




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 (RI 71-006) 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](http://www.geha.com), and view the Glossary at <https://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:  |
|--|---|--|
| <p><b>What is the overall <u>deductible</u>?</b></p>                             | <p><u>For in-network providers</u><br/> <b>\$ 350</b> / Self Only<br/> <b>\$ 700</b> / Self Plus One<br/> <b>\$ 700</b> / Self and Family</p> <p><u>For out-of-network providers</u><br/> <b>\$ 700</b> / Self Only<br/> <b>\$ 1,400</b> / Self Plus One<br/> <b>\$ 1,400</b> / Self and Family</p>                                     | <p>Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. <u>Copayments</u> and <u>coinsurance</u> amounts do not count toward your <u>deductible</u>, which generally starts over January 1. When a covered service/supply is subject to a <u>deductible</u>, only the <u>Plan</u> allowance for the service/supply counts toward the <u>deductible</u>. If you have other family members on the <u>plan</u>, 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>.</p> |
| <p><b>Are there services covered before you meet your <u>deductible</u>?</b></p> | <p>Yes. <u>Preventive care</u>, Office visits, <u>Urgent Care</u> visits, <u>In-Network</u> Maternity care and <u>Prescription drugs</u>.</p>   | <p>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 <u>cost sharing</u> 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>.</p>  |
| <p><b>Are there other <u>deductibles</u> for specific services?</b></p>          | <p>No.</p>  | <p>You don't have to meet <u>deductibles</u> for specific services.</p>  |
| <p><b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b></p>       | <p><u>For in-network providers</u><br/> <b>\$6,500</b> Self Only<br/> <b>\$13,000</b> Self Plus One or Self and Family (one individual not to exceed \$6,500)</p> <p><u>For out-of-network providers</u><br/> <b>\$8,500</b> Self Only<br/> <b>\$17,000</b> Self Plus One or Self and Family (one individual not to exceed \$8,500)</p> | <p>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 <u>plan</u>, 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.</p>  |

| Important Questions  | Answers  | Why This Matters:   |
|--|--|---|
| What is not included in the <u>out-of-pocket limit</u> ?   | Premiums, <u>balance-billed</u> charges, any penalties, non-covered drugs, the difference in price between generic and brand name and services your healthcare <u>plan</u> does not cover. | 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.geha.com/find-care">www.geha.com/find-care</a> or call 1-800-296-0776 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 <u>plan's 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 <u>plan</u> pays ( <u>balance billing</u> ). 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. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ? | 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) |   |
| If you visit a <u>healthcare provider's office</u> or <u>clinic</u> | <u>Primary care</u> visit to treat an injury or illness | \$20 / visit<br><u>Deductible</u> does not apply  | 35% <u>coinsurance</u> after <u>deductible</u>                                     | None  |
|   | <u>Specialist</u> visit                                 | \$35 / visit<br><u>Deductible</u> does not apply  | 35% <u>coinsurance</u> after <u>deductible</u>                                     | None  |
|   | <u>Preventive care/screening/immunization</u>           | No charge   | 35% <u>coinsurance</u> after <u>deductible</u>                                     | You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. |
| If you have a test  | <u>Diagnostic test</u> (x-ray, blood work)              | 15% <u>coinsurance</u> for lab work;<br>15% <u>coinsurance</u> after <u>deductible</u> for x-rays | 35% <u>coinsurance</u> after <u>deductible</u>                                     | Outpatient lab work at QuestSelect locations is available at no charge.   |
|   | Imaging (CT/PET scans, MRIs)                            | \$100 Professional <u>copayment</u><br>\$150 Facility <u>copayment</u>                            | 35% <u>coinsurance</u> after <u>deductible</u>                                     | Must be <u>pre-authorized</u> . 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<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most, plus you may be balance billed)           |   |
| <p><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="https://info.caremark.com/geha">https://info.caremark.com/geha</a>.</p> | Generic drugs             | <p><b>Retail</b> - \$10 or the cost of the drug, whichever is less per 30-day supply</p> <p><b>Mail order</b> -- \$20 or the cost of the drug whichever is less per 90-day supply</p>                              | Same as <u>in-network</u> pharmacy, plus you pay excess over our <u>in-network</u> drug cost | <p>90-day supplies are available at a participating Extended Day Supply (EDS) <u>network</u> pharmacy or through mail order.</p> <p>You pay in full at an <u>out-of-network</u> pharmacy and submit for reimbursement.</p> <p>Brand name when generic available – same as generic drugs, plus the difference in cost of generic and brand name.</p> |
|  | Preferred brand drugs     | <p><b>Retail</b> – 50% not to exceed \$200 per 30-day supply</p> <p><b>Mail order</b> – 50%, not to exceed \$500 per 90-day supply</p>   | Same as <u>in-network</u> pharmacy, plus you pay excess over our <u>in-network</u> drug cost |   |
|  | Non-preferred brand drugs | <p><b>Retail</b> – 50% not to exceed \$300 per 30-day supply</p> <p><b>Mail order</b> – 50%, not to exceed \$600 per 90-day supply</p>   | Same as <u>in-network</u> pharmacy, plus you pay excess over our <u>in-network</u> drug cost |   |
|  | <u>Specialty drugs</u>    | <p>From CVS Specialty Pharmacy</p> <p><b>Generic and Preferred:</b> 50% up to a maximum of \$250 for up to a 30-day supply</p> <p><b>Non-preferred:</b> 50% up to a maximum of \$400 for up to a 30-day supply</p> | <p>Not covered</p> <p>You pay 100%</p>   |   |

