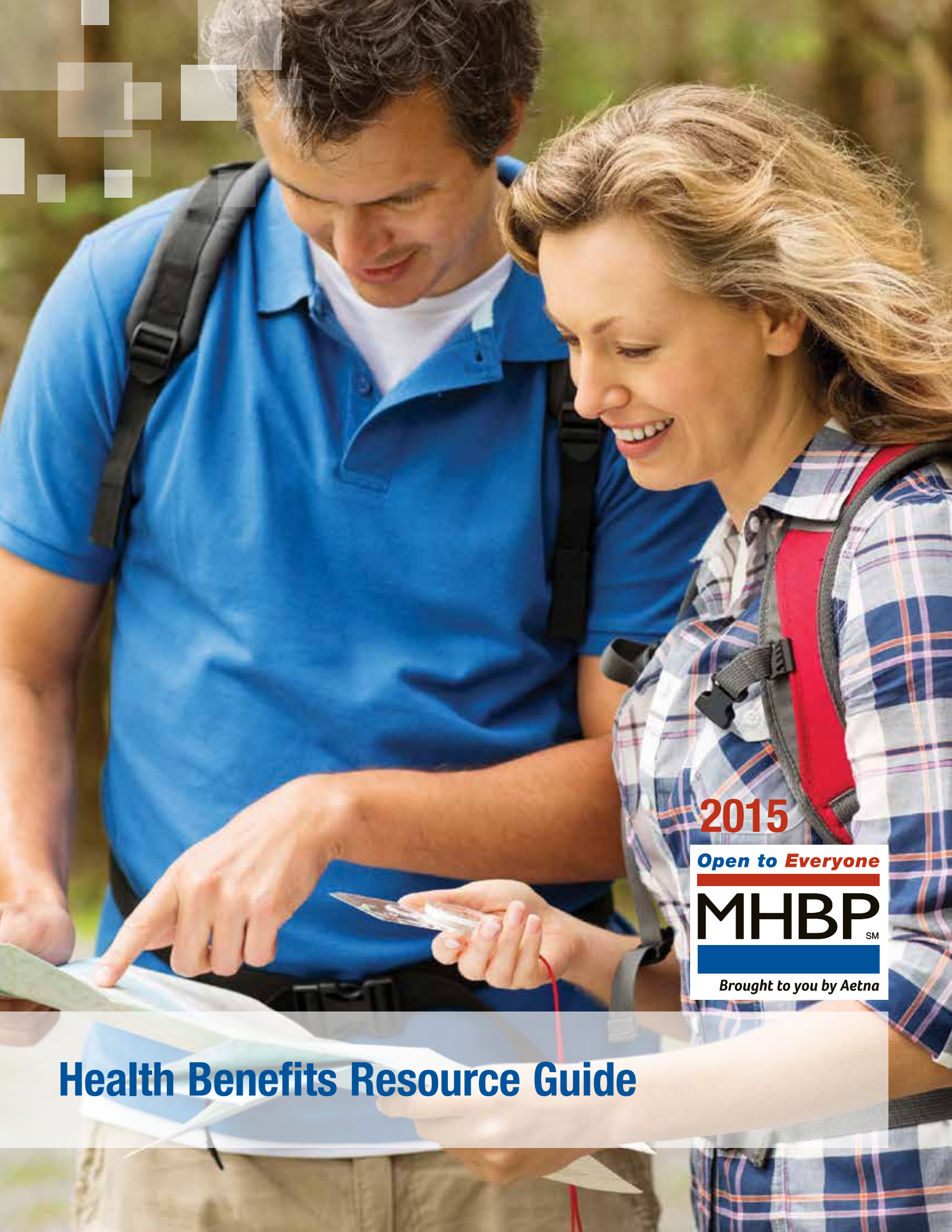

Health Benefits Resource Guide

MHBP has proudly served the FEHBP for over 50 years — providing affordable nationwide health coverage.

MHBP appreciates the important work that federal employees carry out each day in service to our nation's citizens. Your mission in public service is clear and so is ours. For over 50 years, MHBP has served the Federal Employees Health Benefits Program (FEHBP) by providing affordable, nationwide health coverage and supportive services.

We know that choosing a health plan can be time-consuming and complicated. The FEHBP gives you a variety of health plans to choose from, so you can find the one that's best for you. We hope to make this process easier for you by sharing focused information that will help you:

- Understand the type of plans we offer
- Evaluate your health benefit needs
- Get answers to some frequently asked questions
- Know when and how to enroll

Ultimately, it is our goal to provide a health plan experience that enables you to achieve your best health and fulfill the mission of your agency. When the workday is over, you can relax knowing that MHBP has you covered.

This brochure is provided for descriptive purposes only. Please refer to the official brochure of the plan(s) in which you are interested before making a final decision.

Photo: Istockphoto.com

MHBP Serves Federal Employees

MHBP offers you fee-for-service (FFS) health plans that provide both Network and Non-Network benefits. With MHBP you have nationwide coverage, comprehensive benefits, freedom to see the provider of your choice, 24/7 customer service except on major holidays, online support tools, optional dental and vision coverage, and so much more.

This brochure provides an overview of health benefit plans and a summary of all three MHBP options. We believe our health plans are excellent choices for federal employees. We think you'll agree.

