BASIC AND REFRESHER



APWU HEALTH PLAN

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33rd Annual Open Season Seminar

Today's Agenda

Objective: At the end of this presentation, you will understand the following:

- Health Insurance Terminology
- 2019 Brochure
  - Layout
  - Sections
  - 2019 Changes
- Review APWU Health Plan benefits for 2019
  - Examples
  - Live scenarios

APWU HEALTH PLAN

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HEALTH INSURANCE TERMINOLOGY



33rd Annual Open Season Seminar

Basic Terms

PPO vs. Non PPO

Covered Services

Allowed Amount

Preventive Care

Balance Bill

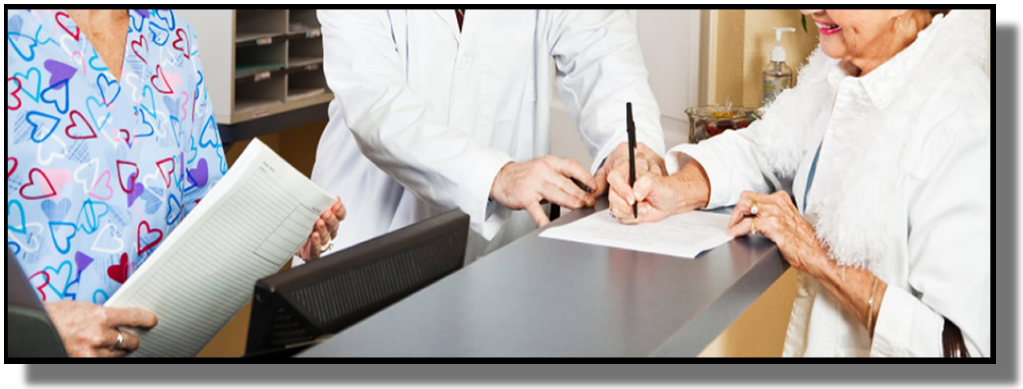
Precertification

Prescription Drugs - Tiers

Personal Care Account (PCA)

PPO vs. Non-PPO

- **In-network = PPO:** Facilities, providers and suppliers who contract with a network to provide health services to our members
- **Out-of-network = Non-PPO:** Facilities, providers and suppliers who do not contract with a network



We participate with the following Networks: Cigna (OAP), V.I. Equicare, UHC, Beacon Health Options

Allowed Amounts

- The maximum amount of money on which payment is based for covered eligible health care services

PPO Provider bills $100	**Non-PPO Provider bills $100**
PPO Network allowable $80	**Health Plan allowable $75**
Payment is based on the $80	**Payment is based on the $75**

Balance Bill

- What a Non-PPO provider can bill you after the Health Plan has paid their portion of covered billed charges
- PPO providers should only charge you your deductible, copay and/or coinsurance; they should not bill you the difference between the PPO allowable and what they billed

Balance Bill

- Non-PPO (or out-of-network) providers can bill you for the coinsurance that you owe and the difference between the Health Plan allowable amount and what they charged for the service

Non-PPO Provider bills $1,500
Health Plan Allowance $1,200
Member Coinsurance $360 ($1200 X 30% = $360)
Plus the difference between the $1,200 and the $1,500 ($300)
Total $660

Precertification

- Before having certain types of medical care or services, you will need to get either prior approval or precertification
- It's important that you understand when prior approval or precertification is needed to keep your benefits from being reduced
- Precert penalty for inpatient services is $500

Precertification

- Examples of services that require precertification include:
  - Inpatient hospital admission
  - Organ transplantation
  - Durable medical equipment
  - Genetic testing
  - Skilled Nursing Facility (SNF)
  - Residential Treatment Facility
  - Other services as outlined in the current brochure



Preventive Care

- Routine screenings are procedures performed to help keep a member healthy and identify conditions that may go unnoticed; when performed by an in-network provider, they are covered at 100%

Immunizations

Labs

X-rays

Annual Visit

Colonoscopy

Cologuard New in 2019

Mammogram

Cost Sharing Terms – Consider more than the premium

Premium

Coinsurance

Copays

Catastrophic Limit

Deductible

Tier

Premium

- The amount that must be paid for your coverage
- One of the first things employees consider:
  - **Postal:** Biweekly reductions from pay by United States Postal Service
  - **Federal:** Biweekly reductions from pay by employing agency
  - **Retiree:** Monthly reductions from pay by Office of Personnel Management

Copay or Copayment

- A fixed amount of money you pay for certain services
- Normally payable at the time of service

High Option:

$25 copay for a PPO office visit and specialist

$40 copay for urgent care facility

$10 generic medication (Tier 1)

Coinsurance

- The percentage that **you must pay** for your care

High Option:

- 10% (in-network)
- 30% (out-of-network)

Consumer Driven Option:

- 15% (in-network)
- 40% (out-of-network)

Deductible (High Option)

- A fixed amount of covered expenses you need to incur for certain covered services before the Health Plan starts paying for those services

PPO:	**$350 (Self Only)**
	$700 (Self Plus One; Self and Family)
Non-PPO:	**$500 (Self Only)**
	$1,000 (Self Plus One; Self and Family)

Deductible Example

- January 17 and you haven't submitted any claims
- You go to the PPO provider and pay a $25 copay *(not subject to deductible)*
- Doctor orders a chest X-ray and charges $300
- The PPO allowable amount is $210
- The entire $210 is your responsibility ***(YOU PAY)*** and the $210 goes towards your deductible

Catastrophic Limit
Out-of-pocket limit (High Option)

- Yearly maximum
- The most you pay during a policy period before your health plan begins to pay 100% of the allowed amount
- This limit never includes your premium, balance-billed charges or health care your health plan doesn't cover

PPO:	**$5,500 (Self Only)**
	$9,000 (Self Plus One; Self and Family)
Non-PPO:	**$10,000 (Self Only)**
	$15,000 (Self Plus One; Self and Family)

Covered Services

- Services we provide benefits for that are listed in our brochure

Doctor Visits

Prescription Drug

RN Visits

Inpatient Hospitalization

Labs

PT, OT, ST, ABA

X-rays

Mental Health Visits

Prescription Drug Terms

- **Preferred Formulary:** A list of selected covered drugs based on clinical effectiveness and lower cost
  - High Option: Express Scripts
  - Consumer Driven Option: OptumRx

Prescription Drug Terms

- **Brand Name Drugs:** Are protected by a patent and manufactured and sold only by the company holding the patent
- **Generic Drugs:** When the patent for the brand name drug expires, generic versions of the drug can be offered for sale if the FDA agrees; generic drugs are *generally* less expensive than brand name drugs

Consumer Driven Option: Personal Care Account (PCA)

- As part of the premium members are given an account that is fully funded by the Health Plan with the following levels:
  - Self Only: $1,200
  - Self Plus One and Self and Family: $2,400
- If you don't use it all, it rolls over to the next year to a maximum account balance of:
  - Self Only: $5,000
  - Self Plus One and Self and Family: $10,000

Prescription Drug Tiers

- High Option – Express Scripts
  - Tier 1 Generic Drugs
  - Tier 2 Preferred Brand Drugs
  - Tier 3 Non-Preferred Brand Drugs
  - Tier 4 Specialty Generic Drugs
  - Tier 5 Specialty Preferred Brand Drugs
  - Tier 6 Specialty Non-Preferred Brand Drugs

Prescription Drug Tiers *(continued)* Consumer Driven Option - OptumRx

Tier 1	**Medications that provide the highest overall value. Mostly generic drugs. Some brand name drugs may also be included.**	**Use Tier 1 drugs for the lowest out-of-pocket costs.**
Tier 2	Medications that provide good overall value. A mix of brand name and generic drugs.	Use Tier 2 drugs, instead of Tier 3, to help reduce your out-of-pocket costs.
Tier 3	Medications that provide the lowest overall value. Mostly brand name drugs, as well as some generics.	Ask your doctor if a Tier 1 or Tier 2 option could work for you.

Consumer Driven Option: PCA

- The PCA is used when services are provided for treatment of an illness
- The cost for services where the brochure indicates “You Pay Nothing” are not taken from your PCA
  - Preventive – in-network
  - Maternity

Consumer Driven Option: PCA

- When the PCA is exhausted, then you have to satisfy the deductible:
  - Self Only: $800
  - Self and Family: $1,600
- After deductible is met; coinsurance is applied to member:
  - 15% for in-network services
  - 85% is paid by the Health Plan

APWU HEALTH PLAN

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High Option and Consumer Driven Option



33rd Annual Open Season Seminar

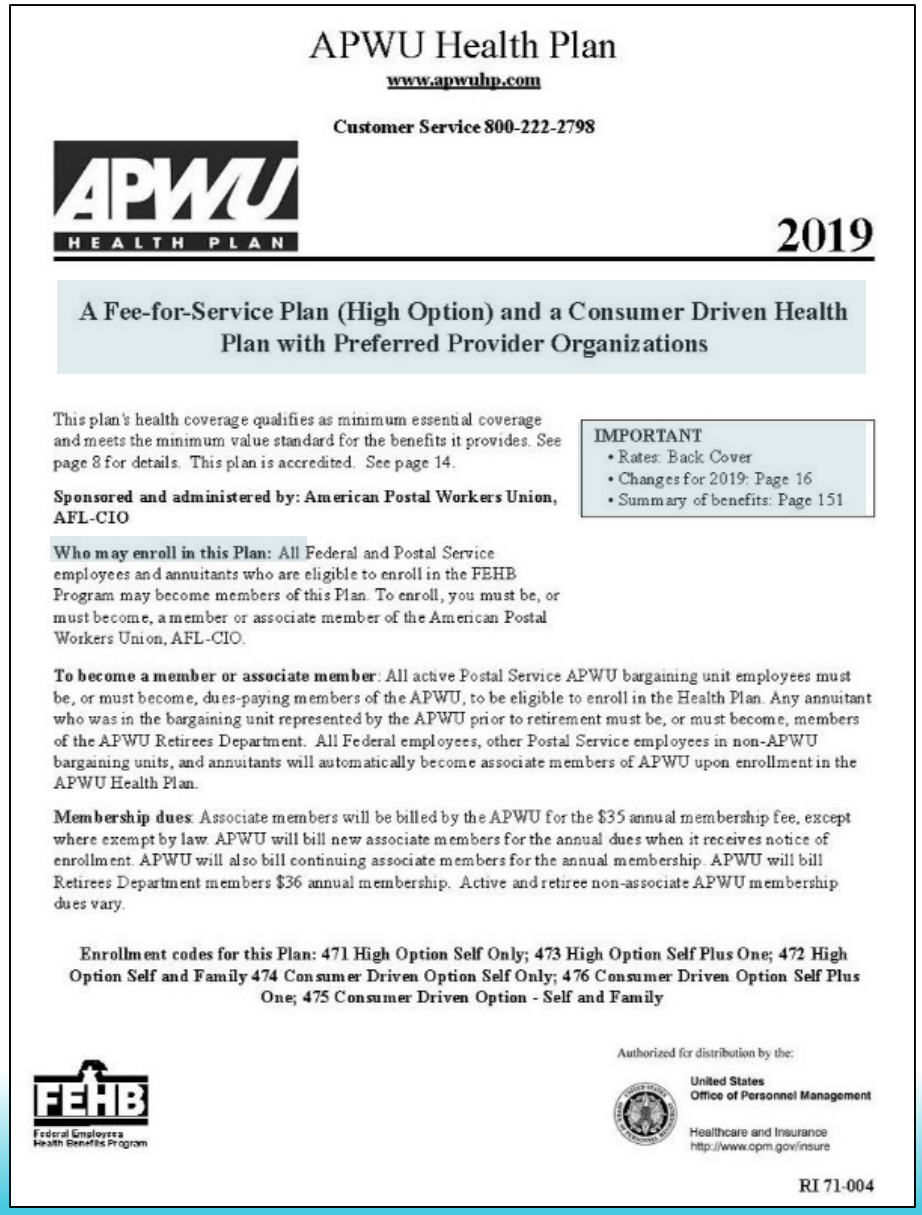
Brochure Tour

Type of Plan…

Who can join…

How to join…

Enrollment Codes



APWU Health Plan

www.apwuhp.com

Customer Service 800-222-2798

APWU HEALTH PLAN

2019

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. This plan is accredited. See page 14.

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.

IMPORTANT
- Rates: Back Cover
- Changes for 2019: Page 16
- Summary of benefits: Page 151

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. Any annuitant who was in the bargaining unit represented by the APWU prior to retirement must be, or must become, members of the APWU Retirees Department. 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. APWU will bill Retirees Department members $36 annual membership. Active and retiree non-associate APWU membership dues vary.

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

FEHB Federal Employees Health Benefits Program

Authorized for distribution by the:

United States Office of Personnel Management

Healthcare and Insurance http://www.opm.gov/insure

RI 71-004

Who is an Associate member…

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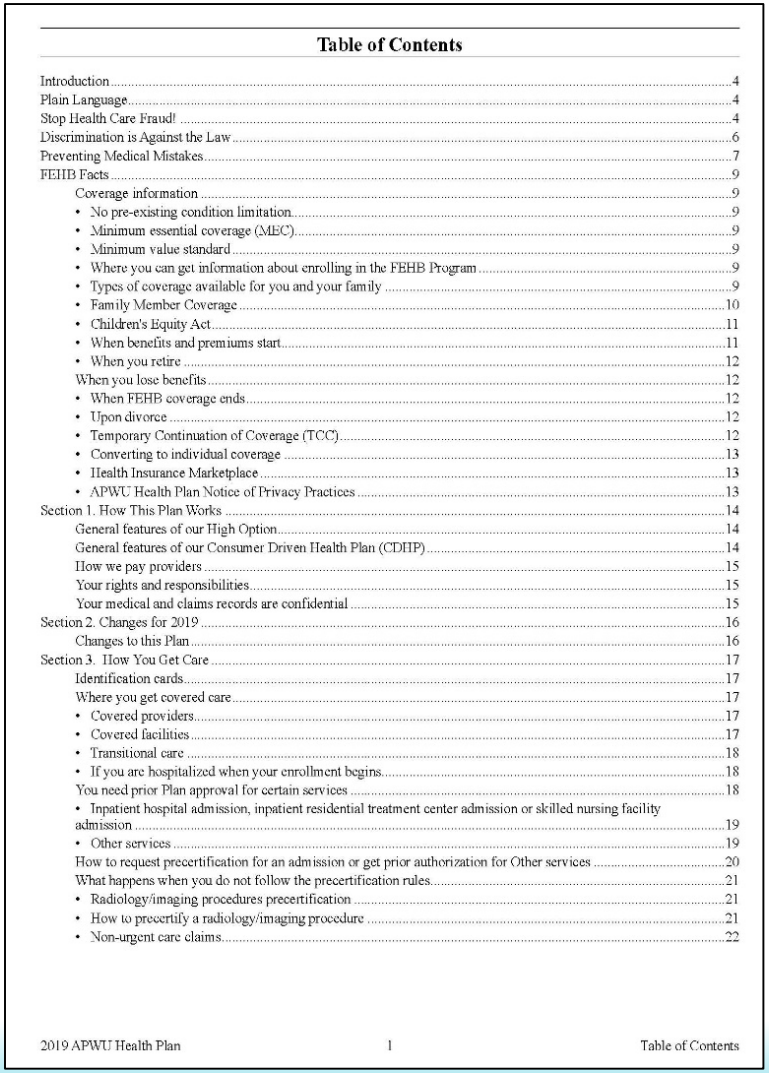
- Section 1: How This Plan Works
- Section 2: Changes for 2019
- Section 3: How You Get Care



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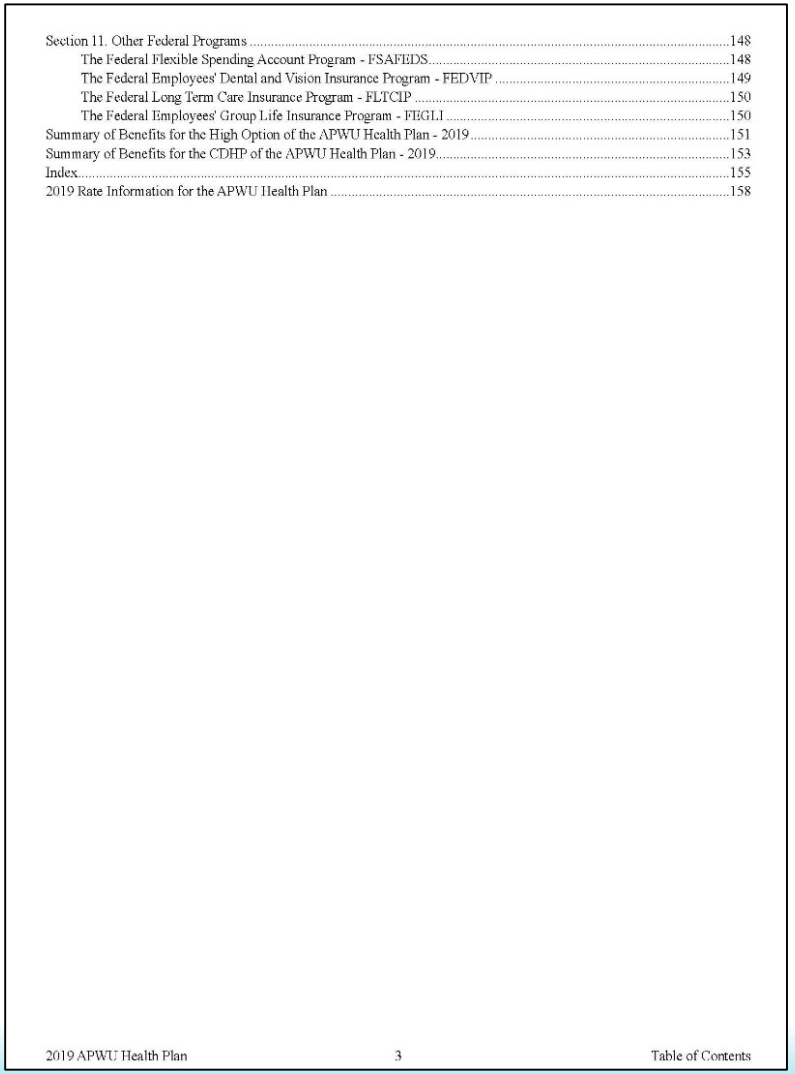

