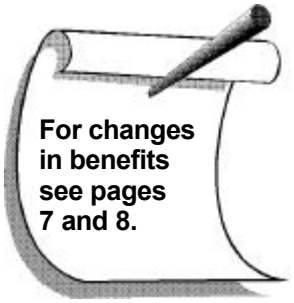
# APWU Health Plan

http://www.apwuhp.com

# 2001

## A fee-for-service plan with preferred provider organizations and a point of service product




**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 of the American Postal Workers Union, AFL-CIO.

**To become a member or associate member:** All active Postal Service bargaining unit employees must be, or must become, dues-paying members of the APWU, except where exempt by law. In item 1 of Part B of your registration form, enter the number of your APWU Local immediately after the name of this Plan.

If you are a non-postal employee/annuitant, you will automatically become an associate member of APWU Health Plan upon enrollment in the APWU Health Plan.

Annuitants (retirees) may enroll in this Plan.

**Membership dues:** $35 per year for an associate membership. 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 retired Postal Service employee's membership dues vary by APWU local.

**Enrollment codes for this Plan:**

**471 High Option - Self Only**
**472 High Option - Self and Family**

Authorized for distribution by the:

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
HTTP://WWW.OPM.GOV/INSURE

FEHB
Federal Employees
Health Benefits Program

**RI 71-004**

## Table of Contents

# Introduction

**APWU Health Plan**
**12345 New Columbia Pike**
**Silver Spring, MD 20904**

This brochure describes the benefits of APWU Health Plan under our contract (CS 1370) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for 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, 2001, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on pages 7 and 8. Rates are shown at the end of this brochure.

# Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. In response, a team of health plan representatives and OPM staff worked cooperatively to make this brochure clearer. Except for necessary technical terms, we use common words. "You" means the enrollee or family member; "we" means APWU Health Plan.

The plain language team reorganized the brochure and the way we describe our benefits. When you compare this Plan with other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

If you have comments or suggestions about how to improve this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov or write to OPM at Insurance Planning and Evaluation Division, P.O. Box 436, Washington, DC 20044-0436.

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

**We also have Preferred Provider Organizations (PPO):**

Our fee-for-service plan offers services through a PPO. When you use our PPO providers, you will receive covered services at reduced cost. Contact us for the names of PPO providers and to verify their continued participation. You can also go to our web page, which you can reach through the FEHB web site, www.opm.gov/insure. Do not call OPM or your agency for our provider directory.

If you need assistance in identifying a participating provider, call the Plan's PPO administrator for your state: Alliance PPO, Inc. 1-800/342-3289 for providers in the District of Columbia, Maryland, Virginia and West Virginia; Beech Street 1-800/923-3248 for providers in California, Florida, Georgia, Ohio, Oklahoma, Tennessee, Texas and Washington; MultiPlan 1-800/672-2140 for providers in New Jersey and New York; MedNet 1-800/556-1144 for providers in Maine; PreferredOne 1-800/451-9597 for providers in Minnesota; or First Health 1-800/447-1704 for all other states. For mental conditions/substance abuse providers (all states), call ValueOptions toll-free 1-888/700-7965.

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.

**We also have Point-of-Service (POS) benefits:**

Our fee-for-service plan offers POS benefits. This means you can get better benefits at less cost by signing up with us for the POS program, selecting a contracted primary care physician (PCP), and letting the PCP manage your care. We offer the POS program in the following areas: Texas and Minneapolis/St. Paul, Minnesota.

**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 the Health Insurance Association of America (HIAA) or other credible sources, including our own data, when necessary. We apply this charge data at the $80^{th}$ percentile.

**Patients' Bill of Rights**

OPM requires that all FEHB Plans comply with the Patients' Bill of Rights, recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. You may get information about us, our networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Spectera, Inc. is the major subcontractor performing hospital precertification and case management for the Plan and is accredited by American Accreditation HealthCare Commission/URAC effective May 24, 1997. PreferredOne Management Company performs hospital precertification and case management for members in the State of Minnesota only and is also URAC accredited effective August 1, 1997.

The following PPO networks are also URAC accredited:

| | | |
|---|---|---|
| PreferredOne | – | effective August 1, 1997 |
| MultiPlan | - | effective August 1, 1998 |
| ValueOptions | - | effective March 1, 1999 |

- The American Postal Workers Union Health Plan is a not-for-profit Voluntary Employee's Beneficiary Association (VEBA) formed in 1972 as the result of a merger between four predecessor union plans.
- 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, or write to APWU Health Plan, P.O. Box 3279, Silver Spring, MD 20918. You may also contact us by fax at 301/622-5712 or visit our website at www.apwuhp.com.

## Section 2. How we change for 2001

**Program-wide changes**

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.
- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our PPO network will be the same with regard to deductibles, coinsurance, copays, and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed higher patient cost sharing on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.
- Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find specific information on our patient safety activities by calling 1-800/222-APWU, or checking our website www.apwuhp.com. You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your healthcare, take these five steps:
  - Speak up if you have questions or concerns.
  - Keep a list of all the medicines you take.
  - Make sure you get the results of any test or procedure.
  - Talk with your doctor and health care team about your options if you need hospital care.
  - Make sure you understand what will happen if you need surgery.
- We clarified the language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Previously, the language referenced only women.
- North Dakota is deleted from the list of states designated as medically underserved in 2001. See page 9 for information on medically underserved areas.

**Changes to this Plan**

- Your share of the Postal premium will increase by 22% for Self Only or 17% for Self & Family.
- Your share of the non-Postal premium will increase by 18% for Self Only or 15% for Self and Family.
- Your out-of-pocket maximum when using preferred providers has increased to $4,000 per year for either a Self Only or a Self and Family enrollment. Last year, this maximum was $2,000.
- Your out-of-pocket maximum when using non-preferred providers has increased to $6,000 per year for either a Self Only or a Self and Family enrollment. Last year, this maximum was $3,500.
- The prescription drug deductible for retail drug purchases has been eliminated.
- For prescription drugs purchased at a network pharmacy, you now pay 25% of the cost of each drug with a minimum cost of $5 per prescription. Last year, you paid 20% with no minimum amount.
- If you have Medicare Parts A&B, you now pay 25% of the cost of each drug purchased at a network pharmacy, with a minimum cost of $5 per prescription. The Plan no longer waives your coinsurance for generic drugs.
- You now pay 45% of the cost of prescription drugs purchased at a non-network pharmacy. Last year, you paid 40%.
- You now pay 20% of the cost of each drug purchased through the mail order program, with a minimum of $5 per prescription. Last year, you paid a $7 copay for generic drugs or a $25 copay for brand name drugs if you were not covered under Medicare. If you were covered under Medicare, you paid a $5 copay for generic drugs or a $15 copay for brand name drugs.

- You are now required to pay the cost difference between a brand name drug and its generic equivalent if you receive the brand name drug when a generic is available. You will not be required to pay this cost difference if the brand name drug is medically indicated and your doctor has received our preauthorization to dispense it as written.
- If you do not use preferred providers, the Plan allowance for surgery, doctor's services, X-ray, lab and therapies may be lower than last year because the Plan now uses the 80$^{th}$ percentile of its prevailing charge guides. Last year, the 90$^{th}$ percentile was used. You may have to pay a larger portion of your bill if you do not use preferred providers. If you use preferred providers, this change will not affect you since preferred providers always accept the Plan's allowance as their charge for services.

## 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 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, call us at 1-800/222-APWU.

