**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 healthcare 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 (71-004) 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 Personal Care Account (PCA)?** | $1,200 /Self Only<br>$2,400 /Self Plus One<br>$2,400 /Self and Family | | Your PCA is funded by the Health Plan and is used to pay for **covered** services at 100%. Any unused amount rolls over annually up to a maximum PCA balance of $5,000 Self Only/$10,000 Self Plus One and Self and Family. |
| **What is the overall deductible?** | **In-Network Net-Deductible:**<br>$1,000 /Self Only<br>$2,000 /Self Plus One<br>$2,000 /Self and Family | **Out-of-Network: Net-Deductible**<br>$1,500 /Self Only<br>$3,000 /Self Plus One<br>$3,000 /Self Plus 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 on 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 and maternity. | | 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:**<br>$6,500 /Self Only<br>$13,000 /Self Plus One Self Plus Family | **Out-of-Network:**<br>$12,000 /Self Only<br>$24,000 /Self Plus One 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. | | 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. For a list of in-network providers, see www.welcometouhc.com/apwu | 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). You are protected under the No Surprises Act and will not be balance billed for services that fall under this law. |
| **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 healthcare provider's office or clinic** | Primary care visit to treat an injury or illness | 15% coinsurance | 50% coinsurance | None |
| | Specialist visit | 15% coinsurance | 50% coinsurance | No referral needed. |
| | Preventive care/screening/ immunization | Nothing | Uses PCA whiles funds are available | 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) | 15% coinsurance | 50% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 15% coinsurance | 50% coinsurance | None |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.apwuhp.com | Tier 1 drugs | 25% coinsurance with a max of $200 retail and $600 mail order | All charges | Covers up to a 90 day supply (retail or mail order prescription) Coverage review (prior authorization) is required for certain FDA-approved prescription drugs. Members are required to purchase their specialty drugs through Optum RX Specialty Pharmacy. |
| | Tier 2 drugs | 25% coinsurance with a max of $200 retail and $600 mail order | All charges | |
| | Tier 3 drugs | 40% coinsurance with a max of $300 retail and $900 mail order | All charges | |

| 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 have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 15% coinsurance | 50% coinsurance | Preauthorization required for some services. |
| | Physician/surgeon fees | 15% coinsurance | 50% coinsurance | Preauthorization required for some services. |
| **If you need immediate medical attention** | Emergency room care | 15% coinsurance | 15% coinsurance | You will not be balanced billed when using out-of-network providers. |
| | Emergency medical transportation | 15% coinsurance | 50% coinsurance<br>15% coinsurance (air ambulance) | Within 24 hours of Medical emergency. You will not be balanced billed when using out-of-network providers for air ambulance (must be medically necessary). |
| | Urgent care | 15% coinsurance | 50% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 15% coinsurance | 50% coinsurance | Precertification required, benefits reduced by $500 for noncompliance. |
| | Physician/surgeon fees | 15% coinsurance | 50% coinsurance | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 15% coinsurance | 50% coinsurance | No preauthorization required for office visits, but may be required for certain procedures. |
| | Inpatient services | 15% coinsurance | 50% coinsurance | Preauthorization required, benefits reduced by $500 for noncompliance. |
| **If you are pregnant** | Office visits | Nothing | 50% coinsurance | None |
| | Childbirth/delivery professional services | Nothing | 50% coinsurance | None |
| | Childbirth/delivery facility services | Nothing | 50% coinsurance | None |
| **If you need help recovering or have other special health needs** | Home healthcare | 15% coinsurance | 50% coinsurance | 50 home visits per calendar year (combined with Skilled nursing care), not to exceed a maximum Plan payment of 2 hours per day. |
| | Rehabilitation services | 15% coinsurance | 50% coinsurance | 60 visits per calendar year for PT/OT/ST combined. |
| | Habilitation services | 15% coinsurance | 50% coinsurance | Refer to Rehabilitation services. |

| | | | | |
|---|---|---|---|---|
| | Skilled nursing care | 15% coinsurance | 50% coinsurance ($300 per admission) | 50 home visits per calendar year (combined with Home healthcare), not to exceed a maximum Plan payment of 2 hours per day. |
| | Durable medical equipment | 15% coinsurance | 50% 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 care planning. $200 bereavement benefit. |
| **If your child needs dental or eye care** | Children's eye exam | All charges | All charges | A portion of your PCA can be applied. |
| | Children's glasses | All charges | All charges | A portion of your PCA can be applied. |
| | Children's dental check-up | All charges | All charges | A portion of your PCA can be applied. |

## 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
- Long-term care
- 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
- Skilled nursing facility
- Hearing aids
- Medically necessary care when traveling abroad
- Virtual Visits
- Applied Behavior Analysis
- Chiropractic care
- Residential treatment center

**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 visit: www.apwuhp.com.

**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 1-800-718-1299.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-718-1299.
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-718-1299.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-718-1299.

*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 prenatal care and a hospital delivery)

- **The plan's overall deductible** **$1,000**
- **Specialist coinsurance** **15%**
- **Hospital (facility) coinsurance** **15%**
- **Other coinsurance** **15%**

**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** **$1,000**
- **Specialist coinsurance** **15%**
- **Hospital (facility) coinsurance** **15%**
- **Other coinsurance** **15%**

**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 | $1,000 |
| Copayments | $0 |
| Coinsurance | $600 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** ***Note: Joe used his PCA*** | **$1,600** |

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

- **The plan's overall deductible** **$1,000**
- **Specialist coinsurance** **15%**
- **Hospital (facility) *coinsurance*** **15%**
- **Other coinsurance** **15%**

**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 | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** ***Note: Mia has a PCA Rollover*** | **$0** |

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