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- Fraud
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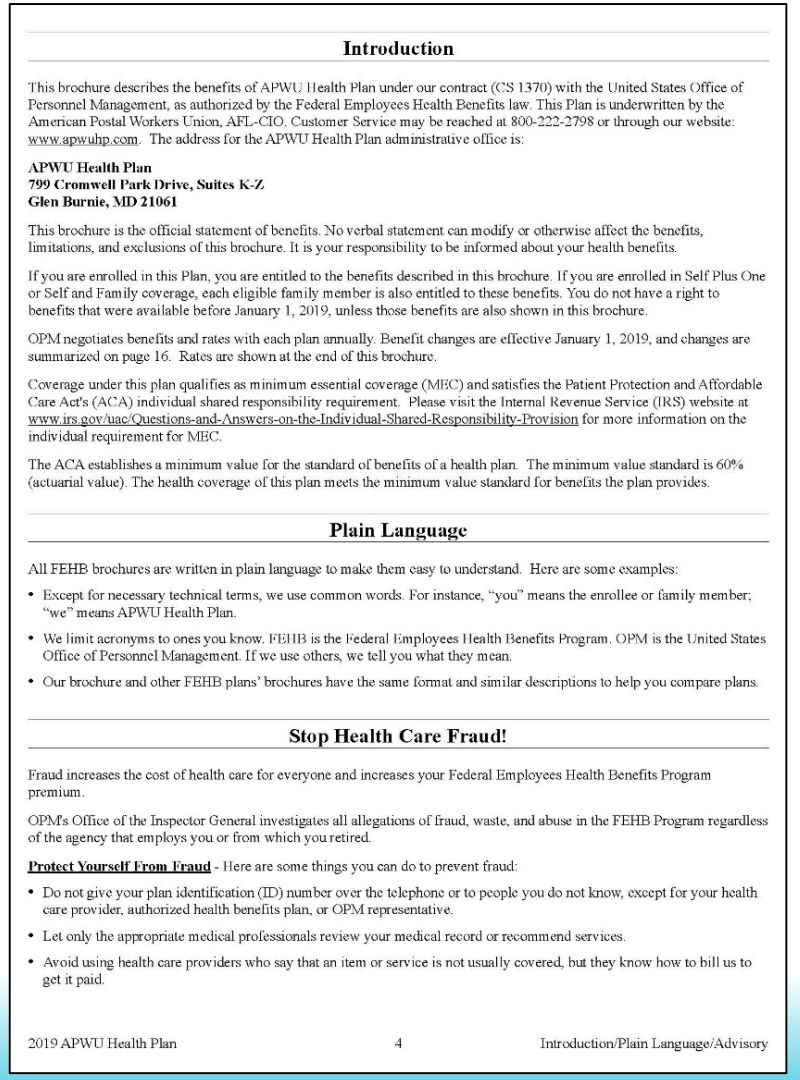
- Patient Safety
- FEHB Facts
- Who's covered and when?



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 800-222-2798 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 Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2019, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2019, and changes are summarized on page 16. 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 meets 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.

2019 APWU Health Plan 4 Introduction/Plain Language/Advisory

Section 1: How This Plan Works (Pg 14)

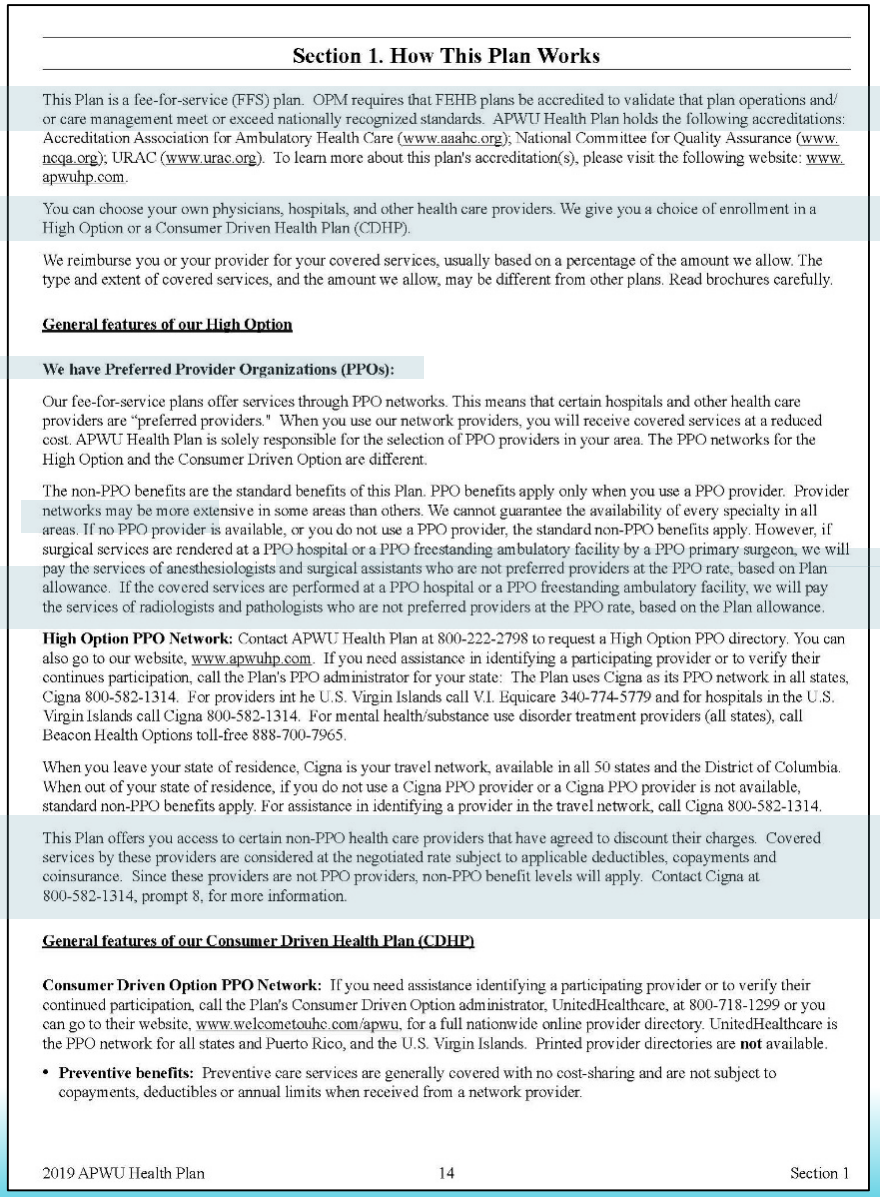
We are a FFS plan

We offer PPO…

Non-PPO is standard…

High Option

Consumer Driven Option



Section 1. How This Plan Works

This Plan is a fee-for-service (FFS) plan. OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet or exceed nationally recognized standards. APWU Health Plan holds the following accreditations: Accreditation Association for Ambulatory Health Care (www.aaahc.org); National Committee for Quality Assurance (www.ncqa.org); URAC (www.urac.org). To learn more about this plan's accreditation(s), please visit the following website: www.apwuhp.com.

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 800-222-2798 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 continues 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 int he 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 use disorder treatment 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, www.welcometouhc.com/apwu, for a full nationwide online provider directory. UnitedHealthcare is the PPO network for all states and Puerto Rico, and the U.S. Virgin Islands. 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.

High Option PPO Vendors:
Cigna
VI Equicare
Beacon Health Options

Consumer Driven Option
PPO Vendors:
UnitedHealthcare
Beacon Health Options

Section 1: How This Plan Works (Pg 15)

Provider payments…

Member rights…

- **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.

Non-PPO providers: We determine our allowance for covered charges by using health care charge data prepared by Context4Healthcare for the High Option and Fair Health for the Consumer Driven Health Plan, including our own data, when necessary. We apply this charge data under the High Option at the 70th percentile and under the Consumer Driven Option at the 80th percentile.

Your rights and responsibilities

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB website, www.opm.gov/insure lists the specific types of information that we must make available to you. Some of the required information is listed below.

- The American Postal Workers Union Health Plan is a not-for-profit Voluntary Employee's Beneficiary Association (VEBA) formed in 1972.
- We meet applicable State and Federal licensing and accreditation requirements for fiscal solvency, confidentiality and transfer of medical records.

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website APWU Health Plan, www.apwuhp.com. You can also contact us to request that we mail a copy to you by calling 800-222-2798, or write to APWU Health Plan, P.O. Box 1358, Glen Burnie, MD 21060-1358. You may also contact us by fax at 410-424-1564.

By law, you have the right to access your personal health information (PHI). For more information regarding access to PHI, visit our website APWU Health Plan at www.apwuhp.com to obtain a Notice of our Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Section 2: Changes for 2019 (Pg 16)

Section 2. Changes for 2019

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

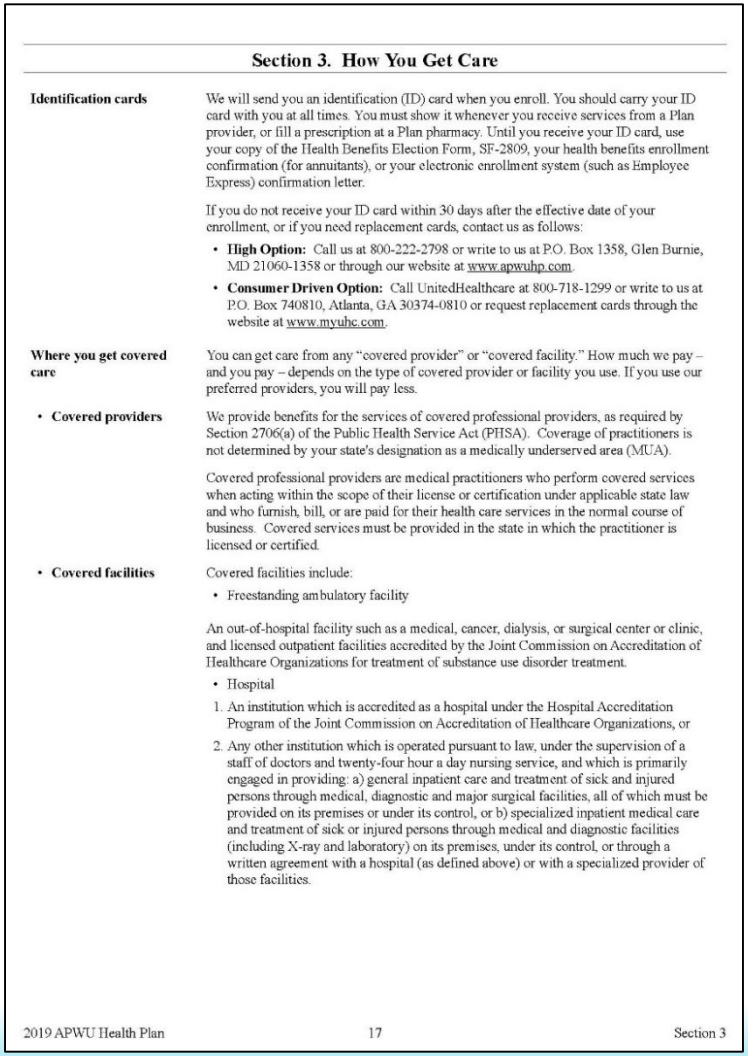
- Your share of the Postal premium will increase for Category 1 and Category 2 Self Only, Self Plus One and Self and Family (see page 158).
- Your share of the non-Postal premium will increase for Self Only, Self Plus One and Self and Family (see page 158).
- The Plan will add coverage for Skilled Nursing Facility care (see page 57).
- The Plan will add 100% coverage for in-network Naloxone and Narcan for the treatment of opioid overdose (see page 67).
- The Plan will cover at home colorectal cancer screening Cologuard Kit (see page 36).
- The Plan will cover Residential Treatment Centers for mental health and substance use disorders (see page 62).
- The Plan will cover transgender surgery (see page 48).
- Accidental injury will now be covered at 100% if care is received within 72 hours (see page 60).
- The Plan will increase the number of visits for chiropractic care to 24 (see page 45).
- The Plan will eliminate the minimum copayment for prescription drugs (see page 66).
- Trigger point injections will no longer require prior approval (see page 19).
- The Plan will reduce the copayment for virtual visits through American Well to $15 (see page 35).
- For prescription drugs, the Plan will now provide the option of obtaining maintenance drugs at a Smart90 Retail Network Pharmacy (see page 64).
- The Plan will now require members to obtain Specialty medications through Accredo (see page 70).
- Prescription drug step therapy will be expanded to include the following therapeutic categories: allergies, respiratory conditions, stimulants, bone conditions, genitourinary conditions, diabetes, endocrine disorders, blood disorders, cardiovascular disease, inflammatory conditions, neurologic disorders, depression, metabolic disorder, migraines, pain, gastrointestinal disorders, and rare disease. (see pages 69).

Changes to our Consumer Driven Health Plan only

- Your share of the Postal premium will increase for Category 1 and for Category 2 Self Only, Self Plus One and Self and Family (see page 158).
- Your share of the non-Postal premium will increase for Self Only, Self Plus One and Self and Family (see page 158).
- The Plan will add coverage for Skilled Nursing Facility (see page 107).
- The Plan will add 100% coverage for in-network Naloxone and Narcan for the treatment of opioid overdose (see page 116).
- The Plan will cover at home colorectal cancer screening Cologuard Kit (see page 78).
- The Plan will cover Residential Treatment Center coverage for mental health and substance use disorder (see page 112).
- The Plan will cover transgender surgery (see page 98).
- The Plan will increase the number of visits for chiropractic care to 24 (see page 95).

Section 3: How You Get Care (Pgs 17-24)

- ID Cards (Pg 17)
- Precertification Process (Pgs 18-22)
  - Inpatient Hospital Admission
  - $500 Penalty
  - High Option: Call Cigna/CareAllies at 800-582-1314
  - Consumer Driven Option: Call UnitedHealthcare at 800-718-1299
- Other Services (Pg 19)



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 800-222-2798 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 use disorder treatment.

- 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.

2019 APWU Health Plan 17 Section 3

Do I need a precertification? High Option

Yes

- ✓ Applied Behavioral Analysis (ABA)
- ✓ Transcranial Magnetic Stimulation (TMS)
- ✓ Bariatric Surgery
- ✓ DME
- ✓ Genetic Testing (i.e. BRCA)
- ✓ In-patient Admission – Medical and/or Mental Health
- ✓ Speech Therapy
- ✓ Treatment Back/Neck Pain
- ✓ Outpatient Radiology Services (CT/MRI/MRA/PET)

No

- ✓ Acupuncture Treatment
- ✓ Chiropractic Care
- ✓ Maternity Care/Admissions
- ✓ Outpatient Services at VA
- ✓ Physical and Occupational Therapy

Do I need a pre-notification? Consumer Driven Option

Yes

- ✓ Applied Behavioral Analysis (ABA)
- ✓ Transcranial Magnetic Stimulation (TMS)
- ✓ Bariatric Surgery
- ✓ DME
- ✓ Genetic testing (i.e. BRCA)
- ✓ In-patient Admission – Medical and/or Mental Health
- ✓ Treatment Back/Neck Pain

No

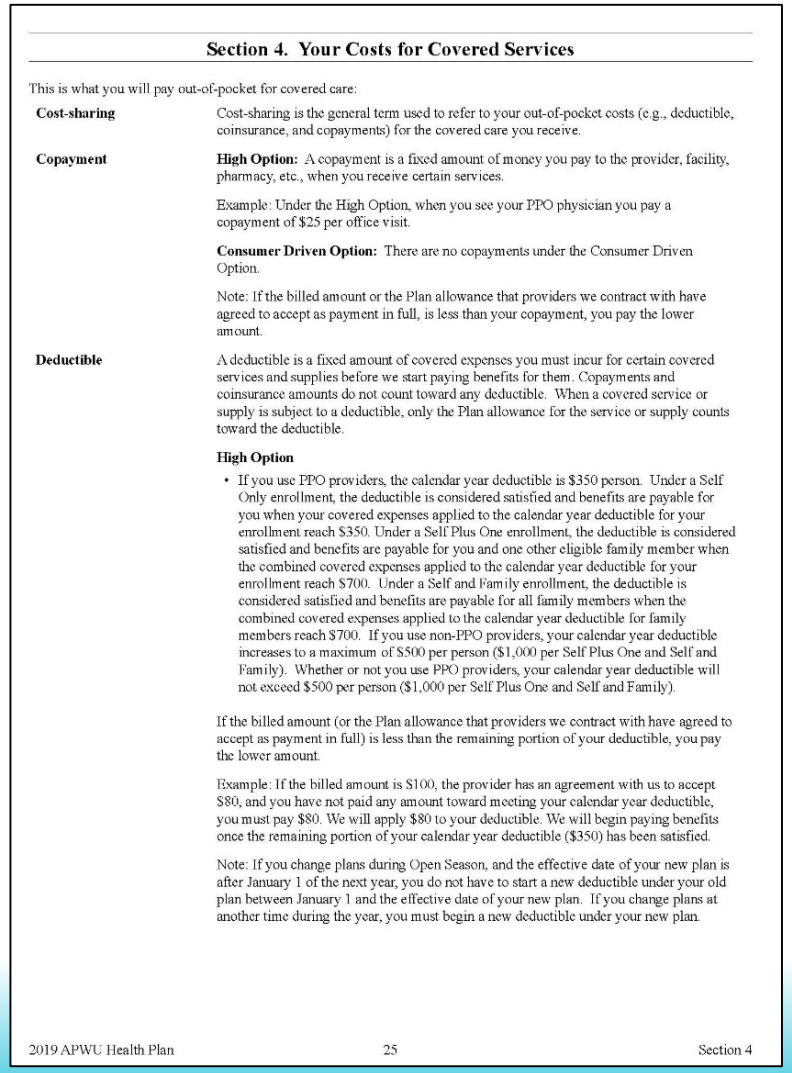
- ✓ Acupuncture Treatment
- ✓ Chiropractic Care
- ✓ Maternity Care/Admissions
- ✓ Outpatient Services at VA
- ✓ Physical, Occupational and Speech Therapy

Reconsiderations/Appeals (Pgs 23-24)

- Steps to request reconsideration of pre-service decision
- Steps to appeal a decision
  - Must appeal within 6 months of initial Health Plan decision

Section 4: Your costs for covered services (Pgs 25-30)

- Out-of-pocket cost
  - Copay
    - CDHP: $0 Copay
  - Deductible
  - Coinsurance
- PPO vs. Non PPO
  - Balance billing
- Catastrophic costs
  - Out-of-pocket max
  - Inclusions/Exclusions



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 $25 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.