| 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 have outpatient surgery</b>          | Facility fee (e.g., ambulatory surgery center) | 15% <u>coinsurance</u> after <u>deductible</u>   | 35% <u>coinsurance</u> after <u>deductible</u>   | Some services must be <u>pre-authorized</u> . If not, care may not be covered.   |
|  | Physician/surgeon fees                         | 15% <u>coinsurance</u> after <u>deductible</u>   | 35% <u>coinsurance</u> after <u>deductible</u>   | Some services must be <u>pre-authorized</u> . If not, care may not be covered.   |
| <b>If you need immediate medical attention</b> | <u>Emergency room care</u>                     | 15% <u>coinsurance</u> after <u>deductible</u>   | 15% <u>coinsurance</u> after <u>deductible</u> for medical emergency<br>35% <u>coinsurance</u> after <u>deductible</u> for other | None   |
|  | <u>Emergency medical transportation</u>        | 15% <u>coinsurance</u> after <u>deductible</u>   | 15% <u>coinsurance</u> after <u>deductible</u>   | Air ambulance must be <u>pre-authorized</u> . If not <u>medically necessary</u> , services will not be covered.<br>Member is responsible for all charges over 100 miles when <u>medically necessary</u> treatment is available within 100 miles. |
|  | <u>Urgent care</u>                             | \$35 / visit<br><u>Deductible</u> does not apply | 35% <u>coinsurance</u> after <u>deductible</u>   | None   |
| <b>If you have a hospital stay</b>             | Facility fee (e.g., hospital room)             | 15% <u>coinsurance</u> after <u>deductible</u>   | 35% <u>coinsurance</u> after <u>deductible</u>   | Semi-private room.<br>Must be precertified. If not, payment reduced by \$500/admission ( <u>in-network</u> ) or \$500/day ( <u>out-of-network</u> ); or care may not be covered.   |
|  | Physician/surgeon fees                         | 15% <u>coinsurance</u> after <u>deductible</u>   | 35% <u>coinsurance</u> after <u>deductible</u>   | None   |

| 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 mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | \$20 / visit for office visits<br><u>Deductible</u> does not apply<br>15% <u>coinsurance</u> after <u>deductible</u> for other outpatient services | 35% <u>coinsurance</u> after <u>deductible</u>                                     | Psychological testing requires <u>pre-authorization</u> . If not, care may not be covered.   |
|  | Inpatient services                        | 15% <u>coinsurance</u> after <u>deductible</u>   | 35% <u>coinsurance</u> after <u>deductible</u>                                     | Semi-private room.<br>Must be precertified. If not, payment reduced by \$500/admission ( <u>in-network</u> ) or \$500/day ( <u>out-of-network</u> ); or care may not be covered. |
| <b>If you are pregnant</b>   | Office visits                             | No charge  | 35% <u>coinsurance</u> after <u>deductible</u>                                     | None   |
|  | Childbirth/delivery professional services | No charge  | 35% <u>coinsurance</u> after <u>deductible</u>                                     | None   |
|  | Childbirth/delivery facility services     | No charge  | 35% <u>coinsurance</u> after <u>deductible</u>                                     | None   |
| <b>If you need help recovering or have other special health needs</b>            | <u>Home health care</u>                   | 15% <u>coinsurance</u> after <u>deductible</u>   | 35% <u>coinsurance</u> after <u>deductible</u>                                     | Limited to 50 2-hour visits/year with an RN, LPN or MSW.   |
|  | <u>Rehabilitation services</u>            | 15% <u>coinsurance</u> after <u>deductible</u>   | 35% <u>coinsurance</u> after <u>deductible</u>                                     | Outpatient services limited to 60 visits/year combined by qualified physical/occupational/speech therapist per person per year.  |
|  | <u>Habilitation services</u>              | 15% <u>coinsurance</u> after <u>deductible</u>   | 35% <u>coinsurance</u> after <u>deductible</u>                                     | Outpatient services limited to 60 visits/year combined by qualified physical/occupational/speech therapist per person per year.  |

