MHBP

www.MHBP.com

Customer Service - 800.410.7778

MHBP SM
Brought to you by Aetna

2021

A Fee for Service Plan (Standard Option and Value Plan) with a Provider Network

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 8 for details. This plan is accredited. See Section 1, *How This Plan Works*.

IMPORTANT
- Rates: Back Cover
- Changes for 2021: Page 14
- Summary of Benefits: Page 122

Sponsored by: The National Postal Mail Handlers Union, AFL-CIO, a Division of LIUNA.

Who may enroll in this Plan: All Federal employees and annuitants who are eligible to enroll in the Federal Employees Health Benefits Program and who are, or become, members or associate members of the National Postal Mail Handlers Union, AFL-CIO, a division of LIUNA.

To become a member or associate member: If you are a non-postal employee or an annuitant, you will automatically become an associate member of the National Postal Mail Handlers Union upon enrollment in MHBP. There is no membership charge for members of the National Postal Mail Handlers Union, AFL-CIO, a division of LIUNA.

Membership dues: $42 per year for an associate membership except where exempt by law. New associate members will be billed by the National Postal Mail Handlers Union for annual dues when the Plan receives notice of enrollment. Continuing associate members will be billed by the National Postal Mail Handlers Union for the annual membership.

Enrollment codes for this Plan:

454 Standard Option - Self Only
456 Standard Option - Self Plus One
455 Standard Option - Self and Family

414 Value Plan - Self Only
416 Value Plan - Self Plus One
415 Value Plan - Self and Family

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

RI 71-007

Important Notice from MHBP About

Our Prescription Drug Coverage and Medicare

The Office of Personnel Management has determined that the MHBP's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all Plan participants and is considered to be Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your Medicare Part D premium will go up at least 1% per month for each month you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what most other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may also have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 800-772-1213, TTY: 800-325-0778.

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help,
- Call 800-MEDICARE 800-633-4227, TTY: 877-486-2048.

MHBP Notice of Privacy Practices

We protect the privacy of your protected health information as described in our current MHBP Notice of Privacy Practices. You can obtain a copy of our Notice by calling us at 800-410-7778 or by visiting our website: www.MHBP.com.

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Introduction

This brochure describes the benefits of the Mail Handlers Benefit Plan (MHBP). The National Postal Mail Handlers Union, a division of LIUNA, AFL-CIO, a division of LIUNA, has entered into a contract (CS1146) with the United States Office of Personnel Management as authorized by the Federal Employees Health Benefit law. This plan is underwritten by First Health Life & Health Insurance Company (a wholly owned subsidiary of Aetna Inc.). Claims Administration Corp, a wholly owned subsidiary of Aetna, Inc. administers the Plan. Customer service may be reached at 800-410-7778 and through our website at www.MHBP.com. The address for the administrative offices is:

MHBP
PO Box 981106
El Paso, TX 79998-1106

This brochure is the official statement of benefits. No verbal statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2021, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2021, and changes are summarized on page 14. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee and each covered family member, "we" means MHBP.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your Plan identification (ID) number over the phone or to people you do not know, except to your health care provider, authorized health benefits plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Periodically review your claims history for accuracy to ensure we have not been billed for services you did not receive.
- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 800-410-7778 and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

877-499-7295

OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

You can also write to:

United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child age 26 or over (unless he/she was disabled and incapable of self support prior to age 26).
  - A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or material misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include falsifying a claim to obtain FEHB benefits, trying to or obtaining services for yourself or for someone who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

MHBP complies with all applicable Federal civil rights laws including Title VII of the Civil Rights Act of 1964.

You can also file a civil rights complaint with the Office of Personnel Management by mail at:

Office of Personnel Management
Healthcare and Insurance
Federal Employee Insurance Operations
Attention: Assistant Director FEIO
1900 E Street NW Suite 3400 S
Washington, DC 20415-3610

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own health care and that of your family members by learning more about and understanding your risks. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you take notes, ask questions and understand answers.

2. Keep and bring a list of all the medications you take.

- Bring the actual medication or give your doctor and pharmacist a list of all the medications and dosages that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food and other allergies you have, such as latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medication is what the doctor ordered. Ask the pharmacist about your medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understanding both the generic and brand names of your medications. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Do not assume the results are fine if you do not get them when expected. Contact your healthcare providers and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital or clinic is best for your health needs.

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, “Who will manage my care when I am in the hospital?”
- Ask your surgeon:
  - "Exactly what will you be doing?"
  - "About how long will it take?"
  - "What will happen after surgery?"
  - "How can I expect to feel during recovery?"

- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx The Joint Commission's Speak Up ™ patient safety program.
- www.jointcommission.org/topics/patient_safety.aspx The Joint Commission helps health care organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.bemedwise.org The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medications.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you do not expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a health care facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and to reduce medical errors that should never happen. When such an event occurs, neither you nor your FEHB plan will incur costs to correct the medical error.

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct never events, if you use Network providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Minimum essential coverage (MEC)**

Coverage under this plan qualifies as minimum essential coverage (MEC). Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

- **Where you can get information about enrolling in the FEHB Program**

See www.opm.gov/healthcare-insurance/healthcare for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies that participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you brochures for other plans and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- What happens when your enrollment ends; and
- When the next Open Season for enrollment begins.

We do not determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

- **Types of coverage available for you and your family**

Self Only coverage is for you alone. Self Plus One coverage is for you and one eligible family member. Self and Family coverage is for you and one eligible family member, or you, your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self Plus One or Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form. Benefits will not be available to your spouse until you are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered until the enrollee's FEHB enrollment.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

If you or one of your family members is enrolled in one FEHB plan, you or they cannot be enrolled in or covered as a family member by another enrollee in another FEHB plan.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/payroll office, or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described in the chart below.

Children	Coverage
Natural children, adopted children, and stepchildren	Natural children, adopted children and stepchildren are covered until their 26th birthday.
Foster children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children incapable of self-support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance.

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll in Self Plus One or Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that does not serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be processed according to the 2021 benefits of your prior plan or option.** If you have met (or pay cost-sharing that results in you meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. However, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan's 2020 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or assistance with enrolling in a conversion policy (a non-FEHB individual policy).

- **Upon divorce**

  If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get addition information about your coverage choices. You can also visit OPM's website, www.opm.gov/healthcare-insurance/healthcare/plan-information/guides. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered until the enrollee's FEHB enrollment.

- **Temporary Continuation of Coverage (TCC)**

  If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 26 regardless of marital status, etc.

  You may not elect TCC if you are fired from your Federal or Tribal job due to gross misconduct.

  Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance/healthcare/plan-information/guides. It explains what you have to do to enroll.

  Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

- **Converting to individual coverage**

  You may convert to a non-FEHB individual policy if:

  - Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
  - You decided not to receive coverage under TCC or the spouse equity law; or
  - You are not eligible for coverage under TCC or the spouse equity law.

  If you leave Federal or Tribal service, your employing office will notify you of your right to convert. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you.

  Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, a waiting period will not be imposed, and your coverage will not be limited due to pre-existing conditions.

- **Finding replacement coverage**

  This Plan no longer offers its own non-FEHB plan for conversion purposes. If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

  When you contact us, we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 800-410-7778 or visit our website, www.MHBP.com.

- **Health Insurance Marketplace**

  If you would like to purchase health insurance through the ACA's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How This Plan Works

This Plan is a fee-for-service (FFS) plan. OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. MHBP holds the following accreditations:

- Health Plan Accreditation from the Accreditation Association of Ambulatory Health Care, Inc. (AAAHC).
- Administered by Claims Administration Corp., an Aetna company is NCQAaccredited for Health Utilization Review and Case Management Programs; NCQA, URAC, and CMS credentialed and credentialed for Aetna Choice POS II (Open Access) Product.
- CVS Health (Pharmacy Benefit Manager) is URAC accredited for Pharmacy Benefit Management, Drug Therapy Management, Mail Service Pharmacy, Specialty Pharmacy and Health Call Center.

To learn more about this plan's accreditation(s) please visit the following websites:

- Accreditation Association of Ambulatory Health Care, Inc.(www.aaahc.org);
- National Committee for Quality Assurance (www.ncqa.org);
- URAC (www.URAC.org)

You can choose your own physicians, hospitals, and other health care providers. We give you a choice of enrollment in Standard Option or Value Plan.

We reimburse you or your provider for your covered services, usually based on a percentage of the amount we allow. The type and extent of covered services, and the amount we allow, may be different from other plans. Read brochures carefully.

General features of our Standard Option and Value Plan

We have Network providers

Our fee-for-service plan offers services through a network of health care providers. If you need assistance with locating a Network provider in your area contact us at 800-410-7778 or access our network directory via our website, www.MHBP.com. When you use Network providers, you will receive covered services at reduced cost. MHBP is solely responsible for the selection of Network providers in your area.

Continued participation of any specific provider cannot be guaranteed. When you phone for an appointment, please remember to verify that the health care professional or facility is still a Network provider. If your doctor is not currently participating in the provider network, you can nominate him or her to join. Physician nomination forms are available on our website, or call us and we'll have a form sent to you. You cannot change health plans outside of Open Season because of changes to the provider network.

This Plan uses either the Utah Connected Network - Choice POS II ("Utah Connected Network") or the standard Utah Network - Aetna Choice POS II ("Standard Network") as its provider network in the state of Utah. During open enrollment, if you are a Utah resident, you will have the opportunity to complete a Utah Network Access form stating your intent to access either the Utah Connected Network or the Standard Network for Utah effective January 1st. If you do not elect a network during open enrollment you will default to the Standard Network. The Utah Connected Network includes Intermountain Healthcare (IHC) and HCA/ Mountainstar facilities as supporting providers. The Standard Network includes HCA/Mountainstar, University of Utah, Steward Healthcare (formerly IASIS) and rural IHC facilities and supporting providers. Please review the provider directory for the network you will be selecting to confirm whether your provider participates in the network you select.

In all other states, the Network providers are those that participate in the Aetna Choice POS II product. Services from providers outside the continental United States, Alaska and Hawaii will be considered at the Network benefit levels. If you receive non-covered services from a Network provider, the Network discount will not apply and the services will be excluded from coverage. To save both you and the Plan money, we encourage the use of primary care physicians where available and appropriate.

The Non-Network benefits are the regular benefits of this Plan. Network benefits apply only when you use a Network provider. Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas. If no Network provider is available, or you do not use a Network provider, the regular Non-Network benefits apply. The nature of the services (such as urgent or emergency situations) does not affect whether benefits are paid as Network or Non-Network. However, we will provide the Network level of benefits for:

- services you receive from Non-Network anesthesiologists (including Certified Registered Nurse Anesthetists (CRNA)), hospitalists, intensivists, radiologists, pathologists, neonatologists and co-surgeons when inpatient services and outpatient surgical services are provided in a Network hospital;

- services you receive from Non-Network emergency room physicians, radiologists and pathologists when emergency treatment of an accidental injury or medical emergency is provided at a Network facility;
- services you receive from a Non-Network radiologist related to prior approved outpatient radiology procedures performed in a Network facility.

You will still be responsible for the difference between our allowance and the billed amount.

Other Non-Network Participating Providers

This Plan offers you access to certain other Non-Network health care providers that have agreed to discount their charges. Covered services at these participating providers are considered at the negotiated rate subject to applicable deductibles, copayments, and coinsurance. Since these other participating providers are not Network providers, Non-Network benefit levels will apply. Contact us at 800-410-7778 for more information about other Non-Network participating providers.

How we pay providers

When you use a Network health care provider or facility, our Plan allowance is the negotiated rate for the service. These Plan providers accept a negotiated payment from us and you will only be responsible for your cost-sharing (copayment, coinsurance, deductible, and non-covered services and supplies). You are not responsible for charges above the negotiated amount for covered services and supplies.

Non-Network facilities and providers do not have special agreements with the Plan. Our payment is based on the Plan allowance for covered services. You may be responsible for amounts over the allowance.

If Network providers are available where you receive care and you do not use them, your out-of-pocket expenses will increase. See Section 10, *Plan allowance*, for further details.

If we obtain discounts from other Non-Network participating providers or through direct negotiations with Non-Network providers, we pass along your share of the savings.

We apply Aetna claim editing criteria and/or the National Correct Coding Initiative (NCCI) edits published by the Centers for Medicare and Medicaid Services (CMS) in reviewing billed services and making Plan benefit payments for them.

Your rights and responsibilities

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- MHBP has been a Plan offering since 1963
- The National Postal Mail Handlers Union is a non-profit entity

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, www.MHBP.com. You can also contact us to request that we mail a copy to you.

If you want more information about us, call 800-410-7778, or write to: MHBP, P.O. Box 981106, El Paso, TX 79998-1106. You may also visit our website at www.MHBP.com.

By law, you have the right to access your protectedhealth information (PHI). For more information regarding access to PHI, visit our MHBP website, at www.MHBP.com to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Patient Management

We have developed a patient management program to assist in determining what health care services are covered and payable under the health plan and the extent of such coverage and payment. The program assists members in receiving appropriate health care and maximizing coverage for those health care services.

Precertification	Precertification is the process of collecting information prior to inpatient admissions and performance of selected ambulatory procedures and services. The process permits advance eligibility verification, determination of coverage, and communication with the physician and/or you. It also allows MHBP to coordinate your transition from the inpatient setting to the next level of care (discharge planning), or to register you for specialized programs like Aetna In Touch Care℠ (see Section 5(h), *Wellness and Other Special Features*), or our prenatal program. In some instances, precertification is used to inform physicians, members and other health care providers about cost-effective programs and alternative therapies and treatments. Certain health care services, such as hospitalization or outpatient surgery, require precertification to ensure coverage for those services. When you are to obtain services requiring precertification through a participating provider, this provider should precertify those services prior to treatment. Note: Since this Plan pays Non-Network benefits and you may self-refer for covered services, it is your responsibility to contact MHBP to precertify those services which require precertification. You must obtain precertification for certain types of care rendered by Non-Network providers to avoid a reduction in benefits paid for that care.
Concurrent Review	The concurrent review process assesses the necessity for continued stay, level of care, and quality of care for members receiving inpatient services. All inpatient services extending beyond the initial certification period will require concurrent review.
Discharge Planning	Discharge planning may be initiated at any stage of the patient management process and begins immediately upon identification of post-discharge needs during precertification or concurrent review. The discharge plan may include initiation of a variety of services/benefits to be utilized by you upon discharge from an inpatient stay.
Retrospective Record Review	The purpose of retrospective record review is to retrospectively analyze potential quality and utilization issues, initiate appropriate follow-up action based on quality or utilization issues, and review all appeals of inpatient concurrent review decisions for coverage and payment of health care services. Our effort to manage the services provided to you includes the retrospective review of claims submitted for payment, and of medical records submitted for potential quality and utilization concerns.

Section 2. Changes for 2021

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Changes to Standard Plan only:

- Your share of the Non-Postal premium will increase for Self only, Self Plus One and for Self Plus Family. See back cover.

Changes to Value Plan only:

- Your share of the Non-Postal premium will increase for Self only, Self Plus One and for Self Plus Family. See back cover.
- We placed a maximum dollar limit on the cost of drugs filled via our network pharmacy, foreign pharmacy, mail order or specialty pharmacy, see Section 5(f), *Prescription drug benefits.*

Changes to Standard Option and Value Plan:

- We added a prior approval requirement for gene therapy, gene editing and gene silencing, see Section 3, *How You Get Care.*
- We removed your cost share for professional non-emergency services provided in a MinuteClinic® at CVS, see Section 5(a), *Diagnostic and treatment services.*
- We modified how the Plan covers hearing service visits, see Section 5(a), *Hearing services.*
- We added telephonic and video consultations for medical, mental health and substance use disorders services, see Section 5(a), *Diagnostic and treatment services* and Section 5(e), *Mental Health and Substance Use Disorder Benefits.*
- We removed the visit limits for physical, speech and occupational therapies with a diagnosis of autism and developmental delays, see Section 5(e), *Behavioral health outpatient/all other services.*
- We removed prenatal vitamins from Section 5(f), *Preventive care medications* list.
- We added a Chronic Kidney Disease Care Program, see Section 5(h), *Wellness and Other Special Features.*
- We replaced our Telephonic health coach program, see Section 5(h), *Wellness and Other Special Features.*
- We added an AccordantCare™ Program, Section 5(h), *Wellness and Other Special Features.*
- We enhanced the Transform Care Program to include prediabetes and hypertension, see Section 5(h), *Wellness and Other Special Features.*
- We increased the number of visits allowed under alternative care treatments, see Section 5(a), *Chiropractic* and *Alternative Treatments.*
- We removed our prior approval requirement and changed how the Plan pays observation stays, see Section 5(c), *Services provided by a hospital or other facility, and ambulance services.*
- We increased the HRA Risk Assessment reward, see Section 5(h), *Wellness and Other Special Features.*
- We increased the Biometric Screening program reward, see Section 5(h), *Wellness and Other Special Features.*
- We increased the wellness incentive max a member can earn in a calendar year, see Section 5(h), *Wellness and Other Special Features.*

Clarifications to Standard Option and Value Plan:

- We clarified how the Plan processes expenses once an individual in a Self Plus one or Self and Family enrollment reaches the Plan's out-of-pocket maximum, see Section 4, *Your catastrophic protection out-of-pocket maximum.*

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800-410-7778 or write to us at MHBP, PO Box 981106, El Paso, TX 79998-1106. You may also request replacement cards through our website: www.MHBP.com.

Where you get covered care

You can get care from any "covered provider" or "covered facility". How much we pay – and you pay – depends on the type of covered provider or facility you use or who bills for the services. If you use Network providers, you will pay less.

- **Covered providers**

We provide benefits for the services of covered professional providers, as required by Section 2706(a) of the Public Health Service Act. Coverage of practitioners is not determined by your state's designation as a medically underserved area.

Covered professional providers are medical practitioners who perform covered services when acting within the scope of their license or certification under applicable state law and who furnish, bill, or are paid for their health care services in the normal course of business. Covered services must be provided in the state in which the practitioner is licensed or certified.

- **Covered facilities**

Covered facilities include:

Hospital. An institution that is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or any other institution that is operated pursuant to law, under the supervision of a staff of doctors (M.D. or D.O.) and with 24-hour-a-day nursing services, and that is primarily engaged in providing:

1. general inpatient acute care and treatment of sick and injured persons through medical, diagnostic, and major surgical facilities, all of which must be provided on its premises or under its control; or
2. specialized inpatient acute medical care and treatment of sick or injured persons through medical and diagnostic facilities (including X-ray and laboratory) on its premises or under its control, or through a written agreement with a hospital or with a specialized provider of those facilities; or
3. a licensed birthing center.

In no event shall the term "hospital" include any part of a hospital that provides long-term care or sub-acute care, rather than acute care, or a convalescent nursing home, or any institution or part thereof that:

1. is used principally as a convalescent facility, rest facility, nursing facility, or facility for the aged; or
2. furnishes primarily domiciliary or custodial care, including training in the routines of daily living; or
3. is operated as a school

Network providers. The Plan may approve coverage of providers who are not currently shown as Covered providers to provide mental health/substance usedisorder treatment under the Network benefit. Coverage of these providers is limited to circumstances where the Plan has approved the treatment plan.

Freestanding ambulatory facility. A facility that meets the following criteria:

1. has permanent facilities and equipment for the primary purpose of performing surgical and/or renal dialysis procedures on an outpatient basis;
2. provides treatment by or under the supervision of doctors and nursing services whenever the patient is in the facility;
3. does not provide inpatient accommodations; and is not, other than incidentally, a facility used as an office or clinic for the private practice of a doctor or other professional.

The Plan will apply its outpatient surgical facility benefits only to facilities that have been accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF), the Accreditation Association for Ambulatory Health Care (AAAHC), or that have Medicare certification as an ASC facility.

Residential treatment centers (RTCs) are accredited by a nationally recognized organization and licensed by the state, district, or territory to provide residential treatment for medical conditions, mental health conditions, and/or substance use disorder. RTCs provide 24-hour residential evaluation, treatment and comprehensive specialized services relating to the individual's medical, physical, mental health, and/or substance use disorder therapy needs, all under the active participation and direction of a licensed physician who is practicing within the scope of the physician's license. RTCs offer programs for persons who need short-term transitional services designed to achieve predicated outcomes focused on fostering improvement or stability in functional, physical and/or mental health, recognizing the individuality, strengths, and needs of the persons served.

Skilled nursing care facility. An institution or that part of an institution, which provides convalescent skilled nursing care 24-hours-a-day and is classified as a skilled nursing care facility under Medicare.

Hospice. A facility that:

1. provides primarily inpatient care to terminally ill patients;
2. is licensed/certified by the jurisdiction in which it operates;
3. is supervised by a staff of doctors (M.D. or D.O.) with at least one such doctor on call 24 hours a day;
4. provides 24-hour-a-day nursing services under the direction of a registered nurse (R.N.) and has a full-time administrator; and
5. provides an ongoing quality assurance program.

- **Transitional Care**

Specialty care: If you have a chronic or disabling condition and

- lose access to your specialist because we drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan, or
- lose access to your Network specialist because we terminate our contract with your specialist for reasons other than for cause,

you may be able to continue seeing your specialist and receive any Network benefits for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist and your Network benefits continue until the end of your postpartum care, even if it is beyond the 90 days.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our Customer Service department immediately at 800-410-7778. If you are new to the FEHB Program, we will reimburse you for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the hospitalized person. If your plan terminates participation in the FEHB in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

The pre-service claim approval processes for inpatient hospital admissions (called precertification) and for other services, are detailed in this Section. A **pre-service claim** is any claim, in whole or in part, that requires approval from us in advance of obtaining medical care or services. In other words, a pre-service claim for benefits (1) requires precertification, prior approval or a referral and (2) will result in a reduction of benefits if you do not obtain precertification, prior approval or a referral.

We make our determination based on nationally recognized clinical guidelines and standard criteria sets. These determinations can affect what we pay on a claim.

- **Inpatient facility admission**

Precertification is the process by which – prior to your inpatient admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition. Unless we are misled by the information given to us, we will not change our decision on medical necessity.

In most cases, your Network physician or hospital will take care of obtaining precertification. Because you are still responsible for ensuring that your care is precertified, you should always ask your physician or hospital whether or not they have contacted us and that we have approved the admission. If you see a Non-Network physician or you are admitted to a Non-Network hospital you must obtain prior approval or precertification.

- Warning

We will reduce our benefits for the Non-Network inpatient facility stay by $500 if no one contacts us for precertification. If the stay is not medically necessary, we will not pay inpatient benefits.

If no one contacts us, we will decide whether the inpatient stay was medically necessary.

- If we determine that the stay was medically necessary, we will pay the inpatient benefits, less the $500 penalty.
- If we determine that it was not medically necessary for you to be an inpatient, we will not pay inpatient benefits. We will pay 70% (Standard Option) or 60% (Value Plan) for covered medical supplies and services that are otherwise payable on an outpatient basis.

If we denied the precertification request, we will not pay room and board inpatient benefits. We will pay 70% (Standard Option) or 60% (Value Plan) for covered medical services and supplies that are otherwise payable on an outpatient basis.

If you remain in the facility beyond the number of days we approved and you do not get the additional days precertified, then:

- we will pay inpatient benefits for the part of the admission that we determined was medically necessary, but we will pay 70% (Standard Option) or 60% (Value Plan) of the covered medical services and supplies otherwise payable on an outpatient basis and will not pay room and board benefits for the part of the admission that was not medically necessary.

Any stay greater than 24 hours that results in a hospital admission must be precertified.

- Exceptions

You do not need precertification in these cases:

- You are admitted to a hospital outside the United States.

- You have another group health insurance policy that is the primary payor for the hospital stay.
- Medicare Part A is the primary payor. Note: If you exhaust your Medicare hospital benefits and do not want to use your Medicare lifetime reserve days, then we will become the primary payor and you do need to precertify your hospital admission.
- Your stay is less than 24 hours.

- **Outpatient imaging procedures**

We require prior approval for the following outpatient radiology/imaging services:

- CT/CAT scan – Computed Tomography/Computerized Axial Tomography
- CTA – Computed Tomography Angiography
- MRA – Magnetic Resonance Angiography
- MRI – Magnetic Resonance Imaging
- NC – Nuclear Cardiac Imaging
- PET – Positron Emission Tomography
- SPECT – Single-Photon Emission Computerized Tomography

You, your representative or your physician must contact us at least two working days prior to scheduling the outpatient imaging procedures listed above. We will evaluate the medical necessity of your proposed procedure to ensure it is appropriate for your condition. See *How to request prior approval for an admission or get prior approval for Other services*, below.

In most cases, your Network physician will take care of obtaining prior approval. Because you are still responsible for ensuring that your procedure is approved, you should always ask your physician whether they have contacted us and that we have approved the procedure. If you see a Non-Network physician, you must obtain prior approval.

When possible, arranging to have the imaging procedures listed above performed at a Network stand-alone imaging center will help you to maximize your benefits.

See Section 5(a), *Lab, X-ray and other diagnostic tests*.

- Warning

If prior approval is denied, we will not pay any benefits.

- Exceptions

You do not need prior approval in these cases:

- The procedure is performed outside the United States.
- You have other group health insurance coverage that is the primary payor, including Medicare.
- The procedure is performed in an emergency situation.
- You have been admitted to a hospital on an inpatient basis.

