



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. You can get the FEHB Plan brochure at www.MHBP.com or by calling 1-800-410-7778.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u>?	For Network providers: \$600 /Self Only; \$1,200 /Self Plus One or Self and Family. For Non-Network providers: \$900 /Self Only; \$1,800 /Self Plus One or Self and Family. Does not apply to preventive care, office visits or prescription drugs.	You must pay all the costs up to the deductible amount before this plan begins to pay for certain covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible and for which services are subject to the deductible .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart beginning on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. For Network providers: \$6,600 /Self Only; \$13,200 /Self Plus One or Self and Family (\$6,600 per covered individual). For Non-Network providers: \$10,000 /Self Only; \$20,000 /Self Plus One or Self and Family (\$10,000 per covered individual).	The out-of-pocket limit , or catastrophic maximum, is the most you could pay during the year for your share of the cost of covered services. This limit helps you plan for health care expenses. The "per covered individual" amount is the most that any one member would have to pay, regardless of whether the individual is enrolled in Self Plus One or Self and Family.
What is not included in the <u>out-of-pocket limit</u>?	Premiums, balance-billed charges, penalties for failure to obtain precertification or preauthorization, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u>?	Yes. Visit www.MHBP.com or call 1-800-410-7778 for a list of Network providers.	If you use a Network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your Network doctor or hospital may use a Non-Network provider for some services. We use the term Network , for providers in our network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a <u>specialist</u>?	No. You don't need a referral to see a specialist .	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See this plan's FEHB brochure for additional information about excluded services .

Questions: Call 1-800-410-7778 or visit us at www.MHBP.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.MHBP.com or call 1-800-410-7778 to request a copy.





- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If a Non-Network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a Non-Network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider (plus you may be balance billed)	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$30 copayment/visit, adult; \$10 copayment/visit, child	40% coinsurance	No deductible for services from Network providers
	Specialist visit	\$50 copayment/visit	40% coinsurance	—————none—————
	Other practitioner office visit	20% coinsurance	40% coinsurance	Maximum 26 visits per person each year for physical, speech and occupational therapies. Maximum 26 visits per person each year for chiropractic and acupuncture services combined. No deductible for services from Network providers. Non-Network chiropractic care is not covered.
	Preventive care/screening/immunization	No charge	Not covered	No deductible for services from Network providers

Questions: Call 1-800-410-7778 or visit us at www.MHBP.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at www.MHBP.com or call 1-800-410-7778 to request a copy.



Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider (plus you may be balance billed)	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	No charge for covered lab tests through the Lab Savings Program – services must be provided by Quest Diagnostics.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Preauthorization is required
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.MHBP.com	Generic drugs	\$10 copayment/prescription (retail); \$30 copayment/prescription (mail order)	Not covered	No deductible. Maximum 30-day supply (retail) or 90-day supply (mail order).
	Preferred brand drugs	45% coinsurance	Not covered	No deductible. Maximum 30-day supply (retail) or 90-day supply (mail order). A brand exception is required when a generic equivalent is available.
	Non-preferred brand drugs	75% coinsurance	Not covered	
	Specialty drugs	50% coinsurance	Not covered	No deductible. Specialty drugs must be obtained through CVS Caremark Specialty Pharmacy. Preauthorization is required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	—————none—————
	Physician/surgeon fees	20% coinsurance	40% coinsurance	

Questions: Call 1-800-410-7778 or visit us at www.MHBP.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at www.MHBP.com or call 1-800-410-7778 to request a copy.



Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider (plus you may be balance billed)	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	—————none—————
	Emergency medical transportation	20% coinsurance	40% coinsurance	—————none—————
	Urgent care	20% coinsurance	40% coinsurance	No deductible for services from a Network provider when related to an accidental injury.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Precertification is required; \$500 penalty for non-compliance.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	—————none—————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$30 copayment/visit, adult; \$10 copayment/visit, child; and 20% coinsurance for other outpatient services	40% coinsurance	No deductible for services from a Network provider. Preauthorization is required for psychological testing.
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	Precertification is required; \$500 penalty for non-compliance.
	Substance use disorder outpatient services	\$30 copayment/visit, adult; \$10 copayment/visit, child; and 20% coinsurance for other outpatient services	40% coinsurance	No deductible for services from a Network provider. Preauthorization is required for psychological testing.
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	Precertification is required; \$500 penalty for non-compliance.
If you are pregnant	Prenatal and postnatal care	No charge	40% coinsurance	—————none—————
	Delivery and all inpatient services	No charge	40% coinsurance	—————none—————

Questions: Call 1-800-410-7778 or visit us at www.MHBP.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at www.MHBP.com or call 1-800-410-7778 to request a copy.



Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider (plus you may be balance billed)	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Limited to 4 visits per year
	Rehabilitation services	20% coinsurance	40% coinsurance	Limited to 26 visits per year
	Habilitation services	20% coinsurance	40% coinsurance	Limited to 26 visits per year
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 28 days in a skilled nursing facility (SNF) per year. Preauthorization is required.
	Durable medical equipment	20% coinsurance	40% coinsurance	none
	Hospice service	No charge	No charge	Limited to 28 days per year
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Excluded
	Glasses	All charges over \$50	All charges over \$50	Must be related to an accidental injury or intraocular surgery.
	Dental check-up	Not covered	Not covered	Excluded

Excluded Services & Other Covered Services:

Services This Plan Does NOT Cover (This isn't a complete list. Check this plan's FEHB brochure for other <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) • 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

Other Covered Services (This isn't a complete list. Check this plan's FEHB brochure for other covered services and your costs for these services.)		
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery 	<ul style="list-style-type: none"> • Chiropractic care • Habilitation services 	<ul style="list-style-type: none"> • Hearing aids • Non-emergency care when traveling outside the U.S.

Questions: Call 1-800-410-7778 or visit us at www.MHBP.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at www.MHBP.com or call 1-800-410-7778 to request a copy.



Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, to convert to an individual policy, and to receive temporary continuation of coverage (TCC). Your TCC rights will be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. An individual policy may also provide different benefits than you had while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, see the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at 1-800-410-7778 or visit www.opm.gov/healthcare-insurance/healthcare.

Your Appeal 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: MHBP Customer Service – 1-800-410-7778.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **Coverage under this plan qualifies as minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.**

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, kwüjigo holne' 1-800-410-7778.

—————To see examples of how this plan might cover costs for a sample medical situation, see the next page.—————

Questions: Call 1-800-410-7778 or visit us at www.MHBP.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.MHBP.com or call 1-800-410-7778 to request a copy.



About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers: \$7,540**
- **Plan pays: \$7,390**
- **Patient pays: \$150**

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$0
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$150
Total	\$150

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers: \$5,400**
- **Plan pays: \$4,320**
- **Patient pays: \$1,080**

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$600
Copays	\$150
Coinsurance	\$250
Limits or exclusions	\$80
Total	\$1,080

Questions: Call 1-800-410-7778 or visit us at www.MHBP.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.MHBP.com or call 1-800-410-7778 to request a copy.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-800-410-7778 or visit us at www.MHBP.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.MHBP.com or call 1-800-410-7778 to request a copy.