UNDERSTANDING FFS PLANS

These types of plans provide health coverage in which doctors and other providers receive a fee for each service such as an office visit, test, procedure or other health care service. You or your health care provider are reimbursed for the allowable cost under the plan for covered services. You may choose your own physician, hospital and other health care providers. If you receive services from a network provider, you will usually have lower out-of-pocket expenses because of the network discounts and other features like a smaller copayment and/or a reduced or waived deductible. All FFS plans require precertification of inpatient admissions and may require preauthorization of certain procedures or other services.

FFS PLAN KEY FEATURES:

- No geographic restrictions on the doctors and other providers you can use; you have nationwide coverage. Plans may also provide overseas coverage
- Freedom to use non-network providers.
- No requirement to select a primary care physician
- Referrals are not required to see specialists
- You typically pay copayments or coinsurance when you receive care
- There is usually an annual deductible that applies to certain benefits
- Preventive care services are covered at no cost to you, but mostly when network providers are used

MHBP PLAN FEATURES:

- 24/7 customer service from knowledgeable, courteous staff
- Nationwide access to Network providers of all types
- Non-Network benefits for covered care
- Claims paid quickly and accurately
- Selecting a primary care physician is not required, but we recommend that doctors help guide your care
- Referral-free access to specialists
- Nurse support around the clock
- Secure online tools to help you manage your health and benefits
- Customized wellness programs to support your health goals
- Plenty of extra savings and discounts

To learn more about the health plans available to you, contact your agency's human resources office, your retirement system, or visit www.opm.gov/healthcare-insurance.

Evaluating a Health Plan

As you research health plans, it's important to look for the best value. Don't get caught up on the plan name (such as High or Standard option). Remember, value is a balance of many factors, including your choice of health care providers, benefit levels for the services that are most important to you, the premiums and other costs you pay, the service you'll get and what's convenient for you.

Provider Choice

Is my doctor in the network? Is access available where I need it?

- Determine if you need a plan with local or national coverage. If you travel frequently or have children away in college, you may want a national health plan.
- Confirm your provider's participation in the network by calling the health plan and the provider before you enroll.
- Make sure the plan's network includes doctors with the specialties you may need, such as dermatology, cardiology, gynecology and others.
- Review any requirements the plan may have for getting care through a specialist, such as getting a referral.

Tip: *Choose providers that participate in your health plan's network. You will maximize your benefits and save money.*

Coverage

What services/expenses do my benefits cover, and what do I need?

- Read the health plan information and benefit descriptions (official plan brochure) to learn what medical expenses and services are covered by the plans you are considering.
- Check coverage for any services you expect you will need, like maternity, chiropractic care, or allergy care.
- Consider how often you expect to need the services that are most important to you. Review any limitations or exclusions for the services you may need. Plan exclusions are listed in the official plan brochure.
- Review the plan's drug formulary to determine if the medications you take are covered and how much they will cost you. A formulary is a list of prescription drugs that are preferred by your health plan based on safety, effectiveness and cost.
- If you have TRICARE, learn how your FEHB Program benefits coordinate with this coverage.

Tip: *Make a list of the medical services you will need, and call the plan(s) you are considering to confirm what is covered. It's important to select a plan with benefits that best meet your needs.*

Cost

How much will I have to pay?

When trying to predict your annual health care costs, you want to look at five key elements: premium, deductible, copayment, coinsurance and the catastrophic protection limit.

Premium — The amount you pay for your coverage, deducted from your biweekly paycheck. Premiums can vary across the benefit plans offered to you.

Deductible — The amount you must pay for health care before your health plan begins to pay. Deductibles typically apply on a per-calendar-year basis and can change from year to year.

Copayment — A fixed dollar amount that you pay as your share of the cost of medical services you receive (for example, $20 for a doctor's office visit).

Coinsurance — A percentage of the cost you pay as your share of the medical services you receive (for example, 20% of the cost of a lab test).

Catastrophic protection limit — The maximum amount for certain covered charges you have to pay out of your pocket during the year. Setting a maximum amount protects you. Separate limits are usually applied on a per-person and per-family basis.

Tip: *As you consider cost, keep in mind the services you use most often and services that you need or want. Also consider any other coverage you may need that provides medical, mental health and prescription drug benefits. This will give you a good indication of your potential out-of-pocket costs.*

Service

Will this health plan be there for me?

Contact the plan you are considering *before* you become a member to experience their customer service. When you call, you can assess how easy it is to reach a real person and get answers to your questions. If your co-workers are enrolled in the health plan you are considering, ask them about their experience. Tools to help you evaluate health plan quality and service are available at www.opm.gov/healthcare-insurance.

Tip: *Good service is essential to your benefits working for you. Choose a plan that has knowledgeable service representatives who are able to answer your questions.*

Photo: Istockphoto.com

MHBP Has a Plan for You

The health plans we offer to federal employees provide comprehensive coverage you can count on regardless of your stage of life, location or health status. Whether you're newly eligible to enroll for coverage or making a change due to a qualifying life event, one of our three national health plans is designed to suit your needs. We're sure to have a plan that's right for you.

Our plans at a glance:

DENTAL AND VISION – Page 7

MHBP offers year-round enrollment in our stand-alone dental and vision plans. Expand your coverage when you add one or both of our affordable options. These plans offer great benefits, national coverage and affordable monthly rates.

VALUE PLAN – Page 8

Enjoy affordable premiums, great benefits and more. This health plan is perfect if you want to save money on your premiums while getting valuable health coverage.