Deductible

Definition: A fixed dollar amount of covered expenses a member must incur before benefits can be paid.

High Option Deductible (Pg 25)

- 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
- Copays and coinsurance do not count toward Deductible amounts

Consumer Driven Option Deductible (Pg 26)

PCA

(Covered services paid at 100%)

Deductible

(You pay full cost until deductible is met)

Coinsurance

(Cost sharing)

Consumer Driven Option Deductible (Pg 26)

Deductible must be met before Traditional Health Coverage Begins

- **Self Only:** $2,000, but the Health Plan prefunds your Personal Care Account (PCA) with $1,200, so **you pay $800**

- **Self Plus One; Self and Family:** $4,000, but the Health Plan prefunds your Personal Account (PCA) with $2,400, so **you pay $1,600**

High Option Coinsurance (Pg 26)

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

Consumer Driven Option Coinsurance (Pg 26)

Definition: The percentage of covered allowances for which the patient is responsible. Coinsurance does not begin until the PCA is used and the Deductible is met.

PPO vs. Non-PPO (Pg 27)

In-network = PPO

- Facilities, providers, and suppliers who contract with a network to provide health services to our members at a discounted rate
  - Member cost share will consist of deductible, coinsurance, or copayment, based on allowable amount

Out-of-network = Non-PPO

- Facilities, providers, and suppliers who do not contract with a network
  - Member cost share will consist of deductible and coinsurance, PLUS any difference between our allowance and billed charges; this difference is considered ‘balanced billing’

High Option
PPO vs. Non-PPO

EXAMPLE	PPO Physician	Non-PPO Physician
Physician's Charge	$150	$150
Our Allowance	$100	$100
We Pay	90% of allowance: $90	70% of allowance: $70
You owe: Coinsurance*	10% of allowance: $10	30% of allowance: $30
+ Difference up to billed charge?	No: $0	Yes: $50
Total You Pay	$10	$80

* ***Example assumes deductible has been met***
* ***Example is not an office visit***

Consumer Driven Option
PPO vs. Non-PPO

EXAMPLE	PPO Physician	Non-PPO Physician
Physician's Charge	$1,500	$1,500
Our Allowance	$1,000	$1,000
We Pay	85% of allowance: $850	60% of allowance: $600
You owe: Coinsurance*	15% of allowance: $150	40% of allowance: $400
+ Difference up to billed charge?	No: $0	Yes: $500
Total You Pay	$150	$900

* ***Example assumes PCA has been used and deductible has been met***

Catastrophic Out-of-Pocket Max (Pgs 28-30)

- When you reach the Catastrophic maximum, you pay no coinsurance for covered services for the remainder of the calendar year
- In-network expenses apply toward out-of-network maximums

High Option			Consumer Driven Option		
	In-network	Out-of-network		In-network	Out-of-network
Self Only	$5,500	$10,000	Self Only	$5,000	$10,200
Self Plus One	$9,000	$15,000	Self Plus One	$10,000	$13,700
Self and Family	$9,000	$15,000	Self and Family	$10,000	$13,700

High Option Catastrophic Costs (Pgs 28-29)

- Expenses that count toward the out-of-pocket max:
  - 10% coinsurance (or 5% for Cancer Centers of Excellence) for covered PPO services
  - 30% coinsurance for covered Non-PPO services
  - Copayments (i.e. $25 for outpatient PPO office, or $15 virtual visits through American Well; $40 for outpatient facility charges in an Urgent Care Center)
  - Prescription drug costs (i.e. the 25%/45%/$10 or $20 you pay for in-network prescription drugs)

Not included in out-of-pocket max-High Option (Pgs 28-29)

The following cannot be included in the accumulation of out-of-pocket expenses:

- Expenses in excess of our allowance or maximum benefit limitations
- Any amounts you pay because benefits have been reduced for non-compliance with this Plan's cost containment requirements (see Section 3)
- The $300 per admission for non-PPO inpatient hospital charges or skilled nursing facility
- Expenses in excess of visit maximums for physical, occupational and speech therapy (see pages 41 and 42), and acupuncture (see page 46)
- Expenses incurred in excess of the $90 per day provided under home nursing care (see page 45); and
- Expenses in excess of Hospice care and preventive care maximums

- The difference in cost when brand name drugs are purchased and a generic is available
- Drugs reimbursed at the non-network pharmacy level
- 50% coinsurance for retail drugs after the first two fills if mail order is not used
- 100% of the cost for targeted drugs if the Plan's step therapy is not followed
- Any associated costs when you purchase medications in excess of the Plan's dispensing limitations
- Cost associated with non-covered drugs and supplies

Consumer Driven Option Catastrophic Costs (Pgs 29-30)

- Expenses that count toward the out-of-pocket max:
  - 15% coinsurance (or 10% for Cancer Centers of Excellence) for covered PPO services; and the deductible
  - 40% coinsurance for covered Non-PPO services; and the deductible
  - 25% or 40% for in-network Prescription drug costs
  - The PCA of $1,200 for Self Only or $2,400 for Self Plus One and Self and Family

Not included in out-of-pocket max – Consumer Driven Option (Pgs 29-30)

The following cannot be included in the accumulation of out-of-pocket expenses:

- Any expenses paid by the Plan under your in-network Preventive Care benefit
- Expenses in excess of our allowance or maximum benefit limitations or expenses not covered under the Traditional Health Coverage
- Dental care or Vision care expenses above the limitations provided under your Personal Care Account
- Any amounts you pay because benefits have been reduced for non-compliance with this Plan's cost containment requirements (see Section 3)
- Expenses in excess of Hospice care maximums
- Drugs purchased at a non-network pharmacy

- The difference in cost when brand name drugs are purchased and a generic is available
- Any associated costs when you purchase medications in excess of the Plan's dispensing limitations
- Cost associated with non-covered drugs and supplies

APWU HEALTH PLAN

TOGETHER.
BETTER HEALTH.®

2019 HIGH OPTION BENEFITS

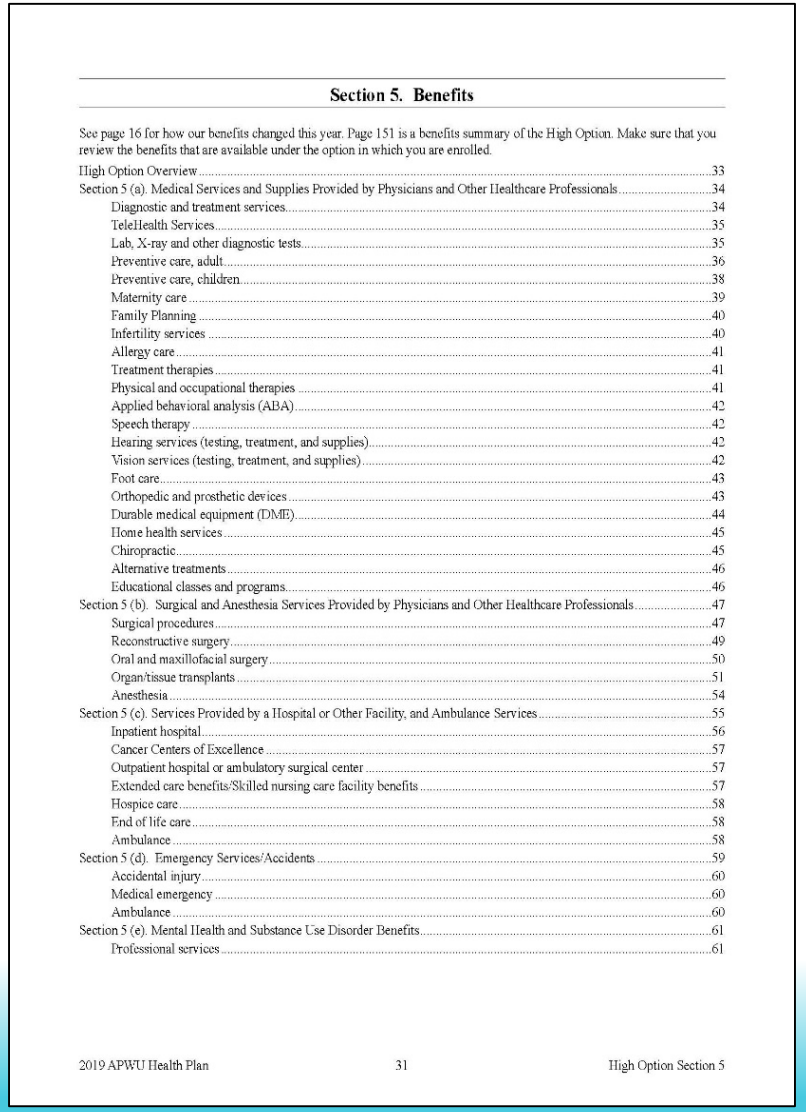


33rd Annual Open Season Seminar

Section 5: Benefits

Sections 5 (a)-(h) (Pgs 31-32)

a) Medical Services and Supplies
b) Surgical and Anesthesia Services
c) Services Provided by Hospital or Other Facility
d) Emergency Services/ Accidents
e) Mental Health and Substance Use Disorder Benefits
f) Prescription Drug Benefits
g) Dental Benefits
h) Wellness and Other Special Features



Section 5. Benefits

See page 16 for how our benefits changed this year. Page 151 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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Speech therapy 42
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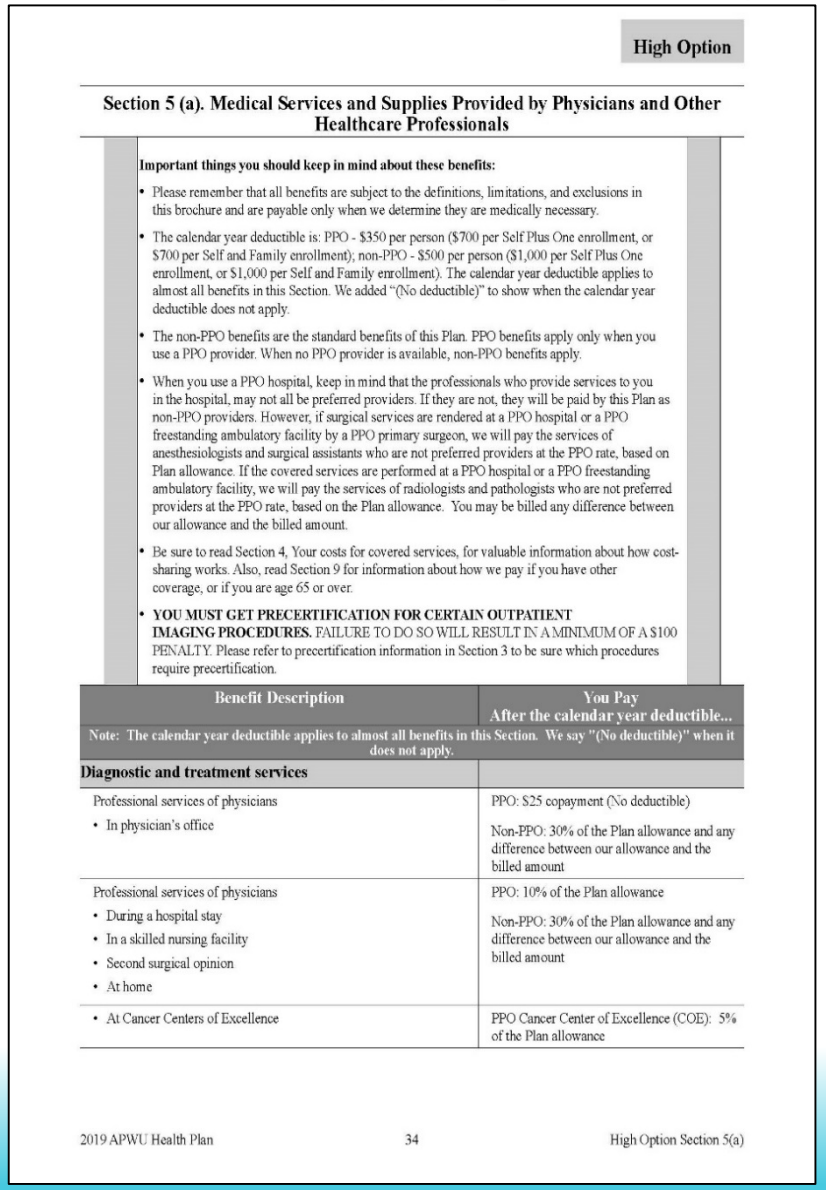
Medical Services and Supplies

Section 5(a) (Pgs 34-46)

Section title

Section specific information…

Left column provides Benefit Description



High Option

Section 5 (a). Medical Services and Supplies Provided by Physicians and Other Healthcare 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. 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: $25 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 Cancer Centers of Excellence	PPO Cancer Center of Excellence (COE): 5% of the Plan allowance

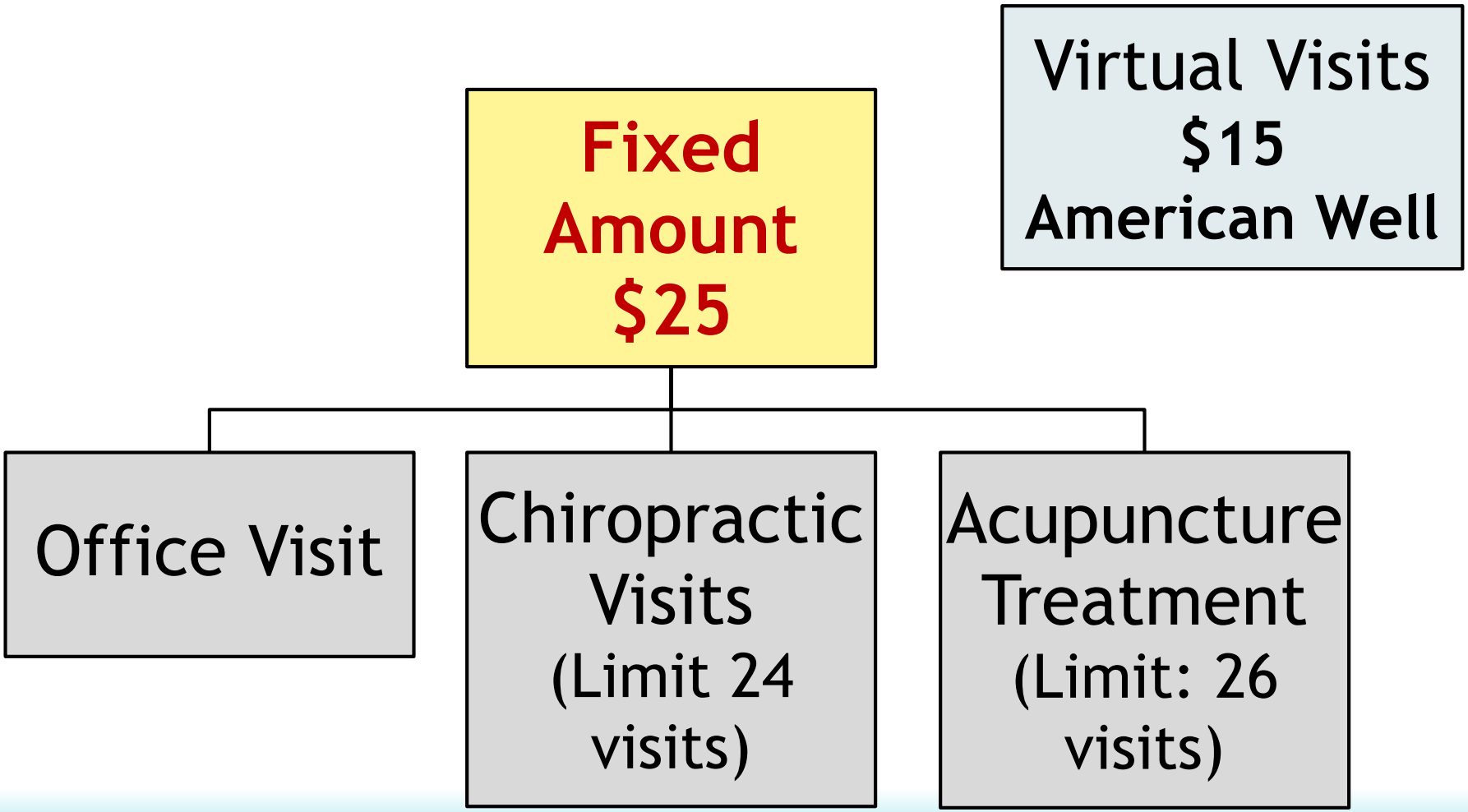
2019 APWU Health Plan 34 High Option Section 5(a)

Deductible

Does the deductible apply…

Right column explains $ amount the member is responsible for (You Pay)

High Option Plan
In-network Office Visit Copay: $25



High Option Coinsurance

- 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 Cancer Centers of Excellence

TeleHealth Services (Pg 35)

- Allows a patient to 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
- American Well: $15 copay
- No out of network benefit
- In-network (PPO): $25 copay

Labs, X-rays and Diagnostic Tests (Pg 35)

- Diagnostic tests are performed to confirm a medical condition, based on symptoms or suspicions; this is not routine or screening
- Benefit:
  - PPO: 10% coinsurance
  - Non-PPO: 30% coinsurance and can be billed the difference between allowance and charges
  - Covered lab services performed at Quest or LabCorp: no out-of-pocket expense
- CT/MRI/PET – Require precertification
- Genetic screening not covered

Preventive Care (Pgs 36-38)

Routine screenings are procedures performed to help keep a member healthy and identify any conditions that may go unnoticed.

