APWU Health Plan

www.apwuhp.com

Customer Service 800-222-2798

2025

A Fee-for-Service Plan (High Option), 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

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

IMPORTANT
- Rates: Back Cover
- Changes for 2025: Page 16
- Summary of Benefits: Page 171

To become a member or associate member: All active Postal Service APWU bargaining unit employees and annuitants must be, or must become, dues-paying members of the APWU, to be eligible to enroll in the Health Plan. All Postal members and annuitants must become associate members of APWU, see page 141 for details.

Membership dues: Associate members will be billed by the APWU for the $35 annual membership fee, except where exempt by law. APWU will bill new associate members for the annual dues when it receives notice of enrollment. APWU will also bill continuing associate members for the annual membership. APWU will bill Retirees Department members $36 annual membership. Active and retiree non-associate APWU membership dues vary.

Enrollment codes for this Plan
High Option:
23A Self Only
23C Self Plus One
23B Self and Family

Consumer Driven Option:
23D Self Only
23F Self Plus One
23E Self and Family

PSHB

Authorized for distribution by the:
United States
Office of Personnel Management
Healthcare and Insurance
http://www.opm.gov/insure
RI 71-019

Important Notice

Important Notice for Medicare-eligible Active Employees from APWU Health Plan
About Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the APWU Health Plan prescription drug coverage for active employees is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means active employees and their covered family members do not need to enroll in an open market Medicare Part D plan and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your PSHB coverage as an active employee.

However, if you (as an active employee and your covered Medicare Part D-eligible family members) choose to enroll in an open market Medicare Part D plan, you can keep your PSHB coverage and your PSHB plan will coordinate benefits with Medicare.

Please be advised

If you lose or drop your PSHB coverage and go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19% higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 800-772-1213 TTY 800-325-0778.

Additional Premium for Medicare's High Income Members

Income-Related Monthly Adjustment Amount (IRMAA)

The Medicare Income-Related Monthly Adjustment Amount (IRMAA) is an amount you may pay in addition to your PSHB premium to enroll in and maintain Medicare prescription drug coverage. **This additional premium is assessed only to those with higher incomes and is adjusted based on the income reported on your IRS tax return.** You do not make any IRMAA payments to your PSHB plan. Refer to the: https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to this additional premium.

You can get more information about open market Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.
- Call 800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048).

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Introduction

This brochure describes the benefits of APWU Health Plan under contract (CS 1370 PS) between APWU Health Plan and the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits (FEHB) law, as amended by the Postal Service Reform Act, which created the Postal Service Health Benefits (PSHB) Program. 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 offices is:

APWU Health Plan
6514 Meadowridge Road, Elkridge, MD 21075

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. If you are a Postal Service annuitant and you are eligible for Medicare Part D, or a covered Medicare Part D-eligible family member of a Postal Service annuitant, your prescription drug benefits are provided under our Medicare Part D Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP) or our High Option Medicare Advantage Prescription Drug (MAPD) EGWP if you choose to enroll in our MAPD EGWP. You do not have a right to benefits that were available before January 1, 2025, under the FEHB Program unless those benefits are also shown in this PSHB Plan brochure.

OPM negotiates benefits and rates for each plan annually. Benefits are effective January 1, 2025. Rates are shown at the end of this brochure.

Plain Language

All PSHB 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 and each covered family member, "we" means APWU Health Plan.
- We limit acronyms to ones you know. OPM is the United States Office of Personnel Management. The FEHB Program is the Federal Employees Health Benefits Program administered by OPM and established under 5 U.S.C. chapter 89. The PSHB Program is the Postal Service Health Benefits Program established within the FEHB Program under 5 U.S.C. section 8903c. PSHB Plan means a health benefits plan offered under the PSHB Program. PSHB means Postal Service Health Benefits. If we use others, we tell you what they mean.
- Our brochure and other PSHB plans' brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

Fraud increases the cost of healthcare for everyone and increases your Postal Service Health Benefits Program premium. OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the PSHB Program regardless of the agency that employs you or from which you retired.

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

- Do not give your plan identification (ID) number over the phone or to people you do not know, except for your healthcare provider, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using healthcare providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services you did not receive.

- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

  - Call the provider and ask for an explanation. There may be an error.

  - If the provider does not resolve the matter, call us at the APWU Health Plan Fraud Hotline at 410-424-1515.

  - If we do not resolve the issue:

Call --The Healthcare Fraud Hotline

877-499-7295
OR go towww.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and

a quicker response time.
You can also write to:
United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400
Washington, DC 20415-1100

Do not maintain family members on your policy:

- Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
- Your child age 26 or over (unless they were disabled and incapable of self-support prior to age 26).

A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's PSHB enrollment.

- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include falsifying a claim to obtain PSHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

We comply with applicable Federal nondiscrimination laws and do not discriminate on the basis of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them differently because of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity).

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination. All coverage decisions will be based on nondiscriminatory standards and criteria. An individual's protected trait or traits, for example a member's gender identity or the fact that the covered benefit is sought in connection with gender-affirming care, will not be used to deny health benefits for items, supplies, or services that are otherwise covered and determined to be medically necessary.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies.
You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you take notes, ask questions and understand answers.

2. Keep and bring a list of all the medications you take.

- Bring the actual medication or give your doctor and pharmacist a list of all the medication and dosage that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medication is what the doctor ordered. Ask the pharmacist about your medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understanding both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Don't assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital or clinic is best for your health needs.

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the healthcare you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"

- Ask your surgeon:
  "Exactly what will you be doing?"
  "About how long will it take?"
  "What will happen after surgery?"
  "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.
- www.jointcommission.org/topics/patient_safety.aspx The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.
- http://www.ahrq.gov/patients-consumers/ . The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality healthcare providers and improve the quality of care you receive.
- https://psnet.ahrq.gov/issue/national-patient-safety-foundation The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.
- www.bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medications.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you do not expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. When such an event occurs, neither you nor your PSHB plan will incur costs to correct the medical error.

APWU Health Plan defines a Never Event as any unanticipated event resulting in death or serious physical or psychological injury to a member of the APWU Health Plan, not related to the natural course of the patient's illness. These incidents/events include loss of a limb or gross motor function, and any event or process variation for which a recurrence would carry a risk of a serious adverse outcome. They also include events such as actual breaches in medical care, administrative procedures or others resulting in an outcome that is not associated with the standard of care or acceptable risks associated with the provision of care and service for a member, including reactions to drugs and materials.

When APWU Health Plan receives notification of a potential Never Event from a member telephone call, by mail, or email or through a claim, or vendor notification, we begin a review process with our management team. An investigation is conducted. If the investigation reveals a Never Event, the member is notified. We conduct a root cause analysis, and provide a final report to the management team and the delegated vendor.

PSHB Facts

Coverage information

- **No pre-existing condition limitation**

  We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage. 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.

- **Minimum value standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

- **Where you can get information about enrolling in the PSHB Program**

  See https://health-benefits.opm.gov/ for enrollment information as well as:

  - Information on the PSHB Program and plans available to you
  - A health plan comparison tool

  Note: Contact the USPS for information on how to enroll in a PSHB Program Plan through the PSHB System.

  Also, your employing or retirement office can answer your questions, give you other plans' brochures and other materials you need to make an informed decision about your PSHB coverage. These materials tell you:

  - When you may change your enrollment
  - How you can cover your family members
  - What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire
  - What happens when your enrollment ends
  - When the next Open Season for enrollment begins

  We do not determine who is eligible for coverage. You will be responsible for making changes to your enrollment status through the PSHB System. In some cases, your employing or retirement office may need to submit documentation. For information on your premium deductions, you must also contact your employing or retirement office.

  Once enrolled in your PSHB Program Plan, you should contact your carrier directly for updates and questions about your benefit coverage.

- **Enrollment types available for you and your family**

  Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee and one or more eligible family members. Family members include your spouse and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

  If you have a Self Only enrollment, you may change to a Self Plus One or Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member.

You enroll in a PSHB Program Plan and make enrollment changes in the PSHB System located at https://health-benefits.opm.gov/. For assistance with the PSHB System, call the PSHBP Helpline at (844) 451-1261. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment request. Benefits will not be available to your spouse until you are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's PSHB enrollment.

Use the PSHB System if you want to change from Self Only to Self Plus One or Self and Family, and to add or remove a family member.

Your employing or retirement office will not notify you when a family member is no longer eligible to receive benefits. Please report changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26 through the PSHB System. We will send written notice to you 60 days before we proactively disenroll your child on midnight of their 26th birthday unless your child is eligible for continued coverage because they are incapable of self-support due to a physical or mental disability that began before age 26.

If you or one of your family members is enrolled in one PSHB plan you or they cannot be enrolled in or covered as a family member by another enrollee in another PSHB or FEHB plan.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the PSHB Program, change your enrollment, or cancel coverage using the PSHB System. For a complete list of QLEs, visit the PSHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, personnel/payroll office, or retirement office.

Family Member Coverage

Family members covered under your Self and Family enrollment are your spouse (including your spouse by a valid common-law marriage from a state that recognizes common-law marriages) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described below.

Natural children, adopted children, and stepchildren
Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children
Coverage: Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.

Children incapable of self-support
Coverage: Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.

Married children
Coverage: Married children (but NOT their spouse or their own children) are covered until their 26th birthday.

Children with or eligible for employer-provided health insurance
Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance.

- **Children's Equity Act** OPM implements the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or Self and Family coverage in the PSHB Program if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

  If this law applies to you, you must enroll in Self Plus One or Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

  - If you have no PSHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in lowest-cost nationwide plan option as determined by OPM.
  - If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
  - If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.

  As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the PSHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that does not serve the area in which your children live, unless you provide documentation that you have other coverage for the children.

  If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for PSHB coverage, you must continue your PSHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information

  For annuitants who are required to be enrolled in Medicare Part B as a condition to continue PSHB coverage in retirement: If you enroll in Medicare Part B and continue PSHB coverage in retirement, the child equity law applies to you and you cannot cancel your coverage, change to Self Only, or change to a plan that does not serve the area in which your child(ren) live as long as the court/administrative order is in effect. You cannot be compelled to enroll or remain enrolled in Medicare Part B to maintain your PSHB enrollment as a condition to satisfy a court/administrative order. However, if you do not enroll (or remain enrolled) in Medicare Part B as required to continue your PSHB coverage in retirement (notwithstanding an existing court/administrative order), you will not be able to continue your PSHB coverage in retirement.

- **Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP)**

  Our PDP EGWP is only available to Postal Service annuitants who are Medicare Part D-eligible and their covered Medicare Part D-eligible family members. Our PDP EGWP is not an open market Medicare Part D Plan. If you are an active Postal Service employee, or covered family member, and become eligible to enroll in Medicare Part D, you are not eligible to enroll in our PDP EGWP. Please contact the Centers for Medicare at 1-800-MEDICARE or 1-800-633-4227 (TTY 1-877-486-2048).

- **When benefits and premiums start**

  The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage and premiums begin on January 1. If you joined at any other time during the year, your employing or retirement office will tell you the effective date of coverage.

  If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

- **When you retire**

  When you retire, you can usually stay in the PSHB Program. Generally, you must have been enrolled in the FEHB and/or PSHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When PSHB coverage ends**

  You will receive an additional 31 days of coverage, for no additional premium, when:

  - Your enrollment ends, unless you cancel your enrollment; or
  - You are a family member no longer eligible for coverage.

  Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

  If you are eligible for coverage under spouse equity, you are only eligible to enroll in the FEHB Program. If you are not eligible for coverage under spouse equity and you are otherwise eligible for Temporary Continuation of Coverage (TCC), then you could enroll in TCC under the PSHB Program.

- **Upon divorce**

  If you are an enrollee and your divorce or annulment is final, your ex-spouse cannot remain covered as a family member under your Self Plus One or Self and Family enrollment. You **must** enter the date of the divorce or annulment and remove your ex-spouse in the PSHB System. We may ask for a copy of the divorce decree as proof. If you need to change your enrollment type, you must use the PSHB System. A change will not automatically be made.

  If you were married to an enrollee and your divorce or annulment is final, you may not remain covered as a family member under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). Former spouses eligible for coverage under the spouse equity law are not eligible to enroll in the PSHB Program. However, former spouses eligible for coverage under the spouse equity law may enroll in the FEHB Program. (Former Spouses seeking but not yet adjudicated as eligible for Spouse Equity may be entitled to TCC under a PSHB plan in the interim).

Former spouses not meeting the spouse equity requirements may be eligible for TCC under the PSHB Program provided you otherwise meet the eligibility requirements for TCC. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get additional information about your coverage choices, https://www.opm.gov/healthcare-insurance/life-events/memy-family/im-separated-or-im-getting-divorced/#url=Health. We may request that you verify the eligibility of any or all family members listed as covered under the enrollee's PSHB enrollment.

- **Medicare PDP EGWP**

When a Postal Service annuitant who is Medicare Part D-eligible or their covered Medicare-eligible family member opts out of or disenrolls from our PDP EGWP, they will not have our prescription drug coverage under this plan. If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Contact us for additional information at 800-222-2798.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your PSHB enrollment after you retire, if you lose your Federal job, or if you are a covered child and you turn age 26, regardless of marital status, etc.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing PSHB Program coverage.

- **Converting to individual coverage**

If you leave Federal service, your employing office will notify you of your right to convert. You must contact us in writing within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will not notify you. You must contact us in writing within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the PSHB Program; however, you will not have to answer questions about your health, a waiting period will not be imposed, and your coverage will not be limited due to pre-existing conditions. When you contact us, we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 800-222-2798 or visit our website at www.apwuhp.com.

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the ACA's Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

- **APWU Health Plan Notice of Privacy Practices**

The APWU Health Plan's Notice of Privacy Practices describes how medical information about you may be used by the Health Plan, your rights concerning your health information and how to exercise them, and APWU Health Plan's responsibilities in protecting your health information. The Notice is posted on the Health Plan's website. If you need to obtain a copy of the Health Plan's Notice of Privacy Practices, you may either contact the Health Plan via email through the website, www.apwuhp.com, or by calling 800-222-2798.

Section 1. How This Plan Works

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

You can choose your own physicians, hospitals, and other healthcare 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.

We have Preferred Provider Organizations (PPOs)

Our fee-for-service plans offer services through PPO networks. This means that certain hospitals and other healthcare 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 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.

General features of our High Option (HO)

High Option PPO Network: You can go to our website, www.apwuhp.com to access an online High Option PPO directory. If you need assistance in identifying a participating provider, call the APWU Health Plan at 800-222-2798. The Plan uses UnitedHealthcare as its PPO network in all states and the U.S. Virgin Islands, as well as its mental health/substance use disorder treatment provider network (all states).

When out of your state of residence, if you do not use a UnitedHealthcare PPO provider or a UnitedHealthcare PPO provider is not available, standard non-PPO benefits apply. For assistance in identifying a provider in the network, call the APWU Health Plan at 800-222-2798.

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.whyuhc.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.
- **For mental health/substance use disorder** treatment providers (all states), call UnitedHealthcare Behavioral Health Solutions toll-free 800-718-1299.
- **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.

For non-PPO providers, we base the Plan allowance on the lesser of the provider's actual charges or the allowed amount for the service you received. We determine the allowed amount by using healthcare charge guides which compare charges of other providers for similar services in the same geographical area. We update these charge guides at least once a year. For surgery, doctor's services, X-ray, lab and therapies (physical, speech and occupational), we use the following:

- For the High Option Plan we use guides specifically prepared by Context4Healthcare at the 60th percentile.
- For the Consumer Driven Option we use guides specifically prepared by Fair Health at the 80th percentile.
- If this information is not available, we will use other credible sources including our own data.

Your rights and responsibilities

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

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

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website APWU Health Plan, www.apwuhp.com. You can also contact us to request that we mail a copy to you by calling 800-222-2798, or write to APWU Health Plan, P.O. Box 8660, Elkridge, MD 21075. You may also contact us by fax at 410-424-1564.

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

Your medical and claims records are confidential

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

Section 2. Changes for 2025

This is the first year for the Postal Service Health Benefits Program (PSHBP). This Section is not an official statement of benefits. For that, go to Section 5 Benefits.

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 PSHB System enrollment confirmation.

Note: If you are enrolled in our Medicare Part D PDP EGWP, you may receive a second ID card for your prescription drug benefits. [Plan specific]

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 (TTY 800-622-2511) or write to us at PO Box 8660, Elkridge, MD 21075 or through our website at www.apwuhp.com. You may print or request an Identification Card via the Member Portal at www.apwuhp.com.
- **Consumer Driven Option:** Call UnitedHealthcare at 800-718-1299 or write to us at PO Box 740800, Atlanta, GA 30374-0800 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.

Balance Billing Protection

PSHB Carriers must have clauses in their in-network (participating) provider agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or for services determined not medically necessary, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in network contracted amount. If an in-network provider bills you for covered services over your normal cost share (deductible, copay, co-insurance) contact your Carrier to enforce the terms of its provider contract.

Covered providers

Covered 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 healthcare services in the normal course of business. Covered services must be provided in the state in which the practitioner is licensed or certified.

Benefits are provided under this Plan for the services of covered providers, in accordance with Section 2706(a) of the Public Health Service Act. Coverage of practitioners is not determined by your state's designation as a medically underserved area.

We list network-contracted covered providers in our network provider directory, which we update periodically, and make available on our website.

This plan recognizes that transgender, non-binary, and other gender diverse members require health care delivered by healthcare providers experienced in gender affirming health. Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex or gender.

This plan provides Care Coordinators for complex conditions through UnitedHealthcare and can be reached at 866-569-2064 for the High Option Plan and 800-718-1299 for the Consumer Driven Option Plan for assistance.

Covered facilities

Covered facilities include:

- **Freestanding ambulatory facility**
  - An out-of-hospital facility such as a medical, cancer, dialysis, or surgical center or clinic, and licensed outpatient facilities accredited by the Joint Commission on Accreditation of Healthcare Organizations for treatment of substance use disorder treatment.
- **Hospital**
  - An institution which is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations, or
  - Any other institution which is operated pursuant to law, under the supervision of a staff of doctors and twenty-four hour a day nursing service, and which is primarily engaged in providing: a) general inpatient care and treatment of sick and injured persons through medical, diagnostic and major surgical facilities, all of which must be provided on its premises or under its control, or b) specialized inpatient medical care and treatment of sick or injured persons through medical and diagnostic facilities (including X-ray and laboratory) on its premises, under its control, or through a written agreement with a hospital (as defined above) or with a specialized provider of those facilities.

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

Transitional care

Specialty care: If you have a chronic or disabling condition and

- lose access to your specialist because your coverage changed from the FEHB to the PSHB and your health plan does not participate in the PSHB, or
- lose access to your specialist because we drop out of the Postal Service Health Benefits (PSHB) Program and you enroll in another PSHB Plan, or
- lose access to your PPO specialist because we terminate our contract with your specialist for reasons other than for cause,

you may be able to continue seeing your specialist and receiving any PPO benefits for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist and your PPO benefits continue until the end of your postpartum care, even if it is beyond the 90 days.

If you are hospitalized when your enrollment begins

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our High Option begins, call our Customer Service Department immediately at 800-222-2798. For the Consumer Driven Option, please call UnitedHealthcare at 800-718-1299. If you are new to the PSHB Program, we will reimburse you for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to this PSHB plan, your former plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the PSHB in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

The pre-service claim approval processes for inpatient hospital admissions (called precertification) and for other services, are detailed in this Section. A **pre-service claim** is any claim, in whole or in part, that requires approval from us in advance of obtaining medical care or services. In other words, a pre-service claim for benefits 1) requires precertification, prior approval or a referral and 2) will result in a reduction of benefits if you do not obtain precertification, prior approval or a referral.

You must get prior approval for certain services. Failure to do so will result in a minimum $500 penalty for inpatient hospital (High Option and Consumer Driven Option) or $100 for certain outpatient radiology/imaging procedures (for High Option only).

Inpatient hospital admission, inpatient residential treatment center admission or skilled nursing facility admission

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition. Unless we are misled by the information given to us, we won't change our decision on medical necessity.

In most cases, your physician or hospital will take care of requesting precertification. Because you are still responsible for ensuring that your care is precertified, you should always ask your physician or hospital whether they have contacted us.

Warning

We will reduce our benefits for the inpatient hospital stay by $500 if no one contacts us for precertification. If the stay is not medically necessary, we will only pay for any covered medical services and supplies that are otherwise payable on an outpatient basis.

Exceptions

You do not need precertification in these cases:

- You are admitted to a hospital outside the United States.
- You have another group health insurance policy that is the primary payor for the hospital stay.
- Medicare Part A is the primary payor for the hospital stay. Note: If you exhaust your Medicare hospital benefits and do not want to use your Medicare lifetime reserve days, then we will become the primary payor and you do need precertification

Other services

Some services and outpatient surgeries require prior approval.

Under the **High Option**, call UnitedHealthcare at 866-569-2064 if you need any of the services listed below:

- Applied Behavioral Analysis (ABA)
- Bariatric surgery (severe obesity)
- Durable medical equipment such as wheelchairs, oxygen equipment and supplies, artificial limbs (prosthetic devices) and braces
- Gender affirming surgery
- Gene Therapy
- Genetic testing, including BRCA testing (see *Definitions*, Section 10)
- Hysterectomy
- Functional endoscopic sinus surgery
- Iatrogenic fertility preservation procedures
- Intensive outpatient treatment

- Minimally invasive treatment of back and neck pain. This requirement applies to both the physician services and the facility. The following services require prior approval: epidural steroid injections and sacroiliac joint injections.
- Orthognathic surgery (Oral maxillofacial surgery)
- Organ transplantation - call before your first evaluation as a potential candidate
- Organic impotence
- Procedures which may be cosmetic in nature such as eyelid surgery (blepharoplasty), varicose vein surgery (sclerotherapy), or Botox injections for medical diagnosis
- Radiation Therapy - Intensity-Modulated Radiation Therapy, Proton Beam Radiation Therapy and Stereotactic Radiation Therapy
- Residential Treatment Center (RTC)
- Services and supplies which may be experimental/investigational
- Skilled Nursing Facilities (SNF)
- Prior approval for outpatient services at Veterans Administration facilities is not needed

Under the **Consumer Driven Option**, call UnitedHealthcare at 800-718-1299 if you need any of the services listed below:

- Air Ambulance - Non emergent
- Applied Behavioral Analysis (ABA)
- Bariatric surgery (severe obesity)
- Cardiology services (outpatient diagnostic catheterizations, echocardiograms, stress echocardiograms and outpatient electrophysiology implant procedures)
- Clinical Trials
- Chemotherapy - outpatient
- Congenital Heart Disease
- Durable Medical Equipment (including Insulin pumps)
- Functional endoscopic sinus surgery
- Gender affirming surgery
- Genetic testing
- Home healthcare - nursing visits, home infusion therapy
- Hospice - inpatient
- Hysterectomy
- Iatrogenic fertility preservation procedures
- Organ transplantation
- Orthognathic surgery
- Potential cosmetic procedures
- Residential Treatment Center (RTC)
- Services and supplies which may be experimental/investigational
- Sinuplasty
- Skilled Nursing Facilities (SNF)
- Sleep apnea procedures and surgery
- Therapeutics (outpatient) dialysis, IV infusion, radiation oncology, intensity modulated radiation therapy, MR-guided focused ultrasound

- Prior approval is required for certain classes of drugs and coverage authorization is required for some medications. This authorization uses Plan rules based on FDA-approved prescribing and safety information, clinical guidelines, and uses that are considered reasonable, safe, and effective. For example, prescription drugs used for cosmetic purposes such as Retin A or Botox may not be covered. Other medications might be limited to a certain amount (such as quantity or dosage) within a specific time period, or require authorization to confirm clinical use based on FDA labeling. To inquire if your medication requires prior approval or authorization, call Express Scripts Customer Service at 800-841-2734 for the High Option (see Section 5(f)), and Optum Rx at 800-718-1299 for the Consumer Driven Option (see Section 5(f)).
- Prior approval is also required for mental health and substance use disorder benefits, inpatient, in-network or out-of-network. Prior approval is required for psychological and neuropsychological testing (CDHP Option only), Electroconvulsive therapy (CDHP Option only), Transcranial Magnetic Stimulation (TMS), and services such as partial or full day hospitalization or facility-based intensive outpatient treatment. For questions, call UnitedHealthcare at 866-569-2064 for the High Option Plan and 800-718-1299 for the Consumer Driven Option Plan.

How to request precertification for an admission or get prior authorization for Other services

- **High Option:** First you, you or your representative, your physician, or your hospital must call UnitedHealthcare at 866-569-2064 at least 2 business days before admission. For other services that require prior approval, call UnitedHealthcare at 866-569-2064 prior to those services being rendered. For mental health and substance use disorder inpatient treatment, your physician or your hospital must call UnitedHealthcare at 866-569-2064 at least 2 business days before admission or services requiring prior authorization. These numbers are available 24 hours every day.
- **Consumer Driven Option:** First you, your representative, your physician, or your hospital must call UnitedHealthcare at 800-718-1299 at least 2 business days before admission or services requiring prior authorization are rendered. For mental health and substance use disorder inpatient treatment, your doctor or your hospital must call UnitedHealthcare Behavioral Health Solutions at 800-718-1299 at least 2 business days before admission or services requiring prior authorization. These numbers are available 24 hours every day.
- If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone the above number at least 2 business days for the High Option and the Consumer Driven Option following the day of the emergency admission, even if you have been discharged from the hospital.
- Next, provide the following information:
  - enrollee's name and Plan identification number
  - patient's name, birth date, and phone number
  - reason for hospitalization, proposed treatment, or surgery
  - name and phone number of admitting physician
  - name of hospital or facility; and
  - number of days requested for hospital stay
- We will then tell the physician and/or hospital the number of approved inpatient days and we will send written confirmation of our decision to you, your physician, and the hospital.

What happens when you do not follow the precertification rules

- If no one contacts us, we will decide whether the hospital stay was medically necessary.
- If we determine that the stay was medically necessary, we will pay the inpatient charges, less the $500 penalty.

If we determine that it was not medically necessary for you to be an inpatient, we will not pay inpatient hospital benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis for High Option and Consumer Driven Option out-of-network stays.

If we denied the precertification request, we will not pay inpatient hospital benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis for High Option and Consumer Driven Option out-of-network stays.

When we precertified the admission but you remained in the hospital beyond the number of days we approved and did not get the additional days precertified, then:

- For the part of the admission that was medically necessary, we will pay inpatient benefits, but
- For the part of the admission that was not medically necessary, we will pay only medical services and supplies otherwise payable on an outpatient basis and will not pay inpatient benefits for High Option and Consumer Driven Option out-of-network services.

Radiology/imaging procedures precertification

High Option: Radiology precertification is required prior to scheduling specific imaging procedures. We evaluate the medical necessity of your proposed procedure to ensure that the appropriate procedure is being requested for your condition. In most cases your physician will take care of the precertification. Because you are responsible for ensuring that precertification is done, you should ask your doctor to contact us.

The following outpatient radiology services require precertification:

- CT/CAT Scan – Computerized Axial Tomography
- MRI – Magnetic Resonance Imaging
- MRA – Magnetic Resonance Angiography
- PET – Positron Emission Tomography

Consumer Driven Option: Radiology services subject to prior authorization include:

- Computerized Tomography (CT)
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Positron-Emission Tomography (PET)
- Nuclear Medicine and Nuclear Cardiology studies

How to precertify a radiology/imaging procedure

For these outpatient studies, you, your representative or doctor must call UnitedHealthcare before scheduling the procedure. For the **High Option** call 866-569-2064 and for the **Consumer Driven Option** call 800-718-1299.

- Provide the following information:
  - patient's name, Plan identification number, and birth date
  - requested procedure and clinical support for request
  - name and phone number of ordering provider
  - name of requested imaging facility

Warning

We will reduce our benefits for these procedures by $100 if no one contacts us for precertification. If the procedure is not medically necessary, we will not pay any benefits (High Option only).

Exceptions

You do not need precertification in these cases:

- You have another health insurance policy that is primary including Medicare Parts A&B or Part B Only
- The procedure is performed outside the United States or Puerto Rico
- You are an inpatient at a hospital
- The procedure is performed while in the Emergency Room

Non-urgent care claims

For **non-urgent care claims**, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim.

If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

Urgent care claims

If you have an **urgent care claim** (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether or not it is an urgent care claim by applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 800-222-2798. You may also call OPM's Postal Service Insurance Operations (PSIO) at 202-936-0002 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 800-222-2798. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

Concurrent care claims

A **concurrent care claim** involves care provided over time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

Emergency inpatient admission

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must call us within two business days following the day of the emergency admission, even if you have been discharged from the hospital. If you do not call the Plan within two business days, penalties may apply - see *Warning* under ***Inpatient hospital admissions*** earlier in this Section and ***If your hospital stay needs to be extended*** below.

Maternity care

You do not need precertification of a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, your physician or the hospital must contact us for precertification of additional days for your baby.

Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

If your hospital stay needs to be extended

High Option: If your hospital stay – including for maternity care – needs to be extended, you, your representative, your physician or the hospital must ask us to approve the additional days by calling the precertification vendor UnitedHealthcare at 866-569-2064. If you remain in the hospital beyond the number of days we approved and did not get the additional days precertified, then

- For the part of the admission that was medically necessary, we will pay inpatient benefits, but
- For the part of the admission that was not medically necessary, we will pay only medical services and supplies otherwise payable on an outpatient basis and will not pay inpatient benefits.

Consumer Driven Option: If your hospital stay – including for maternity care – needs to be extended, you, your representative, your doctor or the hospital must ask us to approve the additional days by calling UnitedHealthcare at 800-718-1299. If you remain in the hospital beyond the number of days we approved and did not get the additional days precertified, then

- For the part of the admission that was medically necessary, we will pay inpatient benefits, but
- For the part of the admission that was not medically necessary, we will pay only medical services and supplies otherwise payable on an outpatient basis and will not pay inpatient benefits for out-of-network services only.

If your treatment needs to be extended

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below. If your claim is in reference to a contraceptive, call 800-841-2734 for the High Option and 800-718-1299 for the Consumer Driven Option.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8

To reconsider a non-urgent care claim

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Precertify your hospital stay or, if applicable, arrange for the healthcare provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
2. Ask you or your provider for more information. You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3. Write to you and maintain our denial.

To reconsider an urgent care claim

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, fax, or other expeditious methods.

To file an appeal with OPM

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Note: If you are enrolled in our Medicare PDP EGWP and do not agree with our benefit coverage decision you have the right to appeal. See Section. 8(a) for information about the PDP EGWP appeal process.

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 $450 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 $450. 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 $800. 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 $800. If you use non-PPO providers, your calendar year deductible increases to a maximum of $1,000 per person ($2,000 per Self Plus One and Self and Family). Whether or not you use PPO providers, your calendar year deductible will not exceed $1,000 per person ($2,000 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 ($450) has been satisfied.

Note: If you change PSHB plans during Open Season, the effective date of your new PSHB plan is January 1 of the next year and a new deductible starts on January 1. If you change plans at another time during the year, you must begin a new deductible under your new plan.

If you change from Self Plus One or Self and Family to Self Only, or from Self Only to Self Plus One or Self and Family during the year, we will credit the amount of covered expenses already applied toward the deductible of your old enrollment to the deductible of your new enrollment. However, if you change from High Option to Consumer Driven Option or from Consumer Driven Option to High Option, during the year, expenses incurred as of the effective date of the option change are subject to the benefit provisions of your new option.

Consumer Driven Option

Your Deductible is the amount of eligible expenses you are required to meet before Traditional Health Coverage begins. Your plan's deductible is reduced by applying the funds in your Personal Care Account (PCA) which is funded in January by the APWU Health Plan. Your Net Deductible is the remaining deductible amount you have to pay once the funds in your PCA have been exhausted. By using the funds in your PCA to pay for eligible medical expenses you decrease your total deductible and out-of-pocket expenses. Your Net Deductible for in-network providers is generally $1,000 for a Self Only enrollment or $2,000 for a Self Plus One or a Self and Family enrollment. For Self Plus One or Self and Family coverage, once one individual meets the Self Only Net Deductible of $1,000, Traditional Health Coverage begins for that individual. Once the other covered members meet the additional $1,000 Net Deductible, Traditional Health Coverage begins for them. If you use out-of-network providers, your calendar year Net Deductible increases to $1,500 Self Only and $3,000 for Self Plus One and Self and Family. Your Deductible in subsequent years may be reduced by rolling over any unused portion of your Personal Care Account remaining at the end of the calendar year(s).

