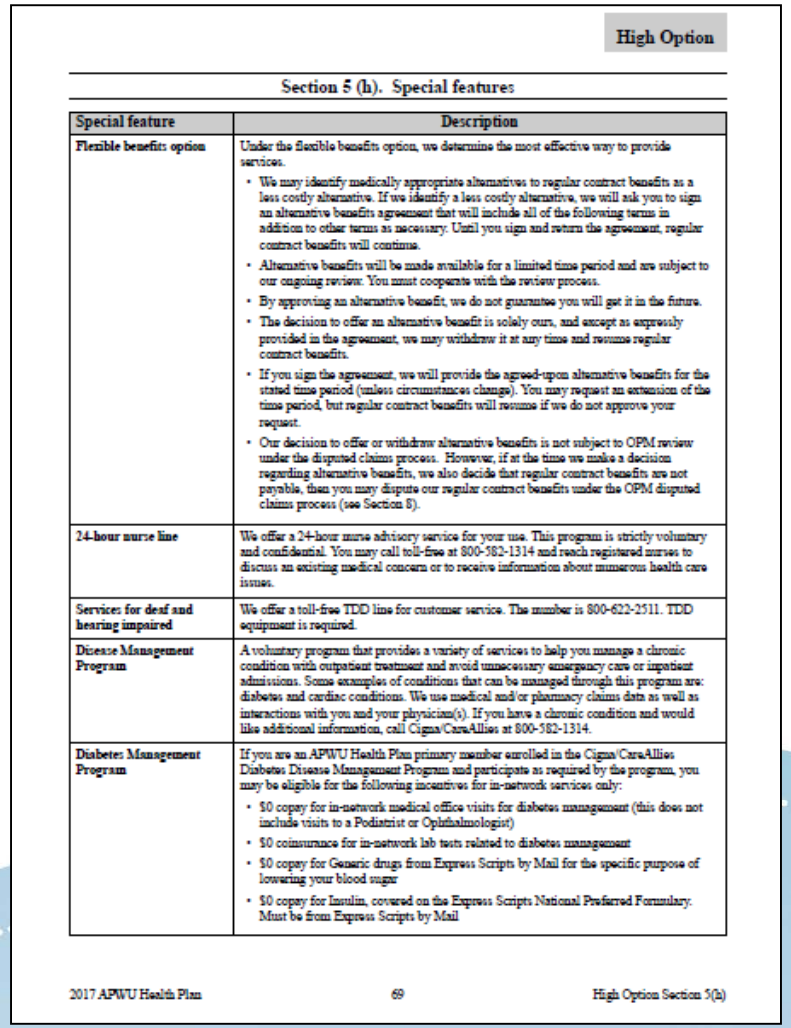
CignaPlus Savings Discount Dental Program

- Discount dental program providing APWU Health Plan members access to discounted fees with participating dental providers ***(for non-routine services not otherwise covered by the Plan)***
- Complete online Health Risk Assessment to become eligible for this program
  - Self-only enrollment, complete online HRA and Plan will pay the premium for Self-only coverage with CignaPlus Dental Program
  - Self Plus One and Self and Family enrollment, at least 2 family members must complete the HRA and the Plan will pay the premium for Self and Family coverage with CignaPlus Discount Dental Program

Special Features

Section 5(h) Pgs 69-72

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



High Option

Section 5 (h). Special features

Special feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits under the OPM disputed claims process (see Section 8).
24-hour nurse line	We offer a 24-hour nurse advisory service for your use. This program is strictly voluntary and confidential. You may call toll-free at 800-582-1314 and reach registered nurses to discuss an existing medical concern or to receive information about numerous health care issues.
Services for deaf and hearing impaired	We offer a toll-free TDD line for customer service. The number is 800-622-2511. TDD equipment is required.
Disease Management Program	A voluntary program that provides a variety of services to help you manage a chronic condition with outpatient treatment and avoid unnecessary emergency care or inpatient admissions. Some examples of conditions that can be managed through this program are: diabetes and cardiac conditions. We use medical and/or pharmacy claims data as well as interactions with you and your physician(s). If you have a chronic condition and would like additional information, call Cigna/CareAllies at 800-582-1314.
Diabetes Management Program	If you are an APWU Health Plan primary member enrolled in the Cigna/CareAllies Diabetes Disease Management Program and participate as required by the program, you may be eligible for the following incentives for in-network services only: • $0 copay for in-network medical office visits for diabetes management (this does not include visits to a Podiatrist or Ophthalmologist) • $0 coinsurance for in-network lab tests related to diabetes management • $0 copay for Generic drugs from Express Scripts by Mail for the specific purpose of lowering your blood sugar • $0 copay for Insulin, covered on the Express Scripts National Preferred Formulary. Must be from Express Scripts by Mail

