POSTAL SUPPORT EMPLOYEES and APWU Health Benefits

ORGANIZATION DEPARTMENT

2015

YOU MAY NOW BE ELIGIBLE FOR HEALTH INSURANCE

Welcome to the APWU!

The APWU Consumer Driven Health Plan offers PSEs important benefits. Because it is a non-profit plan, we are able to keep costs low.

Through negotiations the Union was able to persuade the USPS to pay 75% of the premiums – making it affordable for you.

The Union has already won a major benefit for PSEs and we vow to fight to expand your rights at work.

WHO IS ELIGIBLE?

- After an initial appointment of a 369-day term and upon reappointment of another 360–day term, any eligible PSE may participate in the Federal Employees Health Benefit Program (FEHB) on a pre-tax basis.
- The Postal Service will contribute 75% of the total premium for eligible PSEs if they select the APWU Consumer Driven Plan.
- For all other FEHB plans, the PSEs will have to pay 100% of the premium.

HOW YOU WILL BE NOTIFIED?

Your office will inform you of:

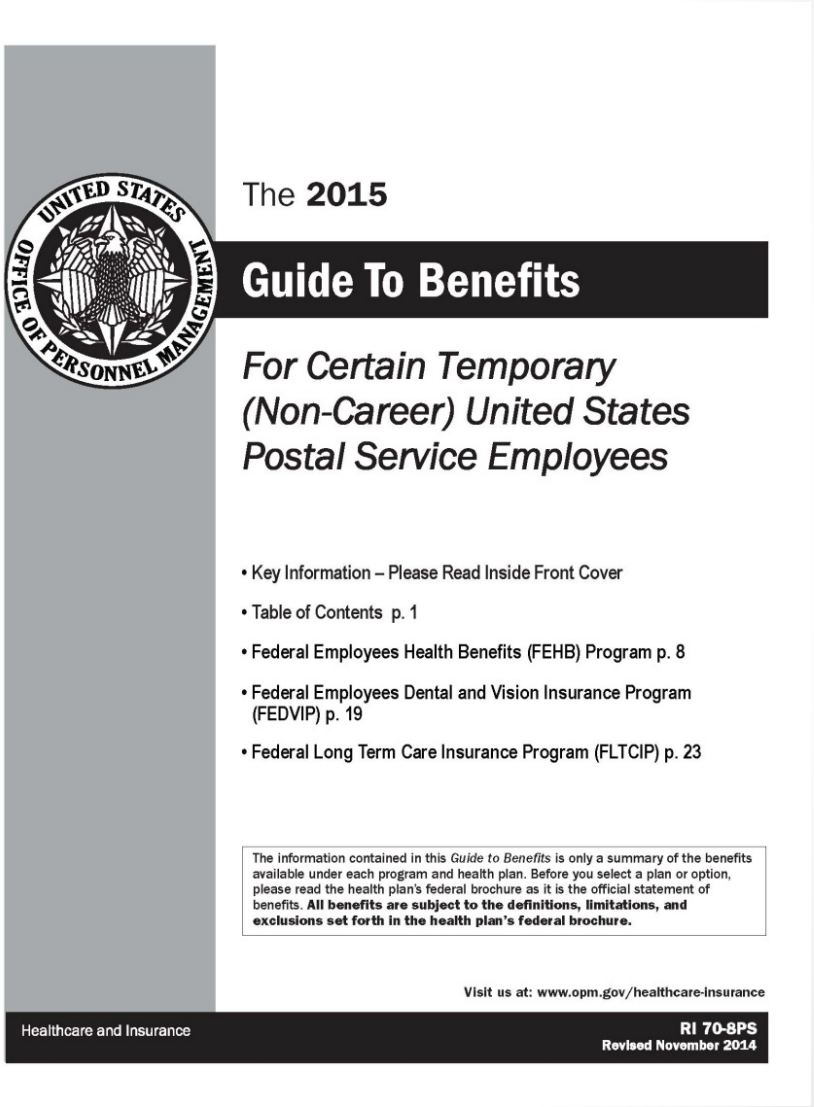
- The date of your break in service and when you will return to work.
- The job/hours/location you will be going back to.
- Two Form 50s will be sent to you:

  Termination and Rehire

HOW YOU WILL BE NOTIFIED? (2)

When you are eligible, you will be sent a detailed letter and told to download this booklet:

- "Guide to Benefits for Certain Temporary (Non-Career) USPS Employees"



OFFICE OF PERSONNEL MANAGEMENT (OPM) & ELIGIBILITY REQUIREMENTS

PSEs must meet these requirements:

1. Complete one full year (365 calendar days) of continuous employment with no breaks in service of more than five days.

2. Maintain sufficient earnings each pay period to cover the cost of premiums after all of mandatory deductions. *(e.g. Social Security, Medicare, and Federal taxes)*

THE "BREAK IN SERVICE"

- A break in service is when an employee is off the rolls for 5 continuous days. *Note: If a PSE has a break of more than 5 days he/she must start a new period of 360 days.*

- Management cannot assign a break in service of more or less than 5 days just to avoid granting eligibility for health insurance. The 5 day break-in-service can be taken at any time.