### 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, or our point-of-service program, 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: In medically underserved areas, we cover any licensed medical practitioner for any covered service performed within the scope of that license in states OPM determines are "medically underserved." For 2001, the states are: Alabama, Idaho, Kentucky, Louisiana, Mississippi, Missouri, New Mexico, South Carolina, South Dakota, Utah, 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 physician 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:

- terminate our contract with your specialist for other than cause; or
- drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan,

you may be able to continue seeing your specialist 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 until the end of your postpartum care, even if it is beyond the 90 days.

**Hospital care:** We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-800/222-APWU.

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.

## 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 we are asked to precertify your care, 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:**

- You, your representative, your doctor, or your hospital must call Spectera/CARE at 1-800/580-8771 at least 48 hours before admission. In Minnesota, call PreferredOne at 1-800/451-9597 to precertify. 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:**

If your hospital stay -- including for maternity care -- needs to be extended, your doctor or the hospital must ask us to approve the additional days by calling Spectera/CARE at 1-800/580-8771 or in Minnesota, call PreferredOne at 1-800/451-9597.

**What happens when you do not follow the precertification rules**

- 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.
- If no one contacted 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.

**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 payer for the hospital stay.
- Your Medicare Part A is the primary payer 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 payer and you do need precertification.

- **Other services**

Some services require prior approval.

- Prior approval is required for organ transplantation. Before your first evaluation as a potential candidate, contact First Health at 1-800/447-1704 and ask to speak to the transplant case manager.
- Prior approval is required for surgical procedures which may be cosmetic in nature such as eyelid surgery (blepharoplasty) or varicose vein surgery (sclerotherapy). Call Spectera/CARE at 1-800/580-8771 before the surgery is done.

- Prior approval is required for recognized surgery for morbid obesity or for organic impotence. Call Spectera/CARE at 1-800/580-8771 before the surgery is done.
- Prior approval 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. Call Spectera/CARE at 1-800/580-8771.
- Prior approval is recommended for durable medical equipment such as wheelchairs, oxygen equipment and supplies, artificial limbs and braces. Call Spectera/CARE at 1-800/580-8771.
- Prior approval is required for mental health and substance abuse benefits, inpatient or outpatient, in-network or out-of-network. Call ValueOptions at 1-888/700-7965.

## Section 4. Your costs for covered services

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

- **Copayments**

  A copayment is a fixed amount of money you pay to the provider when you receive services.

  Example: When you see your PPO physician you pay a copayment of $15 per visit.

- **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 do not count toward any deductible.

  - The calendar year deductible is $250 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 $500.
  - We also have a separate deductible for mental health and substance abuse benefits. The in-network deductible is $250 per person. Under a family enrollment, this deductible is satisfied for all family members when the combined in-network covered expenses applied to this deductible for all family members reach $500. The out-of-network deductible is $750 per person each calendar year with no family maximum.

  Note: If you change plans during open season, 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.

- **Coinsurance**

  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.

  Note: 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).

- **Difference between our allowance and the bill**

  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. Here is an example: 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 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, he can bill you for the $50 difference between our allowance and his 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 |

## Your 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, and your calendar year deductible has been met, you pay no coinsurance for covered services for the remainder of the calendar year.

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.

Non-PPO benefit: Your out-of-pocket maximum is $6,000 for either a Self Only or a Self and Family enrollment if you are using non-PPO providers.

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

- The 10% you pay for PPO Inpatient hospital charges, Surgical, Maternity and Diagnostic and treatment services;
- The 30% you pay for non-PPO Inpatient hospital charges, Surgical, Maternity and Diagnostic and treatment services; and
- The copayment of $15 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;
- Expenses for out-of-network mental health or substance abuse or dental care;
- Any amounts you pay because benefits have been reduced for non-

compliance with this Plan's cost containment requirements (see pages 11 and 14);
- Covered expenses applied to the $250 calendar year deductible;
- The $200 per admission deductible for non-PPO Inpatient hospital charges;
- Expenses for prescription drugs;
- Expenses incurred in excess of the $90 per day provided under home nursing care (see page 28); and
- Expenses in excess of hospice care and preventive care maximums.

**Carryover**

If you enrolled in our Plan during Open Season and your effective date is after January 1, your previous plan will be responsible for any medical care you received before your coverage in our Plan began. The old plan will pay your covered costs under this year's benefits since benefit changes start on January 1. If you did not meet your out-of-pocket maximum under your old plan last year, your covered out-of-pocket expenses will be applied to that maximum. If you did meet that maximum, your old plan's catastrophic protection benefit will continue to apply until your effective date in our Plan.

## 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.

## If we overpay you

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

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

Under the FEHB law, we must limit our payments for those benefits 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. 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 you owe 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; and
- The law prohibits a hospital from collecting more than the Medicare equivalent amount.

**And, for your physician care,** the law requires us to base our payment and your coinsurance 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 with 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 only permitted to collect 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

We limit our payment to an amount that supplements the benefits that Medicare would pay under Part A (Hospital insurance) and 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.

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

- If your physician accepts Medicare assignment, then you pay nothing for covered charges.
- If your physician does not accept Medicare assignment, then you pay the difference between our payment combined with Medicare's payment and the charge.

Note: The 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 them to reduce their charges. If they do not, report them to your Medicare carrier who sent you the MSN form. Call us if you need further assistance.

## When you have a Medicare Private Contract

A physician may ask you to sign a private contract agreeing that you can be billed directly for service ordinarily covered by 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 Medicare's payment.

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

# Section 5. Benefits -- OVERVIEW

***(See page 7 for how our benefits changed this year and pages 70 and 71 for a benefits summary.)***

**NOTE**: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 1-800/222-APWU or at our website at www.apwuhp.com

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

IMPORTANT

**Here are some 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: $250 per person ($500 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, emergency room physicians, anesthesiologists, and pathologists, may not all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers.
- 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.

IMPORTANT

| Benefit Description | You Pay<br>After the calendar year deductible… |
|---|---|
| NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "No deductible" when it does not apply. | |
| **Diagnostic and treatment services** | |
| Professional services of physicians<br>• In physician's office | PPO: $15 copayment (No deductible)<br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount |
| Professional services of physicians<br>• In an urgent care center<br>• During a hospital stay<br>• In a skilled nursing facility<br>• Initial examination of a newborn child covered under a family enrollment<br>• Second surgical opinion<br>• At home | PPO: 10% of the Plan allowance<br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount |
| *Not covered: Routine physical checkups and related tests* | *All charges* |

| Lab, X-ray and other diagnostic tests | You pay |
|---|---|
| Tests, such as:<br>• Blood tests<br>• Urinalysis<br>• Non-routine pap tests<br>• Pathology<br>• X-rays<br>• Non-routine Mammograms<br>• CAT Scans/MRI<br>• Ultrasound<br>• Electrocardiogram and EEG | PPO: 10% of the Plan allowance<br><br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount<br><br>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* |
| **Preventive care, adult** | |
| Routine screenings, limited to:<br>• Total Blood Cholesterol – once annually, ages 19 through 64<br>• Colorectal Cancer Screening, including<br>•• Fecal occult blood test, once annually, ages 40 and older<br>•• Sigmoidoscopy, screening – every five years starting at age 50<br>• Prostate Specific Antigen (PSA test) – one annually for men age 40 and older<br>• Routine pap test, one annually, women age 18 and older | PPO: 10% of the Plan allowance<br><br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount |
| Routine mammogram – covered for women age 35 and older, as follows:<br>• From age 35 through 39, one during this five year period<br>• From age 40 through 64, one every calendar year<br>• At age 65 and older, one every two consecutive calendar years | PPO: 10% of the Plan allowance<br><br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount |
| Routine immunizations, limited to:<br>• Tetanus-diphtheria (Td) booster – once every 10 years, ages19 and over (except as provided for under Childhood immunizations)<br>• Influenza/Pneumococcal vaccines, annually, age 65 and over | PPO: 10% of the Plan allowance<br><br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount |

