




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 71-022) 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 <u>deductible</u>?	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 <u>deductible</u>?	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 <u>deductibles</u> 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 limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <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> doesn't 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 <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 <u>specialist</u> you choose without a <u>referral</u> .
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 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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$30 / visit	Not covered You pay 100%	None
	<u>Specialist</u> visit	\$50 / visit	Not covered You pay 100%	None
	<u>Preventive care/screening/immunization</u>	No charge	Not covered You pay 100%	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. Age and/or diagnosis limitations may apply.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge for blood work; \$50 for X-rays	Not covered You pay 100%	Genetic testing may require preauthorization.
	Imaging (CT/PET scans, MRIs)	\$100 (when billed by professionals). \$75 (billed by facilities)	Not covered You pay 100%	Must be pre-authorized.

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)	
<p>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</p>	Generic drugs	<p>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.</p>	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	<p>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.</p>	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 generic and brand name.
	Non-preferred brand drugs	<p>Retail - 50% of the <u>plan</u> allowance per 30-day supply Mail order – 50% coinsurance</p>	Not covered You pay 100%	
	<u>Specialty drugs</u>	<p>From CVS Specialty Pharmacy, per 30-day supply</p> <p>Generic and Preferred: 40%, not to exceed \$500 Non-preferred: 50%</p>	Not covered You pay 100%	<p>If <u>Specialty drugs</u> are obtained through other sources (physician’s office, <u>home health</u> agencies, outpatient hospitals), you will pay an additional <u>copayment</u> of \$500 and any difference between GEHA’s allowance and the cost of the drug. The additional \$500 <u>copayment</u> will go towards your <u>out-of-pocket limit</u>.</p> <p><u>Copayment</u> based on days of therapy.</p> <p>Brand name when generic available – same as generic drugs, plus the difference in cost of generic and brand name.</p>

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)	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.
	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.
If you need immediate medical attention	<u>Emergency room care</u>	15% <u>coinsurance</u> after <u>deductible</u>	15% <u>coinsurance</u> after <u>deductible</u>	None
	<u>Emergency medical transportation</u>	15% <u>coinsurance</u> after <u>deductible</u>	15% <u>coinsurance</u> after <u>deductible</u>	Air ambulance transportation requires medical necessity review. If not medically necessary, services will not be covered. Post-service review is performed for emergency transportation. Member is responsible for all charges over 100 miles when <u>medically necessary</u> treatment is available within 100 miles.
	<u>Urgent care</u>	\$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 pre-certified. If not, care may not be covered.
	Physician/surgeon fees	15% <u>coinsurance</u> after <u>deductible</u>	Not covered You pay 100%	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 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 <u>pre-authorization</u> . If not, care may not be covered. Outpatient facility 15% <u>coinsurance</u> after <u>deductible</u> applies for services such as partial <u>hospitalization</u> or intensive day treatment programs, electroconvulsive therapy, and transcranial magnetic stimulation.
	Inpatient services (Including Residential treatment centers)	15% <u>coinsurance</u> after <u>deductible</u>	Not covered You pay 100%	Semi-private room. Facility only. Must be pre-certified. If not, care may not be covered.
If you are pregnant	Office visits	No charge	Not covered You pay 100%	None
	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%	<u>Cost sharing</u> does not apply for preventive services. Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply.
If you need help recovering or have other special health needs	<u>Home healthcare</u>	\$30 / visit	Not covered You pay 100%	Limited to 50 2-hour visits/year with an RN, LPN or MSW.
	<u>Rehabilitation services</u>	\$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.
	<u>Habilitation services</u>	\$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.
	<u>Skilled nursing care</u>	15% <u>coinsurance</u> after <u>deductible</u>	Not covered You pay 100%	Facility only. Must be pre-certified. Limited to 50 days per calendar year.
	<u>Durable medical equipment</u>	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.

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)	
	<u>Hospice services</u>	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.
If your child needs dental or eye care	Children's routine eye exam	Not covered You pay 100%	Not covered You pay 100%	Discount program available through EyeMed.
	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 PSHB Plan brochure for more information and a list of any other excluded services .)		
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) 	<ul style="list-style-type: none"> • Long-term care • 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"> • Hearing aids • Infertility treatment 	<ul style="list-style-type: none"> • 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 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 <u>deductible</u>	\$200
■ <u>Specialist copayment</u>	\$50
■ <u>Hospital (facility) coinsurance</u>	15%
■ <u>Other coinsurance</u>	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>	\$50
<u>Coinsurance</u>	\$1,030
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,340

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

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

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:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$2,050
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$2,050

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

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

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:

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