THE "BREAK IN SERVICE" (2)

- A Form 50 is cut and a reappointment is issued. *Annual Leave is not considered a break in service.*
- Union membership carries over to the new appointment, you do not sign up again. However, for all other deductions, you must sign up again.
- Upon reaching 365 days a PSE should immediately apply for insurance.

ENROLLING

- You **MUST** sign up within 60 days from when you become eligible. *Failure to apply for health insurance during the 60 days after the FIRST appointment, will result in only being eligible to apply during Open Season or with a* Qualifying-Life Event (QLE*).*
- All paperwork must be filled out completely.
- Enroll in one of 3 ways; mail the form in, on *PostalEase*, or call Shared Services.

HEALTH PLAN ELIGIBILITY - FAMILY

- A spouse
- Children under age 26 in a regular parent – child relationship
  - ✓ Adopted, recognized natural child, step – child
  - ✓ Foster children are included but must meet certain requirements
  - ✓ Must contact Shared Services who will review it on a case by case basis
- Children age 26 or older incapable of self-support, if disabling condition began before age 26

PRECAUTIONARY STEPS WHEN ENROLLING

- If you delayed in mailing your paperwork in, and you are unable to use *PostalEase* to sign up for benefits, apply over the phone.
- Applying over the phone: write down the date, time, and who you spoke with.
- If you are still ineligible, hang up and speak with another representative.
- If the phone doesn't work, mail certified with a return receipt, or fax completed forms.

CONTACT INFORMATION

Make sure you document the date/time, name of the person, and get a confirmation number when you talk to Shared Services.

HRSSC (Shared Services)

Compensation/Benefits

PO Box 970400

Greensboro, NC 27497-4000

(877) 477 – 3273 option 1

TTY (866) 260 – 7507

CONTACT INFORMATION

PostalEase:

https://liteblue.usps.gov

Employee Self Service Kiosk

Intranet (From the Blue Page)

Office of Personnel Management (OPM):

www.opm.gov/insure/health

PostalEASE FEHB Worksheet

Changes due to a qualifying life event (QLE) cannot be made via PostalEASE

This worksheet will help you prepare to call *PostalEASE*, or use *PostalEASE* on the Internet (https://liteblue.usps.gov), on an Employee Self-Service Kiosk (now available in some facilities) or on the Postal Service Intranet (from the Blue page). You may contact the Human Resources Shared Service Center (HRSSC) by calling 1-877-477-3273, Option 5 or TTY, 1-866-260-7507 for assistance if:

- you are deaf or hard of hearing or
- you cannot use the telephone, Internet, Employee Self Service kiosk or Intranet for a medical reason or
- you receive a message in *PostalEASE* directing you to contact the HRSSC when attempting to make a change.

Please Note:

- You will need to **provide documentation** showing that your election is due to a QLE and that you are contacting the HRSSC within the required time frame.

For more information on QLEs, please refer to the appropriate Guide to Benefits accessible via liteblue at https://liteblue.usps.gov

- RI 70-2 for USPS employees
- RI 70-8PS for certain temporary (noncareer) USPS employees.

Except for open season and the adding of new family members, most enrollments and changes of enrollment are effective on the first day of the pay period after receipt of this form at the HRSSC. The HRSSC can give you the specific date on which your enrollment or enrollment change will take effect.

Part 1 – Employee Information

Your Name (Last, First, Middle Initial)	Employee ID

Part 2 – Type Of Action You Are Requesting

1) Open Season: ☐ New Enrollment ☐ Change Current Enrollment ☐ Cancel Enrollment

2) New Hire: ☐ New Enrollment ☐ Waive Enrollment

3) QLE or Special Enrollment *(Supporting Documentation Needed)*

☐ New Enrollment ☐ Cancel Enrollment

☐ Change Current Enrollment ☐ Update Dependent List Only *(if updating dependent list complete parts 4-7)*

Type of QLE Actions

In most cases enrollment must be received at the HRSSC within 60 days after the QLE

Marriage: ______ (Date)
Divorce: ______ (Date)
Birth of Child: ______ (Date)
Dependent Death: ______ (Date)
Other: ______ (Date)

Part 3 – Enrollment Plan Name And Plan Code

1) New Plan Name: **2) New Enrollment Code:**

3) Old Plan Enrollment Code *(if you are changing plans or canceling your current plan)*

Part 4 – Your Other Group Insurance *(Not used for waiving enrollment as a new employee)*

1) Are you covered by insurance other than Medicare?

☐ Yes ☐ No

If Yes, indicate type of other insurance in item 2.

2) Identify Type of Other Insurance Coverage

☐ Medicare Part A ☐ Medicare Part B ☐ Medicare Part D

☐ TRICARE ☐ OTHER ______

Other Insurance Policy No. ______

☐ FEHB An FEHB Self & Family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment.

