Elevate Plus Option: GEHA Coverage for: Self Only, Self Plus One or Self and Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered healthcare services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) will be provided separately.

This is only a summary. Please read the FEHB <u>Plan</u> brochure (RI 71-018) that contains the complete terms of this <u>plan</u>. All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB <u>Plan</u> brochure. Benefits may vary if you have other coverage, such as Medicare. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can get the FEHB <u>Plan</u> brochure at <u>www.geha.com</u>, and view the Glossary at <u>www.healthcare.gov/sbc-glossary</u>. 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 in-network providers \$ 200 / Self Only \$ 400 / Self Plus One \$ 400 / Self and Family For out-of-network providers No coverage	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> .
Are there services covered before you meet your deductible?	Yes. <u>In-network Preventive care</u> , Office visits, <u>Urgent Care</u> visits, Maternity care and <u>Prescription drugs</u> .	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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet deductibles for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$7,000 / Self Only \$14,000 / Self Plus One or Self and Family	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 limit</u> s until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, any penalties, non-covered drugs, the difference in price between generic and brand name, and services your healthcare plan doesn't 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 https://www.geha.com/elevate-find-care or call 1-800-296-0776 for a list of network providers .	This <u>plan</u> uses a <u>provider network</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 specialist you choose without a referral.



	What You Will Pay			
Common Medical Event	Services You May Need	<u>Network Provider</u> (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	\$30 / visit	Not covered You pay 100%	None
If you visit a healthcare provider's office or	Specialist visit	\$50 / visit	Not covered You pay 100%	None
clinic	Preventive care/screening/immunization	No charge	Not covered You pay 100%	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.
If you have a test	Diagnostic test (x-ray, blood work)	No charge for blood work; \$50 for X-rays	Not covered You pay 100%	None
	Imaging (CT/PET scans, MRIs)	\$100 (when billed by professionals). \$75 (billed by facilities)	Not covered You pay 100%	Must be pre-authorized.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://info.caremark.com/geha	Generic drugs	Retail - \$10 or the cost of the drug, whichever is less, per 30-day supply. Mail order –\$20 or the cost of the drug, whichever is less, per 90-day supply.	Not covered You pay 100%	90 day supplies are available at a participating Extended Day Supply (EDS) <u>network</u> pharmacy or through mail order.
	Preferred brand drugs	Retail - \$80 or the cost of the drug, whichever is less, per 30-day supply. Mail order –\$200 or the cost of the drug, whichever is less, per 90-day supply.	Not covered You pay 100%	Limited pharmacy <u>network</u> with no <u>out-of-network</u> coverage. Brand name when generic available – same as generic drugs, plus the difference in cost of
	Non-preferred brand drugs	Retail - 50% of the <u>plan</u> allowance per 30-day supply Mail order – 50% coinsurance	Not covered You pay 100%	generic and brand name.

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Common Medical Event	Services You May Need	<u>Network Provider</u> (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	Limitations, Exceptions, & Other Important Information	
	Specialty drugs	From CVS Specialty Pharmacy, per 30-day supply Generic and Preferred: 40%, not to exceed \$500 Non-preferred: 50%	Not covered You pay 100%	If Specialty drugs are obtained through other sources (physician's office, home health agencies, outpatient hospitals), you will pay an additional copayment of \$500 and any difference between GEHA's allowance and the cost of the drug. The additional \$500 copayment will go towards your out-of-pocket limit. Copayment based on days of therapy. Brand name when generic available – same as generic drugs, plus the difference in cost of generic and brand name.	
	Facility fee (e.g., ambulatory surgery center)	15% <u>coinsurance</u> after <u>deductible</u>	Not covered You pay 100%	Some services must be <u>pre-authorized</u> . If not, care may not be covered.	
If you have outpatient surgery	Physician/ surgeon fees	15% <u>coinsurance</u> after <u>deductible</u>	Not covered You pay 100%	Some services must be <u>pre-authorized</u> . If not, care may not be covered. <u>Copayment</u> applies to surgeries performed in an outpatient facility or office visit setting.	
	Emergency room care	15% <u>coinsurance</u> after <u>deductible</u>	15% <u>coinsurance</u> after <u>deductible</u>	None	
If you need immediate medical attention	Emergency medical transportation	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. Member is responsible for all charges over 100 miles when <u>medically necessary</u> treatment is available within 100 miles.	