In-Network Plan Deductible:
Self Only: $2,200
Self Plus One: $4,400
Self and Family: 4,400

In-Network PCA (APWU HP Funded)
Self Only: $1,200
Self Plus One: $2,400
Self and Family: $2,400

In-Network Net Deductible (You Pay)
Self Only: **$1,000**
Self Plus One: $**2,000**
Self and Family: $**2,000**

Coinsurance

High Option: Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible.

Example: You pay 40% of our allowance for office visits to a non-PPO physician.

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

If your provider routinely waives your cost

If your provider routinely waives (does not require you to pay) your copayments, deductibles, or coinsurance, the provider is misstating the fee and may be violating the law. In this case, when we calculate our share, we will reduce the provider’s fee by the amount waived.

For example, if your physician ordinarily charges $100 for a service but routinely waives your 40% coinsurance, the actual charge is $60. We will pay $36 (60% of the actual charge of $60).

Waivers

In some instances, an APWU Health Plan provider may ask you to sign a "waiver" prior to receiving care. This waiver may state that you accept responsibility for the total charge for any care that is not covered by your health plan. If you sign such a waiver, whether or not you are responsible for the total charge depends on the contracts that the Plan has with its providers. If you are asked to sign this type of waiver, please be aware that, if benefits are denied for the services, you could be legally liable for the related expenses. If you would like more information about waivers, please contact us at 800-222-2798.

High Option: Our "Plan allowance" is the amount we use to calculate our payment for covered services. Fee-for-service plans arrive at their allowances in different ways, so their allowances vary. For more information about how we determine our Plan allowance, see the definition of Plan allowance in Section 10.

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

- **PPO providers** agree to limit what they will bill you. Because of that, when you use a preferred provider, your share of covered charges consists only of your deductible and coinsurance or copayment. Here is an example about coinsurance: You see a PPO physician who charges $150, but our allowance is $100. If you have met your deductible, you are only responsible for your coinsurance. That is, you pay just -- 15% of our $100 allowance ($15). Because of the agreement, your PPO physician will not bill you for the $50 difference between our allowance and the bill.
- **Non-PPO providers**, on the other hand, have no agreement to limit what they will bill you. When you use a non-PPO provider, you will pay your deductible and coinsurance -- **plus** any difference between our allowance and charges on the bill. Here is an example: You see a non-PPO physician who charges $150 and our allowance is again $100. Because you've met your deductible, you are responsible for your coinsurance, so you pay 40% of our $100 allowance ($40). Plus, because there is no agreement between the non-PPO physician and us, the physician can bill you for the $50 difference between our allowance and the bill.

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

EXAMPLE

PPO physician
Physician's charge: $150
Our allowance: We set it at: $100
We pay: 85% of our allowance: $85
You owe: Coinsurance: 15% of our allowance: $15
+ Difference up to charge?: No: 0
TOTAL YOU PAY: $15

Non-PPO physician
Physician's charge: $150
Our allowance: We set it at: $100
We pay: 60% of our allowance: $60
You owe: Coinsurance: 40% of our allowance: $40
+ Difference up to charge?: Yes: $50
TOTAL YOU PAY: $90

Consumer Driven Option:

Differences between our allowance and the bill

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

Out-of-network providers - If you use an out-of-network provider, you will have to pay the difference between the Plan allowance and the billed amount only if you use up your Personal Care Account for the year. Note that it usually makes sense to use in-network providers because it will make your Personal Care Account go much further since money left in your Personal Care Account can be rolled over to be used in the next year.

You should also see section *Important Notice About Surprise Billing - Know Your Rights* below that describes your protections against surprise billing under the No Surprises Act.

Your catastrophic protection out-of-pocket maximum for deductibles, coinsurance, and copayments

There is a limit to the amount you must pay out-of-pocket for combined medical and prescription drug coinsurance for the year for certain charges. When you have reached this limit, you pay no coinsurance for covered services for the remainder of the calendar year.

High Option:

PPO benefit: Your out-of-pocket maximum is $6,500 for combined medical and prescription drugs for Self Only enrollment or $13,000 for a Self Plus One or a Self and Family enrollment if you are using PPO providers and in-network pharmacies. Only eligible expenses for PPO providers and in-network pharmacies count toward this limit.

Non-PPO benefit: Your out-of-pocket maximum is $12,000 for combined medical and prescription drugs for Self Only enrollment, or $24,000 for a Self Plus One or a Self and Family enrollment if you are using non-PPO providers or out-of-network pharmacies. Eligible expenses for network providers or in-network pharmacies also count toward this limit. Your eligible out-of-pocket expenses will not exceed this amount whether or not you use network providers.

Note: For Self Plus One or Self and Family coverage, the maximum out-of-pocket for any individual in the family will not exceed the maximum out-of-pocket for Self Only coverage. When an individual meets the Self Only out-of-pocket maximum, they pay no coinsurance for covered services for the remainder of the calendar year. Once the other covered members in the family meet the remaining out-of-pocket family maximum, then they pay no coinsurance for covered services for the remainder of the calendar year.

Out-of-pocket expenses for the purposes of this benefit are:

- The 15% you pay (or the 5% you pay for Cancer Centers of Excellence) for PPO; inpatient medical services and supplies, surgical and anesthesia services, services provided by a hospital or other facility and ambulance services, emergency services/ accidents, mental health and substance use disorder treatment; and the medical deductible
- The 40% you pay for non-PPO; medical services and supplies, surgical and anesthesia services, services provided by a hospital or other facility and ambulance services, mental health and substance use disorder treatment, dental (30%); and the medical deductible
- The copayment of $25 for outpatient visits to PPO physicians and $10 for virtual visits
- The copayment of $30 for outpatient facility charges in a PPO Urgent Care Center

- The 25% you pay for in-network preferred brand name prescription drugs (Tier 2), 45% for in-network non-preferred brand name prescription drugs (Tier 3) and the $10 and $20 you pay for in-network generic prescription drugs (Tier 1), and 25% for generic specialty drugs (Tier 4), 25% for preferred brand name drugs (Tier 5) and 45% non-preferred brand name drugs (Tier 6)

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

- Expenses in excess of our allowance or maximum benefit limitations
- Any amounts you pay because benefits have been reduced for non-compliance with this Plan's cost containment requirements, (see Section 3)
- The $300 per admission for non-PPO inpatient hospital charges or skilled nursing facility
- Expenses in excess of visit maximums for physical, occupational and speech therapy, and acupuncture
- 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:

If you have exceeded your Personal Care Account and met your Deductible the following would apply:

In-network benefit: Your out-of-pocket maximum is $6,500 for combined medical and prescription drugs for a Self Only enrollment or $13,000 for a Self Plus One or Self and Family enrollment if you are using in-network providers and pharmacies. Only eligible expenses for network providers and pharmacies count toward this limit.

Out-of-network benefit: Your out-of-pocket maximum is $12,000 for combined medical and prescription drugs for a Self Only enrollment or $24,000 for a Self Plus One or Self and Family enrollment if you are using out-of-network providers. Eligible expenses for network providers and pharmacies also count toward this limit. Your eligible out-of-pocket expenses will not exceed this amount whether or not you use network providers.

Note: For Self Plus One or Self and Family coverage, the maximum out-of-pocket for any individual in the family will not exceed the maximum out-of-pocket for Self Only coverage. When an individual meets the Self Only out-of-pocket maximum, they pay no coinsurance for covered services for the remainder of the calendar year. Once the other covered members in the family meet the remaining out-of-pocket family maximum, then they pay no coinsurance for covered services for the remainder of the calendar year.

Out-of-pocket expenses for the purposes of this benefit are:

- The 15% you pay (or the 10% you pay for Cancer Centers of Excellence) for in-network inpatient and outpatient hospital charges, surgical, medical, virtual visits and emergency services under the Traditional Health Coverage; and the Deductible
- The 50% you pay for out-of-network inpatient and outpatient hospital charges, surgical, medical, and maternity services under the Traditional Health Coverage; and the Deductible

- The 25% you pay for in-network Tier 1 and Tier 2 prescription drugs; and 40% for in-network Tier 3 drugs
- The Personal Care Account (PCA) of $1,200 for Self Only or $2,400 for Self Plus One or Self and Family

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

You should also see section Important Notice About Surprise Billing – Know Your Rights below that describes your protections against surprise billing under the No Surprises Act.

For members enrolled in our Plan's associated MA-PD or PDP EGWP, we are required to accumulate all members' actual out-of-pocket costs for Medicare-covered drugs, services and supplies toward the PSHB catastrophic maximum(s), unless specifically excluded below. Non-covered services, Part B drugs, IRMAA and late enrollment penalties are excluded from catastrophic maximum.

If you are enrolled in our Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP), the prescription drug out-of-pocket maximum is $2,000. After this maximum is met, we pay 100% of all eligible covered prescription drug benefits.

Carryover

If you changed to this PSHB Plan during Open Season from a plan with a catastrophic protection benefit, the effective date of the change is January 1, and covered expenses that apply to this plan's catastrophic protection benefit start on January 1.

Note: If you change PSHB plans during Open Season the effective date of your new PSHB plan is January 1 of the next year, and a new catastrophic protection accumulation starts on January 1. If you change plans at another time during the year, you must begin a new catastrophic protection accumulation under your new plan.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

If we overpay you

We will make diligent efforts to recover benefit payments we made in error but in good faith. We may reduce subsequent benefit payments to offset overpayments.

When Government facilities bill us

Facilities of the Department of Veteran Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Important Notice About Surprise Billing – Know Your Rights

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" for out-of-network emergency services; out-of-network non-emergency services provided with respect to a visit to a participating healthcare facility; and out-of-network air ambulance services.

A surprise bill is an unexpected bill you receive for:

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating healthcare facilities, or for
- air ambulance services furnished by nonparticipating providers of air ambulance services.

Balance billing happens when you receive a bill from the nonparticipating provider, facility, or air ambulance service for the difference between the nonparticipating provider's charge and the amount payable by your health plan.

Your health plan must comply with the NSA protections that hold you harmless from surprise bills.

For specific information on surprise billing, the rights and protections you have, and your responsibilities go to www.apwuhp.com and click on **Members** or contact the Health Plan at 800-222-2798.

Section 5. High Option Health Plan Table of Contents

See page 171 for 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 Health Plan Overview

The Plan offers a High Option, described in this section. Make sure that you review the benefits that are available under the benefit program in which you are enrolled.

The High Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* 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 the High Option benefits, contact us at 800-222-2798 or on our website at www.apwuhp.com.

The APWU Health Plan's High Option provides a wide range of comprehensive benefits for preventive services, doctors' visits and services, care in a hospital, laboratory tests and procedures, accidental and emergency services, mental health and substance use disorder treatment and prescription drugs. We have extensive networks of preferred providers for both medical and mental health services to help lower your costs, but you may use any provider you wish, in or out of our networks.

The High Option includes:

Preventive care

The Plan emphasizes prevention by providing an extensive range of preventive benefits to help members stay well. We include 100% coverage for an array of in-network preventive tests and screenings, routine physical exams, and a Tobacco Cessation program to stop smoking. To keep children well, we have 100% coverage for recommended immunizations, physical exams and laboratory tests for children. We emphasize women's wellness with our Preventive Care benefit that provides 100% coverage for a full range of in-network preventive services, preventive tests and screenings, counseling services and generic and single source brand FDA approved prescription contraceptives.

Medical and Surgical services

The Plan provides coverage for doctors' visits and surgical services and supplies. You pay only a flat copayment for office visits to a network physician, including visits for chiropractic and acupuncture treatment. In-network maternity care is covered 100%, including breastfeeding support. Mental health and substance use disorder treatment has the same comprehensive coverage as is provided for medical care.

Hospitalization and Emergency care

We offer extensive benefits for hospital and other inpatient healthcare services. There is no deductible or per admission charge for in-network hospital care. You also receive 100% coverage for unexpected outpatient care when you need it most with the Plan's Accidental Injury benefit.

Prescription drugs

Our prescription drug program offers prescription savings with no deductible and low copayments for (Tier 1) generic drugs. The prescription drug program is easy to use, with a huge network of pharmacies and a mail order service where medications are delivered right to your door. The Plan's prescription drug program provides savings and convenience for generic and brand name drugs, and you never have to file a claim.

UnitedHealthcare Medicare Advantage (PPO)

We also offer the UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan for High Option retiree/annuitants with primary Medicare Part A and B. Membership is voluntary and members may opt-in or out of this plan at any time. Members have access to a nationwide PPO network and may seek care within the network or out-of-network. Members that join will have access to certain benefit enhancements that are noted in Section 9.

Special features

Obtaining help from a medical professional is quick, confidential, and free with the Plan's voluntary 24-hour NurseLine, available anywhere in the country. Online access to claims information is available through the APWU Health Plan Member Portal. We help members navigate the healthcare system with an online Preferred Provider Organization (PPO) directory, Hospital Quality Ratings Guide, Treatment Cost Estimator, and prescription drug information. We also offer online tools and resources.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: PPO - $450 per person ($800 per Self Plus One enrollment, or $800 per Self and Family enrollment); non-PPO - $1,000 per person ($2,000 per Self Plus One enrollment, or $2,000 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.
- 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.
- If you enroll in APWU Health Plan's High Option and have Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan to our PSHB members. This plan enhances your PSHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. This would be an enhancement to your APWU Health Plan's High Option benefits. It includes a $100 monthly Part B reimbursement. The UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan is subject to Medicare rules. (See Section 9 for additional details.)
- The coverage and cost-sharing listed below are for services provided by physicians and other healthcare professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).

Benefits 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	**High Option**
Professional services of physicians • In physician's office* • Medical consultations in the office * Professional services of a physician via Telehealth/Telemedicine are covered the same as in a physician's office.	PPO: $25 copayment (No deductible) Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Professional services of physicians • During a hospital stay • In a skilled nursing facility • Second surgical opinion • At home	PPO: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount

Diagnostic and treatment services - continued on next page

Benefits Description	You pay After the calendar year deductible…
Diagnostic and treatment services (cont.)	**High Option**
At Cancer Centers of Excellence Note: To receive the higher level of benefits for cancer related treatment, you are required to visit a designated Cancer Center of Excellence facility.	PPO Cancer Center of Excellence (COE): 5% of the Plan allowance
TeleHealth Services	**High Option**
• Virtual visits are available through Teladoc You can receive treatment from board-certified doctors for your non-emergency conditions such as the flu, strep throat, eye infections, bronchitis, and much more. Covered services include visits through the web or your mobile device to obtain a consultation, diagnosis and prescriptions (when appropriate). The service is available 24 hours a day, 7 days a week. Note: Telehealth services are available in most states, but some states do not allow telehealth or prescriptions per state regulations. Please visit www.teladoc.com, or call 800-835-2362 for information on virtual visits Note: There are no out-of-network benefits for Virtual visits.	Teladoc: Nothing (no deductible) for first 2 visits $10 copayment (no deductible) after first 2 visits
Lab, X-ray and other diagnostic tests	**High Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap test • Pathology • X-ray • Non-routine mammogram, including 3D mammogram • CT/CAT Scan/MRI/MRA/NC/PET (Outpatient requires precertification – see Section 3, except for NC) • Ultrasound • Electrocardiogram and EEG	PPO: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount Note: If your PPO provider uses a non-PPO lab or radiologist, we will pay non-PPO benefits for lab and X-ray charges billed by these non-PPO providers.
If LabCorp or Quest Diagnostics performs your covered lab services, you will have no out-of-pocket expense and you will not have to file a claim. To find a location near you, in all states, call APWU Health Plan at 800-222-2798 or visit our website at www.apwuhp.com. Note: Not available in the U.S. Virgin Islands.	Nothing (No deductible)
Not covered: • *Professional fees for automated lab tests* • *Genetic screening (see Definition, Section 10)* • *Qualitative (definitive) urine drug panel testing that is not medically necessary*	*All charges*

Benefits Description	You pay After the calendar year deductible…
Preventive care, adult	**High Option**
• Routine physical every calendar year. **The following preventive services are covered at the time interval recommended at each of the links below:** • U.S. Preventive Services Task Force (USPSTF) A and B recommended screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer. For a complete list of screenings go to the website at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • Individual counseling on prevention and reducing health risks • Well woman care such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of Well Women preventive care services go to the Health and Human Services (HHS) website at www.hrsa.gov/womens-guidelines. • Routine Prostate Specific Antigen (PSA) test, one annually for men age 40 and older • Urinalysis • Routine Electrocardiogram (EKG) • Chest X-ray • Hemoglobin A1C, age 18 and above • At home Colorectal Cancer Screening Cologuard Kit provided through Exact Sciences Laboratories, every three years starting at age 45, prescription needed from physician • Adult Immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. For a complete list of endorsed immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/ • To build your personalized list of preventive services go to https://health.gov/myhealthfinder Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	PPO: Nothing (No deductible) Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
• Routine mammogram - covered for women, including 3D mammograms covered for women age 35 and older; as follows: - From age 35 through 39, one during this five year period - From age 40, one every calendar year • To build your personalized list of preventive services go to https://health.gov/myhealthfinder	PPO: Nothing (No deductible) Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount

Preventive care, adult - continued on next page

Benefits Description	You pay After the calendar year deductible…
Preventive care, adult (cont.)	**High Option**
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family-centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy: - Unlimited preventive medical nutrition therapy (assessment and intervention) - Unlimited preventive medical counseling for the purpose of promoting health and preventing illness - Unlimited visits to a registered dieticians/nutritionist • Family-centered programs when medically identified to support obesity prevention and management by an in-network provider: - Unlimited preventive medical counseling group (including family counseling) • When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See Section 5(f) for cost share requirements for anti-obesity medications. • When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b) for surgery requirements and cost share. For coverage policy, visit www.apwuhp.com and click on Member Resources. Obesity screening and referral, for those persons below the USPSTF obesity prevention risk factor level, see Section 5(h) for Weight Management and Special Programs.	PPO: Nothing (No deductible) Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Adult immunizations not endorsed by the CDC* • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel* • *Immunizations, boosters, and medications for travel or work-related exposure*	*All charges*
Preventive care, children	**High Option**
• Well-child visits examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to www.brightfutures.aap.org • Children's immunizations endorsed by the Centers for Disease Control (CDC) including DTaP/Tdap, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/index.html	PPO: Nothing (No deductible) Non-PPO: Any difference between the Plan allowance and the billed charge (No deductible)

Preventive care, children - continued on next page

Benefits Description	You pay After the calendar year deductible…
Preventive care, children (cont.)	**High Option**
You may also find a complete list of U.S. Preventive Services Task Force (USPSTF) A and B recommendations online at www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations	PPO: Nothing (No deductible) Non-PPO: Any difference between the Plan allowance and the billed charge (No deductible)
• Examinations, limited to: - Examinations for amblyopia and strabismus - limited to one screening examination (ages 3 through 5) - Examinations done on the day of immunizations (ages 3 through 21) - One Screening Examination of Premature Infants for Retinopathy of Prematurity or infants with low birth weight or gestational age of 32 weeks or less • To build your personalized list of preventive services go to www.health.gov/myhealthfinder Note: In-network facility and lab services directly related to covered, in-network preventive care will also be covered at 100%. Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	PPO: Nothing (No deductible) Non-PPO: Any difference between the Plan allowance and the billed charge and any amount above $250 per child (ages 0 through 3) each year and any amount above $150 per child (ages 4 through 18) each year (No deductible)
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family-centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy: - Unlimited preventive medical nutrition therapy (assessment and intervention) - Unlimited preventive medical counseling for the purpose of promoting health and preventing illness - Unlimited visits to a registered dieticians/nutritionist • Family-centered programs when medically identified to support obesity prevention and management by an in-network provider: - Unlimited preventive medical counseling group (including family counseling) • When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See Section 5(f) for cost share requirements for anti-obesity medications. • When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b) for surgery requirements and cost share. For coverage policy, visit www.apwuhp.com and click on Member Resources.	PPO: Nothing (No deductible) Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount

Preventive care, children - continued on next page

Benefits Description	You pay After the calendar year deductible…
Preventive care, children (cont.)	**High Option**
Obesity screening and referral, for those persons below the USPSTF obesity prevention risk factor level, see Section 5(h) for Weight Management and Special Programs.	PPO: Nothing (No deductible) Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Adult immunizations not endorsed by the CDC* • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel* • *Immunizations, boosters, and medications for travel or work-related exposure*	*All charges*
Maternity care	**High Option**
Complete maternity (obstetrical) care, such as: • Screening for gestational diabetes • Prenatal and postpartum care • Delivery • Initial examination of a newborn child covered under a Self Plus One or Self and Family enrollment • Breastfeeding and lactation support, supplies and counseling for each birth • Screening and counseling for prenatal and postpartum depression Note: Maternity care expenses incurred by a Plan member serving as a surrogate mother are covered by the Plan subject to reimbursement from the other party to the surrogacy contract or agreement. The involved Plan member must execute our Reimbursement Agreement completed by APWU Health Plan against any payment they may receive under the surrogacy contract or agreement. Expenses of the newborn child are not covered under this or any other benefit in a surrogate mother situation. Here are some things to keep in mind: You do not need to precertify your vaginal or cesarean delivery; see Section 3 for other circumstances, such as extended stays for you or your baby. • As part of your coverage you have access to in-network certified nurse midwives, home nurse visits and board-certified lactation specialists during the prenatal and post-partum period. • Doula virtual coverage through Maven (a free wellness program). See Section 5(h). • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment.	PPO: Nothing (No deductible) Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount Note: For inpatient hospital care related to maternity, we pay for covered services in full when you use preferred providers. Note: In-network facility and lab services directly related to covered, in-network maternity care will also be covered at 100%. Note: For Non-PPO inpatient hospital, a $300 copayment fee applies.

Maternity care - continued on next page

Benefits Description	You pay After the calendar year deductible…
Maternity care (cont.)	**High Option**
• We pay hospitalization and surgeon services for non-maternity care, as well as covering an extended stay, if medically necessary, the same as for illness and injury. • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b). Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. In addition, circumcision is covered at the same rate as for regular medical or surgical benefits.	PPO: Nothing (No deductible) Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount Note: For inpatient hospital care related to maternity, we pay for covered services in full when you use preferred providers. Note: In-network facility and lab services directly related to covered, in-network maternity care will also be covered at 100%. Note: For Non-PPO inpatient hospital, a $300 copayment fee applies.
• We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self Plus One or Self and Family enrollment.	PPO: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Amniocentesis if for diagnosing multiple births* • *Genetic screening (see Definitions, Section 10)*	*All charges*
Family planning	**High Option**
Contraceptive counseling on an annual basis. Note: If you have concerns about the Health Plan's compliance with the ACA/HRSA requirements or have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov. See OPM's web page about contraception.	PPO: Nothing (No deductible) Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
A range of voluntary family planning services, without cost sharing, that includes at least one form of contraception in each of the categories on the HRSA list. This list includes: • Voluntary female sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo Provera) • Intrauterine devices (IUDs) • Diaphragms Note: See additional Family Planning and Prescription drug coverage Section 5(f)	PPO: Nothing (No deductible) Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount

Family planning - continued on next page

Benefits Description	You pay After the calendar year deductible…
Family planning (cont.)	**High Option**
Note: Your plan offers some type of voluntary female sterilization surgery coverage at no cost to members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any type of voluntary female sterilization surgery that is not already available without cost sharing can be accessed through the contraceptive exceptions process described below. Note: All FDA approved and standard of care are covered. No exception process is needed.	PPO: Nothing (No deductible) Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
• Voluntary male sterilization	PPO: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic testing and counseling*	*All charges*
Infertility services	**High Option**
Diagnosis and treatment of infertility specific to, except as shown in *Not covered,* see Section 10, *Definitions* • Artificial insemination (AI): - Intravaginal insemination (IVI), - Intracervical insemination (ICI) - Intrauterine insemination (IUI) • Infertility medications, including IVF related drugs. See Section 5 (f), *Prescription drug benefits.* For coverage policy, visit www.apwuhp.com and click on Member Resources.	PPO: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance
• Iatrogenic fertility preservation procedures (retrieval of and freezing of eggs or sperm) caused by chemotherapy, pelvic radiotherapy, ovary or testicle removal and other gonadotoxic therapies for the treatment of disease and gender reassignment. Note: Fertility preservation procedures require prior approval (see Section 3, *Other services*). Limited benefits: $12,000 lifetime maximum.	PPO: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance
Not covered: • *Infertility services after voluntary sterilization* • *Assisted reproductive technology (ART) procedures, such as:* - *In vitro fertilization (IVF) (excluding IVF drugs)* - *Embryo transfer and gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures*	*All charges*

Infertility services - continued on next page

Benefits Description	You pay After the calendar year deductible…
Infertility services (cont.)	**High Option**
• *Cost of donor sperm* • *Cost of donor egg*	*All charges*
Allergy care	**High Option**
• Testing and treatment, including materials (such as allergy serum) • Allergy injections	PPO: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*
Treatment therapies	**High Option**
• Chemotherapy • Radiation therapy (preauthorization required by UnitedHealthcare) Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed in Section 5(b). • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Specialty drugs administered on an outpatient basis Note: For Specialty drugs, you or your prescriber must contact Accredo at 844-581-4862 to ask if a specialty medication you are receiving from the physician's office or outpatient setting must be obtained through Accredo Specialty Pharmacy. If the drugs are obtained through Accredo Specialty Pharmacy, they will be paid at the in-network prescription drug benefit, (see Section 5(f), *Prescription drug benefits*). If your specialty medication is available through Accredo Specialty Pharmacy and you do not obtain your medication through Accredo Specialty Pharmacy, you will be responsible for the full cost of your medication. • Respiratory and inhalation therapies • Cardiac rehabilitation following qualifying event/condition	PPO: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
• Medical food formulas ordered by a healthcare provider that are medically necessary to treat specific nutritional risks, including Phenylketonuria (PKU) and other inborn errors of metabolism (IEM). Limited benefits: We pay a maximum of $2,500 for each calendar year.	PPO: 15% of the Plan allowance and all charges after we pay $2,500 in a calendar year Non-PPO: 40% of the Plan allowance and all charges after we pay $2,500 in a calendar year
• Gene Therapy: Curative gene therapy for rare genetic conditions Note: Preauthorization of gene therapy is required, (see *Other services*, Section 3)	PPO: 15% of the Plan allowance Non-PPO: All charges
Not covered: • *Medical foods for conditions other than permanent inborn errors of metabolism.*	*All charges*

Benefits Description	You pay After the calendar year deductible…
Physical and occupational therapies	**High Option**
Physical therapy and occupational therapy provided by a licensed registered therapist or physician up to a combined 60 visits per calendar year Note: We also have the right to deny any type of therapy, service or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or recurring.	PPO: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Maintenance therapies* • *Exercise programs*	*All charges*
Applied behavioral analysis (ABA)	**High Option**
Outpatient Applied Behavioral Analysis (ABA) services, for the treatment of Autism Spectrum Disorder. Services must be provided under the supervision of a Board Certified Behavior Analyst who is contracted with UnitedHealthcare Behavioral Health, or agrees to participate with UnitedHealthcare Behavioral Health's care management activities. **Preauthorization required by UnitedHealthcare Behavioral Health.** Note: UnitedHealthcare Behavioral Health's review of ABA services is based on an intensive care management model that monitors treatment plans, objectives, and progress milestones. We have the right to deny services for treatment when outcomes do not meet the defined treatment plan objectives and milestones.	PPO: 15% of the Plan allowance Non-PPO: All charges
Speech therapy	**High Option**
Speech therapy where medically necessary and provided by a licensed therapist Note: Speech therapy is combined with 60 visits per calendar year for the services of physical therapy and/or occupational therapy (see above). Note: We also have the right to deny any type of therapy, service or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or recurring.	PPO: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Hearing services (testing, treatment, and supplies)	**High Option**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist • One examination and testing for hearing aids every 2 years Note: For routine hearing screening performed during a child's preventive care visit, (see Section 5(a), *Preventive care, children*).	PPO: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
• External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants for bilateral hearing loss	Note: For benefits for the devices see Section 5(a), *Orthopedic and prosthetic devices.*

Hearing services (testing, treatment, and supplies) - continued on next page

Benefits Description	You pay After the calendar year deductible…
Hearing services (testing, treatment, and supplies) (cont.)	**High Option**
Not covered: • *Hearing services that are not shown as covered*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**
Internal (implant) ocular lenses and/or the first contact lenses required to correct an impairment caused by accident or illness. Services are limited to the testing, evaluation and fitting of the first contact lenses required to correct an impairment caused by accident or illness Note: See Section 5(a), *Preventive care*, *children*, for eye exams for children.	PPO: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Eyeglasses or contact lenses and examinations for them* • *Eye exercises and visual training* • *Radial keratotomy and other refractive surgery* • *Refraction*	*All charges*
Foot care	**High Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes	PPO: $25 copayment for the office visit (No deductible) plus 15% of the Plan allowance for other services performed during the visit Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*
Orthopedic and prosthetic devices	**High Option**
• Artificial limbs and eyes • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Leg, arm, neck, joint and back braces • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants for bilateral hearing loss • Internal prosthetic devices, and surgically implanted breast implant following mastectomy Note: We recommend preauthorization of orthopedic and prosthetic devices, (see *Other services*, Section 3).	PPO: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount

Orthopedic and prosthetic devices - continued on next page

Benefits Description	You pay After the calendar year deductible…
Orthopedic and prosthetic devices (cont.)	**High Option**
Note: We require preauthorization of artificial limbs, (see *Other services*, Section 3). Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b), *Surgical procedures*. For information on the hospital and/or ambulatory surgery center benefits see Section 5 (c), *Services provided by a hospital or other facility, and ambulance services*.	PPO: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
External hearing aids • Covered every 3 years limited to $1,500 Note: Excluding batteries, benefits for hearing aid dispensing fees, accessories, supplies, and repair service are included in the benefit limit described above. See Section 5h, *Wellness and Other Special Features*, for information on UnitedHealthcare Hearing.	PPO: All charges in excess of $1,500, up to the PPO allowance (No deductible) Non-PPO: All charges in excess of $1,500 (No deductible)
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices*	*All charges*
Durable medical equipment (DME)	**High Option**
Durable medical equipment (DME) is equipment and supplies that: 1. Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury) 2. Are medically necessary 3. Are primarily and customarily used only for a medical purpose 4. Are generally useful only to a person with an illness or injury 5. Are designed for prolonged use; and 6. Serve a specific therapeutic purpose in the treatment of an illness or injury We cover rental or purchase, of durable medical equipment, at our option, including repair and adjustment. Covered items include but are not limited to: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs (standard and electric) • Ostomy supplies (including supplies purchased at a pharmacy) • Crutches • Walkers	PPO: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount

Durable medical equipment (DME) - continued on next page

Benefits Description	You pay After the calendar year deductible…
Durable medical equipment (DME) (cont.)	**High Option**
Note: Preauthorization of durable medical equipment is required, (see *Other services*, Section 3). Note: We will pay only for the cost of the standard item. Coverage for specialty equipment, such as all-terrain wheelchairs, is limited to the cost of the standard equipment. Note: We limit the Plan allowance for DME rental benefit to an amount no greater than what we would have considered if the equipment had been purchased.	PPO: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered : • *Whirlpool equipment* • *Sun and heat lamps* • *Light boxes* • *Heating pads* • *Exercise devices* • *Stair glides* • *Elevators* • *Air Purifiers* • *Computer "story boards," "light talkers," or other communication aids for communication-impaired individuals*	*All charges*
Home health services	**High Option**
Services for skilled nursing care up to 50 visits per calendar year, not to exceed two hours per day; and • a registered nurse (R.N.), licensed practical nurse (L.P.N.) or licensed vocational nurse (L.V.N.) provides the services; • the attending physician orders the care; • the physician identifies the specific professional skills required by the patient and the medical necessity for skilled services; and • the physician indicates the length of time the services are needed	PPO: 15%; all charges in excess of two hours Non-PPO: 40%; all charges in excess of two hours
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, rehabilitative, or habilitative* • *Services of nurses' aides or home health aides* • *All charges in excess of two hours*	*All charges*

Benefits Description	You pay After the calendar year deductible…
Chiropractic	**High Option**
• Chiropractic treatment limited to 24 visits and/or manipulations per year • Electrical stimulation and ultrasound therapy provided by a licensed chiropractor Note: X-ray covered under Section 5(a), *Lab, X-ray and other diagnostic tests.*	PPO: $25 copayment (No deductible) Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Massage therapy* • *Maintenance therapy*	*All charges*
Alternative treatments	**High Option**
• Acupuncture - by a doctor of medicine or osteopathy, or licensed or certified acupuncture practitioner, benefits are limited to 26 visits per person per calendar year • Dry Needling – by a licensed or certified practitioner	PPO: $25 copayment (No deductible) Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Services of any provider not listed as covered (see Covered providers, Section 3)*	*All charges*
Educational classes and programs	**High Option**
You may enroll in Quit For Life, a tobacco cessation program, by visiting www.quitnow.net for: • Telephonic and/or online counseling sessions • Group therapy sessions Note: Enrollment in the Quit For Life program must be initiated by the member.	PPO: Nothing (No deductible) Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Select over-the-counter and prescription Tobacco Cessation medications approved by the FDA to treat tobacco dependence. For a listing of medications go to our website at: https://www.apwuhp.com/members/high-option/pharmacy/ To qualify for these drugs, you need to be age 18 or older; get a prescription for these products from your doctor, even if the products are sold over-the-counter; fill the prescription at a network pharmacy.	PPO: Nothing (No deductible) Non-PPO: *All charges*
Diabetes self-management training services, up to 10 hours initial training the first year and 2 hours subsequent training annually.	PPO: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: PPO - $450 per person ($800 per Self Plus One enrollment, or $800 per Self and Family enrollment); Non-PPO - $1,000 per person ($2,000 per Self Plus One enrollment, or $2,000 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.
- 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 a physician or other healthcare professional for your surgical care. See Section 5(c) for charges associated with a facility (i.e. hospital, surgical center, etc.)
- **YOU MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES. 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.
- If you enroll in APWU Health Plan's High Option and have Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan to our PSHB members. This plan enhances your PSHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. This would be an enhancement to your APWU Health Plan's High Option benefits. It includes a $100 monthly Part B reimbursement. The UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan is subject to Medicare rules. (See Section 9 for additional details.)