| **Preventive care, adult** – *Continued* | **You pay** |
|---|---|
| *Not covered:*<br>• *Adult immunizations other than those listed above*<br>• *Office visit associated with preventive care.* | *All charges* |
| **Preventive care, children** | |
| • Childhood immunizations recommended by the American Academy of Pediatrics through age 22 | PPO: Nothing (No deductible)<br>Non-PPO: Any difference between the Plan allowance and the billed charge (No deductible) |
| • Examinations, limited to:<br>•• Well-child care charges for physical examinations and laboratory tests through age 12<br>•• Examination for amblyopia and strabismus-limited to one screening examination (age 2 through 6) | PPO: Nothing (No deductible)<br>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) |
| **Maternity care** | |
| Complete maternity (obstetrical) care, such as:<br>• Prenatal care<br>• Delivery<br>• Postnatal care<br>Note: Here are some things to keep in mind:<br>• You do not need to precertify your normal delivery; see pages 11 and 12 for other circumstances, such as extended stays for you or your baby.<br>• 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, but you must precertify.<br>• 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.<br>• We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital Benefits (Section 5c) and Surgery Benefits (Section 5b). | PPO: 10% of the Plan allowance<br>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 | You pay |
|---|---|
| • Voluntary sterilization<br>• Surgically implanted contraceptives<br>• Injectable contraceptive drugs<br>• Intrauterine devices (IUDs)<br>Note: We cover contraceptive drugs in Section 5(f). | PPO: 10% of the Plan allowance<br>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 excluded. | PPO: 10% of the Plan allowance and any amount over $2,500<br>Non-PPO: 30% of the Plan allowance, any difference between our allowance and the billed amount and any amount over $2,500 |
| *Not covered:*<br>• *Fertility drugs*<br>• *Assisted reproductive technology (ART) procedures, such as:*<br>·· *artificial insemination (all procedures)*<br>·· *in vitro fertilization*<br>·· *embryo transfer and GIFT*<br>• *Services and supplies related to ART procedures.* | *All charges* |
| **Allergy care** | |
| Testing and treatment, including materials (such as allergy serum)<br>Allergy injection | PPO: 10% of the Plan allowance<br>Non-PPO: 30% 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* |

| Treatment therapies | You pay |
|---|---|
| • Chemotherapy and radiation therapy<br><br>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed on page 33.<br><br>• Dialysis – Hemodialysis and peritoneal dialysis<br><br>• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy<br><br>• Growth hormone therapy (GHT)<br><br>Note: We only cover IV/Infusion therapy and GHT when we preauthorize the treatment. Call Spectera/CARE at 1-800/580-8771 for preauthorization. Spectera/CARE will ask you to submit information that establishes that the GHT is medically necessary. You should ask for preauthorization before you begin treatment. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3.<br><br>• Respiratory and inhalation therapies | PPO: 10% of the Plan allowance<br><br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount |
| **Rehabilitative therapies** | |
| Physical therapy, occupational therapy, and speech therapy provided by a licensed registered therapist.<br><br>Note: Preauthorization of rehabilitative therapies is required. Call Spectera/CARE at 1-800/580-8771 for preauthorization.<br><br>Note: We only cover therapy to restore bodily function or speech when there has been a total or partial loss of bodily function or functional speech due to illness or injury and when a physician:<br><br>1) orders the care;<br><br>2) identifies the specific professional skills the patient requires and the medical necessity for skilled services; and<br><br>3) indicates the length of time the services are needed. | PPO: 10% of the Plan allowance<br><br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount |
| *Not covered:*<br><br>• *Maintenance therapies*<br><br>• *Speech therapy for developmental delay*<br><br>• *Exercise programs*<br><br>• *Rehabilitative therapies without preauthorization* | *All charges* |

| Hearing services (testing, treatment, and supplies) | You pay |
|---|---|
| Audiologist to diagnose a hearing problem | PPO: 10% of the Plan allowance<br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount |
| *Not covered:*<br>• *Hearing aids, testing and examinations for them.* | *All charges* |
| **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.<br>Note: See Preventive care, children for eye exams for children | PPO: 10% of the Plan allowance<br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount |
| *Not covered:*<br>• *Eyeglasses or contact lenses and examinations for them*<br>• *Eye exercises and visual training*<br>• *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.<br>See Orthopedic and prosthetic devices for information on podiatric shoe inserts. | PPO: $15 copayment for the office visit (No deductible) plus 10% of the Plan allowance for other services performed during the visit<br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount |
| *Not covered:*<br>• *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*<br>• *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 | You pay |
|---|---|
| • Artificial limbs and eyes; stump hose<br>• Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy<br>• Leg, arm, neck and back braces<br>• Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device.<br><br>Note: We recommend preauthorization of orthopedic and prosthetic devices. Call Spectera/CARE at 1-800/580-8771 for preauthorization. | PPO: 10% of the Plan allowance<br><br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount |
| *Not covered:*<br>• *Orthopedic and corrective shoes*<br>• *Arch supports*<br>• *Foot orthotics*<br>• *Heel pads and heel cups*<br>• *Lumbosacral supports*<br>• *Corsets, trusses, elastic stockings, support hose, and other supportive devices* | *All charges* |

| Durable medical equipment (DME) | You pay |
|---|---|
| Durable medical equipment (DME) is equipment and supplies that:<br>• Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury);<br>• Are medically necessary;<br>• Are primarily and customarily used only for a medical purpose;<br>• Are generally useful only to a person with an illness or injury;<br>• Are designed for prolonged use; and<br>• Serve a specific therapeutic purpose in the treatment of an illness or injury.<br>We cover rental or purchase, at our option, including repair and adjustment, of durable medical equipment, such as oxygen and dialysis equipment. Under this benefit, we also cover equipment such as:<br>• Hospital beds;<br>• Wheelchairs;<br>• Crutches; and<br>• Walkers<br>Note: Call Spectera/CARE at 1-800/580-8771 as soon as your physician prescribes this equipment. We arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call. | PPO: 10% of the Plan allowance<br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount |
| *Not covered:*<br>• *Whirlpool equipment*<br>• *Sun and heat lamps*<br>• *Light boxes*<br>• *Heating pads*<br>• *Exercise devices*<br>• *Stair glides*<br>• *Elevators*<br>• *Air Purifiers*<br>• *Computer "story boards", "light talkers", or other communication aids for communication-impaired individuals* | *All charges* |

| Home health services | You pay |
|---|---|
| Services for skilled nursing care up to a maximum plan payment of $90 per day when preauthorized and:<br>• A registered nurse (R.N.), licensed practical nurse (L.P.N.) or licensed vocational nurse (L.V.N.) provides the services;<br>• The attending physician orders the care;<br>• The physician identifies the specific professional skills required by the patient and the medical necessity for skilled services; and<br>• The physician indicates the length of time the services are needed.<br><br>Note: Skilled nursing care must be preauthorized. Call Spectera/CARE at 1-800/580-8771 for preauthorization. | PPO: 10%; all charges after we pay $90 per day<br><br>Non-PPO: 30%; all charges after we pay $90 per day |
| *Not covered:*<br>• *Nursing care requested by, or for the convenience of, the patient or the patient's family*<br>• *Nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication*<br>• *Nursing services without preauthorization*<br>• *Services of nurses aides or home health aides* | *All charges* |
| **Alternative treatments** | |
| Chiropractic treatment limited to 12 visits and/or manipulations per year.<br><br>Acupuncture – by a doctor of medicine or osteopathy | PPO: $15 copayment (No deductible)<br><br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount |
| *Not covered:*<br>• *Services of any provider not listed as covered, see covered providers on page 9*<br><br>*Note: Benefits of certain alternative treatment providers may be covered in medically underserved areas; see page 9* | *All charges* |
| **Educational classes and programs** | |
| Coverage is limited to:<br>• Smoking Cessation – Up to $100 for one smoking cessation program per member per lifetime. | PPO: Nothing<br><br>Non-PPO: Nothing |

