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. You can get the FEHB Plan brochure at www.geha.com or by calling 1-800-821-6136.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$ 350** Self only **$ 700** Self and Family Doesn't apply to some services such as preventive care and prescription drugs.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for certain covered services you use. **Copayments** and **coinsurance** amounts do not count toward your **deductible**, which generally starts over January 1st. When a covered service or supply is subject to a **deductible**, only the Plan allowance for the service or supply counts toward the **deductible**. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible** and for which services are subject to the **deductible**.
Are there other deductibles for specific services?	No.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$5,000** in-network, **$7,000** all providers (includes **$5,000** in-network), **$6,000** for prescriptions	The **out-of-pocket limit,** or catastrophic maximum, is the most you could pay during the year for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, copayments, any penalties, certain drug costs and coinsurance, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.geha.com or call **1-800-821-6136** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. [We use the terms **in-network or participating** for **providers** in our **network**.] See the chart starting on page 2 for how this plan pays different kinds of **providers**.

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Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See this plan's FEHB brochure for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered office visits, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non- Participating Provider (plus you may be balance billed)	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 / visit	35% after deductible	————————none————————
	Specialist visit	$25 / visit	35% after deductible	————————none————————
	Other practitioner office visit	15% after deductible for acupuncture. Chiropractic care subject to balance-billing.	35% after deductible for acupuncture. Chiropractic care subject to balance billing.	Acupuncture limited to 20 visits/year with an M.D. or D.O. Chiropractic care limited to $20/visit, 12 visits/year, and $25/year for chiropractic x-rays.
	Preventive care/ screening/immunization	No charge	35% after deductible	Preventive services required by the Affordable Care Act are covered in full when in-network.
If you have a test	Diagnostic test (x-ray, blood work)	15% after deductible	35% after deductible	Outpatient lab work at Lab Card® locations is available at no charge.
	Imaging (CT/PET scans, MRIs)	15% after deductible	35% after deductible	Must be pre-authorized. If not, payment reduced by $100; care may not be covered.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non- Participating Provider (plus you may be balance billed)	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.geha.com.	Generic drugs	Retail - $10 or the cost of the drug whichever is less. Mail order –$20 or the cost of the drug whichever is less	Same as in-network pharmacy, plus you pay excess over our in-network drug cost.	Maximum days supply per fill is 30 days at retail, 90 days at mail order. You pay in full at an out-of-network pharmacy, then submit for reimbursement. You pay 70% for non-preferred step therapy drugs.
	Brand drugs	Retail - 50%, not to exceed $200 per 30 day supply. Mail order – 50%, not to exceed $500 per 90 day supply	Same as in-network pharmacy, plus you pay excess over our in-network drug cost.	Maximum days supply per fill is 30 days at retail, 90 days at mail order. You pay in full at an out-of-network pharmacy, then submit for reimbursement. You pay 70% for non-preferred step therapy drugs.
	Specialty drugs	From our specialty pharmacy: 50% not to exceed $200 (30-day supply) or $500 (90-day supply).	50% of our specialty pharmacy Plan allowance, $500 per fill, plus any difference between our allowance and the cost of the drug.	When specialty drugs are not dispensed by our specialty pharmacy, the additional $500 copayment you pay is excluded from your out-of-pocket limit. You pay in full at an out-of-network pharmacy, then submit for reimbursement.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% after deductible	35% after deductible	Some services must be pre-authorized. If not, care may not be covered.
	Physician/surgeon fees	15% after deductible	35% after deductible	Some services must be pre-authorized. If not, care may not be covered.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non- Participating Provider (plus you may be balance billed)	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	15% after deductible. Nothing for accidental injury within 72 hours.	After deductible, 15% for medical emergency/35% for other. Nothing for accidental injury within 72 hours.	Coinsurance applies to accidental injury care after 72 hours.
	Emergency medical transportation	15% after deductible Nothing for accidental injury	35% after deductible Nothing for accidental injury	Air ambulance must be pre-authorized. If not medically necessary, services will not be covered. Coinsurance applies to accidental injury care after 72 hours.
	Urgent care	15% after deductible. Nothing for accidental injury within 72 hours.	After deductible, 15% for medical emergency/35% for other. Nothing for accidental injury within 72 hours.	Coinsurance applies to accidental injury care after 72 hours.
If you have a hospital stay	Facility fee (e.g., hospital room)	15% after deductible	35% after deductible	Semi-private room. Must be pre-authorized. If not, payment reduced by $500; care may not be covered.
	Physician/surgeon fee	15% after deductible	35% after deductible	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10/visit	35% after deductible	Psychological testing must be pre-authorized. If not, care may not be covered.
	Mental/Behavioral health inpatient services	15% after deductible	35% after deductible	Semi-private room. Must be pre-authorized. If not, payment reduced by $500; care may not be covered.
	Substance use disorder outpatient services	$10/visit	35% after deductible	——————none——————
	Substance use disorder inpatient services	15% after deductible	35% after deductible	Semi-private room. Must be pre-authorized. If not, payment reduced by $500; care may not be covered.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non- Participating Provider (plus you may be balance billed)	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	No charge	35% after deductible	——————none——————
	Delivery and all inpatient services	No charge	35% after deductible	——————none——————
If you need help recovering or have other special health needs	Home health care	15% after deductible	35% after deductible	Must be pre-authorized. If not, care may not be covered. Limited to 50 2-hour visits/year with an RN or LPN.
	Rehabilitation & Habilitation services	15% after deductible	35% after deductible	Outpatient only. Must be pre-authorized. If not, care may not be covered. Limited to 60 combined 2-hour visits/year by qualified physical/occupational/speech therapist per person/year.
	Skilled nursing care	Subject to balance-billing.	Subject to balance-billing.	Facility only. Must be pre-authorized. If not, care may not be covered. Limited to $700/day for the first 14 days after transfer from an acute care hospital.
	Durable medical equipment	15% after deductible	35% after deductible	Must be pre-authorized. If not, equipment may not be covered.
	Hospice service	Nothing, up to $15,000 limit. Deductible applies.	Nothing, up to $15,000 limit. 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	Eye exam	No charge	No charge	One routine eye exam per calendar year Additional benefits available through EyeMed. Frequency and dollar limits apply.
	Glasses	Not covered	Not covered	Discounted eyewear available through EyeMed.
	Dental check-up	50% co-insurance; subject to balance-billing.	50% co-insurance; subject to balance-billing.	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 Plan Does NOT Cover (This isn't a complete list. Check this plan's FEHB brochure for 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 (This isn't a complete list. Check this plan's FEHB brochure for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- 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:

If you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, to convert to an individual policy, and to receive temporary continuation of coverage (TCC). Your TCC rights will be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. An individual policy may also provide different benefits than you had while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, 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.

Your Appeal 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 Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **Coverage under this plan qualifies as minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.**

Language Access Services:

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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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,370
- **Patient pays** $170

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$20
Coinsurance	$0
Limits or exclusions	$150
Total	**$170**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,680
- **Patient pays** $720

Sample care costs:

Prescriptions	$2,900
Medical equipment and supplies	$1,300
Office visits and procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$80
Copays	$600
Coinsurance	$0
Limits or exclusions	$40
Total	**$720**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.