Part 5 – Personal Information

Your Gender: ☐ Male ☐ Female	**Married:** ☐ Yes ☐ No	**Daytime Telephone Number** (including area code)

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PostalEASE FEHB Worksheet

Employee Name: ______ **EIN:** ______

Part 6 – Dependent Information *(for Self and Family coverage only)*

A complete mailing address (if different from the USPS employee's) and other insurance information, if any, must be provided for each covered dependent. If you are adding or updating information for a dependent who does not reside with you, you will need to use the *PostalEASE* Employee Web on the Internet (https://liteblue.usps.gov), an Employee Self-Service Kiosk (available in some facilities) or on the Postal Service Intranet (Blue page) or submit the completed FEHB worksheet to the HRSSC to process your FEHB enrollment or change.

1) ☐ **Please check here if all dependents reside with you.**

2) Complete the following information for each dependent

Name of family member *(last, first, middle initial)* | Social Security Number | Date of Birth *(mm/dd/yyyy)* | Sex ☐ M ☐ F | Relationship code

Address *(if different from enrollee)* | If you are covered by Medicare, check all that apply ☐ A ☐ B ☐ D | Medicare Claim Number

Are you covered by insurance other than Medicare? ☐ Yes, indicate below. ☐ No

Indicate the type(s) of other insurance: ☐ TRICARE ☐ Other *Name of other insurance:* ______ *Policy number:* ______

☐ FEHB *An FEHB Self and Family enrollment covers all eligible family members. No person may be covered by more than one FEHB enrollment.*

Email address *(if home address is different from enrollee's)* | Preferred telephone number *(if home address is different from enrollee's)*

Name of family member *(last, first, middle initial)* | Social Security Number | Date of Birth *(mm/dd/yyyy)* | Sex ☐ M ☐ F | Relationship code

Address *(if different from enrollee)* | If you are covered by Medicare, check all that apply ☐ A ☐ B ☐ D | Medicare Claim Number

Are you covered by insurance other than Medicare? ☐ Yes, indicate below. ☐ No

Indicate the type(s) of other insurance: ☐ TRICARE ☐ Other *Name of other insurance:* ______ *Policy number:* ______

☐ FEHB *An FEHB Self and Family enrollment covers all eligible family members. No person may be covered by more than one FEHB enrollment.*

Email address *(if home address is different from enrollee's)* | Preferred telephone number *(if home address is different from enrollee's)*

Name of family member *(last, first, middle initial)* | Social Security Number | Date of Birth *(mm/dd/yyyy)* | Sex ☐ M ☐ F | Relationship code

Address *(if different from enrollee)* | If you are covered by Medicare, check all that apply ☐ A ☐ B ☐ D | Medicare Claim Number

Are you covered by insurance other than Medicare? ☐ Yes, indicate below. ☐ No

Indicate the type(s) of other insurance: ☐ TRICARE ☐ Other *Name of other insurance:* ______ *Policy number:* ______

☐ FEHB *An FEHB Self and Family enrollment covers all eligible family members. No person may be covered by more than one FEHB enrollment.*

Email address *(if home address is different from enrollee's)* | Preferred telephone number *(if home address is different from enrollee's)*

*** Relationship Codes:**

01 = Spouse
02 = Common Law Spouse
19 = Child Under Age 26
09 = Adopted Child Under Age 26
10 = Foster Child Under Age 26 (Requires Certification to be Filed With the HRSSC)
17 = Stepchild Under Age 26
99 = Child Age 26 or Older Incapable of Self-Support (Requires Certification to be Filed With the HRSSC)

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FEHB
Federal Employees Health Benefits Program

Form Approved: OMB No. 3206-0160

Health Benefits Election Form

Part A - Enrollee and Family Member Information *(for additional family members use a separate sheet and attach)*

1. Enrollee name *(last, first, middle initial)* | 2. Social Security Number | 3. Date of birth *(mm/dd/yyyy)* | 4. Sex ☐ M ☐ F | 5. Are you married? ☐ Yes ☐ No

6. Home mailing address *(including ZIP Code)*

7. If you are covered by Medicare, check all that apply. ☐ A ☐ B ☐ D | 8. Medicare Claim Number

9. Are you covered by insurance other than Medicare? ☐ Yes, indicate in item 10 below. ☐ No

10. Indicate the type(s) of other insurance:

☐ TRICARE ☐ Other *Name of other insurance:* _____ *Policy Number:* _____

☐ FEHB *An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.*

11. Email address | 12. Preferred telephone number

13. Name of family member *(last, first, middle initial)* | 14. Social Security Number | 15. Date of birth *(mm/dd/yyyy)* | 16. Sex ☐ M ☐ F | 17. Relationship code

18. Address *(if different from enrollee)*

19. If this family member is covered by Medicare, check all that apply. ☐ A ☐ B ☐ D | 20. Medicare Claim Number

21. Is this family member covered by insurance other than Medicare? ☐ Yes, indicate in item 22 below. ☐ No

22. Indicate the type(s) of other insurance:

☐ TRICARE ☐ Other *Name of other insurance:* _____ *Policy Number:* _____

☐ FEHB *An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.*

23. Email address *(if applicable, enter email address of your spouse or adult child)* | 24. Preferred telephone number *(if applicable, enter preferred phone number of your spouse or adult child)*

