



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 deductible?	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 deductible amount before this plan begins to pay. 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: Preventive services , office visits, virtual visits, urgent care, prescription drugs, maternity, some lab work, hearing aids, chiropractic care and acupuncture.		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/
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 One and Self Plus Family	Out-of-Network: \$15,000 /Self Only \$30,000 /Self Plus One and 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 billing) charges, \$300 copayment for Non-PPO.		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 https://www.apwuhp.com/federal-member/find-provider/ 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 healthcare provider's office or clinic	<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> .
If you have a test	<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.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at welcome.optumrx.com/apwuhp (www.apwuhp.com)	Tier 1 drugs	\$10 <u>copayment</u> (retail); \$20 <u>copayment</u> (mail order)	50% coinsurance	No <u>deductible</u> applies.
	Tier 2 drugs	25% <u>coinsurance</u> 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% <u>coinsurance</u> retail max \$300; mail order max \$500	50% coinsurance	
	Diabetes medication	Insulin: \$25 <u>copayment</u> – 30-day \$75 <u>copayment</u> – 90-day	50% coinsurance	Coverage review (prior authorization) is required for certain FDA-approved prescription drugs.

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)	
		Generic oral meds, formulary lancets and test strips: \$0 mail order		
	<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	<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)	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>	
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.

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 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.
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 • Long-term care	• Private duty	• Routine eye care (Adult) • Routine 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 • Chiropractic care	• Dental (Adult-preventive) • Hearing aids • Infertility Treatment (except IVF)	• Non-emergency care when traveling abroad • Weight loss program

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, kwijijigo 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 copayment</u>	\$25
■ Hospital (facility) <u>coinsurance</u>	15%
■ Other <u>coinsurance</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)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$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 copayment</u>	\$25
■ Hospital (facility) <u>coinsurance</u>	15%
■ Other <u>coinsurance</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)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$22
The total Joe would pay is	\$220

Mia's Simple Fracture

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

■ The plan's overall <u>deductible</u>	\$450
■ <u>Specialist copayment</u>	\$25
■ Hospital (facility) <u>coinsurance</u>	15%
■ Other <u>coinsurance</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)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$55
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is (Mia has previously met her \$450 deductible)	\$55

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