TOGETHER.
BETTER HEALTH.

Get comprehensive health benefits at an affordable price.

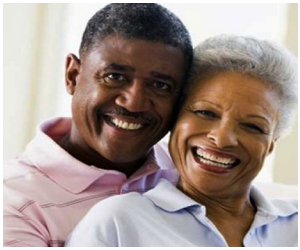
APWU Health Plan's Blueprint to

Medicare

Understanding your health insurance coverage



APWU HEALTH PLAN







This guide is designed to help you understand how APWU Health Plan works with Medicare. Dealing with one health insurance company is complicated enough, having to deal with another can be overwhelming. Medicare is a federal health insurance program for individuals:

- Over 65 years of age
- With certain disabilities
- Who have end-stage renal failure
- Lou Gehrig's disease

Medicare and APWU Health Plan

In general, if you or your spouse are working and are covered by APWU Health Plan, APWU Health Plan is your primary health plan and Medicare is secondary.

If both you and your spouse are retired, Medicare is your primary coverage and APWU Health Plan is secondary.

When you are part of Medicare and the APWU Health Plan, your provider will submit the claim to Medicare. After Medicare pays they will submit the paperwork directly to the APWU Health Plan. As a member there is no need for you to complete any paper work.

To apply for Medicare go to your local Social Security Office, and go through the application process or call 1-800-772-1213. To locate a local Social Security Office visit: www.ssa.gov

If you are eligible for Medicare due to end-stage renal failure (permanent kidney failure), the federal government requires your employer plan (APWU Health Plan) to cover you as the primary health plan for the first 33 months of coverage. After 33 months Medicare becomes your primary health plan and APWU Health Plan becomes secondary.

For more information on Medicare go to:
www.medicare.gov

To get a copy of the Medicare Handbook go to:
www.medicare.gov/publications/pubs/pdf/10050.pdf

Medicare Part A



Part A is the original Medicare insurance coverage and it helps pay for hospital bills. When you sign up for Medicare, you are automatically enrolled in Part A. There usually is no premium for Part A because either you or your spouse paid for Medicare while employed.
Part A covers hospital costs, such as:

- Hospital rooms and in-patient ancillary charges
- Meals
- Nursing services
- Hospice care and home health care

Payment varies based on your employment status. If you or your spouse is still working, APWU Health Plan is your primary health plan and we will pay first. If both you and your spouse are retired then Medicare pays first and APWU Health Plan pays second. Both the High Option and Consumer Driven Option have automatic claims submission agreements with the Centers for Medicare and Medicaid Services.

How APWU Health Plan works with Part A: Hospital Services

In general, members with Medicare Part A as their primary insurance do not have to pre-certify hospital stays with the Health Plan. One exception to this is, a stay must be pre-certified prior to the 60th day of confinement in a Benefit Period. All stays at a Veteran's Affairs or Department of Defense hospital must be pre-certified with the Health Plan, as Medicare does not make payments to those types of facilities. See the Health Plan's Brochure for information regarding pre-certification.

Please refer to the Medicare Handbook for more information on "Benefit Periods," and other services covered by Medicare Part A, such as Home Health Care, Hospice Care and Skilled Nursing Facilities.

When a provider participates with Medicare, they will accept Medicare's allowed payment and will bill Medicare directly.

Worldwide Coverage

Medicare generally does not pay for hospital or medical services outside the United States (Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands are considered part of the United States). However, APWU Health Plan's High Option and Consumer Driven Option coverage travels with you around the world. When you have services outside the United States, you will probably have to pay the bill at the time of service, then submit a bill directly for reimbursement.



Part A

Medicare Part B

Medicare Part B is a supplemental insurance option for people who qualify for Medicare. Its purpose is to provide coverage for health care not covered under Part A. Part B provides coverage for doctors services and other medical services that Part A doesn't cover. Additional services covered include: Doctor visits whether inpatient or outpatient

- Laboratory tests and X-rays
- Physical therapy or rehabilitation services
- Ambulance service
- Some home health care
- Various medical equipment and supplies when they are medically necessary

You must sign up for Medicare Part B and pay a monthly premium, and yearly deductible. The cost for the premium is deducted from your Social Security check. For approved services and supplies, you are responsible for a 20 percent co-insurance after you pay an annual deductible. The premium increases occur in January. If you do not sign up for Medicare Part B when you are first eligible, you may have to permanently pay a higher monthly premium.