25. Name of family member *(last, first, middle initial)* | 26. Social Security Number | 27. Date of birth *(mm/dd/yyyy)* | 28. Sex ☐ M ☐ F | 29. Relationship code

30. Address *(if different from enrollee)*

31. If this family member is covered by Medicare, check all that apply. ☐ A ☐ B ☐ D | 32. Medicare Claim Number

33. Is this family member covered by insurance other than Medicare? ☐ Yes, indicate in item 34 below. ☐ No

34. Indicate the type(s) of other insurance:

☐ TRICARE ☐ Other *Name of other insurance:* _____ *Policy Number:* _____

☐ FEHB *An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.*

35. Email address *(if applicable, enter email address of your spouse or adult child)* | 36. Preferred telephone number *(if applicable, enter preferred phone number of your spouse or adult child)*

37. Name of family member *(last, first, middle initial)* | 38. Social Security Number | 39. Date of birth *(mm/dd/yyyy)* | 40. Sex ☐ M ☐ F | 41. Relationship code

42. Address *(if different from enrollee)*

43. If this family member is covered by Medicare, check all that apply. ☐ A ☐ B ☐ D | 44. Medicare Claim Number

45. Is this family member covered by insurance other than Medicare? ☐ Yes, indicate in item 46 below. ☐ No

46. Indicate the type(s) of other insurance

☐ TRICARE ☐ Other *Name of other insurance:* _____ *Policy Number:* _____

☐ FEHB *An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.*

47. Email address *(if applicable, enter email address of your spouse or adult child)* | 48. Preferred telephone number *(if applicable, enter preferred phone number of your spouse or adult child)*

(Continued on the reverse)

For agency distribution of copies, see page 5 of the instructions

Enrollee name: _____ Date of birth: _____

Part B - FEHB Plan You Are Currently Enrolled In *(if applicable)*

1. Plan name | 2. Enrollment code

Part C - FEHB Plan You Are Enrolling In or Changing To

1. Plan name | 2. Enrollment code

Part D - Event That Permits You To Enroll, Change, or Cancel *(see page 2)*

1. Event code | 2. Date of event

Part E - Election NOT to Enroll *(Employees Only)*

☐ I do NOT want to enroll in the FEHB Program.

My signature in Part H certifies that I have read and understand the information on page 3 regarding this election.

Part F - Cancellation of FEHB

☐ I CANCEL my enrollment.

My signature in Part H certifies that I have read and understand the information on page 3 regarding cancellation of enrollment.

Part G - Suspension of FEHB *(Annuitants/Former Spouses Only)*

☐ I SUSPEND my enrollment.

My signature in Part H certifies that I have read and understand the information on page 4 regarding suspension of enrollment.

Part H - Signature

***WARNING:** Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)*

1. Your signature *(do not print)* | 2. Date *(mm/dd/yyyy)*

Part I - To be completed by agency or retirement system

REMARKS

1. Date received *(mm/dd/yyyy)* | 2. Effective date of action *(mm/dd/yyyy)* | 3. Personnel telephone number ( )

4. Name and address of agency or retirement system | 5. Authorizing official *(please print)*

6. Signature of authorized agency official

7. Payroll office number | 8. Payroll office contact *(please print)* | 9. Payroll telephone number ( )

PRINT SAVE CLEAR

ONCE ENROLLED

- You can use *PostalEase* to apply for the APWUCD Plan. However, once enrolled then you may only use *PostalEase* to make changes.
- You can only make changes during open season or for a QLE. (See Guide for more details on QLE)
- You cannot dual enroll, federal law prohibits two family members from having different (self and family) FEHB insurances.

COVERAGE AND PAYMENTS

- Coverage is effective on the first day of the pay period that begins after Shared Services (HRSSC) receives and processes your completed forms for enrollment and follows a pay period in which you are in a pay status.
- Insurance cards will be sent once your enrollment is processed.

COVERAGE AND PAYMENTS (2)

- Processing may take place several weeks from the effective date when coverage begins.
- If you pay medical expenses during this time, contact your health plan provider to determine if you are entitled to reimbursement.
- You may use Standard Form 2809, Health Benefit Election Form, for proof of your insurance choice.

COVERAGE AND PAYMENTS (3)

- After 2 pay periods of being in a “no-pay” status, the Post Office will send you an invoice for your health insurance.
- Invoice must be paid within 30 days in order to maintain coverage for health insurance.
- If you lose coverage for nonpayment of premiums, you cannot renew their enrollment until the next open season.

PRE-TAX vs AFTER-TAX PREMIUM PAYMENTS

- Save money with pre-tax premiums.
- To use pre-tax premiums, fill out Form 8202, Waiver for Non-Career Employees.
- Must be in the 60-day enrollment period. Otherwise you will have to wait until Open Season or QLE.

UNITED STATES POSTAL SERVICE®

See Instructions and Privacy Act Statement on Reverse

Pre-Tax Health Insurance Premium Election/Waiver Form for Noncareer Employees

Purpose of Form 8202

PS Form 8202 is used by noncareer employees who are eligible under United States Postal Service® policy and/or collective bargaining agreements when they become eligible for Federal Employees Health Benefits (FEHB) coverage during the FEHB Open Season, or following certain qualifying life events to begin pre-tax treatment of employee FEHB premium payments or to waive pre-tax treatment if it was previously elected.

