APWU Health Plan

http://www.apwuhp.com

APWU HEALTH PLAN

2011

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

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

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

For changes in benefits, see page 9.

URAC ACCREDITED CASE MANAGEMENT HEALTH UTILIZATION MANAGEMENT HEALTH CALL CENTER

NCQA Measuring quality. Improving health care.

THE JOINT COMMISSION NATIONAL QUALITY APPROVAL

URAC ACCREDITED DRUG THERAPY MGMT PHARMACY BENEFIT MGMT

NCQA ACCREDITATION DISEASE MGMT PREFERRED PROVIDER ORGANIZATION MANAGED BEHAVIORAL HEALTHCARE ORGANIZATION

CareAllies (Intracorp) is accredited by URAC for Health Utilization Management and Case Management. The CareAllies 24 hour Nurse Line is accredited by URAC as a Call Center. CIGNA is accredited by NCQA for their PPO Network. CIGNA is accredited by URAC and NCQA for Disease Management. ValueOptions is accredited by URAC for Health Utilization Management and by NCQA for Managed Behavioral HealthCare Organizations. Medco is accredited by The Joint Commission under the Home Care Standards for Pharmacy Dispensing Services and by URAC for PBM and Drug Therapy Management Services. UnitedHealthcare (UHC) is accredited by URAC for Case Management and by URAC and NCQA for Disease Management. UnitedHealthcare is accredited by NCQA for their PPO Network. This Health Plan has been awarded the 2010 NCQA HEDIS Compliance Audit seal. ***See the 2011 Guide for more information about accreditation.***

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

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

Enrollment codes for this Plan:

471 - High Option - Self Only / 472 - High Option - Self and Family
474 - Consumer Driven Option - Self Only / 475 - Consumer Driven Option - Self and Family

FEHB Federal Employees Health Benefits Program

Authorized for distribution by the:

United States Office of Personnel Management

Center for Retirement and Insurance Services
http://www.opm.gov/insure

Important Notice from APWU Health Plan About

Our Prescription Drug Coverage and Medicare

OPM has determined that the APWU Health Plan prescription drug coverage 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. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit 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 FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly 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 percent higher than what many other people pay. You'll 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 (November 15th through December 31st) 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 1-800-772-1213 (TTY 1-800-325-0778).

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

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

Table of Contents

Introduction

This brochure describes the benefits of APWU Health Plan under our contract (CS 1370) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. This Plan is underwritten by the American Postal Workers Union, AFL-CIO. The address for the APWU Health Plan administrative office is:

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

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2011, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2011, and changes are summarized on page 9. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

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

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Operations, Program Planning and Evaluation, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

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

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

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

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care provider, authorized health benefits plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Please review your claims history periodically for accuracy to ensure services are not being billed to your accounts that were never rendered.

- 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 1-800-222-APWU (2798) and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE
202-418-3300

OR 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 as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26).
- 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.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or if you are no longer enrolled in the Plan.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are 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.

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. 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. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. 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 ask questions and understand answers.

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription medicines.
- Tell them about any drug allergies you have.

- 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 medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

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

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

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 reaction to anesthesia, and any medications you are taking.

Patient Safety Links

www.ahrq.gov/consumer/. 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 health care providers and improve the quality of care you receive.
www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
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 health care professionals working to improve patient safety.
www.quic.gov/report/toc.htm. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Never Events

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct never events, if you use APWU Health Plan preferred providers. This new policy will help protect you from preventable medical errors and improve the quality of care you receive.

When you enter the hospital for treatment of one medical problem, you don't 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, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that will encourage hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen called "Never Events". When a Never Event occurs, neither you nor your FEHB plan will incur costs to correct the medical error.

Section 1. Facts about this fee-for-service Plan

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

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

This plan is a "grandfathered health plan" under the Affordable Care Act. A grandfathered plan must preserve basic health coverage that was already in effect when the law passed. Specifically, this plan cannot eliminate all or substantially all benefits to diagnose or treat a particular condition; it cannot increase your coinsurance (the percentage of a bill you pay); and any increases in deductibles, out-of-pocket limits, and other copayments (the fixed-dollar amount you pay) must be minimal.

Questions regarding what protections apply and what protections do not apply to a grandfathered health plan may be directed to us at 1-800-222-APWU (2798). You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

General features of our High Option

We have Preferred Provider Organizations (PPOs):

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

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

High Option PPO Network: Contact APWU Health Plan at 1-800-222-APWU (2798) to request a High Option PPO directory. You can also go to our Web page, which you can reach through the FEHB website, www.opm.gov/insure. If you need assistance in identifying a participating provider or to verify their continued participation, call the Plan’s PPO administrator for your state: The Plan uses CIGNA as its PPO network in all states, CIGNA 1-800-582-1314. For providers in the U.S. Virgin islands call V.I. Equicare 1-340-774-5779 and for hospitals in the U.S. Virgin Islands call CIGNA 1-800-582-1314. For mental conditions/substance abuse providers (all states), call ValueOptions toll-free 1-888-700-7965.

When you leave your state of residence, CIGNA is your travel network, available in all 50 states and the District of Columbia. When out of your state of residence, if you do not use a CIGNA PPO provider or a CIGNA PPO provider is not available, standard non-PPO benefits apply. For assistance in identifying a provider in the travel network, call CIGNA 1-800-582-1314.

This Plan offers you access to certain non-PPO health care providers that have agreed to discount their charges. Covered services by these providers are considered at the negotiated rate subject to applicable deductibles, copayments and coinsurance. Since these providers are not PPO providers, non-PPO benefit levels will apply. Contact CIGNA at 1-800-582-1314 for more information.

General features of our Consumer Driven Health Plan (CDHP)

Preventive benefits: This component provides first dollar coverage for specified preventive care for adults and children if you use a network provider.

Personal Care Account (PCA) benefits: This component is used first to provide first dollar coverage for covered medical, dental and vision care services until the account balance is exhausted.

Traditional benefits: After you have used up your Personal Care Account and satisfied a Deductible, the Plan starts paying benefits under the Traditional Health Coverage as described in Section 5.

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 1-800-718-1299 or you can go to their Web page, http://www.welcometouhc.com/apwu, for a full nationwide online provider directory. Printed provider directories are **not** available.

How we pay providers

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

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

Your rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB Web site (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.

- CareAllies inpatient pre-certification and case management services are provided for the High Option in all states. Intracorp, the company through which CareAllies program is administered, is fully accredited by URAC for Health Utilization Management and Case Management. The 24 hour NurseLine is accredited by URAC as a Call Center.
- CIGNA performs Disease Management for the High Option. They are accredited by The American Accreditation Health Care Commission/URAC and The National Committee for Quality Assurance (NCQA) for Disease Management. They are also accredited by NCQA for their PPO Network.
- Medco. the Health Plan's Pharmacy Benefit Manager (PBM), is accredited by The Join Commission under the Home Care Standards for Pharmacy Dispensing Services and by URAC for PBM and Drug Therapy Management Services.
- ValueOptions performs hospital precertification, continued stay review and outpatient prior authorization for mental health/substance abuse services. They are accredited by The American Accreditation Health Care Commission/URAC for Health Utilization Management and by the National Committee for Quality Assurance (NCQA) for Managed Behavioral HealthCare Organizations.
- UnitedHealthcare (UHC) is accredited by URAC for Case Management and by URAC and NCQA for Disease Management. UnitedHealthcare is accredited by NCQA for their PPO Network.
- 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.

If you want more information about us, call 1-800-222-APWU (2798), or write to APWU Health Plan, P.O. Box 1358, Glen Burnie, MD 21060-1358. You may also contact us by fax at 1-410-424-1588 or visit our Web site at www.apwuhp.com.

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. How we change for 2011

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

Program-wide changes

- Several provisions of the Affordable Care Act (ACA) affect eligibility and benefits under the FEHB Program and FSAFEDS beginning January 1, 2011. For instance, children up to age 26 will be covered under a Self and Family enrollment. Please read the information in Sections 11 and 12 carefully.
- We have reorganized organ and tissue transplant benefit information to clarify coverage.
- We have reorganized Mental health and substance abuse benefits to clarify coverage.
- The State of Oklahoma is a Medically Underserved Area.

Changes to this Plan

Changes to our High Option only

- Your share of the Postal premium will increase/decrease for Self Only or increase/decrease for Self and Family (see page 126).
- Your share of the non-Postal premium will increase for Self Only or increase for Self and Family (see page 126).
- We have deleted the separate deductible for Mental health and substance abuse (see page 47).
- The Plan has added Cancer Centers of Excellence (COE) to be paid at 95% (see page 43).
- The Plan now offers a smoking cessation program (see page 34).
- The Plan now offers additional incentives under the diabetes management program (see page 56).
- The Plan has added additional free in-network screenings, see page 26 for full list.
- The Plan now offers routine examinations with a $0 copay in-network (see page 26).

Changes to our Consumer Driven Health Plan only

- Your share of the Postal premium will increase/decrease for Self Only or increase/decrease for Self and Family (see page 126).
- Your share of the non-Postal premium will increase/decrease Self Only or increase/decrease for Self and Family (see page 126).
- The Plan now offers a smoking cessation program (see page 73).
- The Plan now offers additional incentives under the diabetes management program (see page 88).

Section 3. How you get care

Identification cards

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

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

- **High Option:** Call us at 1-800-222-APWU (2798) or write to us at P.O. Box 1358, Glen Burnie, MD 21060-1358 or through our Web site at www.apwuhp.com.
- **Consumer Driven Option:** Call UnitedHealthcare at 1-800-718-1299 or write to us at P.O. Box 740810, Atlanta, GA 30374-0810 or request replacement cards through the Web site at www.myuhc.com.

Where you get covered care

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

- **Covered providers**

We consider the following to be covered providers when they perform services within the scope of their license or certification:

1. Doctor – A licensed doctor of medicine (M.D.), a licensed doctor of osteopathy (D.O.), a licensed doctor of podiatry (D.P.M.), or, for certain specified services covered by this Plan, a licensed dentist, licensed chiropractor, or licensed clinical psychologist practicing within the scope of the license.
2. Alternate Provider – Alternate providers are covered when performing certain specified services covered by this Plan and when such treatment is within the scope of the provider's license. Alternate providers are limited to licensed physical, occupational and speech therapists; licensed physician's assistants; Registered Nurses (R.N.); Licensed Practical Nurses (L.P.N.); Licensed Vocational Nurses (L.V.N.); and Certified Registered Nurse Anesthetists (C.R.N.A.).
3. Other covered providers include a qualified clinical psychologist, clinical social worker, optometrist, audiologist, nurse midwife nurse practitioner/clinical specialist, and nursing school administered clinic. For purposes of this FEHB brochure, the term "doctor" includes all of these providers when the services are performed within the scope of their license or certification.

Medically underserved areas. Note: We cover any licensed medical practitioner for any covered service performed within the scope of that license in the states OPM determines are "medically underserved." For 2011, the states are: Alabama, Arizona, Idaho, Illinois, Kentucky, Louisiana, Mississippi, Missouri, Montana, New Mexico, North Dakota, Oklahoma, South Carolina, South Dakota and Wyoming.

- **Covered facilities**

Covered facilities include:

- Freestanding ambulatory facility

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

- Hospital

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

2. Any other institution which is operated pursuant to law, under the supervision of a staff of doctors and twenty-four hour a day nursing service, and which is primarily engaged in providing:

   a) general inpatient care and treatment of sick and injured persons through medical, diagnostic and major surgical facilities, all of which must be provided on its premises or under its control, or

   b) specialized inpatient medical care and treatment of sick or injured persons through medical and diagnostic facilities (including X-ray and laboratory) on its premises, under its control, or through a written agreement with a hospital (as defined above) or with a specialized provider of those facilities.

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

What you must do to get covered care

It depends on the kind of care you want to receive. You can go to any provider you want, but we must approve some care in advance.

- **Transitional care**

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

- lose access to your specialist because we drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan, or
- lose access to your PPO specialist because we terminate our contract with your specialist for reasons other than 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 1-800-222-APWU (2798). For the Consumer Driven Option, please call UnitedHealthcare at 1-800-718-1299. If you are new to the FEHB 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 us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center; or
- 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 FEHB 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.

How to get approval for…

- **Your hospital stay**

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 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 not pay any benefits.

How to precertify an admission

- **High Option:** You, your representative, your doctor, or your hospital must call CIGNA/CareAllies at 1-800-582-1314 at least 48 hours before admission. For Mental health and substance abuse, both inpatient and outpatient, your doctor or your hospital must call ValueOptions at 1-888-700-7965 at least 48 hours before admission. These numbers are available 24 hours every day.
- **Consumer Driven Option:** You, your representative, your doctor, or your hospital must call UnitedHealthcare at 1-800-718-1299 at least 48 hours before admission. For Mental health and substance abuse, both inpatient and outpatient, your doctor or your hospital must call ValueOptions at 1-888-700-7965 at least 48 hours before admission. 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 doctor, or the hospital must telephone the above number 48 hours following the day of the emergency admission, even if you have been discharged from the hospital.
- 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 doctor
  - Name of hospital or facility; and
  - Number of planned days of confinement
- We will then tell the doctor and/or hospital the number of approved inpatient days and we will send written confirmation of our decision to you, your doctor, and the hospital.

Maternity care

You do not need to precertify 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, then your physician or the hospital must contact us for precertification of additional days for your baby.

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 doctor or the hospital must ask us to approve the additional days by calling the precertification vendor for your state as shown above; CIGNA/CareAllies at 1-800-582-1314.

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 1-800-718-1299.

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.

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.

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.

Exceptions

You do not need precertification in these cases:

- You are admitted to a hospital outside the United States and Puerto Rico.
- 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.