2017 APWU Health Plan 69 High Option Section 5(h)

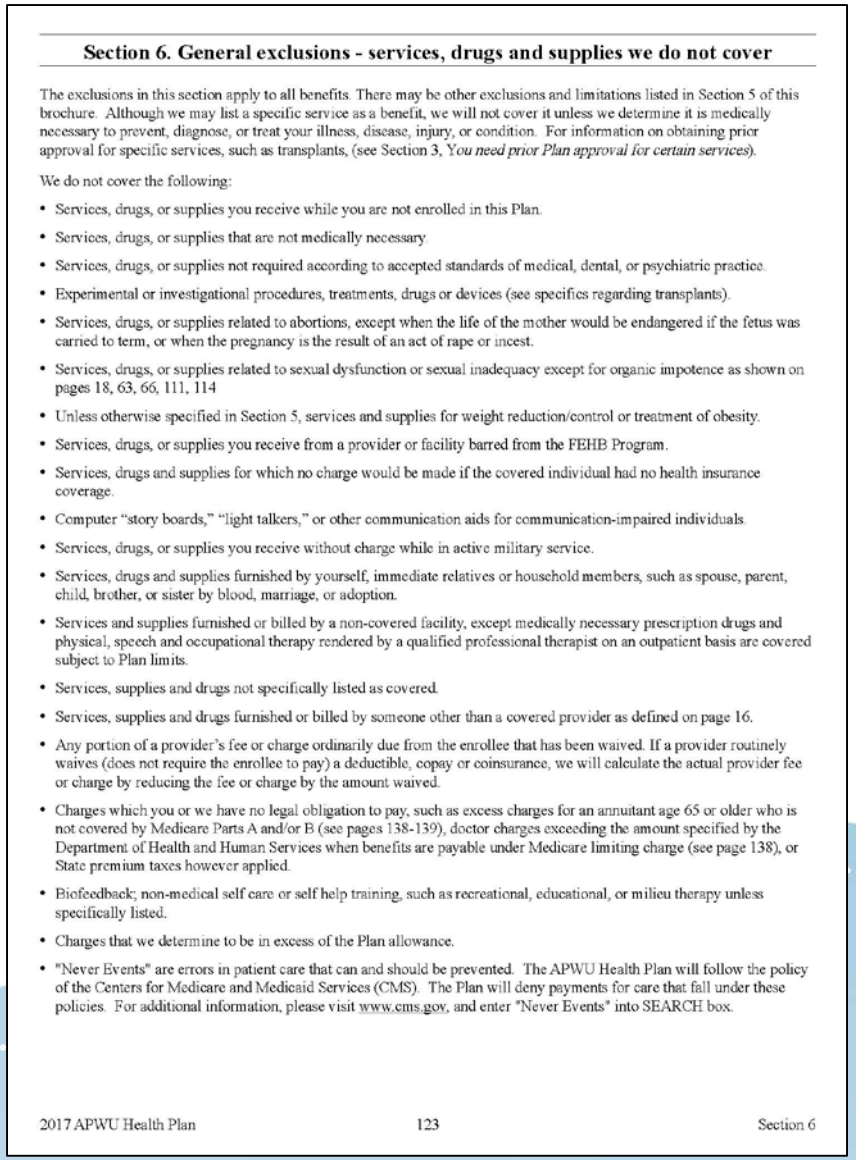
Health Management Programs

Diabetes Management	Office visit Labs Generic medication Insulin
Hypertension Management	Office Visits Labs Generic Medication
Weight Management	Visits to nutritionist Tool kits Call with coach

You Pay Nothing! (in-network)

Section 6: General Exclusions

- Experimental or investigational procedures, drugs, services
- Biofeedback; non-medical self-help training services
- Services, drugs, supplies that are not medically necessary
- See page 123 for a complete list