When an APWU Health Plan member is enrolled in Medicare Part B, Medicare pays first and the Plan is billed the remaining cost. Generally, with the High Option most of your medical expenses are covered; with the Consumer Driven Option the deductibles and coinsurance are not waived. The Health Plan suggests that members explore this option and consider it. It will reduce your total out-of-pocket expense, but is not mandatory.

How APWU Health Plan works with Part B:

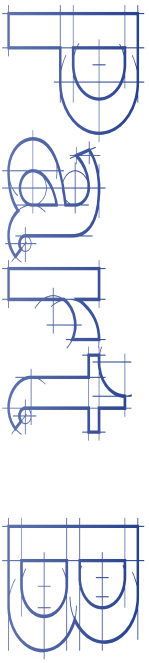
Medicare Participating Doctors and Suppliers

Medicare will pay the provider of service directly. Medicare usually pays for covered services at an 80% payment rate after satisfaction of Medicare Part B's annual deductible.

As long as services represent a covered benefit, the APWU Health Plan's High Option will pay the Part B deductible then pay the 20% coinsurance and $18.00 copayment.

With the Consumer Driven Option, if the benefit dollars are available in the Personal Care Account, the Medicare deductible and coinsurance will be paid.

For both options, if the provider accepts Medicare's assignment, the provider will reduce his or her charge to no more than the Medicare allowance. You pay nothing for the covered charges up to our allowance.



Doctor Does Not Participate With Medicare

If your doctor does not accept Medicare's Assignment, you may be required to pay for your services at the time they are rendered. Additionally, your doctor may charge you (or your secondary plan) more than Medicare's allowed amount. Federal law limits the amount that a doctor or other medical provider can charge you. Doctors cannot charge more than 115% of Medicare's allowance. This means that if a doctor charges $150 for a certain service and Medicare's allowance is $100, the doctor can only collect $115 (115% of $100) for the service. If you have paid for the service in full, you may be due a refund if the charge is over 115% of the allowance. If you think that you have been charged in excess of the 115% ask your doctor for a refund. If you have trouble getting excess charges refunded, contact you Medicare Part B Carrier. Providers of service who repeatedly charge more than this amount may be subject to severe sanctions.

If a doctor has "opted out" of the Medicare program they cannot bill services to Medicare. Often these doctors will ask patients to sign a private contract for services covered by Medicare. If this happens you may be responsible for any or all costs not covered by the APWU Health Plan.

Other Plans

Medicare C (Medicare Advantage Plans) are private health plans that are Medicare approved. As a member of the Health Plan there is no need to take part in Medicare C.

Medicare D is Medicare's prescription drug program. Prescription coverage is an integral part of your total health benefits package with APWU Health Plan. As a member of the APWU Health Plan, the prescription drug benefit you receive through the Health Plan can exceed that of Medicare D. There is no need to take part in Medicare D.
The amount that APWU Health Plan covers and/or its share of the cost of prescription drugs is the same or more than that of the standard Medicare Part D prescription drug benefits. There is an additional premium for Medicare Part D.

If you have a Medicare prescription drug plan and Health Plan coverage, when filling a prescription at a retail pharmacy, be sure to use both prescription drug ID cards; and be sure the retail pharmacy is in the network for both plans. If you use a mail-order pharmacy through your Medicare prescription drug plan, once you receive an Explanation of Benefits from Medicare, submit a claim to the Health Plan with a copy of the EOB and pharmacy receipt.

Prescription Drug Coverage

High Option Prescription Drugs 2016

Network Retail: $10 generic. 25% preferred brand name with a $10 minimum coinsurance up to a maximum of $200 coinsurance per prescription for a 30-day supply. 40% non-preferred brand name with a $20 minimum coinsurance up to a maximum of $300 coinsurance per prescription for a 30-day supply. Non-network Retail: 50% of cost with a $10 minimum coinsurance for a 30-day supply. Network Mail Order: $20 generic. 25% preferred brand name with a $20 minimum coinsurance up to a maximum of $300 coinsurance per prescription for a 90-day supply. 40% non-preferred brand name with a $30 minimum coinsurance up to a maximum of $500 coinsurance per prescription for a 90-day supply.

