

AMERICAN POSTAL WORKERS UNION, AFL-CIO

MARK DIMONDSTEIN, PRESIDENT



Anna Smith, Organization Director
Office Phone: (202) 842-4227



Sarah Rodriguez, Health Plan Director
Office Phone: (410) 424-1503

POSTAL SUPPORT EMPLOYEES (PSE) 2024-2025 APWU HEALTH BENEFITS ORIENTATION

Congratulations!

You may now be eligible for health insurance in the Postal Service Health Benefit Program (PSHB).

Upon your eligibility you will have various options available to you.

However, most of you will find that the APWU Health Insurance Plan is the best choice!





The APWU Consumer Driven Health Plan offers PSEs important health care benefits.

In an effort to make the health insurance affordable through negotiations the APWU was able to persuade the USPS to pay 72% of the total premium when you select the Consumer Driven Plan. For all other PSHB plans, the PSEs will have to pay 100% of the premium.

ELIGIBILITY REQUIREMENTS

Office of Personnel Management (OPM) requires that PSEs must:

- Complete one full year (365 calendar days) of continuous employment with no breaks in service of more than 5-days.
- Maintain sufficient earnings each pay period to cover the cost of premiums after all of mandatory deductions.

ELIGIBILITY NOTIFICATION

- After an initial appointment of a 360-day term and upon reappointment any eligible PSE may participate in the PSHB.
- When you are eligible to enroll in the PSHB, you should be sent a letter from the Postal Service containing important enrollment information.

ENROLLING

Once eligible, PSEs should immediately apply for health insurance.

You must sign up within **60-days** from when you first become eligible at the conclusion of your initial 360-day appointment and upon reappointment to another 360-day term. Failure to do so will result in your only being able to apply during Open Season or with a Qualifying-Life Event (QLE).

You may enroll in various ways:

- ➡ Fax
- ➡ LiteBlue
- ➡ US Mail

At this time, some PSEs cannot enroll online.



CONTACTING SHARED SERVICES

Be sure you document the date/time and get a confirmation number when you call Shared Services, or a fax confirmation when faxing, and/or utilize Return Receipt when contacting via US Mail.



HRSSC (Shared Services)
Compensation/Benefits
PO Box 970400
Greensboro, NC 27497-4000
(877) 477-3273 option 5
TTY (866) 260-7507
FAX (651) 456-6610

WHEN DOES COVERAGE BEGIN?

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.

ONCE ENROLLED

You can only make changes during Open Season or for a QLE. QLE may be a change in family or employment status, or when you or a family member lose PSHB or other coverage. Visit [OPM.gov/healthcare](https://www.opm.gov/healthcare) for more info.

Federal law prohibits dual enrollment. When an individual is covered under more than one PSHB Program enrollment.



LOSS OF COVERAGE

When an event occurs that causes you or your family member to lose coverage, the PSHB 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

NON-PAYMENT OF PREMIUM

After 2 pay periods of being in a “no-pay” status, or when two adjustments for insufficient earnings has occurred. You will receive a statement for the total amount due.

The total amount due must be paid within 30-days in order to maintain your coverage.

If you lose coverage for nonpayment of premiums, you cannot renew your enrollment until the next Open Season.

PRE-TAX & AFTER TAX PAYMENTS

SAVE MONEY WITH PRE-TAX PREMIUMS

If you wish to pay your PSHB premiums with after-tax money, all PSEs must **complete PS Form 8202**. This form may be found on the liteblue.usps.gov website.

- This election must be done within the **60-day** enrollment period. Failure to do so will result in having to wait until Open Season or a QLE.



Personal Care Account (PCA)

\$1,200 Self

\$2,400 Self Plus One & Self and Family

1

When PCA is exhausted members pay a Deductible

\$1,000 Self

\$2,000 Self Plus One & Self and Family

2

Cost Sharing / Co-Insurance

In-Network – 15%

Out-of-Network – 50%

Prescription Drugs – 25% (Tier 1 & Tier 2) 40% (Tier 3)

3

Annual Out-of-Pocket Maximum

In-Network

\$6,500 Self

\$13,000 Self Plus One

\$13,000 Self & Family

Out-of-Network

\$12,000 Self

\$24,000 Self Plus One

\$24,000 Self & Family

4

PERSONAL CARE ACCOUNT (PCA)

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

Members in this plan are given a PCA, which is an allowed amount used to pay for all medical costs at 100% until exhausted.

EXPENSES

PCA COVERAGE

Provides 100% coverage for annual medical expenses up to:

- \$1,200 (Self Only)
- \$2,400 (Self Plus One & Self and Family)

There are **NO** copayments or upfront deductibles

PCA ELIGIBLE EXPENSES

COVERED BY YOUR PCA:

- 1. Basic PCA Expenses:** Are the same medical, surgical, hospital, emergency, mental health and substance abuse, and prescription drug services and supplies covered under the Traditional Health Coverage
- 2. Extra PCA Expenses :** This includes dental and/or vision services and are reimbursable out of your PCA. Note that these expenses must be paid up front by you.