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

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

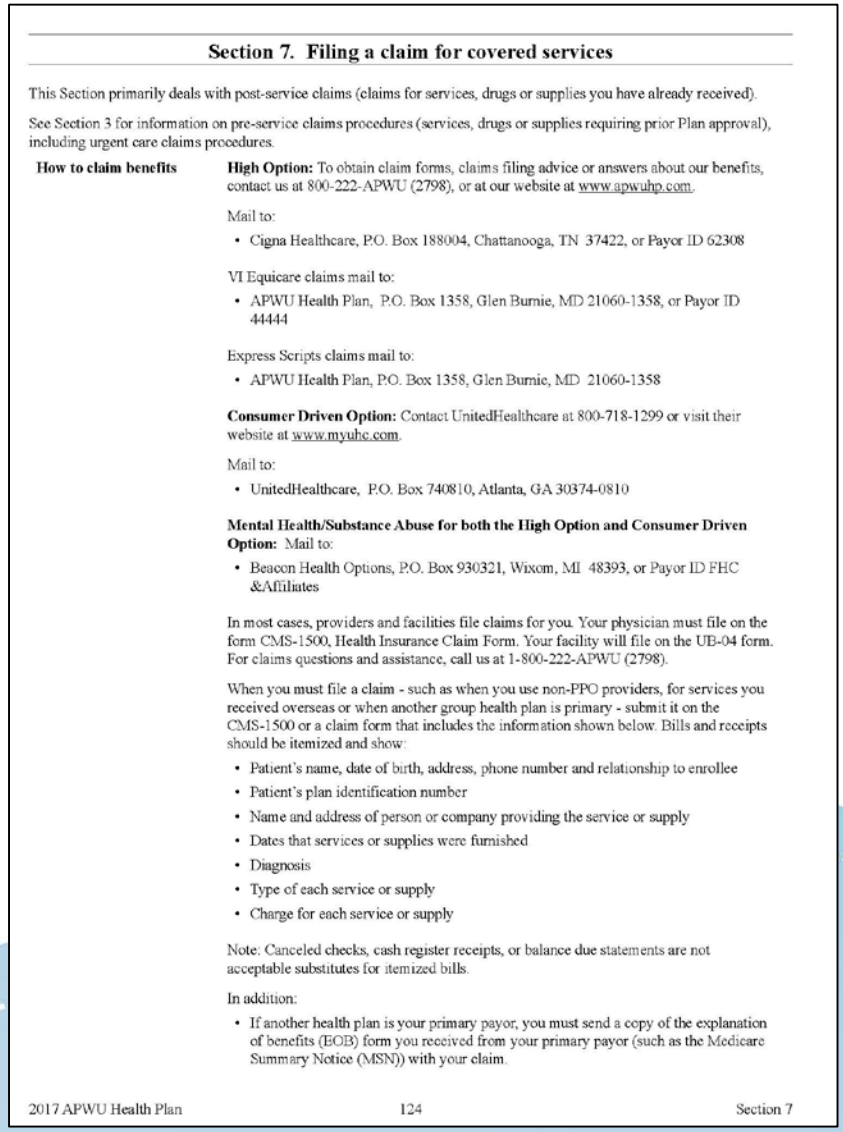
We do not cover the following:

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

2017 APWU Health Plan 123 Section 6

Section 7: Filing a claim

- Claims
  - Where to file
  - Addresses, electronic payor numbers, phone numbers
- Deadlines
  - Timeframe for filing claims based on when services were rendered
- Overseas
  - Documentation needed for reimbursement
  - Address to submit claim



Section 7. Filing a claim for covered services

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

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

How to claim benefits

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

Mail to:

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

VI Equicare claims mail to:

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

Express Scripts claims mail to:

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

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

Mail to:

