



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 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 <u>deductible</u> ?	In-Network: \$450 /Self Only \$800 /Self Plus One \$800 /Self Plus Family	Out-of-Network: \$1,000 /Self Only \$2,000 /Self Plus One \$2,000 /Self Plus Family	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes: <u>Preventive services</u> , office visits, virtual visits, urgent care, prescription drugs, maternity, some lab work, hearing aids, chiropractic care and acupuncture.		This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. See a list of covered <u>preventive services</u> at: https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <u>deductibles</u> for specific services?	No.		You don't have to meet deductibles for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	In-Network: \$6,500 /Self Only \$13,000 /Self Plus One and Self Plus Family	Out-of-Network: \$12,000 /Self Only \$24,000 /Self Plus One and Self Plus Family	The <u>out-of-pocket limit</u> , or catastrophic maximum, is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, non-covered services and balanced billed charges, \$300 copayment for non-PPO.		Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See https://www.apwuhp.com/federal-member/find-provider/ or call 800-222-2798 for a list of <u>network providers</u> .		This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a provider in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your plan pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your provider before you get services.

Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .
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 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	\$25 copayment (No deductible applies).	40% coinsurance	Teladoc Telehealth Visits – first two visits are free with no member cost share; \$10 copayment (no deductible) after first two.
	Specialist visit	\$25 copayment (No deductible applies).	40% coinsurance	No referral needed. No deductible.
	Preventive care/screening/immunization	Nothing (No deductible applies).	40% 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 (No deductible applies); 15% coinsurance for all other locations	40% coinsurance	Authorization is required for genetic testing.
	Imaging (CT/PET scans, MRIs)	15% coinsurance	40% coinsurance	Authorization 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 https://www.express-scripts.com/frontend/c	Tier 1 drugs	\$10 copayment (retail); \$20 copayment (mail order)	50% coinsurance	No deductible applies.
	Tier 2 drugs	25% coinsurance retail max \$200; mail order max \$300	50% coinsurance	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription).
	Tier 3 drugs	45% coinsurance retail max \$300; mail order max \$500	50% coinsurance	

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)	
ommercial-open-enrollment/apwuhealthplan (www.apwuhp.com)	Diabetes medication	Insulin: \$25 <u>copayment</u> –30day \$75 <u>copayment</u> - 90 day Generic oral meds, formulary lancets and test strips: \$0 mail order	50% <u>coinsurance</u>	Coverage review (prior authorization) is required for certain FDA-approved prescription drugs.
	<u>Specialty drugs</u>	25% <u>coinsurance</u> tier 4 - retail max \$300; mail order max \$150; 25% <u>coinsurance</u> tier 5 - retail max \$600; mail order max \$300; 45% <u>coinsurance</u> tier 6 - retail max is \$1,000; mail order max is \$500	50% <u>coinsurance</u>	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% <u>coinsurance</u> (No <u>deductible</u> applies)	40% <u>coinsurance</u>	<u>Authorization</u> required for certain outpatient surgeries.
	Physician/surgeon fees	15% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Copayment</u> required for certain outpatient surgeries.
If you need immediate medical attention	Emergency room care	Nothing for Accidental Injury (no <u>deductible</u> applies); 15% <u>coinsurance</u>	Nothing for Accidental Injury (no <u>deductible</u> applies); 15% <u>coinsurance</u>	Must receive care within 72 hours for accidental injury. You will not be balanced billed when using <u>out-of-network providers</u> .
	<u>Emergency medical transportation</u>	15% <u>coinsurance</u> (No <u>deductible</u> applies)	40% <u>coinsurance</u> (No <u>deductible</u> applies) 15% <u>coinsurance</u> (air ambulance) (No <u>deductible</u> applies)	Within 72 hours of Medical Emergency. You will not be balanced billed for <u>out-of-network providers</u> for air ambulance (must be medically necessary).
	<u>Urgent care</u>	\$30 <u>copayment</u> (No <u>deductible</u> applies)	40% <u>coinsurance</u>	

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 a hospital stay	Facility fee (e.g., hospital room)	15% <u>coinsurance</u> (No <u>deductible</u> applies)	40% <u>coinsurance</u> (\$300 <u>copayment</u>)	<u>Authorization</u> required, benefits reduced by \$500 for noncompliance.
	Physician/surgeon fees	15% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Authorization</u> required for certain surgeries.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copayment</u> office visit; 15% <u>coinsurance</u> for other services	40% <u>coinsurance</u>	No <u>Authorization</u> required for office visits (no deductible), but may be required for certain procedures.
	Inpatient services	15% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Authorization</u> required, benefits reduced by \$500 for noncompliance.
If you are pregnant	Office visits	Nothing (No <u>Deductible</u> Applies)	40% <u>coinsurance</u>	None
	Childbirth/delivery professional services	Nothing (No <u>Deductible</u> Applies)	40% <u>coinsurance</u>	None
	Childbirth/delivery facility services	Nothing (No <u>Deductible</u> Applies)	40% <u>coinsurance</u>	None
If you need help recovering or have other special health needs	<u>Home healthcare</u>	15% <u>coinsurance</u>	40% <u>coinsurance</u>	50 home visits per calendar year (combined with Skilled nursing care), not to exceed a maximum Plan payment of 2 hours per day.
	<u>Rehabilitation services</u>	15% <u>coinsurance</u>	40% <u>coinsurance</u>	60 visits per calendar year for PT/OT/ST combined. <u>Authorization</u> is required ST only.
	<u>Habilitation services</u>	15% <u>coinsurance</u>	40% <u>coinsurance</u>	Refer to Rehabilitation services.
	<u>Skilled nursing care</u>	15% <u>coinsurance</u>	40% <u>coinsurance</u> (\$300 <u>copayment</u>)	50 home visits per calendar year (combined with Home healthcare), not to exceed a maximum Plan payment of 2 hours per day.
	<u>Durable medical equipment</u>	15% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Authorization</u> is required.
	<u>Hospice services</u>	Any amount over the annual max of \$15,000 for combined outpatient and inpatient services	Any amount over the annual max of \$15,000 for combined outpatient and inpatient services	Includes advanced planning and \$200 bereavement benefit.

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 your child needs dental or eye care	Children's eye exam	All charges	All charges	
	Children's glasses	All charges	All charges	
	Children's dental check-up	30% <u>coinsurance</u> (no <u>deductible</u> applies)	30% <u>coinsurance</u> (No <u>deductible</u> applies)	Visits/Cleanings limited to 2 per year which includes X-rays, fillings and simple extractions.

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 <u>excluded services</u> .)		
• Cosmetic Surgery • Weight loss programs	• Long-term care • Routine foot care	• Routine eye care (Adult) • Private duty

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 • Skilled nursing facility • Infertility Treatment (except IVF)	• Dental (Adult-preventive) • Hearing aids • Non-emergency care when traveling abroad • Residential treatment center	• Mental health • Applied Behavior Analysis • Virtual Visits • Weight loss drugs

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 <https://www.opm.gov/healthcare-insurance/healthcare>. 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, 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 1-800-222-2798.

[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, kwijigo 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 <u>deductible</u>	\$450
■ <u>Specialist</u> copay	\$25
■ 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
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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 <u>deductible</u>	\$450
■ <u>Specialist</u> copay	\$25
■ 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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$100
Coinsurance	\$285
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$385

Mia's Simple Fracture

(in-network emergency room visit and follow-up care)

■ The plan's overall <u>deductible</u>	\$450
■ <u>Specialist</u> copay	\$25
■ Hospital (facility) <i>coinsurance</i>	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
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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	\$0