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”
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
Part 1 – Employee Information

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

Part 2 – Type of Action You Are Requesting

3) Open Season:  
   - New Enrollment  
   - Change Current Enrollment  
   - Cancel Enrollment  

2) New Hire:  
   - New Enrollment  
   - New Hire Event  

3) QLE or Special Enrollment (Including Dependent Eligibility):  
   - New Enrollment  
   - Change Current Enrollment  
   - Update Dependent Eligibility  

   Type of QLE Actions

Part 3 – Enrollment Plan Name and Plan Code

1) New Plan Name:  
2) New Enrollment Code:  
3) Old Plan Enrollment Code:  

Part 4 – Your Other Group Insurance

1) Are you covered by insurance other than Medicare?  
   - Yes  
   - No  

   If you indicate type of insurance other than Medicare, please specify:  

2) Identify Type of Other Insurance Coverage
   - Medicare Part A  
   - Medicare Part B  
   - Medicare Part D  
   - TRICARE  
   - Other:  

   Other Insurance Policy:  

   FEHB Age:  

   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  

Your Marital Status:  
   - Yes  
   - No  

Your Daytime Telephone Number (Including area code):  

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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.
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.
**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 if your biweekly earnings statement for items 1-4.)*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>1. Name (Last, first, middle initial)</td>
<td>2. Employee ID</td>
</tr>
<tr>
<td>3. Finance No.</td>
<td>4. Pay Location</td>
</tr>
<tr>
<td>5. Employing Office (City, State, and ZIP + 4)</td>
<td></td>
</tr>
<tr>
<td>6. Participant Daytime Telephone No.</td>
<td>7. Participant Mailing Address (Street, City, State, and ZIP + 4)</td>
</tr>
</tbody>
</table>

**Part B - Begin Pre-Tax Treatment**

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.

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

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.

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

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>1. Effective Date</td>
<td>2. Authorized Official Signature</td>
</tr>
<tr>
<td>3. DDE/DR Office Telephone No. (include area code)</td>
<td></td>
</tr>
</tbody>
</table>

**REMARKS** *(For use by Human Resources personnel only.)*
Notice to Noncareer Employees Eligible to Enroll in FEHBP

Subject: Sufficient Earnings Requirement for Federal Employees Health Benefits Coverage

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:

<table>
<thead>
<tr>
<th>Service Type</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Services</td>
<td>Members: 15%</td>
<td>Members: 40%</td>
</tr>
<tr>
<td></td>
<td>Health Plan: 85%</td>
<td>Health Plan: 60%</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Members: 25%</td>
<td>Members pay all charges</td>
</tr>
<tr>
<td></td>
<td>Health Plan: 75%</td>
<td></td>
</tr>
</tbody>
</table>

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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

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Enrollment Code</th>
<th>Employee Biweekly Premium</th>
<th>USPS Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Only</td>
<td>474</td>
<td>$46.31</td>
<td>$138.93</td>
</tr>
<tr>
<td>Self and Family</td>
<td>475</td>
<td>$104.18</td>
<td>$312.54</td>
</tr>
</tbody>
</table>
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
    - Medical Services: 15%
    - Prescription Drugs (Retail or Mail order): 25%
  - **Out-of-network**
    - You pay
    - Medical Services: 40%
    - Prescription Drugs: 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**
    - Self: $3,000
    - Self and Family: $4,500
  - **Out-of-network**
    - Self: $9,000
    - Self and Family: $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**
- **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

#### Medical Benefits

<table>
<thead>
<tr>
<th>Service</th>
<th>In-network You Pay</th>
<th>OptumRx</th>
<th>Out-of-network You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visits</td>
<td>15%</td>
<td>25% coinsurance</td>
<td>All charges</td>
</tr>
<tr>
<td>Office and Specialist Visits</td>
<td></td>
<td>$200 maximum per RX</td>
<td></td>
</tr>
<tr>
<td></td>
<td>15%</td>
<td>$200 maximum per RX</td>
<td>All charges</td>
</tr>
<tr>
<td>40% of the Plan allowance*</td>
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</table>

