



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 PSHB Plan brochure (71-019) that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the PSHB 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 PSHB Plan brochure at [www.apwuhp.com](http://www.apwuhp.com), and view the Glossary at [www.apwuhp.com](http://www.apwuhp.com). You can call 1-800-222-2798 to request a copy of either document. Visit <https://www.health-benefits.opm.gov/psbh> for more information on PSHB program.

| Important Questions                                                 | Answers                                                                                                                                                                                   |                                                                                                                          | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
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| What is the overall <u>deductible</u> ?                             | <b>In-Network:</b><br><u>\$450</u> /Self Only<br><u>\$800</u> /Self Plus One<br><u>\$800</u> /Self Plus Family                                                                            | <b>Out-of-Network:</b><br><u>\$1,000</u> /Self Only<br><u>\$2,000</u> /Self Plus One<br><u>\$2,000</u> /Self Plus Family | Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> 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. 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. "For example, this <u>plan</u> covers certain <u>preventive services</u> without cost sharing and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                                                                                           |
| 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> ?       | <b>In-Network:</b><br><u>\$6,500</u> /Self Only<br><u>\$13,000</u> /Self Plus Family                                                                                                      | <b>Out-of-Network:</b><br><u>\$12,000</u> /Self Only<br><u>\$24,000</u> /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 hospitals                                                                                         |                                                                                                                          | 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 <a href="http://www.apwuhp.com/our-plans/see-provider-networks/">www.apwuhp.com/our-plans/see-provider-networks/</a> 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 (balance billing). 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 <u>provider</u> before you get services. |
| <b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b> | No. | You can see the <u>specialist</u> you choose without a <u>referral</u> .                                                                                                                                                                                   |

 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<br>(You will pay the least)                                                                                       | Out-of-Network Provider<br>(You will pay the most, plus you may be balance billed) |                                                                                                                                                                             |
| <b>If you visit a health care <u>provider's</u> office or clinic</b> | <u>Primary care</u> visit to treat an injury or illness | \$25 copayment (No <u>deductible</u> applies).                                                                                     | 40% <u>coinsurance</u>                                                             | Teladoc Telehealth Visits – first two visits are free with no member cost share; \$10 <u>copayment</u> (no <u>deductible</u> ) after first two.                             |
|                                                                      | <u>Specialist</u> visit                                 | \$25 copayment (No <u>deductible</u> applies).                                                                                     | 40% <u>coinsurance</u>                                                             | No referral needed. No deductible.                                                                                                                                          |
|                                                                      | <u>Preventive care/screening/immunization</u>           | Nothing (No <u>deductible</u> applies).                                                                                            | 40% <u>coinsurance</u>                                                             | One routine exam per person every calendar year. Services recommended under the Patient Protection and Affordable Care Act paid at 100% using <u>in-network providers</u> . |
| <b>If you have a test</b>                                            | <u>Diagnostic test</u> (x-ray, blood work)              | Nothing for LabCorp and Quest Diagnostics locations (No <u>deductible</u> applies); 15% <u>coinsurance</u> for all other locations | 40% <u>coinsurance</u>                                                             | <u>Authorization</u> is required for genetic testing.                                                                                                                       |
|                                                                      | Imaging (CT/PET scans, MRIs)                            | 15% <u>coinsurance</u>                                                                                                             | 40% <u>coinsurance</u>                                                             | <u>Authorization</u> required, benefits reduced by \$100 for noncompliance.                                                                                                 |

| Common Medical Event                                                                                                                                                                             | Services You May Need                          | What You Will Pay                                                                                                                                                                                                                 |                                                                                                                                | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                  |                                                | Network Provider<br>(You will pay the least)                                                                                                                                                                                      | Out-of-Network Provider<br>(You will pay the most, plus you may be balance billed)                                             |                                                                                                                                                                                                                                         |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <u>prescription drug coverage</u> is available at <a href="#">Open Enrollment - Pharmacy Benefit Plans</a> | Generic drugs<br>Tier 1 drugs                  | \$10 <u>copayment</u> (retail);<br>\$20 <u>copayment</u> (mail order)                                                                                                                                                             | 50% <u>coinsurance</u>                                                                                                         | No <u>deductible</u> applies.<br><br>Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription).<br><br>Coverage review (prior authorization) is required for certain FDA-approved prescription drugs. |
|                                                                                                                                                                                                  | Preferred brand drugs<br>Tier 2 drugs          | 25% <u>coinsurance</u><br>retail max \$200; mail order max \$300                                                                                                                                                                  | 50% <u>coinsurance</u>                                                                                                         |                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                  | Non-preferred brand drugs<br>Tier 3 drugs      | 45% <u>coinsurance</u><br>retail max \$300; mail order max \$500                                                                                                                                                                  | 50% <u>coinsurance</u>                                                                                                         |                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                  | <u>Specialty drugs</u>                         | Tier 4-25% <u>coinsurance</u><br>retail max \$300; mail order max \$150; Tier 5-25% <u>coinsurance</u><br>retail max \$600; mail order max \$300; Tier 6-45% <u>coinsurance</u><br>retail max is \$1,000; mail order max is \$500 | 50% <u>coinsurance</u>                                                                                                         |                                                                                                                                                                                                                                         |
| <b>If you have outpatient surgery</b>                                                                                                                                                            | 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                                                                                                                                                                              |
| <b>If you need immediate medical attention</b>                                                                                                                                                   | <u>Emergency room care</u>                     | 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)                                                                                                                                                                             | 15% <u>coinsurance</u> (No <u>deductible</u> applies)<br>15% <u>coinsurance</u> (air ambulance) (No <u>deductible</u> applies) |                                                                                                                                                                                                                                         |