- See the reverse side of this form for definitions of pre-tax and after-tax treatment and for an important note about Internal Revenue Service (IRS) restrictions on *reduction* of coverage when pre-tax treatment is in effect.
- See the applicable *Guide to Employees Health Benefits Plan (FEHB Guide)*, provided to you by your personnel office, for information about qualifying life events.

To begin pre-tax treatment, complete Parts A, B, and D below.

To waive pre-tax treatment (only if you waived it previously) complete Parts A, C, and D below.

Part A - Participant Information *(Must be completed by all applicants. See the top line of your biweekly earnings statement for items 1-4.)*

1. Name *(Last, first, middle initial)*		2. Employee ID
3. Finance No.	4. Pay Location	5. Employing Office *(City, State, and ZIP + 4®)*
6. Participant Daytime Telephone No.	7. Participant Mailing Address *(Street, City, State, and ZIP + 4)*	

Part B - Begin Pre-Tax Treatment

_____ *(Initials)*

I elect to begin pre-tax treatment of my FEHB health insurance premium contributions and to adhere to the more restrictive IRS guidelines summarized on the reverse side of this form. My election will become effective on the first full pay period in the following calendar year (FEHB Open Season) unless I am making this election as a newly eligible noncareer employee or have a qualifying life event, in which case it will become effective the pay period after I submit this form. Pre-tax treatment will continue into future plan years unless I later complete a new PS Form 8202 during FEHB open season or following a qualifying life event to waive pre-tax treatment.

I understand that because paying my FEHB premiums with pre-tax money reduces the earnings reported to the Social Security Administration, if I begin to collect Social Security when I retire (which normally occurs at age 62 at the earliest), I may receive a lower Social Security benefit. My Medicare, life insurance, retirement plan, and Thrift Savings Plan benefits will not be affected.

Part C - Waive Pre-Tax Treatment *(Complete only if pre-tax treatment was previously elected.)*

_____ *(Initials)*

I elect to waive pre-tax treatment of my FEHB health insurance premium contributions. My election will become effective on the first full pay period in the following calendar year (FEHB Open Season) or, if I have a qualifying life event, on the pay period after I submit this form. This waiver will continue into future plan years unless I later complete a new PS Form 8202 during FEHB Open Season or following a qualifying life event to begin pre-tax treatment.

Part D - Authorization *(After reading the Privacy Act Statement on the reverse side of this form, sign and date below.)*

By signing this form I acknowledge that I have read and understand all the materials explaining the pre-tax treatment of employee contributions towards FEHB health insurance premiums.

I authorize payroll deductions for health insurance premiums in the manner indicated in Part B or Part C above.

Warning: Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of law and could lead to termination of employment.	1. Your Signature *(Do not print)*	2. Date

Part E - Processing *(To be completed by Human Resources personnel.)*

1. Effective Date	2. Authorized Official Signature	3. DDE/DR Office Telephone No. *(Include area code)*

REMARKS *(For use by Human Resources personnel only.)*

Attachment D

UNITED STATES POSTAL SERVICE™

Notice to Noncareer Employees Eligible to Enroll in FEHBP

Subject: Sufficient Earnings Requirement for Federal Employees Health Benefits Coverage

Employee Name *(Last, first, middle initial)*	Social Security Number

Federal Employees Health Benefits Program (FEHBP) regulations provide that temporary (noncareer) employees eligible to enroll in FEHBP coverage must have withheld from their biweekly pay the ***Full*** cost for the health benefits premium. The Postal Service does not contribute toward health benefits for noncareer employees.

To be eligible for FEHBP coverage as a noncareer employee, your biweekly earnings must be sufficient to cover the health benefits premium withholdings, and must be expected to remain sufficient for at least 6 months.

Once enrolled in a health benefits plan, if you fail to earn sufficient pay to allow for health benefits premium withholdings in one pay period, the Minneapolis Postal Data Center (MNPDC) will withhold the unpaid premium in the following pay period, provided you have sufficient earnings to cover the unpaid premium. When two adjustments for insufficient earnings for FEHBP purposes have occurred, the MNPDC will send you an invoice for the total amount due. You must pay the total amount billed within 30 days of the date of the invoice. *If payment is not received by the MNPDC within this timeframe, your health benefits enrollment will be terminated retroactive to the date the initial unpaid premium was due.* Once you lose FEHBP coverage because of insufficient earnings, you will not be eligible to renew your enrollment until the next FEHBP open season or the occurrence of some other change in your status (e.g., conversion to career) which provides you an opportunity to enroll for health benefits coverage.

Please sign and date in the space provided below to acknowledge receipt of this information and return the completed form to your personnel office.

Employee Acknowledgement

I understand that invoices issued by the MNPDC for health benefits premium costs must be paid within 30 days of the date the invoice was issued. I further understand that failure to pay the invoice within the timeframe specified will result in the termination of my health benefits enrollment under the FEHBP noncareer provisions retroactive to the date the initial unpaid premium was due, and that this will result in my being liable to the insurance carrier for any medical expenses incurred since that date.