IDENTITY THEFT PROTECTION – Page 7

When safeguarding your identity means everything to you, it's of the utmost importance that you take measures to protect it. LifeLock® helps you do just that in a way that's truly affordable.

STANDARD OPTION – Page 10

Get comprehensive health coverage, predictable copays and low out-of-pocket costs that take the guesswork out of your health care expenses.

CONSUMER OPTION – Page 12

You are in control of your health care spending with our high-deductible health plan with a health savings account (HSA). This plan puts up to $1,690 tax-free into your HSA annually, pays 100% of your preventive care and provides top-notch coverage after your deductible is met.

Photo: Istockphoto.com

Dental, Vision and More

Enhance your medical coverage by adding one or all of these options.* You will enjoy affordable monthly rates, comprehensive benefits and nationwide coverage.
And you can enroll year-round!

Learn more and enroll. Call 1-800-254-0227 or visit www.MHBP.com.

Dental Plan**	Vision Plan	Identity Theft Protection
Take advantage of nationwide access, comprehensive benefits and affordable group rates for dental coverage whenever you're ready. This benefit plan accepts enrollment year-round and on a stand-alone basis — meaning you don't have to enroll in one of our medical plans to get it.	Just like dental, the vision plan gives you great benefits, access and coverage, but for an undeniably low premium. With rates starting at just $8.60 a month, this coverage is simply a must-have — it's a great addition to any plan.	When safeguarding your identity means everything to you, it's of the utmost importance that you take measures to protect it. LifeLock® Identity Theft Protection helps you do just that in a way that's truly affordable.
Program Features		
Available nationwide	Available nationwide	Available nationwide
Comprehensive coverage	Comprehensive coverage	Comprehensive coverage
Out-of-network benefits	Out-of-network benefits	Does not apply
Affordable monthly rates — based on your home ZIP code: **(call or check online)**	Affordable monthly rates: **$8.60 self/$16.00 family**	Affordable monthly rates: **$8.50 adults/$2.13 minors**
Enroll anytime	Enroll anytime	Enroll anytime
Program Benefits		
• Preventive care covered 100% twice a year • Basic care, such as fillings and extractions, covered at 70% for the first 12 months and 80% thereafter • Major care, such as root canals and crowns, is covered at 50% starting the 13th month • Orthodontia benefits begin the 25th month of coverage (covered dependents up to age 18)	• Eye exams and lenses every 12 months for just a $10 copay each • Up to $120 for frames (every 24 months) or contact lenses (every 12 months)	• Identity threat detection and alerts • Lost wallet protection • Address change verification • Advanced Internet monitoring • Reduced pre-approved credit offers • 24/7/365 member service • $1 Million Total Service Guarantee (in states where permitted)

*A single annual $42 Mail Handlers Benefit Plan associate membership fee makes these plans available to you. Dental and vision coverage are provided by First Health Life & Health Insurance Company, Cambridge Life Insurance Company or Vision Service Plan, Inc. These benefits are neither offered nor guaranteed under contract with the FEHBP, but are made available to all FEHBP enrollees and their covered family members. You cannot file an FEHBP disputed claim about them. The premiums and fees you pay for these services do not count toward FEHBP deductibles or out-of-pocket maximums. See certificates of insurance for full coverage details, exclusions and limitations.

**For dental coverage, the annual deductible ($50 per person, $150 per family) applies to non-preventive care and the annual benefit maximum is $2,000 per person per calendar year. After the first year, premiums are subject to change with 60 days' notice. Coverage will not begin without payment of premium and it is renewable as long as your premiums are paid and the Master Group Policy remains in force, and you remain eligible for this coverage. The dental network is made available by The Guardian Life Insurance Company of America. Benefits are not provided for services rendered outside the 50 United States and the District of Columbia.

Photo: Shutterstock.com

MHBP Value Plan

Get valuable coverage and savings on your premium!

MHBP Value Plan is perfect if you want to pay less for your health coverage and still get the benefits you need. This plan balances your need for great health benefits, preventive care and catastrophic protection while saving you serious money on your premiums.

MHBP Value Plan 2015 Rates	Federal Biweekly	Postal		Annuitants Monthly
		Category 1 Biweekly	Category 2 Biweekly	
Self Only – 414	$56.86	$44.92	$56.86	$123.20
Self and Family – 415	$135.56	$107.09	$135.56	$293.71

These rates don't apply to all enrollees. If you're in a special enrollment category, please refer to your Guide to Federal Benefits or contact the agency that maintains your health benefits enrollment.

MHBP Value Plan continues to offer one of the lowest rates in the FEHBP, along with the health benefits you want — including benefits that give you **100% coverage, with no deductible, when you use Network providers for:**

- Annual physical exams
- Preventive care screenings
- Women's preventive care – includes improved coverage for various services
- Primary care doctor visits after a $30 copay for adults ($10 for dependents through age 21)
- Convenient care clinic visits after a $15 copay for adults ($5 for dependents through age 21)
- Maternity care
- Well-child care and immunizations
- Lab tests (with Quest Diagnostics®)

Plus, you have coverage for other doctor's office visits, hospitalizations, emergency care and surgery. You also have coverage for alternative care such as chiropractic and acupuncture. And you can fill your generic prescriptions at a Network pharmacy for a low $10 copay.