- **Other Services**

Some services require prior approval or precertification before we will consider them for benefits. Your Network physician will take care of obtaining prior approval. If you see a Non-Network physician, you must obtain prior approval. Call us at 800-410-7778 as soon as the need for these services is determined.

For a current list, refer to: https://www.aetna.com/health-care-professionals/precertification/precertification-lists.html.

- Ambulance – required for transportation by fixed-wing aircraft (plane)
- Autologous chondrocyte implantation, Carticel
- BRCA genetic testing
- Certain durable medical equipment (DME) including but not limited to electric or motorized wheelchairs

- Certain mental health services including inpatient admissions, residential treatment center (RTC) admissions, partial hospitalization programs (PHP), transcranial magnetic stimulation (TMS) and applied behavior analysis (ABA)
- Chiari malformation decompression surgery
- Cochlear device and/or implantation
- Dialysis visits – when requested by a Network provider and dialysis is to be performed at a Non-Network facility
- Dorsal column (lumbar) neurostimulators; trial or implantation
- Endoscopic nasal balloon dilation procedures
- Gender reassignment surgery
- Gene therapy, gene editing and gene silencing, even if the proposed treatment is outside of the 50 United States
- Hip surgery to repair impingement syndrome
- Hip and knee arthroplasties
- Hyperbaric oxygen therapy
- Inpatient confinements (except hospice) – For example, surgical and non-surgical stays; stays in a skilled nursing or rehabilitation facility; and maternity and newborn stays that exceed the standard length of stay
- Lower limb prosthetics
- Non-Network freestanding ambulatory surgical facility services, when referred by a Network provider
- Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint (TMJ)
- Osseointegrated implant
- Osteochondral allograft/knee
- Pain Management such as facet and spinal injections
- Pediatric congenital heart surgery
- Polysomnography (sleep studies)
- Power morcellation with uterine myomectomy, with hysterectomy or for removal of uterine fibroids
- Proton beam radiotherapy
- Radiation oncology
- Reconstructive or other procedures that may be considered cosmetic, such as: Blepharoplasty/canthoplasty, Breast reconstruction/breast enlargement, Breast reduction/ mammoplasty, Cervicoplasty, Excision of excessive skin due to weight loss, Gastroplasty/ gastric bypass, Lipectomy or excess fat removal, Surgery for varicose veins (except stab phlebectomy)
- Referral of use of Non-Network physician or provider for non-emergent services, unless the member understands and consents to the use of a Non-Network provider under their Non-Network benefits when available in their Plan
- Rhythm implantable devices
- Shoulder arthroplasty
- Spinal procedures, such as Artificial intervertebral disc surgery, Cervical, lumbar and thoracic laminectomy/laminotomy procedures, Spinal fusion surgery
- Uvulopalatopharyngoplasty, including laser-assisted procedures
- Ventricular assist devices
- Video electroencephalographic (EEG)

Note: Prescription drugs – Some medications and injectables are not covered unless you receive prior authorization. See Section 5(f), *Prescription drug benefits*. You are required to obtain all specialty drugs used for long term therapy from CVS Caremark. To speak to a CVS Caremark representative, please call 866-623-1441.

- **Organ/tissue transplants**

We require prior approval for all organ/tissue transplant procedures and related services (except cornea) when the Plan is the primary payor.

You, your representative, the doctor, or the hospital must contact us before your evaluation as a potential candidate for a transplant procedure so we can arrange to review the evaluation results and determine whether the proposed procedure is approved for coverage. You must have our written approval for the procedure before the Plan will cover any transplant-related expenses.

In most cases, your Network physician will take care of obtaining prior approval. Because you are still responsible for ensuring that this requirement is met, you should always confirm that your physician has contacted us and that we have approved the procedure. If you see a Non-Network physician, you must obtain prior approval.

- Warning

We will not pay any benefits if no one contacts us for prior approval or if prior approval is denied.

- Exceptions

You do not need preauthorization in these cases:

- Corneal transplants.
- Transplant procedures performed outside the United States.

How to request precertification for an admission or get prior approval for other services

First, you, your representative, your physician, or your hospital must call us at 800-410-7778 before admission or services requiring prior approval are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of days requested for hospital stay.

- **Non-urgent care claims**

For non-urgent care claims, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior approval. We will make our decision within 15 days of receipt of the pre-service claim.

If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an **urgent care claim** (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether or not it is an urgent care claim by applying the judgment of a prudent layperson thatpossesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 800-410-7778. You may also call OPM's FEHB 2 at 202-606-3818 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 800-410-7778. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must call us within two business days following the day of the emergency admission, even if you have been discharged from the hospital. If you do not call the Plan within two business days, penalties may apply - see *Warning* under *Inpatient hospital admissions* earlier in this Section and *If your hospital stay needs to be extended* below.

- **Maternity care**

You do not need to precertify a maternity admission for a routine delivery. However, if your medical condition requires you to be confined for more than 3 days for routine delivery or 5 days for a cesarean section, then you, your representative, your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, you, your physician or the hospital must contact us for precertification of additional days for your baby.

Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. See Section 5 (a), *Maternity Care.*

- **If your hospital stay needs to be extended**

If your hospital stay – including for maternity care – needs to be extended, you, your representative, your doctor or the hospital must contact us for precertification of the additional days. If you remain in the hospital beyond the number of days we approved and did not get the additional days precertified, then

- For the part of the admission that was medically necessary, we will pay inpatient benefits, but
- For the part of the admission that was not medically necessary, we will pay only medical services and supplies otherwise payable on an outpatient basis and will not pay inpatient benefits.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Precertify your hospital stay, or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
2. Ask you or your provider for more information.
   - You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.
   - If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by phone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

The Federal Flexible Spending Account Program - FSAFEDS

Health Care FSA (HCFSA) – Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, physician prescribed over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).

FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

Section 4. Your Costs for Covered Services

This is what you will pay out-of-pocket for covered care.

Cost sharing

Cost-sharing is a general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance and copayments) for the covered care you receive.

Copayment

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: When you have Standard Option and see your primary care Network physician you pay a copayment of $20 per visit for adult members or $10 per visit for dependent children through age 21.

Note: If the billed amount (or the Plan allowance that providers we contract with have agreed to accept as payment in full) is less than your copayment, you pay the lower amount.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for them. Copayments and coinsurance amounts do not count toward any deductible. When a covered service or supply is subject to a deductible, only the Plan allowance for the service or supply counts toward the deductible. Covered expenses are applied to the deductible in the order in which claims are processed, which may be different than the order in which services were actually rendered.

- The **Standard Option** calendar year deductible is
  - Network: $350 for a Self Only enrollment and $700 for a Self Plus One or Self and Family enrollment. The Network deductible applies only to services received from Network providers.
  - Non-Network: $600 for a Self Only enrollment and $1,200 for a Self Plus One enrollment or $1,500 for a Self and Family enrollment. The Non-Network deductible applies only to services received form Non-Network providers.

    When the calendar year deductible applies, benefits are payable when covered expenses accumulated to the calendar year deductible reach the limits indicated above. The calendar year deductible will not exceed the per-person limit for any covered individual. Under a Self and Family enrollment, the calendar year deductible is met for all family members when the covered expenses accumulated to the calendar year deductible for any combination of family members reaches the Self and Family limit.
- The **Value Plan** calendar year deductible is:
  - Network: $600 for a Self Only enrollment and $1,200 per Self Plus One or Self and Family enrollment. The Network deductible applies only to services received from Network providers.
  - Non-Network: $900 for a Self Only enrollment and $1,800 per Self Plus One or Self and Family enrollment. The Non-Network deductible applies only to services received from Non-Network providers.

    When the calendar year deductible applies, benefits are payable when covered expenses accumulated to the calendar year deductible reach the limits indicated above. The calendar year deductible will not exceed the per-person limit for any covered individual. Under a Self and Family enrollment, the calendar year deductible is met for all family members when the covered expenses accumulated to the calendar year deductible for any combination of family members reaches the Self and Family limit.

If the billed amount (or the Plan allowance that Network providers have agreed to accept as payment in full) is less than the remaining portion of your deductible, you pay the lower amount.

Example: If the billed amount is $100, the provider has agreed to accept $80, and you have not paid any amount toward your calendar year deductible, you must pay $80. We will apply $80 toward your deductible. We will begin paying benefits once the remaining portion of your calendar year deductible has been satisfied.

Note: If you change plans or plan options during Open Season and the effective date of your new plan or plan option is after January 1 of the next year, you do not have to start a new deductible under your prior plan or plan option between January 1 and the effective date of your new plan or plan option. If you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your prior option to the deductible of your new option.

If you change plans during the year, you must begin a new deductible under your new plan.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible.

Example: You pay 30% of our allowance under Standard Option and 40% of our allowance under Value Plan for Non-Network office visits.

If your provider routinely waives your cost

If your provider routinely waives (does not require you to pay) your copayments, deductibles, or coinsurance, the provider is misstating the fee and may be violating the law. In this case, when we calculate our share, we will reduce the provider's fee by the amount waived.

Example: if your physician ordinarily charges $100 for a covered service but routinely waives your 30% coinsurance (Standard Option), the actual charge is $70. We will pay $49 (70% of the actual charge of $70).

To help keep your coinsurance out-of-pocket costs to a minimum, we encourage you to call us at 800-410-7778 or visit our website at www.MHBP.com for assistance locating Network providers whenever possible.

Waivers

In some instances, a provider may ask you to sign a "waiver" prior to receiving care. This waiver may state that you accept responsibility for the total charge for any care that is not covered by your health plan. If you sign such a waiver, whether or not you are responsible for the total charge depends on the contracts that the Plan has with its providers. If you are asked to sign this type of waiver, please be aware that, if benefits are denied for the services, you could be legally liable for the related expenses. If you would like more information about waivers, please contact us at 800-410-7778.

Differences between our allowance and the bill

Our "Plan allowance" is the amount we use to calculate our payment for covered services. Fee-for-service plans arrive at their allowances in different ways, so their allowances vary. For more information about how we determine our Plan allowance, see the definition of Plan allowance in Section 10.

Often, the provider's bill is more than a fee-for-service plan's allowance. Whether or not you have to pay the difference between our allowance and the bill will depend on the provider you use.

Other Non-Network participating providers agree to limit what they can collect from you. You will still have to pay your deductible, copayment, and coinsurance. These providers agree to write off the difference between billed charges and the discount amount.

- **Network providers** agree to limit what they will bill you. Because of that, when you use a preferred provider, your share of covered charges consists only of your deductible and coinsurance or copayment. Here is a Standard Option example: You see a Network physician for an office visit who charges $150, but our allowance is $100. You are only responsible for your copayment. That is, you pay just $20 of our $100 allowance for an adult office visit. Because of the agreement, your Network physician will not bill you for the $50 difference between our allowance and his/her bill.

- **Non-Network providers**, on the other hand, have no agreement to limit what they will bill you. When you use a Non-Network provider, you will pay your deductible and coinsurance – **plus** any difference between our allowance and charges on the bill. Here is a Standard Option example: You see a Non-Network physician who charges $150 and our allowance is again $100. Because you've met your deductible, you are responsible for your coinsurance, so you pay 30% of our $100 allowance ($30). Plus, because there is no agreement between the Non-Network physician and us, the physician can bill you for the $50 difference between our allowance and his/her bill. For details on how we determine the Plan allowance, please see Section 10.

The following table illustrates the examples of how much you have to pay out-of-pocket for services from a Network physician vs. a Non-Network physician in a non-fully developed market area. The table uses our example of a service for which the physician charges $150 and our allowance is $100. The table shows the amount you pay under Standard Option if you have met your calendar year deductible.

EXAMPLE	**Network physician**	**Non-Network physician**
Physician's charge	$150	$150
Our allowance	We set it at: $100	We set it at: $100
We pay	$80	70% of our allowance: $70
You owe:	Copayment: $20	30% of our allowance: $30
+ Difference up to charge?	No: $0	Yes: $50
TOTAL YOU PAY	$20	$80

If you receive services in a fully developed Network area and use a Non-Network physician, your out-of-pocket expenses may be greater. See Section 10, *Plan Allowance* for more details.

Your catastrophic protection out-of-pocket maximum

For those services with cost-sharing, we pay 100% of the Plan's allowance for the remainder of the calendar year after your out-of-pocket expenses total these amounts:

Standard Option

- $6,000 for Self Only enrollment ($12,000 for Self Plus One or Self and Family enrollment) for covered services and drugs from Network providers/facilities and pharmacies, combined. Only eligible expenses for Network providers/facilities and pharmacies count toward this limit.
- $9,000 for Self Only enrollment ($18,000 for Self Plus One or Self and Family enrollment) for covered services and drugs from Non-Network providers/facilities and pharmacies, combined. Only eligible expenses for Non-Network providers/facilities and pharmacies count toward this limit.

After an individual family member reaches the maximum out-of-pocket expenses of $6,000 ($9,000 Non-Network) and the remaining family members reach $12,000 ($18,000 Non-Network) combined for Self Plus One or Self Plus Family enrollment in a calendar year, you do not have to pay any more for covered services in the calendar year.

Value Plan

- $6,600 for Self Only enrollment ($13,200 for Self Plus One or Self and Family enrollment) for covered services and drugs from Network providers/facilities and pharmacies, combined. Only eligible expenses for Network providers/facilities and pharmacies count toward this limit.
- $10,000 for Self Only enrollment ($20,000 for Self Plus One or Self and Family enrollment) for covered services of Non-Network providers/facilities. Only eligible expenses for Non-Network providers/facilities count toward this limit.

After an individual family member reaches the maximum out-of-pocket expenses of $6,600 ($10,000 Non-Network) and the remaining family members reach $13,200 ($20,000 Non-Network) combined for Self Plus One or Self Plus Family enrollment in a calendar year, you do not have to pay any more for covered services in the calendar year.

The following cannot be included in the accumulation of out-of-pocket expenses. Health care providers can bill you, and you are responsible to pay them even after your expenses exceed the limits described above:

- Expenses in excess of the Plan allowance or maximum benefit limitations
- Expenses for non-covered services, drugs and supplies
- Any amounts you pay because benefits have been reduced for non-compliance with this Plan's cost containment requirements (see Section 3, *You need prior Plan approval for certain services*)
- The difference in cost between a brand name drug and the generic equivalent
- Expenses covered by specialty drug copay assistance cards (only your actual payment will apply)

Carryover

If you changed to this Plan during Open Season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your prior plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your prior plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your prior plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your prior plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your prior option to the catastrophic protection limit of your new option.

If you change plans during the year, you must meet the catastrophic protection out-of-pocket maximum of your new plan in full before catastrophic protection benefits begin.

If we overpay you

We will make diligent efforts to recover benefit payments we made in error but in good faith. We may reduce subsequent benefit payments to offset overpayments.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. Standard Option and Value Plan Benefits

This Plan offers both a Standard Option and a Value Plan. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The Standard Option and Value Plan Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at 800-410-7778 or visit our website at www.MHBP.com.

See page 14 for how our benefits changed this year. Pages 122-126 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Health Care Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
  - The Standard Option calendar year deductible is $350 per person (limited to $700 per Self Plus One or Self and Family enrollment) for services of Network providers and $600 per person (limited to $1,200 per Self Plus One or $1,500 per Self and Family enrollment) for services of Non-Network providers.
  - The Value Plan calendar year deductible is $600 per person (limited to $1,200 per Self Plus One or Self and Family enrollment) for services of Network providers and $900 per person (limited to $1,800 per Self Plus One or Self and Family) for services of Non-Network providers.
- The Non-Network benefits are the regular benefits of this Plan. Network benefits apply only when you use a Network provider. When no Network provider is available, Non-Network benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost -sharing works. Also, read Section 9 about coordinating benefits with Medicare and other coverage.
- You must get prior approval for certain services in this Section, including but not limited to: electric or motorized wheelchairs, cochlear devices and/or implantation, BRCA genetic testing, radiation oncology, CT scans, MRIs, MRAs and nuclear stress tests. Please refer to the prior approval procedures in Section 3.

Benefit Description	You pay After the calendar year deductible...	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Diagnostic and treatment services	**Standard Option**	**Value Plan**
Professional services of a primary care physician, including telephonic and video conferencing (limited to: general practitioner, family practitioner, internist and pediatrician)	Network: $20 copayment per office visit for adults (No deductible); $10 copayment per office visit for dependent children through age 21 (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: $30 copayment per office visit for adults (No deductible); $10 copayment per office visit for dependent children through age 21 (No deductible) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Note: When you receive both a comprehensive preventive evaluation and management (E/M) service and a problem-oriented E/M service during the same office visit, the Plan's benefit is determined as follows: • For the comprehensive preventive care service: - Network: the Plan's full allowance, or - Non-Network: the Plan's full allowance • For the problem-oriented service: - Network: one-half of the Plan's allowance, unless the Network contract provides for a different amount - Non-Network: one-half of the Plan's allowance		

Diagnostic and treatment services - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Diagnostic and treatment services (cont.)	**Standard Option**	**Value Plan**
Professional services of specialists: • In physician's office (this includes evaluation and management services related to chemotherapy, hemodialysis and radiation therapy) • At home • Office medical consultations • Second surgical opinions provided in a physician's office • Advance care planning • Vision examination caused by an accidental ocular injury or intraocular surgery (such as for cataracts) • Dietary and nutritional counseling for adult obesity Note: See Section 5(b) for professional services related to surgery. Note: See Section 5(f), *Prescription Drug Benefits*, for related drug coverage. Certain specialty drugs, oncology drugs and growth hormones require preauthorization; see Section 5 (f), *Specialty drugs* and Section 3, *Other services* under *You need prior Plan approval for certain services*.	Network: $30 copayment per office visit (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: $50 copayment per office visit Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Professional services of physicians during a hospital stay Note: Outpatient cancer treatment and dialysis services are paid under Section 5(a), *Treatment therapies*.	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Same-day services (such as lab tests) performed and billed in conjunction with the office visit (except allergy shots, rabies shots or routine immunizations)	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Professional non-emergency services provided in a convenient care clinic (except in a MinuteClinic® at CVS). See convenient care clinic, Section 10, *Definitions* Note: For services related to an accidental injury or medical emergency, see Section 5(d).	Network: $5 copayment per visit (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: $15 copayment per visit for adults (No deductible); $5 copayment per visit for dependent children through age 21 (No deductible) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Diagnostic and treatment services - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Diagnostic and treatment services (cont.)	**Standard Option**	**Value Plan**
Professional non-emergency services provided in a MinuteClinic® at CVS. See convenient care clinic, Section 10, *Definitions* *Note: For services related to an accidental injury or medical emergency, see Section 5(d).*	Network: Nothing (No deductible) Non-Network: All charges	Network: Nothing (No deductible) Non-Network: All charges
Not covered: • *Routine physical checkups and related tests, except those covered under preventive care* • *Thermography and related visits* • *Orthoptic visits and related services* • *Phone and internet-based consultations, except as stated under TeleHealth Services*	*All charges*	*All charges*
TeleHealth Services	**Standard Option**	**Value Plan**
TeleHealth consultations are available to members in the 50 United States through Teladoc®. See www.teladoc.com or call 855-835-2362 (855-Teladoc) for information regarding consults. Note: Teladoc is not available for phone services in Idaho (video consults only). Note: For Behavioral Health telehealth consults, see Section 5(e), *Telehealth services.* Note: See Section 5(h), *Wellness and other Special Features* for additional information on Telehealth services.	Network: Nothing (No deductible) Non-Network: All charges	Network: Nothing (No deductible) Non-Network: All charges
Lab, X-ray and other diagnostic tests	**Standard Option**	**Value Plan**
Tests, such as: • Blood tests • Urinalysis • Pap tests • Pathology • X-rays • Non-routine mammograms • Unattended or home sleep studies • Ultrasound • Electrocardiogram and EEG • Hearing exam for non-auditory illness or disease Note: If your Network provider uses a Non-Network lab or radiologist, we will pay Non-Network benefits for any lab and X-ray charges.	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Lab, X-ray and other diagnostic tests - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Lab, X-ray and other diagnostic tests (cont.)	**Standard Option**	**Value Plan**
CT/CAT scans, CTA, MRA, MRI, NC, PET, SPECT, provided at a stand-alone imaging center or clinic Note: Prior approval is required. Call us at 800-410-7778 for details about coverage and information about stand-alone imaging centers. Note: If you are having these procedures performed in an outpatient hospital, see Section 5 (c), *Outpatient hospital or ambulatory surgical center.* Note: Expenses for related professional services are covered under this benefit.	Network: 5% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 5% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Genetic testing including risk assessment and counseling when medically necessary (See Section 10, *Definitions)* Note: Prior approval for BRCA genetic testing is required. Call us at 800-410-7778. See Section 3, *Other services* under *You need prior Plan approval for certain services.* Note: The Plan offers confidential phone and web-based genetic counseling services. These services are offered through Informed DNA, a national genetic counseling company staffed with independent board-certified genetic counselors. For more information or to schedule an appointment for genetic counseling, call Informed DNA at 800-975-4819.	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Lab Savings Program You can use this voluntary program for covered lab tests. As long as Quest Diagnostics or LabCorp does the testing and bills us directly, you will not have to file any claims. To find a location near you, visit our Web site at www.MHBP.com. Note: This benefit applies to expenses for lab tests only. Related expenses for services provided by a physician or lab tests performed by an associated facility not participating in the Lab Savings Program are subject to applicable deductibles, copayments and coinsurance.	Nothing (No deductible)	Nothing (No deductible)

Lab, X-ray and other diagnostic tests - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Lab, X-ray and other diagnostic tests (cont.)	**Standard Option**	**Value Plan**
Urine drug testing/screening for non-cancerous chronic pain: • Presumptive (qualitative) drug testing - one encounter per day up to eight (8) encounters per 12 month period • Definitive (quantitative) drug testing - one encounter per day up to eight (8) encounters per 12 month period Note: Urine drug testing/screening is covered only as described in "MHBP Urine Drug Testing Coverage", available on our website, www.MHBP.com, and by calling us at 800-410-7778. Note: If your Network provider uses a Non-Network lab, we will pay Non-Network benefits for any lab charges.	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: • *Handling and administrative charges* • *Routine lab services except as covered under Preventive care* • *Professional fees for automated tests* • *Genetic screening (See Section 10, Definitions)* • *Salivary hormone testing for other than the diagnosis of Cushing's syndrome*	*All charges*	*All charges*
Preventive care, adult	**Standard Option**	**Value Plan**
• Routine physical examination – one per calendar year for members age 22 and older, limited to: - Patient history and risk assessment - Basic metabolic panel - General health panel • Well woman care such as annual counseling for sexually transmitted infections, contraceptive methods, Pap smears, and screening for interpersonal and domestic violence. For a complete list of Well Women preventive care services go to the Health and Human Services (HHS) website, services are covered at the time interval recommended at the following link: www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations Note: When you obtain a biometric screening, you can receive a Wellness Account incentive as a reward for managing your health. See Section 5(h), Biometric screening reward.	Network: Nothing (No deductible) Non-Network: All charges	Network: Nothing (No deductible) Non-Network: All charges

Preventive care, adult - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Preventive care, adult (cont.)	**Standard Option**	**Value Plan**
Routine screenings, including related office visits are covered at the time interval recommended at each of the links below: • Colorectal cancer screening, including: - Fecal occult blood (stool) test — one per calendar year for members age 40 and older - Screening sigmoidoscopy — one every two consecutive calendar years for members age 50 and older • Individual counseling on prevention and reducing health risks • Prostate cancer screening (PSA) - one per calendar year for men age 40 and older. • Screenings such as cancer, depression, diabetes, high blood pressure, HIV, osteoporosis, and total blood cholesterol screening. For a complete list of screenings go to the U.S. Preventive Services Task Force (USPSTF) website at www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations Note: Expenses for anesthesia and outpatient facility services related to covered colorectal cancer screening are covered under this benefit. Note: Expenses for prescribed medications and supplies related to covered colorectal cancer screening are covered under Section 5(f), Prescription drug benefits.	Network: Nothing (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: Nothing (No deductible) Non-Network: All charges
Dietary and nutritional counseling for obesity - limited to 26 visits per person per calendar year	Network: Nothing (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible) Note: Dietary and nutritional counseling for obesity is limited to 26 visits per person per calendar year. Visits exceeding the 26 visit maximum see Section 5(a), Diagnostic and treatment services.	Network: Nothing (No deductible) Note: Dietary and nutritional counseling for obesity is limited to 26 Network visits per person per calendar year. Visits exceeding the 26 visit maximum see Section 5(a), Diagnostic and treatment services Non-Network: All charges Note: Benefits are not available for preventive care or routine screenings, including office visits.