Employee Signature	Date *(Month, day, year)*

PS Form **8141,** March 1992

- If you are enrolled in the APWU Consumer Driven Plan, and change over to a craft represented by another union, you may keep your insurance but you must pay the full premium. This rule is set in place by OPM.

- Letter carriers contract for City Carrier Assistance (CCA) insurance is totally different than APWU's PSE contract.

- PSEs are not eligible for Flexible Spending Accounts (FSA).

CONSUMER DRIVEN OPTION BENEFITS

- 100% of covered services will be paid from your Personal Care Account (PCA):
  - ✓ $1,200 (*Self Only* enrollment)
  - ✓ $2,400 (*Self and Family* enrollment)
  - ✓ There are NO co-payments and upfront deductibles

CONSUMER DRIVEN OPTION BENEFITS

- If you exhaust your PCA in a coverage period (usually one year), you must satisfy the deductible:
  - ✓ $600 (*Self Only*) of covered medical expenses
  - ✓ $1,200 (*Self and Family*) of covered medical expenses
- Once the deductible has been satisfied, the Health Plan will pay 85% of all in-network covered medical expenses. You will be responsible for the remaining 15% for most services.

CONSUMER DRIVEN OPTION BENEFITS

- Once the deductible is met, members pay coinsurance:

	In-Network	Out-of-Network
Medical Services	Members: 15% Health Plan: 85%	Members: 40% Health Plan: 60%
Prescription Drugs	Members: 25% Health Plan: 75%	Members pay all charges

CONSUMER DRIVEN OPTION BENEFITS

- The catastrophic out-of-pocket maximum:
  - ✓ $3,000 (*Self Only*)
  - ✓ $4,500 (*Self and Family*)
  - ✓ $9,000 out-of-network for both self only and self and family
- This is the maximum out-of-pocket expenses you will have for covered services in a calendar year.