Benefits 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	**High Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment of severe obesity (bariatric surgery) (requires preauthorization, see *Other services*, Section 3). For coverage policy, visit www.apwuhp.com and click on Member Resources.	PPO: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount

Surgical procedures - continued on next page

Benefits Description	You pay After the calendar year deductible…
Surgical procedures (cont.)	**High Option**
• Insertion of internal prosthetic devices (see Section 5(a), *Orthopedic and prosthetic devices,* for device coverage information) • Treatment of burns • Assistant surgeons - We cover up to 20% of our allowance for the surgeon's charge Note: For female surgical family planning procedures see Family Planning Section 5(a). Note: For male surgical family planning procedures see Family Planning Section 5(a).	PPO: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
When multiple or bilateral surgical procedures performed during the same operative session add time or complexity to patient care, our benefits are: • For the primary procedure: - PPO: 85% of the Plan allowance; or - Non-PPO: 60% of the Plan allowance • For the secondary procedure(s): - PPO: 85% of one-half of the Plan allowance or - Non-PPO: 60% of one-half of the Plan allowance Note: When multiple or bilateral surgical procedures add complexity to an operative session, the Plan allowance for the second or less expensive procedure is one-half of what the Plan allowance would have been if that procedure had been performed independently. • When a surgery requires two primary surgeons (co-surgeons), the Plan allowance for each surgeon will not exceed 62.5% of our allowance. This allowance will be further reduced by half for secondary procedures. • Multiple or bilateral surgical procedures performed through the same incision are "incidental" to the primary surgery. That is, the procedure would not add time or complexity to patient care. We do not pay extra for incidental procedures.	PPO: 15% of the Plan allowance for the primary procedure and 15% of one-half of the Plan allowance for the secondary procedure(s) Non-PPO: 40% of the Plan allowance for the primary procedure and 40% of one-half of the Plan allowance for the secondary procedure(s); and any difference between our allowance and the billed amount
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))*	*All charges*

Benefits Description	You pay After the calendar year deductible…
Reconstructive surgery	**High Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - The condition produced a major effect on the member's appearance and - The condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks (including port wine stains); and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - Surgery to produce a symmetrical appearance of breasts - Treatment of any physical complications, such as lymphedema - Breast prostheses; and surgical bras and replacements, (see Section 5(a), *Prosthetic devices*, for coverage) Note: We pay for internal breast prostheses as hospital benefits. Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	PPO: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
• Surgical treatment for gender affirmation • Gender affirming surgery benefits are only available for the diagnosis of gender dysphoria Requirements: • Prior approval is required. • Must be at least 18 years of age at time prior approval is requested and treatment plan is submitted. • Must have diagnosis of gender dysphoria by a qualified healthcare professional. • Persistent, well-documented gender dysphoria. • Member's gender dysphoria is not a symptom of another mental disorder or chromosomal abnormality. • Continuous hormone therapy as appropriate. • Two clinical assessments from qualified healthcare professionals are required for genital and gonadal surgeries, all other surgeries require one assessment. • If medical or mental health concerns are present, they are being optimally managed and are reasonably well-controlled. For coverage policy, visit www.apwuhp.com and click on Member Resources.	PPO: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount

Reconstructive surgery - continued on next page

Benefits Description	You pay After the calendar year deductible…
Reconstructive surgery (cont.)	**High Option**
Not covered: • *Cosmetic services that are not medically necessary* • *Travel and lodging*	*All charges*
Oral and maxillofacial surgery	**High Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaw or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures • Extraction of impacted (unerupted) teeth • Alveoplasty, partial ostectomy and radical resection of mandible with bone graft unrelated to tooth structure • Excision of bony cysts of the jaw unrelated to tooth structure • Excision of tori, tumors, and premalignant lesions, and biopsy of hard and soft oral tissues • Reduction of dislocations and excision, manipulation, arthrocentesis, aspiration or injection of temporomandibular joints • Removal of foreign body, skin, subcutaneous alveolar tissue, reaction-producing foreign bodies in the musculoskeletal system and salivary stones • Incision/excision of salivary glands and ducts • Repair of traumatic wounds • Sinusotomy, including repair of oroantral and oromaxillary fistula and/or root recovery • Surgical treatment of trigeminal neuralgia • Frenectomy or frenotomy, skin graft or vestibuloplasty-stomatoplasty unrelated to periodontal disease • Incision and drainage of cellulitis unrelated to tooth structure Note: Call UnitedHealthcare at 866-569-2064 to determine if a procedure is covered.	PPO: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva and alveolar bone)* • *Dental bridges, replacement of natural teeth, dental/orthodontic/ temporomandibular joint dysfunction appliances and any related expenses*	*All charges*

Oral and maxillofacial surgery - continued on next page

Benefits Description	You pay After the calendar year deductible…
Oral and maxillofacial surgery (cont.)	**High Option**
• *Treatment of periodontal disease and gingival tissues, and abscesses* • *Charges related to orthodontic treatment*	*All charges*
Organ/tissue transplants	**High Option**
These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. Refer to *Other services* in Section 3, for prior authorization procedures. Solid organ transplants are limited to: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-pancreas • Liver • Lung single/bilateral/lobar • Pancreas	PPO: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount and any amount over $50,000 for kidney transplants or $100,000 for other listed transplants
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3, for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	PPO: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount and any amount over $50,000 for kidney transplants or $100,000 for other listed transplants
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as indicated below: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin’s lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Amyloidosis	PPO: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount and any amount over $50,000 for kidney transplants or $100,000 for other listed transplants

Organ/tissue transplants - continued on next page

Benefits Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**High Option**
- Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Multiple Myeloma - Myelodysplasia/Myelodysplastic Syndromes - Myeloproliferative disorders - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia (pediatric only) - X-linked lymphoproliferative syndrome • Autologous transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced childhood kidney cancers - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin’s lymphoma with recurrence (relapsed) - Amyloidosis - Aggressive non-Hodgkin's lymphomas - Breast cancer - Childhood rhabdomyosarcoma - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Mantle cell (non-Hodgkin's lymphoma) - Medulloblastoma	PPO: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount and any amount over $50,000 for kidney transplants or $100,000 for other listed transplants

Organ/tissue transplants - continued on next page

Benefits Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**High Option**
- Multiple myeloma - Neuroblastoma - Pineoblastoma - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors - Waldenstrom's macroglobulinemia	PPO: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount and any amount over $50,000 for kidney transplants or $100,000 for other listed transplants
Mini-transplants (non-myeloablative, reduced intensity conditioning or RIC) are subject to medical necessity review by the Plan.	PPO: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount and any amount over $50,000 for kidney transplants or $100,000 for other listed transplants
These **blood or marrow stem cell transplants** are covered only in a National Cancer Institute or National Institutes of Health **approved clinical trial** or a Plan-designated center of excellence. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial.	PPO: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount and any amount over $50,000 for kidney transplants or $100,000 for other listed transplants
Transplant Network The Plan uses specific Plan-designated organ/tissue transplant facilities. Before your initial evaluation as a potential candidate for a transplant procedure, you or your doctor **must** contact the precertification vendor (see *Other services*, Section 3); UnitedHealthcare at 866-569-2064; and ask to speak to a Transplant Case Manager. You will be provided with information about transplant preferred providers. If you choose a Plan-designated transplant facility, you may receive prior approval for travel and lodging costs. Limited Benefits – If you don't use a Plan-designated transplant facility, benefits for pretransplant evaluation, organ procurement, inpatient hospital, surgical and medical expenses for covered transplants, whether incurred by the recipient or donor, are limited to a maximum of $50,000 for kidney transplants or $100,000 for each other listed transplant, including multiple organ transplants. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	PPO: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount and any amount over $50,000 for kidney transplants or $100,000 for other listed transplants
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Transplants not listed as covered*	*All charges*

Benefits Description	You pay After the calendar year deductible…
Anesthesia	**High Option**
Professional services provided in – • Hospital (inpatient)	PPO: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	PPO: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount Note: If surgical services are rendered at a PPO hospital or a PPO freestanding ambulatory facility, we will pay the services of non-PPO anesthesiologists at the PPO rate, based on Plan allowance.

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 - $450 per person ($800 per Self Plus One enrollment, or $800 per Self and Family enrollment); Non-PPO - $1,000 per person ($2,000 per Self Plus One enrollment, or $2,000 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.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- The services listed below are for the charges billed by the facility (i.e. hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e. physicians, etc.) are in Sections 5(a) or (b).
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.
- You must get prior approval for gender reassignment surgery. See Section 3 for prior approval and Section 5(b) for the surgical benefit.
- When you receive hospital observation services, we apply outpatient benefits to covered services up to 48 hours. Inpatient benefits will apply only when your physician formally admits you to the hospital as inpatient. Once you are formally admitted, your entire stay (including observation services) will be processed and paid as inpatient benefits.
- If you enroll in APWU Health Plan's High Option and have Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan to our PSHB members. This plan enhances your PSHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. This would be an enhancement to your APWU Health Plan's High Option benefits. It includes a $100 monthly Part B reimbursement. The UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan is subject to Medicare rules. (See Section 9 for additional details.)

Benefits Description	You pay
Note: The calendar year deductible applies ONLY when we say below: "(calendar year deductible applies)".	
Inpatient hospital	**High Option**
Room and board, such as: • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: We only cover a private room when you must be isolated to prevent contagion. Otherwise, we will pay the hospital's average charge for semiprivate accommodations. If the hospital only has private rooms, we will cover the private room rate.	PPO: 15% of the covered charges Non-PPO: $300 per admission and 40% of the covered charges and any difference between our allowance and the billed amount Note: For inpatient hospital care related to maternity, we pay for covered services in full when you use preferred providers, (see Section 5(a), *Maternity care*.)

Inpatient hospital - continued on next page

Benefits Description	You pay
Inpatient hospital (cont.)	**High Option**
Note: When the non-PPO hospital bills a flat rate, we prorate the charges to determine how to pay them, as follows: 30% room and board and 70% other charges.	PPO: 15% of the covered charges Non-PPO: $300 per admission and 40% of the covered charges and any difference between our allowance and the billed amount Note: For inpatient hospital care related to maternity, we pay for covered services in full when you use preferred providers, (see Section 5(a), *Maternity care.*)
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services Note: We cover appliances, medical equipment and medical supplies provided for take-home use under Section 5(a). We cover prescription drugs and medicines dispensed for take-home use under Section 5(f). Note: We base payment on whether the facility or a healthcare professional bills for the services or supplies. For example, when the hospital bills for its nurse anesthetists' services, we pay Hospital benefits and when the anesthesiologist bills, we pay Surgery benefits.	PPO: 15% of the covered charges Non-PPO: $300 per admission and 40% of the covered charges and any difference between our allowance and the billed amount. Note: For inpatient hospital care related to maternity, we pay for covered services in full when you use preferred providers, (see Section 5(a), *Maternity care.*)
Not covered: • *Any part of a hospital admission that is not medically necessary (see Section 10, Definitions), such as when you do not need acute hospital inpatient (overnight) care, but could receive care in some other setting without adversely affecting your condition or the quality of your medical care. Note: In this event, we pay benefits for services and supplies other than room and board and in-hospital physician care at the level they would have been covered if provided in an alternative setting* • *Custodial care; (see Section 10, Definitions)* • *Non-covered facilities, such as, day and evening care centers, and schools* • *Personal comfort items such as radio, television, air conditioners, beauty and barber services, guest meals and beds* • *Services of a private duty nurse that would normally be provided by hospital nursing staff* • *Take-home items*	*All charges*

Benefits Description	You pay
Cancer Centers of Excellence	**High Option**
The Plan provides access to designated Cancer Centers of Excellence. For information, you must contact UnitedHealthcare at 866-569-2064 prior to obtaining covered services. To receive the higher level of benefits for a cancer related treatment, you are required to visit a designated facility. When you contact UnitedHealthcare, you will be provided with information about the Cancer Centers of Excellence.	PPO Cancer Centers of Excellence (COE): 5% of the Plan allowance
Outpatient hospital or ambulatory surgical center	**High Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by an underlying medical condition. We do not cover the dental procedures. Note: We cover outpatient services and supplies of a hospital or free-standing ambulatory facility the day of a surgical procedure (including change of cast), hemophilia treatment, hyperalimentation, rabies shots, cast or suture removal, oral surgery, foot treatment, chemotherapy for treatment of cancer, and radiation therapy.	PPO: 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Extended care benefits/Skilled nursing care facility benefits	**High Option**
When APWU Health Plan is Primary Semiprivate room, board, services and supplies provided in a skilled nursing care facility (SNF) for up to 30 days per person per calendar year when you are admitted directly from a covered inpatient hospital stay. Your skilled nursing care is supervised by a physician and provided by an R.N., L.P.N., or L.V.N. Note: Prior approval for these services is required. Call UnitedHealthcare at 866-569-2064, (see *Other services*, Section 3). **When Medicare A or Other Insurance is Primary** Semiprivate room, board, services and supplies provided in a skilled nursing care facility (SNF) for up to 30 days per person per calendar year when you are admitted directly from a covered inpatient hospital stay.	PPO: 15% of the covered charges Non-PPO: $300 per admission and 40% of the covered charges and any difference between our allowance and the billed amount Note: If enrolled in Medicare A, we waive the deductible and coinsurance.

Extended care benefits/Skilled nursing care facility benefits - continued on next page

Benefits Description	You pay
Extended care benefits/Skilled nursing care facility benefits (cont.)	**High Option**
Note: If Medicare pays the first 20 days in full, Plan benefits will begin on the 21st day (when Medicare Part A coinsurance begins) and will end on the 30th day.	PPO: 15% of the covered charges Non-PPO: $300 per admission and 40% of the covered charges and any difference between our allowance and the billed amount Note: If enrolled in Medicare A, we waive the deductible and coinsurance.
Not covered: • *Custodial care (see Section 10, Definitions)* • *All charges after 30 days per person per calendar year*	*All charges*
Hospice care	**High Option**
Hospice is a coordinated program of home and inpatient supportive care for the terminally ill patient and the patient's family provided by a medically supervised specialized team under the direction of a duly licensed or certified Hospice Care Program. • We pay up to $15,000 lifetime maximum for combined outpatient and inpatient services, which includes advance care planning • We pay a $200 annual bereavement benefit per family unit	Any amount over the maximums shown
End of life care	**High Option**
End of life care • See *Hospice care* benefit, which includes advance care planning, (see above).	Any amount over the maximums shown
Ambulance	**High Option**
• Local professional ambulance service when medically appropriate immediately before, during or after an inpatient admission	PPO: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Ambulance service used for routine transport*	*All charges*

Section 5(d). Emergency services/accidents

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.
- The calendar year deductible is: PPO - $450 per person ($800 per Self Plus One enrollment, or $800 per Self and Family enrollment); Non-PPO - $1,000 per person ($2,000 per Self Plus One enrollment, or $2,000 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 for emergency services, the emergency room physician who provides the services to you in the emergency room may not be a preferred provider. If they are not, they will be paid by this Plan as a PPO provider at the PPO rate, based on the Plan allowance.
- 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.
- When multiple or bilateral surgical procedures add complexity to an operative session, the Plan allowance for the second or less expensive procedure is one-half of what the Plan allowance would have been if that procedure had been performed independently.
  - When a surgery requires two primary surgeons (co-surgeons), the Plan allowance for each surgeon will not exceed 62.5% of our allowance. This allowance will be further reduced by half for secondary procedures.
  - Multiple or bilateral surgical procedures performed through the same incision are "incidental" to the primary surgery. That is, the procedure would not add time or complexity to patient care. We do not pay extra for incidental procedures.
- If you enroll in APWU Health Plan's High Option and have Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan to our PSHB members. This plan enhances your PSHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. This would be an enhancement to your APWU Health Plan's High Option benefits. It includes a $100 monthly Part B reimbursement. The UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan is subject to Medicare rules. (See Section 9 for additional details.)

What is an accidental injury?

An accidental injury is a bodily injury sustained solely through violent, external, and accidental means, such as broken bones, animal bites, and poisonings.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts, broken bones and mental health related care. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action. If you are unsure of the severity of a condition in terms of this benefit, the Plan recommends that you first call UnitedHealthcare's 24-hour NurseLine at 866-569-2064, or your physician.

Benefits 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	**High Option**
If you receive care for your accidental injury within 72 hours, we cover: • Physician services and supplies • Related outpatient hospital services • Air ambulance to nearest facility where necessary treatment is available is covered if no emergency ground transportation is available or suitable and the patient's condition warrants immediate evacuation. Air ambulance will not be covered if transport is beyond the nearest available suitable facility, but is requested by patient or physician for continuity of care or other reasons Note: See Section 5(c) for hospital benefits if you are admitted. Services received after 72 hours are considered the same as any other illness and regular Plan benefits will apply.	PPO: Nothing (No deductible) Non-PPO: Nothing (No deductible)
If you receive care for your accidental injury within 72 hours, we cover: • Professional Ambulance Services	PPO: Nothing Non-PPO: Only the difference between our allowance and the billed amount (No deductible)
Medical emergency	**High Option**
Outpatient facility charges including medical or surgical services and supplies **in an Urgent Care Center** Note: High technology radiology/imaging services including CT/CAT Scan, MRI, MRA, Nuclear Cardiology and PET are subject to coinsurance and deductible (outpatient requires precertification except for Nuclear Cardiology), (see Section 5(a)).	PPO: $30 copayment (No deductible) Non-PPO: 40% of the Plan allowance 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: 15% of the Plan allowance Non-PPO: 15% of the Plan allowance
Ambulance	**High Option**
Professional ambulance services within 24 hours of a medical emergency Note: See Section 5(c) for non-emergency service.	PPO: 15% of the Plan allowance (No deductible) Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)
Air ambulance	**High Option**
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.	PPO: 15% of the Plan allowance (No deductible) Non-PPO: 15% of the Plan allowance (No deductible)
Not covered: • *Non-emergent Air ambulance* • *Emergent transport beyond the nearest suitable facility*	*All charges*

Air ambulance - continued on next page

Benefits Description	You pay After the calendar year deductible…
Air ambulance (cont.)	**High Option**
• *Air ambulance requested by patient or physician which are beyond the nearest facility for continuity of care or other reasons*	*All charges*

Section 5(e). Mental Health and Substance Use Disorder Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: PPO - $450 per person ($800 per Self Plus One enrollment, or $800 per Self and Family enrollment); Non-PPO - $1,000 per person ($2,000 per Self Plus One enrollment, or $2,000 per Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- The calendar year deductible or, for facility care, the inpatient deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when a deductible does not apply.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOU MUST GET PREAUTHORIZATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.
- To obtain preauthorization of an admission for mental conditions or substance use disorder treatment, call UnitedHealthcare at 866-569-2064.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.
- We do not make available provider directories for mental health or substance use disorder treatment providers. To find a mental health or substance use disorder treatment provider, call APWU Health Plan at 800-222-2798 or visit our website at www.apwuhp.com.
- Schools or other educational institutions are not covered.
- If you enroll in APWU Health Plan's High Option and have Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan to our PSHB members. This plan enhances your PSHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. This would be an enhancement to your APWU Health Plan's High Option benefits. It includes a $100 monthly Part B reimbursement. The UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan is subject to Medicare rules. (See Section 9 for additional details.)

Benefits 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	**High Option**
We cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
In a physician's office * • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment to address gender dysphoria (in-network only), (see Section 5(b) and 5(c) for exclusions) • Diagnosis and treatment of substance use disorders (outpatient) • Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: - Diagnostic evaluation - Crisis intervention and stabilization for acute episodes - Medication evaluation and management (pharmacotherapy) • Professional charges for intensive outpatient treatment in a provider's office or other professional setting (preauthorization required by UnitedHealthcare) * Professional services of a physician via Telehealth/Telemedicine are covered the same as in a physician's office.	PPO: $25 copayment (No deductible) Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed charges
Professional and other services for the diagnosis and treatment of psychiatric conditions, mental illness or mental disorders: • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Diagnosis and treatment of substance use disorders, including detoxification, treatment and counseling (inpatient) • Repetitive Transcranial Magnetic Stimulation, TMS, for the treatment of depressive disorders which have not been responsive to other interventions such as psychotherapy and antidepressant medications (preauthorization required by UnitedHealthcare) • Electroconvulsive therapy Note: Applied Behavioral Analysis (ABA) therapy benefit is listed in Section 5(a), *Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals*.	PPO: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed charges

Benefits Description	You pay After the calendar year deductible…
TeleHealth services	**High Option**
Virtual visits through Teladoc for non-emergency visits. Covered services include consultation, diagnosis and prescriptions (when appropriate) through the web or your mobile device. Note: Telehealth services are available in most states, but some states do not allow telehealth or prescriptions per state regulations. Please visit www.teladoc.com, or call 800-835-2362 to start your virtual visit. Note: There are no out-of-network benefits for Virtual visits.	Teladoc: Nothing (no deductible) for first 2 visits $10 copayment (no deductible) after first 2 visits
Diagnostics	**High Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility	PPO: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed charges
Inpatient hospital or other covered facility	**High Option**
Inpatient services provided and billed by a hospital, Residential Treatment Center (RTC), or other covered facility (preauthorization required by UnitedHealthcare) • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services • Inpatient diagnostic tests provided and billed by a hospital, Residential Treatment Center (RTC), or other covered facility	PPO: 15% of the Plan allowance (No deductible) Non-PPO: After $300 per admission, 40% of our allowance and any difference between our allowance and the billed charges (No deductible)
Not covered: • *For Residential Treatment Centers, benefits are not available for non-covered services, including: respite care; outdoor residential programs; services provided outside of the provider's scope of practice; recreational therapy; educational therapy; educational classes; bio-feedback; Outward Bound programs; equine therapy provided during the approved stay; personal comfort items, such as guest meals and beds, telephone, television, beauty and barber services, which may be part of the treatment program's milieu and/or physical environment, are not covered as separately billed items; custodial or long term care; and domiciliary care provided because care in the home is not available or is unsuitable.*	*All charges*
Outpatient hospital or other covered facility	**High Option**
Outpatient services provided and billed by a hospital or other covered facility • Services such as partial hospitalization or full-day hospitalization (preauthorization required by UnitedHealthcare) • Facility-based intensive outpatient treatment (preauthorization required by UnitedHealthcare)	PPO: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed charges

Outpatient hospital or other covered facility - continued on next page

Benefits Description	You pay After the calendar year deductible…
Outpatient hospital or other covered facility (cont.)	**High Option**
Not covered: • *Services that require preauthorization that are not part of a preauthorized approved treatment plan* • *Services that are not medically necessary* • *Services performed at schools or other education institutions*	*All charges*

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.
- Your prescribers must 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 Section 5(f), *Prescription Drug Utilization Management*, for more information about this program.
- If you enroll in APWU Health Plan's High Option and have Medicare Parts A and B and it is primary, we offer a UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan to our PSHB members. This plan enhances your PSHB coverage by reducing/eliminating cost-sharing for services and/or adding benefits at no additional cost. This would be an enhancement to your APWU Health Plan's High Option benefits. It includes a $100 monthly Part B reimbursement. The UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan is subject to Medicare rules. See Section 9 for additional details.

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/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication.
- **Where can you obtain them.** You can fill the prescription at an Express Scripts network pharmacy, a non-network pharmacy, or by mail. We pay our highest level of benefits for mail order and you should use the mail order program to obtain your maintenance medications.
- You may only obtain a 30-day supply and one refill of maintenance prescriptions at a network pharmacy participating with Express Scripts. After two courtesy 30-day fills at regular network retail, you will pay the non-network pharmacy benefit level.
- You may purchase maintenance prescription medications (non-specialty drugs that you take regularly for ongoing conditions, for a 90-day supply) from a participating Smart90® Retail Network pharmacy or Express Scripts mail order.
- To find a Smart90® Retail Network pharmacy that participates in filling 90-day supplies, log in or register at www.express-scripts.com/rx, select "Manage Prescriptions," and look for a link directing you to the Participating Smart90® Retail Network pharmacies, or call 866-890-1419. The pharmacy can tell you how to transfer your non-specialty maintenance medication prescription or start a new one. If you continue to use a non-participating Smart90® pharmacy, you will pay the non-network pharmacy benefit level.
- Your copayment for your 90-day supply will be the same whether you fill your prescription through Express Scripts Mail order or at a participating Smart90® Retail Network pharmacy.

- **We have a managed 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 prescribers if they feel the formulary alternatives are not appropriate. Prescribers may request a clinical exception by calling 800-753-2851. During the year, the Plan's formulary may change.
- Member cost-share for prescription drugs is determined by the tier to which a drug has been assigned. To determine the tier assignments for formulary drugs, our Pharmacy Benefit Managers (PBM) work with their Pharmacy and Therapeutic Committee, a group of physicians and pharmacists who are not employees or agents of, nor have financial interest in the Plan. The Committee's recommendations, together with our PBM's evaluation of the relative cost of the drugs, determine the placement of formulary drugs on a specific tier. Using lower cost preferred drugs will provide you with a high quality, cost-effective prescription drug benefit. You can view a list on our website at www.apwuhp.com/high_option_pharmacy_program.php.
- Our payment levels are generally categorized as:
  - Tier 1 Includes generic drugs
  - Tier 2 Includes preferred brand name drugs
  - Tier 3 Includes non-preferred brand name drugs
  - Tier 4 Includes generic specialty drugs
  - Tier 5 Includes preferred brand name specialty drugs
  - Tier 6 Includes non-preferred brand name specialty

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 generally less expensive than brand drugs, therefore, you may reduce your out-of-pocket-expenses by choosing to use a generic drug.
- A generic equivalent will be dispensed if it is available, unless your prescriber specifically requires a brand name drug. If you receive a brand name drug when a FDA approved generic drug is available, and your prescriber has not received a preauthorization, you have to pay the difference in cost between the name brand drug and the generic, in addition to your coinsurance. However, if your doctor obtains preauthorization because it is medically necessary that a brand name drug be dispensed, you will not be required to pay this cost difference. Your doctor may seek preauthorization by calling 800-753-2851.
- The Plan may have certain coverage limitations to ensure clinical appropriateness. For example, prescription drugs used for cosmetic purposes may not be covered, a medication might be limited to a certain amount (such as the number of pills or total dosage) within a specific time period, or require authorization to confirm clinical use based on FDA labeling. In these cases, you or your prescriber can begin the coverage review process by calling Express Scripts Customer Service at 800-841-2734.

These are the dispensing limitations:

- The Express Scripts Retail Network – you may obtain up to a 30-day supply plus one 30-day refill for each prescription purchased from an Express Scripts network pharmacy. After one 30-day refill, you must obtain a new prescription and either purchase your non-specialty maintenance prescription medications (drugs you take regularly for ongoing conditions) at either a participating Smart90 Retail Network pharmacy or the Express Scripts mail order. If you do not, we will pay the non-network pharmacy benefit level. To receive maximum savings you must present your card at the time of each purchase, and your enrollment information must be current and correct. In most cases, you simply present the card together with the prescription to the pharmacist. Refills cannot be obtained until 75% of the drug has been used.

- Exceptions for special circumstances – the Plan will authorize up to a 90-day supply at a network pharmacy for covered persons called to active military service. Also, the Plan will authorize an extra 30-day supply, either at network retail or Home Delivery, for civilian Government employees who are relocated for assignment in the event of a national emergency. Authorization may be obtained from Express Scripts at 800-841-2734 or from the Plan at 800-222-2798.
- Non-network pharmacy – if you do not use your identification card, if you elect to use a non-network pharmacy, or if an Express Scripts network pharmacy is not available, you will need to file a claim and we will pay at the non-network retail pharmacy benefit level.
- Mail order – through this program, you may receive up to a 90-day supply of maintenance medications for drugs which require a prescription, diabetic supplies and Insulin, syringes and needles for covered injectable medications, and oral contraceptives. Some medications may not be available in a 90-day supply from Express Scripts by Mail even though the prescription is for 90 days.
- Refills for maintenance medications are not considered new prescriptions except when the doctor changes the strength or 180 days has elapsed since the previous purchase. Refill orders submitted too early after the last one was filled are held until the right amount of time has passed. As part of the administration of the prescription drug program, we reserve the right to maximize your quality of care as it relates to the utilization of pharmacies.
- You may fill your prescription at any pharmacy participating in the Express Scripts system. For the names of participating pharmacies, call 800-841-2734, or go to www.express-scripts.com.

Certain controlled substances and several other prescribed medications may be subject to other dispensing limitations, such as quantities dispensed, and to the judgment of the pharmacist.