Examples: Immunizations, Colonoscopy, Mammogram, PSA Test and PAP Test





Preventive Care (Pgs 36-38)

- New for 2019: At Home Cologuard
- Annual gynecological visit
- Well-child care
- Immunizations recommended by CDC for adults and American Academy of Pediatrics for children routine screenings
- See pages 36-38 for comprehensive list of covered services
- Benefit:
  - PPO: Covered at 100%.
  - Non-PPO: 30% coinsurance and can be billed the difference between allowance and charges

HO Scenario: Preventive Care

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

All three claims are paid at 100%

HO Scenario: Preventive Care

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

- Surgery and anesthesia claim are paid at 100%
- Lab claim will pay at 90%; member will be billed for 10% of the Plan allowance

Maternity (Pg 39)

- Complete maternity care covered at 100% for in-network covered services:
  - Prenatal care, delivery, postnatal care
  - Lab services related to covered, in-network maternity care
  - Breastfeeding support, supplies, equipment rental, and counseling for each birth
- Not covered: Genetic Screening

Family Planning (Pg 40)

Family Planning	
A range of voluntary family planning services, limited to: • Contraceptive counseling for women • Voluntary sterilization for women (See *Surgical* procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives and devices under Section 5(f), *Prescription drug benefits*.	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
• Voluntary sterilization for men (See *Surgical* procedures, Section 5 (b))	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic testing and counseling*	*All charges*

Infertility (Pg 40)

Infertility services	
• Diagnosis and treatment of infertility, except as shown in *Not covered*	PPO: 10% of the Plan allowance and any amount over $2,500 Non-PPO: 30% of the Plan allowance, any difference between our allowance and the billed amount and any amount over $2,500
Not covered: • *Infertility services after voluntary sterilization* • *Assisted reproductive technology (ART) procedures, such as:* - *Artificial insemination (all procedures) (AI)* - *In vitro fertilization (IVF)* - *Embryo transfer and gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* - *Intravaginal insemination (IVI)* - *Intracervical insemination (ICI)* - *Intrauterine insemination (IUI)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges*

Physical/Occupational/Speech Therapies (Pgs 41-42)

- Benefits are limited to a combined outpatient visit limit of 60 for physical, occupational and speech therapy
  - PPO: Deductible, then 10% coinsurance
  - Non-PPO: Deductible, then 30% coinsurance and can be billed the difference between allowance and charges
- Services must be ordered by a physician
- Preauthorization is required for Speech Therapy only

Applied Behavioral Analysis (ABA) (Pg 42)

Outpatient Applied Behavioral Analysis (ABA) services for the treatment of Autism Spectrum Disorder:

- In-network benefit only; deductible, then 10% coinsurance
- Preauthorization required by Beacon Health Options
- Must be provided under the supervision of a Board Certified Behavior Analyst
  - Must be contracted with Beacon Health Options, or agree to participate with Beacon Health Options' care management activities
- Review of ABA services is based on an intensive care management model that monitors treatment plans, objectives and progress milestones

Hearing and Vision Services
(Pgs 42-43)

- One exam and testing every 2 years for hearing aids
- Internal ocular lenses and/or 1st contact lenses to correct impairment caused by an accident or illness

Routine Foot Care (Pg 43)

- 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

Orthopedic and Prosthetic Devices (Pg 44)

- Not covered:
  - Orthopedic and corrective shoes
  - Arch supports
  - Foot/shoe orthotics
  - Heel pads and heel cups

Durable Medical Equipment
(Pgs 44-45)

- Preauthorization is required
- See page 45 of brochure for list of excluded items
- We limit the Plan allowance to an amount no greater than the purchase price

Home Health Services (Pg 45)

- Skilled Nursing Care (RN, LPN, LVN)
  - 25 visits per calendar year
  - Maximum of $90 per day
- Preauthorization required

Chiropractic and Acupuncture (Pgs 45-46)

- Chiro treatment is limited to **24 visits** and/or manipulations per year
  - Massage therapy and Maintenance therapy is not covered
- Acupuncture limited to **26 visits** per year, covered when performed by a doctor of medicine or osteopathy or licensed acupuncturist
- Benefit:
  - PPO: **$25** copay
  - Non-PPO: Deductible, then 30% coinsurance and can be billed the difference between allowance and charges

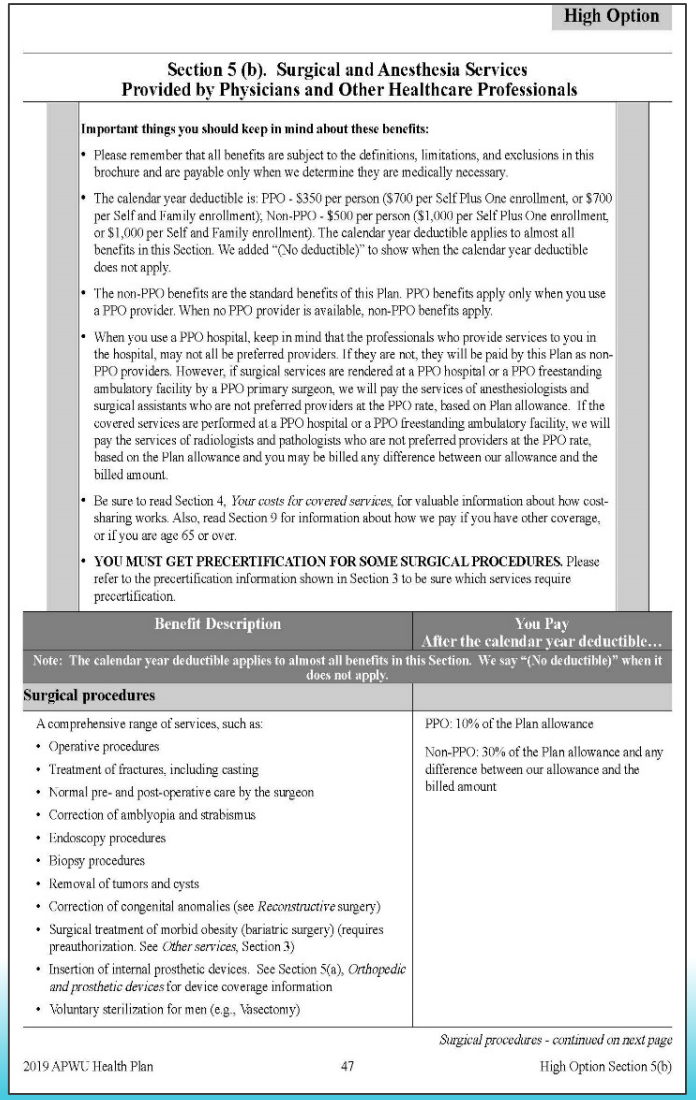
Educational Classes and Programs (Pg 46)

- We encourage you to enroll in a Tobacco Cessation Program by contacting Cigna/ CareAllies
  - Telephonic counseling sessions with Cigna/CareAllies
  - Group therapy
  - Educational sessions with a physician
- Diabetes self-management training services

Surgical and Anesthesia Services

Section 5(b) (Pgs 47-54)

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



High Option

Section 5 (b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare 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

PPO Facility vs. Non-PPO Professionals (Pg 47)

- When you use a PPO hospital, some professionals may not all be PPO providers. If they are not, they will be paid at the non-PPO benefit
- Exceptions:
  - If you use a PPO hospital and have surgery performed by a PPO physician, the Health Plan will pay the Assistant Surgeon and Anesthesiologist at the PPO rate, based on Plan allowance*
  - If you have covered services performed at a PPO hospital, we will pay non-PPO radiologists and pathologists at the PPO rate, based on Plan allowance*

*Note: You still may be billed for the difference between our allowance and the billed amount

Surgical Procedures (Pgs 47-49)

- Precertification required for some surgical procedures. Refer to Section 3 of the brochure
- Not covered:

Not covered:

- *Cosmetic surgery and other related expenses if not preauthorized*
- *Reversal of voluntary sterilization*
- *Services of a standby surgeon, except during angioplasty or other high risk procedures when we determine standbys are medically necessary*
- *Radial keratotomy and other refractive surgery*
- *Routine treatment of conditions of the foot (see Foot care, Section 5 (a))*

Oral Surgery (Pgs 50-51)

- We suggest calling us at 800-222-2798 to determine whether a procedure is covered.

Organ and Tissue Transplants (Pgs 51-54)

- Complete list of transplants begins on page 51
- All transplants are subject to prior authorization; subject to medical necessity and experimental/investigational review
- Out-of-network services have benefit limitations
- Transplant Network
  - Plan-specific organ/tissue transplant facilities.
    - If a Plan-designated transplant facility chosen, travel and lodging costs may be pre-approved
  - Prior to an initial evaluation, physician or patient must contact Cigna to speak with a Transplant Case Manager

Anesthesia (Pg 54)

- Professional services for administration of anesthesia

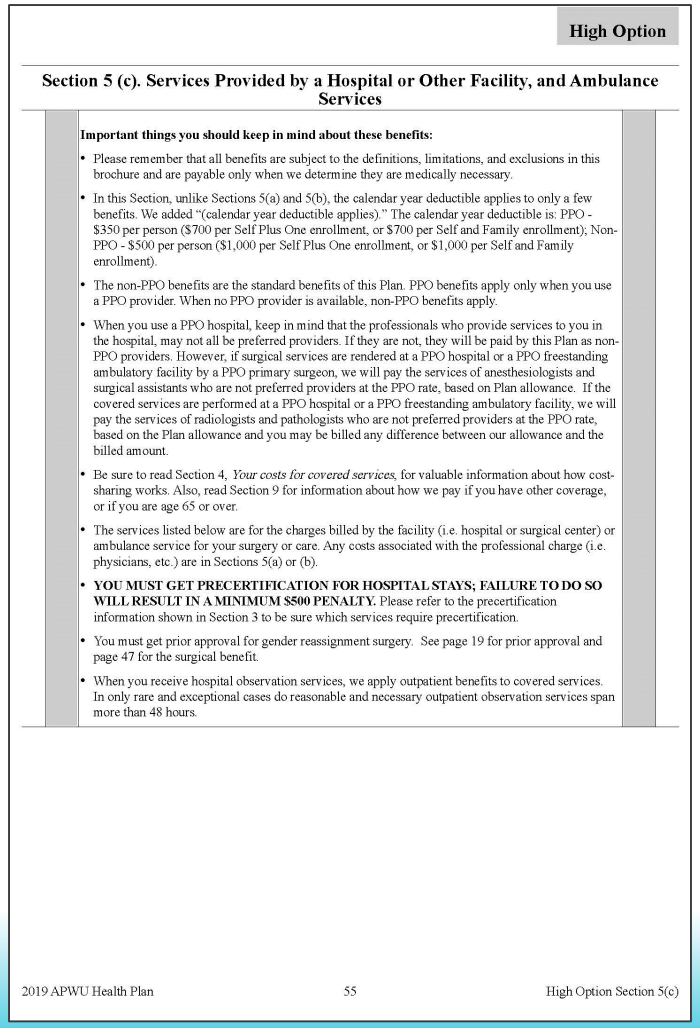
Surgeon	Facility	Benefit
In-network	In-network	In-network*
In-network	Out-of-network	Out-of-network*
Out-of-network	In-network	Out-of-network*

* ***Note: In all scenarios, the out-of-network anesthesiologist may balance bill the difference between our allowance and billed charges.***

Services at Hospital/Facility and Ambulance Services

Section 5(c) (Pgs 55-58)

- Inpatient hospital
- Cancer Centers of Excellence
- Outpatient hospital or ambulatory surgical center
- Extended care benefits/Skilled nursing care facility benefits
- Hospice care
- End of life care
- 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 - $500 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.
- You must get prior approval for gender reassignment surgery. See page 19 for prior approval and page 47 for the surgical benefit.
- 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.

2019 APWU Health Plan 55 High Option Section 5(c)

Inpatient Hospital (Pg 56)

- Subject to pre-authorization *(See section 3)*
  - Call Cigna/CareAllies
- $500 late pre-authorization penalty
  - Emergency admissions: 2 business days from admission date
  - Scheduled admissions: 2 business days prior to scheduled admission
- $300 per admission fee, if confined in an out-of-network facility

Outpatient Hospital or Ambulatory Surgical Center (Pg 57)

- Subject to deductible
- Coinsurance applies based on provider network affiliation

Hospice (Pg 58)

- Up to $15,000 lifetime maximum including:
  - Inpatient hospice
  - Outpatient hospice
  - Advanced care planning
- $200 annual bereavement benefit per family

Emergency Services/Accidents

Section 5(d) (Pgs 59-60)

- Accidental injury
- Medical emergency
- 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 72 hours, we cover: • Physician services and supplies • Related outpatient hospital services • Professional ambulance service • Air ambulance to nearest facility where necessary treatment is available is covered if no emergency ground transportation is available or suitable and the patient's condition warrants immediate evacuation. Air ambulance will not be covered if transport is beyond the nearest available suitable facility, but is requested by patient or physician for continuity of care or other reasons Note: See Section 5(c) for hospital benefits if you are admitted. Services received after 72 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 Note: High technology radiology/imaging services including CAT/CT, MRI, MRA, Nuclear Cardiology and PET are subject to coinsurance and deductible (outpatient requires precertification except for Nuclear Cardiology), see Section 5(a).	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 to nearest facility where necessary treatment is available is covered if no emergency ground transportation is available or suitable and the patient's condition warrants immediate evacuation. Air ambulance will not be covered if transport is beyond the nearest available suitable facility, but is requested by patient or physician for continuity of care or other reasons 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)
Not covered: • *Air ambulance if transport is beyond the nearest available suitable facility, but is requested by patient or physician for continuity of care or other reasons*	*All charges*

Accident (Pg 60)

- "Accident" is defined as resulting from a violent, external force
- Outpatient services, including ambulance and air ambulance* rendered within **72** hours of accident
  - No out-of-pocket expense or cost-sharing (no deductible, coinsurance, co-payment)
  - 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

*** If medically necessary for transport to the closest appropriate facility for treatment.**

Medical Emergency (Pg 60)

- 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

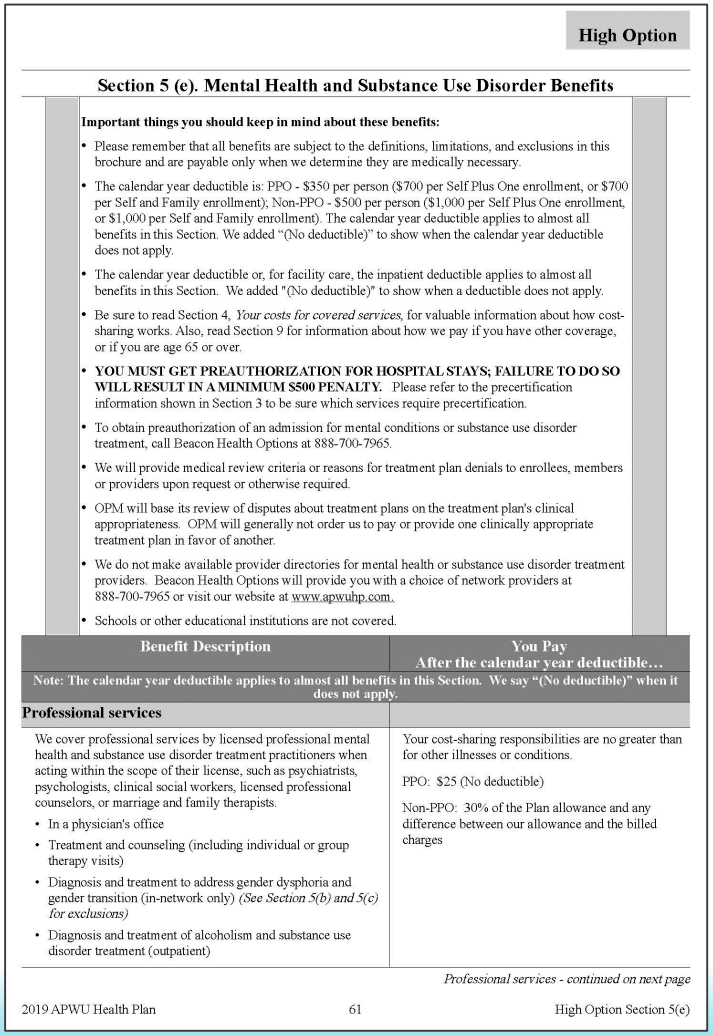
*** High tech imaging (CT, MRI, PET, MRA) at an Urgent Care Center is subject to deductible and coinsurance and requires precertification.**

Ambulance (Pg 60)

- Professional ambulance service within 24 hours of a medical emergency
- Air ambulance transport to nearest facility where necessary treatment is available
- Ambulance services used for routine transport are not covered
- 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 the service

Mental Health and Substance Use Disorder Section 5(e) (Pgs 61-63)

- Beacon Health Options
- Professional services
  - Outpatient in a physician's office
  - Inpatient
- Diagnostics
- Inpatient hospital or other covered facility
- Outpatient hospital or other covered facility



High Option

Section 5 (e). Mental Health and Substance Use Disorder 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 use disorder treatment, 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 use disorder treatment 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.
- Schools or other educational institutions are not covered.

