# BASIC AND REFRESHER CLASS



APWU HEALTH PLAN

TOGETHER.
BETTER HEALTH.®

*32nd Annual Open Season Seminar*

# Today's Agenda

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

- Health Insurance Terminology
- 2018 Brochure
  - Layout
  - Sections
  - 2018 Changes
- Review APWU Health Plan benefits for 2018
  - Examples
  - Live scenarios

APWU HEALTH PLAN

TOGETHER.
BETTER HEALTH.®

# HEALTH INSURANCE TERMINOLOGY

# Basic Terms

PPO vs. Non PPO

Covered Services

Allowed Amount

Preventive Care

Balance Bill

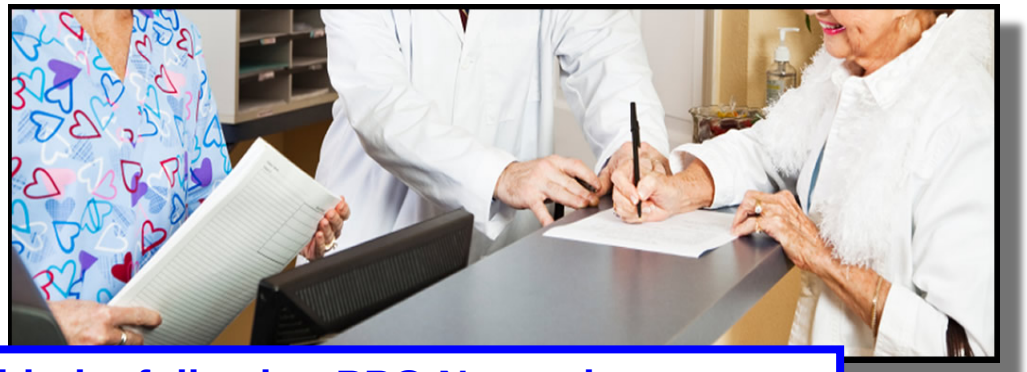
Precertification

Prescription Drugs

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 PPO 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 is $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
  - 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 Visits

Colonoscopy

Mammogram

# Cost Sharing Terms - Consider more than the premium

Premium

Coinsurance

Copays

Catastrophic Limit

Deductible

# 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

# Coinsurance

- The percentage that **you must pay** for your care
  - Health Plans:
    - High Option: 10%
    - Consumer Driven Option: 15%

- PPO provider bills $1,500
- PPO allowable $1,000
- High Option member pays 10% coinsurance
- Member coinsurance $100
- ($1000 X 10% = $100)
- Health Plan pays $900

# 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 Service

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

Prescription Drug

Doctor Visits

RN Visits

Inpatient Hospitalization

Labs

PT, OT, ST, ABA

X-rays

Mental Health Visits

# Prescription Drug Terms

- **National 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 typically 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

# 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

TOGETHER.
BETTER HEALTH.®

# BASIC AND REFRESHER CLASS

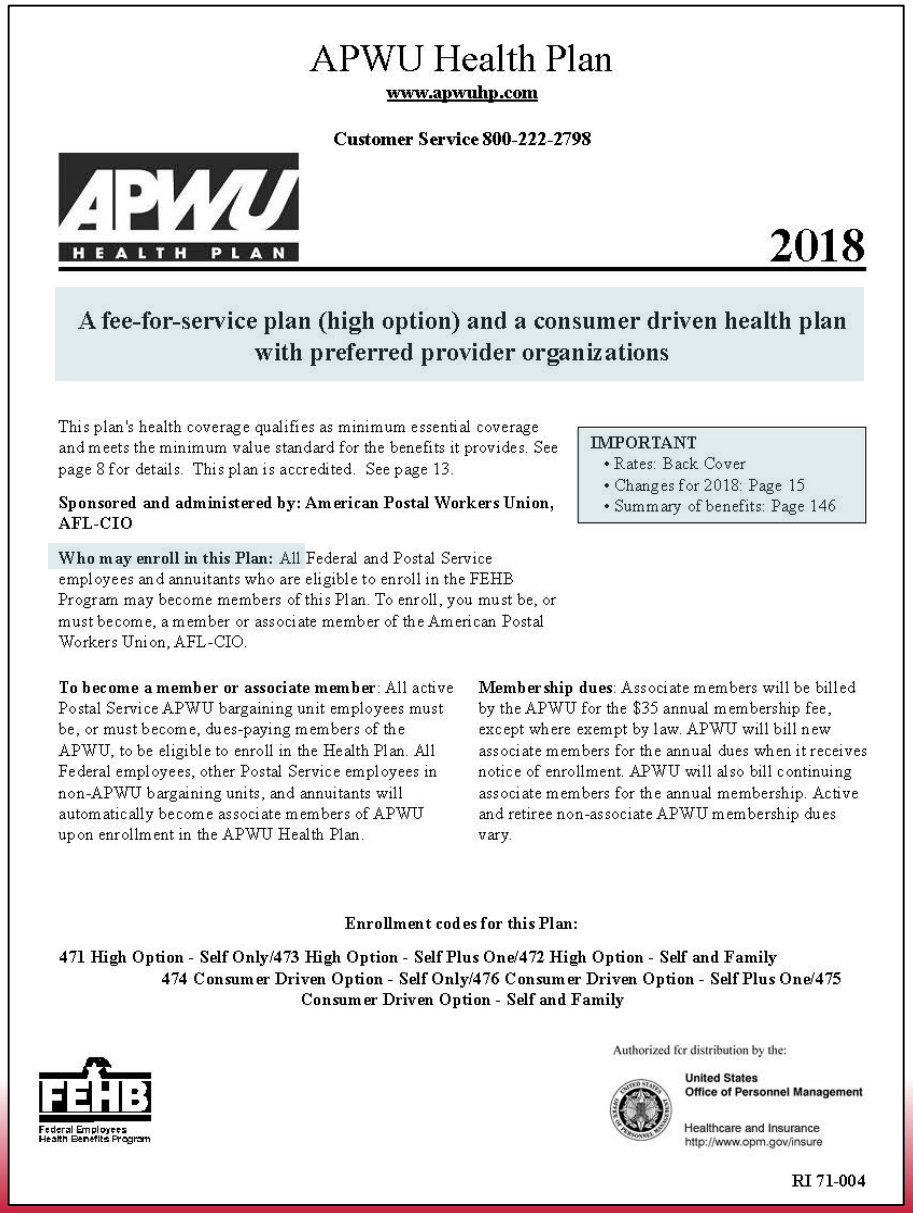
# Brochure Tour

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

2018

**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 13.

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

IMPORTANT
- Rates: Back Cover
- Changes for 2018: Page 15
- Summary of benefits: Page 146

**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.

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

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

**Enrollment codes for this Plan:**

**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…

# Brochure: Table of Contents (Pg 1)

- Introduction/FEHB Facts
- Section 1: How this Plan works
- Section 2: Changes for 2018
- Section 3: How you get care

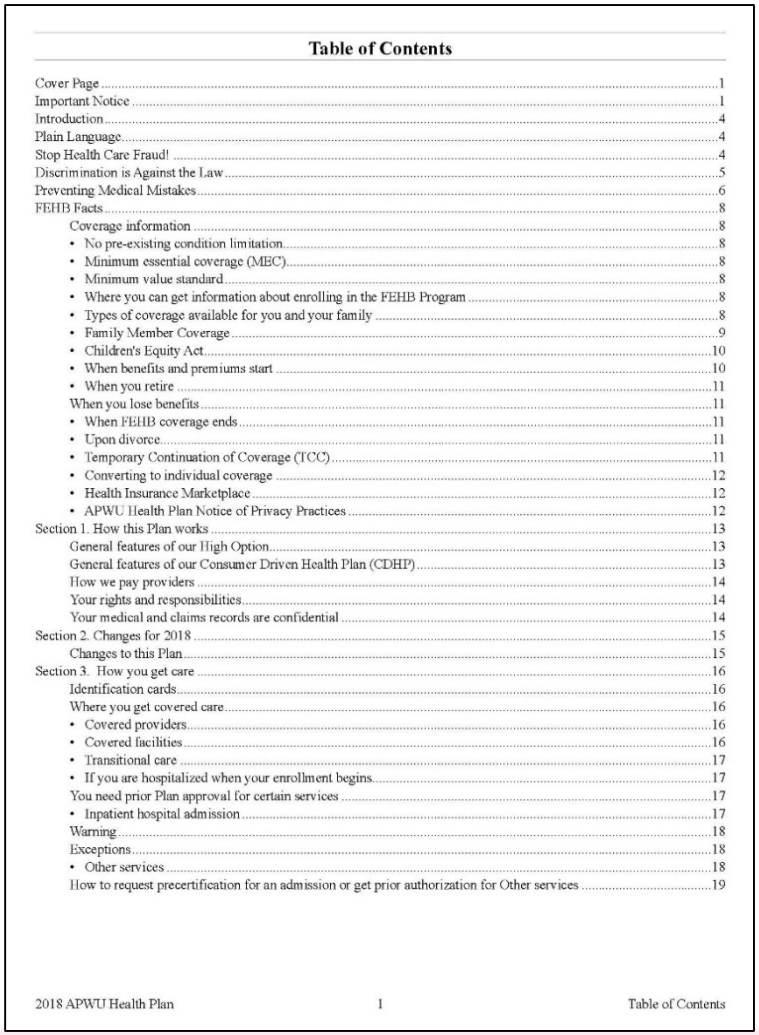
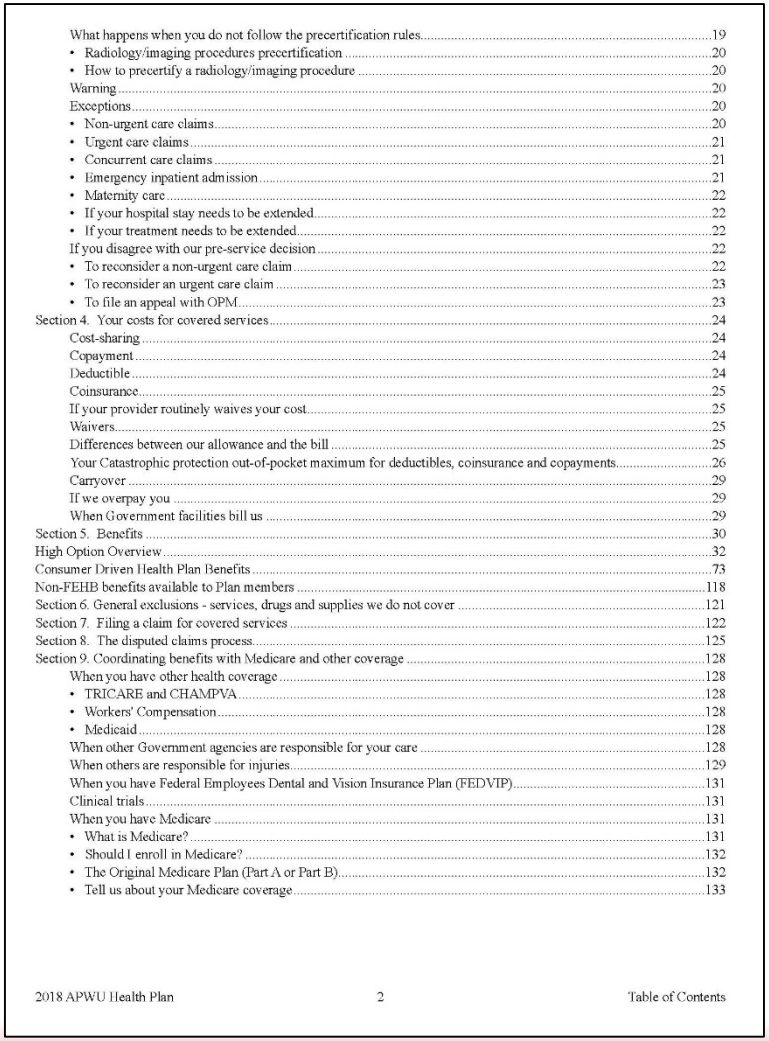


**Table of Contents**


Cover Page ..... 1
Important Notice ..... 1
Introduction ..... 4
Plain Language ..... 4
Stop Health Care Fraud! ..... 4
Discrimination is Against the Law ..... 5
Preventing Medical Mistakes ..... 6
FEHB Facts ..... 8
Coverage information ..... 8
• No pre-existing condition limitation ..... 8
• Minimum essential coverage (MEC) ..... 8
• Minimum value standard ..... 8
• Where you can get information about enrolling in the FEHB Program ..... 8
• Types of coverage available for you and your family ..... 8
• Family Member Coverage ..... 9
• Children's Equity Act ..... 10
• When benefits and premiums start ..... 10
• When you retire ..... 11
When you lose benefits ..... 11
• When FEHB coverage ends ..... 11
• Upon divorce ..... 11
• Temporary Continuation of Coverage (TCC) ..... 11
• Converting to individual coverage ..... 12
• Health Insurance Marketplace ..... 12
• APWU Health Plan Notice of Privacy Practices ..... 12
Section 1. How this Plan works ..... 13
General features of our High Option ..... 13
General features of our Consumer Driven Health Plan (CDHP) ..... 13
How we pay providers ..... 14
Your rights and responsibilities ..... 14
Your medical and claims records are confidential ..... 14
Section 2. Changes for 2018 ..... 15
Changes to this Plan ..... 15
Section 3. How you get care ..... 16
Identification cards ..... 16
Where you get covered care ..... 16
• Covered providers ..... 16
• Covered facilities ..... 16
• Transitional care ..... 17
• If you are hospitalized when your enrollment begins ..... 17
You need prior Plan approval for certain services ..... 17
• Inpatient hospital admission ..... 17
Warning ..... 18
Exceptions ..... 18
• Other services ..... 18
How to request precertification for an admission or get prior authorization for Other services ..... 19

