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 FEHB Plan brochure (RI 71-014) 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 at www.geha.com and view the Glossary at www.healthcare.gov/sbc-glossary. You can call 1-800-821-6136 to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For participating providers $1,500 Self Only $3,000 Self Plus One or Self and Family For non-participating providers $3,000 Self Only $6,000 Self Plus One or Self and 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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care	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?	For participating providers $5,000 Self Only $10,000 Self Plus One or Self and Family (one individual not to exceed $5,000) For non-participating providers $7,000 Self Only $14,000 Self Plus One or Self and Family (one individual not to exceed $7,000)	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 must be met.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, any penalties, non-covered drugs, and services your health care plan does not cover.	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.geha.com or call 1-800-296-0776 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	5% after deductible	25% after deductible	None
	Specialist visit	5% after deductible	25% after deductible	None
	Other practitioner office visit	5% after deductible for acupuncture. Manipulative therapy of the spine subject to balance billing.	25% after deductible for acupuncture. Manipulative therapy of the spine subject to balance billing.	Acupuncture limited to 20 visits/year with a licensed covered provider. Manipulative therapy of the spine limited to $20/visit, 20 visits/year, and $25/year for spinal manipulation related X-rays.
	Preventive care/screening/ immunization	No charge	25% after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.

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 test	Diagnostic test (x-ray, blood work)	5% after deductible	25% after deductible	None
	Imaging (CT/PET scans, MRIs)	5% after deductible	25% after deductible	Must be pre-authorized. If not, payment reduced by $100; or care may not be covered.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.geha.com	Generic drugs	25% after deductible	Same as in-network pharmacy, plus you pay excess over our in-network drug cost.	90 day supplies are available at a participating Extended Day Supply (EDS) network pharmacy or through mail order. You pay in full at an out-of-network pharmacy and submit for reimbursement. Brand name when generic available – same as generic drug, plus the difference in cost of generic and brand name.
	Preferred brand drugs	25% after deductible	Same as in-network pharmacy, plus you pay excess over our in-network drug cost.	
	Non-preferred brand drugs	25% after deductible	Same as in-network pharmacy, plus you pay excess over our in-network drug cost.	
	Specialty drugs	From CVS Specialty Pharmacy 25% after deductible	Same as in-network pharmacy, plus you pay excess over our in-network drug cost.	Maximum day supply per fill is 30 days. Some specialty medications may not be available in a 30-day supply. Brand name when generic available – same as generic drug, plus the difference in cost of generic and brand name.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	5% after deductible	25% after deductible	Some services must be pre-authorized. If not, care may not be covered.
	Physician/surgeon fees	5% after deductible	25% after deductible	Some services must be pre-authorized. If not, care may not be covered.

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 immediate medical attention	Emergency room care	5% after deductible	5% after deductible for medical emergency. 25% after deductible for other.	None
	Emergency medical transportation	5% after deductible	5% after deductible	Air ambulance must be pre-authorized. If not medically necessary, services will not be covered. For ground transportation, member is responsible for all charges over 100 miles when medically necessary treatment is available within 100 miles.
	Urgent care	5% after deductible	25% after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	5% after deductible	25% after deductible	Semi-private room. Must be pre-authorized. If not, payment reduced by $500; or care may not be covered.
	Physician/surgeon fees	5% after deductible	25% after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	5% after deductible	25% after deductible	Psychological testing must be pre-authorized. If not, care may not be covered.
	Inpatient services	5% after deductible	25% after deductible	Semi-private room. Must be pre-authorized. If not, payment reduced by $500; or care may not be covered.
If you are pregnant	Office visits	No charge after deductible	25% after deductible	None
	Childbirth/delivery professional services	No charge after deductible	25% after deductible	None
	Childbirth/delivery facility services	No charge after deductible	25% after deductible	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	5% after deductible	25% after deductible	Must be pre-authorized. If not, care may not be covered. Limited to 50 2-hour visits/year with an RN, LPN or MSW.
	Rehabilitation services	5% after deductible	25% after deductible	Outpatient only. Must be pre-authorized. If not, care may not be covered. Limited to 60 visits/year combined by qualified physical/occupational/speech therapist per person per year.
	Habilitation services	5% after deductible	25% after deductible	Outpatient only. Must be pre-authorized. If not, care may not be covered. Limited to 60 visits/year combined by qualified physical/occupational/speech therapist per person per year.
	Skilled nursing care	Nothing after deductible, up to limit of $700/day for the first 21 days.	Nothing after deductible, up to limit of $700/day for the first 21 days. Subject to balance-billing.	Facility only. Must be pre-authorized. If not, care may not be covered. Limited to $700/day for the first 21 days after transfer from an acute care hospital.
	Durable medical equipment	5% after deductible	25% after deductible	Must be pre-authorized. If not, equipment may not be covered.
	Hospice services	5% up to plan limits. Deductible applies.	25% up to plan limits. Deductible applies.	Coverage limited to $15,000/period of care for combined in-patient and out-patient care.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	One routine eye exam per calendar year. Additional benefits available through EyeMed.
	Children's glasses	Frames - you pay nothing if price of frame is $100 or less. Most lenses - $10 copay	Frames reimbursed up to $45. Reimbursement on lenses depends on the type of lens.	Benefits available through EyeMed. Frequency and dollar limits apply.
	Children's dental check-up	No Charge	All charges in excess of the plan allowance	100% coverage is limited to two exams, cleanings, and fluoride/year; dental X-rays are limited to $150/year.

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 excluded services.)

- Cosmetic surgery
- Long-term care
- Over-the-counter medications
- Private-duty nursing
- Weight loss programs

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
- Dental care (adult)
- Hearing aids
- Infertility treatment
- Manipulative therapy of the spine
- Routine eye care (adult)
- Non-emergency care while traveling outside the U.S. (see www.geha.com/outsideusa).
- Routine foot care for certain diagnoses

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 1-800-821-6136 or visit www.opm.gov/insure/health. 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-FEHB individual policy), 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 contact: GEHA at 1-800-821-6136.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-800-821-6136.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-821-6136.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-800-821-6136.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-821-6136.

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	$1,500
Specialist copayment	5%
Hospital (facility) coinsurance	5%
Other coinsurance	5%

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	$1,500
Copayments	$0
Coinsurance	$10
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,570

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,500
Specialist copayment	5%
Hospital (facility) coinsurance	5%
Other coinsurance	5%

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

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$1,280
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	$2,810

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,500
Specialist copayment	5%
Hospital (facility) coinsurance	5%
Other coinsurance	5%

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

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,520

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