The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. Please read the FEHB Plan brochure ([insert brochure number]) that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure**. Benefits may vary if you have other coverage, such as Medicare. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can get the FEHB Plan brochure at www.apwuhp.com, and view the Glossary at www.apwuhp.com. You can call 1-800-222-2798 to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$ 350 /Self Only $ 700 / Self Plus One $ 700 /Self and Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. Copayments and coinsurance amounts do not count toward your deductible, which generally starts over January 1. When a covered service/supply is subject to a deductible, only the Plan allowance for the service/supply counts toward the deductible.
Are there services covered before you meet your deductible?	Yes: Preventive services, office visits, virtual visits, urgent care, prescription drugs, maternity, some lab work, hearing aids, chiropractic care and acupuncture.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. Services must be performed at an in-network provider.
Are there other deductibles for specific services?	No.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-network: $5,500 self only; $9,000 self plus one and self and family Out-of-network: $10,000 self only; $15,000 self plus one and self and family	The out-of-pocket limit, or catastrophic maximum, is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, non-covered services and balanced billed charges, $300 pre-admission for non-PPO.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.apwuhp.com or call 1-800-222-APWU for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay	30% coinsurance	Includes virtual visits. No deductible.
	Specialist visit	$25 copay	30% coinsurance	No referral needed. No deductible.
	Preventive care/screening/ immunization	Nothing	30% coinsurance	One routine exam per person every calendar year. Services recommended under the Patient Protection and Affordable Care Act paid at 100% using in-network providers.
If you have a test	Diagnostic test (x-ray, blood work)	Nothing for LabCorp and Quest Diagnostics locations; 10% coinsurance for all other locations	30% coinsurance	Prior approval/ Precertification required for genetic testing.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	Precertification required, benefits reduced by $100 for noncompliance.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.apwuhp.com	Generic drugs	$10 copay (retail); $20 copay (mail order)	50% coinsurance ($10 minimum)	Covers up to a 30 day supply (retail prescription); 90 day supply (mail order prescription). Coverage review (prior authorization) is required for certain FDA-approved prescription drugs. No deductible
	Preferred brand drugs	25% coinsurance retail max $200 per RX; mail order max $300 per RX	50% coinsurance ($10 minimum)	
	Non-preferred brand drugs	45% coinsurance retail max $300 per RX; mail order max $500 per RX	50% coinsurance ($10 minimum)	
	Specialty drugs	25% generic-retail max $300 per RX; mail order max $150; 25% preferred brand-retail max $600 per RX;	50% coinsurance ($10 minimum)	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
		mail order max $300; 45% non-preferred-brand retail max is $1,000 per RX; mail order $500		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Precertification required for certain outpatient surgeries.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	Precertification required for certain outpatient surgeries.
If you need immediate medical attention	Emergency room care	Nothing for Accidental Injury; 10% coinsurance	Nothing for Accidental Injury; 10% coinsurance	Must receive care within 24 hours for accidental injury.
	Emergency medical transportation	10% coinsurance	30% coinsurance	Within 24 hours of Medical Emergency, air ambulance is covered if medically necessary.
	Urgent care	$40 copay	$40 copay	No deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance ($300 per admission)	Precertification required, benefits reduced by $500 for noncompliance.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	Precertification required for certain surgeries.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay office visit; 10% coinsurance for other services	30% coinsurance	No preauthorization required for office visits (no deductible), but may be required for certain procedures.
	Inpatient services	10% coinsurance	30% coinsurance	Preauthorization required, benefits reduced by $500 for noncompliance.
If you are pregnant	Office visits	Nothing	30% coinsurance	None
	Childbirth/delivery professional services	Nothing	30% coinsurance	None
	Childbirth/delivery facility services	Nothing	30% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	25 home visits per calendar year (combined with Skilled Nursing Care), not to exceed a maximum Plan payment of $90 per day. Preauthorization is required.
	Rehabilitation services	10% coinsurance	30% coinsurance	60 visits per calendar year for PT/OT/ST combined. Preauthorization is required ST only.
	Habilitation services	10% coinsurance	30% coinsurance	Refer to Rehabilitation services.
	Skilled nursing care	10% coinsurance	30% coinsurance	Refer to Home Health Care.
	Durable medical equipment	10% coinsurance	30% coinsurance	Preauthorization is required.
	Hospice services	Any amount over the lifetime max of $15,000 for combined outpatient and inpatient services	Any amount over the lifetime max of $15,000 for combined outpatient and inpatient services	Includes advanced planning and $200 bereavement benefit.
If your child needs dental or eye care	Children's eye exam	All charges	All charges	Discount program is available.
	Children's glasses	All charges	All charges	Discount program is available.
	Children's dental check-up	30% coinsurance	30% coinsurance	Visits/Cleanings limited to 2 per year which includes x-rays, fillings and simple extractions. Extra Dental Discount program available.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your plan's FEHB brochure for more information and a list of any other excluded services.)

- Cosmetic Surgery
- Infertility treatment
- Long-term care
- Private-duty nursing
- Gender reassignment surgery
- Routine eye care and foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan's FEHB brochure.)

- Acupuncture
- Bariatric Surgery
- Chiropractic care
- Routine dental care
- Hearing aids
- Medically necessary care when traveling abroad
- Weight loss programs
- Mental health
- Applied Behavior Analysis

2018 Premiums

		Non-Postal Premium				Postal Premium		
		Biweekly		Monthly		Biweekly		
Type of Enrollment	Enrollment Code	Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share	APWU Your Share
High Option Self Only	471	$229.25	$93.04	$496.71	$201.59	$86.67	$80.31	$86.67
High Option Self Plus One	473	$491.00	$185.79	$1,063.83	$402.55	$172.15	$158.51	$172.15
High Option Self and Family	472	$521.58	$251.90	$1,130.09	$545.78	$237.41	$222.92	$237.41

Your Rights to Continue Coverage: You can get help if you want to continue your coverage after it ends. See the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at 1-800-222-2798 or visit www.opm.gov.insure/health. Generally, if you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, a conversion policy (a non-FEHB individual policy), spouse equity coverage, or receive temporary continuation of coverage (TCC). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal. For information about your appeal rights please see Section 3, "How you get care," and Section 8 "The disputed claims process," in your plan's FEHB brochure. If you need assistance, you can contact: [insert applicable contact information from instructions].

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-222-2798.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-222-2798.
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码**1-800-222-2798.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-222-2798.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$350**
- **Specialist copay** **$25**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$0**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$350**
- **Specialist copay** **$25**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$25
Copayments	$100
Coinsurance	$285
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$410**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$350**
- **Specialist copay** **$25**
- **Hospital (facility) *coinsurance*** **10%**
- **Other coinsurance** **10%**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$350
Copayments	$0
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$370**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.