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 use disorder treatment 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 disorder treatment (outpatient)	Your cost-sharing responsibilities are no greater than for other illnesses or conditions. PPO: $25 (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed charges

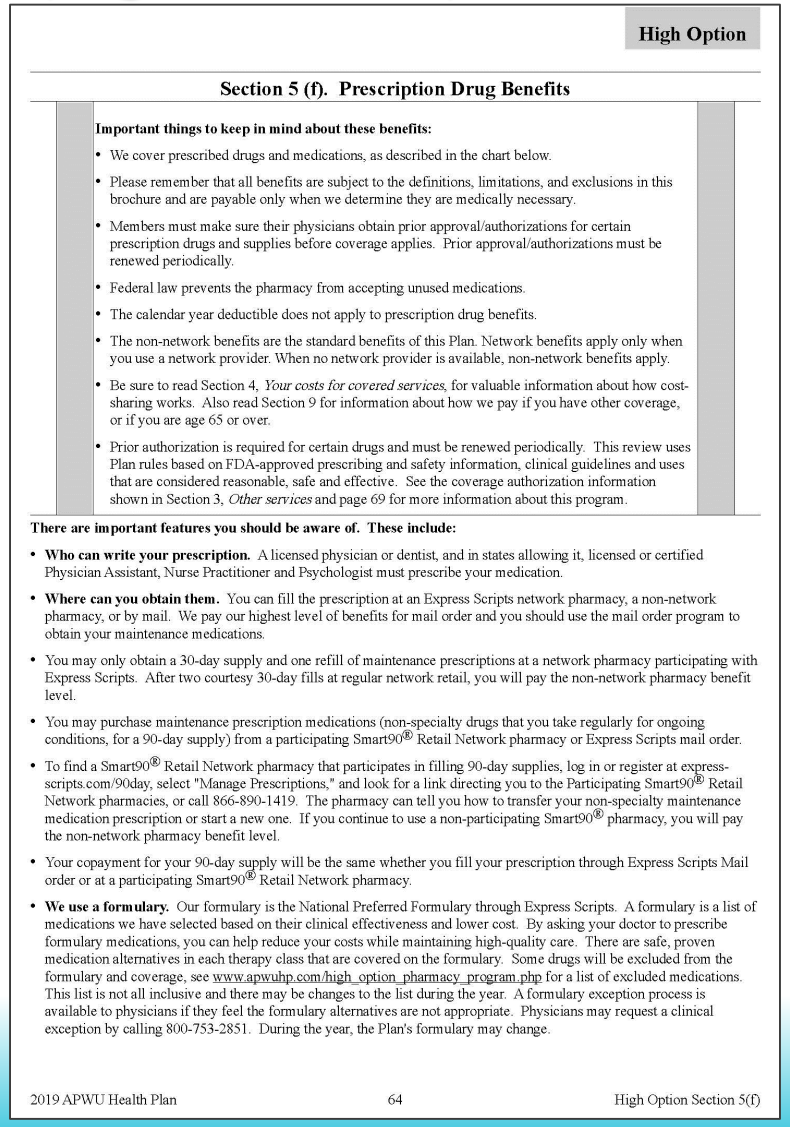
Professional services - continued on next page

Beacon Health Options (Pgs 61-63)

- Must obtain preauthorization for:
  - Inpatient Mental Health or Substance Misuse Disorder Hospital admissions
  - Inpatient treatment, psychological testing, electroconvulsive therapy, and Transcranial Magnetic Stimulation (TMS)
- To obtain preauthorization, call Beacon Health Options
- $500 penalty for failure to obtain precertification
  - 2 business days prior to elective hospital admission
  - 2 business days after an emergency admission

Prescription Drugs
Section 5(f) (Pgs 64-70)

- Express Scripts
- Definitions
  - Preferred Formulary
  - Generic Drugs
- Dispensing Limitations
- Coverage Tiers
- Specialty Drugs
  - Definition
  - Coverage
- Contraceptives
- 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 69 for more information about this program.

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

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed or certified Physician Assistant, Nurse Practitioner and Psychologist must prescribe your medication.
- **Where can you obtain them.** You can fill the prescription at an 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.
- You may only obtain a 30-day supply and one refill of maintenance prescriptions at a network pharmacy participating with Express Scripts. After two courtesy 30-day fills at regular network retail, you will pay the non-network pharmacy benefit level.
- You may purchase maintenance prescription medications (non-specialty drugs that you take regularly for ongoing conditions, for a 90-day supply) from a participating Smart90® Retail Network pharmacy or Express Scripts mail order.
- To find a Smart90® Retail Network pharmacy that participates in filling 90-day supplies, log in or register at express-scripts.com/90day, select "Manage Prescriptions," and look for a link directing you to the Participating Smart90® Retail Network pharmacies, or call 866-890-1419. The pharmacy can tell you how to transfer your non-specialty maintenance medication prescription or start a new one. If you continue to use a non-participating Smart90® pharmacy, you will pay the non-network pharmacy benefit level.
- Your copayment for your 90-day supply will be the same whether you fill your prescription through Express Scripts Mail order or at a participating Smart90® Retail Network pharmacy.
- **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 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. During the year, the Plan's formulary may change.

2019 APWU Health Plan 64 High Option Section 5(f)

Prescription Drug Definitions (Pgs 64-65)

- Express Scripts is our Network Pharmacy
  - For participating pharmacies, call Express Scripts or go to www.express-scripts.com
- National Preferred Formulary
  - List of medications selected based on clinical effectiveness and lower cost
- Brand Name Drugs – Preferred and Non-preferred
  - Protected by a patent and manufactured and sold only by the company holding the patent
- Generic Drugs
  - Chemical equivalent of a corresponding name brand drug, typically available at a lower cost
- To view list of drugs based on payment level, visit www.apwuhp.com/high_option_pharmacy_program.php

Dispensing Limitations (Pgs 65-66)

- Express Scripts Retail Pharmacy
  - Up to a 30-day supply plus one 30-day refill
    - After one 30-day refill, you must submit a new prescription to the mail order program
    - If not, we will pay the non-network pharmacy benefit
- Mail Order
  - Up to a 90-day supply of maintenance drugs, diabetic supplies and Insulin, syringes and needles for covered injectable medications, and oral contraceptives

Prescription Drug Tiers (Pg 66)

	Type of Drug	Network Pharmacy (Retail)	Non-Network Pharmacy (Retail)	Network Mail Order
Tier 1	Generic Drugs	$10 copay for 30-day supply	50% coinsurance for 30-day supply	$20 copay for 90-day supply
Tier 2	Preferred Brand Drugs	25% coinsurance; $200 max for 30-day supply	50% coinsurance for 30-day supply	25% coinsurance; $300 max for 90-day supply
Tier 3	Non-Preferred Brand Drugs	45% coinsurance; $300 max for 30-day supply	50% coinsurance for 30-day supply	45% coinsurance; $500 max for 90-day supply

Specialty Drugs (Pgs 66-67)

- Must be obtained through Accredo Specialty pharmacy*
- 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

* Definition found on Pgs 69-70

Specialty Drug Tiers (Pgs 66-67)

	Type of Drug	Network Pharmacy (Retail)	Non-Network Pharmacy (Retail)	Network Mail Order
Tier 4	Generic Drugs	$25% coinsurance; max $300 for 30-day supply	50% coinsurance for 30-day supply	25% coinsurance; $150 max for 90-day supply
Tier 5	Preferred Brand Drugs	25% coinsurance; $600 max for 30-day supply	50% coinsurance for 30-day supply	25% coinsurance; $300 max for 90-day supply
Tier 6	Non-Preferred Brand Drugs	45% coinsurance; $1,000 max for 30-day supply	50% coinsurance for 30-day supply	45% coinsurance; $500 max for 90-day supply

Prescription Drugs
Section 5(f) (Pgs 67-68)

- $0 out-of-pocket costs
  - Contraceptive Drugs - generic
  - Prescription drugs to treat tobacco dependence (Mail Order)
  - OTC to treat tobacco dependence (Cigna/CareAllies only)
  - Naloxone and Narcan for prevention of opioid overdose related deaths
- Preventive Care Medications with a USPSTF recommendation of A or B when prescribed by a health care professional and filled at a network pharmacy. For current recommendations go to:

www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations

Step Therapy (Pg 69)

- Ensures generic/brand alternative within a therapeutic category is the first-line treatment, before the use of a similar but more expensive drug
- See page 69 of brochure for more information on specific therapeutic categories

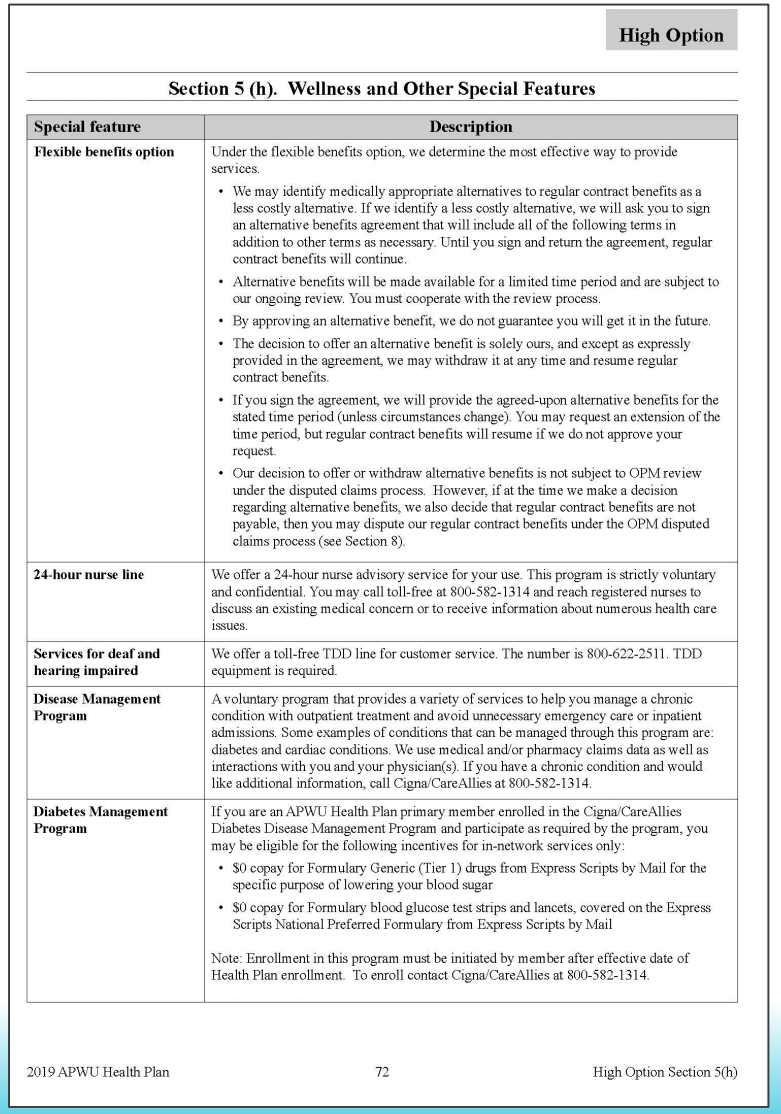
Dental Benefits
Section 5(g), (Pg 71)

- 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 the Plan allowance

Wellness and Other Special Features

Section 5(h) (Pgs 72-74)

- 24-hour Nurse Line
- Diabetes Management Program
- Healthy Pregnancies, Healthy Babies Program
- Special Programs
  - Weight Management
  - Tobacco cessation
- Health Risk Assessment
  - Cigna Plus Savings



High Option

Section 5 (h). Wellness and Other 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 Formulary Generic (Tier 1) drugs from Express Scripts by Mail for the specific purpose of lowering your blood sugar • $0 copay for Formulary blood glucose test strips and lancets, covered on the Express Scripts National Preferred Formulary from Express Scripts by Mail Note: Enrollment in this program must be initiated by member after effective date of Health Plan enrollment. To enroll contact Cigna/CareAllies at 800-582-1314.

24-hour Nurse Line (Pg 72)

- Speak to a registered nurse by calling Cigna/CareAllies to discuss medical concerns or to receive information about health issues
  - Voluntary and confidential

Diabetes Management (Pgs 72-73)

- To enroll, contact Cigna/CareAllies
- If you were in the Consumer Driven Option DM Program and switch to the High Option, you must enroll in the CareAllies DM Program
- Diabetes Management:
  - When you enroll and are compliant with program requirements, you may be eligible for the following incentives when treatment is related to diabetes management:
    - $0 copay for generic drugs from Express Scripts by mail for the specific purpose of lowering blood sugar
    - $0 copay for formulary test strips and lancets from Express Scripts by mail

Healthy Pregnancies, Healthy Babies Program (Pg 73)

- Dedicated nursing staff is available to answer questions and educate pregnant women
- Enroll by calling Cigna/CareAllies, prompt 8



Special Programs (Pg 73)

- Lifestyle Programs – Wellness coaches will help you develop a personalized plan for tobacco cessation and weight management
  - Call Cigna/CareAllies
- Healthy Rewards – MyCareAllies provides non-FEHB savings on gym memberships, tobacco cessation, weight reduction programs, and more
  - Visit www.apwuhp.com or call Cigna/CareAllies

Health Risk Assessment (Pg 74)

- Complete online Health Risk Assessment to become eligible for the CignaPlus Savings Discount Dental Program*
  - Self Only enrollment, complete online HRA and Plan will pay the premium for Self Only 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 CignaPlus Discount Dental Program

* **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)**

APWU HEALTH PLAN

TOGETHER.
BETTER HEALTH.®

QUESTIONS: 2019 HIGH OPTION BENEFITS



33rd Annual Open Season Seminar

How much is the in-network Office Visit copay?

A. $30



B. $25

C. $20

D. No copay

How much is the in-network Deductible, if applicable?

A. Self Only: $350; Self Plus One and Self and Family: $700

B. Self Only: $250; Self Plus One and Self and Family: $500

C. $0 Deductible

D. Self Only: $500; Self Plus One and Self and Family: $1,000

For in-network diagnostic services, how much is your coinsurance?

A. 30%
B. 15%

C. 10%
D. No coinsurance

What will not accumulate toward your Catastrophic out-of-pocket expenses?

A. $500 pre-cert penalty
B. $300 Non-PPO hospital admission fee
C. Expenses in excess of benefit limitations
D. All of the above ✓

What is the Catastrophic out-of-pocket maximum (in-network)?

A. In-network: Self Only; $5,500; Self Plus One and Self and Family: $9,000

   Out-of-network: Self Only $10,000; Self Plus One and Self and Family: $15,000

B. In-network: Self Only; $5,500; Self Plus One and Self and Family: $6,500

   Out-of-network: Self Only, Self Plus One and Self and Family: $10,000

C. In-network: Self Only; $5,500; Self Plus One and Self and Family: $5,500

   Out-of-network: Self Only, Self Plus One and Self and Family: $5,500

D. $10,000 per membership

How much coinsurance do you pay for a Tier 3 drug?

A. 40%
B. 30%

C. 45%
D. Nothing

What is the benefit for Virtual Visits?

A. No benefit; in-network only

B. 30% coinsurance

✓ C. $15 copay for American Well; $25 copay PPO: NO out-of-network benefit

D. $20 copay

MRIs do not require pre-certification.

A. True

✓ B. False

What additions were made to the Preventive Care benefit for 2019?

A. Cologuard colorectal screening
B. All bloodwork requested by an in-network provider
C. Whole body scans
D. CBC, Hemoglobin A1c, Chest X-ray, EKG, 3D Mammograms

Is genetic screening a covered benefit?

A. Yes



B. No

What is covered under Family Planning?

A. Contraceptives, voluntary sterilization
B. Reversal of sterilization
C. Diapers and strollers
D. Gift card to Babies ‘R’ Us

What is covered under the $2,500 maximum infertility benefit?

A. Artificial insemination
B. In Vitro Fertilization (IVF)
C. Infertility services after voluntary sterilization
✓ D. Diagnosis and treatment of infertility

For 2019, does PT/OT require pre-authorization?

A. Yes



B. No

For 2019, does Speech Therapy (ST) require pre-authorization?

A. Yes
B. No

What is the benefit maximum for PT/OT and ST combined?

A. 30 visits



B. 60 visits

C. 40 visits

D. 90 visits

What is the maximum limit for acupuncture visits?

A. 12 visits
B. 60 visits
C. 26 visits ✓
D. 90 visits

What statement is true regarding the new benefit for Residential Treatment Facility?

A. No authorization needed

B. Pre-auth required through Beacon Health Options; covered both in-network and out-of-network

C. Pre-auth required through Beacon Health Options; in-network only; deductible then 10% coinsurance

D. Only payable for the enrollee

Orthotics are covered under routine foot care for Postal Employees only.

A. True

✓ B. False

What is the annual visit limit for chiropractic visits and/or manipulations?

A. 12

✓ B. 24

C. 60

D. There is no visit/ manipulation limit

Pre-authorization is required for medical inpatient confinement, but not if treatment is for behavioral health.