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

IMPORTANT

**Here are some 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: $250 per person ($500 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, emergency room physicians, anesthesiologists, and pathologists, may not all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers.
- 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 OF 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

IMPORTANT

| Benefit Description | You Pay<br>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** | |
| • Operative procedures<br>• Treatment of fractures, including casting<br>• Normal pre- and post-operative care by the surgeon<br>• Correction of amblyopia and strabismus<br>• Endoscopy procedure | PPO: 10% of the Plan allowance<br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount |

| **Surgical procedures** – *Continued* | **You Pay** |
|---|---|
| • Biopsy procedure<br>• Electroconvulsive therapy<br>• Removal of tumors and cysts<br>• Correction of congenital anomalies (see Reconstructive surgery)<br>• Surgical treatment of morbid obesity<br>• Insertion of internal prosthetic devices. See 5(a)– Orthopedic braces and prosthetic devices for device coverage information<br>• Voluntary sterilization, Norplant (a surgically implanted contraceptive), and intrauterine devices (IUDs)<br>• Treatment of burns<br>Assistant surgeons. - We cover up to 20% of our allowance for the surgeon's charge | (see above) |
| When multiple or bilateral surgical procedures performed during the same operative session add time or complexity to patient care, our benefits are:<br>• For the primary procedure:<br>•• PPO: 90% of the Plan allowance or<br>•• Non-PPO: 70% of the Plan allowance<br>• For the secondary procedure(s):<br>•• PPO: 90% of one-half of the Plan allowance or<br>•• Non-PPO: 70% of one-half of the Plan allowance<br>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)<br>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:*<br>• *Cosmetic surgery and other related expenses if not preauthorized*<br>• *Reversal of voluntary sterilization*<br>• *Services of a standby surgeon, except during angioplasty or other high risk procedures when we determine standbys are medically necessary*<br>• *Radial keratotomy and other refractive surgery* | *All charges* |

| Reconstructive surgery | You pay |
|---|---|
| • Surgery to correct a functional defect<br>• Surgery to correct a condition caused by injury or illness if:<br>•• the condition produced a major effect on the member's appearance and<br>•• the condition can reasonably be expected to be corrected by such surgery<br>• 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.<br>• All stages of breast reconstruction surgery following a mastectomy, such as:<br>•• surgery to produce a symmetrical appearance on the other breast;<br>•• treatment of any physical complications, such as lymphedemas;<br>•• breast prostheses; and surgical bras and replacements (see Prosthetic devices for coverage)<br>Note: We pay for internal breast prostheses as hospital benefits.<br>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<br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount |
| *Not covered:*<br>• *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*<br>• *Surgeries related to sex transformation, sexual dysfunction or sexual inadequacy except if preauthorized for organic impotence* | *All charges* |

| Oral and maxillofacial surgery | You pay |
|---|---|
| Oral surgical procedures, limited to:<br>• Reduction of fractures of the jaws or facial bones<br>• Surgical correction of cleft lip, cleft plate or severe functional malocclusion<br>• Removal of stones from salivary ducts<br>• Excision of leukoplakia or malignancies<br>• Excision of cysts and incision of abscesses when done as independent procedures<br>• Other surgical procedures that do not involve the teeth or their supporting structures<br>• Extraction of impacted (unerupted) teeth<br>• Alveoplasty, partial ostectomy and radical resection of mandible with bone graft unrelated to tooth structure<br>• Excision of bony cysts of the jaw unrelated to tooth structure<br>• Excision of tori, tumors, and premalignant lesions, and biopsy of hard and soft oral tissues<br>• Reduction of dislocations and excision, manipulation, arthrocentesis, aspiration or injection of temporomandibular joints<br>• Removal of foreign body, skin, subcutaneous alveolar tissue, reaction-producing foreign bodies in the musculoskeletal system and salivary stones<br>• Incision/excision of salivary glands and ducts<br>• Repair of traumatic wounds<br>• Sinusotomy, including repair of oroantral and oromaxillary fistula and/or root recovery<br>• Surgical treatment of trigeminal neuralgia<br>• Frenectomy or frenotomy, skin graft or vestibuloplasty-stomatoplasty unrelated to periodontal disease<br>• Incision and drainage of cellulitis unrelated to tooth structure<br>Note: We suggest you call us at 1-800/222-APWU to determine whether a procedure is covered. | PPO: 10% of the Plan allowance<br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount |
| *Not covered:*<br>• *Oral implants and transplants*<br>• *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva and alveolar bone)*<br>• *Dental bridges, replacement of natural teeth, dental/orthodontic/temporomandibular joint dysfunction appliances and any related expenses*<br>• *Treatment of periodontal disease and gingival tissues, and abscesses*<br>• *Charges related to orthodontic treatment* | *All charges* |

| Organ/tissue transplants | You pay |
|---|---|
| Limited to:<br>• Cornea<br>• Heart<br>• Heart/lung<br>• Kidney<br>• Kidney/Pancreas<br>• Liver<br>• Lung: Single – only for the following end-stage pulmonary diseases: primary fibrosis, primary pulmonary hypertension, or emphysema; Double – only for patients with cystic fibrosis<br>• Pancreas<br>• Allogeneic bone marrow transplants are limited to patients with leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, aplastic anemia, severe combined immuno-deficiency disease or Wiskott-Aldrich syndrome.<br>• Autologous bone marrow transplants and autologous peripheral stem cell support are limited to patients with acute leukemia in remission, relapsed non-Hodgkin's lymphomas responding to treatment, resistant or recurrent neuroblastoma, relapsed Hodgkin's disease responding to treatment, testicular cancer, mediastinal cancer, retroperitoneal cancer, ovarian germ cell tumors, epithelial ovarian cancer, breast cancer and multiple myeloma.<br><br>National Transplant Program (NTP) – We participate in a National Transplant Program administered by First Health. Before your initial evaluation as a potential candidate for a transplant procedure, you or your doctor must contact First Health at 1-800/447-1704 and ask to speak to a Transplant Case Manager. You will be provided with information about this program and about transplant preferred providers. The NTP is our PPO for organ/tissue transplants. If you participate in the National Transplant Program, you may receive prior approval for travel and lodging costs.<br><br>Limited Benefits – If you don't use the National Transplant Program, 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.<br><br>Note: We cover related medical and hospital expenses of the donor when we cover the recipient. | PPO (NTP): 10% of the Plan allowance<br><br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and any amount over $100,000 |

| **Organ/tissue transplants –** *Continued* | **You pay** |
|---|---|
| *Not covered:*<br>• *Donor screening tests and donor search expenses, except those performed for the actual donor*<br>• *Services or supplies for, or related to, surgical transplant procedures for artificial or human organ transplants not listed as specifically covered. Related services include administration of high dose chemotherapy when supported by autologous bone marrow transplant*<br>• *Transplants not listed as covered* | *All charges* |
| **Anesthesia** | |
| Professional services for administration of anesthesia | PPO: 10% of the Plan allowance<br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount<br>Note: If your PPO provider uses a non-PPO anesthesiologist, we will pay non-PPO benefits for any anesthesia charges. |

## Section 5(c). Services provided by a hospital or other facility, and ambulance services

IMPORTANT

**Here are some 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.
- Unlike Sections (a) and (b), in this section the calendar year deductible applies to only a few benefits. In that case, we added "(calendar year deductible applies)."
- 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, emergency room physicians, anesthesiologists, and pathologists, may not all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers.
- 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 Section 5(a) or (b).
- **YOU MUST GET PRECERTIFICATION OF 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.