- **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:

CAT/CT – Computerized Axial Tomography

MRI – Magnetic Resonance Imaging

MRA – Magnetic Resonance Angiography

NC – Nuclear Cardiology

PET – Positron Emission Tomography

How to precertify a radiology/imaging procedure

For these outpatient studies; you, your representative or doctor must call CIGNA/ CareAllies before scheduling the procedure. The toll free number is 1-800-582-1314.

- 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

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 inpatient hospital
- The procedure is performed as an emergency

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.

- **Other services**

Some services require prior approval **(High Option)** and some require pre-notification **(Consumer Driven Option)**:

- Prior approval/pre-notification is required for organ transplantation. Call before your first evaluation as a potential candidate.
- Prior approval/pre-notification is required for surgical procedures which may be cosmetic in nature such as eyelid surgery (blepharoplasty) or varicose vein surgery (sclerotherapy).
- Prior approval/pre-notification is required for recognized surgery for morbid obesity (bariatric surgery) or for organic impotence.
- Prior approval/pre-notification is required for home health care such as nursing visits, infusion therapy, growth hormone therapy (GHT), rehabilitative therapy (physical, occupational or speech therapy) and pulmonary rehabilitation programs.
- Prior approval/pre-notification is required for durable medical equipment such as wheelchairs, oxygen equipment and supplies, artificial limbs and braces.
- Prior approval/pre-notification 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 MEDCO Customer Service at 1-800-841-2734 for the High Option (See Section 5 (f), page 49 and 1-800-309-5528 for the Consumer Driven Option (Section 5 (c), page 84).

High Option: Call CIGNA/CareAllies at 1-800-582-1314 if you need any of the services listed above.

Consumer Driven Option: Call UnitedHealthcare at 1-800-718-1299 if you need any of the services listed above:

- Prior approval is also required for mental health and substance abuse benefits, inpatient or outpatient, in-network or out-of-network. Under the High Option and the Consumer Driven Option, call ValueOptions at 1-888-700-7965.

Section 4. Your costs for covered services

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

Copayments

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 $18 per 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.

Cost-sharing

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

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 $275 per person. Under a family enrollment, the deductible is satisfied for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $550. If you use non-PPO providers, your calendar year deductible increases to a maximum of $500 per person ($1,000 per family). Whether or not you use PPO providers, your calendar year deductible will not exceed $500 per person ($1,000 per 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 ($275) has been satisfied.

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

If you change from Self and Family to Self Only, or from Self Only to 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 your bridge between your Personal Care Account (PCA) and your Traditional Health Coverage. After you have exhausted your PCA, you must pay your Deductible before your Traditional Health Coverage begins. Your Deductible is generally $600 for a Self Only enrollment or $1,200 for a Self and Family enrollment. 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). Also, there is no separate deductible for mental health and substance abuse benefits under the Consumer Driven Option.

Coinsurance

High Option: Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance doesn't begin until you meet your deductible.

Example: You pay 30% 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 30% coinsurance, the actual charge is $70. We will pay $49 (70% of the actual charge of $70).

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 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 1-800-222-APWU (2798).

Differences between our allowance and the bill

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 -- 10% of our $100 allowance ($10). Because of the agreement, your PPO physician will not bill you for the $50 difference between our allowance and his/her 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 30% of our $100 allowance ($30). 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 his/her bill.

The following table 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 table uses our example of a service for which the physician charges $150 and our allowance is $100. The table shows the amount you pay if you have met your calendar year deductible.

EXAMPLE	PPO physician	Non-PPO physician
Physician's charge	$150	$150
Our allowance	We set it at: 100	We set it at: 100
We pay	90% of our allowance: 90	70% of our allowance: 70
You owe: Coinsurance	10% of our allowance: 10	30% of our allowance: 30
+Difference up to charge?	No: 0	Yes: 50
TOTAL YOU PAY	**$10**	**$80**

Consumer Driven Option:

PPO providers agree to accept our Plan allowance so if you use a PPO 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.

Non PPO Providers - If you use a non-PPO 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 PPO 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.

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 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 $4,000 for either a Self Only or a Self and Family enrollment if you are using PPO providers. Only eligible expenses for PPO providers count toward this limit.

Non-PPO benefit: Your out-of-pocket maximum is $10,000 for either a Self Only or a Self and Family enrollment if you are using non-PPO providers. Eligible expenses for network providers also count toward this limit. Your eligible out-of-pocket expenses will not exceed this amount whether or not you use network providers.

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

- The 10% 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 abuse and dental
- The 30% you pay for non-PPO; 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 abuse and dental
- The copayment of $18 for outpatient visits to PPO physicians

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 pages 12, 13, and 14)
- Covered expenses applied to any deductibles
- The $300 per admission deductible for non-PPO Inpatient hospital charges
- Expenses for prescription drugs
- Expenses in excess of visit maximums for physical, occupational and speech therapy (see page30)
- Expenses incurred in excess of the $90 per day provided under home nursing care (see page 33); and
- Expenses in excess of Hospice care and preventive care maximums

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 $3,000 for a Self Only enrollment or $4,500 for a Self and Family enrollment if you are using network providers. Only eligible expenses for network providers count toward this limit.

Out-of-network benefit: Your out-of-pocket maximum is $9,000 for either a Self Only or a Self and Family enrollment if you are using out-of-network providers. Eligible expenses for network providers also count toward this limit. Your eligible out-of-pocket expenses will not exceed this amount whether or not you use network providers.

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, Maternity and Emergency services under the Traditional Health Coverage
- The 40% you pay for out-of-network Inpatient and Outpatient hospital charges, Surgical, Medical, Maternity and Emergency services under the Traditional Health Coverage

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

- Any expenses paid by the Plan under your Personal Care Account
- Any expenses paid by the Plan under your In-network Preventive Care benefit
- Any expenses you must pay under your Deductible
- Expenses in excess of our allowance or maximum benefit limitations or expenses not covered under the Traditional Health Coverage
- Covered expenses applied to my deductibles
- Expenses you pay for prescription drugs under your 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 pages 12, 13 and 14)
- Expenses in excess of Hospice care maximums

Carryover	If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1. 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. We will generally first seek recovery from the provider if we paid the provider directly, or from the person (covered family member, guardian, custodial parent, etc.) to whom we sent our payment.
When Government facilities bill us	Facilities of the Department of Veterans 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.

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

Under the FEHB law, 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 FEHB 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 former spouse, or as a family member of an annuitant or former spouse; and
- are not employed in a position that gives FEHB 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; and
- 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...	Then you are responsible for...
Participates with Medicare or accepts Medicare assignment for the claim and is a member of our PPO network,	your deductibles, coinsurance, and copayments;
Participates with Medicare and is **not** in our PPO network,	your deductibles, coinsurance, copayments, and any balance up to the Medicare approved amount;
Does not participate in Medicare,	your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount

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.

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.

When you have the Original Medicare Plan (Part A, 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.
- **Consumer Driven Option**: If your physician **accepts** Medicare assignment, then you pay nothing if you have unused benefits available under your Personal Care Account 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, then 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's 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 other coverage,* for more information about how we coordinate benefits with Medicare.

Section 5. Benefits

See page 9 for how our benefits changed this year. Page 116 is a benefits summary of the High Option. Make sure that you review the benefits that are available under the option in which you are enrolled.

High Option Overview

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. To obtain claim forms, claims filing advice, or more information about the High Option benefits, contact us at 1-800-222-APWU (2798) or at 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 abuse 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 an array of preventive tests and screenings, routine physical exams, and educational classes and programs to stop smoking. To keep children well, we have 100% coverage for recommended immunizations, physical exams and laboratory tests for children. We provide a Wellness Benefit that offers a reward for staying well. If you use little or no benefits in a calendar year, our Wellness Benefit reimburses you so that you can tailor benefits to your individual needs.

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. Mental health and substance abuse 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 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.

Special features

Obtaining help from a medical professional is quick, confidential, and free with the Plan's voluntary Nurse Advisory Line, available anywhere in the country. Registered nurses are available 24/7 to assist with medical concerns and to provide healthcare information.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: PPO - $275 per person ($550 per family); Non-PPO - $500 per person ($1,000 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- When you use a PPO hospital, keep in mind that the professionals who provide services to you in the hospital, such as radiologists, and pathologists, may not all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers. However, if surgical services are rendered at a PPO hospital or a PPO freestanding ambulatory facility by a PPO primary surgeon, we will pay the services of anesthesiologists who are not preferred providers at the PPO rate, based on Plan allowance.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PRECERTIFICATION FOR CERTAIN OUTPATIENT IMAGING PROCEDURES.** FAILURE TO DO SO WILL RESULT IN A MINIMUM OF $100 PENALTY. Please refer to precertification information in Section 3 to be sure which procedures require precertification.

Benefit Description	You Pay After the calendar year deductible...
Diagnostic and treatment services	
Professional services of physicians • In physician's office	PPO: $18 copayment (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment • Second surgical opinion • At home	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

Benefit Description	You Pay After the calendar year deductible...
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CT Scans/MRI/MRA/NC/PET (Outpatient requires precertification – See Section 3) • Ultrasound • Electrocardiogram and EEG	PPO: 10% of the Plan allowance Non-PPO: 30% 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 any lab and X-ray charges.
Not covered: Professional fees for automated lab tests	*All charges*
Pharmacogenomic testing to optimize prescription drug therapies for certain conditions: • Tamoxifen (for breast cancer) • Warfarin (anticoagulant)	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Preventive care, adult	
One routine examination per person every two calendar years after age 12. Lab tests covered are: • Comprehensive Metabolic Panel • Lipid Panel • Urinalysis (other laboratory work, X-rays and other diagnostic tests performed during a routine exam is subject to the benefits under *Diagnostic and treatment services*)	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
One annual routine gynecological visit for pap test for women age 18 or over - PPO only	PPO: $18 copayment (No deductible) Non-PPO: All Charges
Routine screenings, limited to: • Total Blood Cholesterol– once annually • Fasting lipoprotein profile, once every 5 years for adults age 20 or over • Osteoporosis screening, once every two years, for women age 65 and older • Chlamydial infection • Colorectal Cancer Screening, including - Fecal occult blood test, once annually, ages 40 and older - Sigmoidoscopy, screening – every five years starting at age 50 - Colonoscopy, once every 10 years starting at age 50	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

Preventive care, adult - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Preventive care, adult (cont.)	
- Double Contrast Barium Enema (DCBE), once every 5 years starting at age 50 • Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older • Routine pap test (lab charge), one annually, women age 18 and older • Abdominal Aortic Aneurysm screening, once for men between the ages of 65 and 75 with a smoking history	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Routine mammograms– covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC)	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Adult immunizations not endorsed by the CDC* • *Routine diagnostic tests associated with preventive care other than those specified as covered* • *Non-PPO routine examinations or gynecological visits*	*All charges*
Preventive care, children	
Childhood immunizations recommended by the American Academy of Pediatrics	PPO: Nothing (No deductible) Non-PPO: Any difference between the Plan allowance and the billed charge (No deductible)
• Examinations, limited to: - Well-child care charges for physical examinations and laboratory tests through age 12 - Examination for amblyopia and strabismus-limited to one screening examination (age 2 through 6) - One Screening Examination of Premature Infants for Retinopathy of Prematurity or infants with low birth weight or gestational age of 32 weeks or less	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 12) each year (No deductible)

Benefit Description	You Pay After the calendar year deductible...
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 12 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay, if medically necessary. • 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 if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision of a covered newborn. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.	PPO: 10% of the Plan allowance. Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: Amniocentesis if for diagnosing multiple births	*All charges*
Family Planning	
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges*
Infertility services	
• Diagnosis and treatment of infertility, except as shown in *Not covered.*	PPO: 10% of the Plan allowance and any amount over $2,500 Non-PPO: 30% of the Plan allowance, any difference between our allowance and the billed amount and any amount over $2,500
Not covered: • *Infertility services after voluntary sterilization* • *Assisted reproductive technology (ART) procedures, such as:* - *artificial insemination (all procedures)* - *in vitro fertilization*	*All charges*

Infertility services - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Infertility services (cont.)	
- *embryo transfer and gamete intrafallopian transfer (GIFT)* - *intravaginal insemination (IVI)* - *intracervical insemination (ICI)* - *intrauterine insemination (IUI)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges*
Allergy care	
• Testing and treatment, including materials (such as allergy serum) • Allergy injections	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed on page 38, 39 and 40. • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: We only cover IV/Infusion therapy and GHT when we preauthorize the treatment. You will be asked to submit information that establishes medical necessity. You should ask for preauthorization before you begin treatment. If you do not ask or if we determine that treatment is not medically necessary, we will not cover the treatment or related services and supplies. See *Other services* under *How to get approval for...* in Section 3. Note: Growth hormone and any drugs used for the administration of Home Intravenous (IV) Infusion are covered under the prescription drug benefit. If the drugs are obtained through Accredo Health Group, Medco's specialty pharmacy, they will be paid at the in-network prescription drug benefit. If they are not obtained through Accredo Health Group, Medco's specialty pharmacy, they will be paid at the out-of-network prescription drug benefit. (Prescription drug benefits, Section 5(f)). • Respiratory and inhalation therapies	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