A. True

✓ B. False

After 1 refill at the in-network retail pharmacy, what are your options?

A. Move your prescription to CVS or Walgreens and get a 90-day supply at retail
B. Move your prescription to Mail Order and get a 90-day supply
C. Continue at your current retail pharmacy (not CVS or Walgreens) where benefits will revert to out-of-network; you will be responsible for 50% of the cost of the drug
D. All of the above ✓

Skilled Nursing Facility following transfer from acute care will be covered in 2019. Prior authorization is required.



A. True

B. False

If you are compliant in the Disease Management Program, which of the following $0 copay incentives will still be available to participants?

A. $0 copay for formulary generic medications for the specific purpose of lowering blood sugar via Express Scripts by Mail; preferred formulary blood glucose test strips and lancets via Express Scripts by Mail
B. $0 copay for Insulin pumps and pump supplies obtained through a PPO provider
C. $0 copay for office visits to an endocrinologist for the diagnosis of Diabetes
D. None

What is the incentive if you complete the Health Risk Assessment?

A. Additional PCA dollars will be put into your PCA account



B. Members will have access to the CignaPlus Dental Discount Program

C. You will receive a free gym membership

D. None of the above

If you go to an urgent care center and have a high-tech radiology imaging procedure (CT, MRI, MRA or PET scan), do you need prior authorization?

✓ A. Yes

B. No

Are the high-tech radiology imaging procedures (CT, MRI, MRA or PET scan) covered under the $40 copayment for urgent care centers?

A. Yes

✓ B. No

APWU HEALTH PLAN

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2019
CONSUMER DRIVEN OPTION BENEFITS



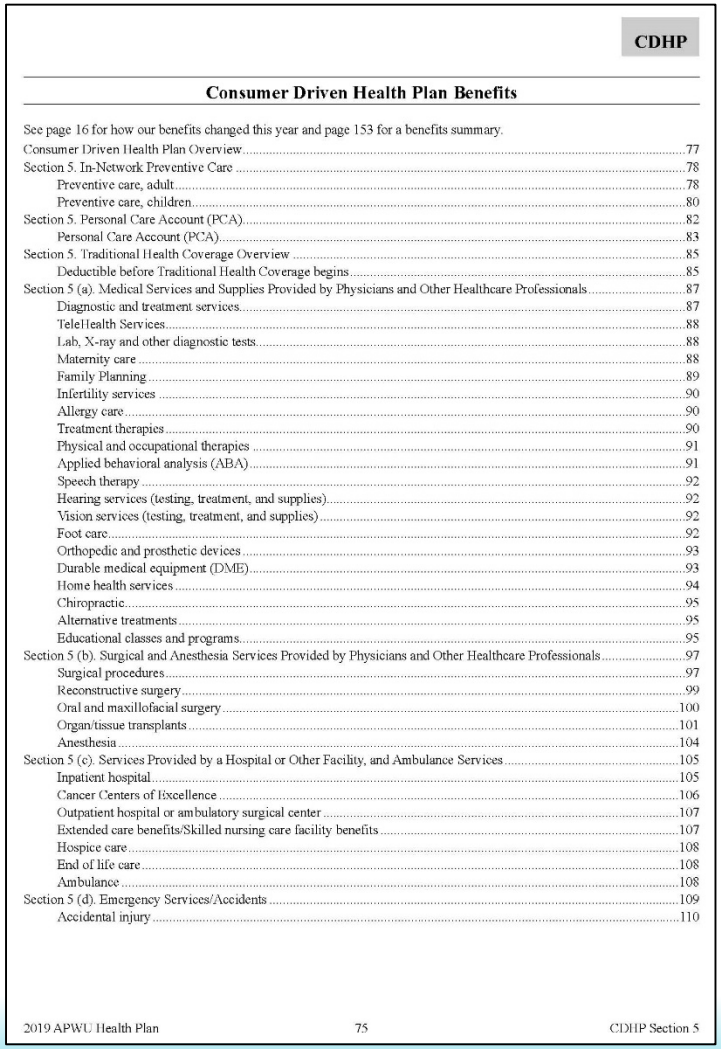
33rd Annual Open Season Seminar

Consumer Driven Option Benefits (Pg 75)

Consumer Driven Health Plan Overview

Section 5:

- In-Network Preventive Care
- Personal Care Account (PCA)
- Traditional Health Coverage Overview
- 5(a) Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals
- 5(b) Surgical and Anesthesia Services Provided by Physicians and Other Healthcare Professionals
- 5(c) Services Provided by a Hospital or Other Facility, and Ambulance Services
- 5(d) Emergency Services/Accidents



CDHP

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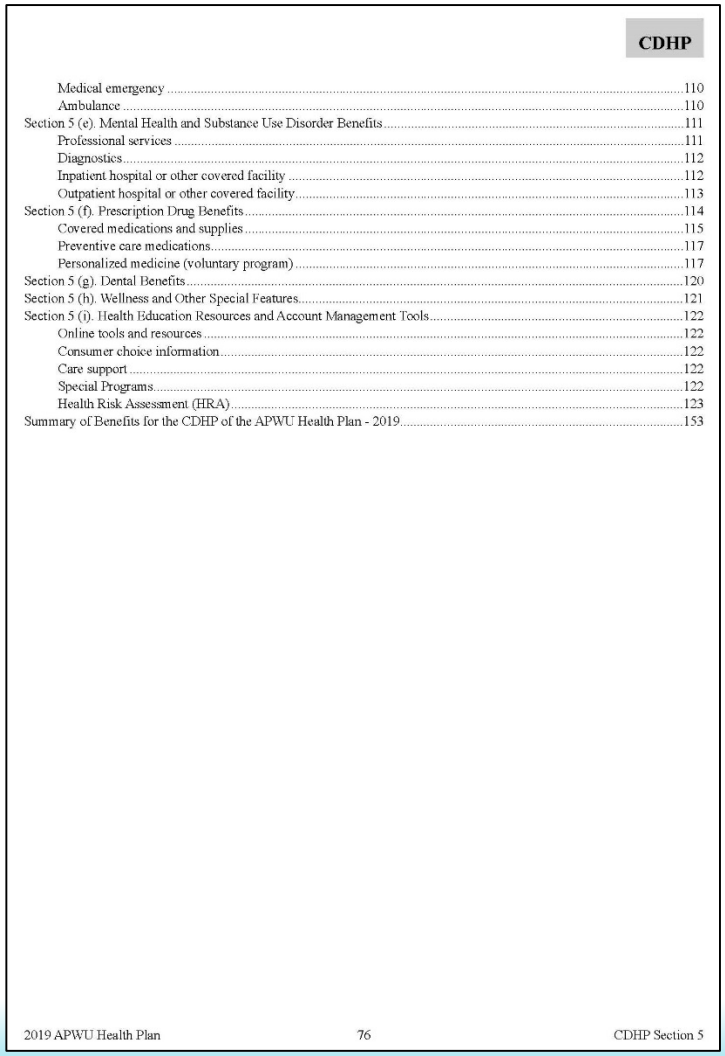
- 5(g) Dental Benefits
- 5(h) Wellness and Other Special Features
- 5(i) Health Education Resources and Account Management Tools
- Summary of Benefits for the CDHP 2019



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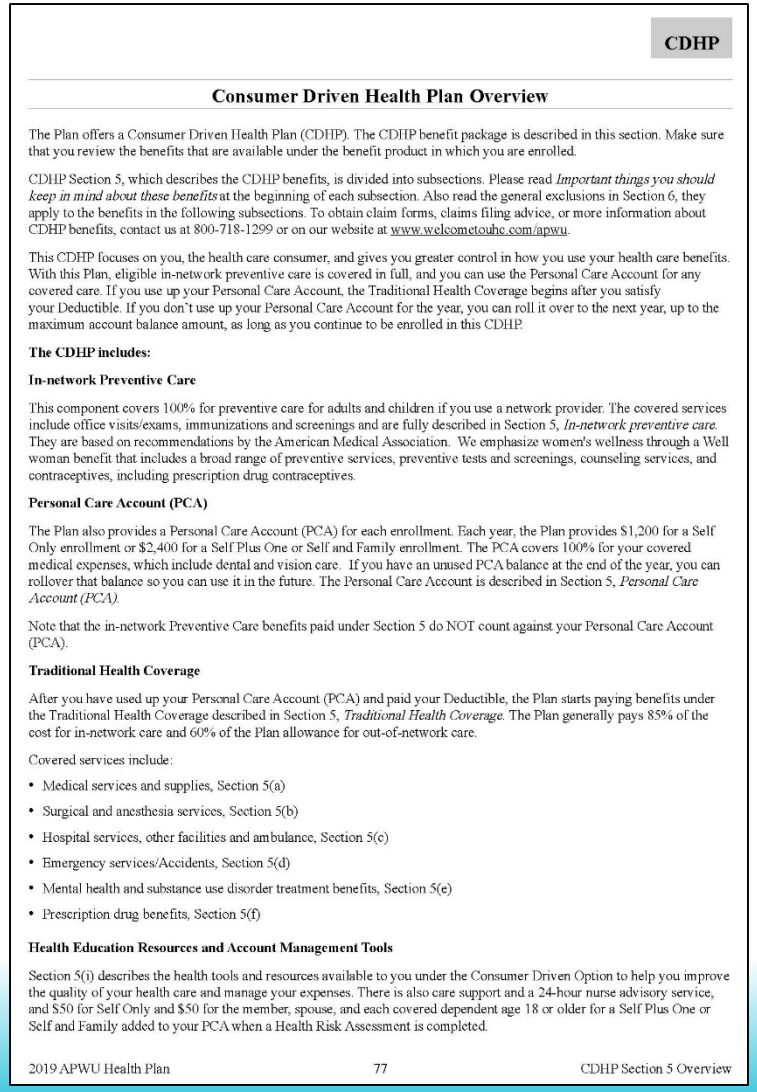
Consumer Driven Health Plan Overview (Pg 77)

In-network Preventive Care

Personal Care Account

Traditional Health Coverage

Health Education Resources



CDHP

Consumer Driven Health Plan Overview

The Plan offers a Consumer Driven Health Plan (CDHP). The CDHP benefit package is described in this section. Make sure that you review the benefits that are available under the benefit product in which you are enrolled.

CDHP Section 5, which describes the CDHP benefits, is divided into subsections. Please read *Important things you should keep in mind about these benefits* at the beginning of each subsection. Also read the general exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about CDHP benefits, contact us at 800-718-1299 or on our website at www.welcometouhc.com/apwu.

This CDHP focuses on you, the health care consumer, and gives you greater control in how you use your health care benefits. With this Plan, eligible in-network preventive care is covered in full, and you can use the Personal Care Account for any covered care. If you use up your Personal Care Account, the Traditional Health Coverage begins after you satisfy your Deductible. If you don't use up your Personal Care Account for the year, you can roll it over to the next year, up to the maximum account balance amount, as long as you continue to be enrolled in this CDHP.

The CDHP includes:

In-network Preventive Care

This component covers 100% for preventive care for adults and children if you use a network provider. The covered services include office visits/exams, immunizations and screenings and are fully described in Section 5, *In-network preventive care*. They are based on recommendations by the American Medical Association. We emphasize women's wellness through a Well woman benefit that includes a broad range of preventive services, preventive tests and screenings, counseling services, and contraceptives, including prescription drug contraceptives.

Personal Care Account (PCA)

The Plan also provides a Personal Care Account (PCA) for each enrollment. Each year, the Plan provides $1,200 for a Self Only enrollment or $2,400 for a Self Plus One or Self and Family enrollment. The PCA covers 100% for your covered medical expenses, which include dental and vision care. If you have an unused PCA balance at the end of the year, you can rollover that balance so you can use it in the future. The Personal Care Account is described in Section 5, *Personal Care Account (PCA)*.

Note that the in-network Preventive Care benefits paid under Section 5 do NOT count against your Personal Care Account (PCA).

Traditional Health Coverage

After you have used up your Personal Care Account (PCA) and paid your Deductible, the Plan starts paying benefits under the Traditional Health Coverage described in Section 5, *Traditional Health Coverage*. The Plan generally pays 85% of the cost for in-network care and 60% of the Plan allowance for out-of-network care.

Covered services include:

- Medical services and supplies, Section 5(a)
- Surgical and anesthesia services, Section 5(b)
- Hospital services, other facilities and ambulance, Section 5(c)
- Emergency services/Accidents, Section 5(d)
- Mental health and substance use disorder treatment benefits, Section 5(e)
- Prescription drug benefits, Section 5(f)

Health Education Resources and Account Management Tools

Section 5(i) describes the health tools and resources available to you under the Consumer Driven Option to help you improve the quality of your health care and manage your expenses. There is also care support and a 24-hour nurse advisory service, and $50 for Self Only and $50 for the member, spouse, and each covered dependent age 18 or older for a Self Plus One or Self and Family added to your PCA when a Health Risk Assessment is completed.

2019 APWU Health Plan 77 CDHP Section 5 Overview

In-network Preventive Care
Section 5, (Pgs 78-81)

- APWU Health Plan is in compliance with the Affordable Care Act's preventive care guidelines
- When using in-network, participating providers:
  - Covered routine preventive care for adults and children is paid at 100%
  - Periodic routine exams, lab, testing, immunizations
    - No reduction to your PCA
    - No deductible
    - No coinsurance

Preventive Care

Routine screenings are procedures performed to help keep a member healthy and identify and conditions that may go unnoticed.

Examples: Immunizations, Colonoscopy, Mammogram, PSA Test and PAP Test





In-network Preventive Care

Adult Care

- One annual visit and exam plus specific labs
- Adult immunizations recommended by the CDC
- Routine screenings
- NEW for 2019: Cologuard (colorectal screening)
- Low-dose CT scan for adults 55-80 with history of smoking

Care for Children

- Well child visits
- Childhood immunizations recommended by the American Academy of Pediatrics
- Routine Screenings

Scenario CDO: Preventive Care

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

All three claims are paid at 100%

Scenario CDO: Preventive Care

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

- Surgery and anesthesia claim are paid at 100%
- Lab claim will pay at **85%**; member will be billed for **15%** of the Plan allowance unless there are funds available in the PCA to cover the coinsurance costs

Personal Care Account (PCA)
Section 5, (Pgs 82-84)

- APWU Health Plan funds your PCA each year
  - Self Only: $1,200
  - Self Plus One:
    Self and Family: $2,400

- PCA is used to reimburse first dollars incurred
  - Coverage for in-network ***and*** out-of-network providers

- A *portion* of PCA dollars can be used for services not otherwise covered by the CDHP ("Extra PCA Expenses") - examples: Dental and/or Vision
  - Single Enrollment: $400
  - Family Enrollment: $800

Controlling PCA (Pg 82)

- If a member has an FSA and doesn't want to use PCA funds, they can turn off PCA; must update annually
- Member can now use FSA for healthcare expenses
  - Member should instruct provider to not submit claim to UHC
  - Member may have to pay claim up front
- Except for Rx



PCA Expense Example (Pg 83)

- If you are ill and you go to an in-network doctor, the doctor will submit your claim and the cost of the visit will be deducted automatically from your PCA. You pay nothing for eligible expenses while you still have funds in your PCA!
  - Balance in PCA: $1,200
  - Less cost of visit: $60
  - Remaining balance in PCA: $1,140

PCA Rollover (Pg 84)

- PCA dollars not used during the current calendar year…
  - are rolled over and added to the following year's PCA to a **maximum PCA balance** of:



    - Self Only: $5,000
    - Self Plus One
      Self and Family > $10,000
    - Maximum PCA Account balance can never exceed these dollar limits
  - reduce the following year's deductible by an equal amount

Traditional Health Coverage Overview Section 5, (Pgs 85-86)

PCA
(Covered services paid at 100%)

Deductible
(You pay full cost until deductible is met)

Coinsurance
(Cost sharing)

Traditional Health Coverage comes into play once your PCA is depleted. This is when you have to meet your deductible. Then you begin paying co-insurance.