Preventive care, adult - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Preventive care, adult (cont.)	**Standard Option**	**Value Plan**
Immunizations such as influenza, human papillomavirus (HPV), Pneumococcal, shingles, and tetanus/DTaP. For a complete list of immunizations go to the Centers for Disease Control (CDC) website, services are covered at the time interval recommended at the following link: www.cdc.gov/vaccines/schedules/ Note: This benefit covers the immunization only. Note: Some seasonal and non-seasonal vaccines may also be obtained from a Vaccine Network pharmacy. See *Prescription drug benefits*, Section 5(f).	Network: Nothing (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)	Network: Nothing (No deductible) Non-Network: All charges
Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayment, coinsurance and/or deductible.		
Not covered: • *Routine physical checkups and related tests except those listed above* • *Routine physical checkups and related tests provided in an urgent care setting* • *Flu vaccines obtained from a non-participating provider* • *Nutritional supplements or food* • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel* • *Immunizations, boosters and medications for travel or work-related exposure*	*All charges*	*All charges*
Preventive care, children	**Standard Option**	**Value Plan**
For covered dependent children through age 21. • Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org - Routine screenings, limited to one per calendar year: - Blood cholesterol - Urinalysis - Body mass index testing	Network: Nothing (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: Nothing (No deductible) Non-Network: All charges

Preventive care, children - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Preventive care, children (cont.)	**Standard Option**	**Value Plan**
• Immunizations such as DTaP, Measles, Mumps, Polio and Rubella (MMR), and Varicella. For a complete list of immunizations go to the Centers for Disease Control (CDC) website at www.cdc.gov/vaccines/schedules/index.html You may also find a complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) online at www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations Note: Some seasonal and non-seasonal vaccines may also be obtained from a Vaccine Network pharmacy, See Section 5(f), Prescription Drug Benefits.	Network: Nothing (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: Nothing (No deductible) Non-Network: All charges
Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayment, coinsurance and/or deductible.		
Not covered: • *Routine testing not specifically listed as covered* • *Routine physical checkups and related tests provided in an urgent care setting* • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel* • *Immunizations, boosters and medications for travel or work-related exposure*	*All charges*	*All charges*
Maternity care	**Standard Option**	**Value Plan**
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Anesthesia • Postnatal care • Screening for gestational diabetes for pregnant women Note: Here are some things to keep in mind: • You do not need to precertify your admission for a routine delivery. See Section 3, *Maternity care* for other circumstances, such as extended stays for you or your baby	Network: Nothing (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: Nothing (No deductible) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Maternity care - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Maternity care (cont.)	**Standard Option**	**Value Plan**
• You may remain confined in the hospital/ birthing center for up to 3 days for your routine delivery and 5 days for your cesarean delivery (you do not need to precertify the normal length of stay). We will cover an extended stay for you or your baby if medically necessary, but you, your representative, your doctor, or your hospital must precertify the extended stay. See Section 3, Y*ou need prior Plan approval for certain services* for other circumstances • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay • The initial newborn exam is payable under this benefit • Maternity benefits will be paid at the termination of pregnancy • Hospital services are covered under Section 5(c) Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. Note: Maternity care expenses incurred by a Plan member serving as a surrogate mother are covered by the Plan subject to reimbursement from the other party to the surrogacy contract or agreement. The involved Plan member must execute our Reimbursement Agreement against any payment she may receive under a surrogacy contract or agreement. Expenses of the newborn child are not covered under this or any other benefit in a surrogate mother situation. Note: IV/infusion therapy and injections for treatment of complications of pregnancy are covered under Section 5(a), *Treatment therapies.*	Network: Nothing (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: Nothing (No deductible) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Maternity care - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Maternity care (cont.)	**Standard Option**	**Value Plan**
• Breastfeeding counseling during pregnancy and/or postpartum period • Breastfeeding equipment rental or purchase to include hospital grade breast pumps Note: We limit our benefit for the rental of breastfeeding equipment to an amount no greater than what we would have paid if the equipment had been purchased. Note: Call us at 800-410-7778 during your last trimester of pregnancy and submit your physician's order. We can provide additional coverage details and information about Network providers.	Network: Nothing (No deductible) Non-Network: All charges	Network: Nothing (No deductible) Non-Network: All charges
Not covered: • *Standby doctors* • *Home uterine monitoring devices* • *Services provided to the newborn if the infant is not covered under yourenrollment*	*All charges*	*All charges*
Family Planning	**Standard Option**	**Value Plan**
Voluntary family planning services, including patient education and counseling, limited to: • Voluntary sterilization - limited to vasectomies and tubal ligations (including related expenses for anesthesia and outpatient facility services, if necessary) • Surgically implanted contraceptives (including related expenses for anesthesia and outpatient facility services, if necessary) • Intrauterine devices (IUDs) • Injectable contraceptive drugs (such as Depo-Provera) Note: We cover other women's contraceptive drugs and devices under Section 5(f), *Prescription Drug Benefits.*	Network: Nothing (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: Nothing (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary surgical sterilization* • *Preimplantation genetic diagnosis (PGD)* • *Genetic testing, counseling and screening* • *Procedures, services and supplies related to Assisted reproductive technology(ART).*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible...	
Infertility services	**Standard Option**	**Value Plan**
Diagnosis and treatment of infertility, except as shown in *Not covered* Note: See Section 5(f), *Prescription Drug Benefits* for related drug coverage. Certain specialty drugs, oncology drugs and growth hormones require preauthorization; see Section 5(f), *Specialty drugs* and Section 3, *Other services* under *You need prior Plan approval for certain services.*	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: • *Infertility services after voluntary sterilization* • *Assisted reproductive technology (ART) procedures, such as:* - *artificial insemination (AI)* - *in vitro fertilization (IVF)* - *embryo transfer and gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* - *intravaginal insemination (IVI)* - *intracervical insemination (ICI)* - *intrauterine insemination (IUI)* • *Services and supplies related to ART procedures* • *Cost of donor sperm or egg* • *Sperm bank collection and storage fees* • *Surrogacy (host uterus/gestational carrier)*	*All charges*	*All charges*
Allergy care	**Standard Option**	**Value Plan**
Evaluation and treatment services, provided in a doctor's office	Network: $20 copayment per office visit for adults (No deductible); $10 copayment per office visit for dependent children through age 21 (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: $50 copayment per office visit Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Allergy testing, including materials	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Allergy care - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Allergy care (cont.)	**Standard Option**	**Value Plan**
Allergy injections, including allergy serum	Network: $5 copayment per visit (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: • *Any services or supplies considered by the National Institute of Health and the National Institute of Allergy and Infectious Disease to be not effective to diagnose allergies and/or not effective in preventing an allergy reaction* • *Provocative food testing and sublingual allergy desensitization* • *Clinical ecology and environmental medicine*	*All charges*	*All charges*
Treatment therapies	**Standard Option**	**Value Plan**
• Chemotherapy, radiation and therapy for treatment of cancer Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed in Section 5(b), *Organ/ tissue transplants*. • Hyperbaric oxygen therapy Note: Prior approval is required for chemotherapy, radiation therapy and hyperbaric oxygen therapy. Call us at 800-410-7778 prior to scheduling treatment. See Section 3, *Other services* under *You need prior Plan approval for certain services*. Note: These therapies (excluding the related office visits) are covered under this benefit when billed by the outpatient department of a hospital, clinic or a physician's office. Pharmacy charges for chemotherapy drugs (including prescription drugs to treat the side effects of chemotherapy) are covered under Section 5, *Prescription drug benefits*. Note: See Section 5(f), *Prescription Drug Benefits* for related drug coverage. Certain specialty drugs, oncology drugs and growth hormones require preauthorization; see Section 5(f), *Specialty drugs* and Section 3, *Other services* under *You need prior Plan approval for certain services*.	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Treatment therapies - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Treatment therapies (cont.)	**Standard Option**	**Value Plan**
• Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/infusion therapy, including TPN • Respiratory therapy • Inhalation therapy • Chelation therapy • Growth hormone therapy Note: Prior approval may be required for some of these procedures. Call us at 800-410-7778 prior to scheduling treatment. See Section 3, *Other services* under *You need prior Plan approval for certain services.* Note: These therapies (excluding the related office visits) are covered under this benefit when performed on an outpatient basis. Note: See Section 5(f), *Prescription Drug Benefits* for related drug coverage. Certain specialty drugs, oncology drugs and growth hormones require preauthorization; see Section 5(f), *Specialty drugs* and Section 3, *Other services* under *You need prior Plan approval for certain services.* Note: See Section 5(e) for coverage of applied behavioral analysis therapy.	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Rabies shots and related services	Nothing (No deductible)	Nothing (No deductible)
Cardiac rehabilitation therapy – Phase 1 and 2 only Note: Benefits are limited to 24 visits per person per calendar year.	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: • *Chemotherapy supported by a bone marrow transplant or with stem cell support for any diagnosis not listed as covered under Section 5 (b)* • *Topical hyperbaric oxygen therapy* • *Prolotherapy* • *Pulmonary rehabilitation*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible...	
Physical, occupational and speech therapies	**Standard Option**	**Value Plan**
Outpatient physical therapy, speech therapy, and occupational therapy Note: Benefits are limited to 40 visits per person per calendar year for combined therapies for physical, occupational, and speech therapy, which includes all covered services and supplies billed for these therapies. When more than one type of therapy, for example physical therapy and speech therapy, are provided on the same day, each will be counted as a separate visit. Note: For the purposes of this benefit, services and supplies provided by a doctor of osteopathy (D.O.) are included in the 40 visit per person annual benefit maximum. Note: Medically necessary outpatient physical or occupational therapy provided by a skilled nursing facility (SNF) is covered under this benefit if you are not confined in the SNF. Note: See Section 5(e), *Behavioral health outpatient/all other services* for physical, occupational and speech therapy for autism and developmental delays.	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: • *Exercise programs* • *Outpatient pulmonary rehabilitation* • *Massage therapy*	*All charges*	*All charges*
Hearing services (testing, treatment, and supplies)	**Standard Option**	**Value Plan**
• Routine hearing exam and testing Note: For child screening, testing, diagnosis, and treatment, see Section 5(a), *Preventive care, children*. Note: For coverage of hearing aids, see Section 5 (a), *Orthopedic and prosthetic devices*. Note: For all hearing services related to medical diagnosis, see Section 5(a), *Diagnostic and treatment services*.	Network: Nothing (No deductible) Non-Network: Any difference between our allowance and the billed amount	Network: Nothing (No deductible) Non-Network: Any difference between our allowance and the billed amount

Benefit Description	You pay After the calendar year deductible...	
Vision services (testing, treatment, and supplies)	**Standard Option**	**Value Plan**
One pair of eyeglasses or contact lenses to correct an impairment directly caused by an accidental ocular injury or intraocular surgery (such as for cataracts). The eyeglasses or contact lenses must be purchased within one year of the injury or surgery and the patient must be covered by the Plan at the time of purchase. Note: We cover the vision examination under Section 5(a), *Diagnostic and treatment services, professional services of a specialists.* Note: See Non-FEHB Benefits section for possible vision discount opportunities.	All charges over $50 for one set of eyeglasses or $100 for contact lenses (No deductible)	Network: All charges over $50 for one set of eyeglasses or $100 for contact lenses (No deductible) Non-Network: 40% of the Plan's allowance and all charges over $50 for one set of eyeglasses or $100 for contact lenses (No deductible)
Dilated retinal eye exam: • non-routine • for established diabetics	Network: Nothing (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: Nothing Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: • Routine eye exams and related office visits • *Eyeglasses, contact lenses and examinations not directly related to an ocular injury or intraocular surgery* • *Eye exercises* • *Refractions* • *Radial keratotomy including laser keratotomy and other refractive surgery*	*All charges*	*All charges*
Foot care	**Standard Option**	**Value Plan**
Professional services for routine foot care for members with an established diagnosis of diabetes or peripheral vascular disease Note: For non-routine foot care, see Section 5(a), *Diagnostic and treatment services.* Note: For medically necessary surgeries, see Section 5(b), *Surgical procedures.*	Network: $20 copayment per office visit for adults (No deductible); $10 copayment per office visit for dependent children through age 21 (No deductible); 10% of the Plan's allowance for other services performed during the visit Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: $50 copayment per office visit; 20% of the Plan's allowance for other services performed during the visit Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: • *Cutting, trimming and removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible...	
Orthopedic and prosthetic devices	**Standard Option**	**Value Plan**
Orthopedic and prosthetic devices (see Section 10, *Definitions*) when recommended by an M.D. or D.O., including: • Artificial limbs and eyes • Prosthetic sleeve or sock • Custom constructed braces • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices such as cochlear implants, bone anchored hearing aids (BAHA), artificial joints, pacemakers and breast implants following mastectomy, if billed by other than a hospital Note: We will only cover the cost of a standard item. Coverage for specialty items such as bionics is limited to the cost of the standard item. Note: For benefit information related to the professional services for the surgery to insert an internal device, see Section 5(b), *Surgical procedures*. For benefit information related to the services of a hospital and/or ambulatory surgery center, see Section 5(c).	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Hearing aids - every five (5) calendar years. Note: See *Non-FEHB Benefits* section for possible hearing aid discount opportunities.	All charges over $2,000 (No deductible)	All charges over $1,500 (No deductible)

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Orthopedic and prosthetic devices (cont.)	**Standard Option**	**Value Plan**
Not covered: • *Orthopedic and corrective shoes unless attached to a brace, arch supports, heel pads and heel cups, foot orthotics and related office visits* • *Lumbosacral supports, corsets, trusses, elastic stockings, support hose, non-custom hinged knee braces and other supportive devices* • *Prosthetic replacements unless a replacement is needed for medical reasons* • *Penile prosthetics* • *Customization or personalization beyond what is necessary for proper fitting and adjustment of the items* • *Hearing aid replacements less than five calendar years after the last one we covered; replacement batteries, service contracts, hearing aid repairs, and all charges after the Plan has paid $2,000 (Standard Option) or $1,500 (Value Plan) for a hearing aid(s)* • *Orthotics, splints, stents and appliances used to treat temporomandibular joint dysfunction and/or sleep apnea*	*All charges*	*All charges*
Durable medical equipment (DME)	**Standard Option**	**Value Plan**
Durable medical equipment (DME) is equipment and supplies that: 1. are prescribed by your attending physician (i.e., the physician who is treating your illness or injury); 2. are medically necessary; 3. are primarily and customarily used only for a medical purpose; 4. are generally useful only to a person with an illness or injury; 5. are designed for prolonged use; and 6. serve a specific therapeutic purpose in the treatment of an illness or injury. We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment, such as: • Oxygen and oxygen equipment • Dialysis equipment • Wheelchairs • Home INR (International Normalized Ratio) monitors and testing materials used in conjunction with anticoagulation therapy when provided by a DME vendor.	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Durable medical equipment (DME) (cont.)	**Standard Option**	**Value Plan**
• Hospital beds • Ostomy supplies (including supplies purchased at a pharmacy) • Audible prescription reading devices Note: Prior approval is required for prescription reading devices. Call us at 800-410-7778. See Section 3, *Other services* under *You need prior Plan approval for certain services.* Note: For items that are available for purchase we will limit our benefit for the rental of durable medical equipment to an amount no greater than what we would have paid if the equipment had been purchased. For coordination of benefits purposes, when we are the secondary payor, we will limit our allowance for rental charges to the amount we would have paid for the purchase of the equipment, except when the primary payor is Medicare Part B and Medicare elects to continue renting the item. Note: Call us at 800-410-7778 for details about coverage and information about durable medical equipment Network providers. Note: When Medicare Part B is your primary payor, drugs and diabetic supplies, such as glucose meters and testing materials are covered under this benefit, even if purchased at a pharmacy. Note: See Section 5(a), T*reatment therapies* for coverage of hyperbaric oxygen therapy. Note: We will only cover the cost of standard equipment. Coverage for specialty items such as all terrain wheelchairs is limited to the cost of the standard equipment. Note: See Section 5(a), *Maternity care* for coverage of breastfeeding equipment	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Augmentative and alternative communication (AAC) devices	All charges after the Plan has paid $500 per device (No deductible)	All charges after the Plan has paid $500 per device (No deductible)

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Durable medical equipment (DME) (cont.)	**Standard Option**	**Value Plan**
Not covered: • *Equipment replacements unless medically necessary* • *Safety, hygiene, convenience and exercise equipment* • *Household or vehicle modifications including seat, chair or van lifts; car seats; computer switchboard* • *Air conditioners, air purifiers, humidifiers, ultraviolet lighting (except for the treatment of psoriasis), heating pads, hot/cold packs, sun or heat lamps* • *Wigs or hair pieces* • *Motorized scooters (see Section 10, Definitions), ramps, prone standers and other items that do not meet the DME definition* • *Dental appliances used to treat sleep apnea and/or temporomandibular joint dysfunction* • *Charges for educational/instructional advice on how to use the durable medical equipment* • *All rental charges above the purchase price or charges in excess of the secondary payor amount when we are the secondary payor, except as noted under covered durable medical equipment above* • *Customization or personalization of equipment* • *Desktop and laptop computers, pagers, personal digital assistants (PDA's), smart phones, and tablet devise (e.g. iPads), or other devices that are not dedicated speech generating devices* • *Blood pressure monitors* • *Enuresis alarms* • *Compression/support garments, except for treatment of varicose veins, lymphedema and severe burns* • *Home test kits except as stated above*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible...	
Home health services - nursing services	**Standard Option**	**Value Plan**
A registered nurse (R.N.) or licensed practical nurse (L.P.N.) is covered for outpatient services when: • prescribed by your attending physician (i.e., the physician who is treating your illness or injury) for outpatient services; • the physician indicates the length of time the services are needed; and • the physician identifies the specific professional skills required by the patient and the medical necessity for skilled services. Note: Benefits are limited to 50 visits (Standard Option) or 25 visits (Value Plan) per person per calendar year.	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: • *Private duty nursing* • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Custodial care, see Section 10, Definitions*	*All charges*	*All charges*
Chiropractic	**Standard Option**	**Value Plan**
Chiropractic care • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation and vibratory therapy Note: Benefits for alternative care combined services are limited to 40 visits per person per calendar year and includes all covered services and supplies billed for chiropractic and alternative treatments. When more than one type of care, for example chiropractic and acupuncture, are provided on the same day, each will be counted as a separate visit.	Network: $20 copayment per visit (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)	Network: 20% of the Plan's allowance (No deductible) Non-Network: All charges
Alternative treatments	**Standard Option**	**Value Plan**
Acupuncture Note: Benefits for alternative care combined services are limited to 40 visits per person per calendar year and includes all covered services and supplies billed for chiropractic and alternative treatments. When more than one type of care, for example chiropractic and acupuncture, are provided on the same day, each will be counted as a separate visit.	Network: 10% of the Plan's allowance (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance (No deductible) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Alternative treatments - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Alternative treatments (cont.)	**Standard Option**	**Value Plan**
Not covered: • *Naturopathic and homeopathic services* • *Thermography, biofeedback and related visits* • *Massage therapy, acupressure, hypnotherapy* • *Self care or home management training or programs*	*All charges*	*All charges*
Educational classes and programs	**Standard Option**	**Value Plan**
Tobacco Cessation • The program covers up to two quit attempts per member per calendar year, including up to four counseling sessions per quit attempt. Note: Physician-prescribed OTC and prescription drugs approved by the FDA to treat nicotine dependence may be obtained from a Network retail pharmacy or through our mail order drug program. See Section 5(f), *Covered medications and supplies.*	Network: Nothing (No deductible) Non-Network: Any difference between our allowance and the billed amount	Network: Nothing (No deductible) Non-Network: Any difference between our allowance and the billed amount
Individual diabetic education provided by a health care professional for members with an established diagnosis of diabetes, including: • Educational supplies • Patient instruction • Medical nutrition therapy Note: Please contact us at 800-410-7778 to obtain information on the specific services covered under this benefit. Note: We offer a diabetes management incentive program that will reward participating members who comply with the program's requirements. See Section 5(h), *Wellness and Other Special Features.*	Network: 10% of the Plan's allowance Non-Network: All charges	Network: 20% of the Plan's allowance Non-Network: All charges
Not covered: • *Self help or self management programs such as diabetic self management, except diabetic education described above* • *Charges for educational/instructional advice on how to use durable medical equipment* • *Programs for nocturnal enuresis* • *Diabetic education classes or sessions provided in a group setting* • *Exercise or weight loss programs and exercise equipment* • *Nutritional supplements or food*	*All charges*	*All charges*

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Health Care Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
  - The Standard Option calendar year deductible is $350 per person (limed to $700 per Self Plus One or Self and Family) for services of Network providers and $600 per person (limited to $1,200 per Self Plus One or $1,500 per Self and Family) for services of Non-Network providers.
  - The Value Plan calendar year deductible is $600 per person (limited to $1,200 per Self Plus One or Self and Family) for services of Network providers and $900 per person (limited to $1,800 per Self Plus One or Self and Family) for services of Non-Network providers.
- The Non-Network benefits are the regular benefits of this Plan. Network benefits apply only when you use a Network provider. When no Network provider is available, Non-Network benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with Medicare and other coverage.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- You or your physician must get precertification or prior approval for some surgical procedures. Please refer to the precertification information shown in Section 3.

Benefit Description	You Pay After the calendar year deductible…	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Surgical procedures	**Standard Option**	**Value Plan**
A comprehensive range of services, such as: • Operative procedures (performed by the primary surgeon) • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Endoscopy procedures (diagnostic and surgical) • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Insertion of internal prosthetic devices. (See Section 5(a), *Orthopedic and prosthetic devices* for device coverage information) • Treatment of severe burns • Correction of amblyopia & strabismus Note: Prior approval is required for all spinal surgeries. Call us at 800-410-7778. See Section 3, *Other services* under *You need prior Plan approval for certain services.*	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Surgical procedures - continued on next page

Benefit Description	You Pay After the calendar year deductible…	
Surgical procedures (cont.)	**Standard Option**	**Value Plan**
Note: Voluntary sterilization procedures and surgically implanted contraceptives and intrauterine devices (IUDs) are covered under Section 5(a), *Family planning*.	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Surgical treatment of morbid obesity (bariatric surgery) – a diagnosed condition in which the body mass index is 40 or greater, or 35 or greater with co-morbidities such as diabetes, coronary artery disease, hypertension, hyperlipidemia, obstructive sleep apnea, pulmonary hypertension, weight-related degenerative joint disease, or lower extremity venous or lymphatic obstruction – when: • There is no treatable metabolic cause for the obesity • Member has participated in a 3-month physician-supervised weight loss program that included dietary therapy, physical activity and behavior therapy within the past 6 months and has failed to lose weight • A psychological evaluation has been completed and member has been recommended for bariatric surgery • Member is age 18 or older Note: Prior approval is required. Call us at 800-410-7778 for more information. See Section 3, *Other services* under *You need prior Plan approval for certain services*.	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance for the individual procedure and any difference between our allowance and the billed amount
Subsequent surgery for morbid obesity is subject to the following additional pre-surgical requirements: • All criteria listed above for the initial procedure must be met again • Previous morbid obesity surgery occurred at least 2 years prior to the requested subsequent surgical procedure • Weight loss from the initial procedure was less than 50% of the member's excess body weight at the time of the initial procedure • Member complied with prescribed post-surgical nutrition and exercise program • Documentation from the member's provider(s) that pre-surgical requirements have been met and must be received prior to surgery	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Surgical procedures - continued on next page

Benefit Description	You Pay After the calendar year deductible…	
Surgical procedures (cont.)	**Standard Option**	**Value Plan**
Surgical transgender services (gender reassignment surgery) to treat gender dysphoria for members age 18 and older who have been diagnosed as a transsexual and have completed a recognized program of transgender identity treatment which includes: • Two referral letters from qualified mental health professionals, one in a purely evaluative role; • Persistent, well-documented gender dysphoria; • Capacity to make a fully informed decision and to consent to treatment, and; • Twelve months of continuous hormone therapy as appropriate to the member's gender goals Covered surgical procedures are limited to: • Female to male surgery: mastectomy, hysterectomy, vaginectomy, salpingo-oophorectomy, metoidioplasty, phalloplasty, urethroplasty, scrotoplasty, and placement of testicular and erectile prosthesis • Male to female surgery: penectomy, orchidectomy, vaginoplasty, clitoroplasty, and labiaplasty Note: Prior approval is required. Call us at 800-410-7778. See Section 3, *Other services* under *You need prior Plan approval for certain services.*	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Pain management Treatment and management of chronic musculoskeleteal pain through interventional procedures such as nerve blocks. Note: Prior approval is required. Call us at 800-410-7778 prior to scheduling treatment. See Section 3, *Other services* under *You need prior Plan approval for certain services.* Note: Benefits for these services will be paid at the Non-Network level when you receive services from a Non-Network provider.	Network: 10% of the Plan’s allowance Non-Network: 30% of the Plan’s allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan’s allowance Non-Network: 40% of the Plan’s allowance and any difference between our allowance and the billed amount
When multiple or bilateral surgical procedures are performed during the same operative session by the same surgeon, the Plan’s benefit is determined as follows: • For the primary procedure: - Network: the Plan’s full allowance, or - Non-Network: the Plan’s full allowance • For the secondary procedure performed during the same operative session, the Plan will allow:	Network: 10% of the Plan’s allowance for the individual procedure Non-Network: 30% of the Plan’s allowance for the individual procedure and any difference between our allowance and the billed amount	Network: 20% of the Plan’s allowance for the individual procedure Non-Network: 40% of the Plan’s allowance for the individual procedure and any difference between our allowance and the billed amount