Benefits Description	You pay After the calendar year deductible…
The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Covered medications and supplies	**High Option**
Each new enrollee will receive a description of our prescription drug program, a prescription drug/Plan identification card, a mail order form/ patient profile and a pre-addressed reply envelope. You may purchase the following medications and supplies prescribed from either a pharmacy or by mail: • Drugs and medications, for use at home that are obtainable only upon a doctor's prescription and listed in official formularies • Drugs and medications (including those administered during a non-covered admission or in a non-covered facility) that by Federal law of the United States require a prescription for their purchase, except those listed as not covered • Insulin, Insulin Pump supplies and test strips for known diabetics • Disposable needles and syringes for the administration of covered medications • Approved drugs for organic impotence such as Viagra and Levitra are subject to prior authorization, (see Section 3, *Other services* and Section 5(f), *Prescription Drug Utilization Management*) • Drugs that could be used for cosmetic purposes such as Retin A or Botox (requires prior authorization, see Section 3, *Other services* and Section 5(f), *Prescription Drug Utilization Management*) • Drugs to treat gender dysphoria. See Section 5(b), *Reconstructive Surgery*, for gender affirming care. • FDA-approved drugs for weight management (requires prior authorization, see *Prescription Drug Utilization Management*).	• **Network Retail**: $10 Tier 1. 25% Tier 2 up to a maximum of $200 coinsurance per prescription for a 30-day supply. 45% Tier 3 up to a maximum of $300 coinsurance per prescription for a 30-day supply • **Non-network Retail**: 50% of cost for a 30-day supply • **Network Mail Order**: $20 Tier 1. 25% Tier 2 up to a maximum of $300 coinsurance per prescription for a 90-day supply. 45% Tier 3 up to a maximum of $500 coinsurance per prescription for a 90-day supply

Covered medications and supplies - continued on next page

Benefits Description	You pay After the calendar year deductible…
Covered medications and supplies (cont.)	**High Option**
• Medications prescribed to treat obesity.	• **Network Retail**: $10 Tier 1. 25% Tier 2 up to a maximum of $200 coinsurance per prescription for a 30-day supply. 45% Tier 3 up to a maximum of $300 coinsurance per prescription for a 30-day supply • **Non-network Retail**: 50% of cost for a 30-day supply • **Network Mail Order**: $20 Tier 1. 25% Tier 2 up to a maximum of $300 coinsurance per prescription for a 90-day supply. 45% Tier 3 up to a maximum of $500 coinsurance per prescription for a 90-day supply
Diabetes medications and supplies • Certain Insulins and non-Insulin Diabetes drugs to treat diabetes For a list of Insulins and non-Insulin Diabetes drugs with fixed copays, go to www.apwuhp.com/members/high-option/pharmacy/ Note: Standard Plan coinsurance applies to all other covered diabetic medications and supplies. Note: Standard dispensing limitations apply (see Section 5(f), *Brand/ Generic Drugs*).	• **Network Retail:** $25 copay for a 30-day supply • **Network Mail Order:** $75 copay for a 90-day supply
Diabetic medications and supplies • Oral Generic medications for the specific purpose of lowering blood sugar • Formulary blood glucose test strips and lancets	• **Network Mail Order:** $0
Specialty Prescription Drugs • Specialty drugs must be obtained through Accredo Specialty Pharmacy. This benefit pertains to specialty drugs administered either at home or in an outpatient setting. Note: See *Prescription Drug Utilization Management* for definition. Note: If your specialty medication is available through Accredo Specialty Pharmacy and you do not obtain your medication through Accredo Specialty Pharmacy, you will be responsible for the full cost of your medication.	• **Network Retail**: 25% Tier 4 with up to a maximum of $300 per prescription for a 30-day supply. 25% Tier 5 up to a maximum of $600 coinsurance per prescription for a 30-day supply. 45% Tier 6 up to a maximum of $1,000 coinsurance per prescription for a 30-day supply • **Non-network Retail**: 50% of cost for a 30-day supply • **Network Mail Order**: 25% Tier 4 with up to a maximum of $150 per prescription for a 90-day supply. 25% Tier 5 up to a maximum of $300 coinsurance per prescription for a 90-day supply. 45% Tier 6 up to a maximum of $500 coinsurance per prescription for a 90-day supply
Contraceptive drugs and devices as listed on the Health Resources and Services Administration site www.hrsa.gov/womens-guidelines.	• **Network Retail:** $0 • **Network Mail order:** $0

Covered medications and supplies - continued on next page

Benefits Description	You pay After the calendar year deductible…
Covered medications and supplies (cont.)	**High Option**
Contraceptive coverage is available at no cost to PSHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. Over-the-counter and prescription drugs approved by the FDA to prevent unintended pregnancies. • In-network prescription drugs from Express Script's Patient Protection and Affordable Care Act (PPACA) Preventive Contraceptive Drug List for contraception. Find list at www.apwuhp.com. • A formulary exception process is available to prescribers if they feel the formulary alternatives are not appropriate. Prescribers should request a clinical exception by calling 800-753-2851. Once your physician receives prior authorization, the contraceptive drug not on the PPACA list will be dispensed and you will pay $0. Express Scripts responds to contraception exception requests within 24 hours of receipt of sufficient information to make a coverage determination. • Reimbursement for covered over-the-counter contraceptives can be submitted in accordance with Section 7. Note: If you have concerns about the Health Plan's compliance with the ACA/HRSA requirements or have difficulty accessing contraceptive coverage or other reproductive healthcare, contact contraception@opm.gov. See OPM's web page about contraception. Note: For additional Family Planning benefits see Section 5(a) Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation Educational Classes and Programs in Section 5(a)	• **Network Retail:** $0 • **Network Mail order:** $0
Opioid rescue agents such as naloxone are covered under this Plan with no cost-sharing when obtained from an in-network pharmacy in any over-the-counter or prescription form available such as nasal sprays and intramuscular injections. For more information consult the FDA guidance at www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to https://www.findtreatment.samhsa.gov/	**Network Retail:** Nothing **Non-network Retail**: 50% of cost for a 30-day supply **Network Mail Order:** Nothing
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Vitamins, nutrients and food supplements not listed as a covered benefit even if a doctor prescribes or administers them* • *Medical supplies such as dressings and antiseptics* • *Nonprescription medications/over-the-counter drugs, except as stated below:*	*All charges*

Covered medications and supplies - continued on next page

Benefits Description	You pay After the calendar year deductible…
Covered medications and supplies (cont.)	**High Option**
- *Over-the counter emergency contraceptive drugs, the "morning after pill", are covered at no cost if prescribed by a doctor and purchased at a network pharmacy* - *Over-the-counter FDA-approved contraception methods are covered at no cost if prescribed by a doctor and purchased at a network pharmacy* • *Prescription drugs approved by the U.S. Food and Drug Administration when an over-the-counter equivalent is available.*	*All charges*
Preventive care medications	**High Option**
The following are covered: • Medications to promote better health as recommended by ACA. • Preventive Medications with USPSTF A and B recommendations. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations	**Network Retail:** Nothing when prescribed by a healthcare professional and filled by a network pharmacy. **Non-network Retail:** 50% of cost for a 30-day supply

Prescription Drug Utilization Management

- The information below describes a feature of your prescription drug plan known as utilization management. Utilization management programs help to ensure you are taking safe and effective medications at a reasonable cost.
- Some medications require a prior authorization and are not covered unless you receive approval through a coverage review (prior authorization). Examples of drug categories that require a coverage review include but are not limited to, growth hormones, Botox, Interferons, rheumatoid arthritis agents, Retin A, drugs for organic impotence/sexual disorders, FDA approved drugs for weight management, gender dysphoria and gender transition, blood disorders treatment, pain treatment, cardiovascular disease, respiratory disease treatment, skin conditions, ophthalmic conditions, neuromuscular, mental/neurological, renal disease, anti infectives, gastrointestinal and endocrine. This review uses Plan rules based on FDA-approved prescribing and safety information, clinical guidelines and uses that are considered reasonable, safe and effective. There are other medications that may be covered with limits (for example, only for a certain amount or for certain uses) unless you receive approval through a review. During this review, Express Scripts asks your doctor for more information than what is on the prescription before the medication may be covered under your plan. If coverage is approved, you simply pay your normal copayment for the medication. If coverage is not approved, you will be responsible for the full cost of the medication.
- In our ongoing effort to provide a robust yet cost-effective prescription drug benefit, APWU Health Plan participates in programs to encourage the prescribing and use of generics and lower-cost alternative brands when appropriate. In most cases, you save money when the preferred generic or formulary brand is dispensed. Step therapy helps to ensure that your prescriber considers cost-effective alternatives before prescribing more expensive medications. If you have received one or more of the less costly alternatives in the past, you will be able to get your medicine at the pharmacy without any delay. Currently the Plan offers step therapy programs on specialty cholesterol, hypnotic, osteoporosis, migraine, glaucoma, hypoglycemic, Non Steroidal Anti-Inflammatory (NSAID's), COX-2 Inhibitors, nasal steroids, Proton Pump Inhibitors (PPI's), oral Tetracyclines, topical acne, topical Corticosteroids, topical Immunomodulator medications, allergies, respiratory conditions, stimulants, bone conditions, genitourinary conditions, diabetes, endocrine disorders, blood disorders, cardiovascular disease, inflammatory conditions, depression, metabolic disorders, pain, gastrointestinal disorders, mental/neurological, electrolyte imbalance, BPH, hypertension, and vitamin deficiency. In situations where your prescribed drug is targeted and there is no history of a first line agent, a new prescription for a first line agent will need to be obtained or a coverage review will be necessary for coverage of your medication. If the coverage review is approved, the member is responsible for the normal coinsurance found in Section (f), *Covered medications and supplies*. If the coverage review is denied, the member is responsible for the full cost of the drug. If the member does not first obtain the coverage review (prior authorization) approval, they will pay the full cost of the drug. Coverage reviews can be initiated by the member, pharmacist, or doctor by calling Express Scripts at 800-841-2734.
- The APWU Health Plan prescription benefit plan will no longer cover prescriptions for certain compound medications. The U.S. Food and Drug Administration (FDA) defines a compound medication as one that requires a licensed pharmacist to combine, mix or alter the ingredients of a medication when filling a prescription. The FDA does not verify the quality, safety and/or effectiveness of compound medications, therefore the Plan will no longer cover certain compounded prescriptions unless FDA approved. To avoid paying the full cost of these medications, you should ask your doctor for a new prescription for a manufactured FDA-approved drug before your next fill.
- The Plan will participate in other approved managed care programs to ensure patient safety and appropriate therapy in accordance with the Plan rules based on FDA guidelines referenced above.
- To find out more about your prescription drug plan, please visit Express Scripts online at www.express-scripts.com or call Express Scripts Member Services at 800-841-2734.
- **"Specialty Drugs"** are injectable, infused, oral or inhaled drugs defined as having one or more of several key characteristics: (1) requires frequent dosing adjustments and intensive clinical monitoring to decrease potential for drug toxicity and increase probability for beneficial treatment outcomes; (2) need for intensive patient training and compliance assistance to facilitate therapeutic goals; (3) limited or exclusive product availability and distribution; (4) specialized product handling and/or administration requirements.

Some examples of the disease categories currently in Express Scripts specialty pharmacy programs include cancer, cystic fibrosis, Gaucher disease, growth hormone deficiency, hemophilia, immune deficiency, hepatitis C, infertility, multiple sclerosis and rheumatoid arthritis.

In addition, a follow-on-biologic or generic product will be considered a Specialty Drug if the innovator drug is a Specialty Drug.

Many of the Specialty Drugs covered by the Plan fall under the Prescription Drug Utilization Management program mentioned. Many of the Specialty medications must be obtained through Accredo. You can send your prescription through your normal mail service process or have your physician fax your prescription to Accredo.

You or your prescriber must contact Accredo at 844-581-4862 to determine if a specialty medication that you are receiving from the physician's office or outpatient setting must be obtained through Accredo Specialty Pharmacy. Contact Accredo to speak to a representative to inquire how your medication can be obtained through Accredo and possibly administered at home using Accredo nursing services. If your specialty medication is available through Accredo Specialty Pharmacy and you do not obtain your medication through Accredo Specialty Pharmacy, you will be responsible for the full cost of the medication.

- **For Medicare Part B insurance coverage.** If Medicare Part B is primary, ask about your options for submitting claims for Medicare-covered medications and supplies, whether you use a Medicare-approved supplier or Express Scripts by Mail. Prescriptions typically covered by Medicare Part B include diabetes supplies (test strips and meters), specific medications used to aid tissue acceptance (such as with organ transplants), certain oral medications used to treat cancer, and ostomy supplies.
- **When you do have to file a claim.** Use a Prescription Drug Claim Form to claim benefits for prescription drugs and supplies purchased from a non-network pharmacy. You may obtain forms by calling 800-222-2798 or from our website at www.apwuhp.com. Your claim must include receipts that show the prescription number, the National Drug Code (NDC) number, name of the drug, prescriber's name, date of purchase and charge for the drug. Mail the claim form and receipt(s) to:

  APWU Health Plan
  P.O. Box 8660, Elkridge, MD 21075

Section 5(f)(a). PDP EGWP Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- These prescription drug benefits are for members enrolled in our Medicare Part D Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP).
- Express Scripts Medicare (PDP) is the administrator for this plan.
- If you are a Postal Service annuitant and their covered Medicare-eligible family member, you will be automatically group enrolled in our PDP EGWP. Contact Express Scripts Medicare Customer Service at 844-818-8790 for additional information.

Note: Notify us as soon as possible if you or your eligible family member is already enrolled in a Medicare Part D Plan. Enrollment in our PDP EGWP will cancel your enrollment in another Medicare Part D plan.

There are advantages to being enrolled in our PDP EGWP:

- In our PDP EGWP, your cost-share for covered drugs, medications, and supplies will be equal to or better than the cost-share for those enrolled in our standard non-PDP EGWP Prescription Drug Program.
- In our PDP EGWP, you have a pharmacy network that may include pharmacies that are out-of-network or excluded for those enrolled in our standard non-PDP EGWP Prescription Drug Program.
- There is custom coverage which includes coverage for some non-Medicare Part D prescription drugs. Please contact customer service for additional information.
- Prescriptions purchased at out-of-network pharmacies are only covered in emergency situations.

Out-of-Network Coverage:

You must use Express Scripts Medicare network pharmacies to fill your prescriptions. Covered Medicare Part D drugs are available at out-of-network pharmacies only in special circumstances, such as illness while traveling outside of the plan's service area where there is no network pharmacy. You generally have to pay the full cost for drugs received at an out-of-network pharmacy at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. Contact Express Scripts Medicare Customer Service at 844-818-8790 for additional information.

We cover drugs, medications, and supplies as described below and on the following pages.

- 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.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused drugs, medications, and supplies.
- The Medicare Part D calendar year deductible is: $0 per person. This deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage.

Warning: If you opt out of or disenroll from our PDP EGWP, you will not have any PSHB Program prescription drug coverage. However, you can enroll in our High Option MAPD during Open Season or for a **qualifying life event (QLE)** and receive PSHB Program Prescription Drug Coverage. Call APWU Health Plan at 800-222-2798 for more information.

Note: If you choose to opt out of or disenroll from our PDP EGWP, your premium will not be reduced, and you may have to wait to re-enroll during Open Season or for a QLE. If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Call APWU Health Plan at 800-222-2798 for more information.

Each new enrollee will receive a description of our PDP EGWP Summary of Benefits, a combined prescription drug/Plan identification card, a mail order form/patient profile and a pre-addressed reply envelope.

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/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication. Your prescribers must have Medicare-approved prescriptive authority.
- **Where you can obtain prescription drugs.** You may fill prescriptions at any network pharmacy. For assistance locating a PDP EGWP network pharmacy, visit our website at www.apwuhp.com or call Express Scripts Medicare (PDP) at 844-818-8790.
- **We have a managed formulary.** Your provider may prescribe drugs that are subject to additional review to determine they are medically necessary. You may view our formulary on our website at www.apwuhp.com or call Express Scripts Medicare (PDP) at 844-818-8790.
- **These are the dispensing limitations**:
  - The Express Scripts Retail Network – you may obtain up to a 90-day supply from participating retail pharmacy.
  - Mail order – through this program, you may receive up to a 90-day supply of maintenance medications for drugs which require a prescription, diabetic supplies and Insulin, syringes and needles for covered injectable medications, and oral some medications may not be available in a 90-day supply from Express Scripts by Mail even though the prescription is for 90 days.
  - Certain controlled substances and several other prescribed medications may be subject to other dispensing limitations, such as quantities dispensed, and to the judgment of the pharmacist.
  - Refills cannot be obtained until 70% of the drug has been used.
- **We may require Utilization Management strategies**:
  - **Step Therapy** – A utilization tool that requires you to first try another drug to treat your medical condition, before coverage of the drug your physician may have initially prescribed is approved.
  - **Prior Authorization** – A type of plan restriction requiring approval in advance to get certain drugs. Express Scripts may ask your physician for more information than what is on the prescription before the medication is approved for coverage.
  - **Quantity Limits** – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug covered per prescription or for a defined period of time.
- **You may request a Formulary Exception.** Call Express Scripts Medicare (PDP) at 844-818-8790.
- **A generic equivalent will be dispensed if it is available** unless your physician specifically requires a brand name drug. If you receive a brand name drug when an FDA approved generic drug is available, and your physician has not specified Dispense as Written for the brand name drug, you have to pay the difference in cost between the brand name drug and the generic.
- **Why use generic drugs.** A generic drug is a prescription drug that has the same active ingredients as the brand-name drug. Generally, generics work just as well as the brand-name drugs and usually cost less. There are generic drug substitutes available for many brand-name drugs.
- **When you do have to file a claim.** You may request Express Scripts to pay you back by sending the request in writing. If you send a request in writing, send your receipt documenting the payment you have made. It's a good idea to make a copy of your receipts for your records. **You must submit your claim to Express Scripts within 36 months** of the date you received the service, item or drug. To make sure you are giving Express Scripts all the information needed to make a decision, you can fill out our claim form to make your request for payment.
  - You don't have to use the form, but it will help us process the information faster.

- Either download a copy of the form from our website, express-scripts.com, or call Customer Service and ask for a "Direct Claim"
- Mail your request for payment, together with any bills or paid receipts, to us at this address: **Express Scripts, Attn: Medicare Part D, Box 14718, Lexington, KY 40512-4718**
- You also have the option of faxing your claim form and receipts to **1-608-741-5483.** Please be sure to contact Express Scripts Customer Service if you have any questions. If you don't know what you should have paid, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

- **If we deny your claim and you want to appeal**, you, your representative, or your prescriber must request an appeal following the process described in Section 8(a). Medicare PDP EGWP Disputed Claims Process. The PDP EGWP appeals process has 5 levels. If you disagree with the decision made at any level of the process, you can generally go to the next level. At each level, you'll get instructions in the decision letter on how to move to the next level of appeal.

PDP EGWP Catastrophic Maximum

You will have a separate $2,000 out-of-pocket maximum for your prescription costs. Once you reach this maximum, you will no longer pay a cost share for covered drugs. Your portion of this $2,000 will also apply to the Plan's out-of-pocket maximum. See Section 4 for details on the out-of-pocket maximum.

Benefits Description	You pay After the calendar year deductible…
The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Covered medications and supplies	**High Option**
You may purchase the following medications and supplies prescribed by a physician from either a pharmacy or by mail: • Drugs and medications (including those administered during a non-covered admission or in a non-covered facility) that by Federal law of the United States require a physician's prescription for their purchase, except those listed as Not covered. • Insulin • Diabetic supplies limited to: - Disposable needles and syringes for the administration of covered medications • Drugs to treat gender dysphoria. The Plan covers medications used for gender affirming care, including anti-androgens, estrogens, and testosterone. • Medications prescribed to treat obesity. See Section 5(h), *Wellness and Other Special Features* • Medical Foods (medical foods are excluded from coverage, see Section 5(a), *Treatment Therapies*) • Sexual dysfunction drugs. Select erectile dysfunction and sexual desire disorder drugs are covered under the plan with quantity limits in place. Please contact customer service for more information. • Select fertility drugs are covered under the plan. Please contact customer service for more information.	**Retail:** • **Up to 30-day supply:** Tier 1 - $10. Tier 2 - 25% of Plan allowance up to a maximum of $200 per prescription for a 30-day supply. Tier 3 - 25% of Plan allowance up to a maximum of $300 per prescription for a 30-day supply. Tier 4 - 25% of Plan allowance up to a maximum of $300 per prescription for a 30-day supply. • **Up to 90-day supply**: Tier 1 - $20. Tier 2 - 25% of Plan allowance up to a maximum of $300 per prescription for a 90-day supply. Tier 3 - 25% of Plan allowance up to a maximum of $500 per prescription for a 90-day supply. Tier 4 - 25% of Plan allowance up to a maximum of $300 per prescription for a 90-day supply. **Mail Order:** • **Up to a 90-day supply:** Tier 1 - $20. Tier 2 - 25% of Plan allowance up to a maximum of $300 per prescription. Tier 3 - 25% of Plan allowance up to a maximum of $500 per prescription. Tier 4 - 25% up to a maximum of $150 per prescription.
Diabetes medications and supplies • Certain Insulins and non-Insulin Diabetes drugs to treat diabetes • For a list of Insulins and non-Insulin Diabetes drugs with fixed copays, go to https://apwuhp.com/members/high-option/pharmacy/ • All other insulin:	**Network Retail:** $25 copay for a 30-day supply **Network Mail Order:** $75 copay for a 90-day supply

Covered medications and supplies - continued on next page

Benefits Description	You pay After the calendar year deductible…
Covered medications and supplies (cont.)	**High Option**
- You pay: $35 for a 30-day supply and $105 for a 90-day supply - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan. Note: Standard Plan coinsurance applies to all other covered diabetic medications and supplies. Note: Standard dispensing limitations apply (see Section 5(f), *Brand/ Generic Drugs*).	**Network Retail:** $25 copay for a 30-day supply **Network Mail Order:** $75 copay for a 90-day supply
Diabetic medications and supplies • Oral Generic medications for the specific purpose of lowering blood sugar • Formulary blood glucose test strips and lancets	**Network Mail Order:** $0
Contraceptive drugs and devices as listed in the Health Resources and Services Administration site https://www.hrsa.gov/womens-guidelines. Contraceptive coverage is available at no cost to PSHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. • Over-the-counter and prescription drugs approved by the FDA to prevent unintended pregnancies. • In-network prescription drugs from Express Script's Patient Protection and Affordable Care Act (PPACA) Preventive Contraceptive Drug List for contraception. Find list at www.apwuhp.com. • A formulary exception process is available to prescribers if they feel the formulary alternatives are not appropriate. Prescribers should request a clinical exception by calling 800-753-2851. Once your physician receives prior authorization, the contraceptive drug not on the PPACA list will be dispensed and you will pay $0. Express Scripts responds to contraception exception requests within 24 hours of receipt of sufficient information to make a coverage determination. • Reimbursement for covered over-the-counter contraceptives can be submitted in accordance with Section 7. Note: If you have concerns about the Health Plan's compliance with the ACA/HRSA requirements or have difficulty accessing contraceptive coverage or other reproductive healthcare, contact contraception@opm.gov. See OPM's web page about contraception. Note: For additional Family Planning benefits see Section 5(a) Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the *Tobacco Cessation Educational Classes and Programs* in Section 5(a).	Nothing

Covered medications and supplies - continued on next page

Benefits Description	You pay After the calendar year deductible…
Covered medications and supplies (cont.)	**High Option**
Not covered • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Nonprescription medications medicines*	*All charges*
Preventive medications	**High Option**
The following are covered: • Preventive Medications with USPSTF A and B recommendations. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations	Nothing when prescribed by a healthcare professional and filled by a network pharmacy.
Opioid rescue agents such as naloxone are covered under this Plan with no cost sharing when obtained from a network pharmacy in any over-the-counter or prescription form available such as nasal sprays and intramuscular injections. For more information consult the FDA guidance at www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to https://www.findtreatment.samhsa.gov/.	Nothing
Not covered: • *Drugs and supplies for cosmetic purposes* • *Nonprescription medications*	*All charges*

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your PSHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your PSHB Plan. See Section 9, *Coordinating Benefits with Medicare and Other Coverage*.
- The calendar year deductible is: PPO - $450 per person ($800 per Self Plus One enrollment, or $800 per Self and Family enrollment); Non-PPO - $1,000 per person ($2,000 per Self Plus One enrollment, or $2,000 per Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also read Section 9, for information about how we pay if you have other coverage, or if you are age 65 or over.

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

Accidental injury benefit	You pay
Accidental injury benefit	**High Option**
We cover restorative services and supplies necessary to repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury (a blow or fall) and must be performed within two years of the accident (see also Section 5(d), *Accidental injury*).	**Within 72 hours of accident:** PPO: Nothing (No deductible) Non-PPO: Only the difference between our allowance and the billed amount (No deductible) **More than 72 hours after accident:** PPO: 15% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Dental benefits service	**High Option**
• Office visits (routine limited to 2 visits per year) • Restorative care (fillings) • X-rays of all types (limited to 2 per year) • Prophylaxis (cleanings), (limited to 2 per year) • Simple extractions Note: Office visits include examinations and fluoride treatment. Note: Restorative care does not include crowns or in-lay/on-lay restoration. Note: General anesthetics not covered unless due to an underlying medical condition.	30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Note: No in-network dental providers; choose any provider.

Section 5(h). Wellness and Other Special Features

Special Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits under the OPM disputed claims process (see Section 8, *The Disputed Claims Process*).
24-hour NurseLine	We offer a 24-hour nurse advisory service for your use. This program is strictly voluntary and confidential. You may call toll-free at 866-569-2064 and reach registered nurses to discuss an existing medical concern or to receive information about numerous healthcare issues.
High Risk Maternity	Members can enroll in our maternity support program and Maven (virtual program) which provide support in every stage of pregnancy, including self measured blood pressure monitoring and support.
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. As an example, members with cardiac conditions can participate in this program. 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 UnitedHealthcare at 866-569-2064.
Review and Reward Program	If you send us a corrected hospital billing, we will credit 20% of any hospital charge over $20 for covered services and supplies that were not actually provided to a covered person. The maximum amount payable under this program is $100 per person per calendar year.
Weight Management	$0 copay for in-network office visits to a registered Dietician/Nutritionist
Special Programs	Online programs and services provide extra support and savings, visit www.apwuhp.com or call 866-569-2064 for more information. • **Pregnancy Support Program** - Enroll in this program and you take the first step toward giving your baby a healthy start in life.

	• **Maven -** Mothers-to-be receive online support through every stage of pregnancy and delivery. • **Cancer Support Program** - Enroll in the program and receive enhanced benefits at Cancer Centers of Excellence. • **Kidney Resources Program** - For those diagnosed with end-stage renal disease or those who are currently receiving dialysis treatment, this program will help you. • **One Pass Select** ™ – visit www.WeRally.com or call 877-515-9364 to sign up for One Pass, a gym membership discount program offering access to national gym memberships, online fitness classes and Grocery Delivery service. • **UnitedHealthcare Hearing-** Call 855-523-9355 or visit www.UHCHearing.com for hearing aids, care options and dedicated support. • **Alternative medicine** - find discounts for acupuncture, chiropractor, and massage.
Online tools and resources	Online tools are available at www.myAPWUHP.com: • **www.myAPWUHP.com** - online information for member services and claims to view claims and find year-to-date information with claim details
Health Risk Assessment (HRA)	A Health Risk Assessment (HRA) is available at Welcome to Rally! (www.werally.com) and via your Member Portal at www.myAPWUHP.com. 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.
Consumer choice information	Access to our website (www.apwuhp.com) is provided to support your important health and wellness decisions, including: • Online Preferred Organization (PPO) Directory - nationwide PPO network to find doctors, hospitals and other outpatient providers anywhere in the country • Hospital Quality Ratings Guide - Compare hospitals for quality in your area or anywhere in the country • Treatment Cost Estimator - receive cost estimates for the most common medical conditions, tests and procedures • Prescription drug information, pricing, and network retail pharmacies

Consumer Driven Option Benefits Table of Contents

See page 173 for a benefits summary of the Consumer Driven Option.

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 healthcare consumer, and gives you greater control in how you use your healthcare 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 Preventive Care 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 Net 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 50% of the Plan allowance for out-of-network care.

Covered services include:

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

Health Education Resources and Account Management Tools

Section 5(i) describes the health tools and resources available to you under the Consumer Driven Option to help you improve the quality of your healthcare and manage your expenses. You can receive a $25 wellness incentive when you complete an annual physical, mammogram or cervical screening with a clinical professional each year.

Section 5. In-Network Preventive Care

Important things you should keep in mind about these in-network preventive care benefits:

- Under the Consumer Driven Option, the Plan pays 100% for the Preventive Care services listed in this Section as long as you use a network PPO provider.
- Preventive care performed using out-of-network providers are paid using your PCA while funds are available. Once your PCA is exhausted, member pays all charges.
- For preventive care not listed in this Section or for preventive care from a non-network provider, please see CDHP Section 5, *Personal Care Account (PCA).*
- For all other covered expenses, please see CDHP Section 5, *Personal Care Account (PCA)* and *Traditional Health Coverage*.
- Note that the in-network Preventive Care paid under this Section does NOT count against or use up your Personal Care Account (PCA).
- 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.
- 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.
- Receive $25 each when you complete an annual physical, mammogram or cervical screening with a clinical professional each year, see Section 5(i) for details.

Benefit Description	You pay
Note: There is no calendar year deductible for in-network preventive care under the Consumer Driven Option.	
Preventive care, adult	**Consumer Driven Option**
Routine physical every calendar year. The following preventive services are covered at the time interval recommended at each of the links below: • Receive $25 each when you complete an annual physical, mammogram or cervical screening with a clinical professional each year (see Section 5(i) for details) • U.S. Preventive Services Task Force (USPSTF) A and B recommended screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer. Preventive medications with a USPSTF recommendation of A or B are covered without cost-share when prescribed by a healthcare professional and filled by a network pharmacy. For a complete list of screenings go to the website at: www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • Individual counseling on prevention and reducing health risks • Well woman care such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of Well Women preventive care services go to the Health and Human Services (HHS) website at www.hrsa.gov/womens-guidelines. • Routine Prostate Specific Antigen (PSA) test, one annually for men age 40 and older	In-network: Nothing Out-of-network: All charges after PCA is exhausted

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**Consumer Driven Option**
• Urinalysis • Routine Electrocardiogram (EKG) • Chest X-ray • Hemoglobin A1C, age 18 and above • At home Colorectal Cancer Screening Cologuard Kit provided through Exact Sciences Laboratories, every three years starting at age 45, prescription needed from physician • Adult Immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. For a complete list of endorsed immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/ • To build your personalized list of preventive services go to https://health.gov/myhealthfinder Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	In-network: Nothing Out-of-network: All charges after PCA is exhausted
• Routine mammogram - covered for women, including 3D mammograms covered for women age 35 and older; as follows: - From age 35 through 39, one during this five year period - From age 40, one every calendar year • To build your personalized list of preventive services go to https://health.gov/myhealthfinder	In-network: Nothing Out-of-network: All charges after PCA is exhausted
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family-centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy: - Unlimited preventive medical nutrition therapy (assessment and intervention) - Unlimited preventive medical counseling for the purpose of promoting health and preventing illness - Unlimited visits to a registered dieticians/nutritionist • Family-centered programs when medically identified to support obesity prevention and management by an in-network provider: - Unlimited preventive medical counseling group (including family counseling) • When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See Sections 5(f) or 5(f)(a) for cost share requirements for anti-obesity medications.	In-network: Nothing Out-of-network: All charges after PCA is exhausted

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**Consumer Driven Option**
• When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b) for surgery requirements and cost share. For coverage policy, visit www.apwuhp.com and click on Member Resources. Obesity screening and referral, for those persons below the USPSTF obesity prevention risk factor level, see Section 5(h) for Weight Management and Special Programs.	In-network: Nothing Out-of-network: All charges after PCA is exhausted
Not covered: • *Adult immunizations not endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule.* • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*
Preventive care, children	**Consumer Driven Option**
• Well-child visits examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to www.brightfutures.aap.org • Children's immunizations endorsed by the Centers for Disease Control (CDC) including DTaP/Tdap, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/index.html You may also find a complete list of U.S. Preventive Services Task Force (USPSTF) A and B recommendations online at www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations	In-network: Nothing Out-of-network: All charges after PCA is exhausted
• Examinations, limited to: - Examinations for amblyopia and strabismus - limited to one screening examination (ages 3 through 5) - Examinations done on the day of immunizations (ages 3 through 21) - One Screening Examination of Premature Infants for Retinopathy of Prematurity or infants with low birth weight or gestational age of 32 weeks or less • To build your personalized list of preventive services go to https://health.gov/myhealthfinder Note: In-network facility and lab services directly related to covered, in-network preventive care will also be covered at 100%.	In-network: Nothing Out-of-network: All charges after PCA is exhausted

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	**Consumer Driven Option**
Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	In-network: Nothing Out-of-network: All charges after PCA is exhausted
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family-centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy: - Unlimited preventive medical nutrition therapy (assessment and intervention) - Unlimited preventive medical counseling for the purpose of promoting health and preventing illness - Unlimited visits to a registered dieticians/nutritionist • Family-centered programs when medically identified to support obesity prevention and management by an in-network provider: - Unlimited preventive medical counseling group (including family counseling) • When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See Section 5(f) for cost share requirements for anti-obesity medications. • When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b) for surgery requirements and cost share. For coverage policy, visit www.apwuhp.com and click on Member Resources. Obesity screening and referral, for those persons below the USPSTF obesity prevention risk factor level, see Section 5(h) for Weight Management and Special Programs.	In-network: Nothing Out-of-network: All charges after PCA is exhausted
Not covered: • *Adult immunizations not endorsed by the Centers for Disease Control (CDC)* • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel* • *Immunizations, boosters, and medications for travel or work-related exposure*	*All charges*

Section 5. Personal Care Account (PCA)

Important things you should keep in mind about your Personal Care Account:

- All eligible healthcare expenses (except in-network preventive care) are paid first from your Personal Care Account (PCA). Traditional Health Coverage (under CDHP Section 5) will only start once your Personal Care Account is exhausted.
- Note that in-network preventive care covered under CDHP Section 5, does NOT count against your PCA.
- The Personal Care Account provides full coverage for both in-network and out-of-network providers. However your Personal Care Account will generally go much further when you use network providers because network providers agree to discount their fees.
- You have flexibility about how to spend your PCA, and the Plan provides you with the resources to manage your PCA. You can track your PCA on your personal private website, by telephone at 1-800-718-1299 (toll-free), or with quarterly statements mailed directly to you at home.
- If you join this Plan during Open Season, you receive the full PCA ($1,200 per Self Only, $2,400 per Self Plus One or $2,400 per Self and Family enrollment) as of your effective date of coverage. If you join at any other time during the year, your PCA for your first year will be prorated at a rate of $100 per month for Self Only or $200 per month for Self Plus One or Self and Family for each full month of coverage remaining in that calendar year.
- Unused PCA benefits are forfeited when leaving this Plan.
- If PCA benefits are available in your account at the time a claim is processed, out-of-pocket expenses will be paid from your PCA regardless of the date the expense was incurred.
- If the member has funds available in the PCA account, claims will always be paid out of the PCA first. If the member would like to use their FSA to pay a bill prior to using the PCA, please instruct the provider not to submit the claim to UnitedHealthcare. The member should get a copy of the bill from the provider and submit to the FSA carrier for reimbursement. This means that in some cases, the member may have to pay the cost of the services up front.
- 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.
- 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.
- Members can turn off the PCA for medical claims only via www.myuhc.com. Medical claims must then be submitted manually to UnitedHealthcare. Pharmacy claims will continue to pay from the PCA.

