NEW HBR TRAINING SCRIPT

Opening

Welcome to the new HBR training session. My name is Melisa Walker and I will be walking you through a few things that you can use to be a more effective health benefits representative or HBR. I cannot impress upon you enough the importance of the position as an HBR. We like to say our customer service representatives are the front line of the Plan, but truthfully, it is you, the HBR. You have the opportunity to interact with members and potential members on a daily basis, to have one on one conversations about the Plan, and to be the voice of membership. We want to hear from you, not only when a member has an issue or when you need materials. The Plan values your insight and wants to know how we can make YOUR plan better.

SLIDE #2

The NALC Health Benefit Plan was started by letter carriers for letter carriers, so it truly is your plan. We represent the interests of the NALC Union and its members. The vast majority of the employees working at the Plan are union members themselves.

SLIDE #3

Before we go into the tips and tools for the HBR role, I want to give you a little history of the Plan. When the Plan was started in 1950, it employed only 2 individuals in an office in Washington DC. At the end of the 1st enrollment period, we had 4,116 members. In 1960, the NALC HBP joined the Federal Employees Health Benefits Program, opening the Plan to Federal as well as Postal employees. Postal employees must be dues paying members of the NALC to join our Plan. Federal employees must become associate members and pay annual membership dues. We are open to both active and retired employees.

Slide #4

A question we would get at health fairs we attended for the federal government was, "Are you a new plan?" The NALC HBP has been in business for over 70 years and has 130,347 members. We are not new to the insurance business. We are the 3rd largest insurer in the FEHB program. We cover over 256,000 lives which includes members and their dependents in the 3 plan options.

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Another testament to our size and experience is that in 2020, we issued more than $1.6 **billion** in benefit payments, processed close to 5 million claims, mailed 6.2 million pieces of mail, and answered 762,255 phone calls from members and providers. This was all done from our Ashburn, VA location. You may be thinking, yes that is a lot of claims and calls, but how efficient is NALC? 98% of all claims are processed within 30 days of receipt with a 98% accuracy rate, and we resolved 98% of the issues we received by phone during the initial call. 100% of all calls are answered by a live person during normal business hours.

Slide #6

None of this would be possible without the knowledge and experience of our employees. We currently have 327 employees, with a mixture of staff and union craft employees. The average tenure of a NALC employee is 15 years. We promote from within the company, putting each employee through extensive training before they put their skills to practical use.

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Experience and tenure are important to living up to our mission. It is the goal of the NALC HBP to provide our members accessibility to quality medical care while maintaining a comprehensive benefit package.

We pride ourselves in offering excellent benefits with affordable premiums and excellent customer service. None of this could be achieved without the dedication and experience of our employees, or our partnership with you as HBR's.

Slide #8

Having the right partners is also important to our mission when it comes to offering quality medical care to our members. We feel we have the right balance of vendor partners to help us achieve that goal.

Slide #9

The Plan partners with Cigna Healthcare to provide our membership with a network of doctors, hospitals, ambulatory surgery centers, and laboratories who all offer their services at a discounted rate. Our percentage of reimbursement is also higher when you use an in-network provider. For example, all preventive care treatment is paid at 100% by the Plan when you use an in-network provider. If you use an out-of-network doctor for the same services, you are responsible for the deductible and then 30% of the plan allowance. Office visits to an in-network doctor are also less expensive.

You pay a low $20 copayment for sick visits to an in-network doctor while that same visit out-of-network will mean you are responsible for the deductible, then 30% of the allowed amount.

Every benefit listed in our brochure includes the in-network and out of network cost share so you can see at a glance why it makes good financial sense to use in-network providers whenever they are available. Cigna has more than 4 million providers and over 21,000 facilities nationwide to choose from. You can use our website, or the number listed on the screen to locate in-network providers before you schedule your next appointment.

Cigna Healthcare also administers the CDHP and Value Option Plans and provides our High Option members with free additional wellness benefits such as the 24-hour Health Information Line and the Your Health First Disease Management Program.

Slide #10

We partner with CVS Caremark to provide our members with prescription drug coverage. Members can get short term medications at any of the more than 68,000 participating CVS pharmacies nationwide. For long term or maintenance medications, our members can use either the mail order program or pick their prescription up at a CVS pharmacy in 60-to-90-day quantities. Specialty medications can also be obtained from the CVS Specialty program in 30, 60, or 90-day quantities for low copayment amounts. You can use our website, or the number listed on the screen to find a CVS participating pharmacy and even reorder your prescription medications. CVS is the prescription drug benefit manager for the High, CDHP, and the Value Option Plans. By partnering with CVS, the Plan can offer our members additional wellness programs at no cost, including the Transform Care Diabetes Management program. Through this program, individuals who are insulin dependent may qualify for a free meter, along with free test strips and lancets.