IMPORTANT

| Benefit Description | You Pay |
|---|---|
| NOTE: The calendar year deductible applies ONLY when we say below: "calendar year deductible applies." | |
| **Inpatient hospital** | |
| Room and board, such as:<br>• ward, semiprivate, or intensive care accommodations;<br>• general nursing care; and<br>• meals and special diets<br><br>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 base our payment on the average semiprivate rate of comparable hospitals in the area.<br><br>Note: When the non-PPO hospital bills a flat rate, we prorate the charges to determine how to pay them, as follows: 30% room and board and 70% other charges. | PPO: 10% of the covered charges<br><br>Non-PPO: $200 per admission and 30% of the covered charges<br><br>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, pathologist, or anesthesiologist who is not a PPO provider. |

| **Inpatient hospital** – *Continued* | **You pay** |
|---|---|
| Other hospital services and supplies, such as:<br><br>• Operating, recovery, maternity, and other treatment rooms<br>• Prescribed drugs and medicines<br>• Diagnostic laboratory tests and X-rays<br>• Blood or blood plasma, if not donated or replaced<br>• Dressings, splints, casts, and sterile tray services<br>• Medical supplies and equipment, including oxygen<br>• Anesthetics, including nurse anesthetist services<br><br>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).<br><br>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. | (see above) |
| *Not covered:*<br><br>• *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*<br><br>• *Custodial care; see definition*<br><br>• *Non-covered facilities, such as nursing homes, extended care facilities, skilled nursing facilities, residential treatment facilities, day and evening care centers, and schools*<br><br>• *Personal comfort items such as radio, television, air conditioners, beauty and barber services, guest meals and beds*<br><br>• *Services of a private duty nurse that would normally be provided by hospital nursing staff* | *All charges* |

| Outpatient hospital or ambulatory surgical center | You pay |
|---|---|
| • Operating, recovery, and other treatment rooms<br>• Prescribed drugs and medicines<br>• Diagnostic laboratory tests, X-rays, and pathology services<br>• Administration of blood, blood plasma, and other biologicals<br>• Blood and blood plasma, if not donated or replaced<br>• Pre-surgical testing<br>• Dressings, casts, and sterile tray services<br>• Medical supplies, including oxygen<br>• Anesthetics and anesthesia service<br><br>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.<br><br>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 Plan allowance (calendar year deductible applies)<br><br>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.<br>• We pay $3,000 annually for outpatient services and $2,000 annually for inpatient services.<br>• 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 | PPO: 10% of the Plan allowance<br><br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount |
| *Not covered:*<br>• *Ambulance service used for routine transport* | *All charges* |

## Section 5(d). Emergency services/accidents

IMPORTANT

**Here are some 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.
- The calendar year deductible is: $250 per person ($500 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, emergency room physicians, anesthesiologists, and pathologists, may not all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers.
- 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.

IMPORTANT

### 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 (1-800/755-2200) 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<br>After the calendar year deductible… |
|---|---|
| NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "No deductible" when it does not apply. | |
| **Accidental injury** | |
| If you receive care for your accidental injury within 24 hours, we cover:<br>• Physician services and supplies<br>• Related outpatient hospital services<br>Note: We pay Hospital benefits if you are admitted. | PPO: Nothing (No deductible)<br>Non-PPO: Only the difference between our allowance and the billed amount (No deductible) |

| **Accidental injury –** *Continued* | **You pay** |
|---|---|
| If you receive care for your accidental injury after 24 hours, we cover:<br>• Physician services and supplies<br>Note: We pay Hospital benefits if you are admitted. | PPO: 10% of Plan allowance<br>Non-PPO: 30% of Plan allowance and any difference between our allowance and the billed amount |
| **Medical emergency** | |
| Outpatient medical or surgical services and supplies | PPO: 10% of Plan allowance<br>Non-PPO: 30% of Plan allowance and any difference between our allowance and the billed amount |
| **Ambulance** | |
| • Professional ambulance service<br>• Air ambulance if medically necessary for transport to the closest appropriate facility for treatment<br>Note: See 5(c) for non-emergency service. | PPO: 10% of Plan allowance<br>Non-PPO: 30% of Plan allowance and any difference between our allowance and the billed amount |

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

IMPORTANT

**Parity:**

Beginning in 2001, all FEHB plans' mental health and substance abuse benefits will achieve "parity" with other benefits. This means that we will provide mental health and substance abuse benefits differently than in the past.

You may choose to get care **In-Network** (same as before) or Out-of-Network. When you receive In-Network care, you must get our approval for services and follow a treatment plan we approve. If you do, cost-sharing and limitations for In-Network mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

**Here are some important things to keep in mind about these benefits:**

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- The calendar year 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 OF THESE SERVICES**. See the instructions after the benefits descriptions below.
- In-Network mental health and substance abuse benefits are below, then Out-of-Network benefits begin on page 42.

IMPORTANT

| Benefit Description | You Pay<br>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. | |
| **In-Network benefits** | |
| All diagnostic and treatment services contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.<br><br>Note: In-Network 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. | Your cost sharing responsibilities are no greater than for other illness or conditions. |
| • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, licensed social workers, or licensed intensive outpatient treatment centers<br>• Medication management | $15 per visit (No deductible) |
| • Diagnostic tests | 10% of the Plan allowance |

*In-Network benefits-Continued on next page*

| **In-Network benefits** – *Continued* | **You pay** |
|---|---|
| • Inpatient services provided by a hospital or other facility<br>• Services in approved partial hospitalization setting. | 10% of the covered charges (No deductible) |
| *Not covered: Services we have not approved.*<br>*Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.* | All charges |

**Preauthorization**

To be eligible to receive these enhanced mental health and substance abuse benefits you must follow your treatment plan and all of our network authorization processes. These include:

- Inpatient care—You must get preauthorization of hospital stays; failure to do so will result in a minimum $500 penalty. Please refer to the precertification information shown in Section 3. To obtain preauthorization of an admission for mental conditions or substance abuse, call ValueOptions at 1-888/700-7965
- Outpatient care—You must get preauthorization of outpatient care for mental conditions or substance abuse. Preauthorization must be obtained by calling ValueOptions at 1-888/700-7965
- 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

**Special transitional benefit**

If a mental health or substance abuse professional provider is treating you under our plan as of January 1, 2001, you will be eligible for continued coverage with your provider for up to 90 days under the following condition:

- If your mental health or substance abuse professional provider with whom you are currently in treatment leaves the plan at our request for other than cause.

If this condition applies to you, we will allow you reasonable time to transfer your care to a network mental health or substance abuse professional provider. During the transitional period, you may continue to see your treating provider and will not pay any more out-of-pocket than you did in the year 2000 for services. This transitional period will begin with our notice to you of the change in coverage. The transitional period will last for up to 90 days from the date you receive notice of the change. You may receive this notice prior to January 1, 2001, and the 90 days period begins with receipt of the notice.