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

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

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

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

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

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

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

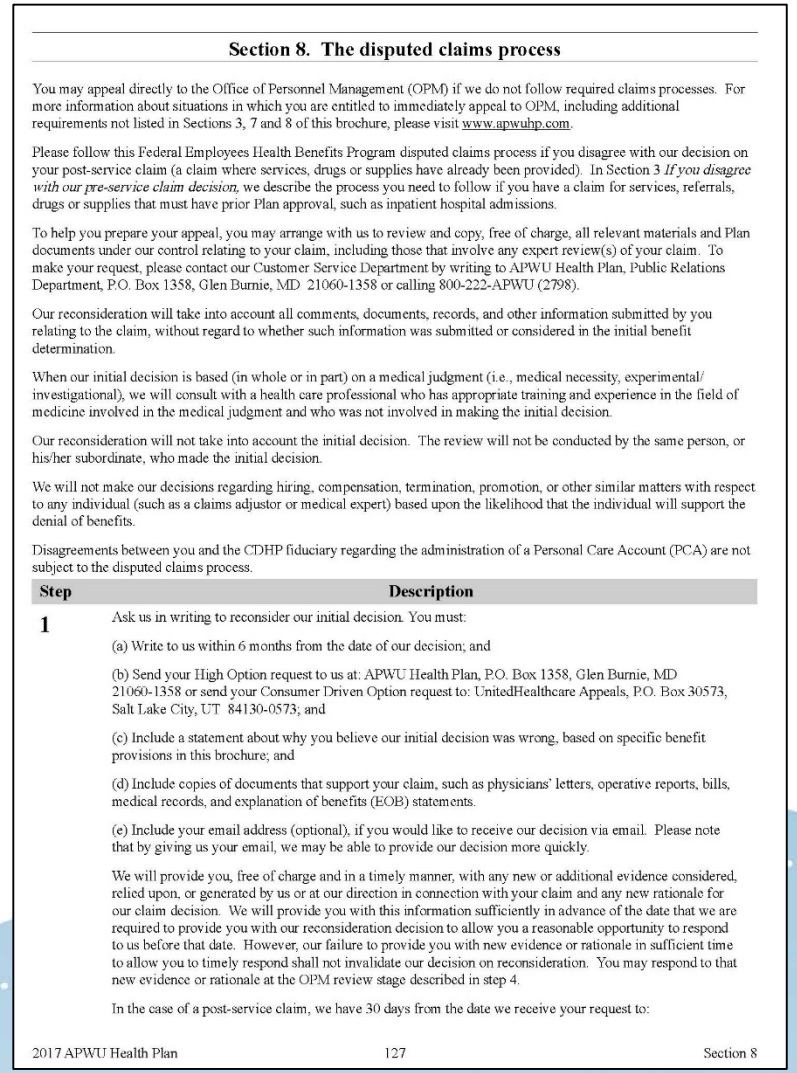
In addition:

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

2017 APWU Health Plan 124 Section 7

Section 8: Disputed Claims

- Written request for reconsideration
  - Timeframes to appeal
  - Supporting documents needed
- APWU response within 30 days
- Member appeals to OPM
- OPM response



Section 8. The disputed claims process

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

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

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

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

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

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

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

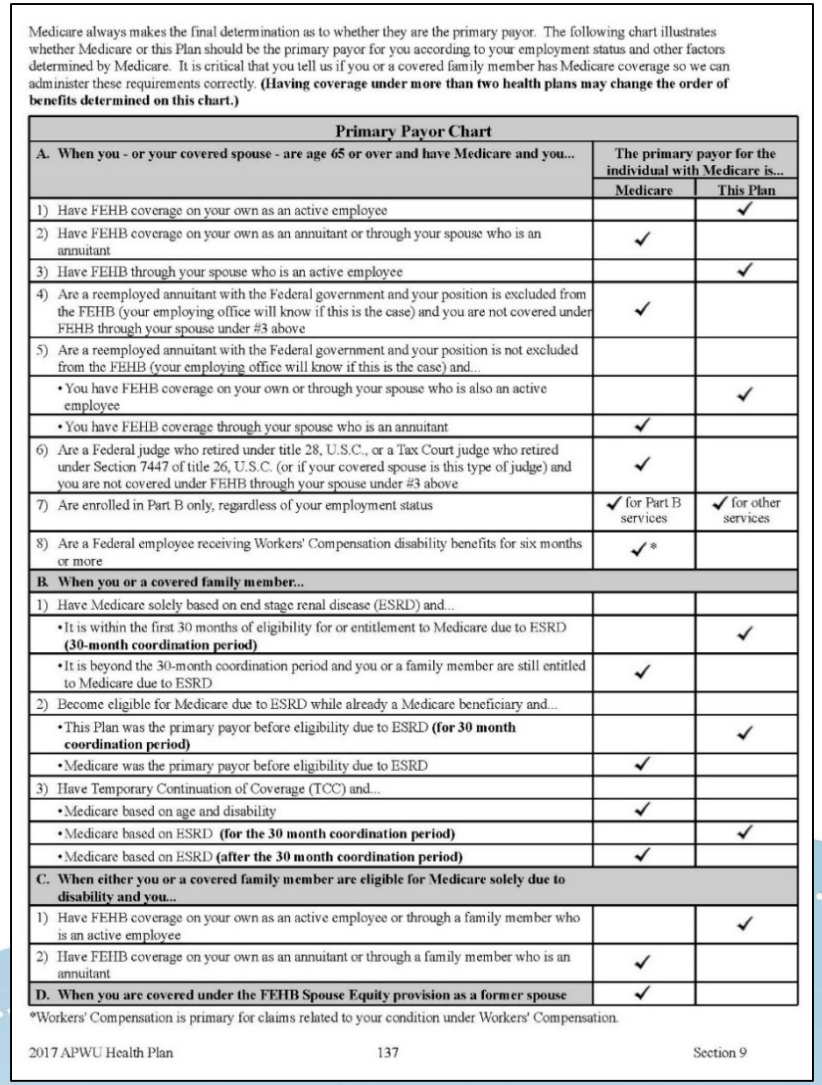
Disagreements between you and the CDHP fiduciary regarding the administration of a Personal Care Account (PCA) are not subject to the disputed claims process.

