




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:
<p>What is the overall deductible?</p>	<p><u>For in-network providers</u> \$ 350 / Self Only \$ 700 / Self Plus One \$ 700 / Self and Family</p> <p><u>For out-of-network providers</u> \$ 1,050 / Self Only \$ 2,100 / Self Plus One \$ 2,100 / 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>Are there services covered before you meet your deductible?</p>	<p>Yes, in-network services including <u>Preventive care</u>, office visits, <u>urgent care</u> visits, 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 https://www.healthcare.gov/coverage/preventive-care-benefits/.</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>You don't have to meet <u>deductibles</u> for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p><u>For in-network providers</u> \$6,000 / Self Only \$12,000 / Self Plus One or Self and Family (one individual not to exceed \$6,000)</p> <p><u>For out-of-network providers</u> \$9,000 / Self Only \$18,000 / Self Plus One or Self and Family (one individual not to exceed \$9,000)</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>

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 www.geha.com/Find-Care or call 800-821-6136 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. An asterisk (*) is added when deductible does not apply.

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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20* / visit	35% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$30* / visit	35% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge*	Child- No charge* Adult -35% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> .
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge* for Lab; 10% <u>coinsurance</u> for other tests	35% <u>coinsurance</u>	Some testing may require preauthorization.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	35% <u>coinsurance</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 (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 <u>prescription drug coverage</u> is available at https://info.caremark.com/oe/postalgeha	Generic drugs	Retail - \$10* /prescription Mail order – \$25*/prescription	Same as <u>in-network</u> pharmacy, plus you pay excess over our <u>in-network</u> drug cost	Maximum day supply per fill is 30 days at retail, 90 days through mail order. Your cost share increases upon the third refill. See Brochure for more information about Maintenance Choice on how to save cost for maintenance medications.
	Preferred brand drugs	Retail – 25%* (up to \$200) Mail order – 25%* (up to \$400)	Same as <u>in-network</u> pharmacy, plus you pay excess over our <u>in-network</u> drug cost	You pay in full at an <u>Out-of-Network</u> Retail pharmacy and can submit for reimbursement. You pay all charges when you use an Out-of-Network Mail Order Provider.
	Non-preferred brand drugs	Retail – 40%* (up to \$300) Mail order – 40%* (up to \$900)	Same as <u>in-network</u> pharmacy, plus you pay excess over our <u>in-network</u> drug cost	Brand name when generic available – same as generic drugs, plus the difference in cost of generic and brand name
	<u>Specialty drugs</u>	Generic and Preferred: 25%* (up to \$200) Non-preferred: 40%* (up to \$300)	Not covered You pay 100%	Services are provided through CVS Specialty Pharmacy. <u>Copayment</u> based on days of therapy (typically 30 days). Brand name when generic available – same as generic drugs, plus the difference in cost of generic and brand name.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	35% <u>coinsurance</u>	Some services must be <u>pre-authorized</u> ; or care may not be covered.
	Physician/surgeon fees	10% <u>coinsurance</u>	35% <u>coinsurance</u>	Some services must be <u>pre-authorized</u> ; or care may not be covered.
If you need immediate medical attention	<u>Emergency room care</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Medical necessity and mileage limitations apply to the nearest facility.
	<u>Urgent care</u>	\$30* / visit	35% <u>coinsurance</u>	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 have a hospital stay	Facility fee (e.g., hospital room)	10%* <u>coinsurance</u> and \$100 per admission <u>copayment</u>	35%* <u>coinsurance</u> and \$300 per admission <u>copayment</u>	Precertification penalty: \$500/admission (<u>in-network</u>) or \$500/day (<u>out-of-network</u>); or care may not be covered.
	Physician/surgeon fees	10% <u>coinsurance</u>	35% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20* / visit for office visits, 10% <u>coinsurance</u> for other outpatient services.	35% <u>coinsurance</u>	Psychological testing requires <u>pre-authorization</u> ; or care may not be covered.
	Inpatient services (Including Residential Treatment Centers)	10%* <u>coinsurance</u> and \$100 per admission <u>copayment</u>	35%* <u>coinsurance</u> and \$300 per admission <u>copayment</u>	Precertification penalty: \$500/admission (<u>in-network</u>) or \$500/day (<u>out-of-network</u>); or care may not be covered.
If you are pregnant	Office visits	No charge*	35% <u>coinsurance</u>	None
	Childbirth/delivery professional services	No charge*	35% <u>coinsurance</u>	None
	Childbirth/delivery facility services	No charge*	35%* <u>coinsurance</u> and \$300 per admission <u>copayment</u>	None
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	35% <u>coinsurance</u>	Limited to 50 visits/year.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	35% <u>coinsurance</u>	Outpatient services limited to 60 visits/year combined per person per year.
	<u>Habilitation services</u>	10% <u>coinsurance</u>	35% <u>coinsurance</u>	Outpatient services limited to 60 visits/year combined per person per year.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	35% <u>coinsurance</u>	Precertification penalty: \$500/admission (<u>in-network</u>) or \$500/day (<u>out-of-network</u>); or care may not be covered. Limited 50 days per calendar year.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	35% <u>coinsurance</u>	Must be <u>pre-authorized</u> over \$1,000; or care may not be covered.
	<u>Hospice services</u>	No charge	No charge	Coverage limited to \$30,000/period of care for combined in-patient and out-patient care.

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 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 the Plan's Vision administrator. Frequency and dollar limits apply.
	Children's glasses	Not covered	Not covered	Discount program available through the Plan's Vision administrator.
	Children's dental check-up	No charge*. Subject to <u>balance-billing</u> up to the provider's contracted amount	No charge*. Subject to <u>balance-billing</u>	Coverage is limited to two visits of \$22/year for routine dental services.

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your PSHB Plan brochure for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none">• Cosmetic surgery• Long-term care	<ul style="list-style-type: none">• Over-the-counter medications• Private-duty nursing	<ul style="list-style-type: none">• 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.)		
<ul style="list-style-type: none">• Acupuncture• Bariatric surgery• Chiropractic care (manipulative therapy)	<ul style="list-style-type: none">• Dental care (adult)• Hearing aids	<ul style="list-style-type: none">• Emergency care while traveling outside the U.S.• 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, kwijigo 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 (OBGYN) 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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$70

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$270
<u>Coinsurance</u>	\$980
<i>What isn't covered</i>	
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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$350
<u>Copayments</u>	\$40
<u>Coinsurance</u>	\$70
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$460