

# Changes brought on by the Postal Service Health Benefits Program



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**T**his month I want to focus on a few items that changed with the creation of the Postal Service Health Benefits (PSHB) Program. I'll also discuss how they affect our members, and how these changes also created a limitation on the Plan's ability to provide assistance. I recognize this will be a repetitive subject for some, but it is my hope that branch leaders will work in partnership with the Plan to help share the message.

First and foremost, I want to start with an issue where many letter carriers have experienced reasonable frustration—eligibility updates or changes to your policy. In the

past, a simple call or written letter sent to the Plan was adequate. However, now that letter carriers are covered under the PSHB Program, the Office of Personnel Management (OPM) is the designated keeper of the records. This means OPM is the responsible party charged with making these changes and the Plan cannot make changes without OPM's approval to do so.

Without proper documentation from the OPM, these are items the Plan cannot take action on:

- Address changes
- Removing or adding dependent(s)
- Changing the plan code (example: Self Only to Self and Family)
- Processing or refunding Health Benefit Plan premiums
- Establishing marriage or divorce updates
- Cancellation of health benefit coverage

If you need to make any of these changes, they must now be addressed through the employment office, which would be the Human Resource Shared Service Center for active carriers and OPM retiree services for annuitants. I can assure you that the Plan shares your frustration with this process, but this is a requirement of the PSHB we must follow.

**Medicare Part D**—Beginning in 2025, all eligible annuitants and their eligible family members enrolled in Medicare A or Medicare A and B *must* be enrolled into their PSHB insurance carrier's Medicare Part D program.

If members or eligible dependents choose to opt out or disenroll from the Part D program, they will not have access to the prescription drug benefits of their PSHB plan for the remainder of the plan year. In summary,

members will continue to be enrolled in their health plan, continue to pay the same premium, however, they will not be eligible to retain prescription drug coverage.

Our Plan offers two Medicare Part D options, giving members the flexibility to choose which option better suits their needs for no additional premium cost:

- **Option 1 is the Plan's designated default option**—Our SilverScript Prescription Drug Plan (PDP). This plan combines a Medicare Part D formulary with the Plan's current year prescription coverage and is available for members with Medicare Part A or Medicare Part A and B.
- **Option 2 is a choice you can select in lieu of Option 1, the NALC High Option Plan**—Aetna Medicare Advantage. This plan offers enhanced level of benefits for High Option annuitants who have Medicare Parts A and B.

It is very important to understand that if you choose to disenroll or opt out from the Plan's Medicare Part D programs, the Plan will not be able to make any enrollment exceptions or provide an alternate prescription coverage.

We continue to speak with members who have been disenrolled from the Plan's Part D options without fully understanding how this decision will affect their health and prescription needs, and we don't want more members to find themselves in this situation.

**Now that we've covered Plan limitations or decisions** that may affect members in an adverse way, I want to shift the subject to positive resources that are available.

Let's start with HealthEquity. Receive up to \$600 per eligible High option member and eligible dependents, for participating in the SilverScript PDP. That's right, up to \$600 for you and \$600 for each eligible member.

All you need to do is fill out some information and provide documentation showing proof of your original Medicare Part B premium payments.

**TASC card—Have you received a TASC debit card?** Make sure you and your eligible family members aged 18 and older are taking advantage of the valuable health savings you can earn by participating in our wellness incentive programs. These rewards are loaded on a debit TASC card, which can be used for eligible medical expenses not covered by insurance.

**Last but not least, we extended our core business hours** last fall to better serve you. If you have any questions about any of the above topics, please contact us Monday through Friday between 8 a.m. to 6 p.m. Eastern time.