| 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) |  |
| If you need help recovering or have other special health needs | <u>Skilled nursing care</u>      | 15% <u>coinsurance</u> after <u>deductible</u>   | 35% <u>coinsurance</u> after <u>deductible</u>                                     | Facility only. Must be precertified. If not, payment reduced by \$500/admission ( <u>in-network</u> ) or \$500/day ( <u>out-of-network</u> ); or care may not be covered.<br>Limited to 50 days per calendar year. |
|  | <u>Durable medical equipment</u> | 15% <u>coinsurance</u> after <u>deductible</u>   | 35% <u>coinsurance</u> after <u>deductible</u>                                     | Must be <u>pre-authorized</u> .<br>If not, equipment may not be covered.   |
|  | <u>Hospice services</u>          | No charge, up to \$30,000 limit. <u>Deductible</u> applies.  | No charge, up to \$30,000 limit. <u>Deductible</u> applies.                        | Coverage limited to \$30,000/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. Frequency and dollar limits apply.   |
|  | Children's glasses               | Not covered  | Not covered  | Discount program available through EyeMed.   |
|  | Children's dental check-up       | 50% <u>coinsurance</u> ; subject to <u>balance-billing</u> up to the provider's contracted amount. | 50% <u>coinsurance</u> ; subject to <u>balance-billing</u> .                       | Coverage is limited to two exams, cleanings, and fluoride/year; dental X-rays are limited to \$75/year.  |

### Excluded Services & Other Covered Services:

| Services Your <u>Plan</u> Generally Does NOT Cover (Check your FEHB <u>Plan</u> brochure for more information and a list of any other <u>excluded services</u> .) |  |  |
|---|--|--|
| <ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Infertility treatment</li> <li>• Long-term care</li> </ul>                                   | <ul style="list-style-type: none"> <li>• Over-the-counter medications</li> <li>• Private-duty nursing</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care (Adult)</li> <li>• Weight loss programs</li> </ul>   |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your FEHB <u>Plan</u> brochure.)                          |  |  |
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Chiropractic care (manipulative therapy)</li> </ul>                  | <ul style="list-style-type: none"> <li>• Dental care (adult)</li> <li>• Hearing aids</li> </ul>                  | <ul style="list-style-type: none"> <li>• Non-emergency care while traveling outside the U.S. (see <a href="http://www.geha.com/outsideusa">www.geha.com/outsideusa</a>).</li> <li>• Routine foot care for certain diagnoses</li> </ul> |

**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/healthcare-insurance/healthcare](http://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, a conversion policy (a non-FEHB 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 FEHB Plan brochure. If you need assistance, you can contact: GEHA at 1-800-821-6136.

**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 1-800-821-6136.

[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, kwijigo 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 <u>deductible</u>   | \$350 |
| ■ <u>Specialist copayment</u>            | \$35  |
| ■ <u>Hospital (facility) coinsurance</u> | 15%   |
| ■ <u>Other 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*)

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

In this example, Peg would pay:

| <u>Cost Sharing</u>               |             |
|-----------------------------------|-------------|
| <u>Deductibles</u>                | \$0         |
| <u>Copayments</u>                 | \$10        |
| <u>Coinsurance</u>                | \$0         |
| <i>What isn't covered</i>         |             |
| Limits or exclusions              | \$60        |
| <b>The total Peg would pay is</b> | <b>\$70</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>   | \$350 |
| ■ <u>Specialist copayment</u>            | \$35  |
| ■ <u>Hospital (facility) coinsurance</u> | 15%   |
| ■ <u>Other 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*)

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

In this example, Joe would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$0            |
| <u>Copayments</u>                 | \$280          |
| <u>Coinsurance</u>                | \$1,450        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Joe would pay is</b> | <b>\$1,450</b> |

### Mia's Simple Fracture

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

|  |       |
|--|-------|
| ■ The plan's overall <u>deductible</u>   | \$350 |
| ■ <u>Specialist copayment</u>            | \$35  |
| ■ <u>Hospital (facility) coinsurance</u> | 15%   |
| ■ <u>Other 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*)

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

In this example, Mia would pay:

| <u>Cost Sharing</u>               |              |
|-----------------------------------|--------------|
| <u>Deductibles</u>                | \$350        |
| <u>Copayments</u>                 | \$80         |
| <u>Coinsurance</u>                | \$80         |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$510</b> |

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