Benefit Description	You Pay After the calendar year deductible...
Physical and occupational therapies	
Physical therapy and occupational therapy provided by a licensed registered therapist up to a combined 60 visits per calendar year. Note: Preauthorization of rehabilitative therapies is required. See *Other services* under *How to get approval for...* in Section 3. Note: We only cover physical and occupational therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury and when a physician: 1. Orders the care 2. Identifies the specific professional skills the patient requires and the medical necessity for skilled services; and 3. Indicates the length of time the services are needed	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Maintenance therapies* • *Exercise programs* • *Physical and occupational therapies without preauthorization*	*All charges*
Speech therapy	
Speech therapy where medically necessary and provided by a licensed therapist Note: Preauthorization of speech therapy is required. See *Other services* under *How to get approval for...* in Section 3. Note: Speech therapy is combined with 60 visits per 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: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Hearing services (testing, treatment, and supplies)	
Diagnostic hearing tests performed by an M.D., D.O. or Audiologist • One examination and testing for hearing aids every 2 years	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Hearing Aids, as shown in Orthopedic and prosthetic devices	
Vision services (testing, treatment, and supplies)	
• Internal (implant) ocular lenses and/or the first contact lenses required to correct an impairment caused by accident or illness. The services of an optometrist 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	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

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

Benefit Description	You Pay After the calendar year deductible...
Vision services (testing, treatment, and supplies) (cont.)	
Not covered: • *Eyeglasses or contact lenses and examinations for them* • *Eye exercises and visual training* • *Radial keratotomy and other refractive surgery*	*All charges*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes	PPO: $18 copayment for the office visit (No deductible) plus 10% of the Plan allowance for other services performed during the visit Non-PPO: 30% 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	
• Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Leg, arm, neck, joint and back braces • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See Section 5(b) for coverage of the surgery to insert the device. Note: We recommend preauthorization of orthopedic and prosthetic devices. See *Other services* under *How to get approval for...* in Section 3. Note: We will pay only for the cost of the standard item. Coverage for specialty items, such as bionics, is limited to the cost of the standard item.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Hearing Aids • Covered every 3 years limited to $1,500	PPO: All charges in excess of $1,500 (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*	*All charges*

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Orthopedic and prosthetic devices (cont.)	
• *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices*	*All charges*
Durable medical equipment (DME)	
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: • Oxygen; • Dialysis equipment; • Hospital beds; • Wheelchairs (standard and electric); • Ostomy supplies (including supplies purchased at a pharmacy); • Crutches; and • Walkers Note: Preauthorization of durable medical equipment is required. See *Other services* under *How to get approval for...* in 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.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *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 After the calendar year deductible...
Home health services	
Services for skilled nursing care up to 25 visits per calendar year, not to exceed a maximum Plan payment of $90 per day, when preauthorized 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. See *Other services* under *How to get approval for...* in Section 3.	PPO: 10%; all charges after we pay $90 per day Non-PPO: 30%; all charges after we pay $90 per day
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, or rehabilitative* • *Nursing services without preauthorization* • *Services of nurses aides or home health aides*	*All charges*
Chiropractic	
Chiropractic treatment limited to 12 visits and/or manipulations per year Note: X-rays covered under *Diagnostic and treatment services* Note: Massage therapy not covered	PPO: $18 copayment (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Alternative treatments	
Acupuncture – by a doctor of medicine or osteopathy	PPO: $18 copayment (No deductible) Non-PPO: 30% 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 on page 10* Note: Benefits of certain alternative treatment providers may be covered in medically underserved areas; see page 10.	*All charges*

Benefit Description	You Pay After the calendar year deductible...
Educational classes and programs	
If you are an APWU Health Plan member you may enroll in a Smoking Cessation Program up to two quit attempts per year as follows: • 4 Telephonic counseling sessions with CIGNA/CareAllies or; • 4 Group therapy sessions or; • 4 Educational sessions with a physician Note: Enrollment in the CIGNA/CareAllies program must be initiated by member after effective date of Health Plan enrollment. For more information contact CIGNA/CareAllies at 1-800-582-1314.	PPO: Nothing (No deductible) Non-PPO: All Charges
Prescription drugs (through Medco by Mail only) approved by the FDA to treat tobacco dependence for smoking cessation. Over-the-counter drugs (through CIGNA/CareAllies only) approved by the FDA to treat tobacco dependence for smoking cessation.	PPO: Nothing (No deductible) Non-PPO: All Charges

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: PPO - $275 per person ($550 per family); Non-PPO - $500 per person ($1,000 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- When you use a PPO hospital, keep in mind that the professionals who provide services to you in the hospital, such as radiologists, and pathologists, may not all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers. However, if surgical services are rendered at a PPO hospital or a PPO freestanding ambulatory facility by a PPO primary surgeon, we will pay the services of anesthesiologists who are not preferred providers at the PPO rate, based on Plan allowance.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOU MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

Precertification/preauthorization is required for:

- Organ transplantations
- Procedures which might be cosmetic in nature, such as eyelid surgery or varicose vein surgery
- Surgery for morbid obesity, or
- Surgery for organic impotence

Benefit Description	You Pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Electroconvulsive therapy • Removal of tumors and cysts	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

Surgical procedures - continued on next page

Benefit Description	You Pay After the calendar year deductible…
Surgical procedures (cont.)	
• Correction of congenital anomalies (see Reconstructive surgery) • Surgical treatment of morbid obesity (bariatric surgery) (requires preauthorization. See *Other services* under *How to get approval for...* in Section 3) • Insertion of internal prosthetic devices. See Section 5 (a) for orthopedic and prosthetic devices for device coverage information • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Surgically implanted contraceptives • Intrauterine devices (IUDs) • Treatment of burns • Assistant surgeons - We cover up to 20% of our allowance for the surgeon's charge	PPO: 10% of the Plan allowance Non-PPO: 30% 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: 90% of the Plan allowance or - Non-PPO: 70% of the Plan allowance • For the secondary procedure(s): - PPO: 90% of one-half of the Plan allowance or - Non-PPO: 70% of one-half of the Plan allowance Note: 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: 10% of the Plan allowance for the primary procedure and 10% of one-half of the Plan allowance for the secondary procedure(s) Non-PPO: 30% of the Plan allowance for the primary procedure and 30% 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*	*All charges*
Reconstructive surgery	
• 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	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

Reconstructive surgery - continued on next page

Benefit Description	You Pay After the calendar year deductible…
Reconstructive surgery (cont.)	
• 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 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: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury if repair is initiated within two years of the accident* • *Surgeries related to sex transformation, sexual dysfunction or sexual inadequacy except if preauthorized for organic impotence*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws 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	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

Oral and maxillofacial surgery - continued on next page

Benefit Description	You Pay After the calendar year deductible…
Oral and maxillofacial surgery (cont.)	
• 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: We suggest you call us at 1-800-222-APWU (2798) to determine whether a procedure is covered.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *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* • *Treatment of periodontal disease and gingival tissues, and abscesses* • *Charges related to orthodontic treatment*	*All charges*
Organ/tissue transplants	
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: • Cornea • Heart • Heart/lung • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	PPO: 10% of the Plan allowance Non-PPO: 30% 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

Benefit Description	You Pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
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: 10% of the Plan allowance Non-PPO: 30% 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 limited to the following diagnoses. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin’s lymphoma with reoccurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin’s lymphoma with reoccurrence (relapsed) - Amyloidosis - Breast Cancer - Epithelial ovarian cancer - Multiple myeloma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	PPO: 10% of the Plan allowance Non-PPO: 30% 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: 10% of the Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You Pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
	Non-PPO: 30% 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 are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. 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: 10% of the Plan allowance Non-PPO: 30% 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 for your state as shown on page 11 (see *Other services* under *How to get approval for...* in Section 3); CIGNA at 1-800-668-9682; 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.	PPO: 10% of the Plan allowance Non-PPO: 30% 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
Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Transplants not listed as covered*	*All charges*

Benefit Description	You Pay After the calendar year deductible…
Anesthesia	
Professional services for administration of anesthesia	PPO: 10% of the Plan allowance
Note: If surgical services are rendered at a PPO hospital or a PPO freestanding ambulatory facility by a PPO primary surgeon, we will pay the services of non-PPO anesthesiologists at the PPO rate, based on Plan allowance.	Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

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 - $275 per person ($550 per family); Non-PPO - $500 per person ($1,000 per family).
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- When you use a PPO hospital, keep in mind that the professionals who provide services to you in the hospital, such as radiologists, and pathologists, may not all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers. However, if surgical services are rendered at a PPO hospital or a PPO freestanding ambulatory facility by a PPO primary surgeon, we will pay the services of anesthesiologists who are not preferred providers at the PPO rate, based on Plan allowance.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts 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.

Benefit Description	You Pay
Note: The calendar year deductible applies ONLY when we say below: "(calendar year deductible applies)."	
Inpatient hospital	
Room and board, such as: • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets 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 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. Note: If you use a PPO provider and a PPO facility, we may still pay non-PPO benefits if you receive treatment from a radiologist or pathologist who is not a PPO provider.	PPO: 10% of the covered charges Non-PPO: $300 per admission and 30% of the covered charges
Other hospital services and supplies, such as:	PPO: 10% of the covered charges

Inpatient hospital - continued on next page

Benefit Description	You Pay
Inpatient hospital (cont.)	
• Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • 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 health care 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: 10% of the covered charges Non-PPO: $300 per admission and 30% of the covered charges
Not covered: • *Any part of a hospital admission that is not medically necessary (see definition), 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 definition* • *Non-covered facilities, such as nursing homes, skilled nursing facilities, residential treatment 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*	*All charges*
Cancer Centers of Excellence	
The Plan provides access to designated Cancer Centers of Excellence. For information, you must contact CIGNA/CareAllies at 1-800-582-1314 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 CIGNA/CareAllies, you will be provided with information about the Cancer Centers of Excellence.	PPO Cancer Centers of Excellence (COE): 5% of the Plan allowance PPO: 10% of the covered charges Non-PPO: $300 per admission and 30% of the covered charges

Benefit Description	You Pay
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • 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: 10% of the Plan allowance (calendar year deductible applies) Non-PPO: 30% 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	
No benefit	All charges
Hospice care	
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 $3,000 annually for outpatient services and $2,000 annually for inpatient services • We pay a $200 annual bereavement benefit per family unit	Any amount over the annual maximums shown
Ambulance	
• Local professional ambulance service when medically appropriate immediately before or after an inpatient admission	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *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 - $275 per person ($550 per family); Non-PPO - $500 per person ($1,000 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- When you use a PPO hospital, keep in mind that the professionals who provide services to you in the hospital, such as radiologists, and pathologists, may not all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers. However, if surgical services are rendered at a PPO hospital or a PPO freestanding ambulatory facility by a PPO primary surgeon, we will pay the services of anesthesiologists who are not preferred providers at the PPO rate, based on Plan allowance.
- When you use a PPO hospital for emergency servcies, 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, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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 and broken bones. 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 its 24-hour nurse advisory service 1-800-582-1314 or your physician.

Note: If you use an emergency room for other than a recognized medical emergency, facility fees and supplies will not be covered.

Benefit Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Accidental injury	
If you receive care for your accidental injury within 24 hours, we cover: • Physician services and supplies • Related outpatient hospital services • Professional ambulance service • Air ambulance if medically necessary for transport to the closest appropriate facility for treatment Note: We pay Hospital benefits if you are admitted.	PPO: Nothing (No deductible) Non-PPO: Only the difference between our allowance and the billed amount (No deductible)
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.	PPO: $18 copayment (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Medical emergency	
Outpatient facility charges in an Urgent Care Center	PPO: $40 copayment (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Outpatient medical or surgical services and supplies, other than an Urgent Care Center	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Ambulance	
• Professional ambulance service within 24 hours of a medical emergency • Air ambulance if medically necessary for transport to the closest appropriate facility for treatment within 24 hours of a medical emergency Note: See Section 5(c) for non-emergency service.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

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

You may choose to get care in-network or out-of-network. You need to get Plan approval (preauthorization) for services and follow a treatment plan we approve in order to get benefits. When you receive services as part of an approved treatment plan, cost-sharing and limitations for Plan mental health and substance abuse benefits are no greater than for similar benefits for other illnesses and conditions.

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 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 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES**. Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan.
- We do not make available provider directories for mental health or substance abuse providers. ValueOptions will provide you with a choice of network providers when you call to preauthorize your care.

Benefit Description	You Pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Professional Services	
We cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. • In Physician's office • Professional charges for intensive outpatient treatment in a provider's office or other professional setting	Your cost-sharing responsibilities are no greater than for other illnesses or conditions. PPO: $18 Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed charges.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders inpatient professional services. 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 • Treatment and counseling (including individual or group therapy visits)	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed charges

Professional Services - continued on next page

Benefit Description	You Pay After the calendar year deductible…
Professional Services (cont.)	
• Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Electroconvulsive therapy	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed charges
Diagnostics	
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed charges
Inpatient hospital or other covered facility	
Inpatient services provided and billed by a hospital or other covered facility • 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 or other covered facility.	PPO: 10% of the Plan allowance Non-PPO: After $300 per admission, 30% of our allowance and any difference between our allowance and the billed charges
Outpatient hospital or other covered facility	
Outpatient services provided and billed by a hospital or other covered facility • Services such as partial hospitalization, full-day hospitalization, or facility-based intensive outpatient treatment	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed charges
Not covered	
• Services that are not part of a preauthorized approved treatment plan • Services that are not medically necessary	All charges

See these sections of the brochure for more valuable information about these benefits:

- Section 4, *Your costs for covered services*, for information about catastrophic protection for these benefits.
- Section 7, *Filing a claim for covered services*, for information about submitting out-of-network claims.

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 on the next page.
- 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 does not apply to prescription drug benefits.
- 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, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Prior authorization 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, page 14 and pages 50-51 for more information about this program.