Special Member Benefits*

MHBP members enjoy vision care discounts and savings from EyeMed® Vision Care providers, laser vision correction savings from the U.S. Laser Network and QualSight®, a hearing aid discount program from HearPO, pharmacy savings with the CVS/Caremark ExtraCare® Health Card and weight management from Weight Watchers®.

*These benefits are neither offered nor guaranteed under contract with the FEHBP, but are made available to all MHBP enrollees and their covered family members. You cannot file an FEHBP disputed claim about them. The fees you pay for these services do not count toward FEHBP deductibles or out-of-pocket maximums.

This is a summary of the Mail Handlers Benefit Plan Value Plan. Before making a final decision, please read the 2015 official Plan brochure (RI 71-007). All benefits are subject to the definitions, limitations and exclusions set forth in the 2015 official Plan brochure. A single annual $42 MHBP associate membership fee makes the Value Plan available to you.

Get all the Value Plan details by reviewing the official Plan brochure at **www.MHBP.com**.

Questions? Call us 24/7 at 1-800-410-7778 or visit www.MHBP.com.

MHBP Value Plan 2015 Benefit Summary

This is a summary of the MHBP Value Plan. DO NOT RELY ON THIS CHART ALONE. All benefits are fully described in the 2015 official Plan brochure (RI 71-007).

MEDICAL COVERAGE	**Network Benefits** (*notes calendar year deductible applies) You pay	**Non-Network Benefits** (calendar year deductible applies to all benefits) You pay
Preventive Care/Wellness		
Adult annual physical exam (office visit)	Nothing	All charges
Adult routine screenings and immunizations including cholesterol screenings, mammograms, Pap and HPV tests, PSA tests, bone density screening, urinalysis, colon cancer screenings and more	Nothing	All charges
Women's Preventive Care – includes improved coverage for various services as outlined in the official Plan brochure	Nothing	All charges
Well-child care (routine office visits, immunizations and certain screenings)	Nothing	All charges
QuitPower® tobacco cessation program – up to two quit attempts per year, with five counseling sessions per attempt	Nothing	Nothing
Physician-prescribed OTC and prescription drugs approved by the FDA to treat tobacco dependence	Nothing	All charges
Physician Care		
Primary Care Physician visits (Family Practice, General Practice, Internal Medicine and Pediatrics)	$30 copay for adults $10 copay for dependents through age 21	40% of the Plan's allowance and any difference between our allowance and the billed amount
Specialist visits	$50 copay*	
Convenient Care Clinic visits (such as MinuteClinic® or Take Care Clinic℠)	$15 copay for adults $5 copay for dependents through age 21	
Maternity	Nothing	
Surgery – Inpatient	20% of the Plan's allowance*	
Surgery – Outpatient (at a hospital or ambulatory surgical center)	Nothing	
Hospital/Facility Care		
Inpatient hospital (room & board and ancillary services, precertification required)	20% of the Plan's allowance*	40% of the Plan's allowance and any difference between our allowance and the billed amount
Inpatient maternity	Nothing	
Outpatient hospital or ambulatory surgical facility – Surgical	$300 copay per occurrence	
Outpatient hospital or ambulatory surgical facility – Non-surgical	20% of the Plan's allowance*	
Emergency Services		
Emergency room visits	20% of the Plan's allowance per visit for the first 5 visits per person per calendar year; 40% of the Plan's allowance per visit for all subsequent visits*	20% of the Plan's allowance per visit and any difference between our allowance and the billed amount for the first 5 visits per person per calendar year; 40% of the Plan's allowance per visit and any difference between our allowance and the billed amount for all subsequent visits
Urgent Care Center visits	20% of the Plan's allowance* (No deductible for accidental injury)	40% of the Plan's allowance and any difference between our allowance and the billed amount
Ambulance	20% of the Plan's allowance*	
Lab, X-ray and Other Diagnostics		
Non-routine Lab, X-ray and other diagnostic tests	20% of the Plan's allowance*	40% of the Plan's allowance and any difference between our allowance and the billed amount
Specialized Imaging Procedures (such as CT/CAT scans, MRI and PET) Preauthorization is required. *Provided in a hospital outpatient setting* *Provided in a stand-alone imaging center or clinic*	 20% of the Plan's allowance* Nothing*	 40% of the Plan's allowance and any difference between our allowance and the billed amount
Lab Savings Program	You pay nothing for covered lab tests with the Lab Savings Program with Quest Diagnostics®	
Alternative Treatments		
Chiropractic	20% of the Plan's allowance up to the 26-visit combined therapies annual maximum; all charges after 26 visits*	All charges
Acupuncture	20% of the Plan's allowance up to the 26-visit combined therapies annual maximum; all charges after 26 visits*	40% of the Plan's allowance and any difference between our allowance and the billed amount up to the 26-visit combined therapies annual maximum; all charges after 26 visits
Calendar Year Deductible		
Self Only	$600	$900
Self and Family	$1,200	$1,800
Catastrophic Protection Out-of-Pocket Maximum		
You pay nothing for the rest of the calendar year after your out-of-pocket expenses for covered services, drugs and supplies total this amount.	$6,600 per person, limited to $13,200 per family	$10,000 per person, limited to $20,000 per family
PRESCRIPTION DRUG COVERAGE (the calendar year deductible does not apply to prescription drug benefits)	**Network Pharmacy and Electronic Claims**	**Non-Network Pharmacy and Paper Claims**
Network Retail Pharmacy (up to a 30-day supply)		
Generic	$10 copay	All charges
Preferred Brand**	45% of the Plan's allowance	
Non-Preferred Brand**	75% of the Plan's allowance	
Mail Order Drug Program – ***mandatory for maintenance medications*** (up to a 90-day supply)		
Generic	$30 copay	All charges
Preferred Brand**	45% of the Plan's allowance	
Non-Preferred Brand**	75% of the Plan's allowance	
**You will pay the copayment or coinsurance amount and the difference in cost between our allowance for the generic and brand-name drugs when a generic is available, unless a brand exception is obtained.		
Specialty Drugs		
Specialty drugs are used to treat chronic, complex conditions and typically require special handling and close monitoring — only available through CVS/Caremark Specialty Pharmacy. Preauthorization is required.	50% of the Plan's allowance	All charges