Surgical procedures - continued on next page

Benefit Description	You Pay After the calendar year deductible…	
Surgical procedures (cont.)	**Standard Option**	**Value Plan**
- Network: 50% of what the Plan would normally allow if that procedure was performed as the primary procedure, unless the Network contract provides for a different amount, or - Non-Network: 50% of what the Plan would normally allow if that procedure was performed as the primary procedure • For tertiary and subsequent procedures performed during the same operative session, the Plan will allow: - Network: 25% of what the Plan would normally allow if that procedure was performed as the primary procedure, unless the Network contract provides for a different amount, or - Non-Network: 25% of what the Plan would normally allow if that procedure was performed as the primary procedure	Network: 10% of the Plan's allowance for the individual procedure Non-Network: 30% of the Plan's allowance for the individual procedure and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance for the individual procedure Non-Network: 40% of the Plan's allowance for the individual procedure and any difference between our allowance and the billed amount
Co-surgeons When the surgery requires two surgeons with different skills to perform the surgery, the Plan's allowance for each surgeon is 62.5% of what it would allow a single surgeon for the same procedure(s), unless the Network contract provides for a different amount.	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance for the individual procedure and any difference between our allowance and the billed amount
Assistant surgeons Assistant surgical services when medically necessary to assist the primary surgeon. The Plan's allowance for an assistant surgeon is 16% of our allowance for the surgery when provided by a qualified surgeon and 12% of our allowance for the surgery when provided by a registered nurse first assistant or certified surgical assistant, unless the Network contract provides for a different amount.	Network: Nothing Non-Network: Any difference between our allowance and the billed amount	Network: Nothing (No deductible) Non-Network: Any difference between our allowance and the billed amount
Not covered: • *Multiple or bilateral surgical procedures performed through the same incision that are "incidental" to the primary surgery. That is, the procedure would not add time or complexity to patient care. We do not pay extra for incidental procedures* • *Reversal of voluntary sterilization* • *Services of a standby surgeon*	*All charges*	*All charges*

Surgical procedures - continued on next page

Benefit Description	You Pay After the calendar year deductible…	
Surgical procedures (cont.)	**Standard Option**	**Value Plan**
• *Routine treatment of conditions of the foot except for services rendered to members with peripheral vascular disease or diabetes. See Section 5(a), Foot care* • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury or caused by illness* • *Radial keratotomy, laser and other refractive surgery* • *Pain management services that have not been prior approved* • *Transgender related services defined as cosmetic including, but not limited to: Abdominoplasty, Blepharoplasty, Brow lift, Calf implants, Cheek/ malar implants, Collagen injections, Drugs for hair loss or growth, Forehead lift, Hair removal, Hair transplantation, Lip reduction, Liposuction, Mastoplexy, Neck tightening, Pectoral implants, Removal of redundant skin, Rhinoplasty, Voice therapy/voice lessons* • *Reversal of transgender surgeries*	*All charges*	*All charges*
Reconstructive surgery	**Standard Option**	**Value Plan**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produces a major effect on the member's appearance, and - the condition can reasonably be expected to be corrected by such surgery. • Surgery to correct a congenital anomaly (a condition that existed at or from birth and is a significant deviation from the common form or norm). Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - Surgery to produce a symmetrical appearance of breasts - Treatment of any physical complications, such as lymphedemas Note: See Section 5(a), *Orthopedic and prosthetic devices* for coverage of breast prostheses and surgical bras and replacements.	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Reconstructive surgery - continued on next page

Benefit Description	You Pay After the calendar year deductible…	
Reconstructive surgery (cont.)	**Standard Option**	**Value Plan**
Note: If you need a mastectomy, you may choose to have this procedure performed on an inpatient basis and remain in the hospital for up to 48 hours after your admission.	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury or caused by illness* • *Charges for photographs to document physical conditions*	*All charges*	*All charges*
Oral and maxillofacial surgery	**Standard Option**	**Value Plan**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of impacted teeth that are not completely erupted (bony, partial bony, and soft tissue impactions) • Removal of stones from salivary ducts • Excision of leukoplakia, tori or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Temporomandibular joint dysfunction surgery • Other surgical procedures that do not involve the teeth or their supporting structures Note: The related hospitalization (inpatient and outpatient) is covered if medically necessary. See Section 5(c).	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: • *Oral/dental implants and transplants* • *Procedures that involve the teeth or their supporting structures, such as the periodontal membrane, gingiva, and alveolar bone* • *Conservative treatment of temporomandibular joint dysfunction (TMJ)* • *Dental/oral surgical splints and stents* • *Orthodontic treatment*	*All charges*	*All charges*

Organ/Tissue Transplant

Prior Approval

All transplant procedures and transplant-related services, except corneal transplants, are subject to medical necessity and experimental/investigational review, and **must be prior approved** when the Plan is the primary payor. You, your representative, the doctor, or the hospital must contact us before your evaluation as a potential candidate for a transplant procedure so we can arrange to review the evaluation results and determine whether the proposed procedure is approved for coverage. You must have our written approval for the procedure before the Plan will cover any transplant-related expenses.

Aetna Institutes of Excellence

The Plan participates in the Aetna Institutes of Excellence Transplant Network program. Because transplantation is a highly specialized area, not all Network hospitals are part of the Aetna Institutes of Excellence program.

- **To qualify for this program, you, your representative, the doctor, or the hospital must call us at 800-410-7778 as soon as the possibility of a transplant is discussed.** When you call, you will be given information about the program and participating facilities.
- To receive the Aetna Transplant Network level of benefits, you must choose an Aetna Institutes of Excellence facility, and all transplant-related services must be received at that facility.
- All transplant admissions must be precertified.
- MHBP must be your primary plan for payment of benefits to use the Aetna Institutes of Excellence program.

Travel Benefit – for patients using the Aetna Institutes of Excellence program, the Plan may approve reasonable travel (air, train, bus and/or taxi), and lodging expenses up to a maximum of $10,000 per transplant for the recipient and one companion. If the transplant recipient is age 21 or younger, we pay up to $10,000 for eligible travel costs for the member and two caregivers. Reimbursement is subject to IRS regulations.

Note: Receipts are required for reimbursement of travel costs.

For more information, contact us at 800-410-7778 before scheduling your pre-transplant evaluation.

Donor Coverage

- We cover donor screening and search expenses for up to four (4) candidate donors per transplant occurrence.
- We cover related medical and hospital expenses of the donor for the initial transplant confinement when we cover the recipient if these expenses are not covered under any other health plan.

Benefit Limitations

The maximum benefit for any organ/tissue transplant(s) is:

- Aetna Transplant Network: $1,000,000 per occurrence, which includes the following transplant-related expenses: pre-transplant evaluation, inpatient and outpatient hospital care, postoperative follow-up care, physician services and donor expenses as described above. To use the Aetna Transplant Network, this must be your primary plan for payment of benefits. Benefits begin on the first date of evaluation for transplant and end one year after the date of transplant for solid organ transplants, or 6 months after the date of stem cell infusion for blood or marrow stem cell transplants.
- Network and Non-Network: $200,000 per occurrence for Network services or $100,000 per occurrence for Non-Network services. These benefit maximums include:
  - Solid organ transplants: all transplant-related expenses from the date of the transplant procedure until the date of discharge from the hospital following the procedure.
  - Autologous blood or marrow stem cell transplants: all inpatient and outpatient transplant-related services from the date of mobilization of stem cells to three months after the date of cell infusion.
  - Allogeneic blood or marrow stem cell transplants: all inpatient and outpatient transplant-related services from the date of pre-transplant high-dose ablation chemotherapy to three months after the date of cell infusion.

Expenses related to complications arising during the transplant admission are considered part of the same occurrence. Outpatient prescription drugs and approved travel expenses related to the transplant are not subject to the transplant maximums. See Section 5(c) for coverage of transplant-related services provided by a hospital.

Note: Benefits will be paid at the Network or Non-Network level of benefits if no Aetna Transplant Network provider is available.

Note: Chemotherapy, when supported by a bone marrow transplant or autologous stem cell support, is covered only for the specific diagnoses listed.

Benefit description	You pay After the calendar year deductible...	
Organ/tissue transplants	**Standard Option**	**Value Plan**
Solid organ transplants are limited to: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs such as the liver, stomach, and pancreas • Kidney • Kidney - pancreas • Liver • Lung: single/ bilateral/ lobar • Pancreas	Aetna Transplant Network: 10% of the Plan's allowance Network: 15% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Aetna Transplant Network: 10% of the Plan's allowance Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to Section 3, *Other services* for prior approval procedures. • Autologous tandem bone marrow transplants for: - AL amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	Aetna Transplant Network: 10% of the Plan's allowance Network: 15% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Aetna Transplant Network: 10% of the Plan's allowance Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Blood or marrow stem cell transplants. The Plan extends coverage for the diagnoses as indicated below: • Allogeneic (donor) transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia	Aetna Transplant Network: 10% of the Plan's allowance Network: 15% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Aetna Transplant Network: 10% of the Plan's allowance Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefit description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	**Standard Option**	**Value Plan**
- Advanced Hodgkin's lymphoma and/or recurrent Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma and/or recurrent non-Hodgkin's lymphoma - Advanced myeloproliferative disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's Paroxysmal Nocturnal Hemoglobinuia, Pure Red Cell Aplasia) - Mucolipidosis (e,g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/myelodysplastic syndromes - Myeloproliferative disorders (MPDs) - Paroxysmal nocturnal hemoglobinuria - Phagocytic/hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe or very severe aplastic anemia - Severe combined immunodeficiency disease - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous (self) transplants (autologous stem cell and peripheral stem cell support) for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma and/or recurrent non-Hodgkin's lymphoma - Amyloidosis - Breast cancer - Ependymoblastoma - Epithelial ovarian cancer	Aetna Transplant Network: 10% of the Plan's allowance Network: 15% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Aetna Transplant Network: 10% of the Plan's allowance Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefit description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	**Standard Option**	**Value Plan**
- Ewing's sarcoma - Medulloblastoma - Multiple myeloma - Neuroblastoma - Pineoblastoma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors	Aetna Transplant Network: 10% of the Plan's allowance Network: 15% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Aetna Transplant Network: 10% of the Plan's allowance Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Mini-transplants performed in a clinical trial setting (non-myeloblative reduced intensity conditioning or RIC) for members with a diagnosis listed below, subject to medical necessity review by the Plan: Refer to Section 3, *Other services* for prior approval procedures. • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e. myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced myeloproliferative disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e. Falconi's, PNH, Pure Red Cell Aplasia - Myelodysplasia/myelodysplastic syndromes - Paroxysmal nocturnal hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	Aetna Transplant Network: 10% of the Plan's allowance Network: 15% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Aetna Transplant Network: 10% of the Plan's allowance Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefit description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	**Standard Option**	**Value Plan**
These blood or marrow stem cell transplants are covered only in a National Cancer Institute (NCI) or the National Institutes of Health (NIH) approved clinical trial or a Plan-designed center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-ray and scans and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic (donor) transplants for: - Advanced Hodgkins lymphom - Advanced non-Hodgkins lymphoma - Beta thalassemia major - Chronic inflammatory demyelinating polyneuropathy (CIPD) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle cell anemia • Mini-transplants (nonmyeloablative allogeneic transplants or Reduced Intensity Conditioning (RIC)) for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkins lymphoma - Advanced non-Hodgkins lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myelodysplasia/myelodysplastic syndromes (MDD's)	Aetna Transplant Network: 10% of the Plan's allowance Network: 15% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Aetna Transplant Network: 10% of the Plan's allowance Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefit description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	**Standard Option**	**Value Plan**
- Myeloproliferative disorders - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous transplants for: - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin lymphomas - Breast cancer - Childhood rhabdomyosarcoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial ovarian cancer - Mantle cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Scleroderma - Scleroderma-SSc (severe, progressive) - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis	Aetna Transplant Network: 10% of the Plan's allowance Network: 15% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Aetna Transplant Network: 10% of the Plan's allowance Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: • *All charges for services over $1,000,000 from Aetna Transplant Network providers; all charges for services over $200,00 from Network providers; all charges for services over $100,000 from Non-Network providers* • *Donor screening and search expenses after four screened donors, except when approved through the Aetna Transplant Network* • *Travel, lodging and meal expenses not approved by the Plan*	*All charges*	*All charges*

Organ/tissue transplants - continued on next page

Benefit description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	**Standard Option**	**Value Plan**
• *Services and supplies for or related to transplants not listed as covered. Related services or supplies include administration of chemotherapy when supported by transplant procedures*	*All charges*	*All charges*
Anesthesia	**Standard Option**	**Value Plan**
Professional services for the administration of anesthesia in hospital and out of hospital Note: When multiple anesthesia providers are involved during the same surgical session, the Plan's allowance for each anesthesia provider will be determined using CMS guidelines. Note: If you use a Network facility, we pay Network benefits when you receive services from an anesthesiologist who is not a Network provider. See Section 1, *We have Network providers* for further details.	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In this Section, unlike Sections 5(a) and 5(b), the calendar year deductible applies to some benefits in this section. We added "(calendar year deductible applies)". If applicable:
  - the Standard Option calendar year deductible is $350 per person (limited to $700 per Self Plus One or Self Plus Family enrollment) for services of Network providers and $600 per person (limited to $1,200 per Self Plus One or $1,500 per Self Plus Family enrollment) for services of Non-Network providers.
  - the Value Plan calendar year deductible is $600 per person (limited to $1,200 per Self Plus One or Self Plus Family enrollment) for services of Network providers and $900 per person (limited to $1,800 per Self Plus One or Self Plus Family enrollment) for services of Non-Network providers.
- The Non-Network benefits are the regular benefits of this Plan. Network benefits apply only when you use a Network provider. When no Network provider is available, Non-Network benefits apply. To help keep your out-of-pocket costs for coinsurance to a minimum, we encourage you to contact us for directions to Network providers whenever possible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with Medicare and other coverage.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Section 5(a) or Section 5(b).

  Note: Observation care is covered as outpatient facility care. As a result, benefits for observation care services are provided at the outpatient facility benefit levels described in Section 5(c). See Section 10, *Observation care*.

  Note: When you use a Network hospital, keep in mind that the professionals who provide services to you in the hospital, such as radiologists, emergency room physicians, anesthesiologists, and pathologists may not all be Network providers.
- YOUR NETWORK PHYSICIAN MUST PRECERTIFY INPATIENT FACILITY STAYS. YOU MUST GET PRECERTIFICATION FOR NON-NETWORK FACILITY STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY. Please refer to the precertification information shown in Section 3.

Benefit Description	You pay	
Note: The calendar year deductible applies ONLY when we say below: "(calendar year deductible applies)".		
Inpatient hospital	**Standard Option**	**Value Plan**
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: We only cover a private room when you must be isolated to prevent contagion or the hospital only has private rooms. Otherwise, our benefit will be based on the hospital's average charge for semiprivate accommodations.	Aetna Transplant Network: $200 copayment per admission Network: $200 copayment per admission Non-Network: $500 copayment per admission and any difference between our allowance and the billed amount	Aetna Transplant Network: 10% of the Plan's allowance (calendar year deductible applies) Network: 20% of the Plan's allowance (calendar year deductible applies) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	**Standard Option**	**Value Plan**
Note: Hospitals billing an all-inclusive rate will be prorated between room and board and ancillary charges. Note: Inpatient hospital care related to maternity, including care at birthing facilities, we waive your cost-share and pay for covered services in full for care provided by a Network facility.	Aetna Transplant Network: $200 copayment per admission Network: $200 copayment per admission Non-Network: $500 copayment per admission and any difference between our allowance and the billed amount	Aetna Transplant Network: 10% of the Plan's allowance (calendar year deductible applies) Network: 20% of the Plan's allowance (calendar year deductible applies) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Other hospital services and supplies (ancillary services), such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic tests, such as X-rays, laboratory and pathology services, MRIs, and CAT Scans • Blood or blood plasma • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Autologous blood donations • Internal prosthesis Note: We base our payment on whether the facility or a health care professional bills for the services or supplies. For example, when the hospital bills for its anesthetists' services, we pay Hospital benefits and when the anesthetist bills, we pay under Section 5(b). Note: The maximum benefit for any organ/tissue transplant(s) as described in Section 5(b), *Organ/ tissue transplants* is: • Aetna Transplant Network: $1,000,000 per occurrence. To use the Aetna Institutes of Excellence program, this must be your primary plan for payment of benefits. • Network: $200,000 per occurrence. • Non-Network: $100,000 per occurrence.	Aetna Transplant Network: 10% of the Plan's allowance Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Aetna Transplant Network: 10% of the Plan's allowance (calendar year deductible applies) Network: 20% of the Plan's allowance (calendar year deductible applies) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	**Standard Option**	**Value Plan**
Note: Expenses related to complications arising during the transplant admission are considered part of the same occurrence. Outpatient prescription drugs and approved travel expenses related to the transplant are not subject to the transplant maximums. See Section 5(b) for transplant-related professional services. Note: To use the Aetna Institutes of Excellence program, this must be your primary plan for payment of benefits. Note: For inpatient hospital care related to maternity, including care at birthing facilities, we waive the cost-share and pay for covered services in full for care provided by a Network facility. Note: Chemotherapy, when supported by a bone marrow transplant or autologous stem cell support is covered only for the specific diagnoses listed in Section 5(b), *Organ/tissue transplants*. Note: The Plan pays Inpatient Hospital Benefits as shown above in connection with dental procedures only when a non-dental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient.	Aetna Transplant Network: 10% of the Plan's allowance Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Aetna Transplant Network: 10% of the Plan's allowance (calendar year deductible applies) Network: 20% of the Plan's allowance (calendar year deductible applies) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Not covered: • *A hospital admission, or portion thereof, that is not medically necessary (see Section 10, Definitions), including an admission for medical services that did not require the acute hospital inpatient (overnight) setting, but could have been provided in a doctor's office, outpatient department of a hospital, or some other setting without adversely affecting the patient's condition or the quality of medical care rendered* • *Hospital admissions for medical rehabilitation unless the admission is to an approved acute inpatient rehabilitation facility and the patient can actively participate in a minimum of 3 hours of acute inpatient rehabilitation to include any combination of the following therapies: physical, occupational, speech, respiratory therapy per day* • *Custodial care, see Section 10, Definitions* • *Non-covered facilities, such as nursing homes, subacute care facilities, extended care facilities, schools, domiciliaries and rest homes* • *Personal comfort items, such as phone, television, barber services, guest meals and beds*	*All charges*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	**Standard Option**	**Value Plan**
• *Private inpatient nursing care* • *All charges for services provided by a Christian Science nursing facility*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**Standard Option**	**Value Plan**
Services and supplies related to outpatient maternity care, including care at birthing facilities, such as: • Delivery, recovery, and other treatment rooms • Prescribed drugs and medications • Diagnostic tests, limited to X-rays, ultrasound, laboratory and pathology services • Medical supplies, including anesthesia and oxygen	Network: Nothing Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	Network: Nothing Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Services and supplies related to outpatient surgical procedures, such as: • Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Diagnostic tests, such as X-rays, laboratory and pathology services • CT/CAT scans, CTA, MRA, MRI, NC, PET, SPECT Note: Prior approval is required. Call us at 800-410-7778 prior to scheduling. See Section 3, *Outpatient imaging procedures* under *You need prior Plan approval for certain services.* Note: For services performed at a stand-alone imaging center, see Section 5(a), *Lab, X-ray and other diagnostic tests.* • Blood and blood plasma, if not donated or replaced, and other biologicals, including administration • Dressings, casts, and sterile tray services • Medical supplies, including anesthesia and oxygen • Anesthetics and anesthesia services Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. Note: If the stay is greater than 24 hours, you need to precertify the admission. See Section 5(c), *Inpatient hospital.*	Network: 10% of the Plan's allowance (calendar year deductible applies) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	Network: 20% of the Plan's allowance (calendar year deductible applies) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You pay	
Outpatient hospital or ambulatory surgical center (cont.)	**Standard Option**	**Value Plan**
Note: For services billed by a surgeon or anesthetist, see Section 5(b). For services related to an accidental injury or medical emergency, see Section 5(d).	Network: 10% of the Plan's allowance (calendar year deductible applies) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	Network: 20% of the Plan's allowance (calendar year deductible applies) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Services and supplies related to outpatient diagnostic testing and rehabilitative therapy, such as: • Diagnostic tests, such as X-rays, laboratory and pathology services • CT/CAT scans, CTA, MRA, MRI, NC, PET, SPECT Note: Prior approval is required. Call us at 800-410-7778 prior to scheduling. See Section 3, *You need prior Plan approval for certain services under Outpatient imaging procedures* Note: For services performed at a stand-alone imaging center, see Section 5(a), *Lab, X-ray and other diagnostic tests.* • Physical, speech and occupational therapy Note: See Section 5(a), *Physical, occupational and speech therapies.* • Treatment rooms Note: If the stay is greater than 24 hours, you need to precertify the admission. See Section 5(c), *Inpatient hospital.* Note: For services related to an accidental injury or medical emergency, see Section 5(d).	Network: 10% of the Plan's allowance (calendar year deductible applies) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	Network: 20% of the Plan's allowance (calendar year deductible applies) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Cardiac rehabilitation therapy - Phase 1 and 2 only Note: Benefits are limited to 24 visits per person per calendar year.	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance	Network: 20% of the Plan's allowance (calendar year deductible applies) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You pay	
Outpatient hospital or ambulatory surgical center (cont.)	**Standard Option**	**Value Plan**
Services and supplies for outpatient diagnostic and treatment services not related to surgical procedures, such as: • Observation services (less than 24 hours) • Non-emergency treatment provided in an emergency room • Chemotherapy and radiation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/infusion therapy • Hyperbaric oxygen therapy • Respiratory and inhalation therapy • Attended sleep studies Note: Prior approval is required. Call us at 800-410-7778. See Section 3, *Other services* under *You need prior plan approval for certain services*. • Growth hormone therapy Note: Pharmacy charges for growth hormones, are covered under Section 5(f), *Prescription drug benefits* and require preauthorization. See Section 5(f), *Specialty drugs* and Section 3, *Other services* under *You need prior Plan approval for certain services*. • Medical supplies, including oxygen Note: See Section 5(d) for services related to an accidental injury or medical emergency.	Network: 10% of the Plan's allowance (calendar year deductible applies) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	Network: 20% of the Plan's allowance (calendar year deductible applies) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Outpatient observation services over 24 hours is performed and billed by a hospital or freestanding ambulatory facility Note: All outpatient services billed by the facility during the time you are receiving observation services are included in the cost-share amounts shown here. See Section 5(a) for services billed by professional providers during an observation stay.	Network: $200 copayment for observation room and 10% of the Plan's allowance for hospital ancillary services (No deductible) Non-Network: $500 copayment for observation room and any difference between our allowance and the billed amount, and 30% of the Plan's allowance for hospital ancillary services and any difference between our allowance and the billed amount (No deductible)	Network: 20% of the Plan's allowance (calendar year deductible applies) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You pay	
Outpatient hospital or ambulatory surgical center (cont.)	**Standard Option**	**Value Plan**
Not covered: • *Surgical facility charges billed by entities that are not accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF), or the Accreditation Association for Ambulatory Health Care (AAAHC), or which do not have Medicare certification as an ASC facility* • *Pulmonary rehabilitation*	*All charges*	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**Standard Option**	**Value Plan**
Semiprivate room, board, services and supplies provided in a skilled nursing care facility (SNF) when you are admitted directly from a covered inpatient hospital stay Note: Prior approval is required. Call us at 800-410-7778. See Section 3, *Other services* under *You need prior Plan approval for certain services*. Note: Benefits are available only when this plan is the primary payor for health benefits. Benefits are limited to 40 days per person per calendar year. When another plan, including Medicare, is the primary payor, these benefits are not payable.	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and anydifference between our allowance and the billed amount	Network: 20% of the Plan's allowance (calendar year deductible applies) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Not covered: • *Custodial care, see Section 10, Definitions*	*All charges*	*All charges*
Hospice care	**Standard Option**	**Value Plan**
Hospice is a coordinated program of maintenance and supportive care for the terminally ill provided by a medically supervised team under the direction of a Plan-approved independent hospice administration. If you use a Network provider, your out-of-pocket expenses will be reduced. Note: See Section 5(h), *Compassionate Care program* for information about additional programs to support end-of-life care.	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: • *Homemaker services*	*All charges*	*All charges*

Benefit Description	You pay	
Ambulance	**Standard Option**	**Value Plan**
Local professional ambulance service when medically appropriate to the first hospital where treated and from that hospital to the next nearest hospital or medical facility if necessary treatment is not available at the first hospital. Services must be related to: • an accidental injury or medical emergency, • a covered inpatient hospitalization, • a direct transfer from a covered inpatient hospitalization to a covered skilled nursing facility confinement, or • covered hospice care. Air ambulance to the nearest hospital where treatment is available and only if there is no emergency ground transportation available or suitable and the patient's condition requires immediate evacuation. Note: Benefits for air or ground ambulance transportation that is not to the nearest hospital where appropriate treatment is available will be prorated based on mileage to the nearest hospital where appropriate treatment is available. Note: Prior approval is required for transportation by fixed-wing aircraft (plane). Call us at 800-410-7778. See Section 3, Other services under *You need prior Plan approval for certain services.*	Network: 10% of the Plan's allowance (calendar year deductible applies) Non-Network: 10% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	Network: 20% of the Plan's allowance (calendar year deductible applies) Non-Network: 20% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Not covered: • *Transportation to other than a hospital, skilled nursing facility, hospice or urgent care medical facility* • *Transportation to or from services including but not limited to physician appointments, dialysis, or diagnostic tests, except as part of covered inpatient hospital care* • *Expenses for ambulance services when the patient is not actually transported*	*All charges*	*All charges*

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- These benefits are payable instead of any other benefit under this Plan for emergency treatment of accidental injuries and medical emergencies.
- The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
  - The Standard Option calendar year deductible is $350 per person (limited to $700 per Self Plus One or Self and Family enrollment) for services of Network providers and $600 per person (limited to $1,200 per Self Plus One or $1,500 per Self and Family enrollment) for services of Non-Network providers.
  - The Value Plan calendar year deductible is $600 per person (limited to $1,200 per Self Plus One or Self and Family) for services of Network providers and $900 per person (limited to $1,800 per Self Plus One or Self and Family enrollment) for services of Non-Network providers.
- The Non-Network benefits are the regular benefits of this Plan. Network benefits apply only when you use a Network provider. When no Network provider is available, Non-Network benefits apply.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with Medicare and other coverage.