Benefits Description	You pay
There is no calendar year deductible for in-network preventive care under the Consumer Driven Option	
Personal Care Account (PCA)	**Consumer Driven Option**
A Personal Care Account (PCA) is provided by the Plan for each enrollment. Each year the Plan adds to your account: • $1,200 per year for a Self Only enrollment or • $2,400 per year for a Self Plus One or Self and Family enrollment The Personal Care Account covers eligible expenses at 100%. For example, if you are ill and go to a network doctor, the doctor will submit your claim and the provider's contracted rate for the visit will be deducted automatically from your PCA; you pay nothing.	In-network and Out-of-network: Nothing up to $1,200 for a Self Only enrollment or $2,400 for a Self Plus One or Self and Family enrollment

Personal Care Account (PCA) - continued on next page

Benefits Description	You pay
Personal Care Account (PCA) (cont.)	**Consumer Driven Option**
Balance in PCA for Self Only $1,200 Less provider contracted rate for visit -$60 Remaining Balance in PCA $1,140 There are two types of eligible expenses covered by your PCA. • **Basic PCA Expenses** are the same medical, surgical, hospital, emergency, mental health and substance use disorder treatment, and prescription drug services and supplies covered under the Traditional Health Coverage (see CDHP Section 5 for details) • **Extra PCA Expenses** include: - Dental and/or vision services are reimbursable out of your PCA. Only the PCA amount paid for the dental/vision services is applied to the plan year deductible/out-of-pocket. We will reimburse up to a combined maximum of $400 per Self Only enrollment or $800 per Self Plus One or Self and Family enrollment each calendar year, including: - Vision exam performed by an optometrist or ophthalmologist - Eyeglasses and contact lenses - Dental treatment (including examinations, cleanings, fillings, restorative treatment, endodontics, and periodontics) - In-network preventive care services not included under CDHP Section 5, *In-network Preventive Care benefits* - *Out-of-network preventive care* limited to services shown as covered under CDHP Section 5 - Amounts in excess of the Plan allowance for services received out-of-network and covered under Basic PCA Expenses - Medicare Part B premium reimbursement – Retirees that participate with Medicare Part B may request reimbursement for their Part B premiums, if PCA funds are available. For reimbursement, members should visit www.MYUHC.com to download a Health Reimbursement Account (HRA) form or to sign in to upload your documents for reimbursement. Note: Both Basic and Extra PCA Expenses are covered at 100% as long as you have not used up your Personal Care Account. To make the most of your Personal Care Account, you should: • Use the network providers wherever possible; • Use Tier 1 prescriptions wherever possible; and • Only use your PCA for Extra PCA Expenses if you expect to have an unused balance in your PCA at the end of the calendar year	In-network and Out-of-network: Nothing up to $1,200 for a Self Only enrollment or $2,400 for a Self Plus One or Self and Family enrollment

Personal Care Account (PCA) - continued on next page

Benefits Description	You pay
Personal Care Account (PCA) (cont.)	**Consumer Driven Option**
Not covered: • *Orthodontia* • *Dental treatment for cosmetic purposes including teeth whitening* • *Out-of-network preventive care services not included under CDHP Section 5* • *Services or supplies shown as not covered under Traditional Health Coverage (see CDHP Section 5) and not included under Extra PCA Expenses above*	*All charges*

PCA Rollover

As long as you remain in this Plan, any unused remaining balance in your PCA at the end of the calendar year may be rolled over to subsequent years. The maximum amount allowed in your PCA may not exceed $5,000 per Self Only enrollment, $10,000 per Self Plus One enrollment and $10,000 per Self and Family enrollment.

Section 5. Traditional Health Coverage Overview

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-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 healthcare expenses.
- If your Personal Care Account has been exhausted, you must pay your Net 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: in-network $83.33 per month for Self Only, $166.67 per month for Self Plus One or Self and Family; or out-of-network $125.00 per month for Self Only or $250.00 per month for Self Plus One or Self and Family for each full month of coverage remaining in that calendar year.
- 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
Deductible before Traditional Health Coverage begins	**Consumer Driven Option**
If your Personal Care Account has been exhausted, you are responsible to pay your Deductible before your Traditional Health Coverage begins. Traditional Health Coverage benefits begin for in-network after covered eligible expenses (deductible) total $2,200 for Self Only, $4,400 for Self Plus One or $4,400 for Self and Family (the combination of eligible expenses paid out of your PCA and your Net Deductible) each calendar year. For out-of-network, covered benefits begin after covered eligible expenses total $2,700 for Self Only, $5,400 for Self Plus One and $5,400 for Self and Family. Note: You must use any available PCA benefits, including any amounts rolled over from previous years, before Traditional Health Coverage begins. In year one, therefore, the Net Deductible is $1,000 for Self Only, $2,000 for Self Plus One and $2,000 for Self and Family enrollment. **Type of Plan**	**In-network**: $1,000 per Self Only enrollment, $2,000 for Self Plus One enrollment or $2,000 per Self and Family enrollment **Out-of-network:** $1,500 per Self Only enrollment, $3,000 for Self Plus One and $3,000 for Self and Family enrollment

Deductible before Traditional Health Coverage begins - continued on next page

Benefit Description	You Pay
Deductible before Traditional Health Coverage begins (cont.)	**Consumer Driven Option**
In-Network Deductible Self Only: $2,200 Deductible ($1,200 PCA + $1,000 Net Deductible) Self Plus One: $4,400 Deductible ($2,400 PCA + $2,000 Net Deductible) Self and Family: $4,400 Deductible ($2,400 PCA + $2,000 Net Deductible **Out-of-Network Deductible** Self Only: $2,700 Deductible ($1,200 PCA + $1,500 Net Deductible) Self Plus One: $5,400 Deductible ($2,400 PCA + $3,000 Net Deductible) Self and Family: $5,400 Deductible ($2,400 PCA + $3,000 Net Deductible) **Basic PCA Expenses paid by PCA** Self Only: $1,200 Self Plus One: $2,400 Self and Family: $2,400 **Deductible paid by you** Self Only: In-network $1,000; Out-of-network $1,500 Self Plus One: In-network $2,000; Out-of-network $3,000 Self and Family: In-network $2,000; Out-of-network $3,000 **Traditional Health Coverage starts after** Self Only: In-network $2,200; Out-of-network $2,700 Self Plus One: In-network $4,400; Out-of-network $5,400 Self and Family: In-network $4,400; Out-of-network $5,400 Any PCA dollars that you rollover at the end of the year will reduce your Deductible next year. In future years, the amount of your Deductible may be lower if you rollover PCA dollars at the end of the year. For example, if you rollover $300 at the end of the year: **PCA for year 2 Rollover from year 1** Self Only: $1,200 + $300 $1,500 Self Plus One: $2,400+ $300 $2,700 Self Self and Family: $2,400+ $300 $2,700 **Net Deductible paid by you** Self Only: In-network + $700 Out-of-network + $1,200 Self Plus One: In-network + $700 Out-of-network + $2,700 In-network + $700 Out-of-network + $2,700 **Traditional Health Coverage starts when eligible expenses total** Self Only: In-network $2,200 Out-of-network $2,700 Self Plus One: In-network $4,400 Out-of-network $5,400 Self and Family: In-network $4,400 Out-of-network $5,400 If you decide to use your PCA for Extra PCA Expenses for other than covered dental and/or vision services, you may increase your Deductible. For example, if you have out-of-network preventive care for $150 and **later** an accident that leads to a hospital stay, you will have to pay your Deductible plus "make up" the $150 dollars you spent on Extra PCA Expenses.	**In-network**: $1,000 per Self Only enrollment, $2,000 for Self Plus One enrollment or $2,000 per Self and Family enrollment **Out-of-network:** $1,500 per Self Only enrollment, $3,000 for Self Plus One and $3,000 for Self and Family enrollment

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

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In-network Preventive Care is covered at 100% under CDHP Section 5 and does not count against your Personal Care Account.
- Your Personal Care Account must be used first for eligible healthcare expenses.
- If your Personal Care Account has been exhausted, you must pay your Net 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: In-network $83.33 per month for Self Only, $166.67 per month for Self Plus One or Self and Family; or out-of-network $125.00 per month for Self Only or $250.00 per month for Self Plus One or Self and Family, for each full month of coverage remaining in that calendar year.
- 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.
- The coverage and cost-sharing listed below are for services provided by physicians and other healthcare professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).

Benefit Description	You pay
Diagnostic and treatment services	**Consumer Driven Option**
Professional services of physicians • In physician's office * • Medical consultations in the office • At home • In an urgent care center • During a hospital stay • In a skilled nursing facility • Second surgical opinion * Professional services of a physician via Telehealth/Telemedicine are covered the same as in a physician's office.	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount
• At a Cancer Center of Excellence	In-network Cancer Center of Excellence (COE): 10% of the Plan allowance

Diagnostic and treatment services - continued on next page

Benefit Description	You pay
Diagnostic and treatment services (cont.)	**Consumer Driven Option**
Note: To receive the higher level of benefits for cancer related treatment, you are required to visit a designated Cancer Center of Excellence facility.	In-network Cancer Center of Excellence (COE): 10% of the Plan allowance
TeleHealth services	**Consumer Driven Option**
• Virtual visits are available through AmWell, Doctor on Demand, or Teladoc Please see www.apwuhp.com for information on virtual visits, or log into www.myuhc.com. Note: There is no out-of-network benefit for virtual visits.	In-network: 15% of the Plan allowance Out-of-network: N/A
Lab, X-ray and other diagnostic tests	**Consumer Driven Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine mammogram, including 3D mammogram • Pathology • X-ray • Non-routine Pap test • CT/CAT Scans/MRI/MRA/NC/PET • Ultrasound • Electrocardiogram and EEG Note: If your network provider uses an out-of-network lab or radiologist, we will pay out-of-network benefits for any lab and X-ray charges.	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Professional fees for automated lab tests* • *Genetic screening (see Definitions, Section 10)* • *Qualitative (definitive) urine drug panel testing that is not medically necessary*	*All charges*
Maternity care	**Consumer Driven Option**
Complete maternity (obstetrical) care, such as: • Screening for gestational diabetes • Prenatal and postpartum care • Delivery • Initial examination of a newborn child covered under a Self Plus One or Self and Family enrollment • Breastfeeding and lactation support, supplies and counseling for each birth • Screening and counseling for prenatal and postpartum depression	In-network: Nothing Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount Note: For inpatient hospital care related to maternity, we pay for covered services in full when you use preferred providers.

Maternity care - continued on next page

Benefit Description	You pay
Maternity care (cont.)	**Consumer Driven Option**
Note - Here are some things to keep in mind: • You do not need to precertify your vaginal or cesarean delivery; see Section 3 for other circumstances, such as extended stays for you or your baby. • As part of your coverage you have access to in-network certified nurse midwives, home nurse visits and board-certified lactation specialists during the prenatal and post-partum period. • Doula virtual coverage through Maven (a free wellness program). See Section 5(i). • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. • We pay hospitalization and surgeon services for non-maternity care, as well as covering an extended stay, if medically necessary, the same as for illness and injury. • Hospital services are covered under Section 5(c), and *Surgical benefits* are covered under Section 5(b). Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. In addition, circumcision is covered at the same rate as for regular medical or surgical benefits. Note: Maternity care expenses incurred by a Plan member serving as a surrogate mother are covered by the Plan subject to reimbursement from the other party to the surrogacy contract or agreement. The involved Plan member must execute our Reimbursement Agreement completed by APWU Health Plan against any payment they may receive under the surrogacy contract or agreement. Expenses of the newborn child are not covered under this or any other benefit in a surrogate mother situation.	In-network: Nothing Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount Note: For inpatient hospital care related to maternity, we pay for covered services in full when you use preferred providers. Note: In-network facility and lab services directly related to covered, in-network maternity care will also be covered at 100%.
• We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self Plus One or Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision of a covered newborn.	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Amniocentesis if for diagnosing multiple births* • *Genetic screening (see Definitions, Section 10)*	*All charges*

Benefit Description	You pay
Family planning	**Consumer Driven Option**
Contraceptive counseling on an annual basis Note: If you have concerns about the Health Plan's compliance with the ACA/HRSA requirements or have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov. See OPM's web page about contraception.	In-network: Nothing Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount
A range of voluntary family planning services, without cost-sharing, that includes at least one form of contraception in each of the categories on the HRSA list. This list includes: • Voluntary female sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo Provera) • Intrauterine devices (IUDs) • Diaphragms Note: See additional Family Planning and Prescription drug coverage Section 5(f) Note: Your plan offers some type of voluntary female sterilization surgery coverage at no cost to members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any type of voluntary female sterilization surgery that is not already available without cost sharing can be accessed through the contraceptive exceptions process described below. A formulary exception process is available to physicians if they feel the formulary alternatives are not appropriate. Prescribers should request a clinical exception by calling 800-718-1299. Once your physician receives prior authorization, the contraceptive drug not on the PPACA list will be dispensed and you will pay $0. Urgent requests are reviewed within 24 hours.	In-network: Nothing Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount
• Voluntary male sterilization	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic testing and counseling*	*All charges*

Benefit Description	You pay
Infertility services	**Consumer Driven Option**
Diagnosis and treatment of infertility specific to, except as shown in *Not covered,* see Section 10*, Definitions* • Artificial insemination (AI): - Intravaginal insemination (IVI), - Intracervical insemination (ICI) - Intrauterine insemination (IUI) • Infertility medications, including IVF related drugs. See Section 5 (f), *Prescription drug benefits.* For coverage policy, visit www.apwuhp.com and click on Member Resources.	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance
• Iatrogenic fertility preservation procedures (retrieval of and freezing of eggs or sperm) caused by chemotherapy, pelvic radiotherapy, ovary or testicle removal and other gonadotoxic therapies for the treatment of disease and gender reassignment. Note: Fertility preservation procedures require prior approval (see Section 3, *Other services*). Limited benefits: $12,000 lifetime maximum.	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance
Not covered: • *Infertility services after voluntary sterilization* • *Assisted reproductive technology (ART) procedures, such as:* - *In vitro fertilization (IVF) (excluding IVF drugs)* - *Embryo transfer and gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges*
Allergy care	**Consumer Driven Option**
• Testing and treatment, including materials (such as allergy serum) • Allergy injections	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*

Benefit Description	You pay
Treatment therapies	**Consumer Driven Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed in Section 5 (b), *Organ/tissue transplants*. • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: We only cover IV/Infusion therapy and GHT when we are pre-notified of the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary, (see *Other services,* Section 3). • Respiratory and inhalation therapies • Cardiac rehabilitation following qualifying event/condition	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount
• Medical food formulas ordered by a healthcare provider that are medically necessary to treat specific nutritional risks, including Phenylketonuria (PKU) and other inborn errors of metabolism (IEM). Limited benefits: We pay a maximum of $2,500 for each calendar year	In-network: 15% of the Plan allowance and all charges after we pay $2,500 in a calendar year Out-of-network: 50% of the Plan allowance and all charges after we pay $2,500 in a calendar year
Not covered: • *Medical foods for conditions other than permanent inborn errors of metabolism.*	*All charges*
Physical and occupational therapies	**Consumer Driven Option**
Physical therapy and occupational therapy provided by a licensed registered therapist or physician up to a combined 60 visits per calendar year We cover rehabilitative and habilitative therapies; a physician should: • Order the care; • Identify the specific professional skills the patient requires and the medical necessity for skilled services; and • Indicate the length of time services are needed. Note: We also have the right to deny any type of therapy, service or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or recurring.	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Maintenance therapies* • *Exercise programs*	*All charges*

Benefit Description	You pay
Applied behavioral analysis (ABA)	**Consumer Driven Option**
Outpatient Applied Behavioral Analysis (ABA) services, for the treatment of Autism Spectrum Disorder. Services must be provided under the supervision of a Board Certified Behavior Analyst who is contracted with UnitedHealthcare Behavioral Health, or agrees to participate with UnitedHealthcare Behavioral Health's care management activities. **Preauthorization required by UnitedHealthcare Behavioral Health.** Note: UnitedHealthcare Behavioral Health's review of ABA services is based on an intensive care management model that monitors treatment plans, objectives, and progress milestones. We have the right to deny services for treatment when outcomes do not meet the defined treatment plan objectives and milestones.	In-network: 15% of the Plan allowance Out-of-network: All charges
Speech therapy	**Consumer Driven Option**
Speech therapy where medically necessary and provided by a licensed therapist Note: Speech therapy is combined with 60 visits per calendar year for the services of physical and/or occupational therapy (see above). Note: We also have the right to deny any type of therapy, service or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or recurring.	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount
Hearing services (testing, treatment, and supplies)	**Consumer Driven Option**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist • One examination and testing for hearing aids every 2 years Note: For routine hearing screening performed during a child's preventive care visit see Section 5, *Preventive care, children.*	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount
• External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants for bilateral hearing los	Note: For benefits for the devices see Section 5(a), *Orthopedic and prosthetic devices.*
Not covered: • *Hearing services that are not shown as covered*	*All charges*
Vision services (testing, treatment, and supplies)	**Consumer Driven Option**
Internal (implant) ocular lenses and/or the first contact lenses required to correct an impairment caused by accident or illness. Services are limited to the testing, evaluation and fitting of the first contact lenses required to correct an impairment caused by accident or illness. Note: See *Preventive care, children*, for eye exams for children.	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Eyeglasses or contact lenses and examinations for them except under PCA* • *Eye exercises and visual training*	*All charges*

Vision services (testing, treatment, and supplies) - continued on next page

Benefit Description	You pay
Vision services (testing, treatment, and supplies) (cont.)	**Consumer Driven Option**
• *Radial keratotomy and other refractive surgery* • *Refraction*	*All charges*
Foot care	**Consumer Driven Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes Note: See *Orthopedic and prosthetic devices* for information on podiatric shoe inserts.	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*
Orthopedic and prosthetic devices	**Consumer Driven Option**
• Artificial limbs and eyes • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Leg, arm, neck, joint and back braces • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants for bilateral hearing loss • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b), *Surgical procedures*. For information on the hospital and/or ambulatory surgery center benefits, see Section 5 (c).	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount
External hearing aids • Covered every 3 years limited to $1,500 Note: Excluding batteries, benefits for hearing aid dispensing fees, accessories, supplies, and repair service are included in the benefit limit described above.	PPO: All charges in excess of $1,500, up to the PPO allowance (No deductible) Non-PPO: All charges in excess of $1,500 (No deductible)
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices*	*All charges*

Benefit Description	You pay
Durable medical equipment (DME)	**Consumer Driven Option**
Durable medical equipment (DME) is equipment and supplies that: 1. Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury) 2. Are medically necessary 3. Are primarily and customarily used only for a medical purpose 4. Are generally useful only to a person with an illness or injury 5. Are designed for prolonged use; and 6. Serve a specific therapeutic purpose in the treatment of an illness or injury We cover rental or purchase, of durable medical equipment, at our option, including repair and adjustment. Covered items include but are not limited to: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs (standard and electric) • Ostomy supplies (including supplies purchased at a pharmacy) • Crutches • Walkers Note: Preauthorization of durable medical equipment is required, (see *Other services*, Section 3). Note: We will pay only for the cost of the standard item. Coverage for specialty equipment, such as all-terrain wheelchairs, is limited to the cost of the standard equipment. Note: We limit the Plan allowance for DME rental benefit to an amount no greater than what we would have considered if the equipment had been purchased.	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount
Not covered : • *Whirlpool equipment* • *Sun and heat lamps* • *Light boxes* • *Heating pads* • *Exercise devices* • *Stair glides* • *Elevators* • *Air Purifiers* • *Computer "story boards," "light talkers," or other communication aids for communication-impaired individuals*	*All charges*

Benefit Description	You pay
Home health services	**Consumer Driven Option**
Services for skilled nursing care up to 50 visits per calendar year, not to exceed two hours per day; and • a registered nurse (R.N.), licensed practical nurse (L.P.N.) or licensed vocational nurse (L.V.N.) provides the services; • the attending physician orders the care; • the physician identifies the specific professional skills required by the patient and the medical necessity for skilled services; and • the physician indicates the length of time the services are needed Note: Skilled nursing care must be preauthorized. Call UnitedHealthcare at 800-718-1299.	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance; all charges in excess of two hours, and any difference between our allowance and the billed amount
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, rehabilitative or Habilitative* • *Nursing services without preauthorization* • *Services of nurses' aides or home health aides*	*All charges*
Chiropractic	**Consumer Driven Option**
• Chiropractic treatment limited to 24 visits and/or manipulations per year • Electrical stimulation and ultrasound therapy provided by a licensed chiropractor Note: X-ray covered under Section 5(a), *Lab, X-ray and other diagnostic tests.*	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Massage therapy* • *Maintenance therapy*	*All charges*
Alternative treatments	**Consumer Driven Option**
• Acupuncture - by a doctor of medicine or osteopathy, or licensed or certified acupuncture practitioner • Dry Needling – by a licensed or certified practitioner	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Services of any provider not listed as covered (see Covered providers, Section 3)*	*All charges*

Benefit Description	You pay
Educational classes and programs	**Consumer Driven Option**
You may enroll in a Tobacco Cessation program as follows: • Telephonic counseling sessions with UnitedHealthcare or; • Group therapy sessions or; • Educational sessions with a physician Note: Enrollment in the UnitedHealthcare program must be initiated by the member. For more information contact UnitedHealthcare at 800-718-1299.	In-network: Nothing Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount
Select over-the-counter and prescription Tobacco Cessation medications approved by the FDA to treat tobacco dependence. For a listing of medications go to our website at: www.apwuhp.com/members/consumer-driven-option/pharmacy/ To qualify for these drugs, you need to be age 18 or older; get a prescription for these products from your doctor, even if the products are sold over-the-counter; fill the prescription at a network pharmacy.	In-network: Nothing Out-of-network: All charges
Diabetes self-management training services, up to 10 hours initial training the first year and 2 hours subsequent training annually	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount

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

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In-network Preventive Care is covered at 100% under CDHP Section 5 and does not count against your Personal Care Account.
- Your Personal Care Account must be used first for eligible healthcare expenses.
- If your Personal Care Account has been exhausted, you must pay your Net 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: In-network $83.33 per month for Self Only, $166.67 per month for Self Plus One or Self and Family; or out-of-network $125.00 per month for Self Only or $250.00 per month for Self Plus One or Self and Family, for each full month of coverage remaining in that calendar year.
- 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.

Benefits Description	You pay
Surgical Procedures	**Consumer Driven Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Section 5(b), *Reconstructive surgery)* • Surgical treatment of severe obesity (bariatric surgery) (requires preauthorization, see Section 3, *Other services*). For coverage policy, visit www.apwuhp.com and click on Member Resources. • Insertion of internal prosthetic devices (see Section 5(a), *Orthopedic and prosthetic devices*, for device coverage information) • Treatment of burns	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount

Surgical Procedures - continued on next page

Benefits Description	You pay
Surgical Procedures (cont.)	**Consumer Driven Option**
• Assistant surgeons - We cover up to 20% of our allowance for the surgeon's charge Note: For female surgical family planning procedures see Family Planning Section 5(a). Note: For male surgical family planning procedures see Family Planning Section 5(a).	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount
When multiple or bilateral surgical procedures performed during the same operative session add time or complexity to patient care, our benefits are: • For the primary procedure: - In-network: 85% of the Plan allowance or - Out-of-network: 50% of the Plan allowance • For the secondary procedure(s): - In-network: 85% of one-half of the Plan allowance or - Out-of-network: 50% of one-half of the Plan allowance Note: When multiple or bilateral surgical procedures add complexity to an operative session, the Plan allowance for the second or less expensive procedure is one-half of what the Plan allowance would have been if that procedure had been performed independently. • When a surgery requires two primary surgeons (co-surgeons), the Plan allowance for each surgeon will not exceed 63% of our allowance. This allowance will be further reduced by half for secondary procedures. • Multiple or bilateral surgical procedures performed through the same incision are "incidental" to the primary surgery. That is, the procedure would not add time or complexity to patient care. We do not pay extra for incidental procedures.	In-network: 15% of the Plan allowance for the primary procedure and 15% of one-half of the Plan allowance for the secondary procedure(s) Out-of-network: 50% of the Plan allowance for the primary procedure and 50% of one-half of the Plan allowance for the secondary procedure (s); and any difference between our payment and the billed amount
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))*	*All charges*

Benefits Description	You pay
Reconstructive Surgery	**Consumer Driven Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - The condition produced a major effect on the member's appearance and - The condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks (including port wine stains); and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - Surgery to produce a symmetrical appearance of breast - Treatment of any physical complications, such as lymphedema - Breast prostheses; and surgical bras and replacements (see Section 5(a), *Prosthetic devices*, for coverage) Note: We pay for internal breast prostheses as hospital benefits. Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount
• Surgical treatment for gender affirmation • Gender affirming surgery benefits are only available for the diagnosis of gender dysphoria Requirements: • Prior approval is required. • Must be at least 18 years of age at time prior approval is requested and treatment plan is submitted. • Must have diagnosis of gender dysphoria by a qualified healthcare professional. • Persistent, well-documented gender dysphoria. • Member's gender dysphoria is not a symptom of another mental disorder or chromosomal abnormality. • Continuous hormone therapy as appropriate. • Two clinical assessments from qualified healthcare professionals are required for genital and gonadal surgeries, all other surgeries require one assessment. • If medical or mental health concerns are present, they are being optimally managed and are reasonably well-controlled. For coverage policy, visit www.apwuhp.com and click on Member Resources.	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount

Reconstructive Surgery - continued on next page

Benefits Description	You pay
Reconstructive Surgery (cont.)	**Consumer Driven Option**
Not covered: • *Cosmetic services that are not medically necessary* • *Travel and lodging*	*All charges*
Oral and Maxillofacial Surgery	**Consumer Driven Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaw or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures • Extraction of impacted (unerupted) teeth • Alveoplasty, partial ostectomy and radical resection of mandible with bone graft unrelated to tooth structure • Excision of bony cysts of the jaw unrelated to tooth structure • Excision of tori, tumors, and premalignant lesions, and biopsy of hard and soft oral tissues • Reduction of dislocations and excision, manipulation, arthrocentesis, aspiration or injection of temporomandibular joints • Removal of foreign body, skin, subcutaneous alveolar tissue, reaction-producing foreign bodies in the musculoskeletal system and salivary stones • Incision/excision of salivary glands and ducts • Repair of traumatic wounds • Sinusotomy, including repair of oroantral and oromaxillary fistula and/or root recovery • Surgical treatment of trigeminal neuralgia • Frenectomy or frenotomy, skin graft or vestibuloplasty-stomatoplasty unrelated to periodontal disease • Incision and drainage of cellulitis unrelated to tooth structure Note: Call UnitedHealthcare at 800-718-1299 to determine if a procedure is covered.	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva and alveolar bone)* • *Dental bridges, replacement of natural teeth, dental/orthodontic/ temporomandibular joint dysfunction appliances and any related expenses*	*All charges*

Oral and Maxillofacial Surgery - continued on next page

Benefits Description	You pay
Oral and Maxillofacial Surgery (cont.)	**Consumer Driven Option**
• *Treatment of periodontal disease and gingival tissues, and abscesses* • *Charges related to orthodontic treatment*	*All charges*
Organ/Tissue Transplants	**Consumer Driven Option**
These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. Refer to *Other services*, Section 3, for prior authorization procedures. Solid organ transplants are limited to: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-pancreas • Liver • Lung single/bilateral/lobar • Pancreas	In-network Transplant Center of Excellence (COE): 10% of the Plan allowance In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount and any amount over $100,000
These **tandem blood or marrow stem cell transplants** for covered transplants are subject to medical necessity review by the Plan. Refer to Section 3, *Other services*, for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	In-network Transplant Center of Excellence (COE): 10% of the Plan allowance In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount and any amount over $100,000
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as indicated below: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin’s lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Amyloidosis	In-network Transplant Center of Excellence (COE): 10% of the Plan allowance In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount and any amount over $100,000

Organ/Tissue Transplants - continued on next page

Benefits Description	You pay
Organ/Tissue Transplants (cont.)	**Consumer Driven Option**
- Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Multiple Myeloma - Myelodysplasia/Myelodysplastic Syndromes - Myeloproliferative disorders - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia (pediatric only) - X-linked lymphoproliferative syndrome • Autologous transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced childhood kidney cancers - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin’s lymphoma with recurrence (relapsed) - Amyloidosis - Aggressive non-Hodgkin's lymphomas - Breast cancer - Childhood rhabdomyosarcoma - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Mantle cell (non-Hodgkin's lymphoma) - Medulloblastoma	In-network Transplant Center of Excellence (COE): 10% of the Plan allowance In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount and any amount over $100,000

Organ/Tissue Transplants - continued on next page

Benefits Description	You pay
Organ/Tissue Transplants (cont.)	**Consumer Driven Option**
- Multiple myeloma - Neuroblastoma - Pineoblastoma - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors - Waldenstrom's macroglobulinemia	In-network Transplant Center of Excellence (COE): 10% of the Plan allowance In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount and any amount over $100,000
Mini-transplants (non-myeloablative, reduced intensity conditioning or RIC) are subject to medical necessity review by the Plan.	In-network Transplant Center of Excellence (COE): 10% of the Plan allowance In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount and any amount over $100,000
These **blood or marrow stem cell transplants** are covered only in a National Cancer Institute or National Institutes of Health **approved clinical trial** or a Plan-designated Center of Excellence. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. **Transplant Network** The Plan uses specific Plan-designated organ/tissue transplant facilities. Before your initial evaluation as a potential candidate for a transplant procedure, you or your doctor **must** contact UnitedHealthcare at 800-718-1299 and ask to speak to a Transplant Case Manager. You will be provided with information about transplant preferred providers. If you choose a Plan-designated transplant facility, you may receive prior approval for travel and lodging costs. Limited Benefits – If you don't use a Plan-designated transplant facility, benefits for pretransplant evaluation, organ procurement, inpatient hospital, surgical and medical expenses for covered transplants, whether incurred by the recipient or donor, are limited to a maximum of $100,000 for each listed transplant, including multiple organ transplants. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	In-network Transplant Center of Excellence (COE): 10% of the Plan allowance In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount and any amount over $100,000
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Transplants not listed as covered* • *Implants of artificial organs*	*All charges*

Benefits Description	You pay
Anesthesia	**Consumer Driven Option**
Professional services provided in – • Hospital (inpatient)	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount Note: If surgical services are rendered at an in-network hospital or an in-network freestanding ambulatory facility, we will pay the services of out-of-network anesthesiologists at the in-network rate, based on Plan allowance.