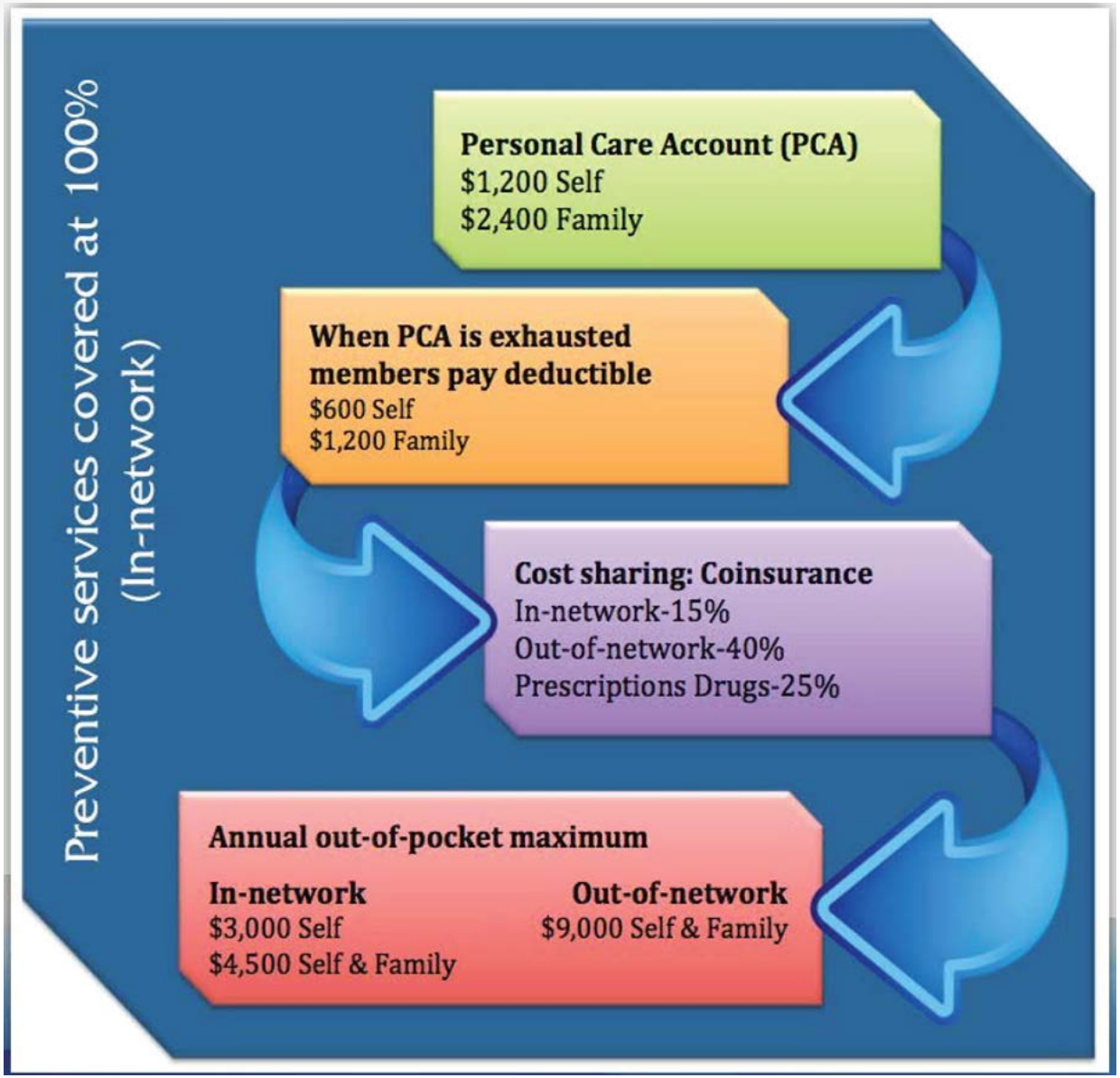
CONSUMER DRIVEN OPTION BENEFITS

- The Health Plan will pay 100% of the cost for "in-network":
  - ✓ Preventative care and screenings
  - ✓ Routine maternity care and delivery
  - ✓ Diabetes management

- Visit any doctor or specialist you wish without the hassles of getting referrals or pre-authorizations.
  - ✓ Stay in-network when possible

APWU CONSUMER DRIVEN OPTION 25% PREMIUM PAYMENT

Plan Name	Enrollment Code	Employee Biweekly Premium	USPS Contribution
Self Only	474	$46.31	$138.93
Self and Family	475	$104.18	$312.54



MEMBER CALENDAR EXPERIENCE

The Consumer Driven Option

Personal Care Account (PCA)	Members of the Consumer Driven Option are given a PCA, which is an allowed amount used to pay for all medical costs at 100% until exhausted. Self $1,200 Self and Family $2,400
Deductible	When the PCA is exhausted, member must meet a deductible.
	Self $600 Self and Family $1,200
Coinsurance	Once the deductible is met, members pay coinsurance for in- or out-of-network medical services and prescription drugs.

	In-network You pay	Out-of-network You pay
Medical Services	15%	40%
Prescription Drugs (Retail or Mail order)	25%	N/A

Out-of-pocket Maximum	Because the unexpected happens, the Consumer Driven Option has a built-in out-of-pocket maximum, which, when reached, allows the rest of your annual healthcare costs to be paid at 100% (both medical and prescription drugs).

	In-network	Out-of-network
Self	$3,000	$9,000
Self and Family	$4,500	$9,000

PCA Rollover	As long as you remain in this Plan, any unused remaining balance in your PCA at the end of the calendar year may be rolled over to subsequent years. The maximum amount allowed in your PCA in any given year may not exceed $5,000 per self only enrollment and $10,000 per self and family enrollment
Adults/Children	In-network preventive care and screenings, such as mammograms, yearly check ups and child and adult immunizations are covered at 100% by the Health Plan. No PCA dollars used.

No out-of-pocket costs for in-network preventive care and screenings

Preventive Care	In-network You Pay	UnitedHealthcare	Out-of-network You Pay
Well-Child Care Immunizations Well-Woman Care Adult Routine Exams Preventive Screenings	Nothing		All charges: May use PCA while funds are available

BENEFITS AT A GLANCE

BENEFITS AT A GLANCE

Medical Benefits		
Office Visits		
Office and Specialist Visits	15% of the Plan allowance	40% of the Plan allowance*
Maternity Care		
Complete maternity (obstetrical) care, such as:		
Prenatal care, delivery, postnatal care and initial examination of a newborn child covered under family enrollment	Nothing	40% of the Plan allowance*
Hearing Services		
Diagnostic Hearing Test (every 2 years)	15%	40% of the Plan allowance*
Hearing Aids (every 3 years)	All charges in excess of $1,500	All charges in excess of $1,500
Hospital/Facility Care		
Diagnostic Tests or Imaging	15%	40% of the Plan allowance*
Outpatient Surgery, Facility Fee, Lab Visits and Surgeon Fee	15%	40% of the Plan allowance*
Inpatient	15%	40% of the Plan allowance*
Cancer Centers Of Excellence	10%	N/A
Emergency Care		
Accidental Injury, Urgent Care, Emergency Room, Ambulance	15%	15%*
Prescription Drug Benefit	**In-network** You Pay — OptumRx	**Out-of-network** You Pay
Retail Prescription (for up to a 30-day supply)	25% coinsurance $200 maximum per RX	All charges
Mail-Order Prescription (for up to a 90-day supply)	25% coinsurance $600 maximum per RX	N/A
Mental Health/ Substance Abuse	**In-network** You Pay — ValueOptions®	**Out-of-network** You Pay
Office Visit	15%	40% of the Plan allowance*
Outpatient Treatment	15%	40% of the Plan allowance*
Diagnostics, Inpatient and Outpatient Services	15%	40% of the Plan allowance*

*If there is a difference between allowance and billed amount member is responsible for that difference

LOSS OF COVERAGE

- When an event occurs that causes you or your family member to lose coverage, the FEHB Program offers a continuation of coverage feature, either temporarily or by permanent conversion to a private sector policy.