Consumer Driven Option Deductible (Pg 85)

Deductible must be met before Traditional Health Coverage Begins

- **Self Only:** $2,000, but the Health Plan prefunds your Personal Care Account (PCA) with $1,200, so **you pay $800**
- **Self Plus One; Self and Family:** $4,000, but the Health Plan prefunds your Personal Account (PCA) with $2,400, so **you pay $1,600**

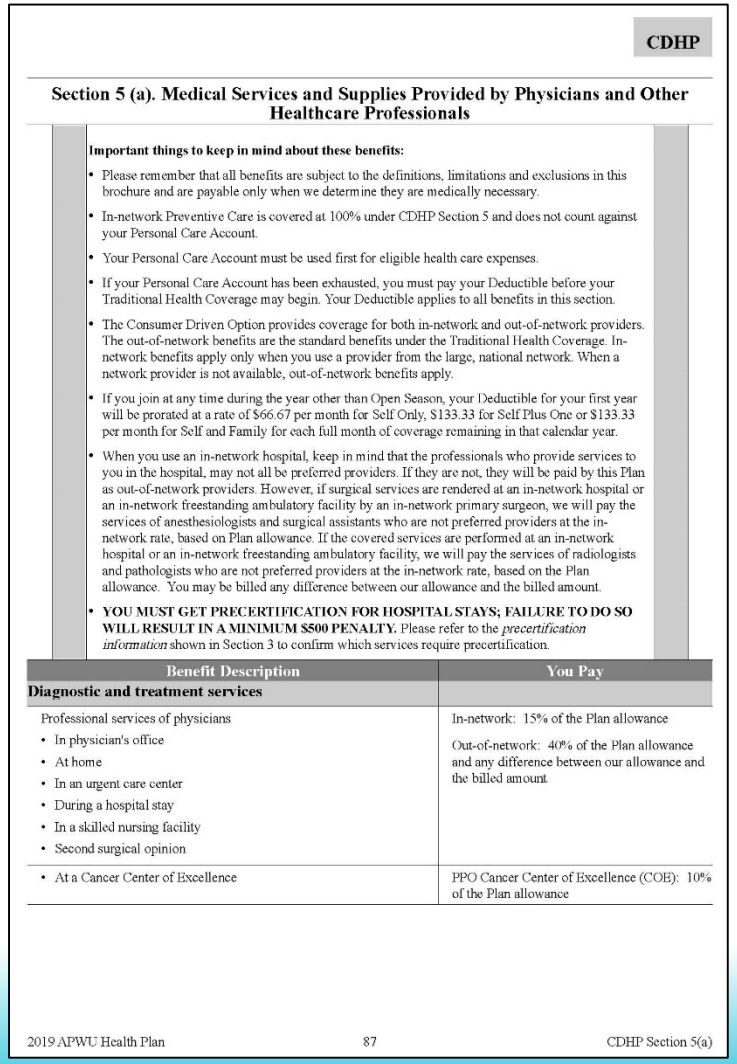
Coinsurance

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 treatment of cancer at Cancer Centers of Excellence
- 15% of allowance for in-network care
- 40% of allowance for out-of-network care
- 25% Tier 1 and Tier 2/40% Tier 3 of prescription formulary allowance

Section 5(a) Medical Services and supplies provided by physicians and other health care professionals (Pgs 87-96)

- Diagnostic and Treatment Services
- TeleHealth Services
- Lab X-ray and Other Diagnostic Tests
- Maternity Care
- Family Planning
- Infertility Services
- Allergy Care
- Treatment Therapies
- Physical and Occupational Therapy
- Applied Behavioral Analysis (ABA)
- Speech Therapy
- Hearing Services
- Vision Services
- Foot Care
- DME
- Home Health Services
- Chiropractic
- Alternative Treatments - Acupuncture
- Educational Classes



CDHP

Section 5 (a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In-network Preventive Care is covered at 100% under CDHP Section 5 and does not count against your Personal Care Account.
- Your Personal Care Account must be used first for eligible health care expenses.
- If your Personal Care Account has been exhausted, you must pay your Deductible before your Traditional Health Coverage may begin. Your Deductible applies to all benefits in this section.
- The Consumer Driven Option provides coverage for both in-network and out-of-network providers. The out-of-network benefits are the standard benefits under the Traditional Health Coverage. In-network benefits apply only when you use a provider from the large, national network. When a network provider is not available, out-of-network benefits apply.
- If you join at any time during the year other than Open Season, your Deductible for your first year will be prorated at a rate of $66.67 per month for Self Only, $133.33 for Self Plus One or $133.33 per month for Self and Family for each full month of coverage remaining in that calendar year.
- When you use an in-network hospital, keep in mind that the professionals who provide services to you in the hospital, may not all be preferred providers. If they are not, they will be paid by this Plan as out-of-network providers. However, if surgical services are rendered at an in-network hospital or an in-network freestanding ambulatory facility by an in-network primary surgeon, we will pay the services of anesthesiologists and surgical assistants who are not preferred providers at the in-network rate, based on Plan allowance. If the covered services are performed at an in-network hospital or an in-network freestanding ambulatory facility, we will pay the services of radiologists and pathologists who are not preferred providers at the in-network rate, based on the Plan allowance. You may be billed any difference between our allowance and the billed amount.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY.** Please refer to the *precertification information* shown in Section 3 to confirm which services require precertification.

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

2019 APWU Health Plan 87 CDHP Section 5(a)

Diagnostic and Treatment Services
Lab, X-ray and Other Diagnostic Tests
Section 5(a), (Pgs 87-88)

- Professional services of physicians
- TeleHealth virtual visits
- Lab, X-ray and other diagnostic tests
  - Blood tests, urinalysis, X-rays, Non-routine mammogram or 3D mammogram, pap test, CT, MRI, PET, EKG, EEG

Maternity Care
Section 5(a), (Pgs 88-89)

- Pre and post-natal care, delivery
  - No need to pre-certify normal deliveries
  - Covered at 100% in-network
- Nursery charges covered while mother confined
  - When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.
- Not covered: genetic screening

Family Planning
Section 5(a), (Pg 89)

- Covered Family Planning Services
  - Contraceptives
  - Oral Contraceptives covered as Pharmacy
  - Voluntary sterilization
- Not covered
  - Reversal of sterilization or genetic counseling

Infertility
Section 5(a), (Pg 90)

- 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

Treatment Therapies
Section 5(a), (Pgs 90-91)

- Chemotherapy and Radiation Therapy
- Dialysis
- IV Infusion Therapy – Home IV and Antibiotic Therapy*
- Growth Hormone Therapy*
- Respiratory and Inhalation Therapy

***Therapies require Pre-notification; Drugs used for GHT covered under Prescription Drug Benefit**

Physical, Occupational, Speech Therapies

Section 5(a), (Pgs 91-92)

- Rehabilitative therapy to restore function
- Habilitative therapy – to learn or establish function
- Licensed, registered therapist
- 60 visit combined annual maximum
- Not covered
  - Maintenance therapy
  - Exercise programs

Applied Behavioral Analysis (ABA)

Section 5(a), (Pg 91)

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

Hearing and Vision Services

Section 5(a), (Pg 92)

- One exam and testing every 2 years for hearing aids
- Internal ocular lenses and/or 1st contact lenses to correct impairment caused by an accident or illness

Routine Foot Care
Section 5(a), (Pgs 92-93)

- 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

Routine Foot Care
Section 5(a), (Pgs 92-93)

- Not covered:
  - Orthopedic and corrective shoes
  - Arch supports
  - Foot/shoe orthotics
  - Heel pads and heel cups

Orthopedic and Prosthetic Devices Section 5(a), (Pg 93)

- Covered devices include:
  - Artificial limbs* and eyes
  - External and internal breast prostheses; surgical bras following a mastectomy
  - Leg, arm, neck, joint and back braces
  - Internal prosthetics: artificial joints, pacemakers, cochlear implants*
  - Hearing aids every 3 years; maximum payout of $1,500

***Pre-notification recommended**

Durable Medical Equipment
Section 5(a), (Pgs 93-94)

- Pre-notification is required
- See page 94 of brochure for list of excluded items
- We limit the Plan allowance to an amount no greater than the purchase price

Home Health Services
Section 5(a), (Pgs 94-95)

- Skilled Nursing Care (RN, LPN, LVN)
  - 25 visits per calendar year
  - Maximum of $90 per day
  - Pre-authorization required

Chiropractic and Alternative Treatments Section 5(a), (Pg 95)

- Chiropractic
  - Treatment limited to 24 visits and/or manipulations per calendar year
    - Massage therapy and maintenance therapy are not covered
    - X-rays covered under diagnostics
- Acupuncture
  - Covered if performed by an MD, DO or a licensed acupuncturist

Educational Classes and Programs
Section 5(a), (Pgs 95-96)

- We encourage you to enroll in a Tobacco Cessation Program by contacting UHC
  - Telephonic counseling sessions
  - Group therapy
  - Educational sessions with a physician
- Diabetes self-management training services

Surgical Procedures
Section 5(b), (Pgs 97-104)

- Operative procedures including pre and post-operative care
- Surgical treatment of morbid obesity* as well as any surgery that could potentially be considered cosmetic
- Reconstructive surgery

Requires pre-notification

Oral Surgery

Section 5(b), (Pgs 100-101)

- We suggest calling UHC to determine if a procedure is covered

Organ and Tissue Transplants
Section 5(b), (Pgs 101-104)

- Complete list of transplants begins on page 101
- All transplants are subject to prior authorization; subject to medical necessity and experimental/ investigational review
- Out-of-network services have benefit limitations
- Transplant Network
  - Plan-specific organ/tissue transplant facilities
    - If a Plan-designated transplant facility chosen, travel and lodging costs may be pre-approved
  - Prior to an initial evaluation, physician or patient must contact UHC to speak with a Transplant Case Manager

Anesthesia

Section 5(b), (Pg 104)

Professional services for administration of anesthesia

Surgeon	Facility	Benefit
In-network	In-network	In-network*
In-network	Out-of-network	Out-of-network*
Out-of-network	In-network	Out-of-network*

*In all scenarios, the out-of-network anesthesiologist may balance bill the difference between our allowance and billed charges.

Scenario CDO: Anesthesia

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

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

Precertification
Section 5(c), (Pg 105)

- Call UnitedHealthcare for precertification
- You may be subject to a **$500 precert penalty** if inpatient precertification is not done:
  - 2 business days prior to an elective admission, or
  - Within 2 business days after an emergency admission



Inpatient Hospital
Section 5(c), (Pgs 105-107)

- Room and Board
- Ancillary/Other Hospital Charges
- Cancer Centers of Excellence
  - Contact UHC to enroll prior to initial treatment for referral
  - Patient pays 10% of Plan allowance
  - May receive pre-approval for travel and lodging expenses
  - Includes in and outpatient services at designated facilities

Outpatient Hospital or Ambulatory Care Facility

Section 5(c), (Pg 107)

- Operating, recovery, treatment rooms
- Pharmacy items and medical supplies
- Diagnostic testing
- Blood and its administration
- Pre-surgical testing
- Anesthetics

Skilled Nursing Facility Benefit
Section 5(c), (Pgs 107-108)

- When APWU Health Plan is Primary
  - And you have had a covered inpatient hospital stay;
  - The Health Plan will approve up to a maximum of 30 days in a skilled Nursing Facility (SNF) based on medical necessity.
  - Prior approval required. Call UnitedHealthcare at 1-800-718-1299.
- Not covered: Custodial Care

Hospice Care
Section 5(c), (Pg 108)

- Maximum lifetime payout of $15,000 includes outpatient/inpatient and advance care planning (end of life care)

- $200 bereavement benefit per family unit

Ambulance
Section 5(c), (Pg 108)

- Local, professional ambulance service
  - Medically appropriate
  - Before or after an inpatient admission
- Ambulance services used for routine transport is not covered

Accident (Pgs 109-110)

- "Accident" is defined as resulting from a violent, external force
- Outpatient services, including ambulance and air ambulance* rendered within 24 hours of accident
  - 15% coinsurance for both in-network and out-of-network care
  - For out-of-network care, members may be billed the different between the Plan allowance and the billed amount

*** If medically necessary for transport to the closest appropriate facility for treatment.**

Medical Emergency (Pgs 109-110)

- 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 = 15% coinsurance
- Treatment at other than an Urgent Care Center
  - Cost share = 15% coinsurance
- For out-of-network care, members may be billed the different between the Plan allowance and the billed amount

Mental Health and Substance Misuse Disorder Section 5(e), (Pgs 111-113)

- Must obtain preauthorization for:
  - Inpatient Mental Health or Substance Misuse Disorder Hospital admissions
  - Inpatient treatment, psychological testing, Electroconvulsive Therapy (ECT), Transcranial Magnetic Stimulation (TMS), ABA, Residential Treatment
- To obtain preauthorization, call Beacon Health Options
- $500 penalty for failure to obtain precertification
  - 2 days prior to elective hospital admission
  - 2 days after an emergency admission

Covered Medication/Supplies

Section 5(f), (Pgs 114-119)

Administered by OptumRx

- Covered Items
  - Rx drugs, diabetic supplies, Insulin





Prescription Drugs (Pg 114)

- **Traditional Prescription Drug Formulary:** A list of selected covered drugs based on clinical effectiveness and lower cost (*There are certain drugs excluded*)
- **Brand Name Drugs:** Are protected by a patent and manufactured and sold only by the company holding the patent
- **Generic Drugs:** When the patent for the brand name drug expires, generic versions of the drug can be offered for sale if the FDA agrees; generic drugs are typically less expensive than brand name drugs



Prescription Drug Tiers
Consumer Driven Option - OptumRx

Tier 1	**Medications that provide the highest overall value. Mostly generic drugs. Some brand name drugs may also be included.**	**Use Tier 1 drugs for the lowest out-of-pocket costs.**
Tier 2	Medications that provide good overall value. A mix of brand name and generic drugs.	Use Tier 2 drugs, instead of Tier 3, to help reduce your out-of-pocket costs.
Tier 3	Medications that provide the lowest overall value. Mostly brand name drugs, as well as some generics.	Ask your doctor if a Tier 1 or Tier 2 option could work for you.

Covered Medication/Supplies (Pg 115)

- Patient Responsibility
  - Network Retail: Tier 1 and Tier 2 25% co-insurance; minimum $15, maximum out-of-pocket $200 for each 30-day supply; Tier 3 40% coinsurance; minimum $15, maximum out-of-pocket $200 for each 30-day supply
  - Network Mail Order: Tier 1 and Tier 2 25% co-insurance; minimum $10, maximum out-of-pocket $200 for each 30-day supply; Tier 3 40% coinsurance; minimum $10, maximum out-of-pocket $200 for each 30-day supply
- No coverage for prescriptions purchased out-of-network

Prescription Drugs
Section 5(f)

- Zero out-of-pocket costs
  - Contraceptive Drugs, generic at Network Retail or Mail Order (Pg 115
  - Select over-the-counter (OTC) and prescription tobacco cessation medications approved by the FDA to treat tobacco dependence (In-network retail/Mail Order) (Pg 95)
  - Preventive Care Medications with a USPSTF recommendation of A or B when prescribed by a health care professional and filled at a network pharmacy; for current recommendations go to: www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations (Pg 117)

Coverage Authorization (Pgs 118-119)

- Prior approval/medical necessity review needed for some medications

  Examples: Growth Hormone, Botox, Rheumatoid Arthritis agents, Specialty cholesterol drugs
- Step Therapy review
- Supply limits
- Compound Medication restrictions
- OptumRx will work w/physician to obtain information needed to give approval *(based on FDA guidelines)*
- If not approved, patient may opt to fill prescription and will assume responsibility for its full cost

Specialty Drugs (Pg 119)

First Fill of Specialty Drugs must be obtained through OptumRx Specialty Pharmacy.

- Cost ranges from $500 per dose or $6000 or more per year
- Complex treatment, care
- Safety monitoring
- Special requirements for shipping, handling
- Disease categories include:
  - Cancer, cystic fibrosis, growth hormone deficiency, hemophilia, immune deficiency, Hepatitis C
- Visit www.myuhc.com or call UnitedHealthcare

Dental Benefits

Section 5(g), (Pg 120)

No benefit except under "Extra PCA"

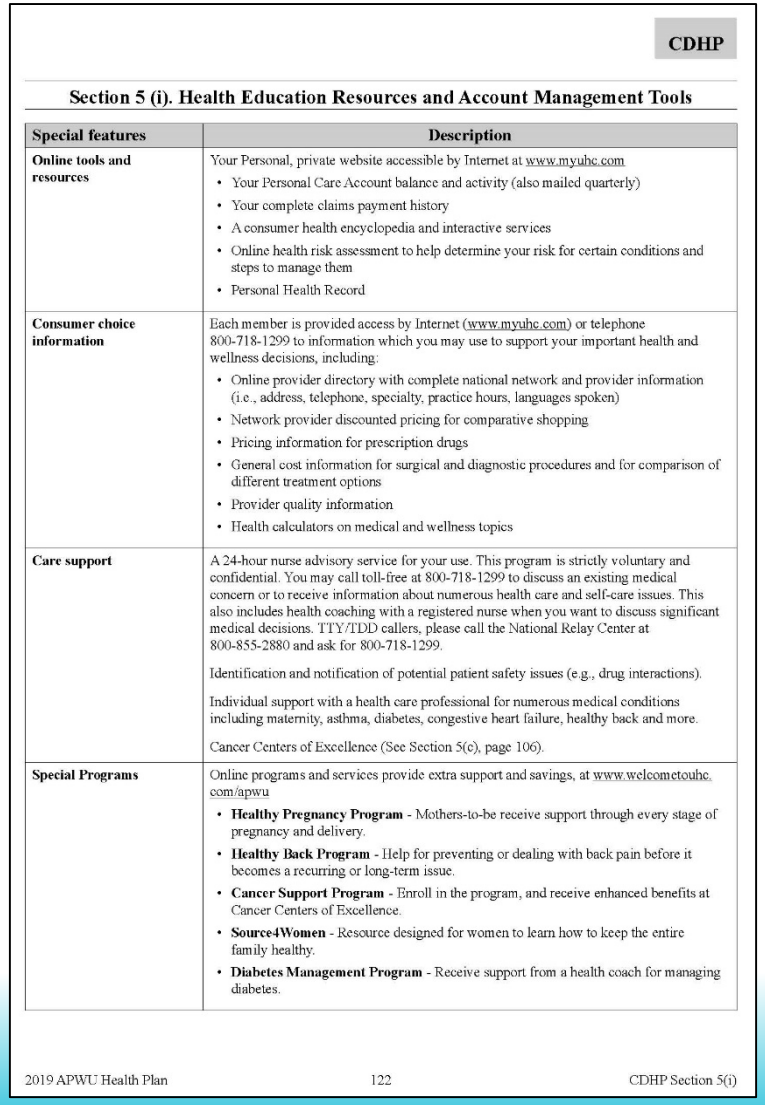
Health Resources and Tools

Section 5(i), (Pg 122)