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

- **Who can write your prescription.** Any covered provider licensed to prescribe drugs may write your prescription.
- **Where can you obtain them.** You can fill the prescription at a Medco Health network pharmacy, a non-network pharmacy, or by mail. We pay our highest level of benefits for mail order and you should use the mail order program to obtain your maintenance medications.
- **We use a formulary.** Our formulary is open and voluntary. 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. Use of a formulary drug is voluntary; there is no financial penalty if your physician does not prescribe a formulary drug.

Brand/Generic Drugs

- **Why use generic drugs?** A generic drug is a chemical equivalent of a corresponding name brand drug. The US Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand name drugs. Generic drugs are less expensive than brand drugs, therefore, you may reduce your out-of-pocket-expenses by choosing to use a generic drug.
- A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician 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 1-800-753-2851.
- 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 physician can begin the coverage review process by calling Medco Health Customer Service at 1-800-841-2734.

These are the dispensing limitations.

- The Medco Health Retail Network – you may obtain up to a 30-day supply plus one 30-day refill for each prescription purchased from a Medco Health network pharmacy. After one 30-day refill, you must obtain a new prescription and submit it to the mail order program. 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 Medco Health at 1-800-841-2734 or from the Plan at 1-800-222-APWU (2798).
- Non-network pharmacy – if you do not use your identification card, if you elect to use a non-network pharmacy, or if a Medco Health 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 Medco 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 Medco Health system. For the names of participating pharmacies, call 1-800-841-2734.

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.

Personalized Medicine (voluntary program)

The Personalized Medicine Program combines a Pharmacogenomic test (genetic lab test) with a clinical program to optimize prescription drug therapies for patients taking Warfarin (anticoagulant) and Tamoxifen (for breast cancer). This program focuses on giving physicians information, on an individual level, on patients who have already been diagnosed with a disease or condition.

The benefits of this testing, done with a simple cheek swab are:

- Greater patient safety and efficacy through more precise dosing for Warfarin and correct therapy decisions for Tamoxifen
- Elimination of adverse events since the patient will be taking the right dose of Warfarin from the early onset of therapy

Pharmacogenomic testing gives physicians personalized information they can use to make more precise prescribing and dosing decisions to help their patients receive the critical care they need. The Personalized Medicine Program is available to you at no additional cost. If your medication history indicates that the testing could be beneficial for you, a pharmacist will contact your physician to discuss the program. If your doctor agrees that the test results would be helpful, you will be contacted by a pharmacist to let you know that the testing is available. If you agree to participate, you will receive a cheek swab test that you can administer on your own.

The results of your test will be sent to your doctor and to a Medco pharmacist who has received special training in personalized medicine. The pharmacist is available to help your doctor interpret the results of your test. Your participation is voluntary, and your doctor is still solely responsible for deciding which drug and dose is right for you.

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). Examples of drug categories that require a coverage review include but are not limited to, Growth Hormones, Botox, Interferons, Rheumatoid Arthritis agents, Retin A and drugs for organic impotence. 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, Medco 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.

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 Medco online at www.medco.com or call Medco Member Services at 1-800-841-2734.

- **"Specialty Drugs"** means those covered drugs that are typically high in cost and have one or more of the following characteristics: (1) complex therapy for complex disease (2) specialized patient training and coordination of care required prior to therapy initiation and/or during therapy; (3) unique patient compliance and safety monitoring requirements; (4) unique requirements for handling, shipping and storage; and (5) potential for significant waste due to the high cost of the drug.

Exceptions to the price threshold may exist based on certain characteristics of the drug or therapy which will still require the drug to be classified as a Specialty Drug. Some examples of the disease categories currently in Medco's specialty pharmacy programs include cancer, cystic fibrosis, Gaucher disease, growth hormone deficiency hemophilia, immune deficiency, Hepatitis C, infertility, multiple sclerosis, rheumatoid arthritis and RSV prophylaxis.

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 program mentioned above.

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 Medco 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 1-800-222-APWU (2798) or from our Web site at www.apwuhp.com. Your claim must include receipts that show the prescription number, the National Drug Code (NDC) number, name of the drug, prescribing physician's name, date of purchase and charge for the drug. Mail the claim form and receipt(s) to:

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

Benefit Description	You Pay
Note: The calendar year deductible does not apply to this section.	
Covered medications and supplies	
Each new enrollee will receive a description of our prescription drug program, a combined 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 by a physician from either a pharmacy or by mail: • Drugs and medicines, including those for smoking cessation, for use at home that are obtainable only upon a doctor's prescription and listed in official formularies • Drugs and medicines (including those administered during a non-covered admission or in a non-covered facility) that by Federal law of the United States requires a physician's prescription for their purchase, except those listed as Not covered • Insulin and test strips for known diabetics • Needles and syringes for the administration of covered medications • Full range of FDA-approved drugs, prescriptions, and devices for birth control • Approved drugs for organic impotence such as Viagra and Levitra are subject to Coverage Authorization as described in Section 3, page 14 and Section 5(f), page 51. • Drugs that could be used for cosmetic purposes such as: Retin A or Botox Note: Copay maximum does not apply to out-of-network retail drugs or to brand name drugs where there is a generic available. Note: If you choose a brand name drug when a generic is available and the physician has not received preauthorization, you are responsible for the difference in cost between the brand name drug and the generic, in addition to your coinsurance. Note: The Plan requires a coverage review (prior authorization) of certain prescription drugs based on FDA-approved prescribing and safety information, clinical guidelines, and uses that are considered reasonable, safe and effective. See page 51 for more information. To find out if your prescription requires prior authorization or more about your prescription drug plan, visit Medco online at www.medco.com or call Medco member services at 1-800-841-2734. Note: Specific covered medications and supplies for patients engaged and compliant with the Plan's Disease Management Programs may have enhanced benefits. See *Disease Management*, Section 5(h), *Special Features*.	• Network Retail: $8 generic. 25% brand name with an $8 minimum coinsurance up to a maximum of $200 coinsurance per prescription for a 30 day supply • Network Retail Medicare: $8 generic. 25% brand name with an $8 minimum coinsurance up to a maximum of $200 coinsurance per prescription for a 30 day supply • Non-network Retail: 50% of cost with an $8 minimum coinsurance for a 30 day supply • Non-network Retail Medicare: 50% of cost with an $8 minimum coinsurance for a 30 day supply • Network Mail Order: $15 generic. 25% brand name with a $12 minimum coinsurance up to a maximum of $600 coinsurance per prescription for a 90 day supply • Network Mail Order Medicare: $15 generic. 25% brand name with a $12 minimum coinsurance up to a maximum of $600 coinsurance per prescription for a 90 day supply
Personalized medicine (voluntary program) • Pharmacogenomic testing to optimize prescription drug therapies for certain conditions: - Tamoxifen (for breast cancer) - Warafin (anticoagulant)	Nothing

Covered medications and supplies - continued on next page

Benefit Description	You Pay
Covered medications and supplies (cont.)	
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins, minerals, nutritional supplements, and enteral formulas (liquid food supplements)* • *Medical supplies such as dressings and antiseptics* • *Nonprescription medicines/over-the-counter drugs* Note: Over-the-counter or prescription drugs approved by the FDA to treat tobacco depdendence are covered under the Smoking cessation program (See Educational classes and programs, page 34).	*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 FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 *Coordinating benefits* with other coverage.
- The calendar year deductible is: PPO - $275 per person ($550 per family); Non-PPO - $500 per person ($1,000 per family). 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, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

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

Section 5 (h). Special features

Special feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. 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. 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 cannot 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 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.
24 hour nurse line	We offer a 24-hour nurse advisory service for your use. This program is strictly voluntary and confidential. You may call toll-free at 1-800-582-1314 and reach registered nurses to discuss an existing medical concern or to receive information about numerous health care issues.
Services for deaf and hearing impaired	We offer a toll-free TDD line for customer service. The number is 1-800-622-2511. TDD equipment is required.
Wellness benefit	We reimburse you up to $250 per Self Only enrollment and $350 per Self and Family enrollment per calendar year for non-covered expenses such as vision and eyeglasses, if received in 2011 and no other benefits for 2011 have been paid. If we paid claims of less than $250 for a Self Only enrollment, the difference up to $250 will be paid. If we paid claims of less than $350 for a Self and Family enrollment, the difference up to $350 will be paid. We will notify you in November if you are eligible for the Wellness benefit. Submit Wellness claims after January 1, 2012. Wellness claims are paid after March 1, 2012. If, after Wellness benefits have been paid, subsequent claims are received for hospital, medical or dental expenses, payments made under the Wellness benefit will be deducted from allowable charges.
Disease Management Program	A voluntary program that provides a variety of services to help you manage a chronic condition with outpatient treatment and avoid unnecessary emergency care or inpatient admissions. Some examples of conditions that can be managed through this program are: diabetes and cardiac conditions. We use medical and/or pharmacy claims data as well as interactions with you and your physician(s). If you have a chronic condition and would like additional information, call CIGNA/CareAllies at 1-800-582-1314.
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.

Special feature	Description
Diabetes Management Program	If you are an APWU Health Plan primary member enrolled in the CIGNA/CareAllies Diabetes Disease Management program and participate as required by the program, you may be eligible for the following incentives for In-network services only: • $0 copay for In-network medical office visits for diabetes management (this does not include visits to a Podiatrist or Ophthalmologist) • $0 coinsurance for In-network lab tests related to diabetes management • $0 copay for Generic drugs from Medco by Mail for the specific purpose of lowering your blood sugar • $0 copay for Insulin from Medco by Mail • $0 copay for test strips, lancets, syringes and pen needles from Medco by Mail • $0 coinsurance for an Insulin Pump (Preauthorization is required) and Insulin Pump supplies purchased in-network If you are an APWU Health Plan member who has other primary insurance (i.e. Medicare primary), you do not have to enroll in the Diabetes Disease Management program, you may be eligible for the following incentives: • $0 copay for Generic drugs from Medco by Mail for the specific purpose of lowering your blood sugar • $0 copay for Insulin from Medco by Mail • $0 copay for test strips, lancets, syringes and pen needles from Medco by Mail • $0 coinsurance for In-network lab tests related to diabetes management • $0 coinsurance for an Insulin Pump (Preauthorization is required) and Insulin Pump supplies purchased in-network Note: Enrollment in this program must be initiated by member after effective date of Health Plan enrollment. To enroll contact CIGNA/CareAllies at 1-800-582-1314.
Hypertension (High Blood Pressure) Management Program	If you are an APWU Health Plan primary member enrolled in the Hypertension Education and Coaching program and participate as required by the program, you may be eligible for the following incentives for In-network services only: • $0 co-pay for In-network office visits for the treatment of hypertension • $0 coinsurance for In-network lab tests related to the treatment of hypertension • $0 co-pay for Generic drugs from Medco by Mail for the specific purpose of lowering your blood pressure If you are an APWU Health Plan member who has other primary insurance (i.e. Medicare primary), you do not have to enroll in the Hypertension Education and Coaching Program. You will be eligible for the following incentives: • $0 co-pay for Generic drugs from Medco by Mail for the specific purpose of lowering your blood pressure Note: Enrollment in this program must be initiated by member after effective date of Health Plan enrollment. To enroll contact CIGNA/CareAllies at 1-800-582-1314.
Medco Health Store	The Medco Health Store™ is Medco's consumer health products website. The site allows for the purchase of consumer health products and shipment through the mail. The site includes over-the-counter (OTC) medicines and is accessed through www.medco.com. Benefits include: • The convenience of 24/7 online access to a broad array of consumer health products, organized by therapeutic category

	• The availability of a wide and deep range of products, at competitive prices • Member-initiated drug safety checking to provide notice when medications may interact with each other • The ability to obtain FSA reimbursement for qualified purchases
Special Programs	• **Lifestyle Programs -** Wellness Coaches help you develop a personalized plan for tobacco cessation and weight management. For information, call CIGNA/CareAllies at 1-800-582-1314, select Hypertension/Weight Management/Tobacco Cessation option. • **Healthy Rewards** - MyCareAllies provides non-FEHB savings on gym memberships, tobacco cessation, weight reduction programs, and more, at www.apwuhp.com. - **Tobacco cessation** - find discounts on smoking cessation products - **Weight and nutrition** - get help to lose weight with discounts on weight reduction programs from Jenny Craig, Weight Watchers and NutriSystem - **Fitness** - get fit and save up to 60% on gym memberships - **Vision and hearing care** - receive vision and hearing exams and discounts on hearing aids, discounts on glasses and frames, and discounts on Lasik Vision Corrections - **Wellness products** - enjoy 40% savings on herbal supplements and vitamins, and 5% at checkout from www.drugstore.com - **Alternative medicine** - find discounts for acupuncture, chiropractor, and massage - **Dental care** - save on dental care with discounts on anti-cavity products and toothbrushes
Online tools and resources	Online tools are available at www.apwuhp.com: • **eHealthRecord** - online information for member services and claims to view claims and find year-to-date information with claim details. • **Personal Health Record** - an online tool to organize important medical information in one secure and central location to share with family and doctors. • **HealthAssessment** - answer questions about your health and receive a personalized health program through MyCareAllies.
Consumer choice information	Access by Internet (www.apwuhp.com) is provided to support your important health and wellness decisions, including: • Online Preferrred 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 (www.apwuhp.com) • Prescription drug information, pricing, and network retail pharmacies.

Consumer Driven Health Plan Benefits

See page 9 for how our benefits changed this year and page 118 for a benefits summary.

Consumer Driven Health Plan Overview

The Plan offers a Consumer Driven Health Plan (CDHP). The CDHP benefit package is described here 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 1-800-718-1299 or at our Web site at www.myuhc.com. User ID: **APWUCDO**, Password: **CDOINFO**

This CDHP focuses on you, the health care consumer, and gives you greater control in how you use your health care benefits. With this Plan, eligible in-network preventive care is covered in full, and you can use the Personal Care Account for any covered care. If you use up your Personal Care Account, the Traditional Medical 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 rollover 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(a). They are based on recommendations by the American Medical Association.