MHBP Standard Option

A winning combination of practical coverage and predictable costs!

MHBP Standard Option is perfect if you want comprehensive health coverage and predictable copays. Manage your health expenses and get the care you need.

MHBP Standard Option 2015 Rates	Federal Biweekly	Postal		Annuitants Monthly
		Category 1 Biweekly	Category 2 Biweekly	
Self Only – 454	$92.65	$78.62	$92.65	$200.74
Self and Family – 455	$225.79	$194.64	$225.79	$489.21

These rates don't apply to all enrollees. If you're in a special enrollment category, please refer to your Guide to Federal Benefits or contact the agency that maintains your health benefits enrollment.

Comprehensive Coverage — Experience a plan that provides a full range of coverage. From preventive care to hospitalizations, emergency care, and prescription drugs, you are covered.

Benefits that provide 100% coverage, with no deductible, when you use Network providers for:

- Adult annual physical exams
- Women's preventive care – includes improved coverage for various services
- Wellness screenings (such as mammograms, cholesterol tests and prostate exams)
- Maternity care (including prenatal, delivery and postnatal)
- Well-child care
- Lab tests (with Quest Diagnostics®)

Predictable out-of-pocket costs that help you budget when you use Network providers, with no deductible:

- $5 copay for convenient care clinic visits
- $20 adult office visit copay ($10 for dependents through age 21)
- $5 copay for generic medications at a Network retail pharmacy
- $20 copay for chiropractic visits (up to a 26-visit combined therapies annual maximum)

Special Member Benefits*

MHBP members enjoy vision care discounts and savings from EyeMed® Vision Care providers, laser vision correction savings from the U.S. Laser Network and QualSight®, a hearing aid discount program from HearPO, pharmacy savings with the CVS/Caremark ExtraCare® Health Card and weight management from Weight Watchers®.

*These benefits are neither offered nor guaranteed under contract with the FEHBP, but are made available to all MHBP enrollees and their covered family members. You cannot file an FEHBP disputed claim about them. The fees you pay for these services do not count toward FEHBP deductibles or out-of-pocket maximums.

This is a summary of the Mail Handlers Benefit Plan Standard Option. Before making a final decision, please read the 2015 official Plan brochure (RI 71-007). All benefits are subject to the definitions, limitations and exclusions set forth in the 2015 official Plan brochure. A single annual $42 MHBP associate membership fee makes the Standard Option available to you.

Get all the Standard Option details by reviewing the official Plan brochure at **www.MHBP.com.**

MHBP Standard Option 2015 Benefit Summary

This is a summary of the MHBP Standard Option. DO NOT RELY ON THIS CHART ALONE. All benefits are fully described in the 2015 official Plan brochure (RI 71-007).

