
 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 71-016 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 1-800-694-9901 to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For <u>Network providers</u> : \$2,000 /Self Only; \$4,000 /Self Plus One or Self and Family. For <u>Non-Network providers</u> : \$2,000 /Self Only; \$4,000 /Self Plus One or Self and Family.	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 Plan allowance for the service/supply counts toward the <u>deductible</u> . If you have other family members on the plan, 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 deductible?	Yes. Preventive care.	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. See a list of covered <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . 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 <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	For <u>Network providers</u> : \$6,000 /Self Only; \$12,000 /Self Plus One or Self and Family (\$6,600 per covered individual). For <u>Non-Network providers</u> : \$7,500 /Self Only; \$15,000 /Self Plus One or Self and Family (\$7,500 per covered individual).	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> , balance-billed charges, penalties for failure to obtain precertification or prior approval, 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 1-800-694-9901 for a list of <u>Network providers</u> .	This <u>plan</u> uses a provider <u>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 an <u>out-of-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 plan pays (<u>balance billing</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.

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	\$15 <u>copayment</u> per visit	40% <u>coinsurance</u>	
	<u>Specialist</u> visit	\$15 <u>copayment</u> per visit	40% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$15 <u>copayment</u> per visit	40% <u>coinsurance</u>	
	Quest Diagnostics Lab	No charge	Not available	
	Imaging (CT/PET scans, MRIs)	5% <u>coinsurance</u> for freestanding imaging center; \$15 copayment/ visit for outpatient hospital	40% <u>coinsurance</u>	Prior approval required.

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 www.MHBP.com</p>	Generic drugs	\$10 <u>copayment</u> (retail) \$20 <u>copayment</u> (mail)	Not covered	Maximum 30-day supply (retail) or 90-day supply (mail).
	Preferred brand drugs	30% of the Plan's allowance and any difference between our allowance and the cost of a generic equivalent unless a brand exception is obtained (retail); \$80 copayment and any difference between our allowance and the cost of a generic equivalent unless a brand exception is obtained (mail)	Not covered	Maximum 30-day supply (retail) or 90-day supply (mail). Member cost-sharing is limited to \$200 per prescription (retail)
	Non-preferred brand drugs	50% of the Plan's allowance and any difference between our allowance and the cost of a generic equivalent unless a brand exception is obtained (retail); \$120 copayment and any difference between our allowance and the cost of a generic equivalent unless a brand exception is obtained (mail)	Not covered	Maximum 30-day supply (retail) or 90-day supply (mail). Member cost-sharing is limited to \$200/prescription (retail)

	<u>Specialty drugs</u>	20% of the Plan's allowance limited to \$200/prescription/ 30 day supply; 20% of the Plan's allowance limited to \$425/prescription/ 90 day supply.	Not covered	<u>Specialty drugs</u> 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)	\$150 <u>copayment</u> per occurrence	40% <u>coinsurance</u>	
	Physician/surgeon fees	No charge	40% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	\$50 <u>copayment</u> per visit	\$50 <u>copayment</u> per visit	
	<u>Emergency medical transportation</u>	No charge	40% <u>coinsurance</u>	
	<u>Urgent care</u>	\$50 <u>copayment</u> per visit	\$50 <u>copayment</u> per visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$75 <u>copayment</u> / day up to \$750/ admission	40% <u>coinsurance</u>	Precertification is required; \$500 penalty for non-compliance.
	Physician/surgeon fees	No charge	40% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 <u>copayment</u> per visit	40% <u>coinsurance</u>	<u>Preauthorization</u> is required for certain outpatient services.
	Inpatient services	\$75 <u>copayment</u> / day up to \$750/admission	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>	\$15 <u>copayment</u> per visit	40% <u>coinsurance</u>	Limited to 3 visits per year
	<u>Rehabilitation services</u>	\$15 <u>copayment</u> per visit	40% <u>coinsurance</u>	Limited to 26 visits per year
	<u>Habilitation services</u>	\$15 <u>copayment</u> per visit	40% <u>coinsurance</u>	Limited to 26 visits per year
	<u>Skilled nursing care</u>	\$75 <u>copayment</u> / day up to \$750/admission	40% <u>coinsurance</u>	Limited to 28 days/ year. Prior approval is required.
	<u>Durable medical equipment</u>	No charge	40% <u>coinsurance</u>	
	<u>Hospice services</u>	\$5 <u>copayment</u> per day	10% <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.)

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| <ul style="list-style-type: none"> • Cosmetic surgery • Dental care • Infertility treatment | <ul style="list-style-type: none"> • Long-term care • Private-duty nursing • Routine eye care (Adult) | <ul style="list-style-type: none"> • Routine foot care • Weight loss programs |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan's FEHB brochure.)

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| <ul style="list-style-type: none"> • Acupuncture • Bariatric surgery | <ul style="list-style-type: none"> • Chiropractic care • Hearing aids | <ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. |
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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 1-800-694-9901 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 1-800-694-9901.

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 1-800-694-9901.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-694-9901.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-694-9907.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-694-9907.]

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>	\$2,000
■ <u>Specialist [cost sharing]</u>	\$15
■ <u>Hospital (facility) [cost sharing]</u>	\$75
■ <u>Other [cost sharing]</u>	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)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,060

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>	\$2,000
■ <u>Specialist [cost sharing]</u>	\$15
■ <u>Hospital (facility) [cost sharing]</u>	\$75
■ <u>Other [cost sharing]</u>	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)

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

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$700
<u>Coinsurance</u>	\$900
<u>What isn't covered</u>	
Limits or exclusions	\$20
The total Joe would pay is	\$3,620

Mia's Simple Fracture

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

■ The plan's overall <u>deductible</u>	\$2,000
■ <u>Specialist [cost sharing]</u>	\$15
■ <u>Hospital (facility) [cost sharing]</u>	\$75
■ <u>Other [cost sharing]</u>	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)

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

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,100
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,100