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 https://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 deductible?	For in-network providers **$ 350** / Self Only **$ 700** / Self Plus One **$ 700** / Self and Family For out-of-network providers **$ 1,050** / Self Only **$ 2,100** / Self Plus One **$ 2,100** / Self and Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes, in-network services including Preventive care, office visits, urgent care visits, maternity care and prescription drugs.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers **$6,500 /** Self Only **$13,000 /** Self Plus One or Self and Family (one individual not to exceed $6,500) For out-of-network providers **$8,500 /** Self Only **$17,000 /** Self Plus One or Self and Family (one individual not to exceed $8,500)	The out-of-pocket limit, or catastrophic maximum, is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, any penalties, non-covered drugs, the difference in price between generic and brand name and services your healthcare plan does not cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.geha.com/Find-Care or call 800-821-6136 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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 provider's office or clinic	Primary care visit to treat an injury or illness	$20 / visit Deductible does not apply	40% coinsurance	$0 copayment applies for the first visit for children under 18, after which the applicable copayment applies
	Specialist visit	$35 / visit Deductible does not apply	40% coinsurance	None
	Preventive care/screening/ immunization	No charge Deductible does not apply	Children – No charge Deductible does not apply Adult - 40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance for Lab, Deductible does not apply 15% coinsurance for other tests	40% coinsurance	Outpatient lab work at QuestSelect locations is available at no charge. Some testing may require preauthorization.
	Imaging (CT/PET scans, MRIs)	$250 / test Deductible does not apply	40% coinsurance	Must be pre-authorized. 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 prescription drug coverage is available at https://info.caremark.com/oe/postalgeha.	Generic drugs	**Retail** - $10/prescription **Mail order** -- $25/prescription Deductible does not apply	Same as in-network pharmacy, plus you pay excess over our in-network drug cost	Maximum day supply per fill is 30 days at retail, 90 days through mail order. 90-day supplies are available at a participating Extended Day Supply (EDS) network pharmacy or through mail order. You pay in full at an Out-of-Network Retail pharmacy and can submit for reimbursement. Brand name when generic available – same as generic drugs, plus the difference in cost of generic and brand name.
	Preferred brand drugs	**Retail** – 40% (up to $350) **Mail order** – 40% (up to $700) Deductible does not apply	Same as in-network pharmacy, plus you pay excess over our in-network drug cost	
	Non-preferred brand drugs	**Retail** – 60% (up to $450) **Mail order** – 60% (up to $900) Deductible does not apply	Same as in-network pharmacy, plus you pay excess over our in-network drug cost	
	Specialty drugs	**Generic and Preferred:** 50% (up to $350) **Non-preferred:** 50% (up to $500) Deductible does not apply	Not covered You pay 100%	Services are provided through CVS Specialty Pharmacy. Cost share 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)	15% coinsurance	40% coinsurance	Some services must be pre-authorized; or care may not be covered.
	Physician/surgeon fees	15% coinsurance	40% coinsurance	Some services must be pre-authorized; or care may not be covered.
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	None
	Emergency medical transportation	15% coinsurance	15% coinsurance	Medical necessity and mileage limitations apply to the nearest facility.
	Urgent care	$30 / visit Deductible does not apply	40% coinsurance	$0 copayment applies for the first two urgent care visits for children under 18, after which the applicable copayment 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 have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	40% coinsurance	Precertification penalty: $500/admission (in-network) or $500/day (out-of-network); or care may not be covered.
	Physician/surgeon fees	15% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 / visit for office visits, 15% coinsurance for other outpatient services Deductible does not apply	40% coinsurance	Psychological testing requires pre-authorization; or care may not be covered.
	Inpatient services (Including Residential Treatment Centers)	15% coinsurance	40% coinsurance	Precertification penalty: $500/admission (in-network) or $500/day (out-of-network); or care may not be covered.
If you are pregnant	Office visits	No charge Deductible does not apply	40% coinsurance	None
	Childbirth/delivery professional services	No charge Deductible does not apply	40% coinsurance	None
	Childbirth/delivery facility services	No charge Deductible does not apply	40% coinsurance	None
If you need help recovering or have other special health needs	Home health care	15% coinsurance	40% coinsurance	Limited to 50 visits/year.
	Rehabilitation services	15% coinsurance	40% coinsurance	Outpatient services limited to 60 visits/year combined per person per year.
	Habilitation services	15% coinsurance	40% coinsurance	Outpatient services limited to 60 visits/year combined per person per year.
	Skilled nursing care	15% coinsurance	40% coinsurance	Precertification penalty: $500/admission (in-network) or $500/day (out-of-network); or care may not be covered. Limited to 50 days per calendar year.
	Durable medical equipment	15% coinsurance	40% coinsurance	Must be pre-authorized over $1,000; or care may not be covered.
	Hospice services	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 Deductible does not apply	No charge Deductible does not apply	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 is available through the Plan's Vision administrator.
	Children's dental check-up	50% coinsurance; subject to balance-billing up to the provider's contracted amount. Deductible does not apply	50% coinsurance; subject to balance-billing. Deductible does not apply	Coverage is limited to two exams, cleanings, and fluoride/year; dental X-rays are limited to $150/year.

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.)		
• Cosmetic surgery • 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 PSHB Plan brochure.)		
• Acupuncture • Bariatric surgery • Chiropractic care (manipulative therapy)	• Dental care (Adult) • Hearing aids • Infertility treatments	• Non-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: G.E.H.A 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, kwiijigo 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** **$35**
- **Hospital (facility) coinsurance** **15%**
- **Other coinsurance** **15%**

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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
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** **$35**
- **Hospital (facility) coinsurance** **15%**
- **Other coinsurance** **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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$280
Coinsurance	$1,090
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,370**

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

- **The plan's overall deductible** **$350**
- **Specialist copayment** **$35**
- **Hospital (facility) coinsurance** **15%**
- **Other coinsurance** **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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$350
Copayments	$40
Coinsurance	$440
What isn't covered0	
Limits or exclusions	$0
The total Mia would pay is	**$830**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.