MEDICAL COVERAGE	**Network Benefits** (*notes calendar year deductible applies) You pay	**Non-Network Benefits** (calendar year deductible applies to all benefits, except as noted) You pay
Preventive Care/Wellness		
Adult annual physical exam (office visit)	Nothing	All charges
Adult routine screenings and immunizations including cholesterol screenings, mammograms, Pap and HPV tests, PSA tests, bone density screening, urinalysis, colon cancer screenings and more	Nothing	30% of the Plan's allowance and any difference between our allowance and the billed amount
Women's Preventive Care – includes improved coverage for various services as outlined in the official Plan brochure	Nothing	See Plan brochure
Well-child care (routine office visits, immunizations and certain screenings)	Nothing	See Plan brochure
QuitPower® tobacco cessation program – up to two quit attempts per year, with five counseling sessions per attempt	Nothing	Nothing
Physician-prescribed OTC and prescription drugs approved by the FDA to treat tobacco dependence	Nothing	All charges
Physician Care		
Primary Care Physician visits (Family Practice, General Practice, Internal Medicine and Pediatrics)	$20 copay for adults $10 copay for dependents through age 21	30% of the Plan's allowance and any difference between our allowance and the billed amount
Specialist visits	$40 copay	
Convenient Care Clinic visits (such as MinuteClinic® or Take Care Clinic℠)	$5 copay	
Maternity	Nothing	
Surgery – Inpatient	10% of the Plan's allowance*	
Surgery – Outpatient (at a hospital or ambulatory surgical center)	10% of the Plan's allowance*	
Hospital/Facility Care		
Inpatient hospital (room & board and ancillary services, precertification required)	$200 per admission copayment and 15% of the Plan's allowance for ancillary services	$500 copay per admission, 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)
Inpatient maternity	Nothing	
Outpatient hospital or ambulatory surgical center	10% of the Plan's allowance*	30% of the Plan's allowance and any difference between our allowance and the billed amount
Emergency Services		
Emergency room visits	$200 copay per visit for the first 5 visits per person per calendar year; $600 copay per visit for all subsequent visits (The calendar year deductible applies to ER visits not related to an accidental injury. Copay is waived if admitted to the hospital.)	$200 copay per visit and any difference between the Plan's allowance and the billed amount for the first 5 visits per person per calendar year; $600 copay per visit and any difference between the Plan's allowance and the billed amount for all subsequent visits (The calendar year deductible does not apply to ER visits related to an accidental injury. Copay is waived if admitted to the hospital.)
Urgent Care Center visits	$50 copay* (No deductible for accidental injury)	30% of the Plan's allowance and any difference between our allowance and the billed amount
Ambulance	10% of the Plan's allowance*	30% of the Plan's allowance and any difference between our allowance and the billed amount
Lab, X-ray and other Diagnostics		
Non-routine Lab, X-ray and other diagnostic tests	10% of the Plan's allowance*	30% of the Plan's allowance and any difference between our allowance and the billed amount
Specialized Imaging Procedures (such as CT/CAT scans, MRI and PET) Preauthorization is required. *Provided in a hospital outpatient setting* *Provided in a stand-alone imaging center or clinic*	 10% of the Plan's allowance* Nothing*	 30% of the Plan's allowance and any difference between our allowance and the billed amount
Lab Savings Program	You pay nothing for covered lab tests with the Lab Savings Program with Quest Diagnostics®	
Alternative Treatments		
Chiropractic	$20 copay per visit up to the 26-visit combined therapies annual maximum; all charges after 26 visits	30% of the Plan's allowance and any difference between our allowance and the billed amount up to the 26-visit combined therapies annual maximum; all charges after 26 visits (no deductible)
Acupuncture	10% of the Plan's allowance up to the 26-visit combined therapies annual maximum; all charges after 26 visits*	30% of the Plan's allowance and any difference between our allowance and the billed amount up to the 26-visit combined therapies annual maximum; all charges after 26 visits
Calendar Year Deductible		
Self Only	$400	$600
Self and Family	$800	$1,500
Catastrophic Protection Out-of-Pocket Maximum		
You pay nothing for the rest of the calendar year after your out-of-pocket expenses for covered services, drugs and supplies total this amount.	$6,000 per person, limited to $12,000 per family	$9,000 per person, limited to $18,000 per family
PRESCRIPTION DRUG COVERAGE (the calendar year deductible does not apply to prescription drug benefits)	**Network Pharmacy and Electronic Claims**	**Non-Network Pharmacy and Paper Claims**
Retail Pharmacy (up to a 30-day supply)		
Generic	$5 copay	50% of the Plan's allowance and any difference between our allowance and the billed amount
Preferred Brand**	30% of the Plan's allowance, limited to $200 per prescription	
Non-Preferred Brand**	50% of the Plan's allowance, limited to $200 per prescription	
Mail Order Pharmacy (up to a 90-day supply)		
Generic	$10 copay	All charges
Preferred Brand**	$80 copay	
Non-Preferred Brand**	$120 copay	
**You will pay the copayment or coinsurance amount and the difference in cost between our allowance for the generic and brand-name drugs when a generic is available, unless a brand exception is obtained.		
Specialty Drugs		
Specialty drugs are used to treat chronic, complex conditions and typically require special handling and close monitoring – only available through CVS/Caremark Specialty Pharmacy. Preauthorization is required.	30-day supply: 15% of the Plan's allowance, limited to $200 per prescription 90-day supply: 15% of the Plan's allowance, limited to $425 per prescription	All charges

MHBP Consumer Option

Your care. Your choice. Your money.

MHBP Consumer Option is our high-deductible health plan with a health savings account (HSA) that lets you decide how and when you spend your health care dollars.

MHBP Consumer Option 2015 Rates	Federal Biweekly	Postal		Annuitants Monthly
		Category 1 Biweekly	Category 2 Biweekly	
Self Only – 481	$64.22	$50.74	$64.22	$139.15
Self and Family – 482	$145.52	$114.96	$145.52	$315.30

These rates don't apply to all enrollees. If you're in a special enrollment category, please refer to your Guide to Federal Benefits or contact the agency that maintains your health benefits enrollment.

The health benefits you get:

- Receive 100% coverage for your preventive care needs (physical exams, screenings, immunizations, mammograms, Pap tests, women's preventive care and more) when you use Network providers — and no deductible applies
- Experience comprehensive coverage for non-preventive health care after your deductible is met. You will pay all costs for these services, but you can use your HSA funds
- Cost sharing begins once your deductible is satisfied — you will pay only your copayment or coinsurance and we will cover the rest

The health savings account (HSA) you control:

- Get up to $845 annually ($70.41 per month) in your HSA for Self Only coverage, or up to $1,690 annually ($140.83 per month) for Self and Family coverage
- Use your convenient debit card to pay for things like doctor visits, prescription drugs or other IRS-qualified medical expenses
- Save your HSA money and let it roll over from year to year, or use the money as you need care — it's up to you
- Take advantage of opportunities to invest funds over $1,000
- HSA funds remain yours if you retire, change jobs or leave federal service — there's no "use it or lose it" rule

The tax benefits you enjoy:

- All of the funds we deposit into your HSA are federal tax-free
- Any money you contribute to your account is tax-free, up to the IRS-defined limits

All of these benefits assume the use of Network providers and pharmacies and that you are eligible to have an HSA under federal tax laws.

