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 PSHB Plan brochure (RI 71-021) that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the PSHB 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 PSHB Plan brochure at www.geha.com, and view the Glossary at www.healthcare.gov/sbc-glossary. You can call 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 **$ 350** / Self Only **$ 700** / Self Plus One **$ 700** / Self and Family For out-of-network providers **$ 700** / Self Only **$ 1,400** / Self Plus One **$ 1,400** / 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 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 care, office visits, urgent care visits, in-network maternity care and prescription drugs.	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 in-network providers **$6,000 /** Self Only **$12,000 /** Self Plus One or Self and Family (one individual not to exceed $6,000) For out-of-network providers **$9,000 /** Self Only **$18,000** Self Plus One or Self and Family (one individual not to exceed $9,000)	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 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 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/Find-Care or call 800-821-6136 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	$20 / visit Deductible does not apply	35% coinsurance after deductible	None
	Specialist visit	$30 / visit Deductible does not apply	35% coinsurance after deductible	None
	Preventive care/screening/ immunization	No charge	35% coinsurance 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. Age and/or diagnosis limitations may apply.
If you have a test	Diagnostic test (x-ray, blood work)	No charge for outpatient lab work; 10% coinsurance after deductible for x-rays	35% coinsurance after deductible	Genetic testing may require preauthorization.
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	35% coinsurance after deductible	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 drugs to treat your illness or condition More information about prescription drug coverage is available at https://info.caremark.com/oe/postalgeha	Generic drugs	**Retail** - $10 initial fill and first refill; subsequent fills, greater of $10 or 50% of drug cost. **Mail order** – $20	Same as in-network pharmacy, plus you pay excess over our in-network drug cost	Maximum day supply per fill is 30 days at retail, 90 days at mail order. Maintenance Choice lets you choose how to get 90-day supplies of your maintenance medications through mail service or at a CVS retail pharmacy. You pay in full at an out-of-network pharmacy and submit for reimbursement. Brand name when generic available – same as generic drugs, plus the difference in cost of generic and brand name
	Preferred brand drugs	**Retail** – 25%, not to exceed $150, initial and first fill; subsequent fills 50%. **Mail order** – 25%, not to exceed $350	Same as in-network pharmacy, plus you pay excess over our in-network drug cost	
	Non-preferred brand drugs	**Retail** – 40% not to exceed $200, initial and first fill; subsequent fills 50%. **Mail order** – 40%, not to exceed $500	Same as in-network pharmacy, plus you pay excess over our in-network drug cost	
	Specialty drugs	From CVS Specialty Pharmacy **Generic and Preferred:** 25% up to a maximum of $150 for up to a 30-day supply **Non-preferred:** 40% up to a maximum of $200 for up to a 30-day supply	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 $300 and any difference between GEHA's allowance and the cost of the drug. The additional $300 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.

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible	35% coinsurance after deductible	Some services must be pre-authorized. If not, care may not be covered.
	Physician/surgeon fees	10% coinsurance after deductible	35% coinsurance after deductible	Some services must be pre-authorized. If not, care may not be covered.
If you need immediate medical attention	Emergency room care	15% coinsurance after deductible No charge for accidental injury with 72 hours.	15% coinsurance after deductible for medical emergency 35% coinsurance after deductible for other. No charge for accidental injury within 72 hours	Coinsurance/deductible applies to accidental injury care after 72 hours.
	Emergency medical transportation	10% coinsurance after deductible No charge for accidental injury	10% coinsurance after deductible No charge for accidental injury.	Air ambulance transportation requires medical necessity review. If not medically necessary, services will not be covered. Post-service review is performed for emergency transportation.. Coinsurance/deductible applies to accidental injury care after 72 hours. For ground transportation, member is responsible for all charges over 100 miles when medically necessary treatment is available within 100 miles.
	Urgent care	$30 / visit Deductible does not apply No charge for accidental injury within 72 hours	35% coinsurance after deductible No charge for accidental injury within 72 hours	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance and $100 per admission copayment	35% coinsurance and $300 per admission copayment	Semi-private room. Must be pre-certified. If not, payment reduced by $500/admission (in-network) or $500/day (out-of-network); or 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)	
	Physician/surgeon fees	10% coinsurance after deductible	35% coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 / visit for office visits, Deductible does not apply. 10% coinsurance after deductible for other outpatient services.	35% coinsurance after deductible	Psychological testing requires pre-authorization. If not, care may not be covered.
	Inpatient services (Including Residential treatment centers)	10% coinsurance and $100 per admission copayment	35% coinsurance after deductible	Semi-private room. Must be pre-certified. If not, payment reduced by $500/admission (in-network) or $500/day (out-of-network); or care may not be covered.
If you are pregnant	Office visits	No charge	35% coinsurance after deductible	None
	Childbirth/delivery professional services	No charge	35% coinsurance after deductible	None
	Childbirth/delivery facility services	No charge	35% coinsurance and $300 per admission copayment	None
If you need help recovering or have other special health needs	Home health care	10% coinsurance after deductible	35% coinsurance after deductible	Limited to 50 2-hour visits/year with an RN, LPN or MSW.
	Rehabilitation services	10% coinsurance after deductible	35% coinsurance after deductible	Outpatient services limited to 60 visits/year combined by qualified physical/occupational/speech therapist per person per year.
	Habilitation services	10% coinsurance after deductible	35% coinsurance after deductible	Outpatient services limited to 60 visits/year combined by qualified physical/occupational/speech therapist per person per year.
	Skilled nursing care	10% coinsurance after deductible	35% coinsurance after deductible	Facility only. Must be pre-certified. If not, payment reduced by $500/admission (in-network) or $500/day (out-of-network); or care may not be covered. Limited 50 days per calendar year.

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)	
	Durable medical equipment	10% coinsurance after deductible	35% coinsurance after deductible	Must be pre-authorized over $1,000. If not, equipment may not be covered.
	Hospice services	No charge, up to $30,000 limit. Deductible applies.	No charge, up to $30,000 limit. Deductible 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	Subject to balance-billing up to the provider's contracted amount	Subject to balance-billing	Coverage is limited to two payments of $22/year.

Excluded Services & Other Covered Services:

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

- Cosmetic surgery
- Long-term care
- Over-the-counter medications
- 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 PSHB Plan brochure.)

- Acupuncture
- Bariatric surgery
- Chiropractic care (manipulative therapy)
- Dental care (adult)
- Hearing aids
- Infertility treatment
- 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 PSHB Plan brochure, contact your HR office/retirement system, contact your plan at 800-821-6136 or visit https://health-benefits.opm.gov/PSHB/. 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-PSHB 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 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 PSHB Plan brochure. If you need assistance, you can contact: GEHA at 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 800-821-6136.

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

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

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 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** **$350**
- **Specialist copayment** **$30**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	$0
Copayments	$30
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$90**

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

- **The plan's overall deductible** **$350**
- **Specialist copayment** **$30**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$270
Coinsurance	$980
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,250**

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

- **The plan's overall deductible** **$350**
- **Specialist copayment** **$30**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$350
Copayments	$70
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$470**

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