# APWU Health Plan: Consumer Driven Option

**Summary of Benefits and Coverage**

**Coverage Period: 01/01/2015-12/31/2015**

**Coverage for: Self Only -or- Self and Family | Plan Type: FFS**

**This is only a summary.** Please read the FEHB Plan brochure (RI 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. You can get the FEHB Plan brochure at www.apwuhp.com or by calling 1-800-222-APWU (2798).

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the Personal Care Account (PCA)?** | $1,200 person/$2,400 family | Your PCA is an allowed amount used to pay for **covered** services at 100%. Any unused amount rolls over annually up to a max of $5,000 person/$10,000 family. |
| **What is the overall deductible?** | $600 person/$1,200 family | Your Deductible is the amount you must pay if you have exhausted your Personal Care Account, before your Traditional Health Coverage begins. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out–of–pocket limit on my expenses?** | Yes. In-network-$3,000 self/$4,500 family<br>Out-of-network-$9,000 self/$9,000 family | The out-of-pocket limit, or catastrophic maximum**,** is the most you could pay during the year for your share of the cost of covered services. Prescriptions: Covered expenses from a network pharmacy count toward this limit. |
| **What is not included in the out–of–pocket limit?** | Premiums, balance billed charges and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. For a list of in-network providers, see www.welcometouhc.com/apwu | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. [We use the terms **preferred** or participating for **providers** in our **network**.] See the chart starting on page 2 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | No. | You can see the specialist you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 4. See this plan's FEHB brochure for additional information about **excluded services**. |

**Questions:** Call 1-800-718-1299 or visit us at **welcometouhc.com/apwu** .
If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at **www.apwuhp.com** or call 1-866-444-3272 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event *(After your Personal Care Account is exhausted and deductible met)* | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider (plus you may be balance billed) | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | 15% coinsurance | 40% coinsurance | ----------none---------- |
| | Specialist visit | 15% coinsurance | 40% coinsurance | ----------none---------- |
| | Other practitioner office visit | 15% coinsurance | 40% coinsurance | Chiropractor-12 visits/manipulations per year.<br>Acupuncture-by a doctor of medicine or osteopathy, or licensed acupuncturist. |
| | Preventive care/screening/immunization | Nothing | You pay 100% after PCA is exhausted | One Routine Exam per person every calendar year.<br>Services recommended under the Patient Protection and Affordable Care Act paid at 100% with in-network providers. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 15% coinsurance | 40% coinsurance | ----------none---------- |
| | Imaging (CT/PET scans, MRIs) | 15% coinsurance | 40% coinsurance | ----------none---------- |

| Common Medical Event *(After your Personal Care Account is exhausted and deductible met)* | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider (plus you may be balance billed) | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.apwuhp.com. | Generic drugs | 25% coinsurance with a minimum of $15 Retail & $10 Mail Order | Not covered | Covers up to a 90 day supply (retail or mail order prescription) |
| | Preferred brand drugs | 25% coinsurance with a minimum of $15 Retail & $10 Mail Order | Not covered | Coinsurance maximum-<br>$200/30 day supply<br>$400/60 day supply<br>$600/90 day supply<br><br>Coverage review (prior authorization) is required for certain FDA-approved prescription drugs. |
| | Non-preferred brand drugs | 25% coinsurance with a minimum of $15 Retail & $10 Mail Order | Not covered | |
| | Specialty drugs | 25% coinsurance with a minimum of $15 Retail & $10 Mail Order | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 15% coinsurance | 40% coinsurance | ----------none---------- |
| | Physician/surgeon fees | 15% coinsurance | 40% coinsurance | ----------none---------- |
| **If you need immediate medical attention** | Emergency room services | 15% coinsurance | 15% coinsurance | Must receive care within 24 hours of injury. |
| | Emergency medical transportation | 15% coinsurance | 15% coinsurance | Within 24 hours of Medical emergency, air ambulance if medically necessary. |
| | Urgent care | 15% coinsurance | 15% coinsurance | ----------none---------- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 15% coinsurance | 40% coinsurance | Precertification required, benefits reduced by $500 for noncompliance. |
| | Physician/surgeon fee | 15% coinsurance | 40% coinsurance | ----------none---------- |