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

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 healthcare expenses.
- If your Personal Care Account has been exhausted, you must pay your Net 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: In-network $83.33 per month for Self Only, $166.67 per month for Self Plus One or Self and Family; or out-of-network $125.00 per month for Self Only or $250.00 per month for Self Plus One or Self and Family, for each full month of coverage remaining in that calendar year.
- 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.
- You must get prior approval for gender affirming surgery. See Section 3 for prior approval and Section 5(b) for the surgical benefit.
- When you receive hospital observation services, we apply outpatient benefits to covered services up to 48 hours. Inpatient benefits will apply only when your physician admits you to the hospital as inpatient. Once you are formally admitted, your entire stay (including observation services) will be processed and paid as inpatient benefits.

Benefits Description	You pay
Inpatient hospital	**Consumer Driven Option**
Room and board, such as: • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: We only cover a private room when you must be isolated to prevent contagion. Otherwise, we will pay the hospital's average charge for semiprivate accommodations. If the hospital only has private rooms, we will consider a semiprivate equivalent allowance of up to 90% of the private room charge. Note: When the out-of-network hospital bills a flat rate, we prorate the charges to determine how to pay them, as follows: 30% room and board and 70% other charges.	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount Note: For inpatient hospital care related to maternity, we pay for covered services in full when you use preferred providers, (see Section 5(a), *Maternity care*)

Inpatient hospital - continued on next page

Benefits Description	You pay
Inpatient hospital (cont.)	**Consumer Driven Option**
Other hospital services and supplies, such as: • Operating, recovery, maternity and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services Note: We base payment on whether the facility or a healthcare professional bills for the services or supplies. For example, when the hospital bills for its nurse anesthetists' services, we pay *Hospital* benefits and when the anesthesiologist bills, we pay *Surgery* benefits.	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount Note: For inpatient hospital care related to maternity, we pay for covered services in full when you use preferred providers, (see Section 5(a), *Maternity care*).
Not covered: • *Any part of a hospital admission that is not medically necessary (see Definitions, Section 10), such as when you do not need acute hospital inpatient (overnight) care, but could receive care in some other setting without adversely affecting your condition or the quality of your medical care. Note: In this event, we pay benefits for services and supplies other than room and board and in-hospital physician care at the level they would have been covered if provided in an alternative setting for out-of-network services only* • *Custodial care (see Definitions, Section 10)* • *Non-covered facilities, day and evening care centers, and schools* • *Personal comfort items such as radio, television, air conditioners, beauty and barber services, guest meals and beds* • *Services of a private duty nurse that would normally be provided by hospital nursing staff* • *Take-home items*	*All charges*
Cancer Centers of Excellence	**Consumer Driven Option**
The Plan provides access to designated Cancer Centers of Excellence. To locate a Cancer Center of Excellence, contact UnitedHealthcare at 800-718-1299 and enroll in the program prior to obtaining covered services. The Plan will only pay the higher level of benefits if UnitedHealthcare provides the proper notification to the designated facility/provider performing the services. To receive the higher level of benefits for a cancer-related treatment, you are required to visit a designated facility. Cancer treatment includes the following: • Physician's office services; • Professional fees for surgical and medical services; • Hospital - inpatient stay; and • Outpatient surgery, diagnostic and therapeutic services. If you decide to use a designated Center of Excellence, you may receive prior approval for travel and lodging costs.	In-network Cancer Centers of Excellence (COE): 10% of the Plan allowance

Benefits Description	You pay
Outpatient hospital or ambulatory surgical center	**Consumer Driven Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by an underlying medical condition. We do not cover the dental procedures. Note: We cover outpatient services and supplies of a hospital or free-standing ambulatory facility the day of a surgical procedure (including change of cast), hemophilia treatment, hyperalimentation, rabies shots, cast or suture removal, oral surgery, foot treatment, chemotherapy for treatment of cancer, and radiation therapy.	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount Note: For inpatient hospital care related to maternity, we pay for covered services in full when you use preferred providers (see Section 5(a), *Maternity care*).
Extended care benefits/Skilled nursing care facility benefits	**Consumer Driven Option**
When APWU Health Plan is Primary Semiprivate room, board, services and supplies provided in a skilled nursing care facility (SNF) for up to 30 days per person per calendar year when you are admitted directly from a covered inpatient hospital stay. Your skilled nursing care is supervised by a physician and provided by an R.N., L.P.N., or L.V.N. Note: Prior approval for these services is required. Call UnitedHealthcare at 800-718-1299, (see *Other services*, Section 3). **When Medicare A or Other Insurance is Primary** Semiprivate room, board, services and supplies provided in a skilled nursing care facility (SNF) for up to 30 days per person per calendar year when you are admitted directly from a covered inpatient hospital stay. Note: If Medicare pays the first 20 days in full, Plan benefits will begin on the 21st day (when Medicare Part A copayments begin) and will end on the 30th day.	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Custodial care (see Section 10, Definitions)* • *All charges after 30 days per person per calendar year*	*All charges*

Benefits Description	You pay
Hospice care	**Consumer Driven Option**
Hospice is a coordinated program of home and inpatient supportive care for the terminally ill patient and the patient's family provided by a medically supervised specialized team under the direction of a duly licensed or certified Hospice Care Program. • We pay up to $15,000 lifetime maximum for combined outpatient and inpatient services, which includes advance care planning • We pay a $200 bereavement benefit per family unit (no deductible or coinsurance).	Any amount over the annual maximums shown
End of life care	**Consumer Driven Option**
End of life care • See *Hospice care* benefit which includes advance care planning, above	Any amount over the annual maximums shown
Ambulance	**Consumer Driven Option**
Local professional ambulance service when medically appropriate immediately before, during or after an inpatient admission	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Ambulance service used for routine transport*	*All charges*

Section 5(d). Emergency Services-Accidents

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 healthcare expenses.
- If your Personal Care Account has been exhausted, you must pay your Net 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: In-network $83.33 per month for Self Only, $166.67 per month for Self Plus One or Self and Family; or out-of-network $125.00 per month for Self Only or $250.00 per month for Self Plus One or Self and Family, for each full month of coverage remaining in that calendar year.
- When you use a PPO hospital for emergency services, the emergency room physician who provides the services to you in the emergency room may not be a preferred provider. If they are not, they will be paid by this Plan as a PPO provider at the PPO rate.
- 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.
- When multiple or bilateral surgical procedures add complexity to an operative session, the Plan allowance for the second or less expensive procedure is one-half of what the Plan allowance would have been if that procedure had been performed independently.
  - When a surgery requires two primary surgeons (co-surgeons), the Plan allowance for each surgeon will not exceed 63% of our allowance. This allowance will be further reduced by half for secondary procedures.
  - Multiple or bilateral surgical procedures performed through the same incision are "incidental" to the primary surgery. That is, the procedure would not add time or complexity to patient care. We do not pay extra for incidental procedures.

What is an accidental injury?
An accidental injury is a bodily injury sustained solely through violent, external, and accidental means, such as broken bones, animal bites, and poisonings.

What is a medical emergency?
A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts, broken bones and mental health related care. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

Benefits Description	You pay
Accidental injury	**Consumer Driven Option**
If you receive care for your accidental injury within 24 hours, we cover: • Physician services and supplies • Related outpatient hospital services Note: We pay hospital benefits if you are admitted. If you receive care for your accidental injury after 24 hours, we cover: • Physician services and supplies Note: We pay hospital benefits if you are admitted.	In-network: 15% of the Plan allowance Out-of-network: 15% of the Plan allowance
Medical emergency	**Consumer Driven Option**
Outpatient facility charges **in an Urgent Care Center**	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance Note: For out-of-network 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**	In-network: 15% of the Plan allowance Out-of-network: 15% of the Plan allowance
Ambulance	**Consumer Driven Option**
Professional ambulance service within 24 hours of an accidental injury or medical emergency Note: See *Hospital benefits*, Section 5(c), for non-emergency service.	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount
Air ambulance	**Consumer Driven Option**
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.	In-network: 15% of the Plan allowance Out-of-network: 15% of the Plan allowance
Not covered: • *Non-emergent Air ambulance* • *Emergent transport beyond the nearest suitable facility* • *Air ambulance requested by patient or physician which are beyond the nearest facility for continuity of care or other reasons*	*All charges*

Section 5(e). Mental Health and Substance Use Disorder Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- 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.
- If you join at any time during the year other than Open Season, your Net Deductible for your first year will be prorated at a rate of: In-network $83.33 per month for Self Only, $166.67 per month for Self Plus One or Self and Family; or out-of-network $125.00 per month for Self Only or $250.00 per month for Self Plus One or Self and Family, for each full month of coverage remaining in that calendar year.
- 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 confirm which services require precertification.
- To obtain preauthorization of an admission for mental conditions or substance use disorder treatment, call UnitedHealthcare Behavioral Health Solutions at 800-718-1299.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.
- We do not make available provider directories for mental health or substance use disorder treatment providers. UnitedHealthcare Behavioral Health Solutions will provide you with a choice of network providers at 800-718-1299 or visit our website at www.myuhc.com.
- Schools or other educational institutions are not covered.

Benefits Description	You pay
Professional services	**Consumer Driven Option**
We cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
• In a physician's office* • Professional charges for intensive outpatient treatment in a provider's office or other professional setting * Professional services of a physician via Telehealth/Telemedicine are covered the same as in a physician's office.	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount

Professional services - continued on next page

Benefits Description	You pay
Professional services (cont.)	**Consumer Driven Option**
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment (preauthorization required by UnitedHealthcare Behavioral Health Solutions) • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of substance use disorders, including detoxification, treatment and counseling • Repetitive Transcranial Magnetic Stimulation, TMS, for the treatment of depressive disorders which have not been responsive to other interventions such as psychotherapy and antidepressant medications (preauthorization required by UnitedHealthcare Behavioral Health Solutions) • Electroconvulsive therapy (preauthorization required by UnitedHealthcare Behavioral Health Solutions) • Professional charges for intensive outpatient treatment in a provider's office or other professional setting (preauthorization required by UnitedHealthcare Behavioral Health Solutions) • Diagnosis and treatment to address gender dysphoria (in-network only). See Sections 5(b) and 5(c) for exclusions.	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount
TeleHealth services	**Consumer Driven Option**
• Virtual visits through UnitedHealthcare Behavioral Health Solutions for non-emergency visits Covered services include consultation, diagnosis and prescriptions (when appropriate) through the web or your mobile device. Please see www.myuhc.com, or call 800-718-1299 to start your virtual visit. Note: There is no out-of-network benefit for virtual visits.	In-network: 15% of the Plan allowance Out-of-network: N/A
Diagnostics	**Consumer Driven Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount

Benefits Description	You pay
Inpatient hospital or other covered facility	**Consumer Driven Option**
Inpatient services provided and billed by a hospital, Residential Treatment Center (RTC), or other covered facility (preauthorization required by UnitedHealthcare Behavioral Health Solutions) • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services • Inpatient diagnostic tests provided and billed by a hospital, Residential Treatment Center (RTC), or other covered facility	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *For Residential Treatment Centers, benefits are not available for non-covered services, including: respite care; outdoor residential programs; services provided outside of the provider's scope of practice; recreational therapy; educational therapy; educational classes; bio-feedback; Outward Bound programs; equine therapy provided during the approved stay; personal comfort items, such as guest meals and beds, telephone, television, beauty and barber services, which may be part of the treatment program's milieu and/or physical environment, are not covered as separately billed items; custodial or long term care; and domiciliary care provided because care in the home is not available or is unsuitable.*	*All charges*
Outpatient hospital or other covered facility	**Consumer Driven Option**
Outpatient services provided and billed by a hospital or other covered facility • Services such as partial hospitalization, or facility-based intensive outpatient treatment (preauthorization required by UnitedHealthcare Behavioral Health Solutions)	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Services that require preauthorization that are not part of a preauthorized approved treatment plan* • *Services that are not medically necessary* • *Services performed at schools or other educational institutions*	*All charges*

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.
- Your prescribers must 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.
- 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 healthcare expenses.
- If your Personal Care Account has been exhausted, you must pay your Net Deductible before your Traditional Health Coverage may begin. Your Deductible applies to all benefits in this section.
- 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/medical necessity review is required for certain drugs and must be renewed periodically. Prior authorization 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 Section 5(f), *Coverage Authorization* for more information about this program.
- Specialty drugs must be obtained through Optum Rx specialty pharmacy. Any discount associated with a manufacturer coupon for specialty medications does not apply toward your Deductible or out-of-pocket expenses.

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/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication.

Where can you obtain them. You can fill the prescription at an Optum Rx 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 have a managed formulary.** Our formulary is the Traditional Prescription Drug Formulary through OptumRx. 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, visit www.myuhc.com to view 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 800-718-1299.
- Member cost-share for prescription drugs is determined by the tier to which a drug has been assigned. To determine the tier assignments for formulary drugs, our Pharmacy Benefit Managers (PBM) work with their Pharmacy and Therapeutic Committee, a group of physicians and pharmacists who are not employees or agents of, nor have financial interest in the Plan. The Committee's recommendations, together with our PBM's evaluation of the relative cost of the drugs, determine the placement of formulary drugs on a specific tier. Using lower cost preferred drugs will provide you with a high quality, cost-effective prescription drug benefit.
  - Tier 1 - Mostly generic drugs, but some brand-name drugs may be included
  - Tier 2 - A mix of brand-name and generic drugs
  - Tier 3 - Mostly brand-name drugs and some generics

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 generally less expensive than brand drugs, therefore, you may reduce your out-of-pocket-expenses by choosing to use a generic drug.
- A generic equivalent will be dispensed if it is available, unless your physician specifically requires a brand name drug.

Benefits Description	You pay
Covered medications and supplies	**Consumer Driven Option**
Each new enrollee will receive a combined prescription drug/Plan identification card. You may purchase the following medications and supplies prescribed by a doctor from either a network pharmacy or by mail: • Drugs and medications, including those for Tobacco Cessation programs, for use at home that are obtainable only upon a doctor's prescription • Drugs and medications (including those administered during a non-covered admission or in a non-covered facility) that by Federal law of the United States require a physician's prescription for their purchase, except those listed as not covered • Insulin and test strips for known diabetics • Disposable needles and syringes for the administration of covered medications • Prior authorization/medical necessity review is required for certain drugs and must be renewed periodically. Prior authorization/medical necessity review uses Plan rules based on FDA-approved prescribing and safety information, clinical guidelines and uses that are considered reasonable, safe and effective. For example, approved drugs for organic impotence are subject to prior Plan approval and limitations on dosage and quantity. See Section 3, *Other services* and Section 5(f), *Coverage Authorization* for more information about this program. • Drugs to treat gender dysphoria. See Section 5(b), *Reconstructive Surgery*, for gender affirming care. • FDA approved drugs for weight management. Prior approval is required, see Section 5(f), *Coverage Authorization.* • Medications prescribed to treat obesity.	• Network Retail: - Tier 1 and Tier 2 - 25% of charge with a minimum of $15 and a maximum per prescription of $200 for a 30-day supply, $400 for a 60-day supply, $600 for a 90-day supply; - Tier 3 - 40% of charge with a minimum $15 and a maximum per prescription of $300 for a 30-day supply, $600 for a 60-day supply, $900 for a 90-day supply • Network Home Delivery: - Tier 1 and Tier 2 - 25% of charge with a minimum of $10 and a maximum per prescription of $200 for a 30-day supply, $400 for a 60-day supply, $600 for a 90-day supply; - Tier 3 - 40% of charge with a minimum $10 and a maximum per prescription of $300 for a 30-day supply, $600 for a 60-day supply, $900 for a 90-day supply
Contraceptive drugs and devices as listed on the Health Resources and Services Administration site https://www.hrsa.gov/womens-guidelines. Contraceptive coverage is available at no cost to PSHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. • In-network prescription drugs from Optum Rx's Patient Protection and Affordable Care Act (PPACA) Preventive Contraceptive Drug List for contraception. Find list at www.apwuhp.com.	Network Retail: $0 Network Home Delivery: $0

Covered medications and supplies - continued on next page

Benefits Description	You pay
Covered medications and supplies (cont.)	**Consumer Driven Option**
• A formulary exception process is available to physicians if they feel the formulary alternatives are not appropriate. Prescribers should request a clinical exception by calling 800-718-1299. Once your physician receives prior authorization, the contraceptive drug not on the PPACA list will be dispensed and you will pay $0. Urgent requests are reviewed within 24 hours. • Reimbursement for covered over-the-counter contraceptives can be submitted by filling out an OptumRX direct member reimbursement (DMR) form (prescription required) which can be found on www.myuhc.com or by contacting customer service at 800-718-1299. Note: If you have concerns about the Health Plan's compliance with the ACA/HRSA requirements or have difficulty accessing contraceptive coverage or other reproductive healthcare, contact contraception@opm.gov. See OPM's web page about contraception. Note: For additional Family Planning benefits see Section 5(a) Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation Educational Classes and Programs in Section 5(a)	Network Retail: $0 Network Home Delivery: $0
Opioid rescue agents such as naloxone are covered under this Plan with no cost-sharing when obtained from an in-network pharmacy in any over-the-counter or prescription form available such as nasal sprays and intramuscular injections. For more information consult the FDA guidance at https://www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to https://www.findtreatment.samhsa.gov/	Network Retail: Nothing Network Home Delivery: Nothing
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them* • *Medical supplies such as dressings and antiseptics* • *Nonprescription medicines/over-the-counter drugs, except as stated below:* - *Over-the-counter emergency contraceptive drugs, the "morning after pill", are covered at no cost if prescribed by a doctor and purchased at a network pharmacy* - *Over-the-counter FDA-approved contraception methods are covered at no cost if prescribed by a doctor and purchased at a network pharmacy* - *Certain new prescription drug products until they are reviewed and evaluated* • *Prescription drugs approved by the U.S. Food and Drug Administration when an over-the-counter equivalent is available.*	*All charges*

Covered medications and supplies - continued on next page

Benefits Description	You pay
Covered medications and supplies (cont.)	**Consumer Driven Option**
Note: For prescription drugs approved by the FDA for contraception and for devices for birth control see *Family planning,* Section 5(a).	*All charges*
Preventive medications	**Consumer Driven Option**
The following are covered: • Preventive Medications with USPSTF A and B recommendations. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations	• Network Retail: Nothing when prescribed by a healthcare professional and filled by a network pharmacy. • Network Home Delivery: Nothing when prescribed by a healthcare professional and filled by a network pharmacy.

Coverage Authorization

- The information below describes a feature of your prescription drug plan known as coverage authorization. Coverage authorization determines how your prescription drug plan will cover certain medications.
- Some medications are not covered unless you receive approval through a coverage review (prior authorization/medical necessity review). Examples of drug categories that require a coverage review include but are not limited to, specialty cholesterol, growth hormones, Botox, Interferons, rheumatoid arthritis agents, Retin A, drugs for organic impotence, and FDA approved drugs for weight management, gender dysphoria and gender transition (in-network only). This review uses plan rules based on FDA-approved prescribing and safety information, clinical guidelines and uses that are considered reasonable, safe and effective. There are other medications that may be covered with limits (for example, only for a certain amount or for certain uses) unless you receive approval through a review. During this review, Optum Rx asks your prescriber for more information than what is on the prescription before the medication may be covered under your plan. If coverage is approved, you simply pay your normal copayment/coinsurance for the medication. If coverage is not approved, you will be responsible for the full cost of the medication.
- To determine if a prescription drug product requires prior authorization/medical necessity review visit www.myuhc.com or call 800-718-1299.
- In our ongoing effort to provide a robust yet cost-effective prescription drug benefit, APWU Health Plan participates in programs to encourage the prescribing and use of generics and lower-cost alternative brands when appropriate. In most cases, you save money when the preferred generic or formulary brand is dispensed. One method that has proved effective in saving members money is "Step Therapy." Step therapy ensures that a first-line generic or brand alternative within a therapeutic category is used first, before the use of a similar but more expensive drug. Specific therapeutic categories are identified as appropriate for step therapy. Currently, the Plan offers step therapy programs on adrenal agents, specialty cholesterol drugs, Amino Acid Disorder, Asthma, Anticonvulsants, Benign Prostatic Hyperplasia/Erectile Dysfunction, depression, Diabetes, fungal infections, heartburn/reflux/ulcer, hemophilia, Hepatitis C, high cholesterol, infertility, Methotrexate, skin conditions, sleep aids, Opioids and Lyrica. In situations where a targeted drug is prescribed, the pharmacist will be notified to discuss Step 1 alternatives with the prescribing physician. If a first line therapy is not appropriate, your physician may contact OptumRx's coverage review unit. If the coverage is approved, the normal coinsurance and a letter of explanation will be sent to both you and your physician. If the coverage is not approved, you will be responsible for the full cost of the prescription. If you do not first obtain the Plan's approval, you will pay the full cost of the prescription. The prescriber can request a notification/prior authorization with OptumRx by logging into www.optumrx.com, Healthcare Professionals, Prior Authorization to submit an online notification/prior authorization request or by calling 800-711-4555. You may determine whether a particular prescription is subject to Step Therapy by visiting www.myuhc.com or by calling the number on the back of your ID card.
- Some Prescription Drugs are subject to supply limits that may restrict the amount dispensed per prescription order or refill and/or the amount dispensed per month's supply. To determine if a Prescription Drug has been assigned a maximum quantity level for dispensing, either visit www.myuhc.com or call the toll-free number on your ID card. Supply limits are subject to periodic review and modification. Supply limits are based upon the dosing recommendations included in the United States Food and Drug Administration (FDA) labeling, manufacturer's package size, and information in the medical literature or guidelines. If your current prescription is more than the supply limit, you have the following options: Accept the supply limit; either pay the full cost or an extra copayment for the additional supply; talk to your doctor about medication alternatives. To determine if your prescription drug product has been assigned a supply limit for dispensing, visit www.myuhc.com or call 800-718-1299.
- The U.S. Food and Drug Administration (FDA) defines a compound medication as one that requires a licensed pharmacist to combine, mix or alter the ingredients of a medication when filling a prescription. The FDA does not verify the quality, safety and/or effectiveness of compound medications, therefore the Plan will no longer cover certain compound prescriptions unless FDA approved. To avoid paying the full cost of these medications, you should ask your prescriber for a new prescription for an FDA-approved drug before your next fill. Your compound medication may require notification/prior authorization. The prescriber can request a notification/prior authorization with OptumRx by logging into www.optumrx.com, Healthcare Professionals, Prior Authorization to submit an online notification/prior authorization request or by calling 800-711-4555. If coverage of the medication is approved, you may continue to fill your prescription at the Plan's normal coinsurance. If the coverage of the medication is not approved, you will be responsible for the full cost of the prescription.
- The Plan will participate in other approved managed care programs to ensure patient safety and appropriate therapy in accordance with the Plan rules based on FDA-guidelines referenced above.

- To find out more about your prescription drug plan, please visit www.myuhc.com or call Member Services at 800-718-1299.
- **"Specialty Drugs"** are injectable, infused, oral or inhaled drugs defined as having one or more of several key characteristics: (1) requires frequent dosing adjustments and intensive clinical monitoring to decrease potential for drug toxicity or increased probability for beneficial treatment outcomes; (2) need for patient training and compliance assistance to facilitate therapeutic goals; (3) limited or exclusive product availability and distribution; (4) specialized product handling and/or administration requirements.

Some examples of the disease categories currently in the Optum Rx specialty pharmacy programs include cancer, cystic fibrosis, growth hormone deficiency, hemophilia, hypercholesterolemia, immune deficiency, hepatitis C, infertility, multiple sclerosis and rheumatoid arthritis. In addition, a follow-on-biologic or generic product will be considered a Specialty Drug if the innovator drug is a Specialty Drug.

Many of the Specialty Drugs covered by the Plan fall under the Coverage Authorization.

To determine if your prescription drug product is a Specialty Drug, visit www.myuhc.com or call 800-718-1299.

Specialty medications must be obtained through the Optum Rx specialty pharmacy. You can send your prescription through your normal mail service process or have your physician fax your prescription to Optum Rx.

Note: If you do not use your identification card at a network pharmacy, or if you use a non-network pharmacy, the Plan provides no benefit and you must pay the full cost of your purchases. Non-network retail drugs will be covered under the in-network benefit only if necessary and prescribed for sudden illness while traveling outside of the United States (including Puerto Rico).

Section 5(f)(a). PDP EGWP Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- These prescription drug benefits are for members enrolled in our Medicare Part D Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP).
- UnitedHealthcare MedicareRx is the administrator for this plan.
- If you are a Postal Service annuitant and their covered Medicare-eligible family member, you will be automatically group enrolled in our PDP EGWP. Contact UnitedHealthcare for additional information at 888-201-4265.

Note: Notify us as soon as possible if you or your eligible family member is already enrolled in a Medicare Part D Plan. Enrollment in our PDP EGWP will cancel your enrollment in another Medicare Part D plan.

There are advantages to being enrolled in our PDP EGWP:

- In our PDP EGWP, your cost-share for covered drugs, medications, and supplies will be equal to or better than the cost-share for those enrolled in our standard non-PDP EGWP Prescription Drug Program.
- In our PDP EGWP, you have a pharmacy network that may include pharmacies that are out-of-network or excluded for those enrolled in our standard non-PDP EGWP Prescription Drug Program.
- In our PDP EGWP, out-of-network pharmacies are not covered.
- There is custom coverage which includes coverage for some non-Medicare Part D prescription drugs. Please contact customer service at 888-201-4265 for additional information.

We cover drugs, medications, and supplies as described below and on the following pages.

- 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.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused drugs, medications, and supplies.
- The Medicare Part D calendar year deductible is: $0 per person. This deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage.

Warning:If you opt out of or disenroll from our PDP EGWP, you will not have any PSHB Program prescription drug coverage. However, you can enroll in our High Option MAPD during Open Season or for a **qualifying life event (QLE)** and receive PSHB Program Prescription Drug Coverage. Call APWU Health Plan at 800-222-2798 for more information.

Note: If you choose to opt out of or disenroll from our PDP EGWP, your premium will not be reduced, and you may have to wait to re-enroll during Open Season or for a QLE. If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Call APWU Health Plan at 800-222-2798 for more information.

Each new enrollee will receive a description of our PDP EGWP Summary of Benefits, a combined prescription drug/Plan identification card, a mail order form/patient profile and a preaddressed reply envelope.

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/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication. Your prescribers must have Medicare-approved prescriptive authority.
- **Where you can obtain prescription drugs.** You may fill prescriptions at any network pharmacy. For assistance locating a PDP EGWP network pharmacy, contact UnitedHealthcare MedicareRx Part D at 888-201-4265.
- **We have a managed formulary.** Your provider may prescribe drugs that are subject to additional review to determine they are medically necessary. For information on our formulary, contact UnitedHealthcare MedicareRx Part D at 888-201-4265.
- **These are the dispensing limitations:**
  - **Quantity limits -** The plan will only cover a certain amount of this drug for 1 copay/coinsurance or over a certain number of days. These limits can help ensure safe and effective use of the drug. If you are prescribed more than this amount or your doctor or prescriber thinks the limit is not right for your situation, you or your doctor or prescriber can ask the plan to cover the additional quantity.
  - **Morphine Milligram Equivalent -** Additional quantity limits may apply to all opioid drugs used to treat pain. This additional limit is called a cumulative Morphine Milligram Equivalent (MME). It's designed to monitor safe dosing levels of opioids for people who may be taking more than 1 opioid drug for pain management. If your doctor or prescriber prescribes more than this amount or thinks the limit is not right for your situation, you or your doctor or prescriber can ask the plan to cover the additional quantity. 7-day limit
    An opioid drug used to treat pain may be limited to a 7-day supply if you don't have a recent history of using opioids. This limit helps minimize long-term opioid use. If you are new to the plan and have a recent history of using opioids, the pharmacy may override the limit when appropriate.
  - **Dispensing limit -** Dispensing limits may apply to certain drugs limiting to a 1-month supply per prescription.
- **We may require Utilization Management strategies**:
  - **Step Therapy** – There may be effective, lower-cost drugs that treat the same medical condition as this drug. You may be required to try 1 or more of these other drugs before the plan will cover your drug. If you have already tried other drugs or your doctor or prescriber thinks they are not right for you, you or your doctor or prescriber can ask the plan to cover this drug.
  - **Prior Authorization** – The plan requires you or your doctor or prescriber to get prior approval for certain drugs. This means the plan needs more information from your doctor or prescriber to make sure the drug is being used and covered correctly by Medicare for your medical condition. Certain drugs may be covered by either Medicare Part B (doctor and outpatient health care) or Medicare Part D (prescription drugs) depending on how it is used. If you don't get prior approval, the plan may not cover the drug.
  - **Quantity Limits** – The plan will only cover a certain amount of this drug for 1 copay/coinsurance or over a certain number of days. These limits can help ensure safe and effective use of the drug. If you are prescribed more than this amount or your doctor or prescriber thinks the limit is not right for your situation, you or your doctor or prescriber can ask the plan to cover the additional quantity.
- **You may request a Formulary Exception.**
  - **How can I get an exception?** Sometimes you may need to ask for drug coverage that's not normally provided by your plan. This is called asking for an exception. When you do, the plan will review your request and give you a coverage decision known as a coverage determination.
  - **Types of exceptions you can ask for:**
    - **Drug List exception:** Ask the plan to cover your drug even if it's not on the Drug List. If approved, this drug will be covered at a pre-determined cost-sharing level. You will not be able to ask us to provide the drug at a lower cost-sharing level.
    - **Utilization exception:** Ask the plan to revise the coverage rules or limits on your drug. For example, if your drug has a quantity limit, you can ask the plan to change the limit and cover more.
    - **Tiering exception:** Ask the plan to cover your drug on our list at a lower cost-sharing level if this drug is not on the Specialty Tier. The plan may approve your request for an exception if the covered alternative drugs wouldn't be as effective in treating your condition or would cause adverse medical effects.

- **Who can ask for an exception?** You, your authorized representative, doctor or prescriber can ask for an exception by calling Customer Service. Your doctor or prescriber must give us a supporting statement with the reason for the exception.
- **How long does it take to get an exception?** After we get the statement from your doctor or prescriber supporting your request for an exception, we'll give you a decision within 72 hours. You can ask for an expedited (fast) decision if you or your doctor or prescriber believes that your health could be seriously harmed by waiting 72 hours. If your request for an expedited review is approved, we'll give you a decision within 24 hours after we get your doctor's or prescriber's supporting statement. Contact UnitedHealthcare MedicareRx Part D for more information at 888-201-4265.