Slide #11

Maintaining good mental health is just as important as receiving an annual medical checkup. Optum Health Behavioral Solutions offers an array of services for our High Option members. Whether you or a family member suffer from depression, needs help coping with stress, or have a substance use disorder issue, Optum has over 246,000 clinicians to choose from. Many offer their services through virtual or telephonic visits, so you can get treatment or assistance without leaving your home. Use our website, or the number listed to find a participating doctor. Our partnership with Optum allows the Plan to offer addition wellness benefits at no cost to our High Option members, such as enhanced substance use disorder programs and the Real Appeal® Weight Management Program.

Slide #12

At the height of the pandemic, virtual doctor visits saw a dramatic increase. Patients realized they could get care for certain illnesses without leaving their home. In 2020, the Plan partnered with American Well to begin offering virtual medical visits at half the cost of a traditional in-person, in-network doctor visit. The fastest and easiest way to access the doctors available for virtual visits is to get the app on your phone or other mobile device, and enroll before you actually need to see a doctor. Download the mobile app for Androidor iOS mobile devices by visiting Google Play™ or the App Store on your Apple device. You can also visit www.nalchbptelehealth.org or call 888-541-7706 to access high quality, affordable care, when you need it, where you need it. Care is provided by U.S. board licensed and credentialed physicians and nurse practitioners who can write a prescription for medication, if appropriate. Virtual visits can be used for adults or children withminor acute, non-emergency medical conditions such as flu, sinus problems, allergies, abrasions, or minor wounds.

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So far, we have talked about vendors relationships for the High Option Plan. I want to take just a few minutes to outline some of the features of our 2 consumer driven health plan options. The 2 plans are called the Consumer Driven Health Plan or CDHP and the Value Option. Consumer driven plans are generally less expensive than traditional plans but have higher out-of-pocket costs for their members. Members receive a personal care account or PCA in each of these plans. Your PCA funds are used towards any medical expenses you may incur before your deductible is met. The calendar year deductible in each plan is $2,000 per person or $4,000 per family when you use in-network providers. The calendar year deductible for each plan is $4,000 per person or $8,000 per family if you choose to use out-of-network providers. For the CDHP, you are given a $1,200 PCA per person or $2,400 PCA per family to use for your medical expenses when you have not met your deductible. In the Value Option, the PCA is $100 per person or $200 per family. These plans are designed for individuals who do not have high medical expenses or use little of their health care benefits. Both plans are administered by Cigna Healthcare with CVS Caremark providing the prescription drug benefits. This means all calls and claims are handled by Cigna, as well as the mental health benefits and wellness benefit programs.

Because the plans are less expensive, people with Medicare as primary may be tempted to leave the High Option plan to join a consumer driven one. The CDHP and Value Option do not coordinate benefits with Medicare the same way. When you are in the High Option Plan, you have no out of pocket costs, in most cases, because we pay 100% of the balance after Medicare. The consumer driven plans will only make a payment after Medicare, if what Medicare paid is equal to or less than what we would have paid if we were primary. That will not be the case in most instances. If you have members in your branch with Medicare as primary and they are considering making this type of change, please refer them to our Customer Service Department so we can be sure they fully understand this difference.

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Now that we have gone over some history and a few high lights of the Plan, I want to talk about your role as an HBR. Being an HBR means being able to sell the Plan to potential members, helping them enroll in our plan, getting them the needed resources, and answering basic questions. When the position of Health Benefit Representative was established during the 43rd National Convention, it was determined that the main duty of a HBR would be to act as a vital link between the NALC Health Benefit Plan, its Director, and the branch members who were enrolled in the Plan. HBR's day-to-day contact with the members, hospitals, doctors, and federal agencies plays a major role in helping the Plan attain its goal of providing personalized service to our membership.

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HBR duties include helping members file medical claims, providing them with up-to-date information on Plan benefits, and maintaining adequate supplies of claim forms and related material. You also act as a liaison between members and the Plan, help the member obtain itemized bills and reports regarding their illness or confinement, and advise the Plan of any improper billing practices by providers or instances of fraudulent activity. The more knowledge you have about the NALC HBP, the more valuable resource you are for existing and potential Plan members.