Special Member Benefits*

MHBP members enjoy vision care discounts and savings from EyeMed® Vision Care providers, laser vision correction savings from the U.S. Laser Network and QualSight®, a hearing aid discount program from HearPO, pharmacy savings with the CVS/Caremark ExtraCare® Health Card and weight management from Weight Watchers®.

*These benefits are neither offered nor guaranteed under contract with the FEHBP, but are made available to all MHBP enrollees and their covered family members. You cannot file an FEHBP disputed claim about them. The fees you pay for these services do not count toward FEHBP deductibles or out-of-pocket maximums.

This is a summary of the Mail Handlers Benefit Plan Consumer Option. Before making a final decision, please read the 2015 official Plan brochure (RI 71-016). All benefits are subject to the definitions, limitations and exclusions set forth in the 2015 official Plan brochure. A single annual $42 MHBP associate membership fee makes the Consumer Option available to you.

Get all the Consumer Option details by reviewing the official Plan brochure at **www.MHBP.com.**

Questions? Call us 24/7 at 1-800-410-7778 or visit www.MHBP.com.

MHBP Consumer Option 2015 Benefit Summary

This is a summary of the MHBP Consumer Option. DO NOT RELY ON THIS CHART ALONE. All benefits are fully described in the 2015 official Plan brochure (RI 71-016).

Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA, only applies if you are not eligible for a HSA)

Annual Contribution	HSA	HRA
MHBP: *(up to)*	$845 (Self Only); $1,690 (Self & Family)	$845 (Self Only); $1,690 (Self & Family)
Member, *Optional: (up to)*	$2,505 (Self Only); $4,960 (Self & Family)	You cannot contribute to an HRA
Calendar Year Deductible	**Self Only**	**Self and Family**
Deductible	$2,000	$4,000

PREVENTIVE CARE/WELLNESS (calendar year deductible does not apply to Network preventive care)	You Pay	
	Network Benefits	**Non-Network Benefits**
Adult annual physical exam (office visit)	Nothing	All charges
Adult routine screenings and immunizations including cholesterol screenings, mammograms, Pap and HPV tests, PSA tests, bone density screening, urinalysis, colon cancer screenings and more.	Nothing	All charges
Women's Preventive Care – includes improved coverage for various services as outlined in the official Plan brochure.	Nothing	All charges
Well-child care (routine office visits, immunizations and certain screenings)	Nothing	All charges
QuitPower® tobacco cessation program – up to two quit attempts per year, with five counseling sessions per attempt.	Nothing	Nothing
Physician-prescribed OTC and prescription drugs approved by the FDA to treat tobacco dependence.	Nothing	All charges

TRADITIONAL MEDICAL COVERAGE (calendar year deductible applies to all benefits)	You Pay	
	Network Benefits	**Non-Network Benefits**
Physician Care		
Doctor's office visits (primary care physicians and specialists)	$15 copay	40% of the Plan's allowance and any difference between our allowance and the billed amount
Convenient Care Clinic visits (such as MinuteClinic® or Take Care Clinic℠)	$5 copay	
Maternity	Nothing	
Surgery – Inpatient	Nothing	
Surgery – Outpatient (at a hospital or ambulatory surgical center)	Nothing	
Hospital/Facility Care		
Inpatient hospital (room and board and ancillary services, precertification required)	$75 copay per day, up to $750 maximum per admission	40% of the Plan's allowance and any difference between our allowance and the billed amount
Inpatient maternity		
Outpatient hospital or ambulatory surgical facility – Surgical	$150 copay per occurrence	
Outpatient hospital or ambulatory surgical facility – Non-surgical	$75 copay per occurrence	
Emergency Services		
Emergency room visits	$50 copay (waived if admitted to the hospital)	$50 copay and any difference between our allowance and the billed amount (copay waived if admitted to the hospital)
Urgent Care Center visits		
Ambulance	Nothing	40% of the Plan's allowance and any difference between our allowance and the billed amount
Lab, X-ray and Other Diagnostics		
Non-routine Lab, X-ray and other diagnostic tests	$15 copay	40% of the Plan's allowance and any difference between our allowance and the billed amount
Specialized Imaging Procedures (such as CT/CAT scans, MRI and PET) Preauthorization is required. *Provided in a hospital outpatient setting* *Provided in a stand-alone imaging center or clinic*	 $75 copay Nothing	40% of the Plan's allowance and any difference between our allowance and the billed amount
Lab Savings Program	You pay nothing for covered lab tests with the Lab Savings Program with Quest Diagnostics®	
Alternative Treatments		
Chiropractic and Acupuncture	$15 copay per visit up to the 26-visit combined therapies annual maximum per person per calendar year; all charges after 26 visits	40% of the Plan's allowance and any difference between our allowance and the billed amount up to the 26-visit combined therapies annual maximum per person per calendar year; all charges after 26 visits
Catastrophic Protection Out-of-Pocket Maximum		
You pay nothing for the rest of the calendar year after your out-of-pocket expenses for covered medical services totals this amount (includes your annual deductible and the copayments and Non-Network coinsurance, but does not include amounts in excess of the Plan's allowance or benefit maximums and certain other expenses).	$5,000 Self Only (Network providers) $10,000 Self & Family (Network providers)	$7,500 Self Only (Non-Network providers) $15,000 Self & Family (Non-Network providers)