| Common Medical Event                                                             | Services You May Need                     | What You Will Pay                                                             |                                                                                    | Limitations, Exceptions, & Other Important Information                                                                          |
|----------------------------------------------------------------------------------|-------------------------------------------|-------------------------------------------------------------------------------|------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|
|                                                                                  |                                           | Network Provider<br>(You will pay the least)                                  | Out-of-Network Provider<br>(You will pay the most, plus you may be balance billed) |                                                                                                                                 |
|                                                                                  | <u>Urgent care</u>                        | \$30 <u>copayment</u> (No deductible applies)                                 | 40% <u>coinsurance</u>                                                             |                                                                                                                                 |
| <b>If you have a hospital stay</b>                                               | Facility fee (e.g., hospital room)        | 15% <u>coinsurance</u> (No deductible 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.                                                                            |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | 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.                                                     |
| <b>If you are pregnant</b>                                                       | 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                                                                                                                            |
| <b>If you need help recovering or have other special health needs</b>            | <u>Home health care</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                                             | Any amount over the annual max of                                                  | 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<br>(You will pay the least)            | Out-of-Network Provider<br>(You will pay the most, plus you may be balance billed) |                                                                                                |
|                                        |                            | \$15,000 for combined outpatient and inpatient services | \$15,000 for combined outpatient and inpatient services                            |                                                                                                |
| 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 deductible applies)          | 30% <u>coinsurance</u> (No deductible 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 PSHB Plan brochure for more information and a list of any other excluded services.)                                                       |                                                                                                                                                                                           |                                                                                                                                                       |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <ul style="list-style-type: none"> <li>Cosmetic Surgery</li> <li>Routine foot care</li> </ul>                                                                                                     | <ul style="list-style-type: none"> <li>Long-term care</li> <li>Private Duty</li> </ul>                                                                                                    | <ul style="list-style-type: none"> <li>Routine eye care (Adult)</li> <li>Gender Affirming Care (chemical or surgical modification )</li> </ul>        |  |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your PSHB Plan brochure.)                                                                 |                                                                                                                                                                                           |                                                                                                                                                       |  |
| <ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric Surgery</li> <li>Chiropractic care</li> <li>Skilled nursing facility</li> <li>Infertility Treatment (except IVF)</li> </ul> | <ul style="list-style-type: none"> <li>Dental (Adult-preventive)</li> <li>Hearing aids</li> <li>Non-emergency care when traveling abroad</li> <li>Residential treatment center</li> </ul> | <ul style="list-style-type: none"> <li>Mental health</li> <li>Applied Behavior Analysis</li> <li>Virtual Visits</li> <li>Weight loss drugs</li> </ul> |  |

**Your Rights to Continue Coverage:** You can get help if you want to continue your coverage after it ends. See the PSHB Plan brochure, contact your HR office/retirement system, contact your plan at 800-222-2798 or visit <https://www.health-benefits.opm.gov/pshb>. 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-PSHB individual policy), spouse equity coverage, or 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](http://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 PSHB Plan brochure. If you need assistance, you can contact: [www.apwuhp.com](http://www.apwuhp.com).

#### Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid,

CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**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): Dinekehgo 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> [ <u>cost sharing</u> ]   | \$25  |
| ■ Hospital (facility) [ <u>cost sharing</u> ] | 15%   |
| ■ Other [ <u>cost sharing</u> ]               | 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

**In this example, Peg would pay:**

| <i>Cost Sharing</i>               |            |
|-----------------------------------|------------|
| <u>Deductibles</u>                | \$0        |
| <u>Copayments</u>                 | \$0        |
| <u>Coinsurance</u>                | \$0        |
| <i>What isn't covered</i>         |            |
| Limits or exclusions              | \$0        |
| <b>The total Peg would pay is</b> | <b>\$0</b> |

### 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> [ <u>cost sharing</u> ]   | \$25  |
| ■ Hospital (facility) [ <u>cost sharing</u> ] | 15%   |
| ■ Other [ <u>cost sharing</u> ]               | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

**In this example, Joe would pay:**

| <i>Cost Sharing</i>               |              |
|-----------------------------------|--------------|
| <u>Deductibles</u>                | \$0          |
| <u>Copayments</u>                 | \$100        |
| <u>Coinsurance</u>                | \$285        |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Joe would pay is</b> | <b>\$385</b> |

### Mia's Simple Fracture

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

|                                               |       |
|-----------------------------------------------|-------|
| ■ The plan's overall <u>deductible</u>        | \$450 |
| ■ <u>Specialist</u> [ <u>cost sharing</u> ]   | \$25  |
| ■ Hospital (facility) [ <u>cost sharing</u> ] | 15%   |
| ■ Other [ <u>cost sharing</u> ]               | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

**In this example, Mia would pay:**

| <i>Cost Sharing</i>               |            |
|-----------------------------------|------------|
| <u>Deductibles</u>                | \$0        |
| <u>Copayments</u>                 | \$0        |
| <u>Coinsurance</u>                | \$0        |
| <i>What isn't covered</i>         |            |
| Limits or exclusions              | \$0        |
| <b>The total Mia would pay is</b> | <b>\$0</b> |