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 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(b).

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

Traditional Health Coverage

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

Covered services include:

- Medical services and supplies
- Surgical and anesthesia services
- Hospital services, other facilities and ambulance
- Emergency services/Accidents
- Mental health and substance abuse benefits
- Prescription drug benefits

Health tools and resources

Section 5(d) describes the health tools and resources available to you under the Consumer Driven Option to help you improve the quality of your health care and manage your expenses. There is also care support and a 24-hour nurse advisory service.

Section 5 (a). 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.
- For preventive care not listed in this Section or for preventive care from a non-network provider, please see CDHP Section 5(b) – Personal Care Account (PCA).
- For all other covered expenses, please see CDHP Section 5(b) – *Personal Care Account* and Section 5(c) – *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, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay
Note: There is no calendar year deductible for in-network preventive care under the Consumer Driven Option.	
Preventive care, adult	
One annual routine office visit and examination per person after age 18	In-network: Nothing Out-of-network: Uses PCA while funds available
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC):	In-network: Nothing Out-of-network: Uses PCA while funds available
Routine screenings: • Total Blood Cholesterol, once annually • Fasting lipoprotein profile, once every 5 years for adults age 20 or older • Osteoporosis screening, once every two years, for women age 65 and older • Chlamydial infection • Routine mammograms covered for women age 35 and older, as follows: - From age 35 through 39, one during this five year period - From age 40 through 64, one every calendar year - At age 65 and older, one every two consecutive calendar years • Pap Smear and Routine Pelvic Exam annually • Colorectal Cancer Screenings, member has the choice of the following: - Fecal occult blood test (FOBT) annually and flexible sigmoidoscopy once every 5 years, both beginning at age 50; or - Colonoscopy once every 10 years beginning at age 50; or - Double contrast barium enema (DCBE) once every five years starting at age 50	In-network: Nothing Out-of-network: Uses PCA while funds available

Preventive care, adult - continued on next page

Benefit Description	You Pay
Preventive care, adult (cont.)	
• Digital rectal examination (DRE) and prostate specific antigen (PSA) test annually starting at age 45 • Abdominal Aortic Aneurysm screening, once for men between the ages of 65 and 75 with a smoking history.	In-network: Nothing Out-of-network: Uses PCA while funds available
Preventive care, children	
Routine office visits, examinations and laboratory tests as follows: • Six visits the first year (to age 1) • Three visits the second year (age 1-2) • Annual visits from age 2 through age 18	In-network: Nothing Out-of-network: Uses PCA while funds available
Childhood immunizations recommended by the American Academy of Pediatrics up to age 22	In-network: Nothing Out-of-network: Uses PCA while funds available
Routine screenings: • One Screening Examination of Premature Infants for Retinopathy of Prematurity or infants with low birth weight or gestational age of 32 weeks or less • Lead level testing, one between ages 9 to 12 months and one between 12 and 24 months • Vision screening at ages 3, 4, 5, 6, 8, 10, 12, 15, and 18 • Hearing screening at ages 4, 5, 6, 8, 10, 12, 15, and 18 • Pap smear and routine pelvic exam annually beginning at age 18 or the onset of sexual activity, whichever comes first.	In-network: Nothing Out-of-network: Uses PCA while funds available

Section 5 (b). Personal Care Account (PCA)

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

- All eligible health care expenses (except in-network preventive care) are paid first from your Personal Care Account (PCA). Traditional Health Coverage (under CDHP Section 5(c)) will only start once your Personal Care Account is exhausted.
- Note that in-network preventive care covered under CDHP Section 5(a) 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 Web site, by telephone at 1-800-718-1299 (toll-free), or with monthly 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 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 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.
- 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, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **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
There is no calendar year deductible for in-network preventive care under the Consumer Driven Option.	
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 and Family enrollment The Personal Care Account covers eligible expenses at 100%. For example, if you are ill and go to a network doctor for a $60 visit, the doctor will submit your claim and the cost of the visit will be deducted automatically from your PCA; you pay nothing. Balance in PCA or Self Only $1,200 Less: Cost of visit -60 Remaining Balance in PCA $1,140 There are two types of eligible expenses covered by your PCA.	In-network and Out-of-network: Nothing up to $1,200 for a Self Only enrollment or $2,400 for a Self and Family enrollment

Personal Care Account (PCA) - continued on next page

Benefit Description	You pay
Personal Care Account (PCA) (cont.)	
• **Basic PCA Expenses** are the same medical, surgical, hospital, emergency, mental health and substance abuse, and prescription drug services and supplies covered under the Traditional Health Coverage (see CDHP Section 5(c) for details) • **Extra PCA Expenses** include: - Dental and/or vision services are reimbursable out of your PCA and must be paid up front by you. We will reimburse up to a combined maximum of $400 per Self Only enrollment or $800 per 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(a) – In-network Preventive Care benefits - Out-of-network preventive care limited to services shown as covered under CDHP Section 5(a) - Amounts in excess of the Plan allowance for services received out-of-network and covered under Basic PCA Expenses 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 generic 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 and Family enrollment
Not covered: • *Orthodontia* • *Dental treatment for cosmetic purposes including teeth whitening* • *Out-of-network preventive care services not included under CDHP Section 5(a)* • *Services or supplies shown as not covered under Traditional Health Coverage (see CDHP Section 5(c)) and not included under Extra PCA Expenses above*	*All charges*

PCA Rollover

Any unused, remaining balance in your PCA at the end of the calendar year may be rolled over to subsequent years, as long as you remain in this Plan, up to a maximum PCA account of $5,000 per Self Only enrollment or $10,000 per Self and Family enrollment, thereby increasing your PCA in the following year(s).

Section 5 (c). Traditional Health Coverage

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(a) and does not count against your Personal Care Account.
- Your Personal Care Account must be used first for eligible health care expenses.
- If your Personal Care Account has been exhausted, you must pay your Deductible before your Traditional Health Coverage may begin. Your Deductible applies to all benefits in this section.
- The Consumer Driven Option provides coverage for both in-network and out-of-network providers. The out-of-network benefits are the standard benefits under the Traditional Health Coverage. In-network benefits apply only when you use a provider from the large, national network. When a network provider is not available, out-of-network benefits apply.
- If you join at any time during the year other than Open Season, your Deductible for your first year will be prorated at a rate of $50 per month for Self Only or $100 per month for Self and Family for each full month of coverage remaining in that calendar year.
- When you use a network hospital, keep in mind that the professionals who provide services to you in the hospital, such as radiologists, anesthesiologists, and pathologists, may not all be network providers. If they are not, they will be paid by this Plan as out-of-network providers under the Traditional Health Coverage. However, if surgical services are rendered at a PPO hospital or a PPO freestanding ambulatory facility by a PPO primary surgeon, we will pay the services of anesthesiologists who are not preferred providers at the PPO rate, based on Plan allowance.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **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	
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 after covered eligible expenses total $1,800 for Self Only or $3,600 for Self and Family (the combination of eligible expenses paid out of your PCA and your Deductible) each calendar year. 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 deductible is $600 for Self Only and $1,200 for Self and Family enrollment.	In-network/Out-of-network: $600 per Self Only enrollment or $1,200 per Self and Family enrollment

Deductible before Traditional Health Coverage begins - continued on next page

<table>
<tr><th>Benefit Description</th><th>You pay</th></tr>
<tr><td>Deductible before Traditional Health Coverage begins (cont.)</td><td></td></tr>
<tr><td>
<table>
<tr><th></th><th>Self Only</th><th>Self and Family</th></tr>
<tr><td>Basic PCA Expenses paid by PCA</td><td>$1,200</td><td>$2,400</td></tr>
<tr><td>Deductible paid by you</td><td>$600</td><td>$1,200</td></tr>
<tr><td>Traditional Health Coverage starts after</td><td>$1,800</td><td>$3,600</td></tr>
</table>
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:

<table>
<tr><th></th><th>Self Only</th><th>Self and Family</th></tr>
<tr><td>PCA for year 2
Rollover from year 1</td><td>$1,200
+ 300
$1,500</td><td>$2,400
+ 300
$2,700</td></tr>
<tr><td>Deductible paid by you</td><td>+ 300</td><td>+ 900</td></tr>
<tr><td>Traditional Health Coverage starts when eligible expenses total</td><td>$1,800</td><td>$3,600</td></tr>
</table>
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 have 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.
</td><td>In-network/Out-of-network: $600 per Self Only enrollment or $1,200 per Self and Family enrollment</td></tr>
<tr><td>Medical services and supplies provided by physicians and other health care professionals</td><td></td></tr>
<tr><td>Diagnostic and treatment services</td><td></td></tr>
<tr><td>Professional services of physicians
• In physician’s office
• At home
• In an urgent care center
• During a hospital stay
• Initial examination of a newborn child covered under a family enrollment
• In a skilled nursing facility
• Second surgical opinion</td><td>In-network: 15% of the Plan allowance

Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount</td></tr>
</table>

Benefit Description	You pay
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CT 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: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: Professional fees for automated lab tests	*All charges*
Pharmacogenomic testing to optimize prescription drug therapies for certain conditions: • Tamoxifen (for breast cancer) • Warfarin (anticoagulant)	In-network: Nothing Out-of-network: 40% of the Plan allowance and any difference between our allowance and billed amount
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see pages 10 and 11 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay, if medically necessary. • 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 if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision of a covered newborn. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: Amniocentesis if for diagnosing multiple births	*All charges*

Benefit Description	You pay
Family planning	
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures below) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit.	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: Reversal of voluntary surgical sterilization and genetic counseling	*All charges*
Infertility services	
Diagnosis and treatment of infertility, except as shown in *Not covered*	In-network: 15% of the Plan allowance and any amount over $2,500 Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount and any amount over $2,500
Not covered: • *Infertility services after voluntary sterilization* • *Assisted reproductive technology (ART) procedures, such as:* - *artificial insemination (all procedures)* - *in vitro fertilization* - *embryo transfer and gamete intrafallopian transfer (GIFT)* - *intravaginal insemination (IVI)* - *intracervical insemination (ICI)* - *intrauterine insemination (IUI)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges*
Allergy care	
Testing and treatment, including materials (such as allergy serum) Allergy injections	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: Provocative food testing and sublingual allergy desensitization	*All charges*

Benefit Description	You pay
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed on pages 76 and 77. • 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. Call UnitedHealthcare at 1-800-718-1299 for pre-notification. UnitedHealthcare will ask you to submit information that establishes that GHT is medically necessary. You should pre-notify before you begin treatment. If you do not ask or if we determine GHT is not medically necessary, we will not cover GHT or related services and supplies. See *Services requiring our prior approval* in Section 3. • Respiratory and inhalation therapies	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Physical and occupational therapies	
Physical therapy and occupational therapy provided by a licensed registered therapist up to a combined 60 visits per calendar year Note: Pre-notification of rehabilitative therapies is required. Call UnitedHealthcare at 1-800-718-1299 for pre-notification. Note: We only cover physical and occupational therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury and when a physician: 1) Orders the care 2) Identifies the specific professional skills the patient requires and the medical necessity for skilled services; and 3) Indicates the length of time the services are needed	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Maintenance therapies* • *Exercise programs* • *Physical and occupational therapies without pre-notification*	*All charges*
Speech therapy	
Speech therapy where medically necessary and provided by a licensed therapist Note: Pre-notification of speech therapy is required. Call UnitedHealthcare at 1-800-718-1299 for pre-notification. Note: Speech therapy is combined with 60 visits per year for the services of physical therapy and/or occupational therapy (see above).	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount

Speech therapy - continued on next page

Benefit Description	You pay
Speech therapy (cont.)	
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: 40% of the Plan allowance and any difference between our allowance and the billed amount
Hearing services (testing, treatment, and supplies)	
Diagnostic hearing tests performed by an M.D., D.O. or Audiologist • One examination and testing for hearing aids every 2 years	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Hearing Aids, as shown in Orthopedic and prosthetic devices	
Vision services (testing, treatment, and supplies)	
• Internal (implant) ocular lenses and/or the first contact lenses required to correct an impairment caused by accident or illness. The services of an optometrist 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: 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 except under PCA* • *Eye exercises and visual training* • *Radial keratotomy and other refractive surgery*	*All charges*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes See Orthopedic and prosthetic devices for information on podiatric shoe inserts	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
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*

Benefit Description	You pay
Orthopedic and prosthetic devices	
• Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Leg, arm, neck, joint and back braces • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See Surgical benefits below for coverage of the surgery to insert the device. Note: We recommend pre-notification of orthopedic and prosthetic devices. Call UnitedHealthcare at 1-800-718-1299 for pre-notification. Note: We will pay only for the cost of the standard item. Coverage for specialty items, such as bionics, is limited to the cost of the standard item.	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Hearing Aids • Covered every 3 years limited to $1,500	In-network: All charges in excess of $1,500 Out-of-network: All charges in excess of $1,500
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)	
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: • Oxygen; • Dialysis equipment; • Hospital beds;	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount

Durable Medical Equipment (DME) - continued on next page

Benefit Description	You pay
Durable Medical Equipment (DME) (cont.)	
• Wheelchairs (standard and electric); • Ostomy supplies (including supplies purchased at a pharmacy); • Crutches; and • Walkers Note: Call UnitedHealthcare at 1-800-718-1299 as soon as your physician prescribes this equipment because pre-notification is required. 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.	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
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	
Services for skilled nursing care up to 25 visits per calendar year, not to exceed a maximum Plan payment of $90 per day, when preauthorized 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 1-800-718-1299 for pre-notification.	In-network: 15% of the Plan allowance; all charges after we pay $90 per day Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount; all charges after we pay $90 per day
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, or rehabilitative* • *Services of nurses aides or home health aides*	*All charges*

