MEDICAL BENEFITS IN-NETWORK	**STANDARD OPTION** WHAT YOU PAY	**HIGH OPTION** WHAT YOU PAY	**HEALTH SAVINGS ADVANTAGE HDHP** WHAT YOU PAY	**MEDICARE A & B STANDARD** WHAT YOU PAY	**MEDICARE A & B HIGH** WHAT YOU PAY
PHYSICIAN CARE					
Primary care physician	**$15** office visit copay (waived for preventive care exam)	**$20** office visit copay (waived for preventive care exam)	**$0** for preventive care / Other – **5%** of allowance ☑	**$0**, 100% coverage	**$0**, 100% coverage
Mental health professional services	**$15** office visit copay	**$20** office visit copay	**5%** of allowance ☑	**$0**, 100% coverage	**$0**, 100% coverage
MinuteClinic *(where available)*	**$10** copay	**$10** copay	**5%** of allowance ☑	**$0**, 100% coverage	**$0**, 100% coverage
Urgent Care	**$35** copay	**$35** single copay	**5%** of allowance ☑	**$0**, 100% coverage	**$0**, 100% coverage
Specialist	**$30** office visit copay	**$20** office visit copay	**5%** of allowance ☑	**$0**, 100% coverage	**$0**, 100% coverage
Surgical care	**15%** of allowance ☑	**10%** of allowance ☑	**5%** of allowance ☑	**$0**, 100% coverage	**$0**, 100% coverage
PREVENTIVE CARE					
Covered lab services	**$0**, through Lab Card®	**$0**, through Lab Card®	**$0**, 100% coverage	**$0**, 100% coverage	**$0**, 100% coverage
Well-child care	**$0**, up to age 22	**$0**, up to age 22	**$0**, up to age 22		
Adult routine screenings	**$0**, 100% coverage	**$0**, 100% coverage	**$0**, 100% coverage	**$0**, 100% coverage	**$0**, 100% coverage
Vision – annual eye exam	**$5** copay through EyeMed	**$5** copay through EyeMed	**$5** copay through EyeMed	**$5** copay through EyeMed	**$5** copay through EyeMed
Dental – diagnostic/preventive	**50%** of allowance, 2 times/year	**Balance**, after GEHA pays $22 per visit, 2 times/year	**$0**, 100% plan allowance, 2 times/year	**50%** of allowance, 2 times/year	**Balance**, after GEHA pays $22 per visit, 2 times/year
MATERNITY					
Physician care	**$0**, 100% coverage	**$0**, 100% coverage	**$0**, 100% coverage ☑	**$0**, 100% coverage	**$0**, 100% coverage
Hospital care	**$0**, 100% coverage	**$0**, 100% coverage	**$0**, 100% coverage ☑		
ACCIDENTAL INJURY/OUTPATIENT CARE					
Ambulance, physician, emergency room	**$0**, if services within 72 hours	**$0**, if services within 72 hours	**5%** of allowance ☑		
HOSPITAL/FACILITY CARE					
Inpatient *(you must pre-certify)*	**15%** of allowance ☑	**$100** per admission copay, **10%** of other charges	**5%** of allowance ☑	**$0**, 100% coverage	**$0**, 100% coverage
Outpatient	**15%** of allowance ☑	**10%** of allowance ☑	**5%** of allowance ☑	**$0**, 100% coverage	**$0**, 100% coverage
Emergency room	**15%** of allowance ☑	**10%** of allowance ☑	**5%** of allowance ☑	**$0**, 100% coverage	**$0**, 100% coverage
Other charges	**15%** of allowance ☑	**10%** of allowance ☑	**5%** of allowance ☑	**$0**, 100% coverage	**$0**, 100% coverage
SPINAL MANIPULATIVE THERAPY	**Balance** after GEHA payment. GEHA pays $20 per visit, 20 times/year, and $25 for X-rays.	**Balance** after GEHA payment. GEHA pays $20 per visit, 20 times/year, and $25 for X-rays.	**Balance** after GEHA payment. GEHA pays $20 per visit, 20 times/year, and $25 for X-rays. ☑	**Balance** after GEHA payment. GEHA pays $20 per visit, 20 times/year, and $25 for X-rays.	**Balance** after GEHA payment. GEHA pays $20 per visit, 20 times/year, and $25 for X-rays.
CATASTROPHIC LIMIT**	**$6,000** Self Only **$7,500** Self Plus One **$7,500** Self and Family	**$5,500** Self Only **$7,000** Self Plus One **$7,000** Self and Family	**$5,000** Self Only **$10,000** Self Plus One **$10,000** Self and Family		
☑ **CALENDAR-YEAR DEDUCTIBLE APPLIES**	**$350** Self Only **$700** Self Plus One **$700** Self and Family	**$350** Self Only **$700** Self Plus One **$700** Self and Family	**$1,500** Self Only **$3,000** Self Plus One **$3,000** Self and Family	**$0** deductible	**$0** deductible
PRESCRIPTIONS^^ IN-NETWORK* *(Refills allowed when 80% of the drug has been used)*					
RETAIL PHARMACY – 30-DAY SUPPLY					
Generic	**$10** copay	**$10** copay‡	**25%** of allowance ☑	**$10** copay	**$10** copay‡
Preferred brand-name medication	**50%**, up to $200 max▫	**25%**, up to $150 max▫‡	**25%** of allowance ☑	**50%**, up to $200 max▫	**20%**, up to $150 max▫‡
Non-preferred brand-name medication	**50%**, up to $300 max▫	**40%**, up to $200 max▫‡	**25%** of allowance ☑	**50%**, up to $300 max▫	**35%**, up to $200 max▫‡
MAIL SERVICE PHARMACY – 90-DAY SUPPLY					
Generic	**$20** copay	**$20** copay	**25%** of allowance ☑	**$20** copay	**$15** copay
Preferred brand-name medication	**50%**, up to $500 max▫	**25%**, up to $350 max▫	**25%** of allowance ☑	**50%**, up to $500 max▫	**15%**, up to $350 max▫
Non-preferred brand-name medication	**50%**, up to $600 max▫	**40%**, up to $500 max▫	**25%** of allowance ☑	**50%**, up to $600 max▫	**30%**, up to $500 max▫

** The catastrophic limit is the maximum amount of coinsurance and deductibles you pay for all family members before GEHA begins paying for 100% of your care. This is a combined maximum for both medical care and prescriptions.

^^ Refer to geha.com/prescriptions for formulary and specialty coverage, for specific medications.

* For out-of-network benefits, see the 2018 GEHA plan brochure, RI 71-006 (High and Standard), or the 2018 HDHP plan brochure, RI 71-014.

▫ If you choose a brand-name medication when a generic is available, you will be charged the generic copay plus the difference in cost between the brand-name and the generic.

‡ Costs for initial prescription and first refill. You pay 50% for third and additional refills at retail for 30-day supply. For long-term prescriptions, use mail order or your local retail CVS Pharmacy store (90-day supply) for greater cost savings.