What is an accidental injury? An accidental injury is a bodily injury sustained through external and accidental means, such as broken bones, animal bites, poisonings and injuries to sound natural teeth. Masticating (chewing) incidents are not considered to be accidental injuries. Services and supplies for the repair of sound natural teeth must be provided within one year of the accident and the patient must be a member of the Plan at the time services are rendered.

What is a medical emergency? A medical emergency is the sudden and unexpected onset of a condition requiring immediate medical care. The severity of the condition, as revealed by the doctor's diagnosis, must be such as would normally require emergency care. Medical emergencies include heart attacks, cardiovascular accidents, loss of consciousness or respiration, convulsions and such other acute conditions as may be determined by the Plan to be medical emergencies.

Benefit Description	You pay After the calendar year deductible…	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Accidental injury	**Standard Option**	**Value Plan**
If you receive outpatient care for your accidental injury in a hospital emergency room, we cover: • Non-surgical physician services and supplies • Related outpatient hospital services • Observation room • Surgery and related services Note: We pay inpatient hospital benefits if you are admitted. See Section 5(c), *Inpatient hospital.* Note: If the stay is greater than 24 hours, you need to precertify the admission. See *Section 5(c), Inpatient hospital.*	Network: $200 copayment per occurrence (No deductible) (if admitted to the hospital, copayment is waived) Non-Network: $200 copayment per occurrence and any difference between our allowance and the billed amount (No deductible) (if admitted to the hospital, copayment is waived)	Network: 20% of the Plan's allowance Non-Network: 20% of the Plan's allowance and any difference between our allowance and the billed amount

Accidental injury - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Accidental injury (cont.)	**Standard Option**	**Value Plan**
If you receive outpatient care for your accidental injury in an urgent care center, we cover: • Non-surgical physician services and supplies • Surgery and related services	Network: $50 copayment per occurrence (No deductible) Non-Network: 30% of thePlan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance (No deductible) Non-Network: 40% of thePlan's allowance and any difference between our allowance and the billed amount
Non-surgical physician services provided in a doctor's office for your accidental injury	Network: $20 copayment per office visit for adults (No deductible), $10 copayment per office visit for dependent children through age 21 (No deductible); and 10% of the Plan's allowance for other services performed during the visit Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount per office visit (No deductible); 30% of the Plan's allowance and any difference between our allowance and the billed amount for other services	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Medical emergency	**Standard Option**	**Value Plan**
If you receive outpatient care for your medical emergency in a hospital emergency room, we cover: • Non-surgical physician services and supplies • Related outpatient hospital services • Observation room • Surgery and related services Note: Outpatient hospital benefits apply when non-emergent treatment is provided in a hospital emergency room. See Section 5(c). Note: We pay Inpatient hospital benefits if you are admitted. See Section 5(c). Note: If the stay is greater than 24 hours, you need to precertify the admission. See Section 5(c), *Inpatient hospital.*	Network: $200 copayment per occurrence (if admitted to the hospital, copayment is waived) Non-Network: $200 copayment per occurrence and any difference between our allowance and the billed amount (if admitted to the hospital, copayment is waived)	Network: 20% of the Plan's allowance Non-Network: 20% of the Plan's allowance and any difference between our allowance and the billed amount
If you receive outpatient care for your medical emergency in an urgent care center, we cover: • Non-surgical physician services and supplies • Surgery and related services	Network: $50 copayment per occurrence (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance (No deductible) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Medical emergency - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Medical emergency (cont.)	**Standard Option**	**Value Plan**
Non-surgical physician services provided in a doctor's office for your medical emergency.	Network: $20 copayment per office visit for adults (No deductible), $10 copayment per office visit for dependent children through age 21 (No deductible); and 10% of the Plan's allowance for other services performed during the visit Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount per office visit (No deductible); 30% of the Plan's allowance and any difference between our allowance and the billed amount for other services	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Ambulance	**Standard Option**	**Value Plan**
Local professional ambulance service when medically appropriate to the first hospital where treated and from that hospital to the next nearest hospital or medical facility if necessary treatment is not available at the first hospital. Services must be related to: • an accidental injury or medical emergency • a covered inpatient hospitalization • a direct transfer from a covered inpatient hospitalization to a covered skilled nursing facility confinement, or • covered hospice care Air ambulance to the nearest hospital where treatment is available and only if there is no emergency ground transportation available or suitable and the patient's condition warrants immediate evacuation. Note: Benefits for air or ground ambulance transportation that is not to the nearest hospital where appropriate treatment is available will be prorated based on mileage to the nearest hospital where appropriate treatment is available. Note: Prior approval is required for transportation by fixed-wing aircraft (plane). Call us at 800-410-7778. See Section 3, *Other services* under *You need prior Plan approval for certain services.*	Network: 10% of the Plan's allowance Non-Network: 10% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 20% of the Plan's allowance and any difference between our allowance and the billed amount

Ambulance - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Ambulance (cont.)	**Standard Option**	**Value Plan**
Not covered: • *Transportation to other than a hospital, skilled nursing facility, hospice or urgent care medical facility* • *Transportation to or from services including but not limited to physician appointments, dialysis, or diagnostic tests, except as part of covered inpatient hospital care* • *Expenses for ambulance services when the patient is not actually transported*	*All charges*	*All charges*

Section 5(e). Mental Health and Substance Use Disorder Benefits

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary and/or clinically appropriate.
- These benefits are payable instead of any other benefits under this Plan for services related to treatment of mental health and substance usedisorder.
- The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
  - The Standard Option calendar year deductible is $350 per person (limited to $700 per Self Plus One or Self and Family enrollment) for services of Network providers and $600 per person (limited to $1,200 per Self Plus One or $1,500 per Self and Family enrollment) for services of Non-Network providers.
  - The Value Plan calendar year deductible is $600 per person (limited to $1,200 per Self Plus One or Self and Family enrollment) for services of Network providers and $900 per person (limited to $1,800 per Self Plus One or Self and Family enrollment) for services of Non-Network providers.
- The Non-Network benefits are the regular benefits of this Plan. Network benefits apply only when you use a Network provider. When a Network provider is not available, Non-Network benefits apply.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with Medicare and other coverage.
- YOUR NETWORK PHYSICIAN MUST PRECERTIFY INPATIENT FACILITY STAYS. YOU MUST GET PRECERTIFICATION FOR NON-NETWORK FACILITY STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY. Please refer to the precertification information shown in Section 3.

Benefits description	You pay After the calendar year deductible…	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Professional services	**Standard Option**	**Value Plan**
We cover professional services, including telephonic and video conferencing by licensed professional mental health and substance use disorder practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, and marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnostic and treatment services: • Outpatient professional services, including individual or group therapy	Network: $20 copayment per office visit for adults (No deductible); $10 copayment per office visit for dependent children through age 21 (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: $30 copayment per visit (No deductible); $10 copayment per office visit for dependent children through age 21 (No deductible) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Professional services - continued on next page

Benefits description	You pay After the calendar year deductible…	
Professional services (cont.)	**Standard Option**	**Value Plan**
• Inpatient professional services	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Diagnostics	**Standard Option**	**Value Plan**
Outpatient lab, X-ray and other diagnostic tests, including psychological and neuropsychological testing.	Network: 10% of the Plan's allowance (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance (No deductible) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Lab Savings Program You can use this voluntary program for covered lab tests. As long as Quest Diagnostics or LabCorp does the testing and bills us directly, you will not have to file any claims. To find a location near you, visit our website, www.MHBP.com. Note: This benefit applied to expenses for lab tests only. Related expenses for services provided by a physician or lab tests performed by an associated facility not participating in the Lab Savings Program are subject to applicable deductibles, copayments and coinsurance.	Nothing (No deductible)	Nothing (No deductible)
TeleHealth Services	**Standard Option**	**Value Plan**
Telehealth consultations are available to members in the 50 United States through Teladoc®. See www.teladoc.com or call 855-835-2362 (855-Teladoc) for information regarding telehealth consults. Note: Teladoc is not available for phone services in Idaho (video consult only).	Network: Nothing (No deductible) Non-Network: All charges	Network: Nothing (No deductible) Non-Network: All charges
AbleTo Web-Based Video Conferencing Service	**Standard Option**	**Value Plan**
An 8-week personalized treatment support program designed to address unique emotional and behavioral health needs of members learning to live with conditions or life events such as: • heart disease • type 2 diabetes • chronic pain • losing a loved one • welcoming a baby	Network: Nothing (No deductible) Non-Network: All charges	Network: Nothing (No deductible) Non-Network: All charges

AbleTo Web-Based Video Conferencing Service - continued on next page

Benefits description	You pay After the calendar year deductible…	
AbleTo Web-Based Video Conferencing Service (cont.)	**Standard Option**	**Value Plan**
Note: See Section 5(h), *Wellness and Other Special Features* for additional information about the AbleTo Support Program.	Network: Nothing (No deductible) Non-Network: All charges	Network: Nothing (No deductible) Non-Network: All charges
Treatment therapy	**Standard Option**	**Value Plan**
Applied behavior analysis (ABA) therapy when provided by: • Licensed clinicians with a Doctorate or Master's degree trained to treat ASD • Board Certified Behavioral Analyst (BCBA) with state licensure/certification in states that require it and a minimum of six months of supervised experience or training in applied behavior analysis/intensive behavior therapies • Providers (e.g. paraprofessionals) under the direct supervision of an eligible provider Note: Prior approval is required. Call us at 800-410-7778 prior to scheduling. See Section 3, *Other services* under *You need prior Plan approval for certain services.*	Network: 10% of the Plan's allowance (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance (No deductible) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Inpatient hospital	**Standard Option**	**Value Plan**
Inpatient services provided and billed by a hospital or other licensed mental health/substance use disorder covered facility: • Services and supplies provided by a hospital or other inpatient facility • Services in an approved residential treatment center Note: Prior approval is required. Call us at 800-410-7778 prior to scheduling. See Section 3, *Other services* under *You need prior Plan approval for certain services.* Note: Our benefit will be based on the hospital's average charge for semiprivate accommodations. Note: We only cover a private room when you must be isolated to prevent contagion or the hospital only has private rooms. Otherwise, we will pay the hospital's average charge for semiprivate accommodations.	Network: $200 copayment per admission, for room and board and 10% of the Plan's allowance for hospital ancillary services (No deductible) Non-Network: $500 copayment for room and board and any difference between our allowance and the billed amount, and 30% of the Plan's allowance for hospital ancillary services and any difference between our allowance and the billed amount (No deductible)	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Benefits description	You pay After the calendar year deductible…	
Behavioral health outpatient/all other services	**Standard Option**	**Value Plan**
Outpatient services provided and billed by a hospital or other covered facility including other outpatient mental health treatment such as: • Electroconvulsive therapy • Transcranial Magnetic Stimulation (TMS) • Partial hospitalization (see Section 10, *Definitions*) • Facility-based intensive outpatient treatment (see Section 10, *Definitions*) • Substance use disorder detoxification • Medication evaluation and management (pharmacotherapy) • Observation care (under 24 hours) • Vagus Nerve Stimulation (VNS) • Physical, occupational and speech therapy for autism and developmental delays Note: Prior approval may be required. Call us at 800-410-7778 prior to scheduling. See Section 3, *Other services* under *You need prior Plan approval for certain services.*	Network: 10% of the Plan's allowance (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance (No deductible) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Outpatient observation services 24 hours or more performed and billed by a hospital or freestanding ambulatory facility Note: All outpatient services billed by the facility during the time you are receiving observation services are included in the cost-share amounts shown here. See Section 5(a) for services billed by professional providers during an observation stay.	Network: 10% of the Plan's allowance (No deductible) Non-Network: $500 copayment for room and board and any difference between our allowance and the billed amount, and 30% of the Plan's allowance for hospital ancillary services and any difference between our allowance and the billed amount (No deductible)	Network: 20% of the Plan's allowance (No deductible) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Psychiatric home health care	**Standard Option**	**Value Plan**
Skilled behavioral health services provided in the home when: • prescribed by your attending physician for outpatient services • you are homebound and unable to receive services outside of your home • services are appropriate for the treatment of a condition, illness or disease to avoid placing you at risk for serious complications	Network: 10% of the Plan's allowance (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance (No deductible) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Benefits description	You pay After the calendar year deductible…	
Not covered	**Standard Option**	**Value Plan**
• *Treatment of learning disorders or specific delays in development, treatment of mental retardation or intellectual disability* • *Treatment for binge eating disorder and gambling disorder* • *Services rendered or billed by schools* • *Services provided by Non-Network residential treatment centers or halfway houses or members of their staffs, unless prior approved* • *Residential treatment center (RTC) benefits are not available for facilities licensed as a skilled nursing facility, group home, therapeutic boarding school, halfway house, or similar type facility* • *Services, including but not limited to: recreational therapy, equine therapy provided during an approved stay, personal comfort items, and domiciliary care provided because care in the home is not available or is unsuitable*	All charges	All charges

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in this section, Covered medications and supplies,
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Members must make sure their prescribers obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- There is no calendar year deductible for prescription drugs.
- YOU MUST GET PREAUTHORIZATION FOR CERTAIN DRUGS including, but not limited to, preferred and non-preferred brand name drugs when a generic equivalent is available, oncology drugs and Specialty drugs. For more information about preauthorization, please call us at 800-410-7778 or visit our website at www.MHBP.com.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with Medicare and other coverage.

There are important features you should be aware of. These include:

- **Who can write your prescription?** A licensed physician or dentist, and in the states allowing it, licensed or certified authority prescribing within their scope of practice must prescribe your medication.
- **Where you can obtain them.** You may fill the prescription at a network pharmacy, a non-network pharmacy, or by mail for certain drugs. We pay a higher level of benefits when you use a network pharmacy.
  - **Network pharmacy** – Present your Plan identification card at a network pharmacy to purchase your prescriptions and have the claim be filed electronically for you. Call 800-410-7778 or check the electronic directory via www.MHBP.com to locate the nearest network pharmacy.
  - **Non-Network pharmacy** – Standard Option members may purchase prescriptions at pharmacies that are not part of our network. You pay the full cost and manually file a claim for reimbursement. See Section 7, *Filing a claim for covered services*. Prescription drugs obtained from a non-network pharmacy are not covered under Value Plan.
  - **Mail order** – To obtain more information about the mail order drug program, order refills, check order status and request additional mail service envelopes and claim forms, or to ask questions about eligibility, copayments or other issues, call CVS/caremark at 866-623-1441 or visit our website, www.MHBP.com.

Remember to use a Network pharmacy whenever possible and show your MHBP ID card to receive the maximum benefits and the convenience of having your claims filed for you.

- **We use a formulary**. A formulary is a list of generic and preferred drugs (see below) that are available through this plan. It places all FDA approved drugs into categories based on their clinical effectiveness, safety and cost and is designed to control costs for you and the Plan. The categories include:
  - **Generic** drug category includes primarily generic drugs;
  - **Preferred** drug category (also called "formulary") includes preferred brand name drugs;
  - **Non-Preferred** drug category (also called "non-formulary") includes non-preferred brand name drugs;
  - **Specialty** drug category (see description of Specialty drugs below).

Occasionally, drugs may change from one category to another category, which can affect your cost-share amount. We will attempt to notify you when this occurs.

When you need a prescription, share the formulary with your physician and request a Generic or Preferred category drug if possible. By choosing Generic or Preferred category drugs, you may decrease your out-of-pocket expenses. While all FDA-approved drugs are available to you, we may have formulary restrictions on certain drugs, including but not limited to, quantity limits, age limits, dosage limits, brand exception and preauthorization. To request a copy of our current formulary, call us at 800-410-7778 or visit our website, www.MHBP.com.

- **A generic equivalent will be dispensed if it is available** when you obtain your prescription from a network pharmacy or through our mail order drug program. If you choose a brand name medication for which a generic medication exists, you will pay your cost-share plus the difference in cost between the brand name and generic medication. If you have a medical condition that requires a brand name drug your prescribing physician must obtain a brand exception. For information on how to obtain a brand exception, you or your physician should call us at 800-410-7778 or visit our website, www.MHBP.com. If the exception is not approved, your cost-sharing will be greater.
- **Why use generic drugs?** A generic drug is the chemical equivalent to a brand name drug, yet it costs much less. Choosing generic drugs rather than brand name drugs can reduce your out-of-pocket expenses. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand name drugs. They must contain the same active ingredients, be equivalent in strength and dosage, and meet the same standards for safety, purity and effectiveness as the original brand name product.
- **Maintenance and long-term medications.** A long-term maintenance medication is one that is taken regularly for chronic conditions or long-term therapy. A few examples include medications for managing high blood pressure, asthma, diabetes or high cholesterol. The program allows members to get up to 90-day refills at a CVS retail pharmacy for the same cost-share as mail order. Under the program, you may get the initial prescription and two refills (up to a 30-day supply each) at a network retail pharmacy. After the second refill at a retail pharmacy, additional refills must be obtained either from a CVS retail pharmacy or through our mail order drug program. You will receive a letter after your second refill that describes your benefits and provides instructions on how to obtain additional refills in up to a 90-day supply. Your participation is required.
- **There are dispensing limitations.** All prescriptions will be limited to a 30-day supply for retail and a 90-day supply for mail order. Also, in most cases, refills cannot be obtained until 75% of the drug has been used. Occasionally, as part of regular review, we may recommend that the use of a drug is appropriate only with limits on its quantity, total dose, duration of therapy, age, gender or specific diagnoses. Since the prescription does not usually explain the reason your provider prescribed a medication, we may implement any of these limits and/or require preauthorization to confirm the intent of the prescriber.
- **Preauthorization**. We require preauthorization (PA) for certain drugs to ensure safety, clinical appropriateness and cost effectiveness. PA criteria are designed to determine coverage and help to promote safe and appropriate use of medications. Drugs subject to PA are screened at the point of service and the dispensing pharmacy is advised to have the prescriber contact the CVS/caremark PA department. CVS/caremark will obtain the relevant information from the prescriber to determine whther the drug use meets the established criteria for the requested drug. In certain circumstances, a preauthorization may require the trial or step of a more appropriate first line agent before the drug being requested is approved.

  To obtain a list of drugs that require preauthorization, please visit our website, www.MHBP.com or call 866-623-1441. We periodically review and update the preauthorization drug list in accordance with guidelines set by the US Food and Drug Administration (FDA), as a result of new drugs, new generic drugs, new therapies and other factors. To request preauthorization, your physician should contact the CVS/caremark Preauthorization Department at 800-294-5979. CVS/caremark will work with your physician to obtain the information needed to evaluate the request. **You may contact CVS/caremark at 866-623-1441 for the status of your request and any questions you have regarding preauthorization**.
- **Specialty drugs**, including biotech drugs, require special handling and close monitoring, and are used to treat chronic complex conditions including, but not limited to: hemophilia, immune deficiency, growth hormone deficiencies, multiple sclerosis, Crohn's disease, hepatitis C, HIV, hormonal disorders, rheumatoid arthritis and pulmonary disorders.To obtain a list of drugs that require preauthorization, a specialty preferred drug trial, or that must be obtained from CVS/caremark Specialty Pharmacy, please review the Specialty Prescription Drug List on our website, www.MHBP.com or call 866-623-1441.
  - **Certain specialty drugs require preauthorization** (also referred to as Specialty Guideline Management (SGM)) to determine medical necessity and appropriate utilization.
  - **A specialty preferred drug trial must be completed before certain non-preferred specialty drug will be authorized.**
  - **Certain specialty drugs must be obtained from CVS/caremark Specialty Pharmacy.**
- **Advanced Control Specialty Formulary** – We use a formulary for specialty drugs that includes generic and preferred brand name drugs that are therapeutically equivalent to non-preferred brand drugs for certain drug classes. An exception process is available. The formulary is subject to change on a quarterly basis.

- **Compound medications**. A compound medication is made by combining, mixing or altering one or more ingredients of a drug (or drugs) to create a customized medication that is not otherwise commercially available. Preauthorization may be required for some compound medications. Certain ingredients contained in some compound medications are excluded from coverage under this Plan. They are certain proprietary bases, drug specific bulk powders, hormone and adrenal bulk powders, bulk nutrients, bulk compounding agents, and miscellaneous bulk ingredients. Dispensing and refill limits may apply.

  Pharmacies must submit all ingredients in a compound medication as part of the claim. At least one of the ingredients in the compound medication must require a physician's prescription in order to be covered by the Plan. CVS/caremark can compound some medications. If the mail order pharmacy cannot accommodate your prescription, please consult your Network retail pharmacy. Ask your pharmacist to submit your claim electronically. If the retail pharmacy is unable to submit the compound medication claim electronically to CVS/caremark, you will pay the full cost of the medication and submit the claim for reimbursement. Make sure that your pharmacist provides the NDC number and quantity for every ingredient in the compound medication, and include this information on your claim. You are responsible for the appropriate copayment or coinsurance based on the compound ingredients. Claim calculations and your cost sharing is performed using an industry standard reimbursement method for compounds.

  Investigational drugs are not FDA approved. If the compound includes an investigational drug, the compound will not be covered.

- We can accommodate your drug refill requests when you are called to active military duty or in the case of a declared emergency. Call 866-623-1441 in advance to request the accommodation. You will be required to provide a copy of your work order.
- **The Plan conducts Drug Utilization Review (DUR).** When you fill your prescription at a network pharmacy or through the mail-order program, we and/or the pharmacist may electronically access information about prior prescriptions, checking for harmful drug interactions, drug duplication, excessive use and the frequency of refills. DUR helps protect against potentially dangerous drug interactions or inappropriate use. When appropriate, your pharmacist(s) and/or CVS/caremark may contact your physician(s) to discuss an alternative drug or treatment option, prescription drug compliance, and the best and most cost-effective use of services. In addition, we may perform a periodic review of prescriptions to help ensure your safety and to provide health education and support. Upon review, we may contact you or your provider(s) to discuss your current medical situation and may offer assistance in coordinating care and treatment. For more information about this program, call us at 866-623-1441.
- **When you have to file a claim.** Standard Option members who purchase prescriptions at a non-network pharmacy, mail your CVS/caremark claim form and prescription receipts to: CVS/caremark, Attn: Claims Department, P.O. Box 52136, Phoenix, AZ 85072-2136. Receipts must include the prescription number, name of drug, date, prescribing doctor's name, charge, name and address of pharmacy and NDC number (included on the bill). See Section 7, *How to claim benefits* for additional information.

Benefits for all prescription drugs will be determined based on the fill date for the prescription.

Note: Some drugs may not be available through the mail order program. Some of the drug classes that may not be available are: narcotics, hospital solutions and certain drugs such as antipsychotic agents and AIDS therapies and other drugs for which state or federal laws or medical judgment limit the dispensing amount to less than 90 days. In addition, some injectables may not be available through the mail order drug program. Covered drugs and supplies that are not available through the mail order drug program may be purchased at a retail pharmacy. For questions about the mail order drug program or to inquire about specific drugs or medications, please call 866-623-1441.

- **When you have other prescription drug coverage**

When we are the primary payor for prescription drug claims, we will pay the benefits described in this brochure.

When we are the secondary payor for prescription drug claims, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit, or up to the member's responsibility as determined by the primary plan if there is no adverse effect on you (that is, you do not pay any more), whichever is less. We will not pay more than our allowance. The combined payment from both plans may be less than (but will not exceed) the entire amount billed by the pharmacy or health care provider.

The provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given to this Plan to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

Other commercial coverage: When you have drug coverage through another group health insurance plan and that coverage is primary, follow these procedures:

Retail pharmacy:

1. Present the ID cards from both your primary insurance plan and MHBP at the pharmacy. Instruct the pharmacy to submit to your primary plan first.

2. If able, the pharmacy will electronically submit claims to both your primary and secondary plans, and the pharmacist will tell you if you have any remaining balance to pay.

3. If the pharmacy cannot electronically submit the secondary (MHBP) claim, pay any copay/coinsurance required by the primary insurance, then manually submit your claim for MHBP benefits. Mail your pharmacy receipt to CVS/caremark for any secondary benefit that may be payable. Submit claims to CVS/caremark, PO Box 52136, Phoenix, AZ 85072-2136.

In order to receive MHBP's Network pharmacy benefit, you must use a Network pharmacy. Otherwise, Non-network pharmacy benefits will apply.

If your primary plan does not provide for electronic claims handling, purchase your prescription from the pharmacy and submit a claim to your primary plan. When the primary plan has made payment, submit the claim and the primary plan's Explanation of Benefit (EOB) to CVS/caremark for any secondary benefit that may be payable. Submit claims to CVS/caremark, PO Box 52136, Phoenix, AZ 85072-2136.

Mail service pharmacy:

1. Purchase the prescription through your primary plan's mail service pharmacy and pay any copay/coinsurance required by the primary plan.

2. Then, then manually submit your claim for MHBP benefits. Mail your pharmacy receipt to CVS/caremark for any secondary benefit that may be payable. Submit claims to CVS/caremark, PO Box 52136, Phoenix, AZ 85072-2136.

