MHBP
Brought to you by Aetna

MHBP Standard Option

Summary of Benefits and Coverage

Coverage Period: 01/01/2017 – 12/31/2017

Coverage for: Self Only, Self Plus One, Self & Family | **Plan Type:** Network

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 deductible?	For Network providers: **$350**/Self Only; **$700**/Self Plus One or Self and Family. For Non-Network providers: **$600**/Self Only; **$1,200**/Self Plus One and **$1,500**/ Self and Family. Does not apply to preventive care, office visits, inpatient hospital services you receive from a Network provider, 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 deductibles 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 out–of–pocket limit on my expenses?	Yes. For Network providers: **$6,000**/Self Only; **$12,000**/Self Plus One or Self and Family ($6,000 per covered individual). For Non-Network providers: **$9,000**/Self Only; **$18,000**/Self Plus One or Self and Family ($9,000 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.
What is not included in the out–of–pocket limit?	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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	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 specialist?	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 provider's office or clinic	Primary care visit to treat an injury or illness	$20 copayment/visit, adult; $10 copayment/visit, child	30% coinsurance	No deductible for services from Network providers.
	Specialist visit	$30 copayment/visit	30% coinsurance	No deductible for services from Network providers.
	Other practitioner office visit	$20 copayment/visit for chiropractor; 10% coinsurance for other covered practitioners	30% 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.
	Preventive care/ screening/immunization	No charge	30% coinsurance	No deductible for services from Network providers.

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)	10% coinsurance	30% coinsurance	No charge for covered lab tests through the Lab Savings Program – services must be provided by Quest Diagnostics.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	Preauthorization is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.MHBP.com	Generic drugs	$5 copayment/prescription (retail); $10 copayment/ prescription (mail order)	$5 copayment/prescription (retail); Not covered (mail order)	No deductible. Maximum 30-day supply (retail) or 90-day supply (mail order).
	Preferred brand drugs	30% coinsurance (retail); $80 copayment/prescription (mail order)	30% coinsurance (retail); Not covered (mail order)	No deductible. Maximum 30-day supply (retail) or 90-day supply (mail order). A brand exception is required when a generic equivalent is available. Out-of-pocket expense is limited to $200/prescription.
	Non-preferred brand drugs	50% coinsurance (retail); $120 copayment/prescription (mail order)	50% coinsurance (retail); Not covered (mail order)	
	Specialty drugs	15% 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)	10% coinsurance	30% coinsurance	——————none——————
	Physician/surgeon fees	10% coinsurance	30% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	$200 copayment/visit	$200 copayment/visit	No deductible when related to an accidental injury.
	Emergency medical transportation	10% coinsurance	30% coinsurance	——————none——————
	Urgent care	$50 copayment/visit	30% coinsurance	No deductible when related to an accidental injury.

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 hospital stay	Facility fee (e.g., hospital room)	$200 copayment/admission and 10% coinsurance for ancillary services	$500 copayment/admission and 30% coinsurance for ancillary services	No deductible. Precertification is required; $500 penalty for non-compliance.
	Physician/surgeon fee	10% coinsurance	30% coinsurance	————none————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copayment/visit, adult; $10 copayment/visit, child; and 10% coinsurance for other outpatient services	30% coinsurance	No deductible for services from a Network provider. Preauthorization is required for psychological testing.
	Mental/Behavioral health inpatient services	$200 copayment/admission and 10% coinsurance for ancillary services	$500 copayment/admission and 30% coinsurance for ancillary services	No deductible. Precertification is required; $500 penalty for non-compliance.
	Substance use disorder outpatient services	$20 copayment/visit, adult; $10 copayment/visit, child; and 10% coinsurance for other outpatient services	30% coinsurance	No deductible for services from a Network provider. Preauthorization is required for psychological testing.
	Substance use disorder inpatient services	$200 copayment/admission and 10% coinsurance for ancillary services	$500 copayment/admission and 30% coinsurance for ancillary services	No deductible. Precertification is required; $500 penalty for non-compliance.
If you are pregnant	Prenatal and postnatal care	No charge	30% coinsurance	————none————
	Delivery and all inpatient services	No charge	$500 copayment/admission and 30% coinsurance for ancillary services	————none————

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	10% coinsurance	30% coinsurance	Limited to 15 visits per year
	Rehabilitation services	10% coinsurance	30% coinsurance	Limited to 26 visits per year
	Habilitation services	10% coinsurance	30% coinsurance	Limited to 26 visits per year
	Skilled nursing care	10% coinsurance	30% coinsurance	Limited to 28 days in a skilled nursing facility (SNF) per year. Preauthorization is required.
	Durable medical equipment	10% coinsurance	30% 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 excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- 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.)

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

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.

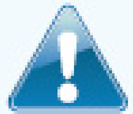
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-410-7778.

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

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

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:** $4,670
- **Patient pays:** $680

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	$350
Copays	$120
Coinsurance	$130
Limits or exclusions	$80
Total	**$680**

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.