Online tools…

24 Hour Nurse Line…

Special Programs…



CDHP

Section 5 (i). Health Education Resources and Account Management Tools

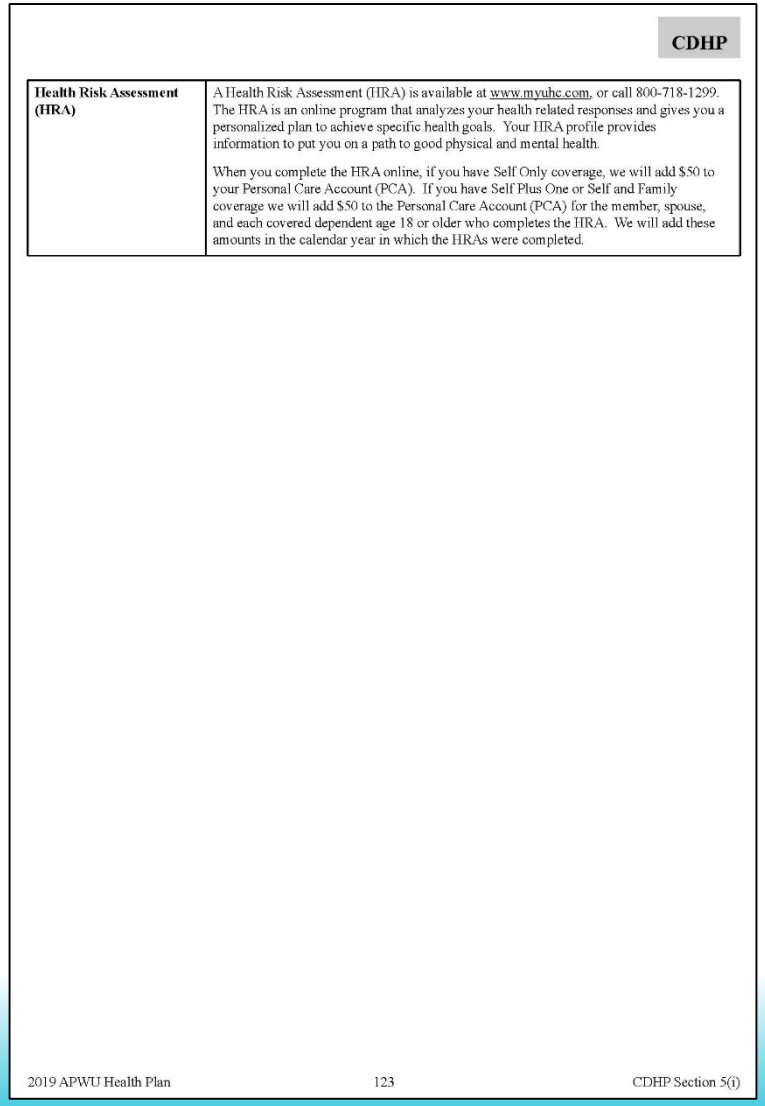
Special features	Description
Online tools and resources	Your Personal, private website accessible by Internet at www.myuhc.com • Your Personal Care Account balance and activity (also mailed quarterly) • Your complete claims payment history • A consumer health encyclopedia and interactive services • Online health risk assessment to help determine your risk for certain conditions and steps to manage them • Personal Health Record
Consumer choice information	Each member is provided access by Internet (www.myuhc.com) or telephone 800-718-1299 to information which you may use to support your important health and wellness decisions, including: • Online provider directory with complete national network and provider information (i.e., address, telephone, specialty, practice hours, languages spoken) • Network provider discounted pricing for comparative shopping • Pricing information for prescription drugs • General cost information for surgical and diagnostic procedures and for comparison of different treatment options • Provider quality information • Health calculators on medical and wellness topics
Care support	A 24-hour nurse advisory service for your use. This program is strictly voluntary and confidential. You may call toll-free at 800-718-1299 to discuss an existing medical concern or to receive information about numerous health care and self-care issues. This also includes health coaching with a registered nurse when you want to discuss significant medical decisions. TTY/TDD callers, please call the National Relay Center at 800-855-2880 and ask for 800-718-1299. Identification and notification of potential patient safety issues (e.g., drug interactions). Individual support with a health care professional for numerous medical conditions including maternity, asthma, diabetes, congestive heart failure, healthy back and more. Cancer Centers of Excellence (See Section 5(c), page 106).
Special Programs	Online programs and services provide extra support and savings, at www.welcometouhc.com/apwu • **Healthy Pregnancy Program** - Mothers-to-be receive support through every stage of pregnancy and delivery. • **Healthy Back Program** - Help for preventing or dealing with back pain before it becomes a recurring or long-term issue. • **Cancer Support Program** - Enroll in the program, and receive enhanced benefits at Cancer Centers of Excellence. • **Source4Women** - Resource designed for women to learn how to keep the entire family healthy. • **Diabetes Management Program** - Receive support from a health coach for managing diabetes.

2019 APWU Health Plan 122 CDHP Section 5(i)

Health Resources and Tools

Section 5(i), (Pg 123)

Health Risk Assessment…



CDHP

Health Risk Assessment (HRA)	A Health Risk Assessment (HRA) is available at www.myuhc.com, or call 800-718-1299. The HRA is an online program that analyzes your health related responses and gives you a personalized plan to achieve specific health goals. Your HRA profile provides information to put you on a path to good physical and mental health. When you complete the HRA online, if you have Self Only coverage, we will add $50 to your Personal Care Account (PCA). If you have Self Plus One or Self and Family coverage we will add $50 to the Personal Care Account (PCA) for the member, spouse, and each covered dependent age 18 or older who completes the HRA. We will add these amounts in the calendar year in which the HRAs were completed.

Health Risk Assessment (Pg 123)

Don’t forget to complete your Health Risk Assessment online at **www.myuhc.com**!

Self Only: We’ll add $50 to your PCA

Self Plus One

Self and Family — We’ll add $50 to your PCA for anyone age 18 or older that completes the HRA

Brochure Tour - Non FEHB Benefits

Our members have access to other benefits that are not part of the FEHB program (Pg 124)

Non-FEHB Benefits Available to Plan Members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file a FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow the Plan's guidelines. For additional information contact the Plan at 800-222-2798 or visit their website at www.apwuhp.com.

Conversion Plan Health Insurance

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

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

For additional information, please contact us by calling 800-222-2798 or by going to www.apwuhp.com/Members/for-all-members/Conversion-Option.

American Hearing Benefits

888-863-7222
www.americanhearingbenefits.com

The American Hearing Benefits program is an optional program with no additional premium that supplements the benefits in your APWU Health Plan coverage. All participants of the APWU Health Plan, either High Option or Consumer Driven Option, who enroll in the American Hearing Benefits Plan through this offer will receive a discount on hearing aid devices and free hearing consultations annually offered through Starkey Hearing Technologies. To enroll in the plan you must call American Hearing Benefits toll free at 888-863-7222. Please specify that you are an APWU Health Plan participant.

The Supplemental Discount Drug Program

800-818-6717
www.express-scripts.com

The Voluntary Benefits Plan

P.O. Box 12009
Cheshire, CT 06410
800-422-4492
www.voluntarybenefitsplan.com

Brochure Tour

Things we don't cover… Pg 125

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*).

How and when to file a paper claim… Pgs 127-129

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).

How to appeal… Pgs 130-132

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 or to make an inquiry 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 call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website.

What if you have Medicare, Other Insurance, TRICARE, CHAMPA… Pgs 133-142

Section 9. Coordinating Benefits with Medicare and Other Coverage

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

Term definitions… Pgs 143-147

Section 10. Definitions of Terms We Use in This Brochure

Section 11. Other Federal Programs

Other programs our members have access… Pgs 148-150

The Federal Flexible Spending Account Program - *FSAFEDS*

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

The Federal Long Term Care Insurance Program - *FLTCIP*

Summary of Benefits – High Option (Pgs 151-152)

Summary of Benefits for the High Option of the APWU Health Plan - 2019

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. You can obtain a copy of our Affordable Care Act Summary of Benefits Coverage at www.apwuhp.com. 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: $25 copay per visit (No deductible); 10% of Plan allowance Non-PPO: 30% of our allowance plus amount over our allowance	34
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	56
• Outpatient*	PPO: 10% of Plan allowance Non-PPO: 30% of our allowance plus amount over our allowance	57
Emergency benefits:		
• Accidental injury	PPO: Nothing Non-PPO: Any amount over our allowance	60
• Medical emergency*	PPO 10% of Plan allowance Non-PPO: 10% of our allowance plus amount over our allowance	60
Mental health and substance use disorder treatment:	PPO: $25 copay per visit (No deductible); 10% of Plan allowance Non-PPO: 30% of our allowance plus amount over our allowance	61
Prescription drugs:		
• Network pharmacy	$10 Tier 1/25% Tier 2/45% Tier 3/Specialty drugs 25% Tier 4/25% Tier 5/45% Tier 6	66
• Non-network pharmacy	50% of cost	66
• Mail order	$20 Tier 1/25% Tier 2/45% Tier 3/25% Tier 4/25% Tier 5/45% Tier 6	66
Dental care:		71

Summary of Benefits – CDHP (Pgs 153-154)

Summary of Benefits for the CDHP of the APWU Health Plan - 2019

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. You can obtain a copy of our Affordable Care Act Summary of Benefits Coverage at www.apwuhp.com. On this page we summarize specific expenses we cover; for more detail, look inside.

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

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

CDHP Benefits	You Pay	Page
In-network preventive care:	Nothing	78
Personal Care Account:		
Up to $1,200 for Self Only or $2,400 for Self Plus One or Self and Family for medical, surgical, hospital, mental health and substance use disorder treatment services and prescription drugs plus certain dental and vision care	Nothing up to $1,200 for Self Only or $2,400 for Self Plus One or Self and Family	82
Traditional Health Coverage after Personal Care Account is exhausted	See Section 5 Traditional Health Overview (Deductible before Traditional Health Coverage Begins)	85
Medical/Surgical services provided by physicians:		
• Diagnostic and treatment services provided in the office*	In-network: 15% of Plan allowance Out-of-network: 40% of our allowance plus amount over our allowance	87
Services provided by a hospital:		
• Inpatient*	In-network: 15% of Plan allowance Out-of-network: 40% of our allowance plus amount over our allowance	105
• Outpatient*	In-network: 15% of Plan allowance Out-of-network: 40% of our allowance plus amount over our allowance	107
Emergency benefits:		
• Accidental injury*	In-network: 15% of Plan allowance Out-of-network: 15% of Plan allowance plus amount over our allowance	110
• Medical emergency*	In-network: 15% of Plan allowance Out-of-network: 15% of Plan allowance plus amount over our allowance	110
Mental health and substance use disorder treatment*:	In-network: 15% of Plan allowance Out-of-network: 40% of our allowance plus amount over our allowance	111

2019 Rate Information (Pg 158)

2019 Rate Information for the APWU Health Plan

To compare your FEHB health plan options please go to www.opm.gov/fehbcompare.

To review premium rates for all FEHB health plan options please go to www.opm.gov/FEHBpremiums or www.opm.gov/Tribalpremium.

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

Postal rates apply to certain United States Postal Service employees as follows:

- **Postal Category 1 rates** apply to career bargaining unit employees who are represented by the following agreements: APWU, IT/AS, NALC, NPMHU, and NRLCA.
- If you are a career bargaining unit employee represented by the agreement with NPPN, you will find your premium rates on https://liteblue.usps.gov/fehb.
- **Postal Category 2 rates** apply to career bargaining unit employees who are represented by the following agreement: PPOA.

APWU rates apply to career Postal employees represented by APWU.

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

If you are a Postal Service employee and have questions or require assistance, please contact:
USPS Human Resources Shared Service Center: 877-477-3273, option 5, Federal Relay Service 800-877-8339

Premiums for Tribal employees are shown under the monthly non-Postal column. If you are a Tribal employee, the amount shown under "Your Share" is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

2019 Rate Information (Pg 158)

Non-Postal Premium:
Biweekly = Federal
Monthly = Retired
Postal & Federal

Postal Premium: Actively Employed

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium		
		Biweekly		Monthly		Biweekly		
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share	APWU Your Share
High Option Self Only	471	$230.18	$105.00	$498.72	$227.50	$101.80	$92.21	$101.80
High Option Self Plus One	473	$492.27	$211.59	$1,066.59	$458.44	$204.75	$184.24	$204.75
High Option Self and Family	472	$525.32	$279.10	$1,138.19	$604.72	$271.80	$249.92	$271.80
CDHP Option Self Only	474	$206.89	$68.96	$448.26	$149.42	$66.20	$57.24	$23.29
CDHP Option Self Plus One	476	$449.66	$149.88	$974.25	$324.75	$143.89	$124.40	$59.41
CDHP Option Self and Family	475	$490.53	$163.51	$1,062.82	$354.27	$156.97	$135.71	$77.65

APWU HEALTH PLAN

TOGETHER.
BETTER HEALTH.®

QUESTIONS: 2019 CONSUMER DRIVEN OPTION BENEFITS



33rd Annual Open Season Seminar

How much is the in-network Office Visit copay?

A. $18
B. $25
C. $20
✓ D. No copay

How much is the in-network Deductible?

A. Self Only: $2,000; Self Plus One and Self and Family: $4,000

B. Self Only: $1,800; Self Plus One and Self and Family: $3,600

C. $0 Deductible

D. Self Only: $800; Self Plus One and Self and Family: $1,600

Do covered in-network preventive care costs deduct anything from your PCA?

A. Yes

✓ B. No

The maximum account balance (including rollover) in your PCA can never exceed $5,000 for Self Only or $10,000 for Self Plus One and Self and Family.

✓ A. True

B. False

How much of your PCA account is funded by the Health Plan?

A. Self Only: $1,800; Self Plus One and Self and Family: $3,600

B. $10,000 per membership



C. Self Only: $1,200; Self Plus One and Self and Family: $2,400

D. Nothing

How much of your PCA dollars can be used toward dental/vision services?

A. Dental and vision services are not covered

B. No restriction

C. Self Only: $600; Self Plus One and Self and Family: $1,200

✓ D. Self Only: $400; Self Plus One and Self and Family: $800

If you do not want certain expenses paid from your PCA account, can it be turned off?

✓ A. Yes

B. No

If you are able to “turn off” your PCA for certain expenses, can you turn it off for prescription drugs?

A. Yes

✓ B. No

For in-network diagnostic services, how much is your coinsurance after your PCA is exhausted and your deductible has been met?

✓ A. 15%

B. 40%

C. 25%

D. No coinsurance

What will not accumulate toward your Catastrophic out-of-pocket expenses?

A. In-network preventive care
B. Drugs purchased at non-network pharmacy
C. Dental and vision care above limitations of PCA
D. All of the above ✓

What is the Catastrophic out-of-pocket maximum?

A. In-network: Self Only; $5,000; Self Plus One and Self and Family: $10,000

Out-of-network: Self Only $10,200; Self Plus One and Self and Family: $13,700

B. In-network: Self Only; $5,500; Self Plus One and Self and Family: $6,500

Out-of-network: Self Only, Self Plus One and Self and Family: $10,000

C. $15,000 per membership

D. In-network: Self Only; $10,000; Self Plus One and Self and Family: $10,000

Out-of-network: Self Only, Self Plus One and Self and Family: $10,000

How much is the coinsurance for Tier 3 Drugs at Retail and at Mail Order?

A. No coinsurance

B. ✓ Retail: 40% of the cost with a $15 minimum up to a max of $200 for a 30-day supply, $400 for a 60-day supply, $600 for a 90-day supply

   Mail: 40% of the cost with a $10 minimum up to a max of $200 for a 30-day supply, $400 for a 60-day supply, $600 for a 90-day supply

C. Retail: 25% of the cost with a $15 minimum up to a max of $200 for a 30-day supply, $400 for a 60-day supply, $600 for a 90-day supply

   Mail: 25% of the cost with a $10 minimum up to a max of $200 for a 30-day supply, $400 for a 60-day supply, $600 for a 90-day supply

D. $100 copay per prescription

What is covered under Family Planning?

A. Contraceptives, voluntary sterilization
B. Reversal of sterilization
C. Diapers and strollers
D. Gift card to Babies ‘R’ Us

What is the benefit for out-of-network Virtual Visits?

A. No benefit; in-network only
B. 40% coinsurance
C. Deductible, then 40% coinsurance
D. $20 copay

Is Cologuard Screening for Colorectal Cancer covered under routine preventive care for 2019?

✓ A. Yes

B. No

Is genetic screening a covered benefit?

A. Yes

✓ B. No

What is not covered under the $2,500 maximum infertility benefit?

A. Artificial insemination
B. In Vitro Fertilization (IVF)
C. Cost of donor sperm/egg
✓ D. All of the above

Do PT/OT/ST require pre-authorization? And what is the benefit maximum?

A. No; 60 visits combined
B. Yes; 60 visits combined
C. Yes; 20 visits each
D. No; 20 visits each

What statement is true regarding the new benefit for care in a Residential Treatment Facility?

A. No authorization needed

B. Pre-auth required through Beacon Health Options; covered both in-network and out-of-network

C. Pre-auth required through Beacon Health Options; in-network only

D. Payable only for the enrollee

Skilled Nursing Facility following transfer from acute care for non-custodial care will be covered in 2019. Prior authorization is required.

A. True
B. False

What is the annual visit limit for chiropractic visits and/or manipulations?

A. No limit restriction
B. 12
C. 6
✓ D. 24

Pre-authorization is required for medical inpatient confinement, but not if treatment is for behavioral health.

A. True

✓ B. False

Can specialty drugs be obtained at the retail pharmacy?

A. Yes

✓ B. No

What is the incentive if you complete the Health Risk Assessment?

A. $50 gift card for medical expenses, per member

B. There is no incentive, other than learning how to better your health

C. $100 Visa gift card

✓ D. Self Only: $50 added to your PCA, Self Plus One and Self and Family: $50 added to your PCA for each covered person 18 years or older

THANK YOU!

You will receive an email following our Seminar with a link to fill out your class evaluations online.

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:

Sunday, October 28, 2018

