
 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 71-007 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.MHBP.com, and view the Glossary at www.MHBP.com. You can call 1-800-410-7778 to request a copy of either document.

Important Questions	Answers	Why This Matters:
<p>What is the overall deductible?</p>	<p>Network providers: \$600/Self Only \$1,200/Self Plus One \$1,200/Self and Family</p> <p>Non-Network providers: \$900/Self Only \$1,800/Self Plus One \$1,800/Self and Family</p>	<p>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. Copayments and coinsurance amounts do not count toward your deductible, which generally starts over January 1. When a covered service/supply is subject to a deductible, only the Plan allowance for the service/supply counts toward the deductible. 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.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. Preventive care/wellness; office visits; maternity care; telemedicine visits; urgent care visits; and preventive prescriptions</p>	<p>This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply See a list of covered preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>You don't have to meet deductibles for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>Network providers: \$6,600/Self Only; \$13,200/Self Plus One or Self and Family (\$6,600 per covered individual).</p> <p>Non-Network providers: \$10,000/Self Only; \$20,000/Self Plus One or Self and Family (\$10,000 per covered individual).</p>	<p>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.</p>



What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , balance-billed charges, penalties, expenses covered by specialty drug <u>copayment</u> assistance cards, and non-covered services.	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.MHBP.com or call 1-800-410-7778 for a list of <u>Network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use a <u>non-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use a <u>non-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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-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 <u>copayment</u> per visit, adult; \$10 <u>copayment</u> per visit, child	40% <u>coinsurance</u>	No <u>deductible</u> for services from <u>Network providers</u> .
	<u>Specialist</u> visit	\$50 <u>copayment</u> per visit	40% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	No <u>deductible</u> for services from <u>Network providers</u> .
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Lab Savings Program	No charge	Not available	
	Imaging (CT/PET scans, MRIs)	5% <u>coinsurance</u> for stand-alone <u>Network</u> imaging centers; 20% <u>coinsurance</u> for outpatient hospital	40% <u>coinsurance</u>	Prior approval is required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
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<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at www.MHBP.com</p>	Generic drugs	\$10 <u>copayment</u> (retail) \$30 <u>copayment</u> (mail)	Not covered	No <u>deductible</u> . Maximum 30-day supply (retail) or 90-day supply (mail).
	Preferred brand drugs	45% of the Plan's allowance and any difference between our allowance and the cost of the generic equivalent, unless a brand exception is obtained (retail and mail)	Not covered	No <u>deductible</u> . Maximum 30-day supply (retail) or 90-day supply (mail).
	Non-preferred brand drugs	75% of the Plan's allowance and any difference between our allowance and the cost of the generic equivalent, unless a brand exception is obtained (retail and mail)	Not covered	No <u>deductible</u> . Maximum 30-day supply (retail) or 90-day supply (mail).
	<u>Specialty drugs</u>	50% of Plan's allowance	Not covered	No <u>deductible</u> . Specialty drugs must be obtained through CVS/caremark Specialty Pharmacy. <u>Preauthorization</u> is required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need immediate medical attention	Emergency room care	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<u>Urgent care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	No <u>deductible</u> for services from a <u>Network provider</u> .

If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Precertification is required; \$500 penalty for non-compliance.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <u>copayment</u> per visit, adult; \$10 <u>copayment</u> per visit, child; and 20% <u>coinsurance</u> for other outpatient services	40% <u>coinsurance</u>	No <u>deductible</u> for services from a <u>Network provider</u> . Prior approval is required for certain outpatient services.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Precertification is required; \$500 penalty for non-compliance.
If you are pregnant	Office visits	No charge	40% <u>coinsurance</u>	
	Childbirth/delivery professional services	No charge	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	No charge	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 4 visits per year
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 26 visits per year
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 26 visits per year
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 40 days in a skilled nursing facility (SNF) per year. Prior approval is required.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Excluded
	Children's glasses	All charges over \$50	All charges over \$50	Must be related to an accidental injury or intraocular surgery.
	Children's dental check-up	Not covered	Not covered	Excluded

Excluded Services & Other Covered Services:

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

- Cosmetic surgery
- Dental care
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan's FEHB brochure.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Non-emergency care when traveling outside the U.S.

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 1-800-410-7778 or visit www.opm.gov/insure/health. 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 receive 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 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 plan's FEHB brochure. If you need assistance, you can contact: customer service at 1-800-410-7778.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-800-410-7778.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-410-7778.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-410-7778.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-410-7778.]

————— *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 network pre-natal care and a hospital delivery)

■ The plan's overall <u>deductible</u>	\$600
■ <u>Specialist</u> [<i>cost sharing</i>]	\$50
■ Hospital (facility) [<i>cost sharing</i>]	20%
■ Other [<i>cost sharing</i>]	20%

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:

<u>Cost Sharing</u>	
Deductibles	\$0
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$60

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

■ The plan's overall <u>deductible</u>	\$600
■ <u>Specialist</u> [<i>cost sharing</i>]	\$50
■ Hospital (facility) [<i>cost sharing</i>]	20%
■ Other [<i>cost sharing</i>]	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*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<u>Cost Sharing</u>	
Deductibles	\$100
<u>Copayments</u>	\$1,000
<u>Coinsurance</u>	\$1,600
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,720

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

■ The plan's overall <u>deductible</u>	\$600
■ <u>Specialist</u> [<i>cost sharing</i>]	\$50
■ Hospital (facility) [<i>cost sharing</i>]	20%
■ Other [<i>cost sharing</i>]	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*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

<u>Cost Sharing</u>	
Deductibles	\$600
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$
The total Mia would pay is	\$900