- **A generic equivalent will be dispensed if it is available** unless your physician specifically requires a brand name drug.
- **Why use generic drugs.** Generic drugs have the same active ingredients as brand name drugs. They usually cost less than brand name drugs and generally work just as well. They usually don't have well-known names. Generic drugs are approved by the Food and Drug Administration (FDA). There are generic drugs available for many brand name drugs. Depending on state laws, generic drugs usually can be substituted for brand name drugs at the pharmacy without a new prescription. Our plan covers both brand name and generic drugs. Talk with your doctor or prescriber to see if any of the brand name drugs you take have generic versions.
- **When you do have to file a claim.** You may have to file a claim if you had to pay prescription costs up front or if you were overseas. Members can sign in or create an account to file a claim. Visit https://retiree.uhc.com/apwuhppartd
- **If we deny your claim and you want to appeal**, you, your representative, or your prescriber must request an appeal following the process described in Section 8(a). Medicare PDP EGWP Disputed Claims Process. The PDP EGWP appeals process has 5 levels. If you disagree with the decision made at any level of the process, you can generally go to the next level. At each level, you'll get instructions in the decision letter on how to move to the next level of appeal.

PDP EGWP Catastrophic Maximum

You will have a separate $2,000 out-of-pocket maximum for your prescription costs. Once you reach this maximum, you will no longer pay a cost share for covered drugs. Your portion of this $2,000 will also apply to the Plan's out-of-pocket maximum. See Section 4 for details on the out-of-pocket maximum.

Benefits Description	You pay
Covered medications and supplies	**Consumer Driven Option**
You may purchase the following medications and supplies prescribed by a physician from either a pharmacy or by mail: • Drugs and medications (including those administered during a non-covered admission or in a non-covered facility) that by Federal law of the United States require a physician's prescription for their purchase, except those listed as Not covered. • Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan. • Diabetic supplies limited to: - Disposable needles and syringes for the administration of covered medications • Drugs to treat gender dysphoria. See Section 5(b), *Reconstructive Surgery*, for gender affirming care. • Medications prescribed to treat obesity. • Medical Foods (medical foods are excluded from coverage, see Section 5(a), *Treatment Therapies*). • Sexual dysfunction drugs. Select erectile dysfunction and sexual desire disorder drugs are covered under the plan with quantity limits in place. Please contact customer service for more information.	**Part D Retail:** • **1 month supply:** Tier 1 - 25% of Plan allowance up to a maximum of $20 per prescription. Tier 2 - 25% of Plan allowance up to a maximum of $45 per prescription. Tier 3 - 40% of Plan allowance up to a maximum of $100 per prescription. Tier 4 - 40% of Plan allowance up to a maximum of $100 per prescription. • **2 month supply:** Tier 1 - 25% of Plan allowance up to a maximum of $40 per prescription. Tier 2 - 25% of Plan allowance up to a maximum of $90 per prescription. Tier 3 - 40% of Plan allowance up to a maximum of $200 per prescription. Tier 4 - 40% of Plan allowance up to a maximum of $200 per prescription.

Covered medications and supplies - continued on next page

Benefits Description	You pay
Covered medications and supplies (cont.)	**Consumer Driven Option**
• Select fertility drugs are covered under the plan. Please contact customer service for more information.	**Part D Retail:** • **1 month supply:** Tier 1 - 25% of Plan allowance up to a maximum of $20 per prescription. Tier 2 - 25% of Plan allowance up to a maximum of $45 per prescription. Tier 3 - 40% of Plan allowance up to a maximum of $100 per prescription. Tier 4 - 40% of Plan allowance up to a maximum of $100 per prescription. • **2 month supply:** Tier 1 - 25% of Plan allowance up to a maximum of $40 per prescription. Tier 2 - 25% of Plan allowance up to a maximum of $90 per prescription. Tier 3 - 40% of Plan allowance up to a maximum of $200 per prescription. Tier 4 - 40% of Plan allowance up to a maximum of $200 per prescription. • **3 month supply:** Tier 1 - 25% of Plan allowance up to a maximum of $60 per prescription. Tier 2 - 25% of Plan allowance up to a maximum of $135 per prescription. Tier 3 - 40% of Plan allowance up to a maximum of $300 per prescription. Tier 4 - 40% of Plan allowance up to a maximum of $300 per prescription. **Part D Mail Order:** • **1 month supply:** Tier 1 - 25% of Plan allowance up to a maximum of $20 per prescription. Tier 2 - 25% of Plan allowance up to a maximum of $45 per prescription. Tier 3 - 40% of Plan allowance up to a maximum of $100 per prescription. Tier 4 - 40% of Plan allowance up to a maximum of $100 per prescription. • **2 month supply:** Tier 1 - 25% of Plan allowance up to a maximum of $40 per prescription. Tier 2 - 25% of Plan allowance up to a maximum of $90 per prescription. Tier 3 - 40% of Plan allowance up to a maximum of $200 per prescription. Tier 4 - 40% of Plan allowance up to a maximum of $200 per prescription. • **3 month supply:** Tier 1 - 25% of Plan allowance up to a maximum of $40 per prescription. Tier 2 - 25% of Plan allowance up to a maximum of $90 per prescription. Tier 3 - 40% of Plan allowance up to a maximum of $200 per prescription. Tier 4 - 40% of Plan allowance up to a maximum of $200 per prescription.

Covered medications and supplies - continued on next page

Benefits Description	You pay
Covered medications and supplies (cont.)	**Consumer Driven Option**
Contraceptive drugs and devices as listed in the Health Resources and Services Administration site https://www.hrsa.gov/womens-guidelines. Contraceptive coverage is available at no cost to PSHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. • Over-the-counter and prescription drugs approved by the FDA to prevent unintended pregnancies. • In-network prescription drugs from Express Script's Patient Protection and Affordable Care Act (PPACA) Preventive Contraceptive Drug List for contraception. Find list at www.apwuhp.com. • A formulary exception process is available to prescribers if they feel the formulary alternatives are not appropriate. Prescribers should request a clinical exception by calling 800-753-2851. Once your physician receives prior authorization, the contraceptive drug not on the PPACA list will be dispensed and you will pay $0. Express Scripts responds to contraception exception requests within 24 hours of receipt of sufficient information to make a coverage determination. • Reimbursement for covered over-the-counter contraceptives can be submitted in accordance with Section 7. Note: If you have concerns about the Health Plan's compliance with the ACA/HRSA requirements or have difficulty accessing contraceptive coverage or other reproductive healthcare, contact contraception@opm.gov. See OPM's web page about contraception. Note: For additional Family Planning benefits see Section 5(a) Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the *Tobacco Cessation Educational Classes and Programs* in Section 5(a).	Nothing
Not covered • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Non-prescription medications medicines*	*All charges*
Preventive medication	**Consumer Driven Option**
The following are covered: Preventive Medications with USPSTF A and B recommendations. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations	Nothing when prescribed by a healthcare professional and filled by a network pharmacy.

Preventive medication - continued on next page

Benefits Description	You pay
Preventive medication (cont.)	**Consumer Driven Option**
Opioid rescue agents such as naloxone are covered under this Plan with no cost sharing when obtained from a network pharmacy in any over-the-counter or prescription form available such as nasal sprays and intramuscular injections. For more information consult the FDA guidance at https://www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to https://www.findtreatment.samhsa.gov/.	Nothing
Not covered: • *Drugs and supplies for cosmetic purposes* • *Nonprescription medications*	*All charges*

Section 5(g). Dental Benefits

Important things to keep in mind about these benefits:

- Refer to Personal Care Account (PCA).

Benefit	You Pay
Dental benefits	**Consumer Driven Option**
No benefit	See Section 5, *Personal Care Account*

Section 5(h). Wellness and Other Special Features

Special features	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process, see Section 8.

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

Special Features	Description
Online tools and resources	• Your Personal Care Account balance and activity (also mailed quarterly) • Your complete claims payment history • A consumer health encyclopedia and interactive services • Online health risk assessment to help determine your risk for certain conditions and steps to manage them • Personal Health Record • You can also download UnitedHealthcare's mobile app for the same great features
Consumer choice information	Each member is provided access by Internet (www.myuhc.com) or telephone 800-718-1299 to information which you may use to support your important health and wellness decisions, including: • Online provider directory with complete national network and provider information (i.e., address, telephone, specialty, practice hours, languages spoken) • Network provider discounted pricing for comparative shopping • Pricing information for prescription drugs • General cost information for surgical and diagnostic procedures and for comparison of different treatment options • Provider quality information • Health calculators on medical and wellness topics
Special Programs	Online programs and services provide extra support and savings, at www.myuhc.com or call 800-718-1299. • **Maternity Support Program (Maven)** - Mothers-to-be receive support through every stage of pregnancy and delivery. • **Kidney Resources Program** - For those diagnosed with end-stage renal disease or those who are currently receiving dialysis treatment, this program will help you manage your care for the best outcome. • **Orthopedic Health Support** - Orthopedic health support provides support for back, hip, knee, shoulder and neck conditions. • **Cancer Support Program** - Enroll in the program, and receive enhanced benefits at Cancer Centers of Excellence. • **AbleTo** - Customized Behavioral Health 6-8 week digital treatment program. Includes evidence-based treatment, care plan, digital reinforcement, and clinician/coaching. 24/7 access. Members are provided access to this program based on medical history and treatment plan. • **UnitedHealthcare Hearing** - Call 855-523-9355 or visit www.UHCHearing.com for hearing aids, care options and dedicated support. • **Careington Dental** - A dental discount plan that gives members access to discounts ranging from 20-50% on procedures using a network provider. For more information on the discounts and providers visit www.welcometouhc.com/apwu. • **One Pass Select ™** – visit www.WeRally.com or call 877-515-9364 to sign up for One Pass, a gym membership discount program offering access to national gym memberships, online fitness classes and Grocery Delivery service.

Special Features - continued on next page

Special Features (cont.)	Description
Wellness Incentive	Receive $25 for each of the following wellness visits - annual physical, mammogram and cervical screening with a clinical professional each year. When you complete these wellness visits, if you have Self Only coverage, we will add $25 to your Personal Care Account (PCA) for each. If you have Self Plus One or Self and Family coverage we will add $25 to the Personal Care Account (PCA) for the member, spouse, and each covered dependent who completes these wellness visits. We will add these amounts in the calendar year in which the visits are completed with a maximum of $75 per member.
Health Risk Assessment	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.
High Risk Maternity	Members can enroll in our Maven (virtual maternity support program) which provide support in every stage of pregnancy including, self measured blood pressure monitoring and support.

Non-PSHB Benefits Available to Plan Members

The benefits on this page are not part of the PSHB contract or premium, **and you cannot file a PSHB disputed claim about them**. Fees you pay for these services do not count toward PSHB 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.

Start Hearing

The Start Hearing 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 Start Hearing Plan through this offer will receive a discount on hearing aid devices and free hearing consultations annually offered through Starkey Hearing Technologies. To enroll in the plan you must call Start Hearing toll free at 888-863-7222 or visit www.starthearing.com/partners/APWU. Please specify that you are an APWU Health Plan participant.

Enroll in our Dental Plans

Anyone who is eligible to sign up for an APWU Health Plan can enroll in the following Dental Plans. These are optional programs with an additional premium that supplements the dental benefits in your medical coverage. PSHB members have two options, **APWU Health Plan Dental Insurance Plan or Voluntary Benefits Plan Dental Plan**. Insured members may use any dentist they choose. The cost of these benefits are not included in the PSHB premium and any charges for these services do not count toward any PSHB deductibles, out-of-pocket maximum, copay, charges, etc. These benefits are not subject to the PSHB disputed claims review procedure. For the **APWU Health Plan Dental Insurance Plan** visit www.apwuhp.com for a brochure and enrollment forms. All participants of the APWU Health Plan, either High Option or Consumer Driven Option, who enroll in the **Voluntary Benefits Plan Dental Plan** automatically receive a 7.5% premium reduction off this dental plan's rates. The Plan is available to all APWU Active, Retired, Associate, PSE and Private Sector due-paying members. To enroll in this additional coverage, complete and sign the Voluntary Benefits Plan Dental Plan enrollment form, which you can obtain from your APWU Health Plan representative or by calling the Voluntary Benefits Plan office at 800-422-4492; or visit www.voluntarybenefitsplan.com; or email VBPlan@alliant.com. Please specify that you are an APWU Health Plan participant. This optional dental plan is an indemnity insurance plan underwritten by the Metropolitan Life Insurance Company, New York, New York.

The Supplemental Discount Drug Program

The Supplemental Discount Drug Program will provide discounts to High Option members on all FDA-approved prescription drugs that are dispensed through Express Scripts Mail Order and Retail pharmacies, yet are not covered on the prescription drug plan administered by Express Scripts; www.express-scripts.com, 800-818-6717.

APWU Membership Information

Any annuitant who was in the bargaining unit represented by the APWU prior to retirement must be, or must become, members of the APWU Retirees Department. All other Postal Service employees in non-APWU bargaining Units, and annuitants will automatically become associate members of the APWU upon enrollment in the APWU Health Plan. Associate members will be billed by the APWU for annual membership dues, except where exempt by law (survivor annuitant or someone who is eligible for coverage under Spouse Equity Law or TCC).

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, Y*ou need prior Plan approval for certain services*).

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies that are not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus was carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies related to sexual dysfunction or sexual inadequacy except for organic impotence, see Sections 3 and 5(f)
- Unless otherwise specified in Section 5, services and supplies for weight reduction/control or treatment of obesity.
- Services, drugs, or supplies you receive from a provider or facility barred from the PSHB Program.
- Services, drugs and supplies for which no charge would be made if the covered individual had no health insurance coverage.
- Services or supplies we are prohibited from covering under Federal Law.
- Computer “story boards,” “light talkers,” or other communication aids for communication-impaired individuals.
- Services, drugs, or supplies you receive without charge while in active military service.
- Services, drugs and supplies furnished by yourself, immediate relatives or household members, such as spouse, parent, child, brother, or sister by blood, marriage, or adoption.
- Services and supplies furnished or billed by a non-covered facility, except medically necessary prescription drugs and physical, speech and occupational therapy rendered by a qualified professional therapist on an outpatient basis are covered subject to Plan limits.
- General anesthetics for dental services unless due to an underlying medical condition.
- Services, drugs and supplies billed by schools or other education institutions.
- Prolotherapy
- Naturopathic and homeopathic services such as naturopathic medications.
- Services, supplies and drugs not specifically listed as covered.
- Services, supplies and drugs furnished or billed by someone other than a covered provider as defined in Section 3.
- Any portion of a provider’s fee or charge ordinarily due from the enrollee that has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible, copay or coinsurance, we will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived.
- Charges which you or we have no legal obligation to pay, such as excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B, see Section 9, *When you are 65 or over and do not have Medicare*, doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare limiting charge, see Section 9, or State premium taxes however applied.
- Biofeedback; non-medical self care or self help training, such as recreational, educational, or milieu therapy unless specifically listed.

- Charges that we determine to be in excess of the Plan allowance.
- "Never Events" are errors in patient care that can and should be prevented. The APWU Health Plan will follow the policy of the Centers for Medicare and Medicaid Services (CMS). The Plan will deny payments for care that fall under these policies. For additional information, please visit www.cms.gov, and enter "Never Events" into SEARCH box.

Section 7. Filing a claim for covered services

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

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

In most cases, providers and facilities file claims for you. Your provider must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. Submit claims to the address on the back of your APWU Health Plan ID card.

If you need assistance or when you must file a claim for reimbursement for services such as dental, out-of-network providers, and overseas, please see below:

High Option (Medical and Behavioral Health)

For claims questions and assistance, call us at 800-222-2798, or visit our website at www.apwuhp.com.

Mail claims to:

- APWU Health Plan, P.O. Box 8660, Elkridge, MD 21075

High Option (Pharmacy)

Mail claims to:

- Express Scripts, Attn: Commercial Claims, P.O. Box 14711, Lexington, KY 40512-4711

Consumer Driven Option (Medical, Behavioral Health and Pharmacy)

For claims questions and assistance, contact UnitedHealthcare at 800-718-1299 or visit their website at www.myuhc.com.

Mail all claims to:

- UnitedHealthcare, P.O. Box 740800, Atlanta, GA 30374-0800

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

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

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

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

How to claim benefits	In addition: • If another health plan is your primary payor, you must send a copy of the explanation of benefits (EOB) statement you received from your primary payor (such as the Medicare Summary Notice (MSN)) with your claim. • If your claim is for the rental or purchase of durable medical equipment; skilled nursing visits; physical therapy, occupational therapy, or speech therapy, you must provide a written statement from the provider specifying the medical necessity for the service or supply and the length of time needed. • Claims for prescription drugs and supplies must include receipts that show the prescription number, name of drug or supply, prescribing provider name, date, and charge. • We will provide translation and currency conversion services for claims for overseas (foreign) services.
Post-service claims procedures	We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected. If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information. If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.
Records	Keep a separate record of the medical expenses of each covered family member as deductibles and maximum allowances apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible. In most instances they will serve as evidence of your claim. We will not provide duplicate or year-end statements.
Deadline for filing your claim	Send us all the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service. If you could not file on time because of Government administrative operations or legal incapacity, you must submit your claim as soon as reasonably possible. Once we pay benefits, there is a three-year limitation on the re-issuance of uncashed checks.
Overseas claims	For covered services you receive by providers and hospitals outside the United States and Puerto Rico, send a completed Claim Form and the itemized bills to the following address. Also, send any written inquiries concerning the processing of overseas claims to: • **High Option:** APWU Health Plan, P.O. Box 8660, Elkridge, MD 21075. • **Consumer Driven Option:** UnitedHealthcare at the claims address shown on the back of your UnitedHealthcare ID card.
When we need more information	Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.
Authorized Representative	You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a healthcare professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

The Secretary of Health and Human Services has identified counties where at least 10% of the population is literate only in certain non-English languages. The non-English languages meeting this threshold in certain counties are Spanish, Chinese, Navajo and Tagalog. If you live in one of these counties, we will provide language assistance in the applicable non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the healthcare provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes and its corresponding meaning, and the treatment code and its corresponding meaning.

Section 8. The disputed claims process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information or to make an inquiry about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website. If you are a Postal Service annuitant, or their covered Medicare-eligible family member, enrolled in our Medicare Part D Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP) and you disagree with our **pre-service or post-service** decision about your prescription drug benefits, please, follow Medicare's appeals process outlined in Section 8a. Medicare PDP EGWP Disputed Claims Process.

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

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing to APWU Health Plan, Public Relations Department, P.O. Box 8660, Elkridge, MD 21075 or calling 800-222-2798.

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

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

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

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

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: 1. Write to us within 6 months from the date of our decision; and 2. Send your **High Option** request to us at: APWU Health Plan, P.O. Box 8660, Elkridge, MD 21075 or send your **Consumer Driven Option** request to: UnitedHealthcare Appeals, P.O. Box 740816, Atlanta, GA 30374-0816; and 3. Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and 4. Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) statements. 5. Include your email address (optional), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly.

	We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: 1. Pay the claim or 2. Write to you and maintain our denial or. 3. Ask you or your provider for more information. You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Postal Service Insurance Operations, 1900 E Street, NW, Washington, DC 20415. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call; • Your email address, if you would like to receive OPM’s decision via email. Please note that by providing your email address, you may receive OPM’s decision more quickly. Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim. Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a healthcare professional with knowledge of your medical condition may act as your authorized representative without your express consent. Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.
4	OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision or notify you of the status of OPM's review within 60 days. There are no other administrative appeals.

	If you do not agree with OPM's decision, your only recourse is to sue. If you decide to file a lawsuit, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended. OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record. You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then, call us at 800-222-2798. We will expedite our review (if we have not yet responded to your claim): or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's PSIO at 202-936-0002 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a family member is covered under this Plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Reminder: If you are a Postal Service annuitant, or their covered Medicare-eligible family member, enrolled in our Medicare Part D PDP EGWP you may appeal an adverse pre-service or post-service determination through Medicare's appeals process. See Section 8(a).

Section 8(a). Medicare PDP EGWP Disputed Claims Process

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you make an appeal, we review the coverage decision we have made to check to see if we followed all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review we give you our decision.

Consumer Driven

How to appeal a decision about your prescription coverage

Appeal Level 1 - You may ask us to review an unfavorable coverage decision we've issued to you, even if only part of our decision is not what you requested. An appeal to the plan about a Medicare Part D drug is also called a plan "redetermination."

Appeal Level 2 – If we reviewed your appeal at "Appeal Level 1" and did not decide in your favor, you have the right to appeal to the Independent Review Entity (IRE).

When we receive your request to review the adverse coverage determination, we give the request to people at our organization not involved in making the initial determination. This helps ensure that we give your request a fresh look.

To file an appeal:

- Write a letter describing your appeal, and include any paperwork that may help in the research of your case. Provide your name, your member identification number, your date of birth, and the drug you need. You may also request an appeal by downloading and mailing in the Redetermination Request Form (pdf) or by secure email.

Send the letter or the Redetermination Request Form to the Medicare Part D Appeals and Grievance Department PO Box 6106, M/S CA 124-0197, Cypress CA 90630-9948. You may also fax your letter of appeal to the Medicare Part D Appeals and Grievances Department at 1-866-308-6294. You must mail your letter within 60 days of the date the adverse determination was issued, or within 60 days from the date of the denial of reimbursement request. If you missed the 60-day deadline, you may still file your appeal if you provide a valid reason for missing the deadline.

- You can also submit an appeal online: Medicare Plan Appeals & Grievances Online Form.
- Note: if you are requesting an expedited (fast) appeal, you may also contact customer service
- The Medicare Part D Appeals and Grievance Department will look into your case and respond with a letter within 7 calendar days of receiving your request. You'll receive a letter with detailed information about the coverage denial.
- The information on how to file a Level 1 Appeal can also be found in the adverse coverage decision letter.

High Option

Grievance Contact Information

Use this contact information to file a grievance.

- Write: Express Scripts Medicare, Attn: Grievance Resolution Team, PO Box 3610, Dublin, OH 43016-0307
- Call: 1-844-818-8790 / 1-800-716-3231(TTY)
- Fax: 1-614-907-8547
- Hours: 24 hours a day / 7 days a week

Initial Coverage Reviews

Use this contact if you need an initial coverage decision for a medication that must be approved before the prescription can be filled at a participating retail or home delivery pharmacy, or to remove or change a restriction on a specific medication.

- Write: Express Scripts, Attn: Medicare Reviews, PO Box 66571, St. Louis, MO 63166-6571

- Call: 1-844-374-7377 / 1-800-716-3231(TTY)
- Fax: 1-877-251-5896
- Hours: 24 hours a day / 7 days a week

Appeals Contact Information

Use this contact information if you need to file an appeal because your coverage review was denied or because your request to remove or change a restriction was denied.

- Write: Express Scripts, Attn: Medicare Appeals, PO Box 66588, St. Louis, MO 63166-6588
- Call: 1-844-374-7377 / 1-800-716-3231(TTY)
- Fax: 1-877-852-4070
- Hours: 24 hours a day / 7 days a week

Paper Claim Submission

Mail requests with receipts to obtain payment for medication already received to: Express Scripts, Attn: Medicare Part D, PO Box 14718, Lexington, KY 40512-4718

To obtain a Direct Claim Form: download from our website, express-scripts.com, in the Medicare Resources Center found in the Benefits menu, or call Customer Service.

The Direct Claim Form is not required, but it will help us proceed the information faster. It's a good idea to make a copy of all your receipts for your records. You can fax us your request for payment 24 hours a day, 7 days a week to 1-608-741-5483.

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 healthcare expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For example:

- If you are covered under our Plan as a dependent, any group health insurance you have from your employer will pay primary and we will pay secondary,
- If you are an annuitant under our Plan and also are actively employed, any group health insurance you have from your employer will pay primary and we will pay secondary.

This Plan always pays secondary to:

- Any medical payment, PIP or No-Fault coverage under any automobile policy available to you,
- Any plan or program which is required by law. You should review your automobile insurance policy to ensure that uncoordinated medical benefits have been chosen so that the automobile insurance policy is the primary payer.

For more information on NAIC rules regarding the coordinating of benefits, visit our website at www.apwuhp.com.

When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will determine our allowance. After the primary plan processes the benefit, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. When we are the secondary payor, we will not waive specified visit limits.

Please see Section 4, *Your Costs for Covered Services,* for more information about how we pay claims.

TRICARE and CHAMPVA

TRICARE is the healthcare program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended PSHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant, you can suspend your PSHB coverage to enroll in one of these programs, eliminating your PSHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your PSHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the PSHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

Workers' Compensation

Every job-related injury or illness should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices. If you are a federal or postal employee, ask your supervisor to authorize medical treatment by use of form CA-16 before you obtain treatment. If your medical treatment is accepted by the Dept. of Labor Office of Workers' Compensation (OWCP), the provider will be compensated by OWCP. If your treatment is determined not job-related, we will process your benefit according to the terms of this plan, including use of in-network providers. Take form CA-16 and form OWCP-1500/HCFA-1500 to your provider, or send it to your provider as soon as possible after treatment, to avoid complications about whether your treatment is covered by this plan or by OWCP.

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar federal or state agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Medicaid

When you have this Plan and Medicaid, we pay first.

Suspended PSHB coverage to enroll in Medicaid or a similar state-sponsored program of medical assistance: If you are an annuitant, you can suspend your PSHB coverage to enroll in one of these state programs, eliminating your PSHB premium. For information on suspending your PSHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the PSHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, state, or federal government agency directly or indirectly pays for them.

When others are responsible for injuries

The terms "Reimbursement" and "Subrogation" are defined by the U.S. Office of Personnel Management in Part 890 of the Code of Federal Regulations, 89 C.F.R. § 890.101(a), and those definitions are hereby incorporated into this brochure. Our subrogation and reimbursement rights arise when the individual who suffers an injury or illness has a right to be compensated from another source for that injury or illness as described below.

Reimbursement means a carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a Workers' Compensation program or insurance policy, and the terms of the carrier's health insurance plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

Subrogation means a carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a Workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

The terms reimbursement and subrogation have the same meaning in this brochure as they do in the OPM Rules. Our right to pursue and receive subrogation and reimbursement recoveries is a condition of and a limitation on the nature of benefits or benefit payments and on the provision of benefits under our coverage. This section explains your basic obligations and procedures related to this reimbursement requirement. The funds the Plan recovers through reimbursement and subrogation help lower the subscription charges for all enrollees.

If we pay benefits for an injury or illness suffered by a covered individual, and monetary compensation related to that injury or illness is received from someone else (referred to as a “third party”), the Plan must be reimbursed out of the compensation received for the total amount of benefits it paid or reasonably expects to pay. The amount the Plan is entitled to recover is sometimes referred to as the Plan’s "lien", and the Plan may ask a court to issue an order confirming the Plan’s lien. Reimbursement to the Plan is a requirement and condition on a covered individual obtaining benefits from the Plan under this brochure. The Plan’s recoveries through reimbursement and subrogation help lower subscription charges for all enrollees in the Plan.

By enrolling in the Plan and in accordance with the PSHB Program and this brochure, you agree that the Plan’s right to pursue and receive subrogation and reimbursement recoveries is a condition of and a limitation on the nature of benefits or benefit payments and on the provision of benefits under our coverage, and you agree to the following:

- The Plan must be reimbursed in any and all situations where a covered individual, or their representatives, heirs, administrators, successors or assignees receive payment from any source related to an injury or illness for which the individual has received benefits or benefit payments from the Plan. This may include money recovered from another party who may be liable, a third party’s insurance policy, your own insurance policy, or a Workers' Compensation program or policy, through a lawsuit, a judgment, settlement, or other recovery. The Plan must be reimbursed to the extent of the benefits we have paid or provided, or reasonably expect to pay or provide, in connection with the injury or illness.
- Reimbursement of the Plan must be done on a first priority basis (before any of the rights of any other party are honored) out of any recovery obtained no matter the source (litigation, judgment, settlement, insurance claim or otherwise) and no matter how the recovery is characterized, designated, or apportioned (such as your claim against the third party being for “pain and suffering”).
- The Plan’s right to reimbursement applies even if the Plan paid benefits before we knew of the accident or illness.
- Restrictive endorsements or other statements on checks accepted by the Plan or its agents to reimburse the Plan in a subrogation matter will not bind the Plan.
- Neither you nor your representatives, heirs, administrators, successors or assignees will do anything that would prevent us from being fully reimbursed for the benefits we paid, and you and your representatives, heirs, administrators, successors and assignees will cooperate in assisting us in recovering the cost of the benefits we paid.
- You agree and authorize the Plan to communicate directly with any involved insurance carriers regarding your injury or illness and their reimbursements.
- This reimbursement responsibility covers benefits for you and any other person on your membership.

The Plan is entitled to be reimbursed fully even if the amount received does not compensate the injured individual fully or if there are other liens or expenses. We are entitled to be reimbursed for our benefit payments even if the injured individual is not legally “made whole” for all damages arising out of the injury or illness. Our right of recovery is also not subject to reductions for attorney’s fees or costs in recovering the money under the “common fund” or other legal doctrines.

If you wish to discuss the amount of reimbursement to pay to the Plan, please contact Customer Service (High Option, 800-222-2798; Consumer Driven Option, 800-718-1299) or our subrogation representatives at the contact information at the end of this section.

If you or your representatives, heirs, administrators, successors or assignees do not pursue a claim or demand against a third party, we may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

What to communicate to the Plan:

- Promptly inform us if a covered individual has an injury or illness for which benefits paid by the Plan might be reimbursed or subrogated as described here. This includes reporting third party cases to Customer Service or responding to any questionnaires or surveys inquiring about benefit claims paid by the Plan. We or our subrogation representatives will communicate with you about whether you owe the Plan any reimbursement. Failure to provide information related to reimbursements may delay the processing of your benefits.
- If you or your representatives, heirs, administrators, successors or assignees make a claim or demand on a third party for compensation for an injury or illness for which the Plan has paid benefits, notify us immediately. We will communicate with you to keep the status of the claim or demand updated in our systems so that there is no delay in processing your claims. We may seek a first priority lien on the proceeds of your claim in order to ensure that the Plan is reimbursed for the benefits we paid or will pay. We may also require you to assign to us (1) your claim or demand or (2) your right to the proceeds of your claim or demand. In all cases, we may enforce our right of recovery and reimbursement by offsetting any undisputed amount owed the Plan as a result of recovering money from a third party against future benefit payments by the Plan.

If you need more information or wish to report or discuss a subrogation or reimbursement matter, please contact Customer Service or our subrogation representatives.

High Option: ODSA, P.O. Box 34188, Washington, DC 20043-4188;
or subroinfo@odsalaw.com, 877-535-1075 or 202-898-1075

Consumer Driven Option: UnitedHealthcare, 800-718-1299

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP)

Some PSHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your PSHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on www.benefeds.gov or by phone at 1-877-888-3337, (TTY 1-877-889-5680), you will be asked to provide information on your PSHB plan so that your plans can coordinate benefits. Providing your PSHB information may reduce your out-of-pocket cost.

Clinical trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either Federally-funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy

- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This Plan does not cover these costs.

When you have Medicare

For more detailed information on "What is Medicare?" and "When do I Enroll in Medicare?" please contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

Important Note: Subject to limited exceptions, Postal Service annuitants entitled to Medicare Part A and their eligible family members who are entitled to Medicare Part A are required to enroll in Medicare Part B to maintain eligibility for the PSHB Program in retirement.

If you are required to enroll in Medicare Part B and fail to do so at your first opportunity, you may be disenrolled (annuitants) and/or your family members removed from coverage.

For more information on these requirements, please contact the PSHB Helpline at 1-844-451-1261.

The Original Medicare Plan (Part A or Part B)

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan. When we are the primary payor, we process the claim first. In this case, we do not waive any out-of-pocket costs.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 800-222-2798 or see our website at www.apwuhp.com.

