



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 healthcare services. **NOTE: Information about the cost of this Plan (called the premium) will be provided separately.**

**This is only a summary.** Please read the FEHB Plan brochure (RI 71-018) 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. 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 FEHB Plan brochure at [www.geha.com](http://www.geha.com), and view the Glossary at [www.healthcare.gov/sbc-glossary](http://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 services including 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
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 charges</u> , 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 <a href="http://geha.com/FindCare">geha.com/FindCare</a> 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> .





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
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most, plus you may be balance billed)	
<b>If you visit a healthcare provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$30* / visit	Not covered	None
	<u>Specialist visit</u>	\$50* / visit	Not covered	None
	<u>Preventive care/screening/immunization</u>	No charge*	Not covered	You may have to pay for services that aren't <u>preventive</u> .
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	No charge* for Lab; \$50* for all other tests	Not covered	Some testing may require pre-authorization.
	Imaging (CT/PET scans, MRIs)	\$100* for Physician + \$75* for Facility (\$175 total per test)	Not covered	Must be <u>pre-authorized</u> . If not, care may not be covered.
<b>If you need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="https://info.caremark.com/oe/geha">https://info.caremark.com/oe/geha</a>	Generic drugs	<b>Retail</b> - \$15* / prescription <b>Mail order</b> - \$20* / prescription	Not covered	Maximum day supply per fill is 30 days at retail, 90 days - through mail order.  You pay in full at an <u>Out-of-Network</u> pharmacy.
	Preferred brand drugs	<b>Retail</b> - \$100* / prescription <b>Mail order</b> - \$200* / prescription	Not covered	Brand name when generic available – same as generic drugs, plus the difference in cost of generic and brand name.
	Non-Preferred brand drugs	<b>Retail</b> - 50%* <u>coinsurance</u> <b>Mail order</b> – 50%* <u>coinsurance</u>	Not covered	
	<u>Specialty drugs</u>	<b>Generic and Preferred:</b> 40%* <u>coinsurance</u> (up to \$700)  <b>Non-Preferred:</b> 50%* <u>coinsurance</u>	Not covered	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.

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)	20% <u>coinsurance</u>	Not covered	Some services must be <u>pre-authorized</u> ; or care may not be covered.
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	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>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Medical necessity and mileage limitations apply to the nearest facility.
	<u>Urgent care</u>	\$50* / visit	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not covered	Precertification penalty: \$500/admission ( <u>in-network</u> ); or care may not be covered.
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	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 20% <u>coinsurance</u> for outpatient facility	Not covered	Some psychological testing may require <u>pre-authorization</u> ; or care may not be covered.
	Inpatient services (Including Residential Treatment Centers)	20% <u>coinsurance</u>	Not covered	Precertification penalty: \$500/admission ( <u>in-network</u> ); or care may not be covered.
If you are pregnant	Office visits	No charge*	Not covered	None
	Childbirth/delivery professional services	No charge*	Not covered	None
	Childbirth/delivery facility services	20% <u>coinsurance</u>	Not covered	None
If you need help recovering or have other special health needs	<u>Home healthcare</u>	\$30* / visit	Not covered	Limited to 50 visits per year.
	<u>Rehabilitation services</u>	\$50* / visit	Not covered	Outpatient services limited to 60 combined visits, per person, per year.
	<u>Habilitation services</u>	\$50* / visit	Not covered	Outpatient services limited to 60 combined visits, per person, per 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)	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	Not covered	Precertification penalty: \$500/admission ( <u>in-network</u> ); or care may not be covered. Limited 50 days per confinement.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not covered	Must be <u>pre-authorized</u> over \$1,000; or care may not be covered.
	<u>Hospice services</u>	No charge	Not covered	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	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

## Excluded Services & Other Covered Services:

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

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- 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 FEHB Plan brochure.)

- Acupuncture
- Bariatric surgery
- Hearing aids
- Chiropractic care (manipulative therapy)
- Emergency care while traveling outside the U.S.
- Routine foot care

**Your Rights to Continue Coverage:** You can get help if you want to continue your coverage after it ends. See the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at 800-821-6136 or visit [www.opm.gov/healthcare-insurance/healthcare/](http://www.opm.gov/healthcare-insurance/healthcare/). 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-FEHB 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](http://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 FEHB 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 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, kwijigo holne' 1-800-821-6136.

*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 \$200
- Specialist copayment \$50
- Hospital (facility)coinsurance 20%
- Other coinsurance 20%

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)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$200
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$1,370
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,640</b>

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

- The plan's overall deductible \$200
- Specialist copayment \$50
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$2,060
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$2,060</b>

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

- The plan's overall deductible \$200
- Specialist copayment \$50
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This **EXAMPLE** event includes services like:

- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$200
<u>Copayments</u>	\$260
<u>Coinsurance</u>	\$260
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$720</b>