# Brochure: Table of Contents (Pg 2)

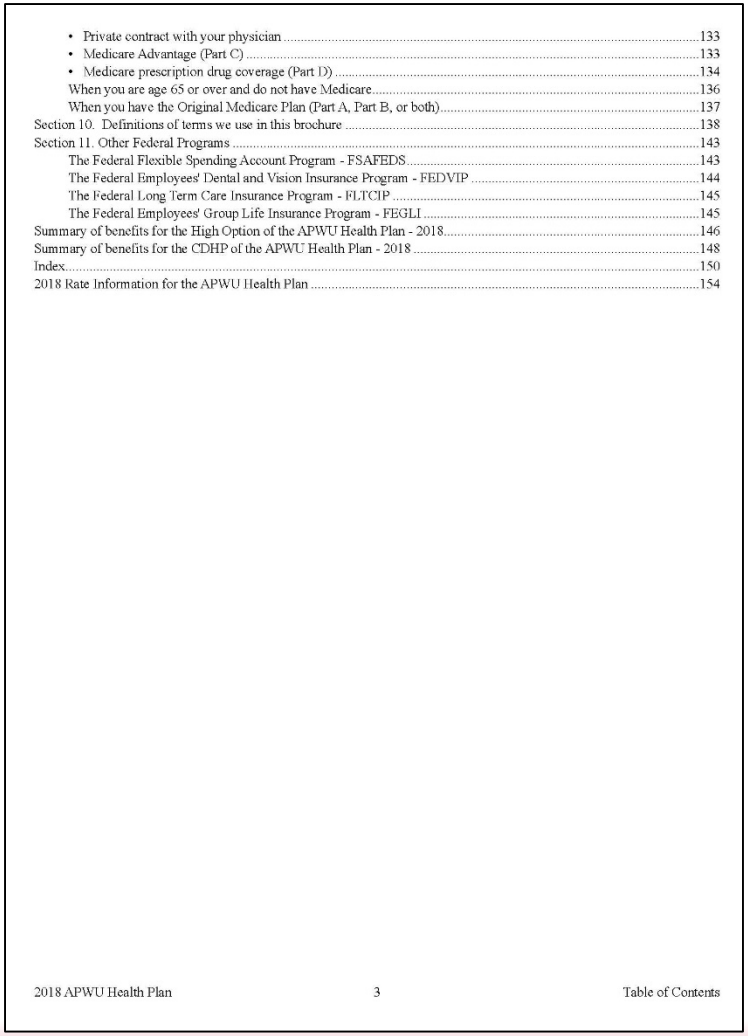
- Section 4: Your Costs for covered services
- Section 5: Benefits
- Section 6: General Exclusions
- Section 7: Filing a claim for covered services
- Section 8: The disputed claims process
- Section 9: Coordinating benefits with Medicare and other coverage




What happens when you do not follow the precertification rules ..... 19
• Radiology/imaging procedures precertification ..... 20
• How to precertify a radiology/imaging procedure ..... 20
Warning ..... 20
Exceptions ..... 20
• Non-urgent care claims ..... 20
• Urgent care claims ..... 21
• Concurrent care claims ..... 21
• Emergency inpatient admission ..... 21
• Maternity care ..... 22
• If your hospital stay needs to be extended ..... 22
• If your treatment needs to be extended ..... 22
If you disagree with our pre-service decision ..... 22
• To reconsider a non-urgent care claim ..... 22
• To reconsider an urgent care claim ..... 23
• To file an appeal with OPM ..... 23
Section 4. Your costs for covered services ..... 24
Cost-sharing ..... 24
Copayment ..... 24
Deductible ..... 24
Coinsurance ..... 25
If your provider routinely waives your cost ..... 25
Waivers ..... 25
Differences between our allowance and the bill ..... 25
Your Catastrophic protection out-of-pocket maximum for deductibles, coinsurance and copayments ..... 26
Carryover ..... 29
If we overpay you ..... 29
When Government facilities bill us ..... 29
Section 5. Benefits ..... 30
High Option Overview ..... 32
Consumer Driven Health Plan Benefits ..... 73
Non-FEHB benefits available to Plan members ..... 118
Section 6. General exclusions - services, drugs and supplies we do not cover ..... 121
Section 7. Filing a claim for covered services ..... 122
Section 8. The disputed claims process ..... 125
Section 9. Coordinating benefits with Medicare and other coverage ..... 128
When you have other health coverage ..... 128
• TRICARE and CHAMPVA ..... 128
• Workers' Compensation ..... 128
• Medicaid ..... 128
When other Government agencies are responsible for your care ..... 128
When others are responsible for injuries ..... 129
When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) ..... 131
Clinical trials ..... 131
When you have Medicare ..... 131
• What is Medicare? ..... 131
• Should I enroll in Medicare? ..... 132
• The Original Medicare Plan (Part A or Part B) ..... 132
• Tell us about your Medicare coverage ..... 133

# Brochure: Table of Contents (Pg 3)

- Section 10: Definitions
- Section 11: Other Federal Programs
- Summary of High Option
- Summary of Consumer Driven Option
- Index
- 2018 Rate Information

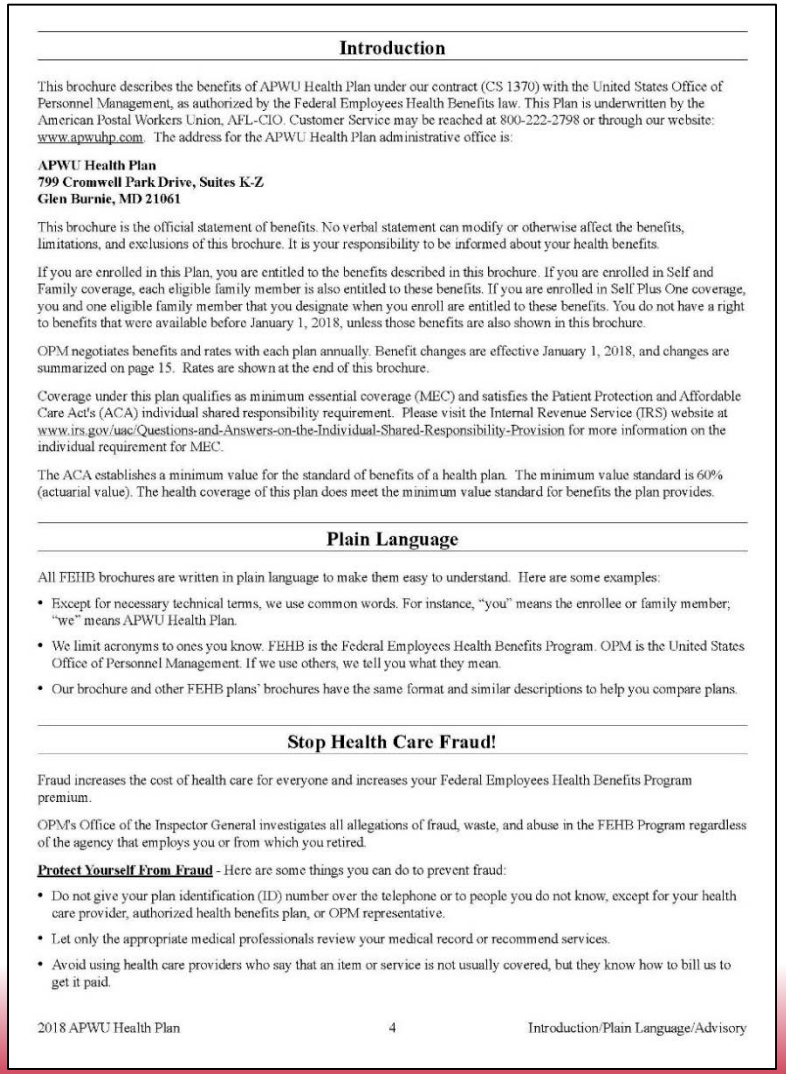



- Private contract with your physician ..... 133
- Medicare Advantage (Part C) ..... 133
- Medicare prescription drug coverage (Part D) ..... 134

When you are age 65 or over and do not have Medicare ..... 136
When you have the Original Medicare Plan (Part A, Part B, or both) ..... 137
Section 10. Definitions of terms we use in this brochure ..... 138
Section 11. Other Federal Programs ..... 143
The Federal Flexible Spending Account Program - FSAFEDS ..... 143
The Federal Employees' Dental and Vision Insurance Program - FEDVIP ..... 144
The Federal Long Term Care Insurance Program - FLTCIP ..... 145
The Federal Employees' Group Life Insurance Program - FEGLI ..... 145
Summary of benefits for the High Option of the APWU Health Plan - 2018 ..... 146
Summary of benefits for the CDHP of the APWU Health Plan - 2018 ..... 148
Index ..... 150
2018 Rate Information for the APWU Health Plan ..... 154

# Introduction
## (Pgs 4-12)

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



**Introduction**

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

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

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. If you are enrolled in Self Plus One coverage, you and one eligible family member that you designate when you enroll are entitled to these benefits. You do not have a right to benefits that were available before January 1, 2018, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2018, and changes are summarized on page 15. Rates are shown at the end of this brochure.

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

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

**Plain Language**

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

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

**Stop Health Care Fraud!**

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

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

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

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

2018 APWU Health Plan 4 Introduction/Plain Language/Advisory

# Section 1: How this Plan works (Pg 13)

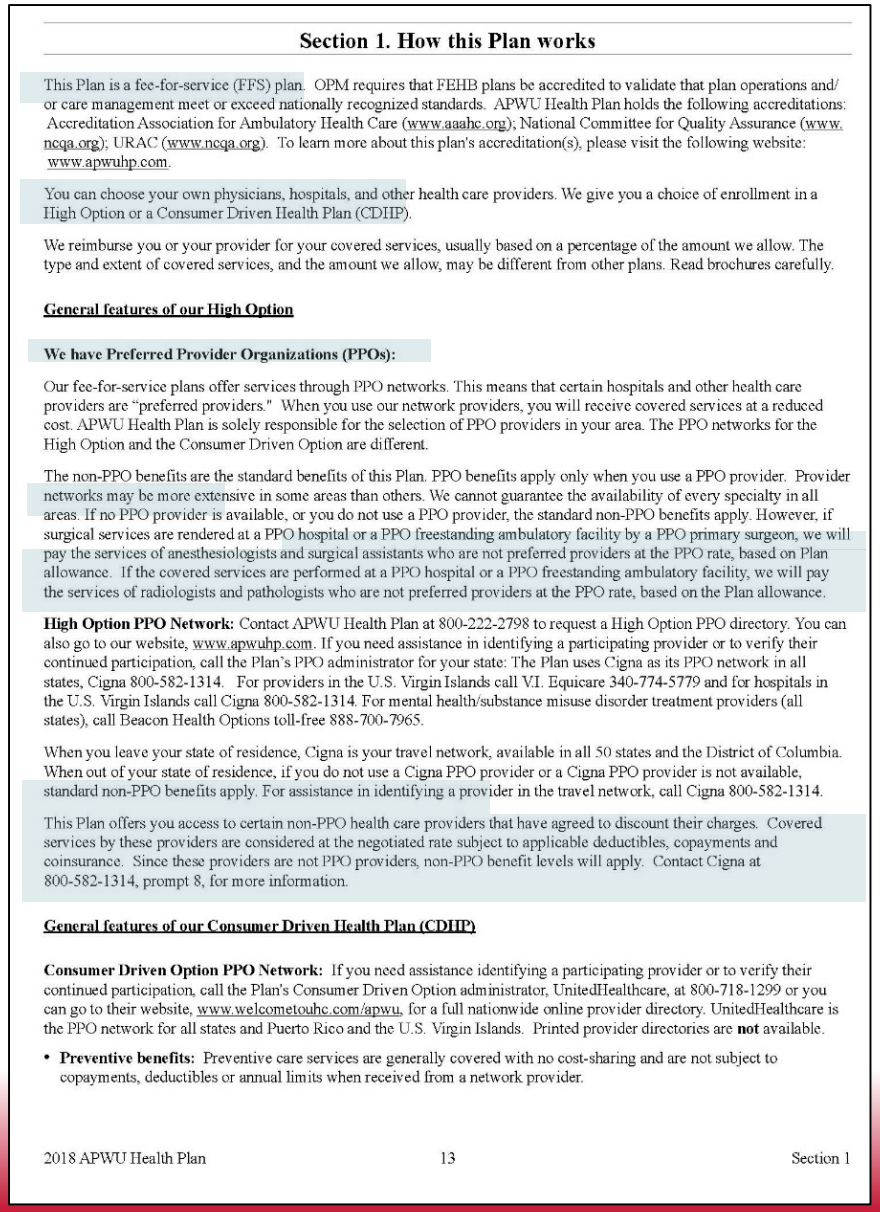
We are a FFS plan

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.ncqa.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 continued participation, call the Plan's PPO administrator for your state: The Plan uses Cigna as its PPO network in all states, Cigna 800-582-1314. For providers in the U.S. Virgin Islands call VI. Equicare 340-774-5779 and for hospitals in the U.S. Virgin Islands call Cigna 800-582-1314. For mental health/substance misuse 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.