**Network limitation**

If you do not obtain and follow an approved treatment plan, we will provide only out-of-network benefits.

| Out-of-Network benefits | You pay |
|---|---|
| Professional outpatient care to treat mental conditions and substance abuse. | After a $750 mental conditions/substance abuse calendar year deductible, 50% of our allowance for up to 15 visits; all charges after 15 visits |
| Inpatient care to treat mental conditions includes ward or semiprivate accommodations and other hospital charges | After a $750 mental conditions/substance abuse calendar year deductible, 50% of charges for up to 30 days per calendar year; all charges after 30 days |
| Inpatient care to treat substance abuse includes room and board and ancillary charges for confinements in a treatment facility for rehabilitative treatment of alcoholism or substance abuse | After a $750 mental conditions/substance abuse calendar year deductible, 50% of charges for one treatment program up to $3,000; all charges over $3,000 per lifetime |
| *Not covered out-of-network:*<br>• *Treatment for learning disabilities and mental retardation.*<br>• *Services rendered or billed by a school or halfway house or a member of its staff.*<br>• *Phototherapy for treatment of Seasonal Affective Disorder (SAD).* | *All charges* |

**Lifetime maximum**

Out-of-Network inpatient care for the treatment of alcoholism and drug abuse is limited to one treatment program per lifetime not to exceed $3,000.

**Precertification**

- Inpatient care – You must get preauthorization of hospital stays; failure to do so will result in a minimum $500 penalty. Please refer to the precertification information shown in Section 3. To obtain preauthorization of an admission for mental conditions or substance abuse, call ValueOptions at 1-888/700-7965
- Outpatient care – You must get preauthorization of outpatient care for mental conditions or substance abuse. Preauthorization must be obtained by calling ValueOptions at 1-888/700-7965

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

- Section 3, *How you get care*, 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

**Here are some important things to keep in mind about these benefits:**

- We cover prescribed drugs and medications, as described in the chart beginning on page 45.
- 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: $250 per person ($500 per family). The calendar year deductible does not apply to benefits in this Section.
- 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.

IMPORTANT

- **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 PAID 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.

Sometimes your physician may prescribe a particular drug when a preferred brand or generic alternative is available. The pharmacist may discuss with your physician whether an alternative drug might be appropriate for you. Your physician always makes the final decision on your medication and you can always choose to keep the original prescription.

- **These are the dispensing limitations.**
  - Network pharmacy – you may obtain up to a 30-day supply plus one 30-day refill for each prescription purchased from a PAID 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
  - Non-network pharmacy – if you do not use your identification card, if you elect to use a non-network pharmacy, or if a PAID 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 – you may receive up to a 90-day supply of prescription medications you take on a regular basis. Refill orders submitted too early after the last one was filled are held until the right amount of time has passed

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.

If you elect to receive a brand name drug, or your doctor specifies to dispense a brand name drug as written, when a generic is available, you must pay the difference in cost between the brand name 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.

- **When you 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 or from our website at www.apwuhp.com. Your claim must include receipts that show the prescription number, the National Drug Code (NDC) number, name of the drug, 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 967
  Silver Spring, MD 20910

*Prescription drug benefits begin on next page.*

| 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 preaddressed reply envelope.<br><br>You may purchase the following medications and supplies prescribed by a physician from either a pharmacy or by mail:<br>• 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<br>• 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 as excluded below<br>• Insulin and reagent strips for known diabetics<br>• Needles and syringes for the administration of covered medications<br>• Full range of FDA-approved drugs, prescriptions, and devices for birth control<br>• Approved drugs for organic impotence subject to prior Plan approval and limitations on dosage and quantity<br><br>Here are some things to keep in mind about our prescription drug program:<br>• A generic equivalent will be dispensed if it is available. If you choose to receive a brand name drug, or if your physician specifies to dispense a brand name drug as written, when a Federally approved generic drug is available, you will have to pay the cost difference between the brand name drug and the generic in addition to your coinsurance. However, you will not be required to pay this cost difference if your doctor obtains preauthorization for the brand name drug because it is medically indicated. Your doctor may seek preauthorization by calling 1-800/841-2734. | • Network Retail: 25% of cost with a minimum $5 per prescription<br>• Network Retail Medicare: 25% of cost with a minimum $5 per prescription<br>• Non-Network Retail: 45% of cost<br>• Non-Network Retail Medicare: 45% of cost<br>• Network Mail Order: 20% of cost with a minimum $5 per prescription<br>• Network Mail Order Medicare: 20% of cost with a minimum $5 per prescription |
| *Not covered:*<br>• *Drugs and supplies for cosmetic purposes*<br>• *Vitamins, minerals, nutritional supplements, and enteral formulas (liquid food supplements)*<br>• *Medical supplies such as dressings and antiseptics*<br>• *Nonprescription medicines* | *All charges* |

## Section 5(g). Special features

| Special features | Description |
|---|---|
| **Flexible benefits option** | Under the flexible benefits option, we determine the most effective way to provide services.<br>• We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit.<br>• Alternative benefits are subject to our ongoing review.<br>• By approving an alternative benefit, we cannot guarantee you will get it in the future.<br>• The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits.<br>• 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 service for your use. This program is strictly voluntary and confidential. You may call toll-free at 1-800/755-2200 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 care, eyeglasses, hearing aids, if received in 2001 and no other benefits for 2001 have been paid. If we paid claims of less than $350 for a Self and Family enrollment, the difference up to $350 will be paid.<br>We will notify you in November if you are eligible for the Wellness benefit. Submit Wellness claims after January 1, 2002. Wellness claims are paid after March 1, 2002. 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. |
| **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. |

## Section 5(h). Dental benefits

IMPORTANT

**Here are some 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: $250 per person ($500 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.

IMPORTANT

| Accidental injury benefit | You pay |
|---|---|
| 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:<br>PPO: Nothing (No deductible)<br>Non-PPO: Only the difference between our allowance and the billed amount (No deductible)<br>More than 24 hours after accident:<br>PPO: 10% of Plan allowance<br>Non-PPO: 30% of Plan allowance and any difference between our allowance and the billed amount |

**Dental benefits**

| Service | We pay (scheduled allowance) | You pay |
|---|---|---|
| Office visits | $25 per visit (limit 2 visits per year) | All charges in excess of the scheduled amounts listed to the left (No deductible) |
| Restorative care (fillings) | $13 per tooth (single surface)<br>$18 per tooth (two or more surfaces) | |
| Simple extractions | $13 per tooth | |
| Note: Office visits include examinations, prophylaxis (cleanings), x-rays of all types and fluoride treatment. | | |

## Section 5(i). Point-of-Service benefits

We offer a Point of Service (POS) program in certain counties in Texas and in the Minneapolis/St. Paul, Minnesota service areas. You must live or work in one of these service areas to enroll in the POS program.

The POS program provides you with a higher level of benefits when services are provided by or referred by a participating primary care physician whom you select. Non-PPO benefits shown in this Brochure are paid for services received without a referral or from a non-participating provider. An addendum and a POS selection form that outline benefit levels and special requirements of the POS program are available by calling us at 1-800/222-APWU or through our website at www.apwuhp.com. POS provider directories may also be obtained by phone or viewed through our website.

## Section 5(j). 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 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 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 Employee APWU Members in all States and Territories of the United States.