Medicare Part B coverage: When Medicare Part B is primary, have the pharmacy submit Medicare covered medications and supplies to Medicare first. Prescriptions typically covered by Medicare Part B include diabetes supplies (test strips, meters), specific medications used to aid tissue acceptance from organ transplants, and certain oral medications used to treat cancer.

Retail pharmacy: Present your Medicare ID card and ask the pharmacy to bill Medicare as primary. Most independent pharmacies and national chains participate with Medicare. To locate a retail pharmacy that participates with Medicare Part B, visit the Medicare website at www.medicare.gov/supplier/home.asp, or call Medicare Customer Service at 800-633-4227. To maximize your benefits, use a pharmacy that participates with Medicare Part B and is also in our network. We will automatically retrieve your claim from Medicare and coordinate benefits for you.

Medicare Part D coverage: MHBP supplements the coverage you get with your Medicare Part D prescription drug plan. Your Medicare drug plan provides your primary prescription drug benefits, and MHBP will provide secondary benefits. To maximize your benefits, use a pharmacy that is in both the Medicare Part D plan's network, and in our network. Provide both your Medicare Part D and MHBP ID cards when filling a prescription allowing the pharmacy to coordinate coverage on your behalf.

Benefits Description	You pay	
Note: The calendar year deductible does not apply to benefits in this section		
Covered medications and supplies	**Standard Option**	**Value Plan**
You may purchase the following medications and supplies prescribed by a physician from either a Network pharmacy or by mail (for certain prescription drugs): • Drugs and medications that by Federal law of the United States require a doctor's written prescription, including chemotherapy and drugs used to treat the side effects of chemotherapy • Disposable needles and syringes, and alcohol swabs (if purchased at a pharmacy) • Insulin and related testing material Note: When you have a medical condition that requires a brand name drug for which a generic equivalent is available, your physician must obtain a brand exception for dispensing the brand name drug at a network retail pharmacy or through our mail order drug program. You or your physician should contact us at 800-410-7778 for instructions on how to obtain a brand exception. Note: When Medicare Parts A and B are your primary coverage, prescription drug benefits will be paid as described in this section when they are not covered by Medicare. Note: For claims that are submitted manually ("paper claims"), member cost-sharing includes both the copayment or coinsurance and any difference between the Plan's allowance and the billed amount. Note: We offer discounts for certain additional drugs. See Discount drug program under Section 5 (h), *Wellness and Other Special Features*.	Network pharmacy, up to a 30-day supply: • Generic: $5 copayment per prescription • Preferred brand name (formulary): 30% of the Plan's allowance (25% when enrolled in Medicare Part B) and any difference between our allowance and the cost of a generic equivalent, unless a brand exception is obtained, limited to $200 per prescription • Non-Preferred brand name (non-formulary): 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, limited to $200 per prescription Foreign pharmacy, up to a 90-day supply: • 30% of the billed charges, limited to $200 per prescription Non-Network pharmacy: • Generic: $5 copayment per prescription and any difference between our allowance and the billed amount • Preferred brand name (formulary): 30% of the Plan's allowance (25% when enrolled in Medicare Part B) and any difference between our allowance and the cost of a generic equivalent, unless a brand exception is obtained • Non-Preferred brand name (non-formulary): 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	Network pharmacy, up to a 30-day supply: • Generic: $10 copayment per prescription • Preferred brand name (formulary): 45% of the Plan's allowance and any difference between our allowance and the cost of a generic equivalent, unless a brand exception is obtained; limited to $300 per prescription • Non-Preferred brand name (non-formulary): 75% of the Plan's allowance and any difference between our allowance and the cost of a generic equivalent, unless a brand exception is obtained; limited to $500 per prescription Foreign pharmacy, up to a 90-day supply: • 45% of the billed charges per prescription; limited to $300 per prescription Non-Network pharmacy: • All charges

Covered medications and supplies - continued on next page

Benefits Description	You pay	
Covered medications and supplies (cont.)	**Standard Option**	**Value Plan**
You may purchase the following medications and supplies prescribed by a physician through our mail order drug program for certain prescription drugs: • Drugs and medications that by Federal law of the United States require a doctor's written prescription • Insulin and related testing material Note: A blood glucose meter is provided at no charge by the manufacturer to those individuals currently using a meter other than the preferred/ formulary product. For more information on how to obtain a blood glucose meter, call 866-623-1441. Note: When you have a medical condition that requires a brand name drug for which a generic equivalent is available, your physician must obtain a brand exception for dispensing the brand name drug through our mail order drug program. You or your physician should contact us at 800-410-7778 for instructions on how to obtain a brand exception. Note: When Medicare Parts A and B are your primary coverage, prescription drug benefits will be paid as described in this section when they are not covered by Medicare.	Mail order drug program, 31 to 90-day supply: • Generic: $10 copayment per prescription • Preferred brand name (formulary): $80 copayment per prescription ($60 when enrolled in Medicare Part B) and any difference between our allowance and the cost of a generic equivalent, unless a brand exception is obtained • Non-Preferred brand name (non-formulary): $120 copayment per prescription and any difference between our allowance and the cost of a generic equivalent, unless a brand exception is obtained	Mail order drug program, 31 to 90-day supply: • Generic: $30 copayment per prescription • Preferred brand name (formulary): 45% of the Plan's allowance and any difference between our allowance and the cost of a generic equivalent, unless a brand exception is obtained; limited to $500 per prescription • Non-Preferred brand name (non-formulary): 75% of the Plan's allowance and any difference between our allowance and the cost of a generic equivalent, unless a brand exception is obtained; limited to $700 per prescription
Specialty drugs: • are used to treat chronic complex conditions and require special handling and close monitoring. • **must** be obtained from CVS/caremark Specialty Pharmacy. Note: Preauthorization is required. Call us at 800-410-7778 if you have any questions regarding preauthorization, quantity limits, or other issues. We can help you understand the preauthorization process, the kinds of drugs that are considered to be specialty drugs, the kinds of medical conditions they are used for, and other questions you may have. Also, see the description of specialty drugs in this Section.	CVS/caremark Specialty Pharmacy: • 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	CVS/caremark Specialty Pharmacy: • 50% of the Plan’s allowance; limited to $600 per prescription for a 30-day supply; limited to $800 per prescription for a 90-day supply
Vaccination program This program covers the following vaccines when obtained from a Vaccine Network pharmacy: • Flu • Pneumonia • Shingles (herpes zoster)	Vaccine Network pharmacy: Nothing Non-Vaccine Network pharmacy: All charges	Vaccine Network pharmacy: Nothing Non-Vaccine Network pharmacy: All charges

Covered medications and supplies - continued on next page

Benefits Description	You pay	
Covered medications and supplies (cont.)	**Standard Option**	**Value Plan**
• Hepatitis A &B • Tetanus, diphtheria, pertusis • Human papillomavirus • Rabies • Measles, mumps, rubella • Meningitis • Varicella Note: Some of these vaccines may not be available in every Vaccine Network pharmacy. Age restrictions may apply on a state-by-state basis. Note: To find a Vaccine Network pharmacy, visit our website, www.MHBP.com, call 866-623-1441	Vaccine Network pharmacy: Nothing Non-Vaccine Network pharmacy: All charges	Vaccine Network pharmacy: Nothing Non-Vaccine Network pharmacy: All charges
Women's contraceptive drugs and devices that require a physician's written prescription, limited to: • generic oral contraceptive drugs and brand name oral contraceptive drugs that do not have a generic equivalent • contraceptive hormonal patches • diaphragms • cervical caps • vaginal rings	Network retail pharmacy, up to a 30-day supply: Nothing Mail order drug program, 31 to 90-day supply: Nothing Non-Network retail pharmacy: All charges	Network retail pharmacy, up to a 30-day supply: Nothing Mail order drug program, 31 to 90-day supply: Nothing Non-Network retail pharmacy: All charges
Women's prescription and over-the-counter emergency oral contraceptive drugs, with a physician's written prescription, limited to generic drugs and brand name drugs that do not have a generic equivalent.	Network retail pharmacy: Nothing Mail order drug program, 31 to 90-day supply: Nothing Non-Network retail pharmacy: All charges	Network retail pharmacy: Nothing Mail order drug program, 31 to 90-day supply: Nothing Non-Network retail pharmacy: All charges
Physician-prescribed over-the-counter or prescription drugs approved by the FDA to treat nicotine dependence	Network retail pharmacy: Nothing Mail order drug program, 31 to 90-day supply: Nothing Non-Network retail pharmacy: All charges	Network retail pharmacy: Nothing Mail order drug program, 31 to 90-day supply: Nothing Non-Network retail pharmacy: All charges
Preventive care medications	**Standard Option**	**Value Plan**
Medications and supplies to promote better health as recommended by the ACA or the U.S. Preventive Services Task Force (USPSTF) with a rating or "A" or "B" The following drugs and supplements are covered without cost-share, even if over-the-counter, when prescribed by a health care professional and filled at a network pharmacy. • Aspirin (81 mg) for adults 50-59 and women of childbearing age	Network retail pharmacy: Nothing Non-Network retail pharmacy: All charges	Network retail pharmacy: Nothing Non-Network retail pharmacy: All charges

Preventive care medications - continued on next page

Benefits Description	You pay	
Preventive care medications (cont.)	**Standard Option**	**Value Plan**
• Folic acid supplements for women of childbearing age, 400 & 800 mcg Note: To receive this benefit a prescription from a doctor must be presented at the pharmacy. Changes can occur throughout the year. A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) with a rating of "A" or "B" is available online at www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations.	Network retail pharmacy: Nothing Non-Network retail pharmacy: All charges	Network retail pharmacy: Nothing Non-Network retail pharmacy: All charges
Not Covered	**Standard Option**	**Value Plan**
• *Drugs and supplies for cosmetic purposes* • *Prescriptions written by a non-covered provider* • *Vitamins, nutrients and food supplements that do not require a physician's prescription, even if a physician prescribes or administers them, except as indicated* • *Total parenteral nutrition (TPN) products and related services* • *Over-the-counter medications even if prescribed by a physician, unless otherwise stated in this section* • *Nonprescription medications* • *Topical analgesics, including patches, lotions and creams* • *Anorexiants or weight loss medications* • *Erectile dysfunction drugs* • *Drugs and supplies covered by Medicare Part B, such as glucose meters and testing materials, when Medicare Part B is the primary payor (see Section 5(a), Durable medical equipment, for Medicare Part B covered drugs and diabetic supplies)* • *Any amount in excess of the cost of the generic drug when a generic is available and a brand exception has not been obtained by the prescribing physician* • *Drugs obtained from a retail pharmacy in excess of a 30-day supply, except maintenance medication obtained at a CVS retail pharmacy* • *Drugs obtained from a foreign pharmacy in excess of a 90-day supply* • *Home test kits*	All Charges	All Charges

Section 5(g). Dental Benefits

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) dental plan, your FEHB Plan will be the first/ primary payor of any benefit payments and your FEDVIP plan is secondary to your FEHB Plan. See Section 9, *Coordinating Benefits with Medicare and Other Coverage*.
- The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
  - The Standard Option calendar year deductible is $350 per person (limited to $700 per Self Plus One or Self and Family enrollment) for services of Network providers and $600 per person (limited to $1,200 per Self Plus One or $1,500 per Self and Family enrollment) for services of Non-Network providers.
  - The Value Plan calendar year deductible is $600 per person (limited to $1,200 per Self Plus One or Self and Family enrollment) for services of Network providers and $900 per person (limited to $1,800 per Self Plus One or Self and Family enrollment) for services of Non-Network providers.
- Be sure to read Section 4, *Your Costs for Covered Services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with Medicare and other coverage.

Note: We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. Inpatient hospitalizations must be precertified by the Plan. See Section 5(c) for inpatient hospital benefits.

Benefit description	You Pay After the calendar year deductible…	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Accidental injury benefit	**Standard Option**	**Value Plan**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. The services and supplies must be provided within one year of the accident and the patient must be a member of the Plan at the time services are rendered. Masticating (chewing) incidents are not considered to be accidental injuries.	Network: See Section 5(d), *Accidental injury* Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: See Section 5(d), *Accidental injury* Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Oral surgery	**Standard Option**	**Value Plan**
Removal of impacted teeth.	See Section 5(b), *Oral and maxillofacial surgery*	See Section 5(b), *Oral and maxillofacial surgery*
Dental benefits	**Standard Option**	**Value Plan**
We have no other dental benefits	All charges	All charges

Section 5(h). Wellness and Other Special Features

Special feature	Description
Aetna In Touch Care℠ Program	Aetna In Touch Care℠ (ITC) program provides you personalized support to help you manage a health event or chronic condition. The program uses a combination of digital and one-on-one support that's right for you. The program offers you: • Ongoing, one-on-one phone calls with a nurse who serves as a trusted resource for you and your family • Digital support that provides a variety of resources to help you better manage your health • Customized health action plans based on your needs and preferences To start using Aetna's ITC digital support, log in to your Aetna member website from www.MHBP.com. First-time users will need to register and then go to your health dashboard. We're committed to giving you all the support you deserve. That's why we offer both digital and nurse support, and you can move easily between the two. You'll benefit from many digital health and wellness related programs and resources: • Personal health record – organize and store your health history and information, plus get health alerts and notifications. • Health assessment – get a custom, step-by-step plan based on questions about your health and habits. • Health Decision Support – learn about your health care and treatment options. • Online coaching programs – find dynamic health coaching programs that give you personalized support. • Aetna Health Dashboard – view your health information, and find entry points to health and wellness programs and resources. Aetna ITC Program also includes a Social Work Program designed to improve the quality of life by taking steps to help members locate the right resources. Social workers can help connect plan members with community resources that can provide services to them in times of need. Some examples include: • local food pantries • utility or rental assistance programs • home-delivered meal services • support groups • counseling services Social workers can also refer our members to Federal and State programs, such as: • Social Security • Medicare • Medicaid Our social workers are licensed and degreed professionals who work in a variety of settings, including government and non-profit organizations, hospitals, schools and clinics. Social workers also help treat mental, emotional, and behavioral issues in clinical settings.

	The Aetna ITC Program also includes a Compassionate Care Program (formerly Advanced Illness Program designed to improve the quality of life through health condition management and to reduce costs for members with advanced illness, including those facing imminent end-of-life decisions. It provides tools and information to encourage advanced planning for the kind of issues often associated with an advanced illness, such as living wills, advance directives and tips on how to begin conversations about these issues with loved ones. This program is designed to provide quality of life improvement through timely member and caregiver education. It encourages better use of community-based services and resources, systemic palliative care integration and enhanced hospice utilization and retention. If you would like to contact the Plan for more information about the ITC Program, please call 800-410-7778. We are available to assist you Monday-Friday from 6:00 a.m. - 5:00 p.m. Mountain Standard Time (MST).
Lifestyle and Condition Coaching Program	Aetna's Lifestyle and Condition Coaching (LLC) Program, provides you or your covered dependents personalized support that helps you manage existing conditions, learn new habits and stay on their path to better health. Our Health Coach will partner with you to transform your health goals into action. Your Health Coach will provide guidance, support, and resources to help you overcome obstacles that may be keeping you from realizing optimal health. You can talk to a Coach about the following health-related matters: • Tobacco Cessation • Weight Management • Exercise • Nutrition • Stress Management • Pain Management How does health coaching work? • You can talk with your Health Coach over the phone through conveniently scheduled appointments and create a plan that is right for you to meet your health goals. Everything in the program is tailored to you. • You can explore ways to make changes in your behavior that will last. • You will receive written materials from your Health Coach that can help you decide where you want to go with your health and how to get there. • Appointments can range from 20 minutes to 30 minutes at least twice a month. How long and how often you meet with your Health Coach depends on your individual needs. Aetna's Lifestyle and Condition Coaching Program also provides pain management/opioid support. The program is designed for members with chronic pain and either taking opioids or trying to avoid opioids. Members enrolled will receive coaching and support, which includes assisting with identifying the availability of other treatment plans that may include non-pharmacologic modalities for the treatment of pain such as, but not limited to: injection therapies, cognitive therapies, psychosocial support, massage therapy, or physical therapy visits as applicable. The program also helps with psychological effects of chronic pain, reduction of opioid use, avoiding opioid use and resources for those who are dependent on opioid medications. To self-refer or enroll in the program, contact LCC at 866-533-1410. Our Health Coaches are available Monday through Friday from 8 a.m. – 8 p.m. ET.
Flexible Benefits Option	Under the flexible benefits option, we determine the most effective way to provide services.

	We may identify medically appropriate alternatives to regular contract benefits and coordinate other benefits as a less costly alternative benefit. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Aetna Member Website	Aetna member website, our secure member self-service website, provides you with the tools and personalized information to help you manage your health. Click on Aetna member website from www.MHBP.com to register and access a secure, personalized view of your benefits. You can: • Print temporary ID cards • Download details about a claim such as the amount paid and the member's responsibility • Contact member services at your convenience through secure messages • Access cost and quality information through our transparency tools • View and update your Personal Health Record • Find information about the perks that come with your Plan • Access health information through Healthwise® Knowledgebase Registration assistance is available toll free, Monday through Friday, from 7am to 9pm Eastern Time at 800-225-3375. Register today at www.MHBP.com. Wellness fund balance: To monitor the availability of funds in your Wellness Fund Account, log in to your Aetna member website from www.MHBP.com. Once you log in, select "Discover a Healthier You" under the "Health and Wellness" icon and proceed.
Aetna Health Mobile App	You can use the Aetna Health Mobile app to: • Find doctors and facilities using location and see maps for directions • Save doctors and facilities to contacts to use text and email • Locate urgent care - walk-in clinics, urgent care clinics, emergency rooms • View claims and claim details • View benefits and balances • Track out-of-pocket dollars

	• View ID card information • Store ID card offline • Save money by using the Cost Estimator to compare cost estimates • View your Health History • Share your opinion (feedback) The app can be downloaded for free onto your mobile device
Personal Health Record	The new MHBP Personal Health (PHR) record provides members a dashboard view of their health. Members can view, track and add personal health data and use personalized tools and health information to proactively manage their health care. Access the PHR through the secure member portal at www.MHBP.com.
TeleHealth	MHBP offers access to Teladoc® telemedicine consultations any time, day or night that is easy to use, private and secure. Teladoc is the nation's leading virtual care provider with over 3,600 board certified, state-licensed, primary care physicians, pediatricians and specialists that have on average 20 years of experience and are available by web, phone and the Teladoc mobile app. With Teladoc, you can take care of most common issues such as: cold & flu symptoms, allergies, cough, sinus infection,respiratory infection, eye infection, skin problems and more. You can also see a therapist for ongoing counseling for concerns such as: depression, anxiety, stress, as well as for diet and nutrition assistance. How to sign up: 1. Download the iOS or Android App by searching "Teladoc" 2. Sign-up on the web at www.teladoc.com 3. Sign-up by phone, call 855-835-2362 (855-Teladoc) Note: Teladoc does not replace your primary care physician. Teladoc does not guarantee that a prescription will be written. Teladoc operates subject to state regulations and may not be available in certain states. Teladoc does not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. Teladoc physicians reserve the right to deny care for potential misuse of services. If you have any questions or would like more information about the program, please call us at 800-410-7778.
Health Risk Assessment	A health risk assessment (HRA) can help individuals identify potential risks to their physical and mental health. The HRA starts with a questionnaire that asks about your nutrition, weight, physical activity, stress, safety and mental health, kind of like an interview. Your responses can lead to suggestions and programs that can help you improve your health by reducing risks. After you complete the questionnaire you'll get a personalized summary that helps you identify and understand potential risks. MHBP offers a free and confidential HRA online. To take the HRA, log in to your Aetna member website from www.MHBP.com, under Health and Wellness, select Discover A Healthier You and proceed. If you haven't logged in before, you'll need to register for a member account. If you prefer to complete the HRA by phone, call us at 866-533-1410 to schedule an appointment so a Health Coach can assist you with completing the HRA. You'll get your results by mail and you'll have the opportunity to participate in health coaching programs by phone. After you complete your HRA, you are eligible for a reward. See *Health Risk Assessment* reward, below.

Health Risk Assessment reward	After you complete the Health Risk Assessment (HRA), you are eligible to receive a $100 (Standard Option) or a $75 (Value Plan) credit to your Wellness Fund account that can be used for qualified medical expenses, such as your cost sharing amounts for future services. The reward is available one per calendar year to all members age 18 and older, and can be used by any covered family member. After you have completed the HRA, we will credit your Wellness Fund Account with your incentive reward amount. If you have any questions or would like more information about the program, please call us at 800-410-7778.
Biometric screening reward	Complete a biometric screening through Quest Diagnostics and receive a Wellness Fund Account incentive reward of $100 (Standard Option) or $75 (Value Plan) that can be used for qualified medical expenses, such as your cost sharing amounts for future services. The reward is available once per calendar year to all members age 18 and older, and can be used by any covered family member. You can qualify for your reward in two ways: • Make an appointment for your biometric screening at a Quest Diagnostics Patient Service Center (PSC). To register for your screening call 855.6.BE.WELL (855-623-9355) or visit My.QuestforHealth.com and enter the registration key: mhbp • Have your physician perform the biometric screening as part of your annual check-up, record the results on the Biometric Screening Physician Results form and fax the form to Quest Diagnostics no later than November 30. The Biometric Screening Physician Results form is available at My.QuestforHealth.com Once your biometric screening is complete, your results will be available online at My.QuestforHealth.com After you have completed the biometric screening, we will credit your Wellness Fund Account with your incentive reward amount. If you have any questions or would like more information about the program, please call us at 800-410-7778.
Health Coaching programs	MHBP offers health coaching programs for members who complete a health risk assessment (HRA) to identify their health risks. The health coaching programs can help members identify behaviors that may lead to increased health risks, establish health goals and make lifestyle changes that can reduce those risks and lead to improved overall health.
• **Digital (online) health coaching**	Digital coaching programs — These include nine base programs for weight management, smoking cessation, stress management, nutrition, physical activity, cholesterol management, blood pressure, depression management, and sleep improvement. Programs are prioritized based on a member's health risk assessment to help create a personalized plan for successful behavior change. Members can engage and participate through personalized messaging with tools and resources to help track their progress and stay on the path to wellness. This provides you secure access to a broad range of your personal health information after you register. Access the Plan's website tool from your Aetna member website at www.MHBP.com. Select "Discover a Healthier You" under the Health and Wellness icon, then "Dashboard" and finally "Digital Coach".

• **AbleTo Support**	AbleTo is a 8-week personalized web-based video conferencing treatment support program designed to help you address the unique emotional and behavioral health needs of living with conditions such as heart disease, diabetes, chronic pain, or life events such as losing a loved one or having a baby. Members work with the same therapist and coach each week to set reasonable goals toward healthier lifestyles. You may obtain more information or enroll in this voluntary program by calling AbleTo at 866-287-1802. To self enroll, go to www.AbleTo.com/enroll, enter all the required information on the Speak to an AbleTo Specialist landing page, then submit using the "Request a Call" icon. An AbleTo specialist will contact you within 24 hours Your nurses or clinicians may refer you to AbleTo as they work directly with you and believe you may benefit from the AbleTo support program. If identified, an Engagement Specialist from AbleTo will contact you to introduce the treatment option. If you have any questions or would like more information about the program, please call us at 800-410-7778.
Informed Health® Line	MHBP offers members 24 hours a day, 7 days a week access to registered nurses experienced in providing information on a variety of health topics. Call us for more information at 800-410-7778. Foreign language translation for non-English speaking members is available and TDD service for the hearing and speech-impaired is provided. Nurses cannot diagnose, prescribe medication, or give medical advice.
Aexcel Designated Providers	Aexcel is a blue star designation for high-performing specialty physicians and physician groups in 12 medical specialty areas: Cardiology / Neurology / Otolaryngology/ENT Cardiothoracic surgery / Neurosurgery / Plastic surgery Gastroenterology / Obstetrics and gynecology / Urology General surgery / Orthopedics / Vascular surgery Physicians with the Aexcel specialist designation have met added standard for volume, clinical performance, and efficiency. Aetna evaluates these providers using specific standards and, based on the results, gives them the Aexcel specialty designation. Visit www.MHBP.com, select "Find a Provider", and look for the blue star next to the provider's name for an Aexcel designated provider. If a specialist does not have a blue star, this does not mean the physician does not provide quality services. It could be that Aetna does not have enough information available to evaluate a particular physician. The Aexcel information is only a guide. Please note that ratings have a chance for error. An Aexcel designation is not a guarantee of service quality or treatment outcome. Therefore, the Aexcel designation should not be the only reason for choosing a specialty doctor.
ExtraCare® Health card	The ExtraCare® Health Card is a value-added program through CVS/caremark that gives you a 20 percent discount on thousands of eligible CVS/pharmacy brand health-related items, from cough and cold medicine to pain and allergy relief. The card is different from your MHBP ID card and is mailed separately. This program is offered at no additional charge to you. Use your ExtraCare® Health Card at any CVS pharmacy store nationwide or online at www.CVS.com.
Discount drug program	MHBP members can receive a discount on certain drugs prescribed for cosmetic purposes, weight loss and impotency. You pay 100% of the discounted price at a network retail pharmacy. Call CVS/caremark at 866-623-1441 to determine whether your drug qualifies for a discounted price.
Round-the-clock member support	We provide integrated health benefit services including a national provider network, clinical management services, a national transplant program, and Aetna In Touch Care℠ Program with round-the-clock benefits support, pharmacy network and plan administration.