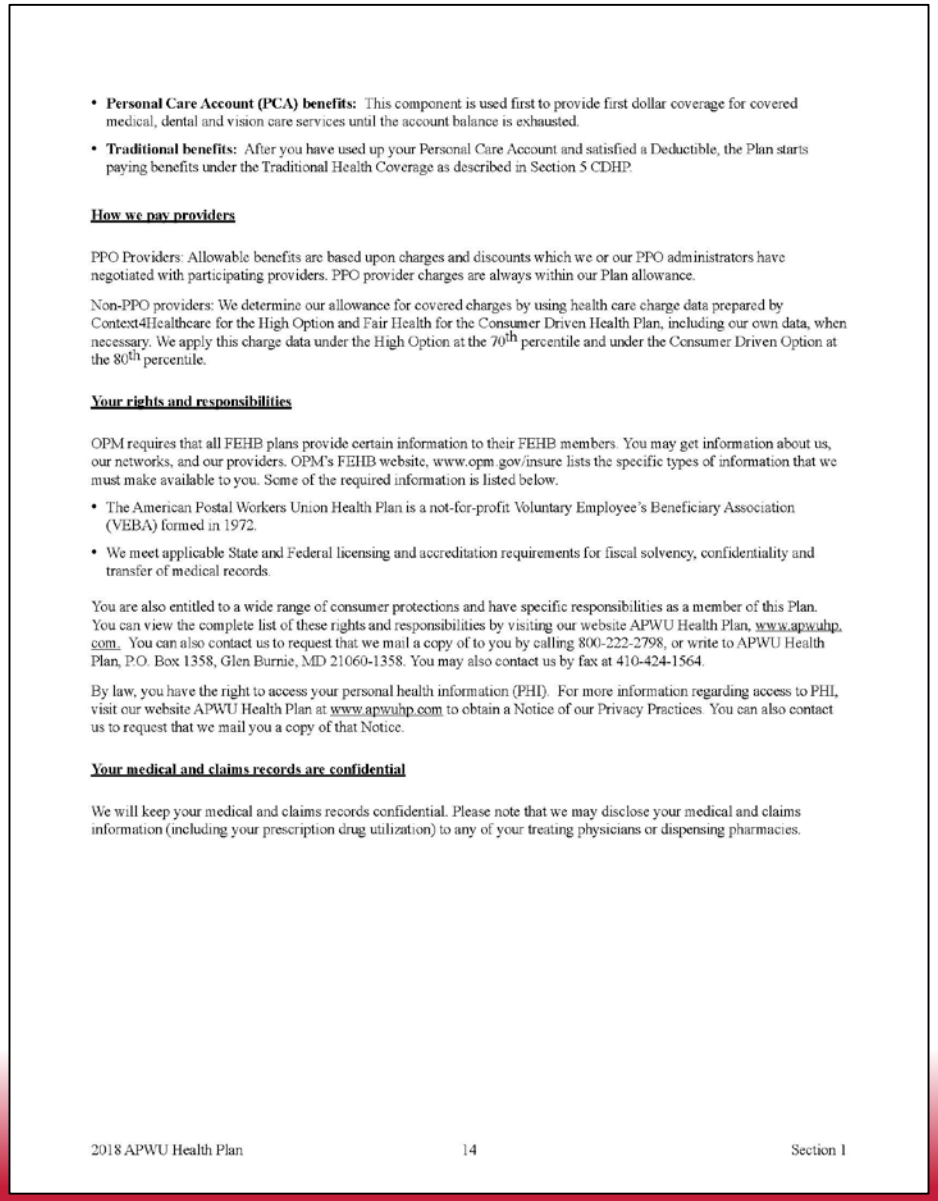
High Option PPO Vendors:
Cigna
VI Equicare
Beacon Health Options

Consumer Driven Option
PPO Vendors:
UnitedHealthcare
Beacon Health Options

# Section 1: How this Plan works (Pg 14)

**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 70$^{th}$ percentile and under the Consumer Driven Option at the 80$^{th}$ 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 of 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.

2018 APWU Health Plan 14 Section 1

# Section 2: Changes for 2018 (Pg 15)

## Section 2. Changes for 2018

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

### Changes to this Plan

**Changes to our High Option only**

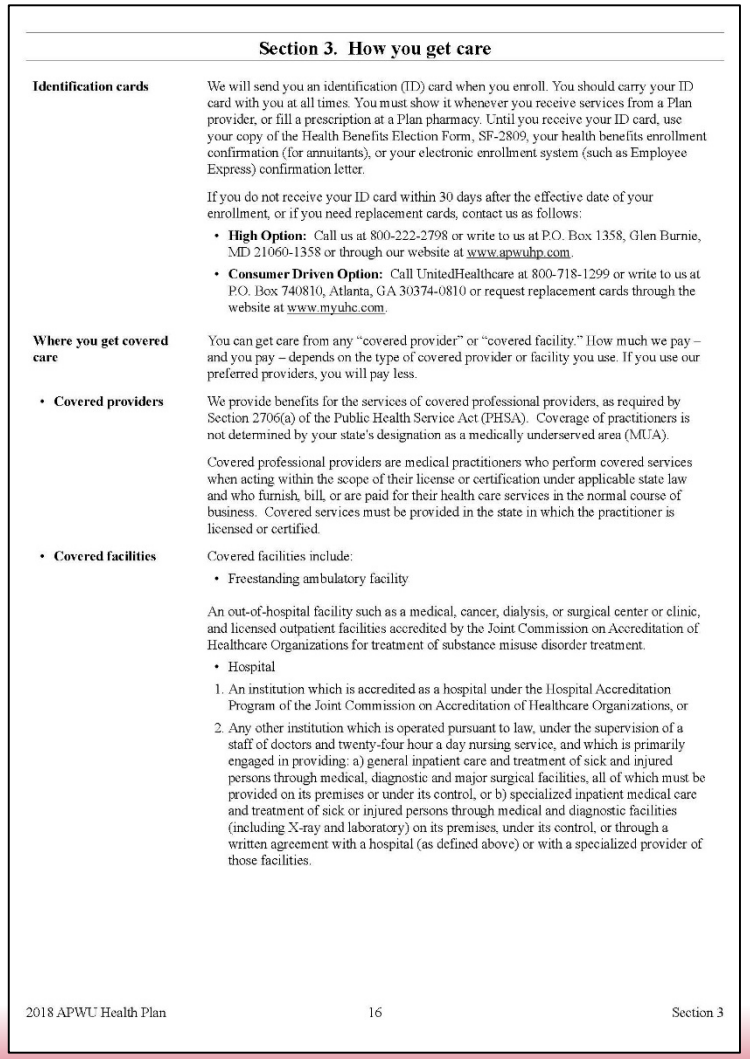
- Your share of the Postal premium will increase for Self Only, Self Plus One and Self and Family (see page 154).
- Your share of the non-Postal premium will increase for Self Only, Self Plus One and Self and Family (see page 154).
- The Plan will add coverage for 3D mammograms under preventive and diagnostic and treatment services (see pages 34 and 35).
- The Plan will add coverage for Transcranial Magnetic Stimulation (TMS) for the treatment of depressive disorders not responsive to other mental health interventions (see page 60).
- High technology imaging (CAT/CT, MRI, MRA, Nuclear Cardiology and PET) at an Urgent Care Center are subject to deductible and coinsurance in Section 5(a) and require precertification (see page 58).
- The Plan's Diabetes Management Program will apply regular cost-sharing to in-network medical visits and lab tests; syringes, pen needles and Insulin Pump supplies; and in-network Insulin Pump. The Program will continue to offer 100% coverage for formulary generic drugs and blood glucose test strips and lancets by mail order (see pages 70-71).
- The Plan will eliminate the Hypertension Management Program.
- The catastrophic out-of-pocket maximum costs will increase for Self Plus One and Self and Family: In-network will be $9,000 and out-of-network will be $15,000 (see pages 26-28).
- Prior approval/pre-notification will not be required for physical and occupational therapy (see page 40).
- Acupuncture procedures will be limited to 26 procedures per person per year (see page 44).
- The Plan will increase the coinsurance for non-preferred brand name drugs to 45% (see page 64).
- The in-network copayment to see a physician, including specialists, will be $25 (see pages 33-34 and 59-60).

**Changes to our Consumer Driven Health Plan only**

- Your share of the Postal premium will increase for Self Only, Self Plus One and Self and Family (see page 154).
- Your share of the non-Postal premium will increase for Self Only, Self Plus One and Self and Family (see page 154).
- The Plan will add coverage for 3D mammograms under preventive and diagnostic and treatment services (see pages 77 and 85).
- The Plan will add coverage for Transcranial Magnetic Stimulation (TMS) for the treatment of depressive disorders not responsive to other mental health interventions (see page 107).
- The Plan will eliminate the Diabetes Management Program 100% incentives, but will continue to offer health coaching for diabetes (see page 116).
- The Plan will add a 40% coinsurance for non-preferred brand name drugs (see page 109).
- The Plan will add to the Step therapy program asthma, hemophilia, hepatitis C, high cholesterol, and methotrexate (see page 112).

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

- ID Cards (Pg 16)
- Precertification Process (Pgs 17-18)
  - Inpatient Hospital Admission
  - $500 Penalty
  - High Option: Call Cigna/CareAllies at 800-582-1314
  - Consumer Driven: Call UnitedHealthcare at 800-718-1299
- Other Services (Pg 18)



**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 misuse 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.

2018 APWU Health Plan 16 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

## 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

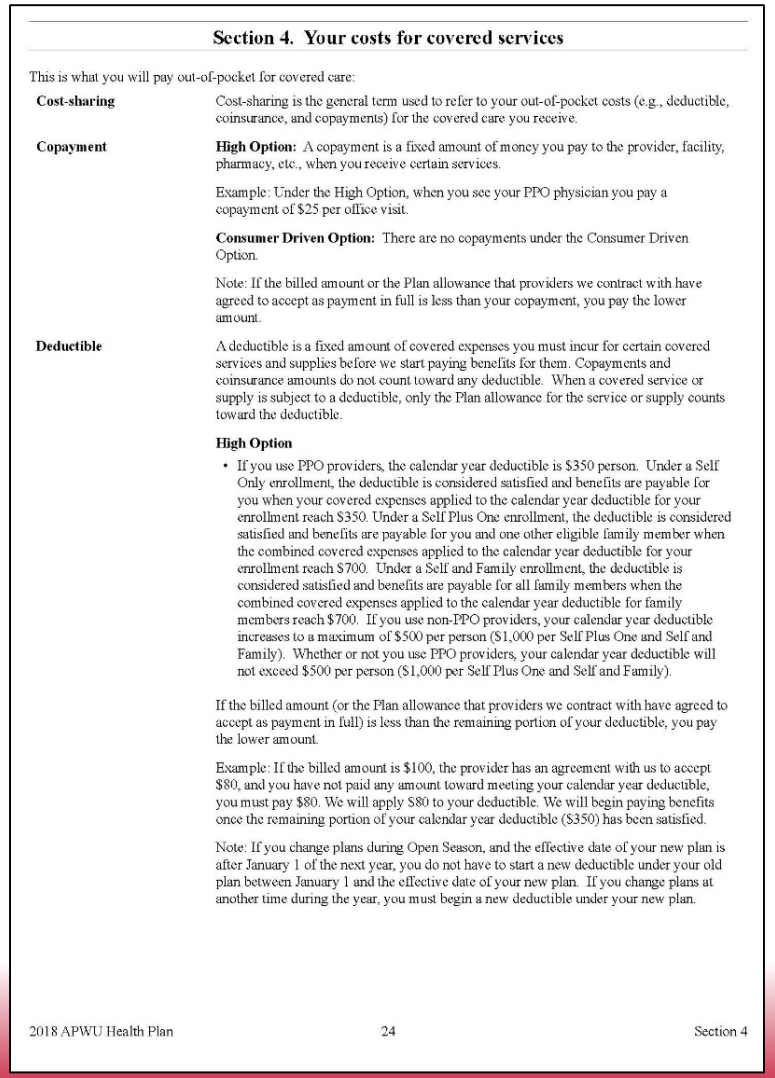
- ✓ Acupuncture Treatment
- ✓ Chiropractic Care
- ✓ Maternity Care/Admissions
- ✓ Outpatient Services at VA
- ✓ Physical, Occupational and Speech Therapy

# Reconsiderations/Appeals
## (Pgs 22-23)

- 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 24-29)

- 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.