**Coverage Description**

This optional dental plan is an indemnity insurance plan underwritten by the Reliance Insurance Company. You may use any dentist you choose. Covered services are reimbursed as a percentage of the "Usual 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: $1,000 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

| **BENEFIT SCHEDULE** | After the Annual Deductible, this plan will pay: | |
|---|---|---|
| | HIGH OPTION PLAN | LOW OPTION PLAN |
| **TYPE I BENEFITS**<br>Preventive Services<br>• Exams<br>• X-rays<br>• Cleanings | 100%<br>of the Usual and Customary charges | 100%<br>of the Usual and Customary charges |
| **TYPE II BENEFITS**<br>Basic Services<br>• Fillings<br>• Oral Surgery<br>• Extractions | 80%<br>of the Usual and Customary charges (after 6 months of continuous coverage) | 50%<br>of the Usual and Customary charges (after 6 months of continuous coverage) |
| **TYPE III BENEFITS**<br>Major Services<br>• Crowns<br>• Bridges<br>• Dentures<br>• Periodontics | 50%<br>of the Usual and Customary charges (after 12 months of continuous coverage) | 50%<br>of the Usual and Customary charges (after 18 months of continuous coverage) |
| **TYPE IV BENEFITS**<br>(Optional Coverage)<br>• Orthodontic | 50%<br>of the Usual and Customary charges (after 24 months of continuous coverage) | 50%<br>of the Usual and Customary charges (after 24 months of continuous coverage) |

This is a partial summary of the terms, conditions and limitations of the Dental Plan policy #NVO-0144842. 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**
1-800/237-5536 (In CT)
1-203/754-4410 (T.D.D.)

*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. **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.**

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;
- 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 29 and 45;
- 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 and supplies furnished without charge (except as described on page 59); while in active military service; or required for illness or injury sustained on or after the effective date of enrollment (1) as a result of an act of war within the United States, its territories, or possessions or (2) during combat;
- 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 9;
- 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 17 and 18), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge) (see page 18), or State premium taxes however applied
- Biofeedback; nonmedical 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.

## Section 7. Filing a claim for covered services

### How to claim benefits

To obtain claim forms or other claims filing advice or answers about our benefits, contact us at 1-800/222-APWU, or at our website at www.apwuhp.com.

In most cases, providers and facilities file claims for you. Your physician must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 1-800/222-APWU.

When you must file a claim -- such as for overseas claims or when another group health plan is primary -- submit it on the HCFA-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) from any primary payer (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 include 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.

### 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: APWU Health Plan, P.O. Box 967, Silver Spring, MD 20910. Send any written inquiries concerning the processing of overseas claims to this address.

**When we need more information**

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

## Section 8. The disputed claims process

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:

| Step | Description |
|---|---|
| **1** | Ask us in writing to reconsider our initial decision. You must:<br>(a) Write to us within 6 months from the date of our decision; and<br>(b) Send your request to us at: APWU Health Plan, P.O. Box 3279, Silver Spring, MD 20918; and<br>(c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and<br>(d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. |
| **2** | We have 30 days from the date we receive your request to:<br>(a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or<br>(b) Write to you and maintain our denial -- go to step 4; or<br>(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.<br>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.<br>We will write to you with our decision. |
| **4** | If you do not agree with our decision, you may ask OPM to review it.<br>You must write to OPM within:<br>• 90 days after the date of our letter upholding our initial decision; or<br>• 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or<br>• 120 days after we asked for additional information.<br>Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division II, P.O. Box 436, Washington, D.C. 20044-0436. |

## The disputed claims process - *Continued*

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.

Note: If you want OPM to review different claims, 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 provide a copy of your specific written consent with the review request.

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.

**6** 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. 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

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-800/222-APWU and we will expedite our review; or

(b) We denied your initial request for care or preauthorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division II at 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 are covered or a family member is covered under another group health plan or have 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 payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

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

When we are the secondary payer, 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.

- **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.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A.
- Part B (Medical Insurance). Most people pay monthly for Part B.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare+Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare+Choice plan you have.

- **The Original Medicare Plan**

The Original Medicare Plan is available everywhere in the United States. It is the way most people get their Medicare Part A and Part B benefits. You may go to any doctor, specialist, or hospital that accepts Medicare. Medicare pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

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

**Claims process –** You probably will never have to file a claim form when you have both our Plan and Medicare.

- When we are the primary payer, we process the claim first. In this case, we do not waive any out-of-pocket costs.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 1-800/222-APWU or contact us at our website at www.apwuhp.com.

**We waive some costs when you have Medicare** -- When Medicare is the primary payer, we will waive some out-of-pocket costs, as follows:

- Inpatient hospital service. If you are enrolled in Medicare Part A, the Plan 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.

The following chart illustrates whether Original Medicare or this Plan should be the primary payer 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.

| Primary Payer Chart | | |
|---|---|---|
| **A. When either you -- or your covered spouse -- are age 65 or over and …** | **Then the primary payer is…** | |
| | **Original Medicare** | **This Plan** |
| 1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability), | | ✓ |
| 2) Are an annuitant, | ✓ | |
| 3) Are a reemployed annuitant with the Federal government when…<br>a) The position is excluded from FEHB, or……..……..……..……✓<br>b) The position is not excluded from FEHB……..……✓<br>Ask your employing office which of these applies to you | | |
| 4) 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), | ✓ | |
| 5) Are enrolled in Part B only, regardless of your employment status, | ✓ (for Part B services) | ✓ (for other services) |
| 6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty, | ✓ (except for claims related to Workers' Compensation.) | |
| **B. When you -- or a covered family member -- have Medicare based on end stage renal disease (ESRD) and…** | | |
| 1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD, | | ✓ |
| 2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD, | ✓ | |
| 3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision, | ✓ | |
| **C. When you or a covered family member have FEHB and…** | | |
| 1) Are eligible for Medicare based on disability, and<br>a) Are an annuitant, or……..……..……✓<br>b) Are an active employee……..……..✓ | | |

- **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans cover all Medicare part A and B benefits. Some cover extras, like prescriptions drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. If you enroll in a Medicare managed care plan, the following options are available to you:

**This Plan and another Plan's Medicare managed care plan:** You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care plan's network and/or service area, but we will not waive any of our copayments, coinsurance, or deductibles.

**Suspended FEHB coverage and a Medicare managed care plan:** If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare managed care 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 managed care plan's service area.

- **Private Contract**

A physician may ask you to sign a private contract agreeing that you can be billed directly for service 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.

- **Enrollment in Medicare Part B**

Note: We cannot require you to enroll in Medicare. If you choose not to enroll in Medicare Part B, you can still be covered under the FEHB Program.

## TRICARE

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

## Workers' Compensation

We do not cover services that:

- you need because of a workplace-related disease 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 benefits.

## Medicaid

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

## 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 you or your dependent's injury or illness is caused by another person or entity, the Health Plan will pay benefits for that injury or illness according to the terms of the Brochure in effect at the time services are provided. If the Health Plan pays any benefits for that injury or illness, when you or your dependent receive money or have a right to receive money from any source, including underinsured and uninsured automobile coverage, as a result of this injury or illness, you or your dependent must reimburse the Health Plan for any expenses we paid for that injury or illness. The amount owed to the Health Plan will not be reduced for attorney's fees or costs nor because you or your dependent was not fully compensated for the injury or illness, unless the Plan agrees in writing to a reduction.

If you do not seek damages you must agree to let us try. This includes the right of the Plan to sue the responsible person or entity in your or your dependent's name. This is called subrogation. You must inform the Plan if you or your dependent's injury or illness is caused by another person. You must agree that you will not do anything that would prevent the Plan from being reimbursed for the benefits it paid and will cooperate in doing what is reasonably necessary to assist the Plan in recovering the benefits it paid because of that injury or illness. 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 need more information, contact us for our subrogation procedures.

## 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.

**Copayment**

A copayment is a fixed amount of money you pay when you receive covered services. See page 14.

**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 14.

**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.

**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 14.

**Experimental or investigational services**

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

A medical treatment or procedure, or a drug, device, or biological product is experimental or investigational if 1) reliable evidence shows that it is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its

efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or 2) reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or biological product or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the 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.

**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.

**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 reasonable and customary charge for the service you received. We determine the reasonable and customary allowance 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 Health Insurance Association of America (HIAA) and apply these guides at the 80$^{th}$ percentile. We update these charges guides at least once each year. If HIAA 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.

