




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 FEHB Plan brochure (RI 73-849) 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.geisinger.org/federal](http://www.geisinger.org/federal) and view the Glossary at [www.Healthcare.gov/sbc-glossary.com](http://www.Healthcare.gov/sbc-glossary.com). You can call 1-800- 447-4000 to request a copy of either document.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$ 1,500 / Self Only \$ 3,000 / Self Plus One \$ 3,000 / Self and Family	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. <a href="#">Copayments</a> and <a href="#">coinsurance</a> amounts do not count toward your <a href="#">deductible</a> , which generally starts over January 1. When a covered service/supply is subject to a <a href="#">deductible</a> , only the Plan allowance for the service/supply counts toward the <a href="#">deductible</a> . If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$ 8,550 Self Only / \$17,100 Self Plus One and Family.	The <a href="#">out-of-pocket limit</a> , or catastrophic maximum, is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall <a href="#">family out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance billing</a> , charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.geisinger.org/federal">www.geisinger.org/federal</a> or call 1-800-447-4000 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a provider in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.



Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .
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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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	30% <a href="#">coinsurance</a>	Not Covered	None
	<a href="#">Specialist</a> visit	30% <a href="#">coinsurance</a>	Not Covered	None
	<a href="#">Preventive care</a> / <a href="#">screening</a> / immunization	No charge <a href="#">Deductible</a> does not apply.	Not Covered	Limited to 1 routine exam per year. You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	30% <a href="#">coinsurance</a>	Not Covered	None
	Imaging (CT/PET scans, MRIs)	30% <a href="#">coinsurance</a>	Not Covered	<a href="#">Precertification/prior authorization</a> required
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.geisinger.org/federal">www.geisinger.org/federal</a> .	Generic drugs	30% <a href="#">coinsurance</a> (minimum \$5 / maximum \$15) <a href="#">Deductible</a> does not apply.	Not Covered	Covers up to a 34-day supply.
	Preferred brand drugs	40% <a href="#">coinsurance</a> (minimum \$40 / maximum \$120) <a href="#">Deductible</a> does not apply.	Not Covered	
	Non-preferred brand drugs	50% <a href="#">coinsurance</a> (minimum \$60/ maximum \$180) <a href="#">Deductible</a> does not apply.	Not Covered	
	<a href="#">Specialty drugs</a>	50% <a href="#">coinsurance</a> (minimum \$85 / maximum \$250) <a href="#">Deductible</a> does not apply.	Not 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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <a href="#">coinsurance</a>	Not Covered	<a href="#">Precertification/prior authorization</a> may be required.
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	Not Covered	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$250 <a href="#">copay</a> / visit <a href="#">Deductible</a> does not apply.	\$250 <a href="#">copay</a> / visit <a href="#">Deductible</a> does not apply.	<a href="#">Copay</a> waved if admitted to the hospital.
	<a href="#">Emergency medical transportation</a>	No charge <a href="#">Deductible</a> does not apply.	No charge <a href="#">Deductible</a> does not apply.	None
	<a href="#">Urgent care</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <a href="#">coinsurance</a>	Not Covered	<a href="#">Precertification/prior authorization</a> required.
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	Not Covered	<a href="#">Precertification/prior authorization</a> required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% <a href="#">coinsurance</a>	Not Covered	None
	Inpatient services	30% <a href="#">coinsurance</a>	Not Covered	<a href="#">Precertification/prior authorization</a> required.
If you are pregnant	Office visits	No charge for prenatal exams. <a href="#">Deductible</a> does not apply.	Not Covered	None.
	Childbirth/delivery professional services	30% <a href="#">coinsurance</a>	Not Covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Maternity care may include tests and services as described elsewhere in the SBC (i.e., ultrasound). Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply.
	Childbirth/delivery facility services	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Precertification/prior authorization</a> required.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge <a href="#">Deductible</a> does not apply.	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 help recovering or have other special health needs	<a href="#">Rehabilitation services</a>	30% <a href="#">coinsurance</a>	Not Covered	None
	<a href="#">Habilitation services</a>	30% <a href="#">coinsurance</a>	Not Covered	None
	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a>	Not Covered	60 days/period of confinement/person
	<a href="#">Durable medical equipment</a>	No charge <a href="#">Deductible</a> does not apply.	Not Covered	None
	<a href="#">Hospice services</a>	No charge <a href="#">Deductible</a> does not apply.	Not covered	None
If your child needs dental or eye care	Children's eye exam	30% <a href="#">coinsurance</a>	Not Covered	1 exam/member/benefit period.
	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 <a href="#">Plan</a> Generally Does NOT Cover (Check your FEHB Plan brochure for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Cosmetic Surgery</li> <li>Dental Care (Adult)</li> <li>Hearing Aids</li> </ul>	<ul style="list-style-type: none"> <li>Infertility Treatment</li> <li>Long-Term Care</li> <li>Non-Emergency Care When Traveling Outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>Private-Duty Nursing</li> <li>Routine Foot Care</li> <li>Weight Loss Programs</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your FEHB Plan brochure.)		
<ul style="list-style-type: none"> <li>Bariatric Surgery</li> </ul>	<ul style="list-style-type: none"> <li>Chiropractic Care</li> </ul>	<ul style="list-style-type: none"> <li>Routine Eye Care (Adult)</li> </ul>

**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 1-800-447-4000 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 1-800-318-2596.

**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: 1-877-881-6388.

**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:**

To access our Language helpline, please call 1-800-447-4000.

*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](#) \$1,500
- [Specialist coinsurance](#) 30%
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 0%

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*)

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

Cost Sharing	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$3,200
What isn't covered	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$4,700</b>

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

- The plan's overall [deductible](#) \$1,500
- [Specialist coinsurance](#) 30%
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 0%

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:

Cost Sharing	
<a href="#">Deductibles</a>	\$900
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,700
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$2,600</b>

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

- The plan's overall [deductible](#) \$1,500
- [Specialist coinsurance](#) 30%
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 0%

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:

Cost Sharing	
<a href="#">Deductibles</a>	\$900
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,200</b>