- ✓ Child reaching age 26
- ✓ Insufficient Pay
- ✓ Application for Spouse Equity
- ✓ Separation
- ✓ Divorce
- ✓ Death
- ✓ Relocation

ELIGIBILITY FOR FEDERAL EMPLOYEES DENTAL AND VISION INSURANCE (FEDVIP)

- Must be eligible for FEHB to enroll
- It is a supplemental benefit (you don't have to have health insurance to enroll).
- You must apply within 60 days of eligibility (after 365 days).
- You can apply for pre-tax premiums.
- You can pay through payroll deductions or direct bill for payment.

ENROLLMENT IN FEDVIP

- Vision and Dental (FEDVIP) are two individual plans.
- You must apply for them separately.
- Once you make your choice within the 60 days, you may not change your mind until Open Season or a QLE.
- You must apply though the link or phone number below, not with form SF2809 that is used for Health Benefits.
  - ✓ **www.benefeds.com /1-877-888-3337**

WHO IS COVERED UNDER FEDVIP

- A spouse
- Unmarried dependent children under age 22 living with the employee in a regular parent-child relationship:
  - ✓ Adopted, recognized natural child, step-child or foster child
- Children age 22 or older incapable of self-support, if disabling condition began before age 22

DENTAL PLANS AND RATES

- Dental Plans are determined by where you live, the plan, and options you choose:

Self Only	ranges from $5-$25 bi-weekly
Self + 1	ranges from $9-$50 bi-weekly
Self & Family	ranges from $12-$60 bi-weekly

Find the current rates and plans at:

www.opm.gov/healthcare-insurance/dental-vision/plan-information/#url=Premiums

VISION PLANS AND RATES

- For enrollment/premium questions regarding the Dental and Vision Insurance Program, contact BENEFEDS at 1(877)888-3337.

Plan Name	Telephone & Website	Plan Option	Biweekly Premium			Monthly Premium		
			Self Only	Self Plus One	Self & Family	Self Only	Self Plus One	Self & Family
Aetna Vision	1-877-459-6604 aetnafeds.com/vision	Standard High	$3.18 $6.17	$6.08 $11.75	$8.93 $17.25	$6.89 $13.37	$13.17 $25.46	$19.35 $37.38
FEP BlueVision	1-888-550-2583 fepblue.org	Standard High	$3.73 $4.71	$7.45 $9.42	$11.18 $14.14	$8.08 $10.21	$16.14 $20.41	$24.22 $30.64
UnitedHealthcare Vision Plan	1-866-249-1999 TTY: 1-800-524-3157 fedvip.myuhcvision.com	Standard High	$2.91 $4.12	$5.69 $8.04	$8.47 $11.97	$6.31 $8.93	$12.33 $17.42	$18.35 $25.94
VSP (Vision Service Plan)	1-800-807-0764 choosevsp.com	Standard High	$3.67 $6.34	$7.33 $12.69	$11.01 $19.04	$7.95 $13.74	$15.88 $27.50	$23.86 $41.25

ADDITIONAL COVERAGE

- Voluntary Benefits provides Dental Plan

  http://www.voluntarybenefitsplan.com/products/Pages/Dental-Plan.aspx

- APWU Health Plan members receive a 7.5% premium reduction

Voluntary Benefits Plan

HEALTH INSURANCE TERMS

Allowed amount is the amount of covered services that the plan pays for.

- If an out-of-network provider charges more than the **allowed amount**, you may have to pay the difference, if PCA is exhausted.

  For example: If an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing).

HEALTH INSURANCE TERMS (2)

Co-insurance is your share of the costs of a covered service which is calculated as a percentage of the **allowed amount** for the service, after PCA is exhausted and deductible is met.

For example: If the plan's allowed amount for an overnight stay in the hospital stay is $1,000, your co-insurance payment of 15% would be $150.

HEALTH INSURANCE TERMS (3)

Co-payments are fixed dollar amounts.

- You pay for covered health care, usually, when you receive the service. **There are no co-payments under the Consumer Driven Option.**

Deductible is the amount you must pay if you have exhausted your **Personal Care Account** before Traditional Health Coverage begins.

HEALTH INSURANCE TERMS (3)

Catastrophic out-of-pocket maximum is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services.

- This limit helps you plan for health care expenses

Personal Care Account (PCA) is an established benefit amount which is available for you to use first to pay for covered hospital, medical, prescriptions, dental and vision care expenses.

YOU ARE THE UNION

- Together we exist to represent workers and give them a voice at work.
- We remain dedicated to improving the lives of working families, to bring fairness and dignity to the workplace, and to secure equity across the nation.
- Our goal is to create a work environment where workers are valued, respected and rewarded.

TOGETHER WE…

- Support the labor movement – fight for the American way of life for all workers, not just union members.

- Remain strong because of our support for each other.
- Work together to continue to have a job and a decent income.

WE BRING BENEFITS TO OUR COMMUNITIES

- Stronger economy
- Union workers make 28% more
- Health care and disability benefits
- Guaranteed pensions – 77% vs 32%
- Raise the standard of living
- Jobs
- Stability