We waive some costs if the Original Medicare Plan is your primary payor.

Under the High Option, we will waive some out-of-pocket costs as follows:

- Inpatient hospital service. If you are enrolled in Medicare Part A, we will waive the deductible and coinsurance.
- Medical services and supplies provided by physicians and other healthcare professionals. If you are enrolled in Medicare Part B, we will waive the deductible, coinsurance and copayment.
- We offer a Medicare Advantage plan, UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan for Federal members. Please review the information on coordinating benefits with Medicare Advantage plans below.

Under the Consumer Driven Option, when Original Medicare (either Medicare Part A or Medicare Part B) is the primary payer, we will not waive any out-of-pocket costs.

Note: We do not waive our deductible, copayments or coinsurance for prescription drugs or for services and supplies that Medicare does not cover. Also, we do not waive benefit limitations, such as the 24-visit limit for chiropractic services or the 60-visit limit for physical, occupational or speech therapy.

Retirees that participate with Medicare Part B may request reimbursement for their Part B premiums, if PCA funds are available (see Section 5, PCA).

You can find more information about how our Plan coordinates benefits with Medicare in APWU Health Plan's Blueprint to Medicare at www.apwuhp.com. We do not waive any costs if the Original Medicare Plan is your primary carrier.

Please review this information. It illustrates your cost share if you are enrolled in Medicare Part B. Medicare will be primary for all Medicare eligible services. Members must use providers who accept Medicare's assignment.

Tell us about your Medicare coverage

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

Private contract with your physician

If you are enrolled in Medicare Part B, a physician may ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. Should you sign an agreement, Medicare will not pay any portion of the charges, and we will not increase our payment. We will still limit our payment to the amount we would have paid after Original Medicare's payment. You may be responsible for paying the difference between the billed amount and the amount we paid.

If you are eligible for Medicare, you may choose to enroll and get your Medicare benefits from a Medicare Advantage plan. These are private healthcare choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 800-MEDICARE (800-633-4227), (TTY: 877-486-2048) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and our Medicare Advantage plan: If you elect to enroll in our Medicare Advantage plan you must also remain enrolled in our PSHB plan**.** For more information on our Medicare Advantage plan, please contact 855-383-8793. Enrollment in UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan is voluntary. Members must complete an application for enrollment. Eligible enrollees voluntarily opt into UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan and may opt out at any time. You may enroll in the UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan, if:

- You are a retiree or annuitant enrolled in the High Option and have both Medicare Part A and Part B.
- You are a United States citizen or are lawfully present in the United States.
- You do NOT have End-Stage Renal Disease (ESRD). Enrollees who have ESRD cannot enroll until after the 30-month grace period has expired. Members diagnosed with ESRD while enrolled in UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan may remain enrolled and ESRD services will be covered.
- You complete an application for enrollment in the UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan.

Medicare B Premium Reimbursement

- We offer a plan designed to help members with their Medicare Part B premium. This plan is called UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan. If you have Medicare Part A and B and enroll in this plan, **you will be reimbursed $100 of your Medicare Part B monthly premium**. This will be sent from Centers for Medicare and Medicaid Services (CMS) directly to your Social Security. Please review the information below. It illustrates your cost share if you are enrolled in the High Option only, the High Option with Medicare Part B or the UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan. Members must use providers who accept Medicare's assignment.

Please review the following examples which illustrate your cost share if you are enrolled in Medicare Part B. If you purchase Medicare Part B, your provider is in our network and participates in Medicare, then we waive some costs because Medicare will be the primary payor.

Benefit Description: Deductible
High Option You Pay **without** Medicare (In-Network): $450 Self Only/$800 Family
High Option You Pay **with** Medicare B (In-Network): $0
UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan
- (UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan) (In-network): $0

Benefit Description: Out-of-Pocket Maximum
High Option You Pay **without** Medicare (In-Network): $6,500 Self Only/$13,000 Family
High Option You Pay **with** Medicare B (In-Network): $6,500 Self Only/$13,000 Family
UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan -
(UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan) (In-network): $0

Medicare Advantage (Part C)

Benefit Description: Part B Premium Reimbursement Offered
High Option You Pay **without** Medicare (In-Network): N/A
High Option You Pay **with** Medicare B (In-Network): N/A
UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan -
(UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan) (In-network): $100 per month

Benefit Description: Primary Care Provider
High Option You Pay **without** Medicare (In-Network): $25
High Option You Pay **with** Medicare B (In-Network): $0
UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan -
(UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan) (In-network): $0

Benefit Description: Specialist
High Option You Pay **without** Medicare (In-Network): $25
High Option You Pay **with** Medicare B (In-Network): $0
UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan -
(UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan) (In-network): $0

Benefit Description: Inpatient Hospital
High Option You Pay **without** Medicare (In-Network): 15%
High Option You Pay **with** Medicare B (In-Network): $0
UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan -
(UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan) (In-network): $0

Benefit Description: Outpatient Hospital
High Option You Pay **without** Medicare (In-Network): 15%
High Option You Pay **with** Medicare B (In-Network): $0
UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan - (UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan) (In-network): $0

Benefit Description: Incentives offered
High Option You Pay **without** Medicare (In-Network): N/A
High Option You Pay **with** Medicare B (In-Network): Waive deductible, coinsurance and copayment
UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan - (UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan) (In-network): gym memberships, dental, vision, eyewear allowance every 24 months (glasses and contacts), podiatry, hearing aids and a nationwide network

To learn more about the UnitedHealthcare Medicare Advantage (PPO) for APWU Health Plan and how to enroll, call us at 855-383-8793, 8 a.m. to 8 p.m., local time, Monday through Friday. For TTY for the deaf, hard of hearing, or speech impaired, call 711. We will send you additional information and an application for enrollment.

This Plan and another plan's Medicare Advantage plan: You may enroll in another non-PSHB plan's Medicare Advantage plan and also remain enrolled in our PSHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers). For the High Option, we waive some costs if Medicare Advantage is your primary payor. We will waive our copayments, coinsurance, or deductibles. For the Consumer Driven Option, we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended PSHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant, you can suspend your PSHB coverage to enroll in a Medicare Advantage plan, eliminating your PSHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your PSHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the PSHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

If you elect to enroll in APWU Health Plan's PSHB Medicare Advantage plan it will take over as the primary and only payer so you will not need to coordinate benefits, however, you must remain enrolled in the APWU Health Plan High Option if you elect the Medicare Advantage plan. Do not suspend or cancel your coverage with OPM or you will also be terminated from the Medicare Advantage plan.

Medicare Part D Prescription Drug Plans

When we are the primary payor, we process the claim first. If you (as an active employee eligible for Medicare Part D or their covered Medicare Part D-eligible family member) enroll in any open market Medicare Part D plan and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by that Medicare Part D plan and consider them for payment under the PSHB plan.

Note: If you are a Postal Service annuitant or their covered Medicare-eligible family member enrolled in our Medicare Part D PDP EGWP, this does not apply to you because you may not be enrolled in more than one Medicare Part D plan at the same time. If you opt out of or disenroll from our PDP EGWP you do not have our PSHB Program prescription drug coverage and we are not a secondary payor for prescription drug benefits.

Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP)

If you are enrolled in Medicare, and are not enrolled in a Medicare Advantage Plan (Part C), you will be automatically enrolled in the Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP) for APWU Health Plan. Our PDP EGWP is a prescription drug benefit for Postal Service annuitants and their covered Medicare-eligible family members. This allows you to receive benefits that will never be less than the standard prescription drug coverage that is available to members with non-PDP EGWP prescription drug coverage. But more often you will receive benefits that are better than members with standard non-PDP EGWP prescription drug coverage. **Note:You have the choice to opt out of or disenroll from our PDP EGWP at any time and may obtain prescription drug coverage outside of the PSHB Program.**

When you are enrolled in our Medicare PDP EGWP for your prescription drug benefits you continue to have our medical coverage.

See our Health Plan specific details: for the High Option and Consumer Driven Plans refer to Section 5(f)(a)

Members with higher incomes may have a separate premium payment for their Medicare Part D Prescription Drug Plan (PDP) benefit. Please refer to the Part D-IRMAA section of the Medicare website: https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to an additional premium.

For people with limited income and resources, Extra Help is a Medicare program to help with Medicare prescription drug plan costs. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov or call the SSA at 800-772-1213 TTY 800-325-0778. You may also contact APWU Health Plan at 800-222-2798.

The PDP EGWP opt out process:

If you were automatically group enrolled into our PDP EGWP and choose to opt out, you may contact APWU Health Plan at 800-222-2798.

The PDP EGWP disenrollment process:

When you are enrolled in our PDP EGWP, you may choose to disenroll at any time. You may contact APWU Health Plan at 800-222-2798 to opt out.

Warning:If you opt out of or disenroll from our PDP EGWP, you will not have any PSHB Program prescription drug coverage. However, you can enroll in our High Option MAPD during Open Season or for a QLE and receive PSHB Program Prescription Drug Coverage. Contact APWU Health Plan at 800-222-2798 for more information.

Note: If you choose to opt out of or disenroll from our PDP EGWP, your premium will not be reduced, and you may have to wait to re-enroll when and if you are eligible. If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Contact APWU Health Plan at 800-222-2798 for more information.

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

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

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

When you are age 65 or over and do not have Medicare

Under the FEHB law, which includes the PSHB Program, we must limit our payments for inpatient hospital care and physician care to those payments you would be entitled to if you had Medicare. Your physician and hospital must follow Medicare rules and cannot bill you for more than they could bill you if you had Medicare. You and the PSHB benefit from these payment limits. Outpatient hospital care and non-physician based care are not covered by this law; regular Plan benefits apply. The following chart has more information about the limits.

If you:

- are age 65 or over; and
- do not have Medicare Part A, Part B, or both; and
- have this Plan as an annuitant, **or** as a family member of an annuitant; and
- are not employed in a position that gives PSHB coverage. (Your employing office can tell you if this applies.)

Then, for your inpatient hospital care:

- The law requires us to base our payment on an amount - the "equivalent Medicare amount" - set by Medicare's rules for what Medicare would pay, not on the actual charge.
- You are responsible for your applicable deductibles, coinsurance, or copayments under this Plan.
- You are not responsible for any charges greater than the equivalent Medicare amount; we will show that amount on the explanation of benefits (EOB) form that we send you.
- The law prohibits a hospital from collecting more than the "equivalent Medicare amount".

And, for your physician care, the law requires us to base our payment and your coinsurance or copayment on:

- an amount set by Medicare and called the "Medicare approved amount," or
- the actual charge if it is lower than the Medicare approved amount.

If your physician:
Participates with Medicare or accepts Medicare assignment for the claim and is a member of our PPO network,
Then you are responsible for:
your deductibles, coinsurance, and copayments.

If your physician:
Participates with Medicare and is not in our PPO network,
Then you are responsible for:
your deductibles, coinsurance, copayments, and any balance up to the Medicare approved amount.

If your physician:
Does not participate with Medicare,
Then you are responsible for:
your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount.

If your physician:
Does not participate with Medicare and is not a member of our PPO network
Then you are responsible for:
your out-of-network deductibles, coinsurance, and any balance up to 115% of the Medicare approved amount

If your physician:
Opts out of Medicare via private contract
Then you are responsible for:
your deductibles, coinsurance, copayments, and any balance your physician charges

It is generally to your financial advantage to use a physician who participates with Medicare. Such physicians are permitted to collect only up to the Medicare approved amount.

Physicians Who Opt-Out of Medicare

A physician may have opted-out of Medicare and may or may not ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. This is different than a non-participating doctor, and we recommend you ask your physician if they have opted-out of Medicare. Should you visit an opt-out physician, the physician will not be limited to 115% of the Medicare approved amount. You may be responsible for paying the difference between the billed amount and our regular in-network/out-of-network benefits.

Our explanation of benefits (EOB) form will tell you how much the physician or hospital can collect from you. If your physician or hospital tries to collect more than allowed by law, ask the physician or hospital to reduce the charges. If you have paid more than allowed, ask for a refund. If you need further assistance, call us. It is generally to your financial advantage to use a physician who participates with Medicare. Such physicians are permitted to collect only up to the Medicare approved amount.

When you have the Original Medicare Plan (Part A, Part B, or both)

We limit our payment to an amount that supplements the benefits that Medicare would pay under Medicare Part A (Hospital insurance) and Medicare Part B (Medical insurance), regardless of whether Medicare pays. Note: We pay our regular benefits for emergency services to an institutional provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare.

We use the Department of Veterans Affairs (VA) Medicare-equivalent Remittance Advice (MRA) when the statement is submitted to determine our payment for covered services provided to you if Medicare is primary, when Medicare does not pay the VA facility.

If you are covered by Medicare Part B and it is primary, your out-of-pocket costs for services that both Medicare Part B and we cover depend on whether your physician accepts Medicare assignment for the claim.

High Option: If your physician **accepts** Medicare assignment, then you pay **nothing** for covered charges up to our allowance.

Consumer Driven Option: If your physician **accepts** Medicare assignment, then you pay nothing if you have unused benefits available under your Personal Care Account (PCA) to pay the difference between the Medicare approved amount and Medicare's payment. If your PCA is exhausted, you must pay either this full difference under your Deductible or the lesser of your coinsurance or the full difference if your Deductible has been met.

If your physician **does not accept** Medicare assignment, you pay the difference between the “limiting charge” or the physician’s charge (whichever is less) and our payment combined with Medicare’s payment.

It is important to know that a physician who does not accept Medicare assignment may not bill you for more than 115% of the amount Medicare bases its payment on, called the “limiting charge.” The Medicare Summary Notice (MSN) that Medicare will send you will have more information about the limiting charge. If your physician tries to collect more than allowed by law, ask the physician to reduce the charges. If the physician does not, report the physician to the Medicare carrier that sent you the MSN form. Call us if you need further assistance.

Please see Section 9, *Coordinating benefits with Medicare and other coverage*, for more information about how we coordinate benefits with Medicare.

Section 10. High Option Health Plan Definitions

Accidental injury

An injury resulting from a violent external force.

Admission

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

Assignment

An authorization by you (the enrollee or covered family member) that is approved by us (the Carrier), for us to issue payment of benefits directly to the provider.

- We reserve the right to pay you directly for all covered services. Benefits payable under the contract are not assignable by you to any person without express written approval from us, and in the absence of such approval, any assignment shall be void.· We reserve the right to pay you directly for all covered services. Benefits payable under the contract are not assignable by you to any person without express written approval from us, and in the absence of such approval, any assignment shall be void.
- Your specific written consent for a designated authorized representative to act on your behalf to request reconsideration of a claim decision (or, for an urgent care claim, for a representative to act on your behalf without designation) does not constitute an Assignment.
- OPM's contract with us, based on federal statute and regulation, gives you a right to seek judicial review of OPM's final action on the denial of a health benefits claim but it does not provide you with authority to assign your right to file such a lawsuit to any other person or entity. Any agreement you enter into with another person or entity (such as a provider, or other individual or entity) authorizing that person or entity to bring a lawsuit against OPM, whether or not acting on your behalf, does not constitute an Assignment, is not a valid authorization under this contract, and is void.

Calendar year

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

Clinical trials cost categories

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either Federally-funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

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

Coinsurance

See Section 4, *Coinsurance.*

Copayment

See Section 4, *Copayment*.

Cost-sharing

See Section 4, *Cost-sharing*.

Covered services

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

Custodial care

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

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

We determine which services are custodial care. Custodial care that lasts 90 days or more is sometimes known as long term care.

Deductible

See Section 4, *Deductible*.

Experimental or investigational services

A drug, device, or biological product is experimental or investigational if the drug, device, or biological product cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time it is furnished. Approval means all forms of acceptance by the FDA.

A medical treatment or procedure, or a drug, device, or biological product is experimental or investigational if 1) reliable evidence shows that it is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or 2) reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or biological product or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocols of another facility studying substantially the same drug, device, or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

Determination of experimental/investigational status may require review by a specialty appropriate board-certified healthcare provider or appropriate government publications such as those of the National Institutes of Health, National Cancer Institute, Food and Drug Administration, Agency for Healthcare Research and Quality, and the National Library of Medicine.

Gender affirming services

Healthcare that can include therapy to address feelings of gender dysphoria, as well as medical treatments that help individuals achieve physical characteristics that better align with their gender identity.

Genetic screening	The diagnosis, prognosis, management, and prevention of genetic disease for those patients who have no current evidence or manifestation of a genetic disease and those who have not been determined to have an inheritable risk of genetic disease.
Genetic testing	The diagnosis and management of genetic disease for those patients with current signs and symptoms and for those who we have determined have an inheritable risk of genetic disease.
Group health coverage	Healthcare coverage that a member is eligible for because of employment by, membership in, or connection with, a particular organization or group that provides payment for hospital, medical, or other healthcare services or supplies, or that pays a specific amount for each day or period of hospitalization if that specified amount exceeds $200 per day, including extension of any of these benefits through COBRA.
Habilitative services	Healthcare services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.
Healthcare professional	A physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law.
Home healthcare agency	An agency which meets all of the following: • Is primarily engaged in providing, and is duly licensed or certified to provide, skilled nursing care and therapeutic services • Has policies established by a professional group associated with the agency or organization. This professional group must include at least one registered nurse (R.N.) to direct the services provided and it must provide for full-time supervision of each service by a physician or registered nurse • Maintains a complete medical record on each individual; and • Has a full-time administrator
Hospice care program	A coordinated program of home and inpatient palliative and supportive care for the terminally ill patient and the patient's family provided by a medically supervised specialized team under the direction of a duly licensed or certified Hospice Care Program.
Infertility	Infertility is defined as: The inability to conceive after 1 year of regular unprotected sexual intercourse for an individual with female reproductive organs under 35 years of age. The inability to conceive after 6 months for an individual with female reproductive organs over age 35 years of age. The inability to conceive after 1 year of artificial insemination (AI) for those under age 35 and 6 months for those over age 35. The diagnosis of a disease or condition of the male or female reproductive tract such that regular unprotected sex or artificial insemination would be ineffective. The inability to carry a pregnancy to delivery.
Maintenance therapy	Includes but is not limited to physical, occupational, or speech therapy where continued therapy is not expected to result in significant restoration of a bodily function but is utilized to maintain the current status.
Medical necessity	Services, drugs, supplies or equipment provided by a hospital or covered provider of healthcare services that we determine: • Are appropriate to diagnose or treat the patient's condition, illness or injury • Are consistent with standards of good medical practice in the United States

- Are not primarily for the personal comfort or convenience of the patient, the family, or the provider
- Are not a part of or associated with the scholastic education or vocational training of the patient; and
- In the case of inpatient care, cannot be provided safely on an outpatient basis

The fact that a covered provider has prescribed, recommended, or approved a service, supply, drug or equipment does not, in itself, make it medically necessary.

Medicare Part A Part A helps cover inpatient hospital stays, skilled nursing facility care, hospice care, and some home healthcare.

Medicare Part B Part B covers medically necessary services like doctors' services and tests, outpatient care, home health services, durable medical equipment, and other medical services.

Medicare Part C Part C is a Medicare Advantage plan that combines the coverage of Medicare Part A and Part B. Part C typically also covers additional benefits like, dental, vision, and hearing services. Some Part C plans also include Medicare Part D coverage.

Medicare Part D Medicare Part D plans provide coverage for prescription drugs. Private insurers contract with CMS on an annual basis for the right to offer Part D plans. Part D can be offered as a standalone Prescription Drug Plan (PDP) or as part of a Medicare Advantage Prescription Drug Plan (MAPD).

Medicare Part D EGWP A Medicare Part D Employer Group Waiver Plan (EGWP) is a type of Medicare prescription drug plan that can be offered to employees and retirees of certain companies, unions, or government agencies, which allows for flexibility and enhanced coverage of traditional Medicare pharmacy benefits. Examples of Medicare Part D EGWPs are Medicare Advantage Prescription Drug (MAPD) plan EGWPs that include both health and drug benefits, as well as Prescription Drug Plan (PDP) EGWPs, which only cover the prescription drug benefit.

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

For PPO providers, our allowance is based on negotiated rates. PPO providers always accept the Plan's allowance as their charges for covered services.

For non-PPO providers, we base the Plan allowance on the lesser of the provider's actual charges or the allowed amount for the service you received. We determine the allowed amount by using healthcare charge guides which compare charges of other providers for similar services in the same geographical area. We update these charge guides at least once a year. For surgery, doctor's services, X-ray, lab and therapies (physical, speech and occupational), we use the following:

- **For the High Option Plan** we use guides specifically prepared by Context4Healthcare at the 60th percentile.
- **For the Consumer Driven Option** we use guides specifically prepared by Fair Health at the 80th percentile.
- If this information is not available, we will use other credible sources including our own data.

For more information, see *Differences between our allowance and the bill* in Section 4.

	You should also see section *Important Notice About Surprise Billing - Know Your Rights* below that describes your protections against surprise billing under the No Surprises Act.
Post-service claims	Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.
Pre-service claims	Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.
Rehabilitative care	Treatment that reasonably can be expected to restore and/or substantially restore a bodily function that was impaired as a result of trauma or disease.
Reimbursement	A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.
Residential Treatment Center	Residential Treatment Centers (RTCs) are accredited by a nationally recognized organization and licensed by the state, district, or territory to provide short-term transitional residential treatment for medical conditions, mental health conditions, and/or substance use. Accredited healthcare facilities (excluding hospitals, skilled nursing facilities, group homes, halfway houses, and similar types of facilities) provide 24-hour residential evaluation, treatment and comprehensive specialized services relating to the individual's medical, physical, mental health, and/or substance use therapy needs.
Subrogation	A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.
Surprise bill	An unexpected bill you receive for: • emergency care – when you have little or no say in the facility or provider from whom you receive care, or for • non-emergency services furnished by nonparticipating providers with respect to patient visits to participating healthcare facilities, or for • air ambulance services furnished by nonparticipating providers of air ambulance services.
Urgent care claims	A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts: • Waiting could seriously jeopardize your life or health; • Waiting could seriously jeopardize your ability to regain maximum function; or • In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

	Urgent care claims usually involve pre-service claims and not post-service claims. We will determine whether or not a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 800-222-2798. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.
Us/We	Us and We refer to APWU Health Plan.
Virtual visits	A virtual visit lets you see and talk to a doctor from your phone, tablet or computer. A doctor can see and speak to you about minor medical concerns, provide a diagnosis and, if appropriate, a prescription can be sent to your local pharmacy.
You	You refers to the enrollee and each covered family member.

Section 10. Consumer Driven Health Plan Definitions

Consumer Driven Option	A fee-for-service option under the PSHB that offers you greater control over choices of your healthcare expenditures. You decide what healthcare services will be reimbursed under the Health Plan funded Personal Care Account (PCA). Unused funds from the PCA will roll over at the end of the year. If you spend the entire PCA fund before the end of the year, then you must satisfy a deductible before benefits are payable under the traditional type of insurance covered by your Plan. You decide whether to use in-network or out-of-network providers to reach the maximum fund allowed under your PCA.
Deductible	Under the Consumer Driven Option, your plan's deductible is reduced by applying the funds in your Personal Care Account (PCA) which is funded in January by APWU Health Plan. Your Net Deductible is the remaining deductible amount you have to pay once the funds in your PCA have been exhausted. By using the funds in your PCA to pay for eligible medical expenses you decrease your total deductible and out-of-pocket expenses. See Section 4.
Personal Care Account	Under the Consumer Driven Option, your Personal Care Account (PCA) is an established benefit amount which is available for you to use first to pay for covered hospital, medical, dental and vision care expenses. You determine how your PCA will be spent and any unused amount at the end of the year may be rolled over to increase your available PCA in the subsequent year(s).
Rollover	As long as you remain in this Plan, any unused remaining balance in your PCA at the end of the calendar year may be rolled over to subsequent years. The maximum amount allowed in your PCA may not exceed $5,000 per Self Only enrollment and $10,000 per Self Plus One or Self and Family enrollment.

Summary of Benefits for the High Option Plan - 2025

Do not rely on this chart alone. This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this PSHB Brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.apwuhp.com. On this page we summarize specific expenses we cover; for more detail, look inside.

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

Below, an asterisk (*) means the item is subject to the calendar year deductible, $450 (PPO) or $1,000 (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 healthcare professional.

High Option Benefits	You pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	PPO: $25 copay per covered office visit (no deductible); 15% of the Plan allowance Non-PPO: 40% of our allowance plus amount over allowance	36
Services provided by a hospital: Inpatient	PPO: 15% of the covered charges Non-PPO: $300 admission and 40% of the covered charges and any difference between our allowance and the billed amount	58
Services provided by a hospital: Outpatient	PPO: 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	60
Emergency benefits: Accidental injury	In-network: 15% of the Plan allowance Out-of-network: 15% of the Plan allowance	63
Emergency benefits: Medical emergency (other than an Urgent Care)	In-network: 15% of the Plan allowance Out-of-network: 15% of the Plan allowance	63
Mental health and substance misuse disorder treatment:	PPO: $25 copayment (No deductible) Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed charges	66
Prescription drugs: Retail pharmacy	• **Network Retail**: $10 Tier 1. 25% Tier 2 up to a maximum of $200 coinsurance per prescription for a 30-day supply. 45% Tier 3 up to a maximum of $300 coinsurance per prescription for a 30-day supply • **Non-network Retail**: 50% of cost for a 30-day supply	71

High Option Benefits	You pay	Page
Prescription drugs: Mail order	• **Network Mail Order**: $20 Tier 1. 25% Tier 2 up to a maximum of $300 coinsurance per prescription for a 90-day supply. 45% Tier 3 up to a maximum of $500 coinsurance per prescription for a 90-day supply	71
Specialty drugs	• **Network Retail**: 25% Tier 4 with up to a maximum of $300 per prescription for a 30-day supply. 25% Tier 5 up to a maximum of $600 coinsurance per prescription for a 30-day supply. 45% Tier 6 up to a maximum of $1,000 coinsurance per prescription for a 30-day supply • **Non-network Retail**: 50% of cost for a 30-day supply • **Network Mail Order**: 25% Tier 4 with up to a maximum of $150 per prescription for a 90-day supply. 25% Tier 5 up to a maximum of $300 coinsurance per prescription for a 90-day supply. 45% Tier 6 up to a maximum of $500 coinsurance per prescription for a 90-day supply	72
Medicare PDP EGWP	**Retail:** • **Up to 30-day supply:** Tier 1 - $10. Tier 2 -25% of Plan allowance up to a maximum of$200 per prescription for a 30-day supply. Tier 3 - 25% of Plan allowance up to a maximum of $300 per prescription for a 30-day supply. Tier 4 - 25% of Plan allowance up to a maximum of $300 per prescription for a 30-day supply. • **Up to 90-day supply:** Tier 1 - $20. Tier 2 -25% of Plan allowance up to a maximum of$300 per prescription for a 90-day supply. Tier 3 - 25% of Plan allowance up to a maximum of $500 per prescription for a 90-day supply. Tier 4 - 25% of Plan allowance up to a maximum of $300 per prescription for a 90-day supply.	79
Dental care:	30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)	82
Special features:	See Section 5(h)	83

Summary of Benefits for the Consumer Driven Option Plan - 2025

Do not rely on this chart alone. This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this PSHB Brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.apwuhp.com. On this page we summarize specific expenses we cover; for more detail, look inside.

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

Below, an asterisk (*) means the item is subject to the calendar year Net Deductible, $1,000 (PPO) or $1,500 (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 healthcare professional.

CDHP Benefits	You pay	Page
In-network preventive care:	Nothing	88
Personal Care Account (PCA)	A Personal Care Account (PCA) is provided by the Plan for each enrollment. Each year the Plan adds to your account: • $1,200 per year for a Self Only enrollment or • $2,400 per year for a Self Plus One or Self and Family enrollment	92
Medical services provided by physicians: Diagnostic and treatment services provided in the office	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount	97
Services provided by a hospital: Inpatient	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount	116
Services provided by a hospital: Outpatient	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount	118
Emergency benefits: Accidental injury	In-network: 15% of the Plan allowance Out-of-network: 15% of the Plan allowance	118
Emergency benefits: Medical emergency (other than an Urgent Care)	In-network: 15% of the Plan allowance Out-of-network: 15% of the Plan allowance	118
Mental health and substance use disorder treatment**:**	In-network: 15% of the Plan allowance Out-of-network: 50% of the Plan allowance and any difference between our allowance and the billed amount	122

CDHP Benefits	You pay	Page
Prescription drugs: Retail	• **Network Retail**: - Tier 1 and Tier 2 - 25% of charge with a minimum of $15 and a maximum per prescription of $200 for a 30-day supply, $400 for a 60-day supply, $600 for a 90-day supply; - Tier 3 - 40% of charge with a minimum $15 and a maximum per prescription of $300 for a 30-day supply, $600 for a 60-day supply, $900 for a 90-day supply	126
Prescription drugs: Mail Order	• **Network Home Delivery:** - Tier 1 and Tier 2 - 25% of charge with a minimum of $10 and a maximum per prescription of $200 for a 30-day supply, $400 for a 60-day supply, $600 for a 90-day supply; - Tier 3 - 40% of charge with a minimum $10 and a maximum per prescription of $300 for a 30-day supply, $600 for a 60-day supply, $900 for a 90-day supply	126
Specialty drugs	• **Network Retail:** - Tier 3 - 40% of charge with a minimum $15 and a maximum per prescription of $300 for a 30-day supply, $600 for a 60-day supply, $900 for a 90-day supply • **Network Home Delivery:** - Tier 3 - 40% of charge with a minimum $10 and a maximum per prescription of $300 for a 30-day supply, $600 for a 60-day supply, $900 for a 90-day supply	126
Medicare PDP EGWP	**Part D Retail:** • **1 month supply:** Tier 1 - 25% of Plan allowance up to a maximum of $20 per prescription. Tier 2 - 25% of Plan allowance up to a maximum of $45 per prescription. Tier 3 - 40% of Plan allowance up to a maximum of $100 per prescription. Tier 4 -40% of Plan allowance up to a maximum of$100 per prescription.	134

	• **2 month supply:** Tier 1 - 25% of Plan allowance up to a maximum of $40 per prescription. Tier 2 - 25% of Plan allowance up to a maximum of $90 per prescription. Tier 3 - 40% of Plan allowance up to a maximum of $200 per prescription. Tier 4 -40% of Plan allowance up to a maximum of$200 per prescription. • **3 month supply:** Tier 1 - 25% of Plan allowance up to a maximum of $60 per prescription. Tier 2 - 25% of Plan allowance up to a maximum of $135 per prescription. Tier 3 - 40% of Plan allowance up to a maximum of $300 per prescription. Tier 4 -40% of Plan allowance up to a maximum of$300 per prescription.	
Dental care:	Dental services are reimbursable out of your PCA. We will reimburse up to a combined maximum of $400 per Self Only enrollment or $800 per Self Plus One or Self and Family enrollment each calendar year.	137
Special features:	See Section(5i)	139

Index

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

2025 Rate Information for the APWU Health Plan

To compare your PSHB health plan options please go to https://health-benefits.opm.gov/.

To review premium rates for all PSHB health plan options please go to www.opm.gov/healthcare-insurance/pshb/premiums/.

APWU rates apply to career Postal employees represented by APWU that have been enrolled in PSHB or FEHB for one year.

Premium Rates:

Type of Enrollment	Enrollment Code	Biweekly Gov't Share	Biweekly Your Share	Monthly Gov't Share	Monthly Your Share	Biweekly APWU Your Share
High Option Self Only	23A	$286.09	$109.86	$619.86	$238.03	$109.86
High Option Self Plus One	23C	$618.40	$213.05	$1,339.87	$461.61	$213.05
High Option Self and Family	23B	$672.95	$277.28	$1,458.06	$600.77	$277.28
CDHP Option Self Only	23D	$241.87	$80.62	$524.05	$174.68	$16.12
CDHP Option Self Plus One	23F	$525.68	$175.23	$1,138.98	$379.66	$35.05
CDHP Option Self and Family	23E	$573.47	$191.16	$1,242.53	$414.17	$38.23