Benefit Description	You pay
Chiropractic	
Chiropractic treatment limited to 12 visits and/or manipulations per year Note: X-rays covered under *Diagnostic and treatment services* Note: Massage therapy not covered	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Alternative treatments	
Acupuncture – by a doctor of medicine or osteopathy	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Services of any provider not listed as covered; see Covered providers on page 10* Note: Benefits of certain alternative treatment providers may be covered in medically underserved areas; see page 10.	*All charges*
Educational classes and programs	
If you are an APWU Health Plan member you may enroll in a Smoking Cessation Program up to two quit attempts per year as follows: • 4 Telephonic counseling sessions with UnitedHealthcare or; • 4 Group therapy sessions or; • 4 Educational sessions with a physician Note: Enrollment in the UnitedHealthcare program must be initiated by member after effective date of Health Plan enrollment. For more information contact UnitedHealthcare at 1-800-718-1299.	In-network: Nothing Out-of-network: All charges
Prescription drugs (through Medco by Mail only) approved by the FDA to treat tobacco dependence for smoking cessation. Over-the-counter drugs (through UnitedHealthcare only) approved by the FDA to treat tobacco dependence for smoking cessation.	In-network: Nothing Out-of-network: All charges
Surgical and anesthesia services provided by physicians and other health care professionals	
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Electroconvulsive therapy • Removal of tumors and cysts	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	
• Correction of congenital anomalies (see Reconstructive surgery) • Surgical treatment of morbid obesity (bariatric surgery) (requires pre-notification. See *How to get approval for...* in Section 3) • Insertion of internal prosthetic devices (see Orthopedic and prosthetic devices above for device coverage information) • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Surgically implanted contraceptives • Intrauterine devices (IUDs) • Treatment of burns • Assistant surgeons - We cover up to 20% of our allowance for the surgeon's charge	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
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: 60% of the Plan allowance • For the secondary procedure(s): - In-network: 85% of one-half of the Plan allowance or - Out-of-network: 60% of one-half of the Plan allowance Note: 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: 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 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*	*All charges*
Reconstructive surgery	
• 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.	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount

Reconstructive surgery - continued on next page

Benefit Description	You pay
Reconstructive surgery (cont.)	
• 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 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: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Cosmetic surgery– any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury if repair is initiated within two years of the accident* • *Surgeries related to sex transformation, sexual dysfunction or sexual inadequacy except if preauthorized for organic impotence*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft plate 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	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay
Oral and maxillofacial surgery (cont.)	
• 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: We suggest you call UnitedHealthcare at 1-800-718-1299 to determine whether a procedure is covered.	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
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* • *Treatment of periodontal disease and gingival tissues, and abscesses* • *Charges related to orthodontic treatment*	*All charges*
Organ/tissue transplants	
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: • Cornea • Heart • Heart/lung • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	In-network Transplant Center of Excellence (COE): 10% of the Plan allowance In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount 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 *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)	In-network Transplant Center of Excellence (COE): 10% of the Plan allowance In-netwok: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount over $100,000

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
	In-network Transplant Center of Excellence (COE): 10% of the Plan allowance In-netwok: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount over $100,000
Blood or marrow stem cell transplants limited to the following diagnoses. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Breast Cancer - Epithelial ovarian cancer - Multiple myeloma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	In-network Transplant Center of Excellence (COE): 10% of the Plan allowance In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount 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

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
	Out-of-network: 40% 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 are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. 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.	In-network Transplant Center of Excellence (COE): 10% of the Plan allowance In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount and any amount over $100,000
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 1-800-718-1299 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.	
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Transplants not listed as covered* • *Implants of artificial organs*	*All charges*
Anesthesia	
Professional services for administration of anesthesia Note: If surgical services are rendered at an in-network hospital or an in-network freestanding ambulatory facility by an in-network primary surgeon, we will pay the services of out-of-network anesthesiologists at the in-network rate, based on Plan allowance.	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount

Benefit Description	You pay
Services provided by a hospital or other facility, and ambulance services	
Inpatient hospital	
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: 40% of the Plan allowance and any difference between our allowance and the billed amount Note: If you use a network provider and a network facility, we may still pay out-of-network benefits on any services received from a radiologist or pathologist who is not a network provider.
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • 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 health care 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: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Any part of a hospital admission that is not medically necessary (see definition), 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 definition* • *Non-covered facilities, such as nursing homes, skilled nursing facilities, residential treatment 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*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	
Cancer Centers of Excellence The Plan provides access to designated Cancer Centers of Excellence. To locate a Cancer Center of Excellence, contact UnitedHealthcare at 1-800-718-1299 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 In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and billed amount
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • 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: 40% of the Plan allowance and any difference between our allowance and the billed amount

Benefit Description	You pay
Extended care benefits/Skilled nursing care facility benefits	
No benefit	All charges
Hospice care	
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 $3,000 annually for outpatient services and $2,000 annually for inpatient services • We pay a $200 annual bereavement benefit per family unit	Any amount over the annual maximums shown
Ambulance	
Local professional ambulance service when medically appropriate immediately before or after an inpatient admission	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Ambulance service used for routine transport*	*All charges*
Emergency services/accidents	
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 and broken bones. 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. Note: If you use an emergency room for other than a recognized medical emergency, facility fees and supplies will not be covered. Note: 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.	

Benefit Description	You pay
Accidental injury	
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 and any difference between our allowance and the billed amount
Medical emergency	
• Outpatient facility charges in an Urgent Care Center • 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 and any difference between our allowance and the billed amount
Ambulance	
• Professional ambulance service within 24 hours of an accidental injury or medical emergency • Air ambulance if medically necessary for transport to the closest appropriate facility for treatment within 24 hours of an accidental injury Note: See Hospital benefits above for non-emergency service.	In-network: 15% of the Plan allowance Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount
Mental health and substance abuse benefits	
You may choose to get care in-network or out-of-network. You need to get Plan approval (preauthorization) for services and follow a treatment plan we approve in order to get benefits. When you receive services as part of an approved treatment plan, cost-sharing and limitations for Plan mental health and substance abuse benefits are no greater than for similar benefits for other illnesses and conditions. **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 about coordinating benefits with other coverage, including with Medicare. **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES**. Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process shown in Section 3 and get Plan approval of your treatment plan.	

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay
Mental health and substance abuse benefits (cont.)	
• We do not make available provider directories for mental health or substance abuse providers. ValueOptions will provide you with a choice of network providers when you call to preauthorize your care.	
Professional Services	
We cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
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 • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance
Diagnostics	
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance
Inpatient hospital or other covered facility	
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services.	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance

Benefit Description	You pay
Outpatient hospital or other covered facility	
Outpatient services provided and billed by a hospital or other covered facility • Services such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment - *Outpatient services provided and billed by a hospital or other covered facility* - *Services such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based* intensive outpatient treatment	In-network: 15% of the Plan allowance Out-of-network: 40% of the Plan allowance
See these sections of the brochure for more valuable information about these benefits: • Section 4, *Your costs for covered services*, for information about catastrophic protection for these benefits. • Section 7, *Filing a claim for covered services*, for information about submitting out-of-network claims.	
Prescription drug benefits	
Covered medications and supplies	
Each new enrollee will receive a description of our prescription drug program administered by Medco Health, a combined prescription drug/ Plan identification card, a mail order form/patient profile and a reply envelope. You may purchase the following medications and supplies prescribed by a physician from either a network pharmacy or by mail: • Drugs and medicines, including those for smoking cessation, for use at home that are obtainable only upon a doctor's prescription • Drugs and medicines (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 • Needles and syringes for the administration of covered medications • Full range of FDA-approved drugs, prescriptions, and devices for birth control • Prior authorization 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. For example, approved drugs for organic impotence are subject to prior Plan approval and limitations on dosage and quantity. See the coverage authorization information shown in Section 3, page 14 and page 82 for more information about this program.	• Network Retail: 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 • Network Retail Medicare: 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 • Network Mail Order: 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 • Network Mail Order Medicare: 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
Not covered: • *Drugs and supplies for cosmetic purposes*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	
• *Vitamins, minerals, nutritional supplements, and enteral formulas (liquid food supplements)* • *Medical supplies such as dressings and antiseptics* • *Nonprescription medicines/over-the-counter drugs* • *Non-network retail drugs (unless for a sudden illness while traveling outside the United States or Puerto Rico)* Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Smoking cessation program (See Educational classes and programs page 73).	*All charges*
Personalized Medicine (voluntary program) The Personalized Medicine Program combines a Pharmacogenomic test (genetic lab test) with a clinical program to optimize prescription drug therapies for patients taking Warfarin (anticoagulant) and Tamoxifen (for breast cancer). This program focuses on giving physicians information, on an individual level, on patients who have already been diagnosed with a disease or condition. The benefits of this testing, done with a simple cheek swab are: • Greater patient safety and efficacy through more precise dosing for Warfarin and correct therapy decisions for Tamoxifen • Elimination of adverse events since the patient will be taking the right dose of Warfarin from the early onset of therapy Pharmacogenomic testing gives physicians personalized information they can use to make more precise prescribing and dosing decisions to help their patients receive the critical care they need. The Personalized Medicine Program is available to you at no additional cost. If your medication history indicates that the testing could be beneficial for you, a pharmacist will contact your physician to discuss the program. If your doctor agrees that the test results would be helpful, you will be contacted by a pharmacist to let you know that the testing is available. If you agree to participate, you will receive a cheek swab test that you can administer on your own. The results of your test will be sent to your doctor and to a Medco pharmacist who has received special training in personalized medicine. The pharmacist is available to help your doctor interpret the results of your test. Your participation is voluntary, and your doctor is still solely responsible for deciding which drug and dose is right for you. Personalized medicine (voluntary program) • Genetic testing to optimize prescription drug therapies for certain conditions: - Tamoxifen (for breast cancer) - Warfarin (anticoagulant)	

Benefit Description	You pay
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). Examples of drug categories that require a coverage review include but are not limited to, Growth Hormones, Botox, Interferons, Rheumatoid Arthritis agents, Retin A and drugs for organic impotence. 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, Medco 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. • 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 Medco online at www.medco.com or call Medco Member Services at 1-800-309-5528. • "Specialty Drugs" means those covered drugs that typically cost $500 or more per dose or $6,000 or more per year and have one or more of the following characteristics: (1) complex therapy for complex disease (2)specialized patient training and coordination of care (services, supplies, or devices) required prior to therapy initiation and/or during therapy; (3) unique patient compliance and safety monitoring requirements; (4)unique requirements for handling, shipping and storage; and (5) potential for significant waste due to the high cost of the drug. Exceptions to the price threshold may exist based on certain characteristics of the drug or therapy which will still require the drug to be classified as a Specialty Drug. Some examples of the disease categories currently in Medco's specialty pharmacy programs include cancer, cystic fibrosis, Gaucher disease, growth hormone deficiency hemophilia, immune deficiency, Hepatitis C, infertility, multiple sclerosis, rheumatoid arthritis and RSV prophylaxis. 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 program mentioned above.	

Coverage Authorization - continued on next page

Benefit Description	You pay
Coverage Authorization (cont.)	
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).	
Dental benefits	
No benefit	See Personal Care Account, page 63

Section 5 (d). Health tools and resources

Special features	Description
Online tools and resources	Your Personal, private Web site accessible by Internet at www.myuhc.com • Your Personal Care Account balance and activity (also mailed quarterly) • Your complete claims payment history • A consumer health encyclopedia and interactive services • Online health risk assessment to help determine your risk for certain conditions and steps to manage them • Personal Health Record
Consumer choice information	Each member is provided access by Internet (www.myuhc.com) or telephone (1-800-718-1299) to information which you may use to support your important health and wellness decisions, including: • Online provider directory with complete national network and provider information (i.e., address, telephone, specialty, practice hours, languages spoken) • Network provider discounted pricing for comparative shopping • Pricing information for prescription drugs • General cost information for surgical and diagnostic procedures and for comparison of different treatment options • Provider quality information • Health calculators on medical and wellness topics
Care support	A 24-hour nurse advisory service for your use. This program is strictly voluntary and confidential. You may call toll-free at 1-800-718-1299 to discuss an existing medical concern or to receive information about numerous health care and self-care issues. This also includes health coaching with a registered nurse when you want to discuss significant medical decisions. TTY/TDD callers, please call the National Relay Center at 1-800-855-2880 and ask for 1-800-718-1299. Identification and notification of potential patient safety issues (e.g., drug interactions). Individual support with a health care professional for numerous medical conditions including maternity, asthma, diabetes, congestive heart failure, healthy back and more. Cancer Centers of Excellence (See Section 5(c), page 80).
Diabetes Management Program	If you are an APWU Health Plan primary member enrolled in the Consumer Driven Option's Diabetes Disease Management program and participate as required by the program, you may be eligible for the following incentives payable at 100% for In-network services only: • In-network medical office visits for diabetes management (this does not include visits to a Podiatrist or Ophthalmologist) • In-network lab tests related to diabetes management • Generic drugs from Medco by Mail for the specific purpose of lowering your blood sugar • Insulin from Medco by Mail • Test strips, lancets, syringes and pen needles from Medco by Mail • Insulin Pump (Preauthorization is required) and Insulin Pump supplies purchased in-network

If you are an APWU Health Plan member who has other primary insurance (i.e. Medicare primary), you do not have to enroll in the Diabetes Disease Management program, you may be eligible for the following incentives payable at 100%:

- Generic drugs from Medco by Mail for the specific purpose of lowering your blood sugar
- Insulin from Medco by Mail
- Test strips, lancets, syringes and pen needles from Medco by Mail
- In-network lab tests related to diabetes management
- Insulin Pump (Preauthorization is required) and Insulin Pump supplies purchased in-network

Note: Enrollment in this program must be initiated by member after effective date of Health Plan enrollment. For more information contact UnitedHealthcare at 1-800-718-1299.