**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.

## Section 11. FEHB facts

### No pre-existing condition limitation

We will not refuse to cover the treatment of a condition that 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. Also, your employing or retirement office can answer your questions, and give you *a Guide to Federal Employees Health Benefits Plans,* brochures for other plans, and other materials you need to make an informed decision about:

- 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;
- 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.

### Types of coverage available for you and your family

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, 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 22 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 health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

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.

## When benefits and premiums start

The benefits in this brochure are effective on January 1. If you are new to this Plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin on January 1.

## Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

## 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.

  You may be eligible for spouse equity coverage or Temporary Continuation of Coverage.

- **Spouse equity coverage**

  If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. 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 Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices.

- **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.

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

  Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure.

- **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

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.

## Inspector General Advisory

**Stop health care fraud!** Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital 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 and explain the situation.
- If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE—202/418-3300** or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

- **Penalties for fraud**

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

# Department of Defense/FEHB Demonstration Project

## What is it?

The Department of Defense/FEHB Demonstration Project allows some active and retired uniformed service members and their dependents to enroll in the FEHB Program. The demonstration will last for three years and began with the 1999 open season for the year 2000. Open season enrollments will be effective January 1, 2001. DoD and OPM have set up some special procedures to implement the Demonstration Project, noted below. Otherwise, the provisions described in this brochure apply.

## Who is eligible

DoD determines who is eligible to enroll in the FEHB Program. Generally, you may enroll if:

- You are an active or retired uniformed service member and are eligible for Medicare;
- You are a dependent of an active or retired uniformed service member and are eligible for Medicare;
- You are a qualified former spouse of an active or retired uniformed service member and you have not remarried; or
- You are a survivor dependent of a deceased active or retired uniformed service member; and
- You live in one of the geographic demonstration areas.

If you are eligible to enroll in a plan under the regular Federal Employees Health Benefits Program, you are not eligible to enroll under the DoD/FEHBP Demonstration Project.

## The demonstration areas

- Dover, AFB, DE
- Fort Knox, KY
- Dallas, TX
- New Orleans, LA
- Adair County, IA area
- Commonwealth of Puerto Rico
- Greensboro/Winston Salem/High Point, NC
- Humboldt County, CA area
- Naval Hospital, Camp Pendleton, CA
- Coffee County, GA area

## When you can join

You may enroll under the FEHB/DoD Demonstration Project during the 2000 open season, November 13, 2000, through December 11, 2000. Your coverage will begin January 1, 2001. DoD has set-up an Information Processing Center (IPC) in Iowa to provide you with information about how to enroll. IPC staff will verify your eligibility and provide you with FEHB Program information, plan brochures, enrollment instructions and forms. The toll-free phone number for the IPC is 1-877/DOD-FEHB (1-877/363-3342).

You may select coverage for yourself (Self Only) or for you and your family (Self and Family) during the 2000 and 2001 open seasons. Your coverage will begin January 1 of the year following the open season during which you enrolled.

If you become eligible for the DoD/FEHB Demonstration Project outside of open season, contact the IPC to find out how to enroll and when your coverage will begin.

DoD has a web site devoted to the Demonstration Project. You can view information such as their Marketing/Beneficiary Education Plan, Frequently Asked Questions, demonstration area locations and zip code lists at www.tricare.osd.mil/fehbp. You can also view information about the demonstration project, including "The 2001 Guide to Federal Employees Health Benefits Plans Participating in the DoD/FEHB Demonstration Project," on the OPM web site at www.opm.gov.

## TCC eligibility

See Section 11, FEHB Facts; it explains temporary continuation of coverage (TCC). Under this DoD/FEHB Demonstration Project the **only** individual eligible for TCC is one who ceases to be eligible as a "member of family" under your Self and Family enrollment. This occurs when a child turns 22, for example, or if you divorce and your spouse does not qualify to enroll as an unremarried former spouse under title 10, United States Code. For these individuals, TCC begins the day after their enrollment in the DoD/FEHB Demonstration Project ends. TCC enrollment terminates after 36 months or the end of the Demonstration Project, whichever occurs first. You, your child, or another person must notify the IPC when a family member loses eligibility for coverage under the DoD/FEHB Demonstration Project.

TCC is not available if you move out of a DoD/FEHB Demonstration Project area, you cancel your coverage, or your coverage is terminated for any reason. TCC is not available when the demonstration project ends.

## Other features

The 31-day extension of coverage and right to convert do not apply to the DoD/FEHB Demonstration Project.

# Index



**continued on page next page**

## Summary of benefits for the APWU Health Plan - 2001

- **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 $250 calendar year deductible. 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.

| Benefits | You Pay | Page |
|---|---|---|
| Medical services provided by physicians: | | |
| • Diagnostic and treatment services provided in the office* | PPO: $15 copay per visit (No deductible); 10% of Plan allowance<br>Non-PPO: 30% of our allowance plus amount over our allowance | 20 |
| Services provided by a hospital: | | |
| • Inpatient | PPO: 10% of Plan allowance<br>Non-PPO: $200 copay and 30% of our allowance plus amount over our allowance | 35 |
| • Outpatient* | PPO: 10% of Plan allowance<br>Non-PPO: 30% of our allowance plus amount over our allowance | 37 |
| Emergency benefits: | | |
| • Accidental injury | PPO: Nothing<br>Non-PPO: Any amount over our allowance | 38 |
| • Medical emergency* | Regular benefits | 39 |
| Mental health and substance abuse treatment | In-Network: Regular cost sharing.<br>Out-of-Network: Benefits are limited. | 40 |
| Prescription drugs: | | 43 |
| • Network pharmacy | 25% of cost/minimum $5 | |
| • Network pharmacy Medicare | 25% of cost/minimum $5 | |
| • Non-network pharmacy | 45% of cost | |
| • Non-network pharmacy Medicare | 45% of cost | |
| • Mail order | 20% of cost/minimum $5 | |
| • Mail order Medicare | 20% of cost/minimum $5 | |

*Summary of benefits - Continued on next page*

## Summary of benefits (continued)

| Benefits | You Pay | Page |
|---|---|---|
| Dental Care..... | Any difference between our allowance and the billed amount for covered services | 47 |
| Special features: Flexible benefits option, 24-hour nurse line, Services for deaf and hearing-impaired, Wellness benefit, Review and reward program…….. | | 46 |
| Point of Service benefits -- Yes *See POS Addendum for Texas and Minnesota Service Areas*…… | | 48 |
| Protection against catastrophic costs (your out-of-pocket maximum)..... | PPO: Nothing after $4,000/Self Only or Family enrollment per year<br>Non-PPO: Nothing after $6,000/ Self Only or Family enrollment per year<br>Some costs do not count toward this protection | 15 |

# 2001 Rate Information for
# APWU Health Plan

**Non-Postal rates** apply to most non-Postal enrollees. If you are in a special enrollment category, refer to the FEHB Guide 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 FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and special FEHB guides are published for Postal Service Nurses and Tool & Die employees (see RI 70-2B); and for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-21N).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization. Refer to the applicable FEHB Guide.

| | | Non-Postal Premium | | | | Postal Premium | |
|---|---|---|---|---|---|---|---|
| | | Biweekly | | Monthly | | Biweekly | |
| Type of Enrollment | Code | Gov't Share | Your Share | Gov't Share | Your Share | USPS Share | Your Share |
| Self Only | 471 | $86.59 | $46.78 | $187.61 | $101.36 | $102.22 | $31.15 |
| Self and Family | 472 | $195.82 | $96.87 | $424.28 | $209.88 | $231.17 | $61.52 |