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

2017 APWU Health Plan 127 Section 8

Section 9: Coordinating Benefits

- Medicare A and B Primary
  - APWU Health Plan waives deductible, copays and coinsurance
  - Claims submitted electronically by Medicare (Traditional Coverage)
  - Paper claims required when a patient has a Medicare Advantage Plan
  - Minimal, if any, patient out-of-pocket costs
  - Preauthorization requirements waived when APWU Health Plan is secondary



Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart

A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

2017 APWU Health Plan 137 Section 9

Section 9: Coordinating Benefits *(cont.)*

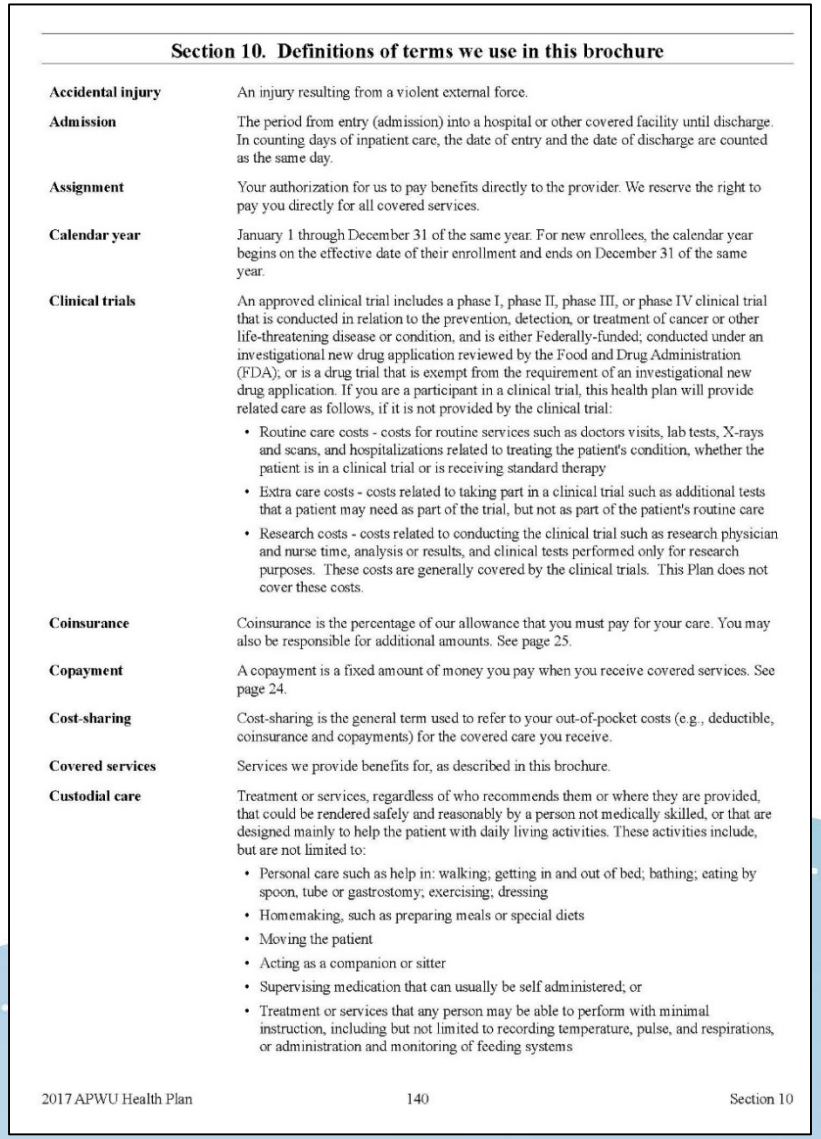
- Other Primary Medical, Dental, or No Fault Insurance
  - Primary payor based on employment status, and relationship to insured
  - Deductibles, copays and coinsurance are not waived
  - Plan pays its normal benefit or the amount due after the primary carriers pays, whichever is lower
  - Paper claims to include the primary payor's EOB/Remittance Advice would be filed to receive reimbursement
  - Preauthorization requirements waived when APWU Health Plan is secondary