Specialty Prescription Drugs

Network Retail: 25% generic with up to a maximum of $300 per prescription for a 30-day supply. 25% preferred brand name with a $40 minimum coinsurance up to a maximum of $600 coinsurance per prescription for a 30-day supply. 40% non-preferred brand name with a $60 minimum coinsurance up to a maximum of $1,000 coinsurance per prescription for a 30-day supply. Non-network Retail: 50% of cost with a $10 minimum coinsurance for a 30-day supply. Network mail Order: 25% generic with a maximum of $150 coinsurance per prescription for a 90-day supply. 25% preferred brand name with a $20 minimum coinsurance up to a maximum of $300 coinsurance per prescription for a 90-day supply. 40% non-preferred brand name with a $30 minimum coinsurance up to a maximum of $500 coinsurance per prescription for a 90-day supply

Consumer Driven Option

Prescription drugs are covered at 100% through your Personal Care Account as long as you use a network pharmacy. If the PCA is exhausted and your Deductible met, Traditional Health Coverage begins. There is no prescription drug deductible. Members pay 25% of the charge for either Network Retail (minimum $10), with a maximum of $200 per prescription; or Mail Order drugs (minimum $15), and a maximum of $600 per prescription. There is no prescription drug benefit if you use out-of-network pharmacies.

Medicare Part D- The amount that APWU Health Plan covers and/or its share of the cost of prescription drugs is the same or more than that of the standard Medicare Part D prescription drug benefit. There is an additional premium for Medicare Part D.

If you use a mail-order pharmacy through your Medicare prescription drug plan, once you receive an Explanation of Benefits from Medicare, submit a drug reimbursement form available at myuhc.com to the Health Plan with a copy of the EOB and pharmacy receipt.

For more information on prescription coverage with the Consumer Driven Option call 1-(800) 309-5528.

If you have a Medicare prescription drug plan and Health Plan coverage, when filling a prescription at a Retail Pharmacy, be sure to use both prescription drug ID cards; and be sure the Retail Pharmacy is in the network for both plans.



Medicare Limiting Charge

All insurance carriers in the Federal Employees Health Benefits Program (FEHBP) have been mandated by federal law to limit payments for retired members 65 and older who do not have Medicare.

Doctors, hospitals and other medical providers will absorb any reductions in payment. Our members will still only be responsible for deductibles, coinsurance, amounts over reasonable and customary limits and non-covered charges. If a retired member, 65 and over without Medicare Part A, requires an inpatient hospital stay, the APWU Health Plan will:

1. Determine if the hospital participates with Medicare
2. If the hospital participates, the Health Plan will base its payment on the same formula that Medicare uses to price and pay for inpatient hospital stays

After the plan makes payment, the law prohibits the hospital from charging you more for covered services, any deductibles, coinsurance or copayments that you owe under the Plan. Any coinsurance you owe will be based on the Medicare equivalent amount, not actual charges.

If a retired member, age 65 or older without Medicare Part B requires services that are normally covered by Part B of Medicare, the Plan is mandated to base its payment on the Medicare Part B fee schedule or the doctor's actual charge, whichever is lower. If you see a doctor who normally participates with Medicare, the doctor has to accept the Plan's approved amount as payment in full. In other words, the doctor may not charge for more than the deductible, coinsurance or copayments, and any non-covered charges. He or she may not charge you for amounts over the Medicare fee schedule.

Please refer to the APWU Health Plan's Federal Brochure for more information about the Medicare limiting charges.



Claims Filing

If you are still working send your claims to:

For High Option
CIGNA HealthCare
PO Box 188004
Chattanooga, TN 37422

For Consumer Driven Option
UnitedHealthcare
PO Box 740810
Atlanta, GA 30374-0810

If you are retired:
Your provider of medical service will bill Medicare on your behalf if Medicare covers the services. Your Medicare carrier will process charges, and after processing they will:

- Send you a copy of their payment statement.
- Electronically send payment data to the Health Plan so we can consider any balance due. (This means that you do not need to submit a separate claim to us, it is done automatically.)

For charges that Medicare does not cover, such as dental services, you will need to submit a claim to the Health Plan for the High Option or UnitedHealthcare for the Consumer Driven Option.

Contact Us

High Option
(8:30 am - 7:00 pm, EST, Monday through Friday)
(800) 222-APWU (222-2798)
(800) 622-2511 (TDD)
apwuhp.com
custser@apwuhp.com

Consumer Driven Option
UnitedHealthcare
(800) 718-1299
apwu.welcometouhc.com

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Together. Better Health.®

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This is a summary of features of the APWU Health Plan. Before making a final decision, please read the Health Plan's Federal Brochure (RI 71-004). Other benefits not shown above are shown in the Brochure. All benefits are subject to the definitions, limitations and exclusions set forth in the Plan's Brochure.

The information in this brochure is based on the Health Plan's interpretation of the Medicare Handbook. If you have questions about how Medicare processes its claims, please contact the Medicare carrier that serves your geographic area.

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