Special Programs

Online programs and services provide extra support and savings, at www.myuhc.com
User ID: APWUCDO; Password: CDOINFO

- **Healthy Pregnancy Program** - Mothers-to-be receive support through every stage of pregnancy and delivery.
- **Healthy Back Program** - Help for preventing or dealing with back pain before it becomes a recurring or long-term issue.
- **Cancer Support Program** - Enroll in the program, and receive enhanced benefits at Cancer Centers of Excellence.
- **Source4Women** - Resource designed for women to learn how to keep the entire family healthy.

Section 5 (e). 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 traditional care and coordinate other benefits as a less costly alternative benefit. 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. 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 cannot 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 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.

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow the Plan's guidelines. For additional information contact the Plan at 1-800-222-APWU (2798) or visit their website at www.apwuhp.com.

American Hearing Benefits 1-866-925-1287
www.americanhearingbenefits.com

The American Hearing Benefits program is an optional program with no additional premium that supplements the benefits in your APWU Health Plan coverage. All participants of the APWU Health Plan, either High Option or Consumer Driven Option, who enroll in the Amercan Hearing Benefits Plan through this offer will receive a discount on hearing aid devices offered through Starkey. To enroll in the plan you must call American Hearing Benefits toll free at 1-866-925-1287. Please specify that you are an APWU Health Plan participant.

Availability: The American Hearing Benefits Plan is available to all Active, Retired, Associate and Transitional Employees, APWU Members in all States and Territories of the United States.

Coverage Description: With this optional plan you must contact American Hearing Benefits (AHB) to activate the benefit. AHB will locate a local provider in your area and schedule your first member visit. After the first visit with a provider, members may schedule additional appointments with the same provider at will. Discounts are applied at the time services are rendered.

This Program is available to Group members and their immediate families without any charge. This Program involves the extension of a negotiated discount on certain product and services available from certain hearing aid providers and does not involve the provision of insurance. The program discounts are subject to change. It is your responsibility to determine whether the products and services you elect to purchase are covered by the Program by calling AHB toll free at 1-866-925-1287.

Coverage Schedule:

- Free hearing screenings annually for members and their immediate family
- Referrals to local providers
- Discounts up to 40%-60% off suggested MSRP prices on Starkey digital hearing instruments
- A full two year extended warranty included with every purchase of Starkey hearing aid at no additional cost

The Supplemental Discount Drug Program 1-800/818-6717
www.medco.com

The Supplemental Discount Drug Program is a value-added program that provides members with access to discounts on prescription drugs not covered by the prescription drug plan when ordered through Medco's Mail Service Pharmacies. Specifically, the Supplemental Discount Drug Program will provide discounts to members on all FDA-approved prescription drugs that are dispensed through Medco mail-order pharmacies, yet are not covered under the prescription drug plan administered by Medco.

Availability: The Supplemental Discount Drug Program is available to all High Option Plan members only.

Coverage Description: You pay 100% of the discounted price. You cannot file a claim for off-plan prescriptions.

- Call Medco first at 1-800-818-6717 to find out the price of off-plan prescriptions.
- Obtain the prescription from your physician.
- Complete a Medco mail order envelope and enclose your prescription along with your check or credit card number. You must include full payment with your order for prescriptions.

Benefits on this page are not part of the FEHB contract

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums.

Voluntary Benefits Plan Dental Plan

The Voluntary Benefits Plan Dental program is an optional program with an additional premium that supplements the dental 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 Voluntary Benefits Plan Dental Plan through this offer will receive a discount in the regular premiums for that program. 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 the toll-free number listed below. Please specify that you are an APWU Health Plan participant.

Availability: The Voluntary Benefits Plan Dental Plan is available to all Active, Retired, Associate and Transitional Employees, APWU Members in all 50 States and The District of Columbia.

Coverage Description: This optional dental plan is an indemnity insurance plan underwritten by the United States Life Insurance Company. You may use any dentist you choose. Covered services are reimbursed as a percentage of the "Reasonable and Customary" charges for that service in the state where the charge is incurred. Once you have satisfied the continuous coverage limitations of the program, there are no further waiting periods as long as you remain continuously insured under the plan. Both you and your eligible dependents (spouse and unmarried children to age 19 - full-time students to age 25) can be insured under this plan.

Coverage Schedule:

- Calendar Year Deductible:
  - $50 per person - Type I benefits
  - $100 per person - Type II and Type III benefits, combined
- Calendar Year Maximum:
  - $1,500 per person for all covered services
  - $500 per person for all eligible Orthodontic services, if Optional Orthodontic Coverage is selected
- Lifetime Maximum:
  - $1,000 for Orthodontic services, if Optional Orthodontic Coverage is selected

	After the Annual Deductible, this plan will pay:	
Benefit Schedule	**High Option Plan**	**Low Option Plan**
Type I Benefits: Preventive Services Exams / X-rays / Cleanings	100% of the Reasonable and Customary charges	100% of the Reasonable and Customary charges
Type II Benefits: Basic Services Fillings / Oral Surgery / Extractions	80% of the Reasonable and Customary charges (6 month waiting period)	50% of the Reasonable and Customary charges (6 month waiting period)
Type III Benefits: Major Services Crowns / Bridges / Dentures / Periodontics	50% of the Reasonable and Customary charges (12 month waiting period)	50% of the Reasonable and Customary charges (18 month waiting period)
Type IV Benefits: (Optional Coverage) Orthodontic	50% of the Reasonable and Customary charges (24 month waiting period)	50% of the Reasonable and Customary charges (24 month waiting period)

This is a partial summary of the terms, conditions and limitations of the Dental Plan policy #G-224,540. For more information regarding the coverage, rates or to receive an enrollment form, please contact the Voluntary Benefits Plan office by calling or writing:

Voluntary Benefits Plan
P.O. Box 1471
Waterbury, CT 06721

1-800-422-4492
1-203-754-4410 (TDD)
www.voluntarybenefitsplan.com

Benefits on this page are not part of the FEHB contract

Section 6. General exclusions – things we don't 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** (see specifics regarding transplants)**.**

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 were carried to term, or when the pregnancy is the result of an act of rape or incest
- Services, drugs, or supplies related to sex transformations, sexual dysfunction or sexual inadequacy except for organic impotence as shown on pages 14, 37, 51, 75 and 84
- Services, drugs, or supplies for weight reduction/control or treatment of obesity except as shown under Surgical benefits, Section 5
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program
- Services, drugs and supplies for which no charge would be made if the covered individual had no health insurance coverage
- Computer "story boards," "light talkers," or other communication aids for communication-impaired individuals
- Services, drugs, or supplies you receive without charge while in active military service
- Services, drugs and supplies furnished by 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 noncovered facility, except that medically necessary prescription drugs and physical, speech and occupational therapy rendered by a qualified professional therapist on an outpatient basis are covered subject to Plan limits
- Services, supplies and drugs not specifically listed as covered
- Services, supplies and drugs furnished or billed by someone other than a covered provider as defined on page 10
- Any portion of a provider's fee or charge ordinarily due from the enrollee but that has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible, copay or coinsurance, we will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived
- Charges which you or we have no legal obligation to pay, such as excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see pages 19, 20 and 21), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge) (see page 21, or State premium taxes however applied
- Biofeedback; non-medical self care or self help training, such as recreational, educational, or milieu therapy; or
- 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

There are four types of claims. Three of the four types - Urgent care claims, Pre-service claims, and Concurrent review claims - usually involve access to care where you need to request and receive our advance approval to receive coverage for a particular service or supply covered under this Brochure. See Section 3 for more information on these claims/requests and Section 10 for the definitions of these three types of claims.

The fourth type - Post-service claims - is the claim for payment of benefits after services or supplies have been received.

- **How to claim benefits**

High Option: To obtain claim forms, claims filing advice or answers about our benefits, contact us at 1-800-222-APWU (2798), or at our Web site at www.apwuhp.com.

Mail to:

- CIGNA Healthcare, P.O. Box 5909, Scranton, PA 18505, Or Payor ID 62308

VI Equicare claims to:

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

Consumer Driven Option: Contact UnitedHealthcare at 1-800-718-1299 or visit their Web site at www.myuhc.com. User ID: APWUCDO Password: CDOINFO

Mail to:

- United HealthCare, P.O. Box 740810, Atlanta, GA 30374-0810

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

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

- Name of patient and relationship to enrollee
- Plan identification number of the enrollee
- Name, address and taxpayer identification number of person or firm providing the service or supply
- Dates that services or supplies were furnished
- Diagnosis
- Type of each service or supply; and
- The charge for each service or supply

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

In addition:

- You must send a copy of the explanation of benefits (EOB) statement you received from any primary payor (such as the Medicare Summary Notice (MSN)) with your claim.
- Bills for home nursing care must show that the nurse is a registered nurse, licensed practical nurse or licensed vocational nurse.

- Claims for rental or purchase of durable medical equipment; private duty nursing; and physical, occupational, and speech therapy require a written statement from the physician specifying the medical necessity for the service or supply and the length of time needed.
- Claims for prescription drugs and supplies that are not obtained from a network pharmacy or through the Mail Service Prescription Drug Program must include receipts that show the prescription number, the National Drug Code (NDC) number, name of drug or supply, prescribing physician's name, date, and charge.
- You should provide an English translation and currency conversion rate at the time of services for claims for overseas (foreign) services.

Urgent care claims procedures

If you have an urgent care claim, please contact our Customer Service Department at 1-800-222-APWU (2798). Urgent care claims must meet the definition found in Section 10 of this brochure, and most urgent care claims will be claims for access to care rather than claims for care already received. We will notify you of our decision not later than 24 hours after we receive the claim as long as you provide us with sufficient information to decide the claim. If you or your authorized representative fails to provide sufficient information to allow us to make a decision, we will inform you or your authorized representative of the specific information necessary to complete the claim not later than 24 hours after we receive the claim and a time frame for our receipt of this information. We will decide the claim within 48 hours of (i) receiving the information or (ii) 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 a written or electronic notification within three days of oral notification.

Concurrent care claims procedures

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment as an appealable decision. 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, then we will make a decision within 24 hours after we receive the claim.

Pre-service claims procedures

As indicated in Section 3, certain care requires Plan approval in advance. We will notify you of our decision within 15 days after the 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 before the expiration 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.

If you fail to follow these pre-service claim procedures, then we will notify you of your failure to follow these procedures as long as (1) your request is made to our customer service department and (2) your request names you, your medical condition or symptom, and the specific treatment, service, procedure, or product requested. We will provide this notice within five days following the failure or 24 hours if your pre-service claim is for urgent care. Notification may be oral, unless you request written correspondence.

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 requried and we will allow you up to 60 days from the receipt of the notice to provide the information.

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 of 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, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible. Once we pay benefits, there is a three-year limitation on the reissuance of uncashed checks.

Overseas claims

For covered services you receive in hospitals outside the United States and Puerto Rico and performed by physicians outside the United States, 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 1358, Glen Burnie, MD 21060-1358.
- **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 health care 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.

Section 8. The disputed claims process

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies - including a request for preauthorization/prior approval required by Section 3. You may be able to appeal to the U.S. Office of Personnel Management (OPM) immediately if we do not follow the particular requirements of this disputed claims process. For more information about situations in which you are entitled to immediately appeal and how to do so, please visit www.apwuhp.com. Disagreements between you and the CDHP or HDHP fiduciary regarding the adminstration of an HSA or HRA are not subject to the disputed claims process.

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.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your High Option request to us at: APWU Health Plan, P.O. Box 1358, Glen Burnie, MD 21060-1358 or send your Consumer Driven Option request to: UnitedHealthcare Appeals, P.O. Box 30573, Salt Lake City, UT 84130-0573; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) statements. (e) Include your email address (optional), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care or precertify your hospital stay or grant your request for prior approval for a service, drug, or supply); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request -- go to step 3.
3	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. In the case of an appeal of an urgent care claim, we will notify you of our decision not later than 72 hours after receipt of your reconsideration request. We will hasten the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.
4	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, Insurance Operations, Health Insurance 2, 1900 E Street, NW, Washington, DC 20415-3620.

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 health care 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.

5 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 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 sue, 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 sue 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 1-800-222-APWU (2798). We will hasten 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 Health Insurance at 1-202-606-3818 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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' guidelines.

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 pays, 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 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.

What is Medicare?

Medicare is a health insurance program for:

- People 65 years of age and older;
- Some people with disabilities, under 65 years of age; and
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We do not offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on page 102.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call them at 1-800-772-1213, (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213, (TTY 1-800-325-0778) to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10 % increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

(Please refer to pages 19, 20 and 21 for information about how we provide benefits when you are age 65 or older and do not have Medicare.)

- **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 1-800-222-APWU (2798) or contact us at our Web site 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, copayment and coinsurance
- Medical services and supplies provided by physicians and other health care professionals. If you are enrolled in Medicare Part B, we will waive the deductible and coinsurance

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 12-visit limit for chiropractic services or the 60-visit limit for physical, occupational or speech therapy.

You can find more information about how our plan coordinates benefits with Medicare in APWU Health Plan's Guide to Medicare at www.apwuhp.com.