2018 APWU Health Plan 24 Section 4

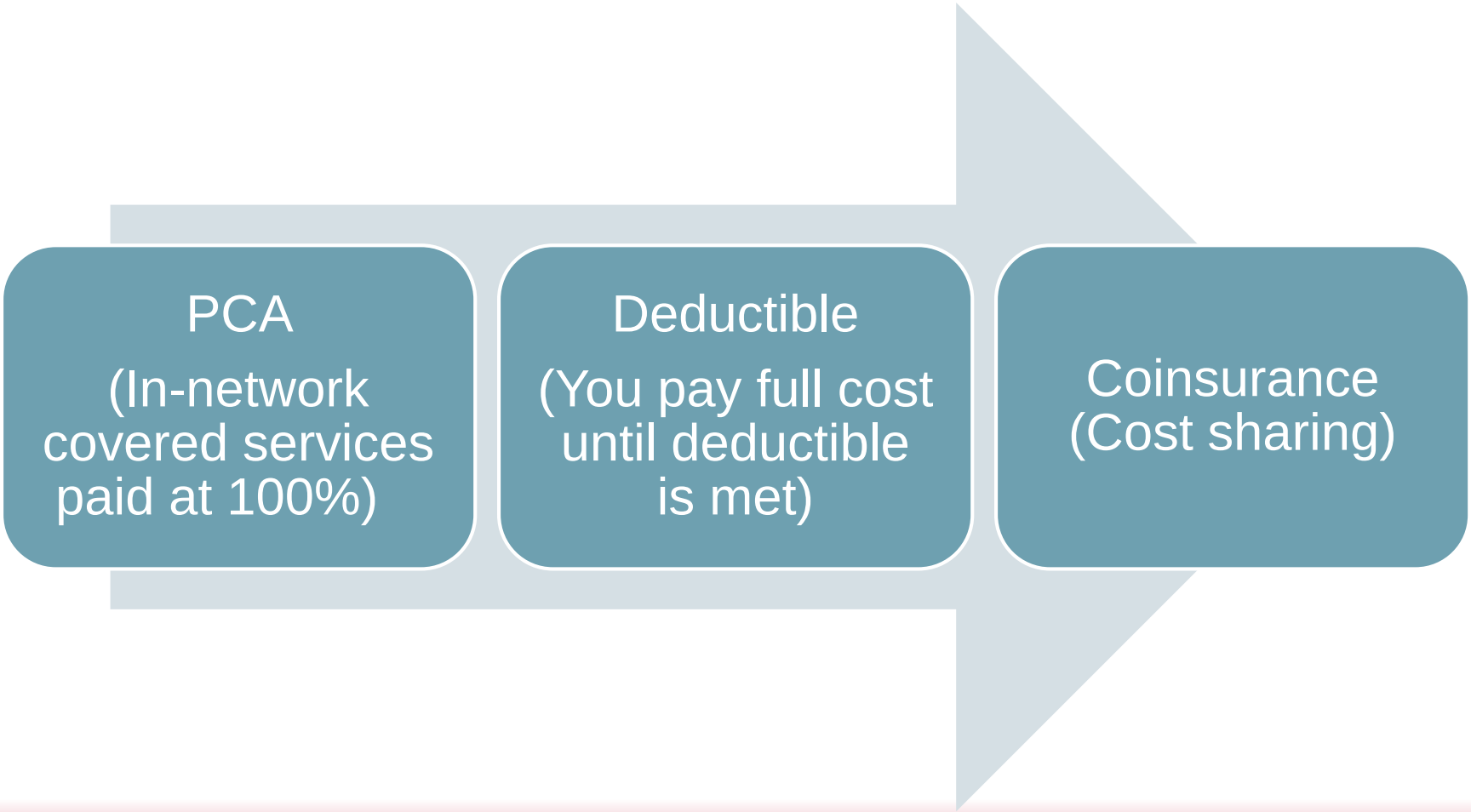
# Deductible

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

# High Option Deductible (Pg 24)

- 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 25)



# Consumer Driven Option Deductible (Pg 25)

**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 25)

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 25)

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 (Pgs 26)

## 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
## (Pg 26)

| 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***

# 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 26-28)

- 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 (Pg 27)

- 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 virtual visits; $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 (Pg 27)

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
- Expenses in excess of visit maximums for physical, occupational and speech therapy (see page 40), and acupuncture (see page 44)
- Expenses incurred in excess of the $90 per day provided under home nursing care (see pages 43-44); 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 27-28)

- 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 (Pg 28)

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

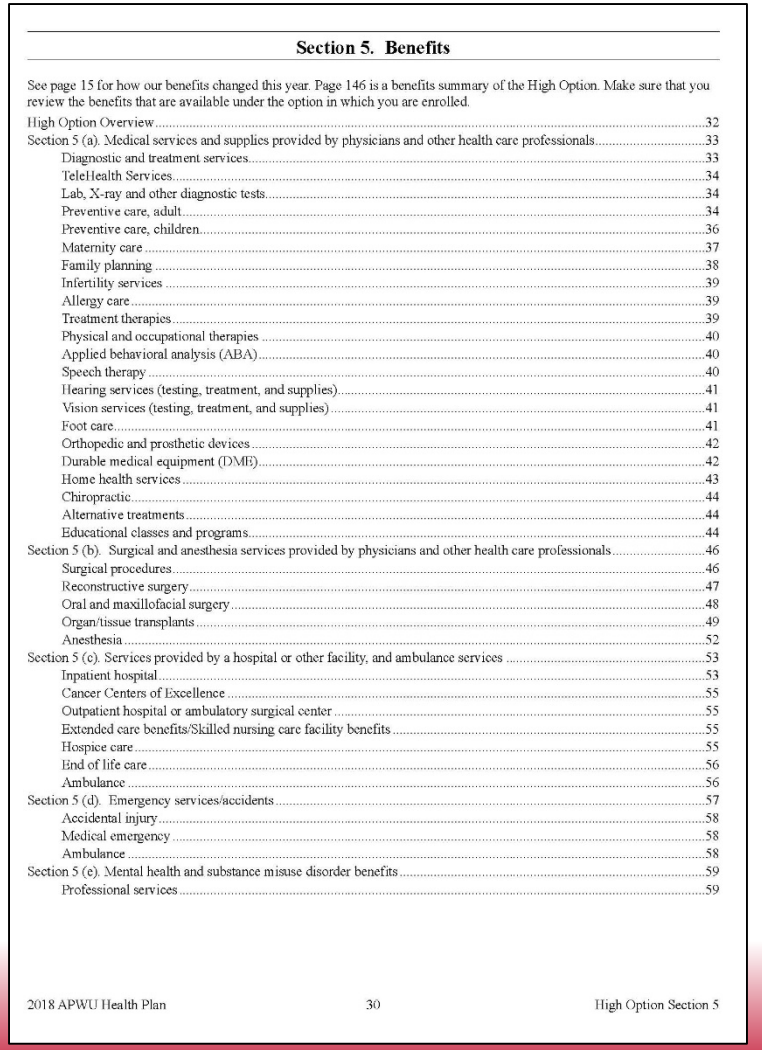
TOGETHER.
BETTER HEALTH.®

# 2018
# HIGH OPTION BENEFITS

# Section 5: Benefits

## Sections 5 (a)-(h), (Pgs 30-31)

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



**Section 5. Benefits**

See page 15 for how our benefits changed this year. Page 146 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.


High Option Overview ..... 32
Section 5 (a). Medical services and supplies provided by physicians and other health care professionals ..... 33
- Diagnostic and treatment services ..... 33
- TeleHealth Services ..... 34
- Lab, X-ray and other diagnostic tests ..... 34
- Preventive care, adult ..... 34
- Preventive care, children ..... 36
- Maternity care ..... 37
- Family planning ..... 38
- Infertility services ..... 39
- Allergy care ..... 39
- Treatment therapies ..... 39
- Physical and occupational therapies ..... 40
- Applied behavioral analysis (ABA) ..... 40
- Speech therapy ..... 40
- Hearing services (testing, treatment, and supplies) ..... 41
- Vision services (testing, treatment, and supplies) ..... 41
- Foot care ..... 41
- Orthopedic and prosthetic devices ..... 42
- Durable medical equipment (DME) ..... 42
- Home health services ..... 43
- Chiropractic ..... 44
- Alternative treatments ..... 44
- Educational classes and programs ..... 44

Section 5 (b). Surgical and anesthesia services provided by physicians and other health care professionals ..... 46
- Surgical procedures ..... 46
- Reconstructive surgery ..... 47
- Oral and maxillofacial surgery ..... 48
- Organ/tissue transplants ..... 49
- Anesthesia ..... 52

Section 5 (c). Services provided by a hospital or other facility, and ambulance services ..... 53
- Inpatient hospital ..... 53
- Cancer Centers of Excellence ..... 55
- Outpatient hospital or ambulatory surgical center ..... 55
- Extended care benefits/Skilled nursing care facility benefits ..... 55
- Hospice care ..... 55
- End of life care ..... 56
- Ambulance ..... 56

Section 5 (d). Emergency services/accidents ..... 57
- Accidental injury ..... 58
- Medical emergency ..... 58
- Ambulance ..... 58

Section 5 (e). Mental health and substance misuse disorder benefits ..... 59
- Professional services ..... 59

# Medical Services and Supplies

## Section 5(a), (Pgs 33-45)

Section title

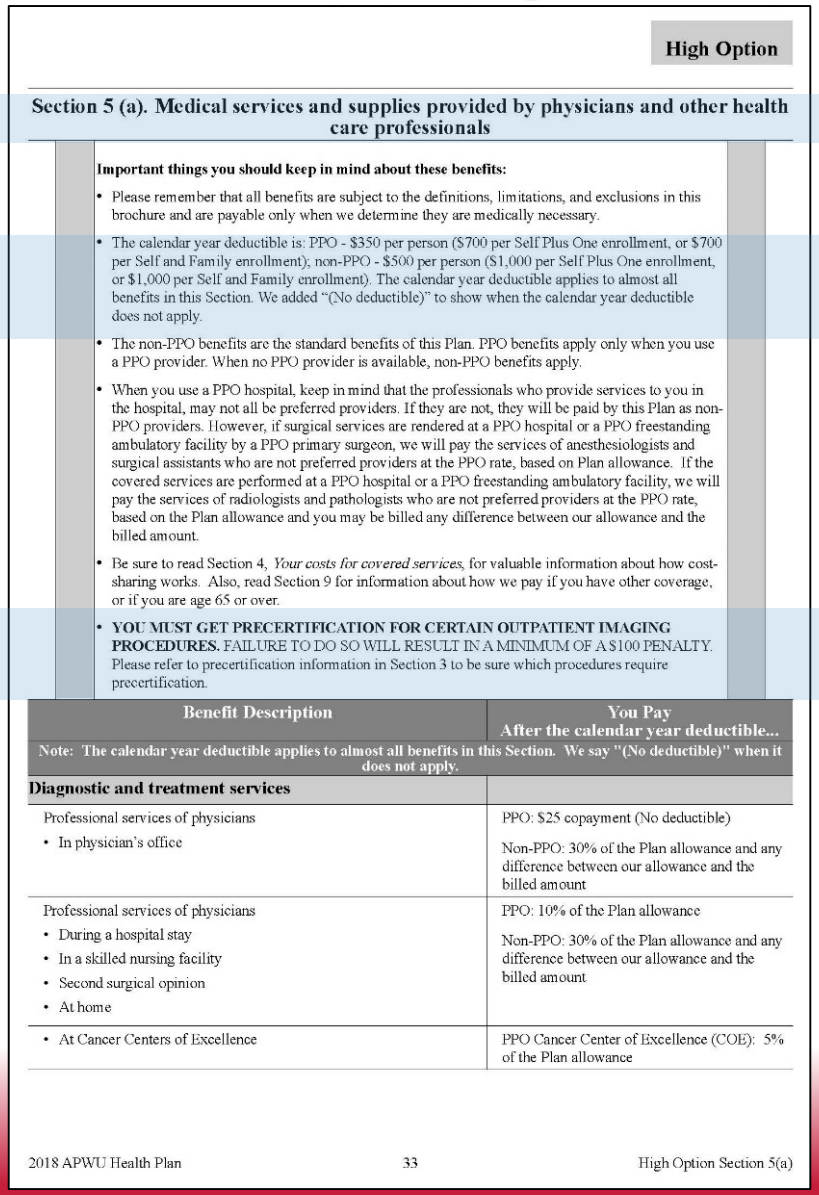
Section specific information…

Deductible

Does the deductible apply…

Left column provides Benefit Description

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



High Option

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

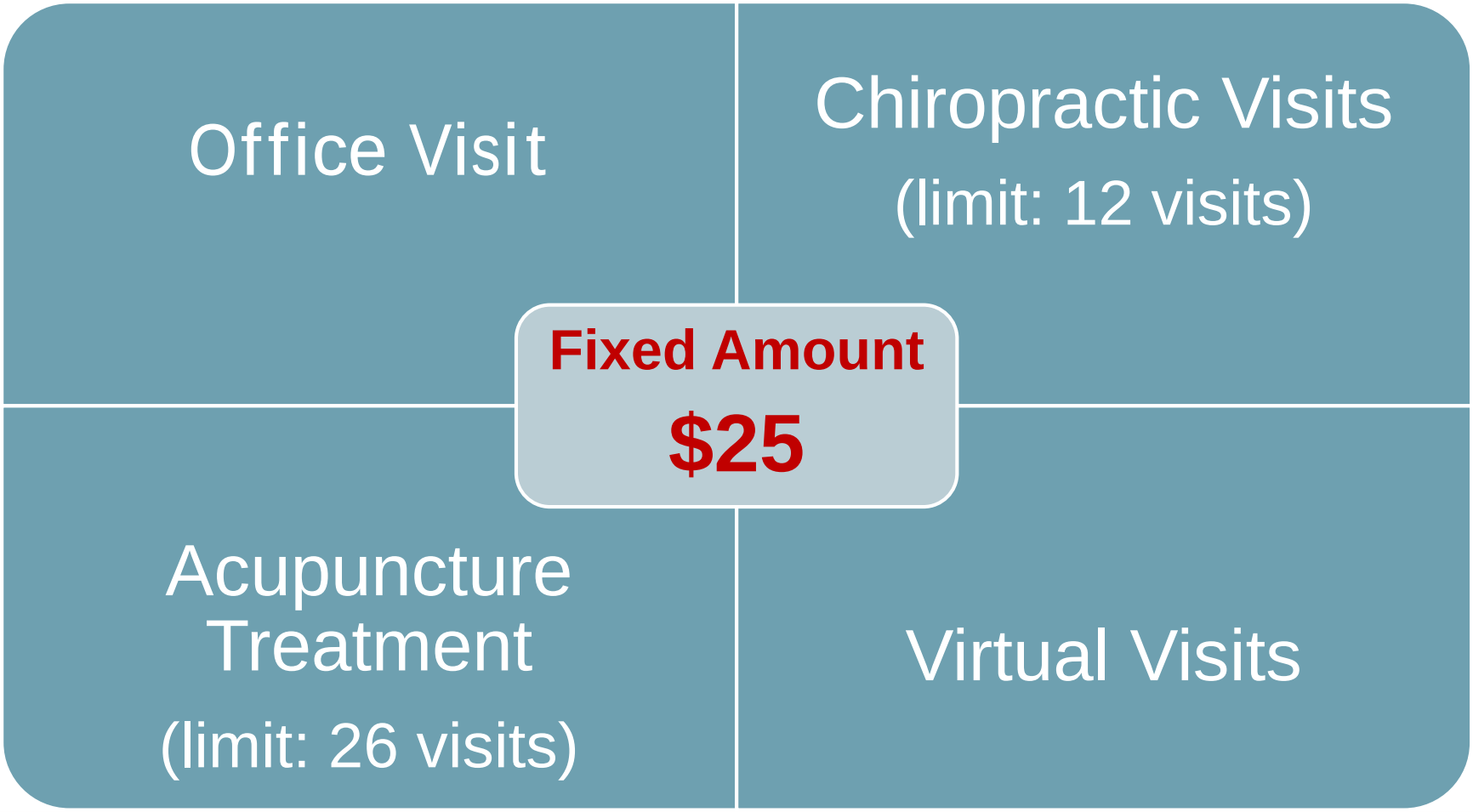
**Important things you should keep in mind about these benefits:**