WHAT IS AN ALLOWED AMOUNT?

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).

PCA ROLLOVER

As long as you remain in the APWU Consumer Driven Plan, any unused remaining balance in your PCA at the end of the calendar year may be rolled over to subsequent years.

Maximum amount allowed in your PCA in any given year are:

- \$5,000 (Self Only)
- \$10,000 (Self Plus One & Self and Family)

ONCE YOUR PCA IS EXHAUSTED

Members must meet an in-network deductible:

- \$1000 (Self Only)
- \$2000 (Self Plus One & Self and Family)

You must pay all the costs up to the deductible amount prior to the plan paying covered services.

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%.

WHAT IS A DEDUCTIBLE?

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

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

ONCE THE DEDUCTIBLE IS MET

Members pay as follows:

Type of Coverage	In-Network Providers	Out-of-Network Providers
Medical Services	Members: 15% Health Plan: 85%	Members: 50% Health Plan: 50%
Prescription Drugs (Tier 1 & Tier 2)	Members: 25% Health Plan: 75%	Members pay all charges
Prescription Drugs (Tier 3)	Members: 40% Health Plan: 60%	Members pay all charges

WHAT IS CO-INSURANCE?

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.

CATASTROPHIC OUT-OF-POCKET



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.

OUT-OF-POCKET EXPENSES

Maximum out-of-pocket expense in a calendar year:

In Network:

- \$6,500 Self Only
- \$13,000 Self Plus One & Self and Family

Out of Network:

- \$12,000 Self Only
- \$24,000 Self Plus One & Self and Family

Once these limits are reached, your annual health care costs are to be paid at 100% by the APWU Health Plan

DENTAL AND VISION

As a member of the Consumer Driven Option Plan you can use your PCA to be reimbursed for dental and vision expenses. You pay for dental and vision services at the time of service.

Maximum reimbursable amount in a calendar year:

- \$400 per Self
- \$800 per Self Plus One or Self and Family

2023 APWU Consumer Driven Option



Plan Name	Enrollment Code	Employee Biweekly Premium
Self Only	474	\$80.62
Self + One	476	\$175.23
Self + Family	475	\$191.16

WHEN CHANGING CRAFTS

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 regulation is set in place by OPM.



MEMBER-ONLY BENEFITS



Voluntary Benefits Plan

You can sign up for this plan either during enrollment in your health plan, or at any time throughout the year.

APWU Health Plan members receive a 7.5% premium reduction.

VBP offers members-only discounts on dental insurance, cancer recovery, disability income insurance, group life insurance.

[voluntarybenefitsplan.com](https://www.voluntarybenefitsplan.com)

(877) 229-0451

FEDERAL EMPLOYEES DENTAL AND VISION INSURANCE PROGRAM (FEDVIP)

- Must be eligible for PSHB 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.

FEDVIP – 3 types of enrollment

1. **Self Only:** You may choose a Self Only enrollment even though you have a family.
2. **Self Plus One:** Yourself plus one eligible family member whom you specify.
3. **Self and Family:** A Self and Family enrollment covers you and all of your eligible family members. You must list all eligible family members when enrolling.