PRESCRIPTION DRUG COVERAGE (calendar year deductible applies to prescription drug benefits)	You pay	
	Network Pharmacy and Electronic Claims	**Non-Network Pharmacy and Paper Claims**
Network Retail Pharmacy (up to a 30-day supply)		
Generic	$10 copay	All charges
Preferred Brand*	$25 copay	
Non-Preferred Brand*	$40 copay	
Mail Order Drug Program (up to a 90-day supply)		
Generic	$20 copay	All charges
Preferred Brand*	$50 copay	
Non-Preferred Brand*	$80 copay	

*You will pay the copayment amount and the difference in cost between the generic and brand name drugs when a generic is available, unless a brand exception is obtained.

Frequently Asked Questions

Who is eligible to enroll in an FEHB plan?

As a federal employee, you are entitled to enroll yourself and any eligible family members in a health plan offered under the FEHB Program, unless your position is excluded from coverage by law or regulation. Your human resources personnel can help you determine your eligibility.

Who can enroll in the MHBP?

MHBP is open to everyone — federal and postal employees and annuitants alike. Enroll using the method supported by your agency. For example, most federal employees use Employee Express, and most postal employees use PostalEASE.

What are the enrollment levels?

There are two types of enrollment: Self Only and Self and Family. A Self Only enrollment provides benefits only for you as the enrollee. You may enroll for Self Only even though you have a family, but your family members will not be eligible for FEHB coverage (even upon your death or disability). A Self and Family enrollment generally covers you, your spouse and your dependent children under age 26.

What are enrollment codes?

An enrollment code identifies the plan, the option (High, Standard, Value, etc.), and the type of enrollment (Self Only or Self and Family) you have chosen. The first two places in the three-digit code identify the plan, and the third position identifies the option and type of enrollment. Enrollment codes are found on the front and back covers of each plan's brochure and in the Guide to Federal Benefits published by the U.S. Office of Personnel Management.

Up to what age are dependent children covered?

In FEHBP, your dependent children can be covered under your Self and Family enrollment until age 26. In some cases, dependent children over age 26 may be covered if they are incapable of self-support. Consult your human resources office for more information.

Are pre-existing conditions covered?

Yes. There are no exclusions or waiting periods for pre-existing conditions in any plan in the FEHB Program.

What is an official plan brochure?

You may receive informational or promotional brochures from health plans, but always refer to the official plan brochure before making any decisions. Official plan brochures contain complete information on your benefits including exclusions, limitations and other major provisions. Each plan produces a new brochure every calendar year. You should review the brochures for the plans that you are eligible to join to help you make an informed choice. You can access all plan brochures at www.opm.gov/healthcare-insurance. You can also obtain brochures from your employing office or by contacting the health plans directly. You should keep your plan's brochure to reference the benefits that it provides.

Get more answers to frequently asked questions and other information when you visit:

www.opm.gov/healthcare-insurance/insurance-faqs/health

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Enrolling in FEHBP

Newly eligible employees have 60 days from your entry on duty date to sign up for a health insurance plan. If you don't make an election, you are considered to have declined coverage and you must wait until the next Open Season to enroll. It is to your advantage to elect coverage as soon as possible in case of accident or illness. There is no retroactive coverage of your expenses prior to the effective date of your enrollment. There are other circumstances that may make you eligible to enroll or change your FEHB coverage outside of Open Season. Visit www.opm.gov/healthcare-insurance or consult your agency's human resources office for more information.

During the annual FEHBP Open Season, anyone eligible to participate in the FEHB Program may enroll, change health plans or options, cancel FEHB enrollment, or change participation in premium conversion (waive or begin participation). Open Season generally runs from the Monday of the second full work week in November through the Monday of the second full work week in December.

How to Enroll

1 Start by selecting the enrollment code for the level of coverage you need. For your quick reference, here are the plan codes for MHBP:

Plan	Level	Enrollment Code
Value Plan	Self Only	**414**
Value Plan	Self and Family	**415**
Standard Option	Self Only	**454**
Standard Option	Self and Family	**455**
Consumer Option	Self Only	**481**
Consumer Option	Self and Family	**482**

2 Enroll using the method preferred by your agency:

- **Federal Employees** may use Employee Express to enroll (if offered by your agency). Go to www.employeeexpress.gov
- **Postal Employees** may enroll using PostalEase. Go to https://liteblue.usps.gov
- **Paper Enrollment** — if online enrollment is not available, complete an SF 2809 Employee Health Benefits Election Form and return it to your health benefits officer. This form can be found at www.opm.gov/forms/pdf_fill/sf2809.pdf

3 Receive confirmation of enrollment from your chosen plan. MHBP will send you a welcome package that will include your health plan ID card, the official Plan brochure and other information to help you successfully navigate your new coverage.

Contact Us

MHBP Telephone Numbers

MHBP Main Number **1-800-410-7778**

Overseas Members **1-480-445-5106**
(For a listing of overseas toll-free numbers, visit www.MHBP.com)

Dental, Vision and Identity Theft Protection **1-800-254-0227**

MHBP Website ..... www.MHBP.com

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To learn more about MHBP, please contact us anytime at 1-800-410-7778 or visit www.MHBP.com.

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