#### 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

<table>
<thead>
<tr>
<th>Service</th>
<th>In-network You Pay</th>
<th>OptumRx</th>
<th>Out-of-network You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic Hearing Test (every 2 years)</td>
<td>15%</td>
<td>25% coinsurance</td>
<td>All charges</td>
</tr>
<tr>
<td>Hearing Aids (every 3 years)</td>
<td></td>
<td>$200 maximum per RX</td>
<td></td>
</tr>
<tr>
<td>All charges in excess of $1,500</td>
<td>15%</td>
<td></td>
<td>All charges in excess of $1,500</td>
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<td></td>
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</tbody>
</table>

#### Hospital/Facility Care

<table>
<thead>
<tr>
<th>Service</th>
<th>In-network You Pay</th>
<th>OptumRx</th>
<th>Out-of-network You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic Tests or Imaging</td>
<td>15%</td>
<td>25% coinsurance</td>
<td>All charges</td>
</tr>
<tr>
<td>Outpatient Surgery, Facility Fee, Lab Visits and Surgeon Fee</td>
<td>15%</td>
<td>$200 maximum per RX</td>
<td>All charges</td>
</tr>
<tr>
<td>Inpatient</td>
<td>15%</td>
<td>25% coinsurance</td>
<td>All charges</td>
</tr>
<tr>
<td>Cancer Centers Of Excellence</td>
<td>10%</td>
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</tbody>
</table>

#### Emergency Care

<table>
<thead>
<tr>
<th>Service</th>
<th>In-network You Pay</th>
<th>OptumRx</th>
<th>Out-of-network You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidental Injury, Urgent Care, Emergency Room, Ambulance</td>
<td>15%</td>
<td>25% coinsurance</td>
<td>All charges</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$200 maximum per RX</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>All charges in excess of $1,500</td>
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<td></td>
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</tr>
</tbody>
</table>

#### Prescription Drug Benefit

<table>
<thead>
<tr>
<th>Service</th>
<th>In-network You Pay</th>
<th>OptumRx</th>
<th>Out-of-network You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail Prescription (for up to a 30-day supply)</td>
<td>15%</td>
<td>25% coinsurance</td>
<td>All charges</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$200 maximum per RX</td>
<td></td>
</tr>
<tr>
<td>Mail-Order Prescription (for up to a 90-day supply)</td>
<td>15%</td>
<td>25% coinsurance</td>
<td>All charges</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$600 maximum per RX</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>All charges</td>
</tr>
</tbody>
</table>

#### Mental Health/Substance Abuse

<table>
<thead>
<tr>
<th>Service</th>
<th>In-network You Pay</th>
<th>OptumRx</th>
<th>Out-of-network You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visit</td>
<td>15%</td>
<td>40% of the Plan allowance*</td>
<td>All charges</td>
</tr>
<tr>
<td>Outpatient Treatment</td>
<td>15%</td>
<td>40% of the Plan allowance*</td>
<td>All charges</td>
</tr>
<tr>
<td>Diagnostics, Inpatient and Outpatient Services</td>
<td>15%</td>
<td>40% of the Plan allowance*</td>
<td>All charges</td>
</tr>
</tbody>
</table>

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

VISION PLANS AND RATES

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

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Telephone &amp; Website</th>
<th>Plan Option</th>
<th>Biweekly Premium</th>
<th>Monthly Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Self Only</td>
<td>Self Plus One</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$6.17</td>
<td>$11.75</td>
</tr>
<tr>
<td>FEP BlueVision</td>
<td>1-888-550-2583, fepblue.org</td>
<td>Standard High</td>
<td>$3.73</td>
<td>$7.45</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$4.71</td>
<td>$9.42</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$4.12</td>
<td>$8.04</td>
</tr>
<tr>
<td>VSP (Vision Service Plan)</td>
<td>1-800-807-0764, choosevsp.com</td>
<td>Standard High</td>
<td>$3.67</td>
<td>$7.33</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$6.34</td>
<td>$12.69</td>
</tr>
</tbody>
</table>
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
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.
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