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

| Benefit Description | You Pay After the calendar year deductible... |
|---|---|
| **Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.** | |
| **Diagnostic and treatment services** | |
| Professional services of physicians<br>• In physician's office | PPO: $25 copayment (No deductible)<br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount |
| Professional services of physicians<br>• During a hospital stay<br>• In a skilled nursing facility<br>• Second surgical opinion<br>• At home | PPO: 10% of the Plan allowance<br>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 |

2018 APWU Health Plan 33 High Option Section 5(a)

# 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 34)

- 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
- In-network only benefit: $25 copay

# Labs, X-rays and Diagnostic Tests (Pg 34)

- 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 (Pg 34-37)

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 34-37)

- New for 2018: 3D mammograms
- Annual gynecological visit
- Well-child care
- Immunizations recommended by CDC for adults and American Academy of Pediatrics for children routine screenings
- See pages 34-37 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 (Pgs 37-38)

- 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 38)

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

# Infertility (Pg 39)

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

# Physical/Occupational/Speech Therapies (Pg 40)

- 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
- New for 2018: Preauthorization is only required for Speech Therapy

# Applied Behavioral Analysis (ABA)
## (Pg 40)

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
## (Pg 41)

- 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 41)

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

# Routine Foot Care (Pg 42)

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

# Durable Medical Equipment
## (Pgs 42-43)

- Preauthorization is required
- See page 43 of brochure for list of excluded items
- We limit the Plan allowance to an amount no greater than the purchase price

# Home Health Services (Pgs 43-44)

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

# Chiropractic and Acupuncture (Pg 44)

- Chiro treatment is limited to **12 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
## (Pgs 44-45)

- 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 46-52)

- 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 health care professionals**

**Important things you should keep in mind about these benefits:**

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

| Benefit Description | You Pay After the calendar year deductible… |
|---|---|
| **Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.** | |
| **Surgical procedures** | |
| A comprehensive range of services, such as:<br>• Operative procedures<br>• Treatment of fractures, including casting<br>• Normal pre- and post-operative care by the surgeon<br>• Correction of amblyopia and strabismus<br>• Endoscopy procedures<br>• Biopsy procedures<br>• Removal of tumors and cysts<br>• Correction of congenital anomalies (see *Reconstructive* surgery)<br>• Surgical treatment of morbid obesity (bariatric surgery) (requires preauthorization. See *Other services*, Section 3)<br>• Insertion of internal prosthetic devices. See Section 5(a), *Orthopedic and prosthetic devices* for device coverage information<br>• Voluntary sterilization for men (e.g., Vasectomy) | PPO: 10% of the Plan allowance<br>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 46)

- 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 46-48)

- 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))*
- *Gender reassignment surgery and surgeries to improve physical appearance*

# Oral Surgery (Pgs 48-49)

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

# Organ and Tissue Transplants
## (Pgs 49-52)

- Complete list of transplants begins on page 49
- 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 52)

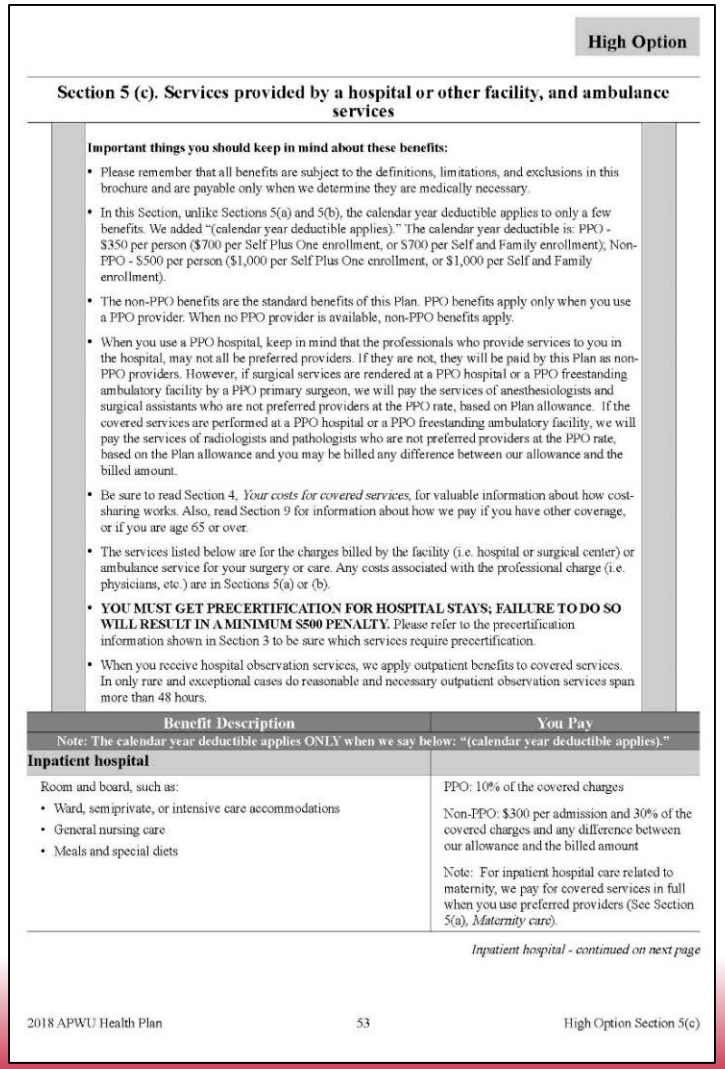
- Professional services for administration of anesthesia

| 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 53-56

- Inpatient Hospital
- Cancer Centers of Excellence
- Outpatient Hospital or Ambulatory Surgical Center
- Extended Care/ Skilled Nursing
- Hospice
- 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.
- When you receive hospital observation services, we apply outpatient benefits to covered services. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours.

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

*Inpatient hospital - continued on next page*

# Inpatient Hospital (Pgs 53-54)

- 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 55)

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

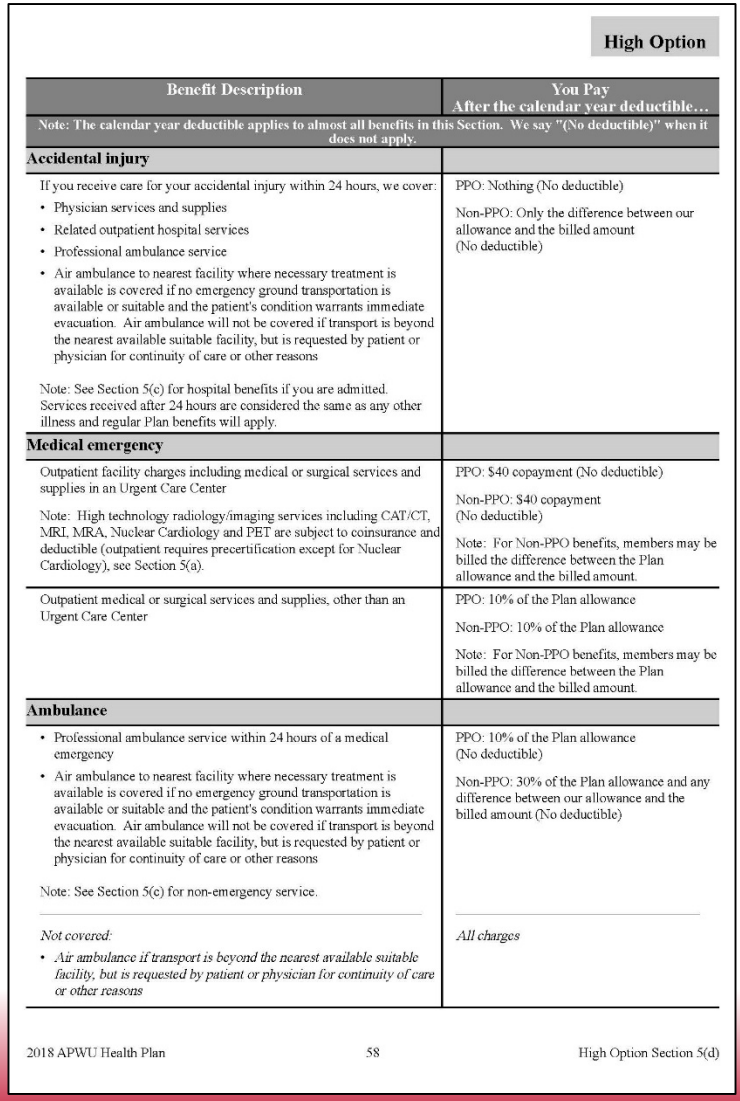
# Hospice (Pg 55)

- 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 57-58)

- Accident
- 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 24 hours, we cover:<br>• Physician services and supplies<br>• Related outpatient hospital services<br>• Professional ambulance service<br>• 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<br><br>Note: See Section 5(c) for hospital benefits if you are admitted. Services received after 24 hours are considered the same as any other illness and regular Plan benefits will apply. | PPO: Nothing (No deductible)<br><br>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<br><br>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)<br><br>Non-PPO: $40 copayment (No deductible)<br><br>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<br><br>Non-PPO: 10% of the Plan allowance<br><br>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<br>• 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<br><br>Note: See Section 5(c) for non-emergency service. | PPO: 10% of the Plan allowance (No deductible)<br><br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) |
| *Not covered:*<br>• *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 58)

- "Accident" is defined as resulting from a violent, external force
- Outpatient services, including ambulance and air ambulance* rendered within 24 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 58)

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

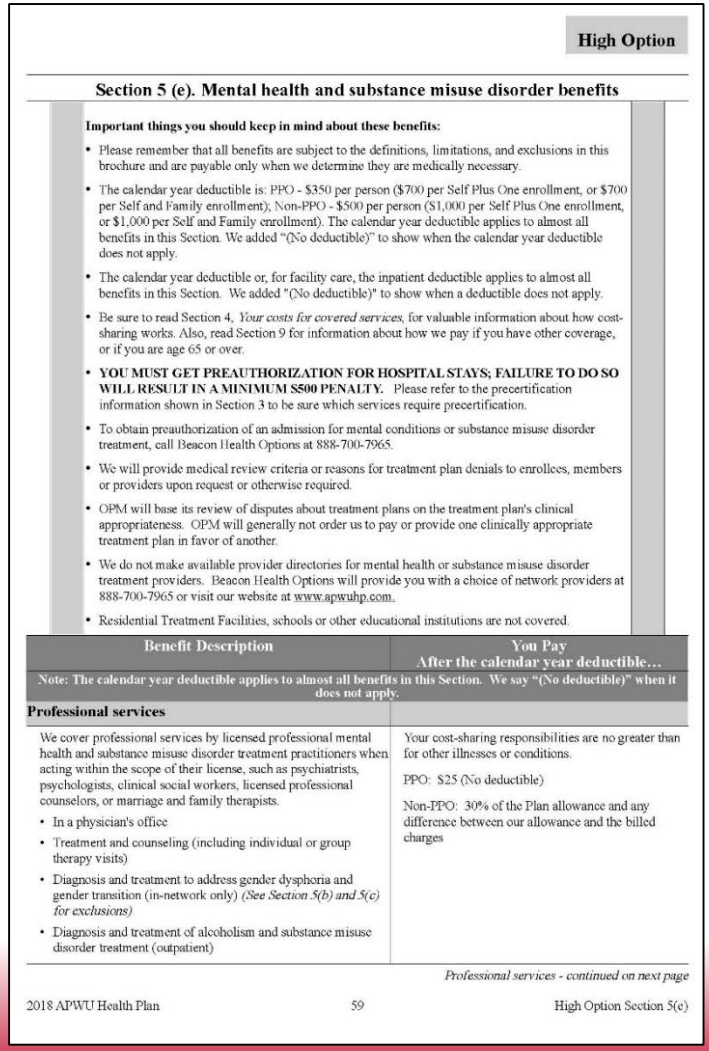
*** High tech imaging (CT, MRI, PET, MRA) at an Urgent Care Center is subject to deductible and coinsurance and requires precertification.**