| Common Medical Event *(After your Personal Care Account is exhausted and deductible met)* | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider (plus you may be balance billed) | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | 15% coinsurance | 40% coinsurance | No preauthorization required for office visits, but maybe required for certain procedures. |
| | Mental/Behavioral health inpatient services | 15% coinsurance | 40% coinsurance | Preauthorization required, benefits reduced by $500 for noncompliance. |
| | Substance use disorder outpatient services | 15% coinsurance | 40% coinsurance | No preauthorization required for office visits, but maybe required for certain procedures. |
| | Substance use disorder inpatient services | 15% coinsurance | 40% coinsurance | Preauthorization required, benefits reduced by $500 for noncompliance. |
| **If you are pregnant** | Prenatal and postnatal care | Nothing | 40% coinsurance | ----------none---------- |
| | Delivery and all inpatient services | Nothing | 40% coinsurance | ----------none---------- |

| Common Medical Event *(After your Personal Care Account is exhausted and deductible met)* | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider (plus you may be balance billed) | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need help recovering or have other special health needs** | Home health care | 15% coinsurance | 40% coinsurance | 25 home visits per calendar year (combined with Skilled Nursing Care), not to exceed a maximum Plan payment of $90 per day. Pre-notification is required. |
| | Rehabilitation services | 15% coinsurance | 40% coinsurance | 60 visits per calendar year for PT/OT/ST combined. |
| | Habilitation services | 15% coinsurance | 40% coinsurance | 60 visits per calendar year for PT/OT/ST combined. |
| | Skilled nursing care | 15% coinsurance | 40% coinsurance | Refer to Home Health Care. Pre-notification is required. |
| | Durable medical equipment | 15% coinsurance | 40% coinsurance | Pre-notification is required. |
| | Hospice service | Any amount over the annual maximums of $3,000 outpatient service, $2,000 inpatient services, and $200 bereavement benefit. | Any amount over the annual maximums of $3,000 outpatient service, $2,000 inpatient services, and $200 bereavement benefit. | ----------none---------- |
| **If your child needs dental or eye care** | Eye exam | Not covered | Not covered | A portion of your PCA can be applied. |
| | Glasses | Not covered | Not covered | A portion of your PCA can be applied. |
| | Dental check-up | Not covered | Not covered | A portion of your PCA can be applied. |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover (This isn't a complete list. Check this plan's FEHB brochure for other excluded services.)**

- Cosmetic Surgery
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss program

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**Other Covered Services** **(This isn't a complete list. Check this plan's FEHB brochure for other covered services and your costs for these services.)**

- Acupuncture (MD/DO/LAC only)
- Bariatric surgery
- Hearing aids
- Chiropractic care
- Medically necessary care when traveling outside the U.S

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, to convert to an individual policy, and to receive temporary continuation of coverage (TCC). Your TCC rights will be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. An individual policy may also provide different benefits than you had while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, see the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at 1-800-222-APWU or visit www.opm.gov/insure/health.

## Your Appeal 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: Call 1-800-222-2798 (APWU) or visit www.apwuhp.com

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **Coverage under this plan qualifies as minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **The health coverage of this plan does meet the minimum value standard for the benefits the plan provides**

## 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 page.*

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,540
- **Patient pays** $0

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| Total | $7,540 |

**Patient pays:**

| | |
|---|---|
| Deductibles | $0 |
| Copays | $0 |
| Coinsurance | $0 |
| Limits or exclusions | $0 |
| Total | $0 |

For more information, please contact: 1-800-718-1299.

### Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $5400
- **Patient pays** $0

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| Total | $5,400 |

**Patient pays:**

| | |
|---|---|
| Deductibles | $0 |
| Copays | $0 |
| Coinsurance | $0 |
| Limits or exclusions | $0 |
| Total | $0 |

Note: These numbers assume the patient is participating in our diabetes management program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes management program, please contact: 1-800-718-1299.

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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