Slide #16

Many members will want their HBR to call the Plan and speak on their behalf. Because of HIPAA privacy laws, we are not able discuss specific member information with anyone who does not have the member's signed permission to do so. The member can verbally authorize for one of our Customer Service Reps to speak with you if they are present on the call, however, if a member wishes to give you full authorization on their file for any future inquiries when they are not present, we suggest a HIPAA form is filled out. It is recommended that you order a supply of HIPAA authorization forms to have on hand at the branch. Your members should complete the form and designate you as their personal representative. Once the form is received at the Plan, we update the member records to reflect this authorization. Without it, we would not be able to disclose member information to you even though you are their HBR. If you are calling with general benefit questions, a HIPAA form is not required.

If there are any questions on how to complete this form, one of our trained Customer Service Reps can walk you through it. Later in the presentation, I will show you where you can access the form online.

Slide #17

Get familiar with your Plan brochure and benefits. It is a breakdown of what is covered and what the member will be expected to pay for a specific service. By using the index at the back of the brochure or a search of the electronic version, you will be taken to benefits in that section that you are being asked about. Once you locate the benefit, only quote directly from the brochure, if you are unsure of a benefit question, always call the Plan for assistance.

Keep up with new benefits and benefit changes. Knowing what benefits change or are added each year is important. We make improvements to our benefits every year. You can quickly see what those changes are by referring to Section 2 in our brochure. You should keep extra copies on hand for members who may request one or know where to locate the current year's brochure from our website. You can access the electronic version from the Quicklinks section on the main page of our website. Use the electronic version to search for key words.

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Understanding our explanation of benefits, or EOB, will greatly assist you in your role as HBR. An EOB is sent to the member each time we process a claim. Members may come to you for an explanation of what is on the EOB. Here is a breakdown for you. We have labeled each part of the EOB to help you read an EOB. The current EOB we are looking at is for an in-network PPO priced claim.

- Section 1 contains the member's name, patient name and the provider's patient account number provided.
- Section 2 contains the member's identification number (or N number) the claim number, the name of the provider who was paid, along with the provider's federal tax identification number. To the right of this, you will see the claim date.
- Section 3 gives the details of the claim information. From left to right, you will see the rendering provider name and description of services provided, the date of service, and the total charges billed. If there are multiple lines on a claim, each of these will be represented on the EOB. For this example, there was one charge for $164.00.
- Continuing from left to right, you will see the Discount/Disallowed and Covered Charges section. The Discount/Disallowed section represents the savings on a claim, which is the difference between the charged amount and the Cigna rate used. If you add up the Discount/Disallowed section and the Covered Charges section, they equal the total charges billed.
- Next you will see the Copayment and Deductible Sections. If there was any copayment or deductible applied, you will see this here. Notice on this EOB that there was a $20 PPO office visit copayment applied, but no deductible.

- Next will be the Payable section, which lists the amount payable. The total billed charges of $164.00, minus the discount of $27.40 equals $136.60. When you subtract the $20 copayment, it leaves you with a payable amount of $116.60, which was paid to the provider.
- The payable amount, or contract allowance, is $116.60. Following the claims details, there is a remark code. This represents internal programming codes which helps decipher what type of pricing is used. If you look down at section 5, the remark code is explained. Remark codes also include important claims processing information. On this particular claim you will see the privacy rule referenced.
- Section 4 is the overall claims summary which breaks down the Total billed ($164.00), less Discount/Disallowed or savings ($27.40), the amount that NALC paid the provider ($116.60), and the remaining patient liability (the $20 copayment).
- Lastly, section 6 will list year-to-date calendar year deductible, and out-of-pocket information for both the patient and family, at the time the claim was processed. If you have any questions on reading a particular EOB, please give us a call and we can help walk you through it. If anything seems incorrect or questionable, please give the Plan a call.

Slide #19

Members may come to you due to a denial of services on their claim. Knowing your brochure is an important piece to this. However, if you are unable to find the answer yourself, no worries, because we are here to help. As long as you are an authorized HIPAA representative, you can reach out to the Plan with questions on the member's behalf.

Sometimes, being able to provide an explanation from the brochure will answer the member's question. However, after their review, if a member wishes to appeal a denied charge, there are steps outlined in our Plan brochure in section 8, The Disputed Claims Process. I will provide a brief breakdown for you, but please refer to the current brochure for details on the appeals and disputed claims process.

STEP 1: Members must ask in writing to reconsider our initial decision, and must write within 6 months from the date of our decision (or date claim was paid).

STEP 2: The Plan has 30 days from the date we receive the request to pay the claim, write to the member and maintain our denial, or ask the member or their provider for more information.

Step 3: If the member does not agree with our decision, they may ask OPM to review it.

