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 , and view the Glossary at www.apwuhp.com. You can call 1-800-222-2798 to request a copy of either document. Visit https://www.health-benefits.opm.gov/pshb for more information on PSHB program.

Important Questions	Answers		Why This Matters:
What is the Personal Care Account (PCA)?	$1,200 /Self Only $2,400 /Self Plus One $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:** $1,000 /Self Only $2,000 /Self Plus One $2,000 /Self and Family	**Out-of-Network: Net-Deductible** $1,500 /Self Only $3,000 /Self Plus One $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 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 deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes: In-network preventive care 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. "For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.		You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**In-Network:** $6,500 /Self Only $13,000 /Self Plus Family	**Out-of-Network:** $12,000 /Self Only $24,000 /Self Plus Family	The out-of-pocket limit, 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 out-of-pocket limits until the overall family out-of-pocket limit has been met.

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. See www.apwuhp.com/our-plans/see-provider-networks/ or call 800-222-2798 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 a referral.

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	15% coinsurance	50% coinsurance	None.
	Specialist visit	15% coinsurance	50% coinsurance	No referral needed.
	Preventive care/screening/ immunization	Nothing (No deductible applies).	All charges once PCA is exhausted	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	Authorization is required for genetic testing.
	Imaging (CT/PET scans, MRIs)	15% coinsurance	50% coinsurance	Authorization 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 (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.[insert].com	Generic drugs Tier 1 drugs	25% coinsurance with a max of $200 retail and $600 mail order	All charges	Deductible applies. 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.
	Preferred brand drugs Tier 2 drugs	25% coinsurance with a max of $200 retail and $600 mail order	All charges	
	Non-preferred brand drugs Tier 3 drugs	40% coinsurance with a max of $300 retail and $900 mail order	All charges	
	Specialty drugs	See tiers 1-3	All charges	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	50% coinsurance	Authorization required for some services.
	Physician/surgeon fees	15% coinsurance	50% coinsurance	Authorization required for some services.
If you need immediate medical attention	Emergency room care	15% coinsurance	15% coinsurance	None
	Emergency medical transportation	15% coinsurance	15% coinsurance (air ambulance)	None
	Urgent care	15% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	50% coinsurance	Authorization required
	Physician/surgeon fees	15% coinsurance	50% coinsurance	Authorization required for certain surgeries.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% coinsurance	50% coinsurance	No Authorization required for office visits but may be required for certain procedures.
	Inpatient services	15% coinsurance	50% coinsurance	Authorization required.
If you are pregnant	Office visits	Nothing (No Deductible Applies)	50% coinsurance	None
	Childbirth/delivery professional services	Nothing (No Deductible Applies)	50% coinsurance	None
	Childbirth/delivery facility services	Nothing (No Deductible Applies)	50% 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	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	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	Authorization 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	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 PSHB Plan brochure for more information and a list of any other excluded services.)

- Cosmetic Surgery
- Weight loss programs
- Routine Dental
- 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 PSHB Plan brochure.)

- Acupuncture
- Bariatric Surgery
- Hearing aids
- Non-emergency care when traveling abroad
- Mental health
- Applied Behavior Analysis

- Chiropractic care
- Skilled nursing facility
- Infertility Treatment (except IVF)
- 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 PSHB Plan brochure, contact your HR office/retirement system, contact your plan at [contact number] 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 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: [insert applicable contact information from instructions].

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): 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	**$450**
Specialist *[cost sharing]*	**$25**
Hospital (facility) *[cost sharing]*	**15%**
Other *[cost sharing]*	**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	**$450**
Specialist *[cost sharing]*	**$25**
Hospital (facility) *[cost sharing]*	**15%**
Other *[cost sharing]*	**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	**$5,600**

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 deductible	**$450**
Specialist *[cost sharing]*	**$25**
Hospital (facility) *[cost sharing]*	**15%**
Other *[cost sharing]*	**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	**$2,800**

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**

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