- **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**

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.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048) or at www.medicare.gov.

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB 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), but 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 FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB 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.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

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

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

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

TRICARE and CHAMPVA

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

Workers' Compensation

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.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

Medicaid

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

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB 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

If we pay any benefits for an injury or illness caused by another person or entity or for which you are monetarily compensated based in whole or in part on the benefits paid by the Plan, the Plan must be reimbursed up to the total amount of benefits we have paid. This is called subrogation, and the obligation to reimburse the Plan extends to all situations where you recover money from any source for an injury or illness on which the Plan has paid benefits. This may include compensation coming from a lawsuit or claims against a third party who caused your injury or illness; a third party's insurance; or your own automobile or homeowner's insurance. The Plan must be reimbursed up to the total amount of benefits paid for the injury or illness to you, your heirs, estate, administrators, successors or assignees. The amount owed to the Plan will not be reduced for attorney's fees or costs nor because you were not fully compensated or "made whole" for the injury or illness. You are obligated to reimburse the Plan even if the amount you receive is not sufficient to compensate you fully. If you wish to discuss the amount of reimbursement owed to the Plan, please contact our subrogation vendor at the contact information below.

You must promptly inform us if you or any one receiving benefits under the Plan has an injury or illness for which the benefits paid might be subrogated. This includes promptly responding to any questionnaires or surveys you receive inquiring about benefit claims paid by the Plan. Failure to provide this information will delay the processing of your benefit claims. If you make a claim or demand, whether in a lawsuit, insurance claim, or otherwise, for compensation for an injury or illness for which the Plan has paid benefits you must notify us of the status of all stages of your claim or demand, and inform us about any recoveries you obtain, whether in or out of court. We may seek a lien on the proceeds of your claim in order to reimburse the Plan up to the full amount of benefits we paid or will pay. You agree that you will not do anything that would prevent us from being fully reimbursed for benefits paid, and will cooperate in doing what is necessary to assist us in recovering the benefits paid. All money recovered and in whatever manner it is recovered, and regardless of how it is designated, must first be used to reimburse the Plan before it is distributed in any form. If you receive a recovery and do not reimburse us, we may reduce any subsequent benefit payments to you or any provider who provide you or your dependents with medical care, until the Plan's payments are recovered in total. If you do not seek damages, you agree to let us try if we notify you of our intent and interest in doing so; this includes the right of the Plan to sue the financially responsible person or entity in your name.

You agree to assign any proceeds or recovery to the Plan when asked to do so. The Plan's right to full 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. If you need more information, please contact our subrogation vendor ODSA at P.O. Box 34188, Washington, DC 20043-4188, subroinfo@odsalaw.com, or 1-877-535-1075 or 1-202-898-1075.

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

Some FEHB plans already cover some dental and vision services. When you are covered by more than one health/dental plan,

Coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information will reduce your out-of-pocket cost.

Clinical Trials

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

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

Section 10. Definitions of terms we use in this brochure

Accidental injury

An injury resulting from a violent external force.

Admission

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

Assignment

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

Calendar year

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

Clinical Trials

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 16.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 15.

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 your receive.

Covered services

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

Custodial care

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

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

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

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 those services. See page 15.

Experimental or investigational service

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 protocol(s) 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 health care provider or appropriate government publications such as those of the National Institute of Health, National Cancer Institute, Food and Drug Administration, Agency of Health Care Policy & Research, and the National Library of Medicine.

Group health coverage

Health care 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 health care 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.

Health care professional

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Home health care 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.

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.

Medically necessary

Services, drugs, supplies or equipment provided by a hospital or covered provider of health care 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.

Pharmacogenomics The study of a patient's genes to predict response to drugs and hence select the right drug and the right quantity.

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 charge for covered services.

For non-PPO providers, we base the Plan allowance on the lesser of the provider's actual charge or the allowed amount for the service you received. We determine the allowed amount by using health care charges guides which compare charges of other providers for similar services in the same geographical area. For surgery, doctor's services, X-ray, lab and therapies (physical, speech and occupational), we use guides prepared by the EMC Corporation and Ingenix and apply these guides under the High Option at the 70^{th} percentile and under the Consumer Driven Option at the 80^{th} percentile. We update these charges guides at least once each year. 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.

Post-service claims Any claims that are not pre-service. 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.

Us/We Us and We refer to APWU Health Plan.

You You refers to the enrollee and each covered family member.

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 judge whether 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 1-800-222-APWU (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.

Consumer Driven Health Plan Definitions

Consumer Driven Option	A fee-for-service option under the FEHB that offers you greater control over choices of your health care expenditures. You decide what health care 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 Deductible is the amount you must pay, if you have exhausted your Personal Care Account, before your Traditional Health Coverage begins. See page 15.
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	Any unused, remaining balance in your PCA at the end of the calendar year may be rolled over to subsequent years up to a maximum PCA account of $5,000 per Self Only enrollment or $10,000 per Self and Family enrollment, thereby increasing your PCA in the following year(s). You must use any available PCA benefits, including any amounts rolled over from previous years, before Traditional Health Coverage begins.

Section 11. FEHB 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.

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

See www.opm.gov/insure/health for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you *a Guide to* Federal *Benefits* brochures for other plans, and other materials you need to make an informed decision about your FEHB 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; and
- When the next Open Season for enrollment begins.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

- **Types of coverage available for you and your family**

Several provisions of the Affordable Care Act (ACA) affect the eligibility of family members under the FEHB Program effective January 1, 2011.

Children	Coverage
Between ages 22 and 26	Children between the ages of 22 and 26 are covered under their parent's Self and Family enrollment up to age 26.
Married Children	Married children (but **NOT** their spouse or their own children) are covered up to age 26. This is true even if the child is currently under age 22.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are eligible for coverage up to age 26.
Stepchildren	Stepchildren do not need to live with the enrollee in a parent–child relationship to be eligible for coverage up to age 26.
Children Incapable of Self-Support	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 formation.
Foster Children	Foster children are eligible for coverage up to age 26.

You can find additional information at www.opm.gov/insure.

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children or stepchildren your employing or retirement office authorizes coverage for. 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 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 and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to 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 form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 26 turns age 26.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB 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 for 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 FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- 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 and Family 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 and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

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 FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't 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 FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2011 benefits of your old plan or option** except when you are enrolled under this Plan's Consumer Driven Option. Under this Plan's Consumer Driven Option, between January 1 and the effective date of your new plan (or change to High Option of this Plan) you will **not** receive a new Personal Care Account (PCA) for 2011 but any unused PCA benefits from 2010 will be available to you. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2010 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing 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.

Under the Consumer Driven Option, if you joined this Plan during Open Season, you receive the full Personal Care Account (PCA) as of your effective date of coverage. If you joined at any other time during the year, your PCA and your Deductible for your first year will be prorated for each full month of coverage remaining in that calendar year.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB 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 FEHB 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.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy).

- **Upon divorce**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits 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 FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

- **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 FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent 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, and the RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us 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 apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

- **Getting a Certificate of Group Health Plan Coverage**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Web site (www.opm.gov/insure/health); refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

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 e-mail through the website, www.apwuhp.com, or by calling 1-800-222-APWU (2798).

Section 12. Three Federal Programs complement FEHB benefits

Important information

OPM wants to make sure you are aware of three Federal programs that complement the FEHB Program.

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS**,** lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

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

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

The Federal Flexible Spending Account Program - *FSAFEDS*

What is an FSA?

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

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $250 and a maximum annual election of $5,000.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin, products, physician prescribed over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA**) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependant on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

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

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program and was established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations.

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

Dental plans provide a comprehensive range of services, including all the following:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 24-month waiting period.

Vision Insurance

Vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/vision and www.opm.gov/insure/dental. This site also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY 1-877-889-5680).

The Federal Long Term Care Insurance Program - *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives, are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com .

Summary of benefits for the High Option of the APWU Health Plan - 2011

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

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

Below, an asterisk (*) means the item is subject to the calendar year deductible, $275 (PPO) or $500 (Non-PPO). And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a Non-PPO physician or other health care professional.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office*	PPO: $18 copay per visit (No deductible); 10% of Plan allowance Non-PPO: 30% of our allowance plus amount over our allowance	25
Services provided by a hospital:		
• Inpatient	PPO: 10% of Plan allowance Non-PPO: $300 copay and 30% of our allowance plus amount over our allowance	42
• Outpatient*	PPO: 10% of Plan allowance Non-PPO: 30% of our allowance plus amount over our allowance	44
Emergency benefits:		
• Accidental injury	PPO: Nothing Non-PPO: Any amount over our allowance	46
• Medical emergency*	Regular benefits	46
Mental health and substance abuse treatment:	PPO: $18 copay per visit (No deductible); 10% of Plan allowance Non-PPO: 30% of our allowance plus amount over our allowance	47
Prescription drugs:		
• Network pharmacy	$8 generic/25% brand name	52
• Network pharmacy Medicare	$8 generic/25% brand name	52
• Non-network pharmacy	50% of cost	52
• Non-network pharmacy Medicare	50% of cost	52
• Mail order	$15 generic/25% brand name	52
• Mail order Medicare	$15 generic/25% brand name	52

High Option Benefits	You pay	Page
Dental care:	30% of Plan allowance plus amount over our allowance	54
Special features:	Flexible benefits option, 24-hour nurse line, Services for deaf and hearing-impaired, Wellness benefit, Disease Management Program, Review and reward program	55
Protection against catastrophic costs (out-of-pocket maximum):	PPO: Nothing after $4,000/Self Only or Family enrollment per year Non-PPO: Nothing after $10,000/Self Only or Family enrollment per year Some costs do not count toward this protection	17

Summary of benefits for the CDHP of the APWU Health Plan - 2011

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

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

  Below, an asterisk (*) means the item is subject to the Deductible, generally $600 per Self Only and $1,200 per Self and Family, once your Personal Care Account has been spent. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use an out-of-network physician or other health care professional.

CDHP Benefits	You Pay	Page
In-network preventive care:	Nothing	61
Personal Care Account:		
Up to $1,200 for Self Only or $2,400 for Self and Family for medical, surgical, hospital, mental health and substance abuse services and prescription drugs plus certain dental and vision care	Nothing up to $1,200 for Self Only or $2,400 for Self and Family	63
Traditional Health Coverage after Personal Care Account is exhausted		65
Medical/Surgical services provided by physicians:		
• Diagnostic and treatment services provided in the office*	In-network: 15% of Plan allowance Out-of-network: 40% of our allowance plus amount over our allowance	66
Services provided by a hospital:		
• Inpatient*	In-network: 15% of Plan allowance Out-of-network: 40% of our allowance plus amount over our allowance	79
• Outpatient*	In-network: 15% of Plan allowance Out-of-network: 40% of our allowance plus amount over our allowance	80
Emergency benefits:		
• Accidental injury*	In-network: 15% of Plan Allowance	82
• Medical emergency*	Out-of-network: 15% of Plan Allowance plus amount over our allowance	82
Mental health and substance abuse treatment*:	In-network: 15% of Plan allowance Out-of-network: 40% of our allowance plus amount over our allowance	82
Prescription drugs:		
• Network pharmacy*	25%/minimum $10	84
• Network pharmacy Medicare*	25%/minimum $10	84
• Mail order*	25%/minimum $15	84

CDHP Benefits	You Pay	Page
• Mail order Medicare*	25%/minimum $15	84
Dental Care/Vision Care (covered only under Personal Care Account):	Any amount over $400 per Self Only or $800 per Family (see Section 5(b) Extra PCA Expenses).	64
Special features: Online tools and resources, Consumer choice information, Services for deaf and hearing-impaired, 24-hour nurse advisory service and Care support		88
Protection against catastrophic costs (out-of-pocket maximum):	In-network: Nothing after $3,000 Self Only or $4,500 Family enrollment per year Out-of-network: Nothing after $9,000/Self Only or Family enrollment per year Some costs do not count toward this protection	17

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2011 Rates for the APWU Health Plan

Non-Postal rates apply to most non-Postal enrollees. If you are in a special enrollment category, refer to the Guide to Federal Benefits for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the Guide to Benefits *for Career* United States Postal Service Employees, RI 70-2, and to the rates shown below.

CDHP Preferred rates apply to career postal employees represented by the APWU (including MDC, HQ Operating Services and IT/ASC) and the National Postal Professional Nurses Union (NPPN) who meet certain eligibility requirements.

PostalEASE, the employee self-service system used for FEHB enrollment, automatically provides the applicable premium to individual employees. Career non-law enforcement employees may also refer to the Guide to Federal Benefits for United States Postal Service Employees, RI 70-2 for eligibility criteria and to determine their rates.

The rates shown below do not apply to Postal Service Inspectors, Office of Inspector General (OIG) employees and Postal Service Nurses. Rates for members of these groups are published in special Guides. Postal Service Inspectors and OIG employees should refer to the *Guide to Benefits for United States Postal Inspectors and Office of Inspector General Employees* (RI 70-2IN). Postal Service Nurses should refer to the *Guide to Benefits for United States Postal Nurses* (RI 70-2NU).

For further assistance, Postal Service employees should call:

Human Resources Shared Service Center

1-877-477-3273, Option 5

TTY: 1-866-260-7507

Postal rates do no apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to applicable *Guide to Federal Benefits.*

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	471	$165.14	$55.05	$357.81	$119.27	$186.06	$34.13
High Option Self and Family	472	$373.40	$124.47	$809.04	$269.68	$420.70	$77.17
CDHP Option Self Only	474	$116.55	$38.85	$252.53	$84.17	$131.31	$24.09
CDHP Option Self and Family	475	$262.20	$87.40	$568.10	$189.37	$295.41	$54.19