Section 9: Coordinating Benefits *(cont.)*

- Medicaid
  - We do not coordinate with Medicaid; APWU Health Plan is the primary payor when a patient has Medicaid coverage
- Worker's Compensation
  - We do not cover services where OWCP (or similar agency) assumes liability
- TRICARE/CHAMPVA
  - APWU Health Plan is the primary payor when a patient is also covered by TRICARE or CHAMPVA

Section 10: Definitions

- Section lists, alphabetically and defines many common terms used in the Brochure
  - Genetic Testing
  - Genetic Screening
  - Medically Necessary
  - Pre-service Claim
  - Post-service Claim
  - Subrogation



Section 10. Definitions of terms we use in this brochure

Accidental injury — An injury resulting from a violent external force.

Admission — The period from entry (admission) into a hospital or other covered facility until discharge. In counting days of inpatient care, the date of entry and the date of discharge are counted as the same day.

Assignment — Your authorization for us to pay benefits directly to the provider. We reserve the right to pay you directly for all covered services.

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

Clinical trials — An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either Federally-funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application. If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs - costs for routine services such as doctors visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy
- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis or results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This Plan does not cover these costs.

Coinsurance — Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 25.

Copayment — A copayment is a fixed amount of money you pay when you receive covered services. See page 24.

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

Covered services — Services we provide benefits for, as described in this brochure.

Custodial care — Treatment or services, regardless of who recommends them or where they are provided, that could be rendered safely and reasonably by a person not medically skilled, or that are designed mainly to help the patient with daily living activities. These activities include, but are not limited to:

- Personal care such as help in: walking; getting in and out of bed; bathing; eating by spoon, tube or gastrostomy; exercising; dressing
- Homemaking, such as preparing meals or special diets
- Moving the patient
- Acting as a companion or sitter
- Supervising medication that can usually be self administered; or
- Treatment or services that any person may be able to perform with minimal instruction, including but not limited to recording temperature, pulse, and respirations, or administration and monitoring of feeding systems