Slide 20

Because when it comes to health care costs, nobody likes surprises. The new Cigna Care and Cost Directory, available to NALC Health Benefit High Option Plan members at no additional cost, is an easy-to-use online tool that allows members to estimate the costs of care based on your specific medical plan and deductible status. Members will know exactly how much care will cost before they even go for their visit. It's all part of our commitment to provide easy access to quality and affordable care. Register at: nalc.yourcareallies.com and click the Find Care & Costs tab. A pop-up window will appear and members should follow the prompts to register.

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The NALC HBP has limited opportunities to interact with potential members. But you, as an HBR, can help us with that. You have the opportunity to talk with new full time hires and those who may have coverage through other health plans. Hosting health fairs and printing health related articles in your newsletters are also a great way to promote YOUR plan.

Being familiar with our website and having the new and upcoming mobile app are also important. You can have everything you need to know about benefits and special features right at your fingertips.

Federal agencies (including postal) request our participation in their health fairs. Because the Health Benefit Plan is unable to participate in each and every fair, we notify you of the date, time, and place of the health fair. The agency is advised that participation in the fair is left entirely to the discretion of the local branch representative. It is your job to notify the agency as to whether or not you plan to participate in the fair. If you need materials to distribute or put in your local branches or break rooms at the Postal facility (when allowed), simply give us a call and we can get the materials shipped to you.

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A good place to start when promoting the plan is the rates or costs to the enrollee. These rates can be located on the back cover of each brochure. How much someone has to spend for quality healthcare is important. Our benefit package and low rates make the NALC HBP a smart choice!

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While actively comparing one plan to another is frowned upon, ever member has an easy tool to do it for themselves. Encourage members to visit OPM's website at www.opm.gov/insure. On the left side, click on FEHB Plan Comparison Tool. Enter your zip code, employee type, and pay frequency. Putting in your current health plan is optional.

You will then be able to select 3 plans and have their benefits and costs displayed side by side for easy comparison. It shows costs, benefits, and quality performance measures for each plan selected. There is even an option to print the results if you prefer paper. When potential members have questions about the Plan and how it stacks up to their plans this is the best way to compare. You will find it is a helpful tool when promoting the Plan and that we are a comprehensive plan that offers quality services and benefits with an affordable premium.

Slide #24

Now that you have successfully recruited more of your fellow Postal service employees to join the Plan, it is important to know how to enroll. In the past, there were several ways to make changes or join a new plan during Open Season. For those who ask, you should encourage them to join through Postal Ease. *And as a good union advocate - be sure to tell them to print the confirmation screen.*

Slide #25

Despite the fact that this is the age of technology, sometimes you need to pick up the phone and talk to a real person. Knowing the right numbers to call in those moments is key. On the screen we have listed some of the most frequently used numbers for the Plan. The most important being our Customer Service line when you need assistance. If needed, call the Plan directly at 888-636-6252 for any questions you have. We are here to assist you in this important role. Keep phone numbers and other resources handy. It is important to know what numbers can be used for different needs. Our main customer service number should be used for all general health questions and claims status calls, along with prior approvals for durable medical equipment.

The number for Cigna and CareAllies (877-220-6252) is used to precertify hospital and non-Medicare skilled nursing facility admissions, certain surgeries and musculoskeletal procedures. It is also used to locate a PPO provider.

Members should call the CVS line if they have questions about their prescription medications. Certain drugs like compound drugs also require prior authorization and they can use the CVS number.

Optum Health Behavioral Solutions is our mental health and substance use disorder provider. Members should call Optum to locate an in-network provider, to precertify mental health and substance use related hospital stays, including residential treatment stays, and certain outpatient procedures. You can refer to the Important section of 5e in the brochure for a complete list.

It is also important to have the CHDP and Value Option number handy. As I mentioned, these plans are administered by Cigna so most questions on these plans should be directed to the number listed on the screen. This includes status calls, benefits questions, precertification requests, and approvals for hospital admissions for members in these plans.

You can also use our website to get information on all 3 plans. Our newest and most member friendly resource is the new and upcoming Mobile app. We will having a special training session on the mobile app during our October seminar sessions, so be sure to sign up for the seminar and download the app when it is available. Most importantly, know when to contact the Plan for assistance.

Slide #26

Open Season for this year is November 8, 2021, through December 13, 2021. Our goal, with your help, is to not only get potential members interested in the Plan, but also to retain those members that we have. Give them a reason to stay. Knowing the new benefits and the cost of the Plan is a great start. And, if you have questions or are unsure of something, we encourage you to reach out to our Customer Service Department to get the answers. They are available from 8 AM to 3:30 PM, Monday through Friday. During Open Season, those hours will be extended.