# Ambulance (Pg 58)

- 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 Misuse Disorder Section 5(e), Pgs 59-61

- Beacon Health Options
- Professional Services
  - Outpatient in a physician's office
  - Inpatient
- Diagnostics
- Inpatient Hospital/ Facility
- Outpatient Hospital/ Facility



High Option

**Section 5 (e). Mental health and substance misuse 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 misuse 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 misuse 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.
- Residential Treatment Facilities, 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 misuse 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.<br>• In a physician's office<br>• Treatment and counseling (including individual or group therapy visits)<br>• Diagnosis and treatment to address gender dysphoria and gender transition (in-network only) *(See Section 5(b) and 5(c) for exclusions)*<br>• Diagnosis and treatment of alcoholism and substance misuse disorder treatment (outpatient) | Your cost-sharing responsibilities are no greater than for other illnesses or conditions.<br>PPO: $25 (No deductible)<br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed charges |

*Professional services - continued on next page*

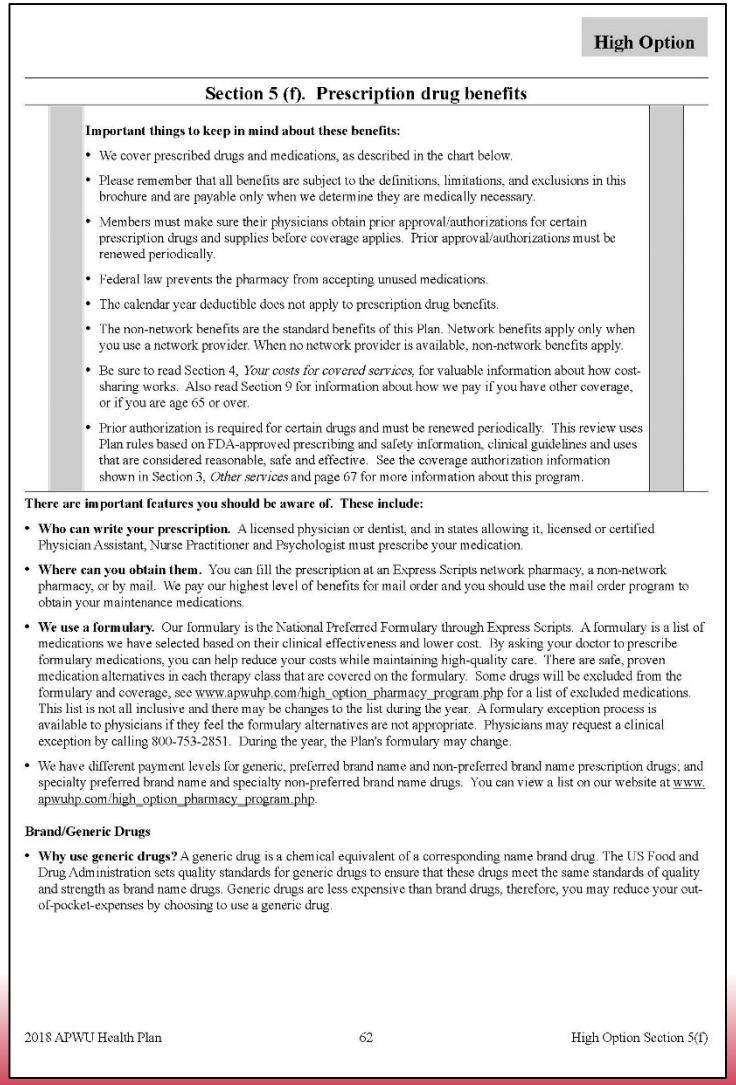
# Beacon Health Options (Pgs 59-61)

- 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 days prior to elective hospital admission
  - 2 days after an emergency admission

# Prescription Drugs

## Section 5(f), (Pgs 62-67)

- 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 67 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.
- **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.
- We have different payment levels for generic, preferred brand name and non-preferred brand name prescription drugs; and specialty preferred brand name and specialty non-preferred brand name drugs. You can view a list on our website at www.apwuhp.com/high_option_pharmacy_program.php.

**Brand/Generic Drugs**

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

2018 APWU Health Plan 62 High Option Section 5(f)

# Prescription Drug Definitions (Pg 62)

- 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 (Pg 63)

- 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 64)

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

# Specialty Drugs (Pg 64)

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

# Specialty Drug Tiers (Pg 64)

| Type of Drug | Network Pharmacy (Retail) | Non-Network Pharmacy (Retail) | Network Mail Order |
|---|---|---|---|
| Generic Drugs | 25% coinsurance; max $300 for 30-day supply | 50% coinsurance; $10 min for 30-day supply | 25% coinsurance; $150 max for 90-day supply |
| Preferred Brand Drugs | 25% coinsurance; $40 min/$600 max for 30-day supply | 50% coinsurance; $10 min for 30-day supply | 25% coinsurance; $20 min/$300 max for 90-day supply |
| Non-Preferred Brand Drugs | 45% coinsurance; $60 min/$1,000 max for 30-day supply | 50% coinsurance; $10 min for 30-day supply | 45% coinsurance; $30 min/$500 max for 90-day supply |

# Prescription Drugs
## Section 5(f), (Pgs 66)

- $0 out-of-pocket costs
  - Contraceptive Drugs - generic
  - Prescription drugs to treat tobacco dependence (Mail Order)
  - OTC to treat tobacco dependence (Cigna/CareAllies only)
- 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 67)

- 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 67 of brochure for more information on specific therapeutic categories

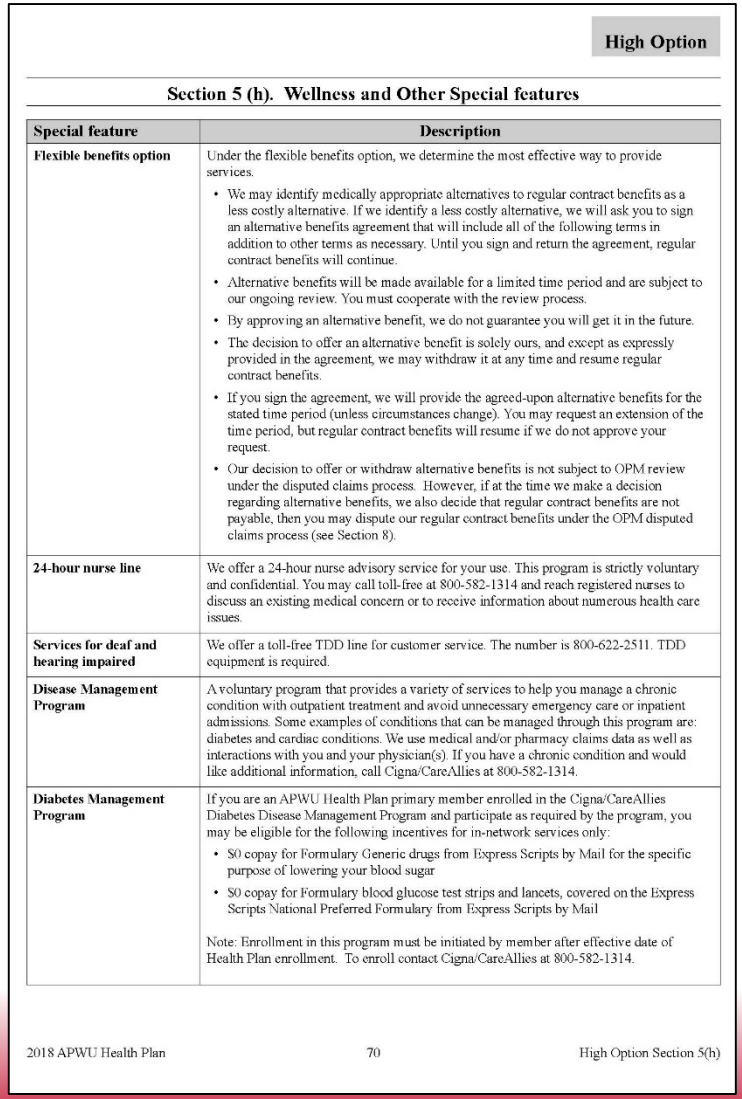
# Dental Benefits
## Section 5(g), (Pg 69)

- 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

# Special Features

## Section 5(h), (Pgs 70-72)

- 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.<br>• 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.<br>• 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.<br>• By approving an alternative benefit, we do not guarantee you will get it in the future.<br>• 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.<br>• 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.<br>• 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:<br>• $0 copay for Formulary Generic drugs from Express Scripts by Mail for the specific purpose of lowering your blood sugar<br>• $0 copay for Formulary blood glucose test strips and lancets, covered on the Express Scripts National Preferred Formulary from Express Scripts by Mail<br><br>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. |

2018 APWU Health Plan 70 High Option Section 5(h)

# 24-hour Nurse Line (Pg 70)

- 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 70-71)

- 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 71)

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



# Special Programs (Pg 71)

- 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 72)

- 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)**

# 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, 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 non-preferred brand-name drug?

A. 40%

B. 30%



C. 45%

D. Nothing

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

A. No benefit; in-network only
B. 30% coinsurance
C. Deductible, then 30% coinsurance
D. $20 copay

# MRIs do not require pre-certification.

A. True

✓ B. False

# What additions were made to the Preventive Care benefit for 2018?

A. 3-D mammograms

B. All bloodwork requested by an in-network provider

C. Whole body scans

D. CBC, Hemoglobin A1c, Chest X-ray, EKG

# 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 2018, does PT/OT require pre-authorization?

A. Yes



B. No

# For 2018, 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 Transcranial Magnetic Stimulation (TMS) for the treatment of depressive disorders not responsive to other mental health interventions?

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 will happen if you do not submit a new prescription to the mail order pharmacy?

A. Nothing; in-network retail copays will still apply
B. You will not be able to refill your prescription
C. The pharmacy will give you your prescription for free until you determine the next step
D. ✓ Benefits will revert to out-of-network; you will be responsible for 50% of the cost of the drug

**The Hypertension Disease Management Program and incentives will no longer be available in 2018. The program has terminated.**

✓ A. True

B. False

# There have been changes to the Disease Management Program incentives for 2018. If you are compliant in the 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; formulary blood glucose test strips and lancets via Express Script 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

TOGETHER.
BETTER HEALTH.®

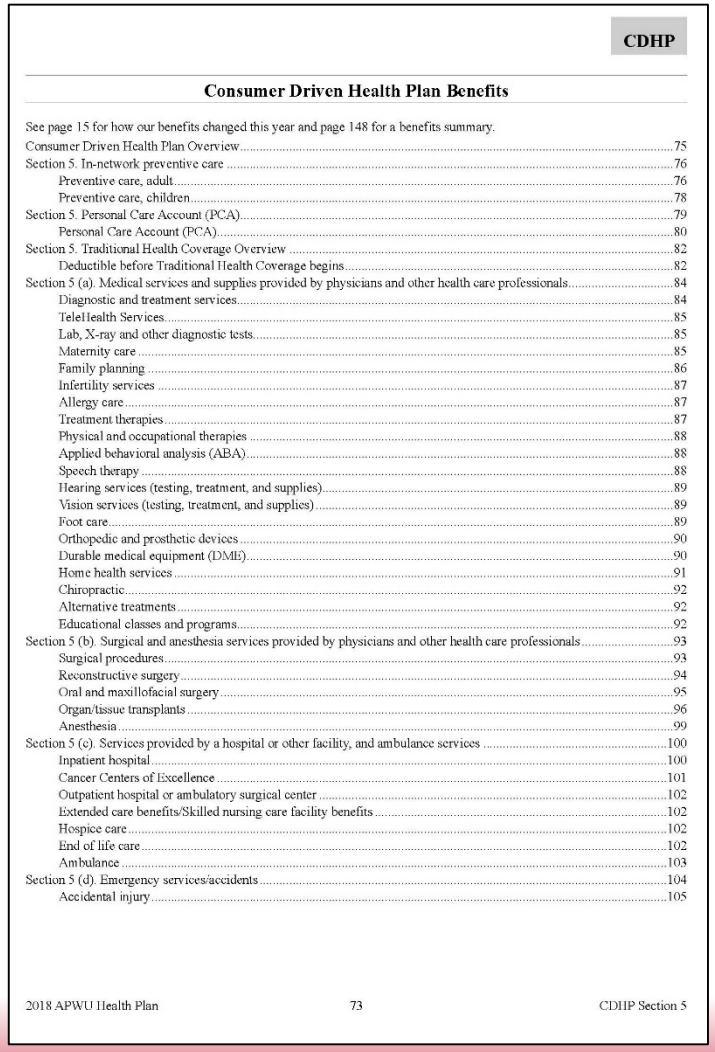
# 2018
# CONSUMER DRIVEN OPTION BENEFITS

# Consumer Driven Option Benefits (Pg 73)

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 health care professionals
- 5(b) Surgical and anesthesia services provided by physicians and other health care professionals
- 5(c) Services provided by a hospital or other facility, and ambulance services
- 5(d) Emergency services/accidents



CDHP

**Consumer Driven Health Plan Benefits**


See page 15 for how our benefits changed this year and page 148 for a benefits summary.