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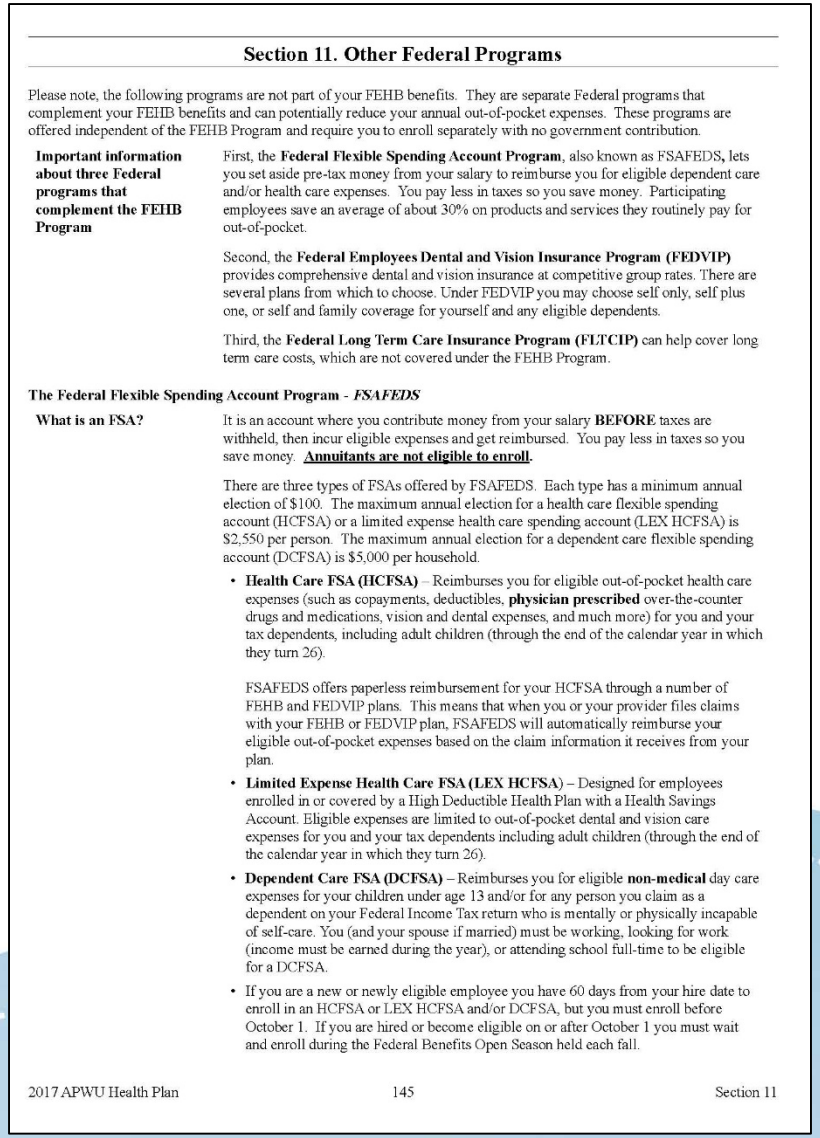
Section 11: Other Federal Programs

- FSA – FSAFEDS
  - Set aside pre-tax money for use in dependent care and/or health care expenses
  - www.FSAFEDS.com
- FEDVIP
  - Program provides comprehensive dental and vision insurance
  - Premiums are withheld on a pre-tax basis
  - www.BENEFEDS.com to enroll



Section 11. Other Federal Programs

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

Important information about three Federal programs that complement the FEHB Program

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

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

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

The Federal Flexible Spending Account Program - *FSAFEDS*

What is an FSA?

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

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

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

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

2017 APWU Health Plan 145 Section 11

Summary: High Option

Summary of benefits for the High Option of the APWU Health Plan - 2017

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

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

Below, an asterisk (*) means the item is subject to the calendar year deductible, $350 (PPO) or $500 (Non-PPO). And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a Non-PPO physician or other health care professional.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office*	PPO: $20 copay per visit (No deductible); 10% of Plan allowance Non-PPO: 30% of our allowance plus amount over our allowance	33
Services provided by a hospital:		
• Inpatient	PPO: 10% of Plan allowance Non-PPO: $300 per admission and 30% of our allowance plus amount over our allowance	53
• Outpatient*	PPO: 10% of Plan allowance Non-PPO: 30% of our allowance plus amount over our allowance	55
Emergency benefits:		
• Accidental injury	PPO: Nothing Non-PPO: Any amount over our allowance	58
• Medical emergency*	PPO 10% of Plan allowance Non-PPO: 10% of our allowance plus amount over our allowance	58
Mental health and substance abuse treatment:	PPO: $20 copay per visit (No deductible); 10% of Plan allowance Non-PPO: 30% of our allowance plus amount over our allowance	59
Prescription drugs:		
• Network pharmacy	$10 generic/25% preferred brand name/40% non-preferred brand name/Specialty drugs 25% generic/25% preferred brand name/40% non-preferred brand name	63
• Non-network pharmacy	50% of cost	63
• Mail order		63

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Thank You!

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

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

The Roundtable discussion will be during Closing Session:

Thursday, October 20, 2016