	You can call us toll-free at any time, day or night, except major holidays, to: • Initiate the precertification, prior approval or preauthorization process • Get assistance in locating network providers • Obtain general health care information • Have your questions about health care issues answered This 24/7 service is a benefit to you, allowing you to be informed about your health care options. There is no penalty for not using it. If you have questions about any of the programs, your benefits or would like general health information, call us at 800-410-7778, 24 hours a day, 7 days a week, except major holidays.
AccordantCare™ Program	If you are managing a chronic, complex or rare condition, AccordantCare provides one-on-one, personalized support that is tailored to your needs. The program gives you access – anytime, day or night – to a nurse and a resource specialist who specialize in your condition. The AccordantCare Program is for patients or parents of children with certain rare or complex medical conditions. This comprehensive patient care program is offered to members with the following conditions: • Amyotrophic Lateral Sclerosis (ALS) • Chronic Inflammatory Demyelinating Polyradiculoneuropathy (CIPD) • Crohn's Disease • Cystic Fibrosis • Dermatomyositis • Epilepsy (Seizures) • Gaucher Disease • Hemophilia • Hereditary Angioedema • Human Immunodeficiency (HIV) • Multiple Sclerosis (MS) • Myasthenia Gravis (MG) • Parkinson's Disease (PD) • Polymyositis • Rheumatoid Arthritis (RA) • Scleroderma • Sickle Cell Disease (SCD) • Systematic Lupus Erythematosus (SLE or Lupus) • Ulcerative colitis If you would like more information or find out if you are eligible, call us at 844-923-0807.
Aetna Maternity Program	MHBP would like to extend you a lot of support during your pregnancy and after your baby is born. This program provides nurse support and educational materials for healthy and high risk pregnancies. Contact the Plan at 855-282-6344 to sign up or for more information.
Chronic Kidney Disease Care Management Program	The Chronic Kidney Disease Care program (CKD) program uses advanced analytics based on medical claims data, pharmacy data, and lab data to identify members who are at high risk for late stage kidney disease. Once a member is identified, they are categorized into low touch, medium touch, high touch, and face-to-face engagement tiers. Low touch members will be eligible for our digital solutions. Members identified as medium or higher touch, will receive a mailer saying that they are eligible for the program and will be contacted via phone call to enroll.

	Once a member enrolls in the program, they will receive a call from a trained CKD management nurse. Participants will receive calls at least once a quarter, however members who are newly enrolled or have higher health needs will receive engagement calls more frequently. In the first few calls, our nurse care manager will go through a comprehensive assessment to establish a kidney health baseline. On subsequent calls, the nurse care manager will work to fill gaps in care, offer comprehensive kidney health education, and help solve for any urgent health issues. If a participant nears dialysis, our nurse care manager will help them understand renal replacement therapy choices and plan for a smooth start to dialysis. For our highest-risk participants, we also offer access to our face-to-face educator modality. The educator meets with the participant one-on-one in the member's home or in a CVS facility. During the in-person meeting, the educator will provide information on the different renal replacement therapy options and help the member, as well as their caregivers and medical support team understand available options so that they can select the optimal therapy choice. For participants who do not have a face-to-face educator option present in their community, telehealth video consults will be available to allow participants to speak with a nurse care manager. Participants will also have access to a digital application to help them manage their care. This application will allow members to easily connect with their caregivers, access high-quality kidney education materials, and track their health and wellness over time.
Transform Care Programs	The Transform Care Programs for prediabetes, diabetes and hypertension help you stay medication adherent, control your blood glucose and your blood pressure. The programs help improve your health and decrease associated healthcare costs. These programs provide eligible members with a connected glucometer and digital blood pressure cuff. Digital apps are provided for easier monitoring of your condition. The readings are shared with a health coach that you can interact with through messaging and phone sessions. Eligible participants are targeted based on their medication history. All eligible members are offered two MinuteClinic® visits at a CVS and unlimited coaching. For questions regarding this program, call 855-808-0837.
Wellness Incentives	Healthy actions that make you eligible to earn $50 to be deposited into a Wellness Incentive Fund account that can be used for qualified medical expenses, such as your cost sharing amounts for future services are: Controlling Blood Pressure for members with high blood pressure The Plan will reach out to you if you are identified through claims data as having high blood pressure and will provide you a form for your provider to complete. On the form, your provider must document two (2) controlled blood pressure readings below 140/90 on separate visits during the current calendar year for you to earn the incentive. If you are unable to meet this goal, you will receive the incentive if one of the following is completed by December 1st of the calendar year: • Lifestyle and Condition Coaching Program (Tobacco Cessation, Weight Management, Exercise, Nutrition, Stress Management) • Dietary and nutritional counseling (obtain three counseling visits, which includes individual and group behavioral counseling) (See Section 5(a) *Preventive Care, adult*) Controlling A1c Hemoglobin levels for members with diabetes The Plan will reach out to you if you are identified through claims data as having diabetes and ask you to have your provider submit your A1c laboratory results. Your A1c laboratory results must be less than 8% during the calendar year for you to earn the incentive. If your HbA1c is greater than or equal to 8%, you will receive the incentive if one of the following is completed by December 1st of the calendar year:

	• Dietary and nutritional counseling (obtain three counseling visits, which includes individual and group behavioral counseling) (See Section 5(a), *Preventive Care, adult*) • Diabetic Education or Training (see Section 5(a) *Educational classes and programs* • Transform Care Program (enroll in the Transform Care Program and check your blood glucose four times per month for four continuous months in the calendar year). Prenatal Care for members who are pregnant If you are pregnant, your provider must submit documentation of a prenatal are visit during the first trimester. The documentation submitted must include a copy of the prenatal care medical record from your provider for you to earn the incentive. To receive your $50 incentive for any of the above noted healthy actions, you must submit the required documentation by December 1 of the calendar year to the following address: Aetna C/O FEHB QM, 4400 NW Loop 410, STE 101, San Antonio, TX 78229 Members 18 years of age or older who earn financial incentives through participation in the Health Risk Assessment, Biometric Screening and Wellness Incentives Programs will have funds deposited into a Wellness Fund Account. Standard Option members are eligible to earn up to $350 per person per calendar year. Value Plan members are eligible to earn up to $300 per person per calendar year. Wellness fund account: To monitor the availability of funds in your Wellness Fund Account, log in to the Aetna member website from www.MHBP.com. Once you log in, select "Discover a Healthier You" under the "Health and Wellness" icon and proceed. If you would like to contact the Plan for more information about the Wellness Incentives Program, please call 800-410-7778, 24 hours a day, 7 days a week, except major holidays.

Non-FEHB Benefits Available to Plan Members

The benefits in this Non-FEHB benefits section are not part of the FEHB contract or premium, and **you cannot file an FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs are the responsibility of the Plan, and all appeals must follow our guidelines. For additional information contact us at 800-410-7778 or visit our website, www.MHBP.com.

The MHBP Dental and Vision Plans

Two programs are available to ALL Federal and Postal employees and annuitants eligible for FEHBP and their family members. Help plug the gaps in your FEHBP coverage with comprehensive benefits at affordable group rates. They are brought to you by the MHBP, but you do not have to be an MHBP member to get them. A single annual $42 MHBP associate membership fee makes the MHBP Supplemental Dental and Vision Plans available to you.

Enroll in either plan – or both – any time! The sooner you enroll, the sooner your coverage starts!

Get all the details on both plans at www.MHBP.com, and enroll too! Or call toll-free: 800-254-0227.

Hearing Care Solutions offers a wide selection of digital hearing aids from major nationwide providers at the most affordable prices. Additional services are also available to help you save. Call 866-344-7756 or visit www.MHBP.com for more information. One of our representatives will help you find a provider and set up an appointment.

Amplifon Hearing Health Care is one of the largest providers of hearing health care benefits in the United States offering members discounts on hearing exams, services and a variety of hearing aids. Call 888-901-0129, or visit www.AmplifonUSA.com/MHBP and one of our friendly representatives will explain the Amplifon process and assist you in scheduling your appointment with a hearing care provider.

EyeMed Vision Care Program: Save up to 40% with your EyeMed Vision Care discount program. Members are eligible for discounts on exams, glasses and contact lenses at thousands of providers nationwide. Members have access to over 58,000 providers including optometrists, ophthalmologists, opticians and leading optical retailers such as: LensCrafters, Sears Optical, Target Optical, JCPenney Optical, participating Pearle Vision locations and many independents. For more information concerning the program or to locate a participating provider, visit the Plan's website, www.MHBP.com, or call 866-559-5252 and refer to plan id# 9235631.

Laser Vision Correction: EyeMed and LCA-Vision have arranged to provide a discount program to all EyeMed members through one of the largest laser networks available, the US Laser Network. Simply call 800-422-6600 for more information and to find a network provider near you and begin the process.

LifeStation® Medical Alert: MHBP members can receive a discounted rate from LifeStation, a leading provider of medical alert systems. LifeStation offers traditional landline, cellular, mobile and GPS-enabled systems to ensure a solution for every member. Call toll-free at 855-322-5011 or visit www.lifestation.com/mhbp to learn more! about the low monthly rate with no long-term contracts.

Section 6. General Exclusions – Services, Drugs and Supplies We Do Not Cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice in the United States.
- Experimental or investigational procedures, treatments, drugs or devices.
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies for which there would be no charge if the covered individual had no health insurance coverage.
- Services, drugs, or supplies related to sexual dysfunction, impotency or sexual inadequacy.
- Services, drugs, or supplies you receive from a provider or facility barred or precluded from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.
- Services and supplies furnished by yourself, household members or immediate relatives, such as spouse, parents, grandparents, children, brothers or sisters by blood, marriage or adoption.
- Services, drugs, or supplies ordered or furnished by a non-covered provider.
- Services and supplies furnished or billed by a non-covered facility, except medically necessary prescription drugs.
- Services, drugs and supplies associated with care that is not covered.
- Any portion of a provider's fee or charge ordinarily due from the enrollee but that has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible, copayment or coinsurance, the Plan will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived.
- Charges which the enrollee or Plan has no legal obligation to pay, such as excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B, doctor's charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare or State premium taxes however applied. See Section 9, *Coordinating benefits with Medicare and other coverage.*
- Educational, recreational or milieu therapy, whether in or out of the hospital.
- Biofeedback.
- Services and supplies for cosmetic purposes.
- Travel, even if prescribed by a doctor, except as provided under the Aetna Institutes of Excellence transplant program or Ambulance benefit.
- Handling charges, administrative charges or late charges, including interest, billed by providers of care. Charges for medical records or fees for missed appointments.
- Services and/or supplies not listed as covered.
- "Never Events" are errors in patient care that can and should be prevented. We will follow the policy of the Centers for Medicare and Medicaid Services (CMS). The Plan will not cover care that falls under these policies. For additional information, visit www.CMS.gov, enter Never Events into SEARCH.

Section 7. Filing a Claim for Covered Services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received).

See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures.

How to claim benefits

To obtain claim forms, claims filing advice or answers about our benefits, contact us at 800-410-7778, or visit our website at www.MHBP.com.

In most cases, providers and facilities file claims for you. Your provider must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. All claims should be completed in ink or type that is readable by an optic scanner. For claims questions and assistance, call us at 800-410-7778.

When you must file a claim – such as for services you received overseas or when another group health plan is primary – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Name of patient and relationship to enrollee;
- Plan identification number of the enrollee;
- Name, address and provider or employer tax identification of person or firm providing the service or supply;
- Dates that services or supplies were furnished;
- Diagnosis;
- Type of each service or supply; and
- The charge for each service or supply.

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

In addition:

- If another health plan is your primary payor, you must send a copy of the explanation of benefits (EOB) form you received from your primary payor (such as the Medicare Summary Notice (MSN)) with your claim.
- Bills for home nursing care must show that the nurse is a registered or licensed practical nurse.
- Claims for rental or purchase of durable medical equipment; private duty nursing; and physical, occupational, and speech therapy require a written statement from the provider specifying the medical necessity for the service or supply and the length of time needed.

Medical claims

After completing a claim form and attaching proper documentation, send medical claims to:

MHBP Medical Claims
PO Box 981106
El Paso, TX 79998-1106

Prescription drug claims

Claims for covered prescription drugs and supplies that are not ordered through the mail order prescription drug program or not purchased from and electronically filed with a participating CVS/caremark network pharmacy must include receipts that show the prescription number, NDC number (included on the bill), name of drug or supply, prescribing provider's name, date, charge and name and address of the pharmacy.

After completing a claim form and attaching proper documentation send prescription claims to:

CVS Caremark
Attn: Claims Department
PO Box 52136
Phoenix, AZ 58072-2136

Note: Do not include any medical or dental claims with your claims for drug benefits.

If all the required information is not included on the claim, the claim may be delayed or denied.

Post-service claim procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Records

Keep a separate record of the medical expenses of each covered family member as deductibles and maximum allowances apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible. In most instances they will serve as evidence of your claim. We will not provide year-end statements.

Deadline for filing your claim

Send us all the documents for your claim as soon as possible. We must receive all charges for each claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible. Once we pay benefits, there is a three-year limitation on the re-issuance of uncashed checks.

Note: You are responsible to ensure that your claims are filed in a timely manner. Check with your provider of care about their policies regarding filing of claims.

Overseas (foreign) claims

Overseas providers (those outside the continental United States, Alaska and Hawaii) will be paid at the Network level of benefits for covered services. Overseas hospitals and physicians are under no obligation to file claims for you. **You may be required to pay for the services at the time you receive them and then submit a claim to us for reimbursement.**

- We will provide translation and currency conversion services for claims for overseas (foreign) services.
- For inpatient hospital services, the exchange rate will be based on the date of admission. For all other services, we will apply the exchange rate for the date the services were rendered.
- All foreign claim payments will be made directly to the enrollee except for services rendered to beneficiaries of the United States Department of Defense third party collection program.
- Canceled checks, cash register receipts, or balance due statements are not acceptable.

Direct Payment to hospital or provider of care

Claims that are submitted by the hospital will be paid directly to the hospital (with the exception of foreign claims). You may authorize direct payment to any other provider of care by signing the assignment of benefits section on the claim form, or by using the assignment form furnished by the provider of care. The provider of care's Tax Identification Number must accompany the claim. The Plan reserves the right to make payment directly to you, and to decline to honor the assignment of payment of any health benefits claim to any person or party.

Claims submitted by Network hospitals and medical providers will be paid directly to the hospital or provider.

Note: Benefits for services provided at Department of Defense, Veterans Administration or Indian Health Service facilities will be paid directly to the facility.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if we do not receive the requested information within 60 days. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.

The Plan, its medical staff and/or an independent medical review, determines whether services, supplies and charges meet the coverage requirements of the Plan (subject to the disputed claims procedure described in Section 8, *The disputed claims process*). We are entitled to obtain medical or other information — including an independent medical examination — that we feel is necessary to determine whether a service or supply is covered.

Authorized representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

The Secretary of Health and Human Services has identified counties where at least 10 percent of the population is literate only in certain non-English languages. The non-English languages meeting this threshold in certain counties are Spanish, Chinese, Navajo and Tagalog. If you live in one of these counties, we will provide language assistance in the applicable non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as phone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes and its corresponding meaning, and the treatment code and its corresponding meaning.

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information or to make an inquiry about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please call MHBP customer service at the phone number found on your enrollment card, plan brochure or plan website www.MHBP.com.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3, *If you disagree with our pre-service claim decision,* we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing to us at MHBP, PO Box 981106, El Paso, TX 79998-1106 or by calling us at 800-410-7778.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or his/her subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: MHBP, PO Box 981106, El Paso, TX 79998-1106; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in Step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim, or b) Write to you and maintain our denial, or c) Ask you or your provider for more information.

	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, FEHB 2, 1900 E Street, NW, Washington, DC 20415-3620. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; • Your daytime phone number and the best time to call; and • Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly. Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim. Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent. Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.
4	OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals. If you do not agree with OPM's decision, your only recourse is to sue. If you decide to file a lawsuit, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that can not be extended. OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record. You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 800-410-7778. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's FEHB 2 at 202-606-3818 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage".

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit our website at www.MHBP.com.

When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit, or up to the member's responsibility as determined by the primary plan if there is no adverse effect on you (that is, you do not pay any more), whichever is less. We will not pay more than our allowance. The combined payment from both plans may be less than (but will not exceed) the entire amount billed by the provider.

The provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given to this Plan to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

Please see Section 4, *Your Costs for Covered Services*, for more information about how we pay claims.

- **TRICARE and CHAMPVA**

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs. If you are enrolled in the Uniformed Services Family Health Plan, MHBP is primary.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

- **Workers' Compensation**

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar federal or state agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

- **Medicaid**

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar state-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these state programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the state program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, state, or federal government agency directly or indirectly pays for them.

When others are responsible for injuries

Our reimbursement and subrogation rights are both a condition of, and a limitation on, the benefit payments that you are eligible to receive from us. By accepting Plan benefits, you agree to the terms of this provision.

If you receive (or are entitled to receive) a monetary recovery from any source as the result of an injury or illness, we have the right to be reimbursed out of that recovery for any and all of our benefits paid to diagnose and treat that illness or injury to the full extent of the benefits paid or provided. The Plan's right of reimbursement extends to all benefit payments for related treatment up to and including the date of settlement or judgment, regardless of the date that those expenses were submitted to the Plan for payment. This reimbursement right extends to any monetary recovery that your representatives (for example; heirs, estate) receive (or are entitled to receive) from any source as a result of an accidental injury or illness. This is known as our reimbursement right.

The Plan may also, at its option, pursue recovery as successor to the rights of the enrollee or any covered family member who suffered an illness or injury, which includes the right to file suit and make claims in your name, and to obtain reimbursement directly from the responsible party, liability insurer, first party insurer, or benefit program. This is known as our subrogation right.

Examples of situations to which our reimbursement and subrogation rights apply include, but are not limited to, when you become ill or are injured due to (1) an accident on the premises owned by a third party, (2) a motor vehicle accident, (3) a slip and fall, (4) an accident at work, (5) medical malpractice, or (6) a defective product.

Our reimbursement and subrogation rights extend to all benefits available to you under any law or under any type of insurance or benefit program, including but not limited to:

- Third party liability coverage
- Personal or business umbrella coverage
- Uninsured and underinsured motorist coverage
- Workers' Compensation benefits
- Medical reimbursement or payment coverage
- Homeowners or property insurance
- Payments directly from the responsible party
- Funds or accounts established through settlement or judgment to compensate injured parties
- No-fault insurance and other insurance that pays without regard to fault, including personal injury protection benefits, regardless of any election made by you to treat those benefits as secondary to us. When you are entitled to the payment of healthcare expenses under automobile insurance, including no-fault insurance and other insurance that pays without regard to fault, your automobile insurance is the primary payor and we are the secondary payor.

Our reimbursement right applies even if the monetary recovery may not compensate you fully for all of the damages resulting from the injuries or illness. In other words, we are entitled to be reimbursed for those benefit payments even if you are not "made whole" for all of your damages by the compensation you receive.

Our right of reimbursement is not subject to reduction for attorney's fees under the "common fund" or any other doctrine. We are entitled to be reimbursed for 100% of the benefits we paid on account of the injuries or illness unless we agree in writing to accept a lesser amount.

We enforce this right of reimbursement by asserting a first priority lien against any and all recoveries you receive by court order or out-of-court settlement, insurance or benefit program claims, or otherwise, regardless of whether medical benefits are specifically designated in the recovery and without regard to how it is characterized (for example as "pain and suffering"), designated, or apportioned. Our subrogation or reimbursement interest shall be paid from the recovery you receive before any of the rights of any other parties are paid.

You agree to cooperate with our enforcement of our right of reimbursement by:

- telling us promptly whenever you have filed a claim for compensation resulting from an accidental injury or illness and responding to our questionnaires;
- pursuing recovery of our benefit payments from the third party or available insurance company;
- accepting our lien for the full amount of our benefit payments;
- signing our Reimbursement Agreement when requested to do so;
- agreeing to assign any proceeds or rights to proceeds from third party claims or any insurance to us;
- keeping us advised of the claim's status;
- agreeing and authorizing us to communicate directly with any relevant insurance carrier regarding the claim related to your injury or illness;
- advising us of any recoveries you obtain, whether by insurance claim, settlement or court order, and;
- agreeing that you or your legal representative will hold any funds from settlement or judgment in trust until you have verified our lien amount, and reimbursed us out of any recovery received to the full extent of our reimbursement right.

We also expect you to fully cooperate with us in the event we exercise our subrogation right.

Failure to cooperate with these obligations may result in the temporary suspension of your benefits and/or offsetting of future benefits.

For more information about this process, please call our Third Party Recovery Services unit at 202-683-9140 or 855-661-7973 (toll free). You also can email them at info@elgtprs.com

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP)

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com or by phone at 877-888-3337, TTY 877-889-5680, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either Federally-funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide benefits for related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this Plan.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This Plan does not cover these costs.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This Plan does not cover these costs.

When you have Medicare

For more detailed information on "What is Medicare?" and "Should I Enroll in Medicare?" please contact Medicare at 800-MEDICARE (800-633-4227), (TTY 877-486-2048) or at www.medicare.gov.

Please refer to page 113 for information about how we provide benefits when you are age 65 or older and do not have Medicare.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

- When we are the primary payor, we process the claim first.
- When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 800-410-7778 or see our website at www.MHBP.com.

We waive some costs if the Original Medicare Plan is your primary payor – We will waive some out-of-pocket costs as follows:

Standard Option

- When Medicare Part A is primary, we will waive applicable per-admission copayments and coinsurance for inpatient hospital benefits, inpatient mental health/substance use disorder benefits and nursing benefits.
- When Medicare Part B is primary, we will waive applicable deductibles, copayments and coinsurance for surgical and medical services billed by physicians, durable medical equipment, orthopedic and prosthetic appliances, ambulance services and outpatient mental health/substance use disorder services.

Note: We will not waive the copayments and coinsurance for prescription drugs.

Value Plan

- We will not waive any deductibles, copayments or coinsurance when you have Medicare Part A and/or B as your primary payor.

Please review the following table. It illustrates your cost share if you are enrolled in Medicare Part B. If you purchase Medicare Part B, your provider is in our network and participates in Medicare, then we waive some costs because Medicare will be the primary payor.

Benefit Description	Standard Option You pay without Medicare		Standard Option You pay with Medicare Part A & B	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	350/700	600/1,200/1,500	N/A	N/A
Catastrophic Protection **Out-of-pocket maximum**	6,000/12,000	9,000/18,000	6,000/12,000	9,000/18,000
Part B premium **reimbursement offered**	N/A	N/A	N/A	N/A
Primary care physician	$20 copay	30% of Plan allowance and any difference after deductible	Nothing	Nothing
Specialist	$30 copay	30% of Plan allowance and any difference after deductible	Nothing	Nothing
Inpatient hospital	$200 copay per admission	$500 copay per admission and any difference after deductible	Nothing	Nothing
Outpatient hospital	10% of Plan's allowance after calendar year deductible	30% of Plan allowance and any difference after deductible	Nothing	Nothing
Incentives offered	N/A	N/A	N/A	N/A

Call us at 800-410-7778 or visit our website at www.MHBP.com/member-resources/medicare-coordination for more information about how we coordinate benefits with Medicare.

- **Tell us about your Medicare coverage**

  You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Private contract with your physician**

  If you are enrolled in Medicare Part B, a physician may ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. Should you sign an agreement, Medicare will not pay any portion of the charges, and we will not increase our payment. We will still limit our payment to the amount we would have paid after Original Medicare's payment. You may be responsible for paying the difference between the billed amount and the amount we paid. We will not waive any deductibles, coinsurance or copayments when paying these claims.

- **Medicare Advantage (Part C)**

  If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about enrolling in a Medicare Advantage plan, contact Medicare at 800-MEDICARE 800-633-4227, TTY: 877-486-2048 or at www.Medicare.gov.

  If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area. However, we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage Plan, tell us. We will need to know whether you are in the Original Medicare Plan or in Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan. We will not waive any copayments or coinsurance when you have Medicare Part D as your primary payor.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

When you are age 65 or over and do not have Medicare

Under the FEHB law, we must limit our payments for **inpatient hospital care** and **physician care** to those payments you would be entitled to if you had Medicare. Your physician and hospital must follow Medicare rules and cannot bill you for more than they could bill you if you had Medicare. You and the FEHB benefit from these payment limits. Outpatient hospital and non-physician based care are not covered by this law; regular Plan benefits apply. The following chart has more information about the limits.

If you:

- are age 65 or over, and
- do not have Medicare Part A, Part B, or both; and
- have this Plan as an annuitant or as a former spouse, or as a family member of an annuitant or former spouse; and
- are not employed in a position that gives FEHB coverage. (Your employing office can tell you if this applies.

Then, for your inpatient hospital care:

- The law requires us to base our payment on an amount - the "equivalent Medicare amount" - set by Medicare's rules for what Medicare would pay, not on the actual charge.
- You are responsible for your applicable deductibles, coinsurance, or copayments under this Plan.
- You are not responsible for any charges greater than the equivalent Medicare amount; we will show that amount on the explanation of benefits (EOB) form that we send you.
- The law prohibits a hospital from collecting more than the "equivalent Medicare amount".

And, for your physician care, the law requires us to base our payment and your coinsurance or copayment on…

- an amount set by Medicare and called the "Medicare approved amount," or
- the actual charge if it is lower than the Medicare approved amount.