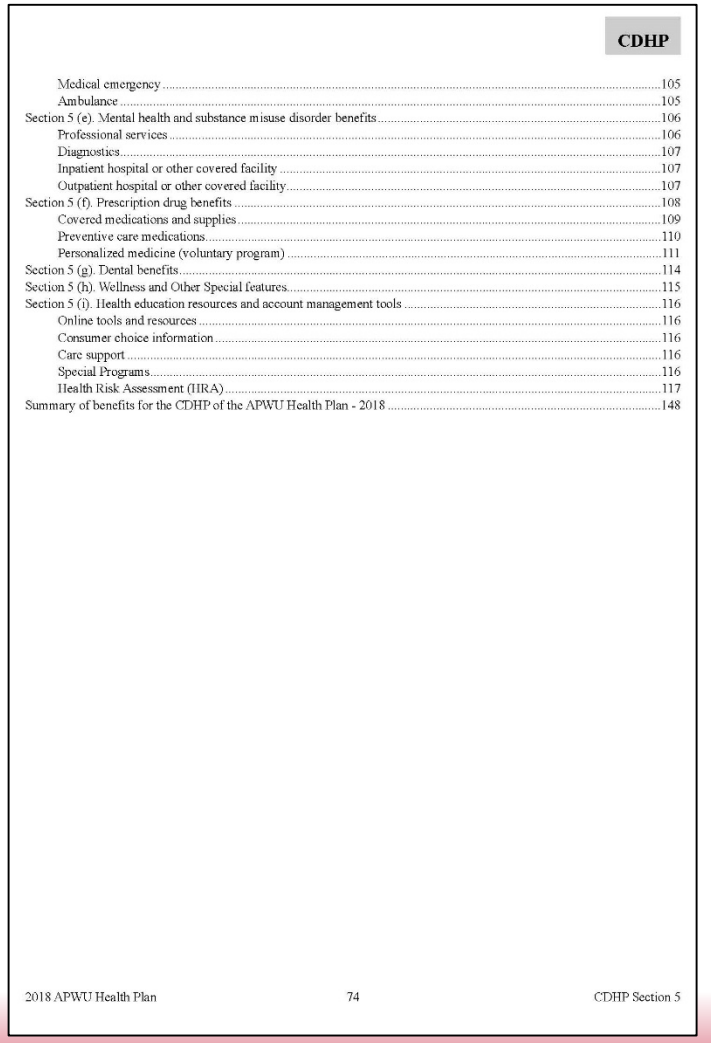
Consumer Driven Health Plan Overview ..... 75
Section 5. In-network preventive care ..... 76
Preventive care, adult ..... 76
Preventive care, children ..... 78
Section 5. Personal Care Account (PCA) ..... 79
Personal Care Account (PCA) ..... 80
Section 5. Traditional Health Coverage Overview ..... 82
Deductible before Traditional Health Coverage begins ..... 82
Section 5 (a). Medical services and supplies provided by physicians and other health care professionals ..... 84
Diagnostic and treatment services ..... 84
Telehealth Services ..... 85
Lab, X-ray and other diagnostic tests ..... 85
Maternity care ..... 85
Family planning ..... 86
Infertility services ..... 87
Allergy care ..... 87
Treatment therapies ..... 87
Physical and occupational therapies ..... 88
Applied behavioral analysis (ABA) ..... 88
Speech therapy ..... 88
Hearing services (testing, treatment, and supplies) ..... 89
Vision services (testing, treatment, and supplies) ..... 89
Foot care ..... 89
Orthopedic and prosthetic devices ..... 90
Durable medical equipment (DME) ..... 90
Home health services ..... 91
Chiropractic ..... 92
Alternative treatments ..... 92
Educational classes and programs ..... 92
Section 5 (b). Surgical and anesthesia services provided by physicians and other health care professionals ..... 93
Surgical procedures ..... 93
Reconstructive surgery ..... 94
Oral and maxillofacial surgery ..... 95
Organ/tissue transplants ..... 96
Anesthesia ..... 99
Section 5 (c). Services provided by a hospital or other facility, and ambulance services ..... 100
Inpatient hospital ..... 100
Cancer Centers of Excellence ..... 101
Outpatient hospital or ambulatory surgical center ..... 102
Extended care benefits/Skilled nursing care facility benefits ..... 102
Hospice care ..... 102
End of life care ..... 102
Ambulance ..... 103
Section 5 (d). Emergency services/accidents ..... 104
Accidental injury ..... 105

# Consumer Driven Option Benefits (Pg 74)

Consumer Driven Health Plan Overview

Section 5:

- 5(e) Mental health and substance misuse disorder benefits
- 5(f) Prescription drug benefits
- 5(g) Dental benefits
- 5(h) Special features
- 5(i) Health education resources and account management tools
- Summary of benefits for the CDHP 2018



CDHP


Medical emergency ..... 105
Ambulance ..... 105
Section 5 (e). Mental health and substance misuse disorder benefits ..... 106
Professional services ..... 106
Diagnostics ..... 107
Inpatient hospital or other covered facility ..... 107
Outpatient hospital or other covered facility ..... 107
Section 5 (f). Prescription drug benefits ..... 108
Covered medications and supplies ..... 109
Preventive care medications ..... 110
Personalized medicine (voluntary program) ..... 111
Section 5 (g). Dental benefits ..... 114
Section 5 (h). Wellness and Other Special features ..... 115
Section 5 (i). Health education resources and account management tools ..... 116
Online tools and resources ..... 116
Consumer choice information ..... 116
Care support ..... 116
Special Programs ..... 116
Health Risk Assessment (HRA) ..... 117
Summary of benefits for the CDHP of the APWU Health Plan - 2018 ..... 148

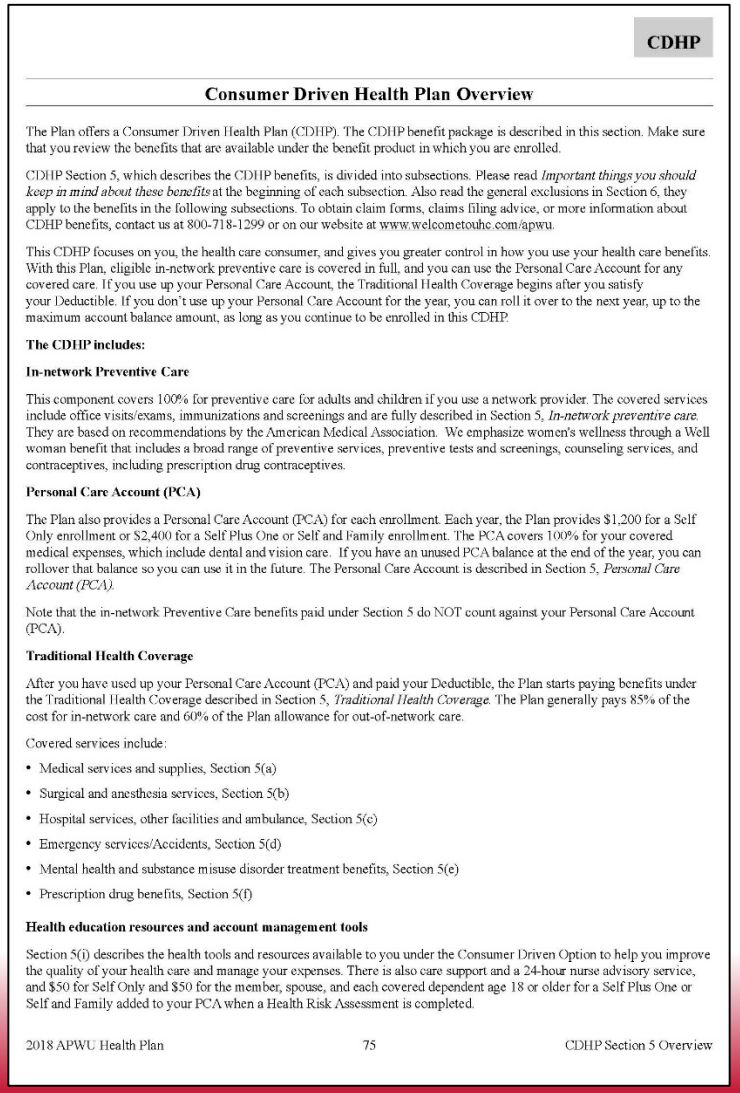
# Consumer Driven Health Plan Overview (Pg 75)

**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 misuse 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.

# In-network Preventive Care

## Section 5, (Pgs 76-78)

- 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 2018: 3D Mammograms for women
- 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 79-81)

- 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 79)

- 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 80)

- 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 81)

- 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 82-83)

PCA

(In-network 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 82)

**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**

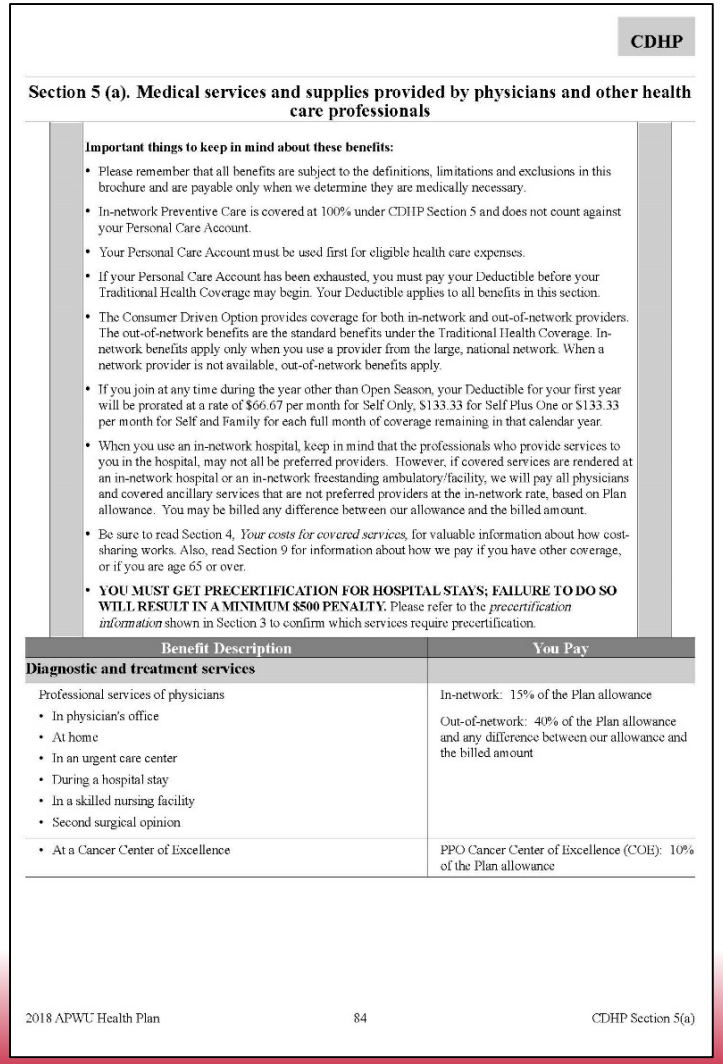
# Coinsurance

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% generic and preferred brand/40% non-preferred brand of prescription formulary allowance

# Section 5(a) Medical Services and supplies provided by physicians and other health care professionals (Pgs 84-92)

- 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 health care 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. However, if covered services are rendered at an in-network hospital or an in-network freestanding ambulatory/facility, we will pay all physicians and covered ancillary services that are not preferred providers at the in-network rate, based on 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 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<br>• In physician's office<br>• At home<br>• In an urgent care center<br>• During a hospital stay<br>• In a skilled nursing facility<br>• Second surgical opinion | In-network: 15% of the Plan allowance<br>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 |

2018 APWU Health Plan 84 CDHP Section 5(a)

# Diagnostic and Treatment Services
## Lab, X-ray and Other Diagnostic Tests
Section 5(a), (Pgs 84-85)

- 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 85-86)

- 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 86)

- 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 87)

- 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 87-88)

- 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), (Pg 88)

- 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 88)

- 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 89)

- 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), (Pg 89)

- 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), (Pg 89)

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

# **Orthopedic and Prosthetic Devices** Section 5(a), (Pg 90)

- 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 90-91)

- Pre-notification is required
- See page 91 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 91-92)

- 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 92)

- Chiropractic
  - Treatments/manipulations limited to 12 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), (Pg 92)

- 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 93-99)

- 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 95-96)

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

# Organ and Tissue Transplants
## Section 5(b), (Pgs 96-99)

- Complete list of transplants begins on page 96
- 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 99)

- 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.