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Common Medical Event	Services You May Need	Network Provider / Vou will nay the		Limitations, Exceptions, & Other Important Information	
	Urgent care	\$50 / visit	Not covered You pay 100%	None	
If you have a hospital stay	Facility fee (e.g., hospital room)	15% <u>coinsurance</u> after <u>deductible</u>	Not covered You pay 100%	Semi-private room. Facility only. Must be precertified.	
	Physician/ surgeon fees	15% <u>coinsurance</u> after <u>deductible</u>	Not covered You pay 100%	None	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 / visit for office visits 15% <u>coinsurance</u> after <u>deductible</u> for outpatient facility	Not covered You pay 100%	Psychological testing may require pre- authorization. If not, care may not be covered. Outpatient facility 15% coinsurance after deductible applies for services such as partial hospitalization or intensive day treatment programs, electroconvulsive therapy, and transcranial magnetic stimulation.	
	Inpatient services	15% <u>coinsurance</u> after <u>deductible</u>	Not covered You pay 100%	Semi-private room. Must be precertified. Facility only.	
	Office visits	No charge	Not covered You pay 100%	None	
If you are pregnant	Childbirth/delivery professional services	No charge for routine delivery	Not covered You pay 100%	None	
	Childbirth/delivery facility services	15% <u>coinsurance</u> after <u>deductible</u>	Not covered You pay 100%	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply.	

		What You Will Pay		
Common Medical Event	Services You May Need	<u>Network Provider</u> (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	Limitations, Exceptions, & Other Important Information
	Home healthcare	\$30 / visit	Not covered You pay 100%	Limited to 50 2-hour visits/year with an RN, LPN or MSW.
	Rehabilitation services	\$50 / visit	Not covered You pay 100%	Outpatient services limited to 60 visits/year combined by qualified physical/occupational/speech therapist per person per year.
If you need help recovering or have other special health	Habilitation services	\$50 / visit	Not covered You pay 100%	Outpatient services limited to 60 visits/year combined by qualified physical/occupational/speech therapist per person per year.
needs	Skilled nursing care	15% <u>coinsurance</u> after <u>deductible</u>	Not covered You pay 100%	Facility only. Must be precertified. Limited to 50 days per calendar year.
	Durable medical equipment	15% <u>coinsurance</u> after <u>deductible</u>	Not covered You pay 100%	Must be <u>pre-authorized</u> over \$1,000. If not, equipment may not be covered.
	Hospice services	No charge, up to \$30,000 limit <u>Deductible</u> applies.	Not covered You pay 100%	Coverage limited to \$30,000/period of care for combined in-patient and out-patient care.
	Children's eye exam	Not covered You pay 100%	Not covered You pay 100%	Discount program available through EyeMed.
If your child needs dental or eye care	Children's glasses	Not covered You pay 100%	Not covered You pay 100%	Discount program available through EyeMed.
	Children's dental check-up	Not covered You pay 100%	Not covered You pay 100%	Discount program available through Connection Dental

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your FEHB Plan brochure for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)

- Long-term care
- Private-duty nursing

- Routine eye care (Adult)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your FEHB Plan brochure.)

- Acupuncture
- Bariatric surgery
- Chiropractic care (manipulative therapy)
- Hearing aids
- Infertility treatment

- Non-emergency care while traveling outside the U.S. (Coverage provided outside the United States. See www.geha.com/outsideusa).
- Routine foot care

Your Rights to Continue Coverage: You can get help if you want to continue your coverage after it ends. See the FEHB <u>Plan</u> brochure, contact your HR office/retirement system, contact your <u>plan</u> at 1-800-821-6136 or visit <u>www.opm.gov/healthcare-insurance/healthcare/</u>. Generally, if you lose coverage under the <u>plan</u>, 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 or call 1-800-318-2596.

Your <u>Grievance</u> and <u>Appeals Rights</u>: If you are dissatisfied with a denial of coverage for <u>claims</u> under your <u>plan</u>, you may be able to <u>appeal</u>. For information about your <u>appeal</u> rights please see Section 3, "How you get care," and Section 8 "The disputed <u>claims</u> process," in your FEHB <u>Plan</u> 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, kwiijigo holne' 1-800-821-6136.

To see examples of how this <u>plan</u> 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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of <u>in-network</u> pre-natal care and a hospital delivery)

■ The <u>plan</u> 's overall <u>deductible</u>	\$200
■ Specialist copayment	\$50
■ Hospital (facility)coinsurance	15%
Other coinsurance	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>	\$200		
<u>Copayments</u>	\$10		
<u>Coinsurance</u>	\$1030		
What isn't covered			
Limits or exclusions	\$60		
The total Peg would pay is	\$1300		

Managing Joe's type 2 Diabetes

(a year of routine <u>in-network</u> care of a wellcontrolled condition)

■ The <u>plan</u> 's overall <u>deductible</u>	\$200
■ Specialist copayment	\$50
Hospital (facility) coinsurance	15%
Other coinsurance	15%

This EXAMPLE event includes services like:

<u>Primary care physician</u> 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		
<u>Deductibles</u>	\$0	
Copayments	\$2050	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$0	
The total Joe would pay is	\$2050	

Mia's Simple Fracture

(<u>in-network</u> emergency room visit and follow up care)

■ The plan's overall deductible	\$200
Specialist copayment	\$50
■ Hospital (facility) coinsurance	15%
Other coinsurance	15%

This EXAMPLE event includes services like:

<u>Emergency room care</u> (including medical supplies)

Diagnostic test (x-ray)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

Total Example Cost \$2,

In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$200
Copayments	\$260
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$650