If your physician:	Then you are responsible for:
Participates with Medicare or accepts Medicare assignment for the claim and is a member of our Network,	your deductibles, coinsurance, and copayments;
Participates with Medicare and is **not** in our Network,	your deductibles, coinsurance, copayments, and any balance up to the Medicare approved amount;
Does not participate with Medicare,	your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount
Does not participate with Medicare and is not a member of our network	your Non-network deductibles, coinsurance, and any balance up to a 115% of the Medicare approved amount
Opts-out of Medicare via private contract	your deductibles, coinsurance, copayments and any balance your physician charges

It is generally to your financial advantage to use a physician who participates with Medicare. Such physicians are permitted to collect only up to the Medicare approved amount.

Physicians Who Opt-Out of Medicare

A physician may have opted-out for Medicare and may or may-not ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. This is different than a non-participating doctor, and we recommend you ask your physician if he or she has opted–out of Medicare. Should you visit an opt-out physician, the physician will not be limited to 115% of the Medicare approved amount. You may be responsible for paying the difference between the billed amount and our regular network/non-network benefits.

Our explanation of benefits (EOB) form will tell you how much the physician or hospital can collect from you. If your physician or hospital tries to collect more than allowed by law, ask the physician or hospital to reduce the charges. If you have paid more than allowed, ask for a refund. If you need further assistance, call us at 800-410-7778.

When you have the Original Medicare Plan (Part A, Part B, or both)

We limit our payment to an amount that supplements the benefits that Medicare would pay under Medicare Part A (Hospital insurance) and Medicare Part B (Medical insurance), regardless of whether Medicare pays. Note: We pay our regular benefits for emergency services to an institutional provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare.

We use the Department of Veterans Affairs (VA) Medicare-equivalent Remittance Advice (MRA) when the statement is submitted to determine our payment for covered services provided to you if Medicare is Primary, when Medicare does not pay the VA facility.

When you are covered by Medicare Part A and it is primary:

- **Standard Option**: We will waive applicable per-admission copayments and coinsurance for inpatient hospital benefits, inpatient mental health/substance use disorder benefits and nursing benefits.
- **Value Plan**: We will not waive any deductibles, copayments or coinsurance.

When you are covered by Medicare Part B and it is primary, your out-of-pocket costs for services that both Medicare Part B and we cover depend on whether your physician accepts Medicare assignment for the claim.

- **Standard Option**: When Medicare Part B is primary, we will waive applicable deductibles, copayments and coinsurance for surgical and medical services billed by physicians, durable medical equipment, orthopedic and prosthetic appliances, ambulance services and outpatient mental health/substance use disorder services. We will not waive the copayment and/or coinsurance for prescription drugs.
  - If your physician accepts Medicare assignment, you pay nothing for services that both Medicare and we cover.
  - If your physician does not accept Medicare assignment, you pay the difference between Medicare's "limiting charge" or the physician's actual charge (whichever is less) and our payment combined with Medicare's payment.
- **Value Plan**: We will not waive any deductibles, copayments or coinsurance.
  - If your physician accepts Medicare assignment, you pay the difference (if any) between Medicare's allowed amount and our payment combined with Medicare's payment.
  - If your physician does not accept Medicare assignment, you pay the difference between Medicare's "limiting charge" or the physician's actual charge (whichever is less) and our payment combined with Medicare's payment.

Note: We will not waive the copayment and/or coinsurance for prescription drugs.

Note: When Medicare benefits are exhausted or services are not covered by Medicare, our benefits are subject to the definitions, limitations and exclusions in this brochure.

It is important to know that a physician who does not accept Medicare assignment may not bill you for more than 115% of the amount Medicare bases its payment on, called the "limiting charge." The Medicare Summary Notice (MSN) that Medicare will send you will have more information about the limiting charge. If your physician tries to collect more than allowed by law, ask the physician to reduce the charges. If the physician does not, report the physician to the Medicare carrier that sent you the MSN form. Call us if you need further assistance.

Section 10. Definitions of Terms We Use in This Brochure

Accidental injury

A bodily injury sustained through external and accidental means, such as broken bones, animal bites, poisonings and injuries to sound natural teeth. Masticating (chewing) incidents are not considered to be accidental injuries.

Admission

The period from entry (admission) into a hospital or other covered facility until discharge. In counting days of inpatient care, the date of entry and the date of discharge are counted as the same day.

Assignment

An authorization by an enrollee or spouse for the Plan to issue payment of benefits directly to the provider. The Plan reserves the right to pay the member directly for all covered services.

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Cardiac rehabilitation

A comprehensive exercise, education, and behavioral modification program designed to improve the physical and emotional conditions of patients with heart disease. There are four phases of cardiac rehabilitation:

- Phase I begins in the hospital (inpatient) after experiencing a heart attack or other major heart event. During this phase, individuals receive a visit by a member of the cardiac rehabilitation team who provides education about their disease, recovery, personal encouragement, and nutritional counseling to prepare them for discharge.
- Phase II begins after leaving the hospital. As described by the U.S. Public Health Service, it is a comprehensive, long-term program that includes medical evaluation, prescribed exercise, cardiac risk factor modification, education and counseling. Phase II refers to constant medically supervised programs that typically begin one to three weeks after discharge and provide appropriate electrocardiographic monitoring. Phase 2 may last 3 to 6 months.
- Phase III utilizes a supervised program that encourages exercise and healthy lifestyle and is usually performed at home or in a fitness center with the goal of continuing the risk factor modification and exercise program learned in phase II.
- Phase IV is based on an indefinite exercise program. These programs encourage a commitment to regular exercise and healthy habits for risk factor modification, such as tobacco cessation, stress reduction, nutrition and weight loss, to establish lifelong cardiovascular fitness. Some programs combine phases III and IV.

Clinical trials cost categories

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either Federally-funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See Section 4.

Congenital anomaly

A condition existing at or from birth which is a significant deviation from the common form or norm. For purposes of this Plan, congenital anomalies include protruding ear deformities, cleft lips, cleft palates, birthmarks, webbed fingers or toes, and other conditions that the Plan may determine to be congenital anomalies. In no event will the term congenital anomaly include conditions relating to teeth or intraoral structures supporting the teeth.

Convenient care clinic

A small healthcare facility, usually located in a high-traffic retail outlet, with a limited pharmacy, that provides non-emergency health care on a walk-in basis. Examples include MinuteClinics in CVS retail stores and Take Care Health clinics at Walgreen's. Convenient care clinics are different from Urgent care centers (See *Urgent care center* at the end of this section.)

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See Section 4.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Covered services

Services we provide benefits for, as described in this brochure.

Custodial care

The Plan determines what services are custodial in nature. Custodial care that lasts 90 days or more is sometimes known as Long term care. For instance, the following are considered custodial services:

- Help in walking; getting in and out of bed; bathing; eating (including help with tube feeding or gastrostomy) exercising and dressing;
- Homemaking services such as making meals or special diets;
- Moving the patient;
- Acting as companion or sitter;
- Supervising medication when it can be self-administered; or·
- Services that anyone with minimal instruction can do, such as taking a temperature, recording pulse, respiration or administration and monitoring of feeding systems.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See Section 4.

Experimental or investigational services

A drug, device, or biological product is experimental or investigational if the drug, device, or biological product cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time it is furnished. Approval means all forms of acceptance by the FDA.

A medical treatment or procedure, or a drug, device, or biological product is experimental or investigational if 1) reliable evidence shows that it is the subject of ongoing phase I, II, or III clinical trial or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or 2) reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or biological product or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol (s) of another facility studying substantially the same drug, device, biological product, or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, biological product, or medical treatment or procedure.

If you wish additional information concerning the experimental/investigational determination process, please contact the Plan.

Genetic screening	The diagnosis, prognosis, management, and prevention of genetic disease for those patients who have no current evidence or manifestation of a genetic disease and those who we have not determined to have an inheritable risk of genetic disease.
Genetic testing	The diagnosis and management of genetic disease for those patients with current signs and symptoms, and for those who we have determined to have an inheritable risk of genetic disease.
Group health coverage	Health care coverage that a member is eligible for because of employment, by membership in, or connection with, a particular organization or group that provides payment for hospital, medical, or other health care services or supplies, or that pays a specific amount for each day or period of hospitalization if the specified amount exceeds $200 per day, including extension of any of these benefits through COBRA.
Health care professional	A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.
Hospice care program	A formal program directed by a doctor to help care for a terminally ill person. The services may be provided through either a centrally-administered, medically-directed, and nurse-coordinated program that provides primarily home care services 24 hours a day, seven days a week by a hospice team that reduces or abates mental and physical distress and meets the special stresses of a terminal illness, dying and bereavement, or through confinement in a hospice care program. The hospice team must include a doctor and a nurse (R.N.) and also may include a social worker, clergyman/counselor, volunteer, clinical psychologist, physical therapist, or occupational therapist.
Incurred	An expense is incurred on the date a service or supply is rendered or received unless otherwise noted in this brochure.
Infertility	The inability to conceive after 12 months of unprotected intravaginal sexual relations (or 12 cycles of artificial insemination) for women under age 35, and 6 months of unprotected intravaginal sexual relations (or 6 cycles of artificial insemination) for women age 35 and over.
Inpatient care	Inpatient care is rendered to a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that the patient will remain at least overnight and occupy a bed. The hospital bills for inpatient room and board charges for each day (24 hour period) of the inpatient confinement as well as for hospital incidental services. Inpatient hospital benefits apply to services provided by the hospital during an inpatient admission. We make our determination based on nationally recognized clinical guidelines and standard criteria sets.
Intensive outpatient treatment	Intensive outpatient treatment programs must be licensed to provide mental health and/or substance use treatment. Services must be provided for at least two hours per day and may include group, individual, and family therapy along with psychoeducational services and adjunctive psychiatric medication management.
Medical emergency	The sudden and unexpected onset of a condition requiring immediate medical care. The severity of the condition, as revealed by the doctor's diagnosis, must be such as would normally require emergency care. Medical emergencies include heart attacks, cardiovascular accidents, loss of consciousness or respiration, convulsions and such other acute conditions as may be determined by the Plan to be medical emergencies.
Medical necessity	Services, drugs, supplies, or equipment provided by a hospital or covered provider of health care services that the Plan determines: 1. are appropriate to diagnose or treat the patient's condition, illness, or injury; 2. are consistent with standards of good medical practice in the United States; 3. are not primarily for the personal comfort or convenience of the patient, the family, or the provider;

4. are not a part of or associated with the scholastic education or vocational training of the patient; and
5. in the case of inpatient care, cannot be provided safely on an outpatient basis.

The fact that a covered provider has prescribed, recommended, or approved a service, supply, drug or equipment does not, in itself, make it medically necessary.

Mental health/substance use disorder

Conditions and diseases listed in the most recent edition of the International Classification of Diseases (ICD) as Mental, Behavioral, and Neurodevelopmental disorders.

Morbid obesity

A diagnosed condition in which the bodymass index is 40 or greater, or 35 or greater with co-morbidities such as diabetes, coronary artery disease, hypertension, hyperlipidemia, obstructive sleep apnea, pulmonary hypertension, weight-related degenerative joint disease, or lower extremity venous or lymphatic obstruction. Eligible members must be age 18 or older.

Observation care

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are provided while a decision is being made regarding whether a patient will require further treatment as a hospital inpatient or whether the patient will be able to be discharged from the hospital. Observation services are commonly ordered for a patient who presents to the emergency room department and who then requires a significant period of treatment or monitoring in order to make a decision regarding their inpatient admission or discharge. Some hospitals will bill for observation room status (hourly) and hospital incidental services.

If you are in the hospital for more than a few hours, always ask your physician or the hospital staff if your stay is consider inpatient or outpatient. Although you may stay overnight in a hospital room and receive meals and other hospital services, some hospital services-including "observation care"- are actually outpatient care. Since observation services are billed as outpatient care, outpatient facility benefit levels apply and your out-of-pocket expenses may be higher as a result.

We make our determination based on nationally recognized clinical guidelines and standard criteria sets.

Orthopedic appliance

Any custom fitted external device used to support, align, prevent, or correct deformities, or to restore or improve function.

Partial hospitalization

Partial hospitalization programs must be licensed to provide mental health and/or substance use treatment. Services must be at least four hours per day and may include group, individual, and family therapy along with psychoeducational services and adjunctive medication management.

Plan allowance

Our Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Fee-for-service plans determine their allowances in different ways. We determine our allowance as follows:

Network allowance: an amount that we negotiate with each provider or provider group who participates in our network. For these Network allowances, the Network provider has agreed to accept the negotiated reduction and you are not responsible for the discounted amount. In these instances, the benefit we pay plus any applicable deductible, copayment or coinsurance you are responsible for equals payment in full.

Non-Network allowance: the amount the Plan will consider for services provided by Non-Network providers. Non-Network allowances are determined as follows:

Our Plan allowance is the lesser of: (1) the provider's billed charge; or (2) the Plan's Non-Network fee schedule amount. The Plan's Non-Network fee schedule amount is equal to the 80th percentile amount for the charges listed in the Prevailing Healthcare Charges System, administered by Fair Health, Inc. The Non-Network fee schedule amounts vary by geographic area in which services are furnished. We base our coinsurance of this Non-Network fee schedule amount. This applies to all benefits in Section 5 of this brochure.

For certain services, exceptions may exist to the use of the Non-Network fee schedule to determine the Plan's allowance for Non-Network providers, including, but not limited to, the use of Medicare fee schedule amounts. For claims governed by OBRA '90 and '93, the Plan allowance will be based on Medicare allowable amounts as is required by law. For claims where the Plan is the secondary payer to Medicare (Medicare COB situations), the Plan allowance is the Medicare allowable charge.

If you do not have adequate choice in selecting Network providers, please contact us prior to receiving services at 800-410-7778 for more information about Non-Network providers.

For all dialysis services and all urine drug testing services, the Non-Network allowance is the maximum Medicare allowance for such services.

Other Non-Network Participating Provider allowance:

This Plan offers you access to certain other Non-Network health care providers that have agreed to discount their charges. Covered services at these participating providers are considered at the negotiated rate subject to applicable deductibles, copayments, and coinsurance. Since these other participating providers are not Network providers, Non-Network benefit levels will apply. Contact us at 800-410-7778 for more information about other Non-Network participating providers.

For services received from other participating providers (see Other Participating Providers), the Plan's allowance will be the amount the provider has negotiated and agreed to accept for the services and/or supplies. Benefits will be paid at Non-Network benefit levels, subject to the applicable deductibles, coinsurance and copayments.

Network retail pharmacy allowance: the amount negotiated by the Plan's pharmacy benefit manager with the pharmacy or pharmacy group at which the drug is purchased.

Non-Network retail pharmacy allowance: the guaranteed discounted price for the drug negotiated by the Plan in its contract with its pharmacy benefit manager.

Allowance for drugs provided by Network providers: the amount negotiated with each Network provider or provider group.

Allowance for drugs provided by Non-Network providers:

- 80% of the Average Wholesale Price (AWP) of the drug (or its equivalent if AWP data is no longer published)

We apply Aetna claim editing criteria and/or the National Correct Coding Initiative (NCCI) edits published by the Centers for Medicare and Medicaid Services (CMS) in reviewing billed services and making Plan benefit payments for them.

For more information, see Section 4, *Differences between our allowance and the bill.*

Post-service claims Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Prosthetic appliance An artificial substitute for a missing body part such as an arm, eye, or leg. This appliance may be used for a functional or cosmetic reason, or both.

Reimbursement — A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

Routine services — Services that are not related to any specific illness, injury, set of symptoms or maternity care.

Scooters — A power-operated vehicle (chair or cart) with a base that may extend beyond the edge of the seat, a tiller-type control mechanism which is usually center mounted and an adjustable seat that may or may not swivel.

Sound Natural Tooth — A tooth that has sound root structure and an intact, complete layer of enamel or has been properly restored with a material or materials approved by the ADA and has healthy bone and periodontal tissue.

Subrogration — A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

Urgent care center — An ambulatory care center, outside of a hospital emergency department, that provides treatment for medical conditions that are not life-threatening, but need quick attention, on a walk-in basis.

Urgent care claims — A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve pre-service claims and not post-service claims. We will determine whether or not a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service department at 800-410-7778. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We — Us and We refer to MHBP (Mail Handlers Benefit Plan).

You — You refers to the enrollee and each covered family member.

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Summary of MHBP Standard Option Benefits – 2021

Do not rely on this chart alone. This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.MHBP.com.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Below, an asterisk (*) means the item is subject to the calendar year medical deductible of $350 per person (Network)/$600 per person (Non-Network). And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a Non-Network physician or other health care professional.

Standard Option Benefits	You pay	Page(s)
Medical services provided by physicians		
Diagnostic and treatment services provided in the office	Network: • Primary care physician: $20 copayment per office visit for adults; $10 copayment per office visit for dependent children through age 21; • Specialty physician: $30 copayment per visit • Diagnostic X-rays, laboratory services and other professional services: 10%* of the Plan's allowance Non-Network: • Primary care physician and Specialty physician: 30%* of the Plan's allowance and any difference between our allowance and the billed amount • Diagnostic X-rays, laboratory services and other professional services: 30%* of the Plan's allowance and any difference between our allowance and the billed amount	29
Services provided by a hospital		
• Inpatient	Network: $200 copayment per admission and 10% of the Plan's allowance for hospital ancillary services (No deductible) Non-Network: $500 copayment per admission; 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)	63
• Outpatient	Network: 10%* of the Plan's allowance Non-Network: 30%* of the Plan's allowance and any difference between our allowance and the billed amount	66
Emergency benefits		
• Accidental injury	Network: • Emergency room: $200 copayment per occurrence • Urgent care center: $50 copayment per occurrence Non-Network: • Emergency room: $200 copayment per occurrence and any difference between our allowance and the billed amount • Urgent care center: 30%* of the Plan's allowance and any difference between our allowance and the billed amount	71

Standard Option Benefits	You pay	Page(s)
• Medical emergency	Network: • Emergency room: $200 copayment per occurrence* • Urgent care center: $50 copayment per occurrence* Non-Network: • Emergency room: $200 copayment* per occurrence and any difference between our allowance and the billed amount • Urgent care center: 30%* of the Plan's allowance and any difference between our allowance and the billed amount	72
Mental health and substance use disorder treatment	Your cost-sharing responsibilities are no greater than for other illnesses or conditions	75
Prescription drugs	Network retail: • Generic: $5 copayment per prescription • Preferred brand name: 30% of the Plan's allowance (25% when enrolled in Medicare Part B) and any difference between our allowance and the cost of a generic equivalent unless a brand exception is obtained, limited to $200 per prescription • Non-Preferred brand name: 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, limited to $200 per prescription Non-Network retail: • Generic: $5 copayment per prescription and any difference between our allowance and the billed amount • Preferred brand name: 30% of the Plan's allowance (25% when enrolled in Medicare Part B) and any difference between our allowance and the cost of a generic equivalent unless a brand exception is obtained • Non-Preferred brand name: 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 Mail order drug program: • Generic: $10 copayment per prescription • Preferred brand name: $80 copayment ($60 copayment when enrolled in Medicare Part B) per prescription and any difference between our allowance and the cost of a generic equivalent unless a brand exception in obtained. • Non-Preferred brand name: $120 copayment per prescription and any difference between our allowance and the cost of a generic equivalent unless a brand exception is obtained. Specialty drugs: 15% of the Plan's allowance, limited to $200 per prescription for a 30-day supply; 15% of the Plan's allowance, limited to $425 per prescription for a 90-day supply	80
Dental care	Accidental injury; Oral surgery	88

Standard Option Benefits	You pay	Page(s)
Special Features	Aetna In Touch CareSM Program; Pain Management Program, Flexible Benefits Option; Compassionate Care program; Health Risk Assessment; Wellness Incentives; Health Coaching programs; Personal Health Record; ExtraCare Health Card; Discount Drug program; Round-the-clock Member Support	89
Protection against catastrophic costs (out-of-pocket maximum)	Nothing after your covered medical and prescription drug expenses total: • $6,000/person ($12,000/family) per calendar year, for services, drugs and supplies from Network providers/facilities and pharmacies, combined • $9,000/person ($18,000/family) for services drugs and supplies from Non-Network providers/facilities and pharmacies, combined Some costs do not count toward this protection.	25

Summary of MHBP Value Plan Benefits – 2021

Do not rely on this chart alone. This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.MHBP.com.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Below, an asterisk (*) means the item is subject to the calendar year medical deductible of $600 per person (Network)/$900 per person (Non-Network). And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a Non-Network physician or other health care professional.

Value Plan Benefits	You pay	Page(s)
Medical services provided by physicians		
Diagnostic and treatment services provided in the office	Network: • Primary care physician: $30 copayment per office visit for adults; $10 copayment per office visit for dependent children through age 21 • Specialty physician: $50 copayment* per office visit • Diagnostic X-rays, laboratory services and other professional services: 20%* of the Plan's allowance Non-Network: • Primary care physician and Specialty physician: 40%* of the Plan's allowance and any difference between our allowance and the billed amount • Diagnostic X-rays, laboratory services and other professional services: 40%* of the Plan's allowance and any difference between our allowance and the billed amount	29
Services provided by a hospital		
• Inpatient	Network: 20%* of the Plan's allowance Non-Network: 40%* of the Plan's allowance and any difference between our allowance and the billed amount	63
• Outpatient	Network: 20%* of the Plan's allowance Non-Network: 40%* of the Plan's allowance and any difference between our allowance and the billed amount	66
Emergency benefits		
• Accidental injury/Medical emergency	Network: • Emergency room: 20%* of the Plan's allowance • Urgent care center: 20% of thePlan's allowance for an accidental injury; 20%* of the Plan's allowance for a medical emergency Non-Network: • Emergency room: 20%* of the Plan's allowance and any difference between our allowance and the billed amount • Urgent care center: 40%* of the Plan's allowance and any difference between our allowance and the billed amount	71-72

Value Plan Benefits	You pay	Page(s)
Mental health and substance use disorder treatment	Your cost-sharing responsibilities are no greater than for other illnesses or conditions	75
Prescription drugs	Network retail: • Generic: $10 copayment per prescription • Preferred brand name: 45% of the Plan's allowance and any difference between our allowance and the cost of a generic equivalent unless a brand exception is obtained; limited to $300 per prescription • Non-Preferred brand name: 75% of the Plan's allowance, and any difference between our allowance and the cost of a generic equivalent unless a brand exception is obtained; limited to $500 per prescription Non-Network retail: All charges Mail order drug program: • Generic: $30 copayment per prescription • Preferred brand name: 45% of the Plan's allowance and any difference between our allowance and the cost of a generic equivalent unless a brand exception is obtained; limited to $300 per prescription • Non-Preferred brand name: 75% of the Plan's allowance, and any difference between our allowance and the cost of a generic equivalent unless a brand exception is obtained; limited to $700 per prescription Specialty drugs: 50% of the Plan's allowance; limited to $600 per prescription for a 30-day supply; limited to $800 per prescription for a 90-day supply	80
Dental care	Accidental injury; Oral surgery	88
Special features	Aetna In Touch CareSM Program; Pain Management Program, Flexible Benefits Option; Compassionate Care program; Health Risk Assessment; Wellness Incentives; Health Coaching programs; Personal Health Record; ExtraCare Health Card; Discount Drug program; Round-the-clock Member Support	89
Protection against catastrophic costs (out-of-pocket maximum)	Nothing after your covered medical and prescription drug expenses total: • $6,600/person ($13,200/family) per calendar year, for services, drugs and supplies from Network providers/facilities and pharmacies • $10,000/person ($20,000/family) for services from Non-Network providers/facilities Some costs do not count towards this protection.	25

Notes

2021 MHBP Standard Option and Value Plan Rate Information

To compare your FEHB health plan options please go to www.opm.gov/fehbcompare.

To review premium rates for all FEHB health plan options, please go to www.opm.gov/FEHBpremiums or www.opm.gov/Tribalpremium.

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, contact the agency that maintains your health benefits enrollment.

Postal rates apply to certain United States Postal Service employees as follows:

- **Postal Category 1** rates apply to career bargaining unit employees who are represented by the following agreement: NALC.
- **Postal Category 2 rates** apply to career bargaining unit employees who are represented by the following agreement: PPOA.

Non-Postal rates apply to all career non-bargaining unit Postal Service employees and career bargaining unit employees who are represented by the following agreements: APWU, IT/AS, NPMHU, NPPN and NRLCA. Postal rates do not apply to non-career Postal employees, Postal retirees, and associate members of any Postal employee organization who are not career Postal employees.

If you are a Postal Service employee and have questions or require assistance, please contact:

USPS Human Resources Shared Service Center: 1-877-477-3273, option 5, Federal Relay Service 1-800-877-8339.

Premiums for Tribal employees are shown under the monthly non-Postal column. The amount shown under employee contribution is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
Nationwide							
Standard Option Self Only	454	$215.39	$71.80	$466.69	$155.56	$68.93	$59.59
Standard Option Self Plus One	456	$495.80	$165.26	$1,074.23	$358.07	$158.65	$137.17
Standard Option Self and Family	455	$500.56	$166.85	$1,084.55	$361.51	$160.18	$138.49
Nationwide							
Value Option Self Only	414	$160.06	$53.35	$346.79	$115.60	$51.22	$44.28
Value Option Self Plus One	416	$379.24	$126.41	$821.69	$273.89	$121.36	$104.92
Value Option Self and Family	415	$386.81	$128.94	$838.10	$279.36	$123.78	$107.02