# 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 100)

- 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 100-102)

- 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 102)

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

# Hospice Care

## Section 5(c), (Pg 102)

- 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 103)

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

# **Accident** (Pgs 104-105)

- "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 104-105)

- 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 106-107)

- Must obtain preauthorization for:
  - Inpatient Mental Health or Substance Misuse Disorder Hospital admissions
  - Inpatient treatment, psychological testing, electroconvulsive therapy, Transcranial Magnetic Stimulation (TMS)
- 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 108-113)

### Administered by OptumRx

- Covered Items
  - Rx drugs, diabetic supplies, Insulin





# Prescription Drugs (Pg 108)

- **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



# Covered Medication/Supplies (Pg 109)

- Patient Responsibility
  - Network Retail: generic and preferred brand 25% co-insurance; minimum $15, maximum out-of-pocket $200 for each 30-day supply; non-preferred brand 40% coinsurance; minimum $15, maximum out-of-pocket $200 for each 30-day supply
  - Network Mail Order: generic and preferred brand 25% co-insurance; minimum $10, maximum out-of-pocket $200 for each 30-day supply; non-preferred brand 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), (Pg 112)

- Zero out-of-pocket costs
  - Contraceptive Drugs, generic at Network Retail or Mail Order
  - Prescription drugs to treat tobacco dependence (Mail Order)
  - OTC to treat tobacco dependence (See educational classes and programs, page 92)
  - 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

# Coverage Authorization (Pg 112)

- 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 113)

***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 114)

**No benefit except under "Extra PCA"**

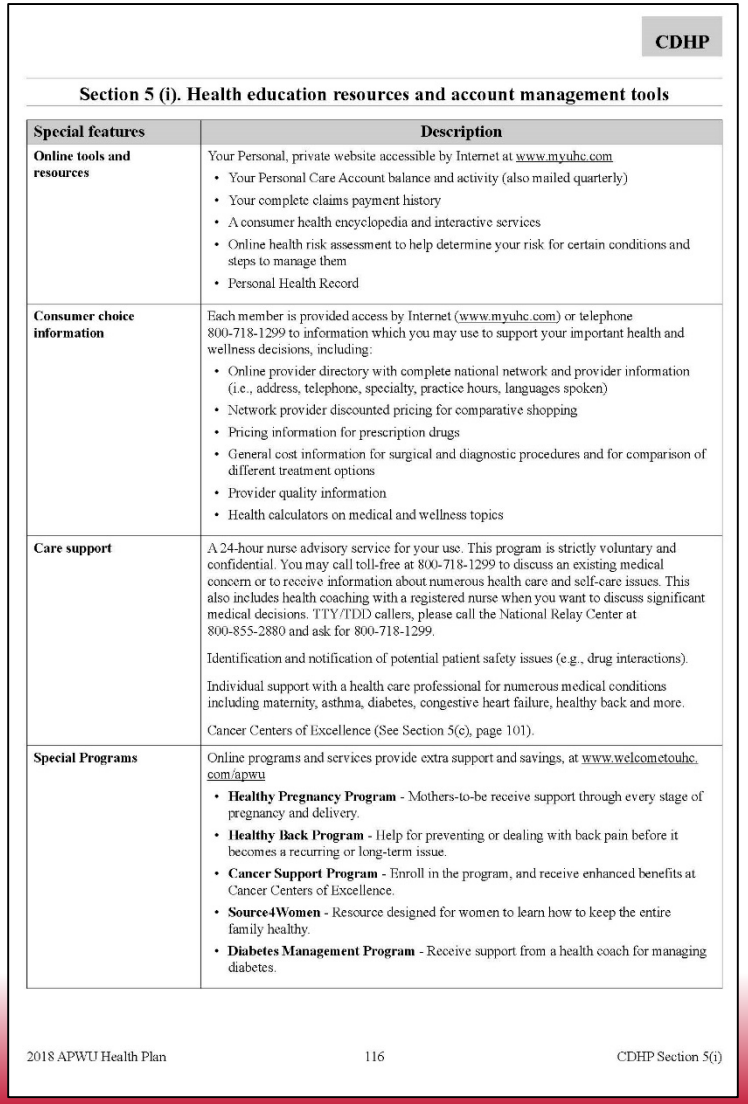
# Health Resources and Tools

## Section 5(i), (Pg 116)

**Online tools…**

**24 Hour Nurse Line…**

**Special Programs…**



CDHP

**Section 5 (i). Health education resources and account management tools**

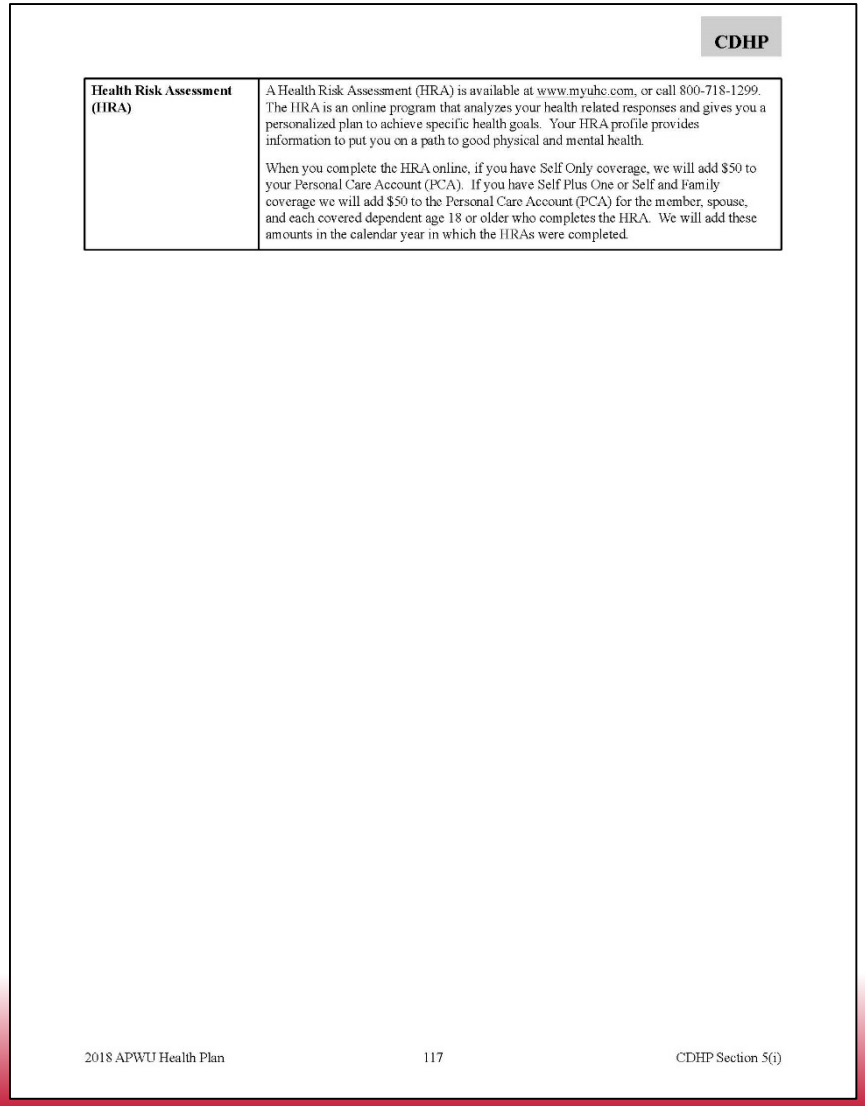
| Special features | Description |
|---|---|
| **Online tools and resources** | Your Personal, private website accessible by Internet at www.myuhc.com<br>• Your Personal Care Account balance and activity (also mailed quarterly)<br>• Your complete claims payment history<br>• A consumer health encyclopedia and interactive services<br>• Online health risk assessment to help determine your risk for certain conditions and steps to manage them<br>• 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:<br>• Online provider directory with complete national network and provider information (i.e., address, telephone, specialty, practice hours, languages spoken)<br>• Network provider discounted pricing for comparative shopping<br>• Pricing information for prescription drugs<br>• General cost information for surgical and diagnostic procedures and for comparison of different treatment options<br>• Provider quality information<br>• 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.<br>Identification and notification of potential patient safety issues (e.g., drug interactions).<br>Individual support with a health care professional for numerous medical conditions including maternity, asthma, diabetes, congestive heart failure, healthy back and more.<br>Cancer Centers of Excellence (See Section 5(c), page 101). |
| **Special Programs** | Online programs and services provide extra support and savings, at www.welcometouhc.com/apwu<br>• **Healthy Pregnancy Program** - Mothers-to-be receive support through every stage of pregnancy and delivery.<br>• **Healthy Back Program** - Help for preventing or dealing with back pain before it becomes a recurring or long-term issue.<br>• **Cancer Support Program** - Enroll in the program, and receive enhanced benefits at Cancer Centers of Excellence.<br>• **Source4Women** - Resource designed for women to learn how to keep the entire family healthy.<br>• **Diabetes Management Program** - Receive support from a health coach for managing diabetes. |

2018 APWU Health Plan 116 CDHP Section 5(i)

# Health Resources and Tools

## Section 5(i), (Pg 117)

**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.<br><br>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. |

2018 APWU Health Plan 117 CDHP Section 5(i)

# Health Risk Assessment (Pg 117)

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 (Pages 118-120)**

## 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/Conversion_Plan_Option.php.

**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 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 121**

## 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… Pg 122**

## 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… Pg 125**

## Section 8. The disputed claims process

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

**What if you have Medicare, Other Insurance, TRICARE, CHAMPA… Pg 128**

## 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… Pg 138**

## Section 10. Definitions of terms we use in this brochure

## Section 11. Other Federal Programs

**Other programs our members have access… Pg 143**

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 146-147)

## Summary of benefits for the High Option of the APWU Health Plan - 2018

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

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

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

| High Option Benefits | You pay | Page |
|---|---|---|
| **Medical services provided by physicians:** | | |
| • Diagnostic and treatment services provided in the office* | PPO: $25 copay per visit (No deductible); 10% of Plan allowance<br>Non-PPO: 30% of our allowance plus amount over our allowance | 33 |
| **Services provided by a hospital:** | | |
| • Inpatient | PPO: 10% of Plan allowance<br>Non-PPO: $300 per admission and 30% of our allowance plus amount over our allowance | 53 |
| • Outpatient* | PPO: 10% of Plan allowance<br>Non-PPO: 30% of our allowance plus amount over our allowance | 55 |
| **Emergency benefits:** | | |
| • Accidental injury | PPO: Nothing<br>Non-PPO: Any amount over our allowance | 58 |
| • Medical emergency* | PPO 10% of Plan allowance<br>Non-PPO: 10% of our allowance plus amount over our allowance | 58 |
| **Mental health and substance misuse disorder treatment:** | PPO: $25 copay per visit (No deductible); 10% of Plan allowance<br>Non-PPO: 30% of our allowance plus amount over our allowance | 59 |
| **Prescription drugs:** | | |
| • Network pharmacy | $10 generic/25% preferred brand name/45% non-preferred brand name/Specialty drugs 25% generic/25% preferred brand name/45% non-preferred brand name | 64 |
| • Non-network pharmacy | 50% of cost | 64 |
| • Mail order | | 64 |

# Summary of Benefits – CDHP (Pgs 148-149)

**Summary of benefits for the CDHP of the APWU Health Plan - 2018**

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

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

  Below, an asterisk (*) means the item is subject to the 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 | 76 |
| **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 misuse 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 | 79 |
| **Traditional Health Coverage after Personal Care Account is exhausted** | See Section 5 Traditional Health Overview (Deductible before Traditional Health Coverage Begins) | 82 |
| **Medical/Surgical services provided by physicians:** | | |
| • Diagnostic and treatment services provided in the office* | In-network: 15% of Plan allowance<br>Out-of-network: 40% of our allowance plus amount over our allowance | 84 |
| **Services provided by a hospital:** | | |
| • Inpatient* | In-network: 15% of Plan allowance<br>Out-of-network: 40% of our allowance plus amount over our allowance | 100 |
| • Outpatient* | In-network: 15% of Plan allowance<br>Out-of-network: 40% of our allowance plus amount over our allowance | 102 |
| **Emergency benefits:** | | |
| • Accidental injury* | In-network: 15% of Plan allowance<br>Out-of-network: 15% of Plan allowance plus amount over our allowance | 105 |
| • Medical emergency* | In-network: 15% of Plan allowance<br>Out-of-network: 15% of Plan allowance plus amount over our allowance | 105 |
| **Mental health and substance misuse disorder treatment*:** | In-network: 15% of Plan allowance<br>Out-of-network: 40% of our allowance plus amount over our allowance | 106 |
| **Prescription drugs:** | | |

# 2018 Rate Information (Pg 154)

## 2018 Rate Information for the APWU Health Plan

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

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 United States Postal Service employees.**

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

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

**Non-Postal rates apply to all career non-bargaining unit Postal Service employees.**

For further assistance, Postal Service employees should call:

Human Resources Shared Service Center: 877-477-3273, Option 5, TTY: 866-260-7507

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

Premiums for Tribal employees are shown under the monthly non-Postal column. The amount shown under employee contribution 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.

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

| 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 | $229.25 | $93.04 | $496.71 | $201.59 | $86.67 | $80.31 | $86.67 |
| High Option Self Plus One | 473 | $491.00 | $185.79 | $1,063.83 | $402.55 | $172.15 | $158.51 | $172.15 |
| High Option Self and Family | 472 | $521.58 | $251.90 | $1,130.09 | $545.78 | $237.41 | $222.92 | $237.41 |
| CDHP Option Self Only | 474 | $191.92 | $63.97 | $415.82 | $138.61 | $58.21 | $53.10 | $12.79 |
| CDHP Option Self Plus One | 476 | $422.21 | $140.74 | $914.80 | $304.93 | $128.07 | $116.81 | $28.15 |
| CDHP Option Self and Family | 475 | $460.59 | $153.53 | $997.94 | $332.65 | $139.71 | $127.43 | $41.83 |

**Postal Premium: Actively Employed**

# 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 Non-Preferred Brand Name 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

# Are 3-D mammograms covered under routine preventive care for 2018?

- ✓ 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 Transcranial Magnetic Stimulation (TMS) for the treatment of depressive disorders not responsive to other mental health interventions?

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.

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

**The Diabetes Management Programs with associated incentives will no longer be in place for 2018.**

✓ A. True

B. False

# 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:

**Thursday, October 19, 2017**