FEDVIP – ELIGIBLE FAMILY MEMBERS

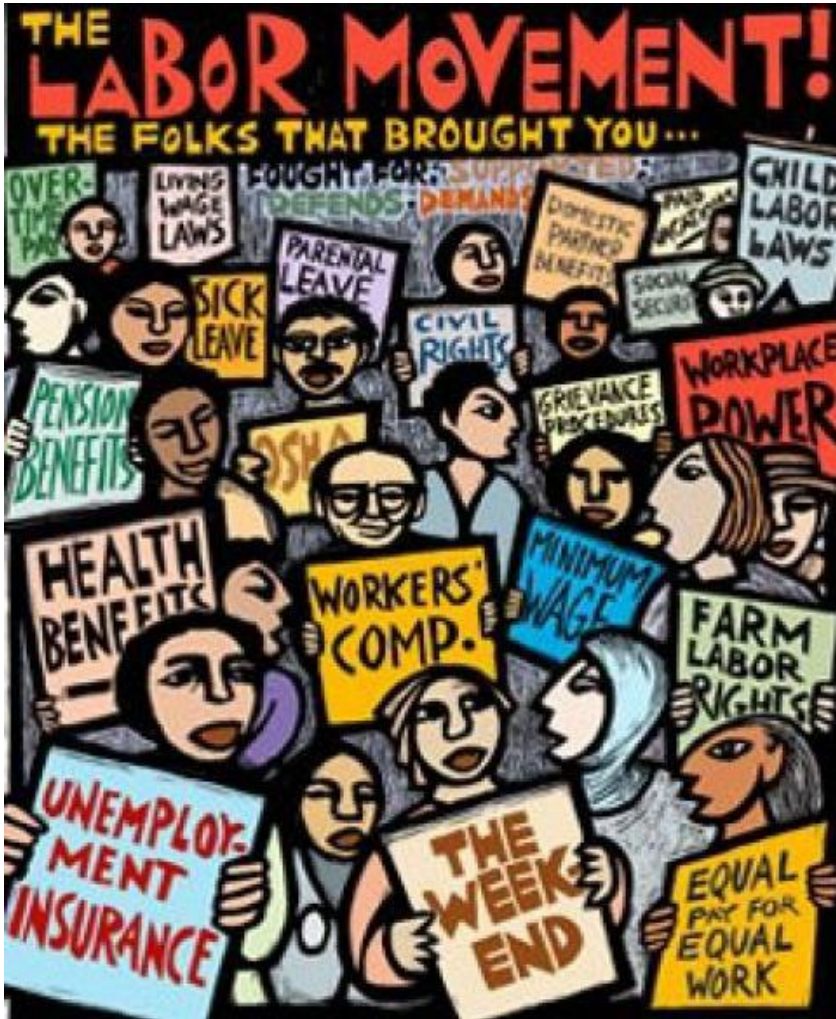
- A spouse
- Unmarried dependent children under age 22.
- Adopted & recognized natural children who meet certain dependency requirements.
- Step-child or foster child who live with you in a regular parent-child relationship.
- Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

FEDVIP - ENROLLMENT

- 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 through a link on the website below or by phone.
(You may not use SF2809 form that is used for health benefits)

www.benefeds.com / 1-877-888-3337

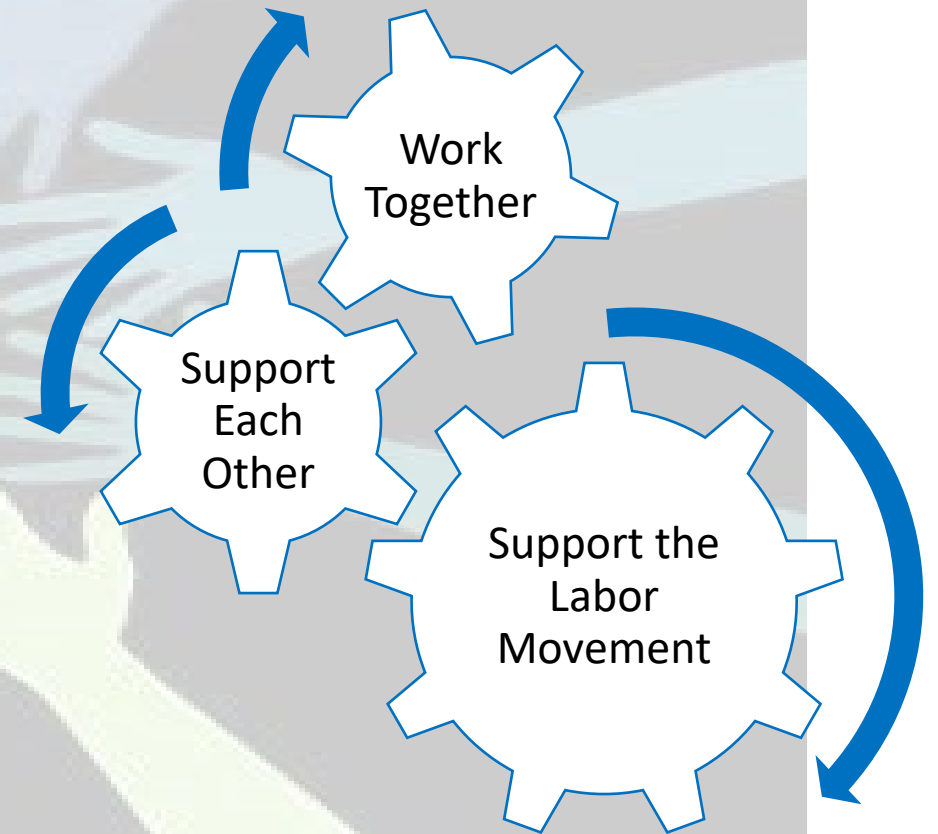
You Are The Union!



- 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.

Standing 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.



APWU Health Plan

A health insurance option dedicated to serving its members.

Like you, your APWU Health Plan Director is a current Postal Employee and federal worker. This health plan belongs to you, and it will only be as strong as you make it.

